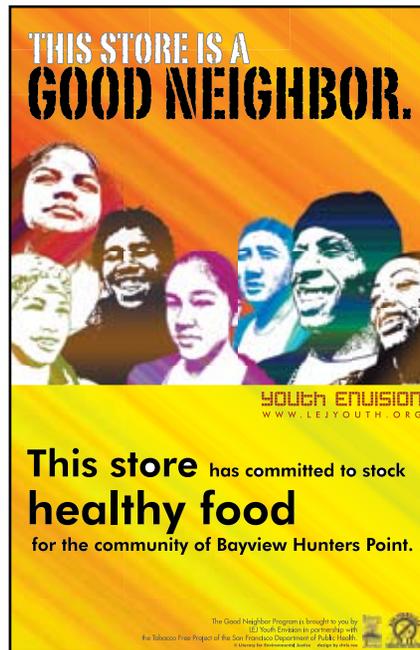


# Promoting Health Equity

*A Resource to Help Communities Address  
Social Determinants of Health*





Cover art is based on original art by Chris Ree developed for the Literacy for Environmental Justice/Youth Envision Good Neighbor program, which addresses links between food security and the activities of transnational tobacco companies in low-income communities and communities of color in San Francisco. In partnership with city government, community-based organizations, and others, Good Neighbor provides incentives to inner-city retailers to increase their stocks of fresh and nutritious foods and to reduce tobacco and alcohol advertising in their stores (see Case Study # 6 on page 24. Adapted and used with permission.).

# Promoting Health Equity

## *A Resource to Help Communities Address Social Determinants of Health*

Laura K. Brennan Ramirez, PhD, MPH  
Transtria LLC.

Elizabeth A. Baker, PhD, MPH  
Saint Louis University School of Public Health

Marilyn Metzler, RN  
Centers for Disease Control and Prevention

This document is published in partnership  
with the Social Determinants of Health  
Work Group at the Centers for Disease  
Control and Prevention, U.S. Department of  
Health and Human Services.

### **Suggested Citation**

Brennan Ramirez LK, Baker EA, Metzler M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008.

### **For More Information**

E-mail: [ccdinfo@cdc.gov](mailto:ccdinfo@cdc.gov).

Mail: Community Health and Program Services Branch  
Division of Adult and Community Health  
National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention  
4770 Buford Highway, Mail Stop K-30  
Atlanta, GA 30041

E-mail: [laura@transtria.com](mailto:laura@transtria.com)

Mail: Laura Brennan Ramirez, Transtria L.L.C.  
6514 Lansdowne Avenue  
Saint Louis, MO 63109

Online: This publication is available at  
<http://www.cdc.gov/nccdphp/dach/chaps>  
and <http://www.transtria.com>.

### **Acknowledgements**

The authors would like to thank the following people for their valuable contributions to the publication of this resource: the workshop participants (listed on page 5), Lynda Andersen, Ellen Barnidge, Adam Becker, Joe Benitez, Julie Claus, Sandy Ciske, Tonie Covelli, Gail Gentling, Wayne Giles, Melissa Hall, Donna Higgins, Bethany Young Holt, Jim Holt, Bill Jenkins, Margaret Kaniewski, Joe Karolczak, Leandris Liburd, Jim Mercy, Eveliz Metellus, Amanda Navarro, Geraldine Perry, Amy Schulz, Eduardo Simoes, Kristine Suozzi and Karen Voetsch. A special thanks to Innovative Graphic Services for the design and layout of this book.

### **This resource was developed with support from:**

- National Center for Chronic Disease Prevention and Health Promotion  
Division of Adult and Community Health  
Prevention Research Centers  
Community Health and Program Services Branch
  
- National Center for Injury Prevention and Control

Web site addresses of nonfederal organizations are provided solely as a service to our readers. Provision of an address does not constitute an endorsement of an organization by CDC or the federal government, and none should be inferred. CDC is not responsible for the content of other organizations' web pages.

## Table of Contents

**Introduction** p.4

**Participants** p.5

**Chapter One: Achieving Health Equity** p.6

What is health equity? p.6

How do social determinants influence health? p.10

Learning from doing p.11

**Chapter Two: Communities Working to Achieve Health Equity** p.12

Background: The Social Determinants of Disparities in Health Forum p.12

Small-scale program and policy initiatives p.14

Case Study 1: Project Brotherhood p.14

Case Study 2: Poder Es Salud (Power for Health) p.16

Case Study 3: Project BRAVE: Building and Revitalizing an Anti-Violence Environment p.18

Traditional public health program and policy initiatives p.20

Case Study 4: Healthy Eating and Exercising to Reduce Diabetes p.20

Case Study 5: Taking Action: The Boston Public Health Commission's Efforts to Undo Racism p.22

Case Study 6: The Community Action Model to Address Disparities in Health p.24

Large-scale program and policy initiatives p.26

Case Study 7: New Deal for Communities p.26

Case Study 8: From Neurons to King County Neighborhoods p.28

Case Study 9: The Delta Health Center p.30

**Chapter Three: Developing a Social Determinants of Health Inequities Initiative in Your Community** p.32-89

Section 1: Creating Your Partnership to Address Social Determinants of Health p.34

Section 2: Focusing Your Partnership on Social Determinants of Health p.42

Section 3: Building Capacity to Address Social Determinants of Health p.54

Section 4: Selecting Your Approach to Create Change p.58

Section 5: Moving to Action p.76

Section 6: Assessing Your Progress p.82

Section 7: Maintaining Momentum p.88

**Chapter Four: Closing Thoughts** p.90

### Tables

Table 1.1: Examples of Health Disparities by Racial/Ethnic Group or by Socioeconomic Status p.7

Table 1.2: Social Determinants by Populations p.8

Table 3.1: Applying Assessment Methods to Different Types of Social Determinants p.47

### Figures

Figure 1.1: Pathways from Social Determinants to Health p.10

Figure 1.2: Growing Communities: Social Determinants, Behavior, and Health p.11

Figure 3.1: Phases of a Social Determinants of Health Initiative p.33

**Suggested Readings and Resources** p.92

**References** p.106

## Introduction

This workbook is for public health practitioners and partners interested in addressing social determinants of health in order to promote health and achieve health equity. In its 1988 landmark report, and again in 2003 in an updated report,<sup>1,2</sup> the Institute of Medicine defined public health as “what we as a society do to collectively assure the conditions in which people can be healthy.”

Early efforts to describe the relationship between these conditions and health or health outcomes focused on factors such as water and air quality and food safety.<sup>3</sup> More recent public health efforts, particularly in the past decade, have identified a broader array of conditions affecting health, including community design, housing, employment, access to health care, access to healthy foods, environmental pollutants, and occupational safety.<sup>4</sup>

The link between social determinants of health, including social, economic, and environmental conditions, and health outcomes is widely recognized in the public health literature. Moreover, it is increasingly understood that inequitable distribution of these conditions across various populations is a significant contributor to persistent and pervasive health disparities.<sup>5</sup>

One effort to address these conditions and subsequent health disparities is the development of national guidelines, Healthy People 2010 (HP 2010). Developed by the U.S. Department of Health and Human Services, HP 2010 has the vision of “healthy people living in healthy communities” and identifies two major goals: increasing the quality and years of healthy life and eliminating health disparities. To achieve this vision, HP 2010 acknowledges “that communities, States, and national organizations will need to take a multidisciplinary approach to achieving health equity – an approach that involves improving health, education, housing, labor, justice, transportation, agriculture, and the environment, as well as data collection itself” (p.16). To be successful, this approach requires community-, policy-, and system-level changes that combine social, organizational, environmental, economic, and policy strategies along with individual behavioral change and clinical services.<sup>6</sup> The approach also requires developing partnerships with groups that traditionally may not have been part of public health initiatives, including community organizations and representatives from government, academia, business, and civil society.

This workbook was created to encourage and support the development of new and the expansion of existing, initiatives and partnerships to address the social determinants of health inequities. Content is drawn from [Social Determinants of Disparities in Health: Learning from Doing](#), a forum sponsored by the U.S. Centers for Disease Control and Prevention in October 2003. Forum participants included representatives from community organizations, academic settings, and public health practice who have experience developing, implementing, and evaluating interventions to address conditions contributing to health inequities. The workbook reflects the views of experts from multiple arenas, including local community

**“Inequalities in health status in the U.S. are large, persistent, and increasing. Research documents that poverty, income and wealth inequality, poor quality of life, racism, sex discrimination, and low socioeconomic conditions are the major risk factors for ill health and health inequalities... conditions such as polluted environments, inadequate housing, absence of mass transportation, lack of educational and employment opportunities, and unsafe working conditions are implicated in producing inequitable health outcomes. These systematic, avoidable disadvantages are interconnected, cumulative, intergenerational, and associated with lower capacity for full participation in society....Great social costs arise from these inequities, including threats to economic development, democracy, and the social health of the nation.”<sup>7</sup>**

knowledge, public health, medicine, social work, sociology, psychology, urban planning, community economic development, environmental sciences, and housing. It is designed for a wide range of users interested in developing initiatives to increase health equity in their communities. The workbook builds on existing resources and highlights lessons learned by communities working toward this end. Readers are provided with information and tools from these efforts to develop, implement, and evaluate interventions that address social determinants of health equity.

We hope you will join us in learning from doing.

## Participants

October 28–29, 2003

### Social Determinants of Disparities in Health: Learning From Doing

**Alex Allen**

Community Planning & Research Isles, Inc.  
Trenton, NJ

**Alma Avila**

San Francisco Department of Public Health  
San Francisco, CA

**Elizabeth Baker**

Saint Louis University  
Saint Louis, MO

**Adam Becker**

Tulane University  
New Orleans, LA

**Rajiv Bhatia**

San Francisco Department of Public Health  
San Francisco, CA

**Judy Bigby**

Brigham and Women's Hospital  
Boston, MA

**Angela Glover Blackwell**

PolicyLink  
Oakland, CA

**Laura Brennan Ramirez**

Transtria LLC  
Saint Louis, MO

**Gregory Button**

University of Michigan School of Public Health  
Ann Arbor, MI

**Cleo Caldwell**

University of Michigan School of Public Health  
Ann Arbor, MI

**Sandy Ciske**

Public Health - Seattle & King County  
Seattle, WA

**Stephanie Farquhar**

School of Community Health  
Portland, OR

**Stephen B. Fawcett**

University of Kansas  
Lawrence, KS

**Barbara Ferrer**

Boston Public Health Commission  
Boston, MA

**Nick Freudenberg**

Hunter College  
New York, NY

**Sandro Galea**

New York Academy of Medicine  
New York, NY

**H. Jack Geiger**

City University of New York Medical School  
New York, NY

**Gail Gentling**

Minnesota Department of Health  
Saint Paul, MN

**Virginia Bales Harris**

Centers for Disease Control and Prevention  
Atlanta, GA

**Kathryn Horsley**

Public Health - Seattle & King County  
Seattle, WA

**Ken Judge**

University of Glasgow  
Glasgow, United Kingdom

**Margaret Kaniewski**

Centers for Disease Control and Prevention  
Atlanta, GA

**James Krieger**

Public Health - Seattle and King County  
Seattle, WA

**Alicia Lara**

The California Endowment  
Woodland Hills, CA

**Susana Hennessey Lavery**

San Francisco Department of Public Health  
San Francisco, CA

**E. Yvonne Lewis**

Faith Access to Community Economic  
Development  
Flint, MI

**Marilyn Metzler**

Centers for Disease Control and Prevention  
Atlanta, GA

**Yvonne Michael**

Oregon Health and Sciences University  
Portland, OR

**Linda Rae Murray**

Project Brotherhood/Woodlawn Health Center  
Chicago, IL

**Ann-Gel Palermo**

Mount Sinai School of Medicine  
New York, NY

**Jayne Parry**

University of Birmingham  
Birmingham, United Kingdom

**Jim Randels**

Project Director, Students at the Center  
New Orleans, LA

**William J. Ridella**

Detroit Health Department  
Detroit, MI

**Amy Schulz**

University of Michigan  
Ann Arbor, MI

**Eduardo Simoes**

Centers for Disease Control and Prevention  
Atlanta, GA

**Mele Lau Smith**

San Francisco Department of Public Health  
San Francisco, CA

**Kristine Suozzi**

Bernalillo County Office of Environment  
Health  
Albuquerque, NM

**Bonnie Thomas**

Project Brotherhood/Woodlawn Health Center  
Chicago, IL

**Susan Tortolero**

Science Center at Houston School of  
Public Health  
Houston, TX

**Junious Williams**

Urban Strategies Council  
Oakland, CA

**Mildred Williamson**

Project Brotherhood/Woodlawn Health Center  
Chicago, IL

# Achieving Health Equity

## What is health equity?

A basic principle of public health is that all people have a right to health.<sup>8</sup> Differences in the incidence and prevalence of health conditions and health status between groups are commonly referred to as health disparities (see Table 1.1).<sup>9</sup> Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in such groups not only experience worse health but also tend to have less access to the social determinants or conditions (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination) that support health (see Table 1.2). Health disparities are referred to as health inequities when they are the result of the systematic and unjust distribution of these critical conditions. Health equity, then, as understood in public health literature and practice, is when everyone has the opportunity to “attain their full health potential” and no one is “disadvantaged from achieving this potential because of their social position or other socially determined circumstance.”<sup>10</sup>

**“Social determinants of health are life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines length and quality of life.”<sup>11</sup>**

**Table 1.1: Examples of Health Disparities by Racial/Ethnic Group or by Socioeconomic Status**

<p><b>Infant mortality</b></p>	<p>Infant mortality increases as mother’s level of education decreases. In 2004, the mortality rate for infants of mothers with less than 12 years of education was 1.5 times higher than for infants of mothers with 13 or more years of education.<sup>12,13</sup></p>
<p><b>Cancer deaths</b></p>	<p>In 2004, the overall cancer death rate was 1.2 times higher among African Americans than among Whites.<sup>12,13</sup></p>
<p><b>Diabetes</b></p>	<p>As of 2005, Native Hawaiians or other Pacific Islanders (15.4%), American Indians/Alaska Natives (13.6%), African Americans (11.3%), Hispanics/Latinos (9.8%) were all significantly more likely to have been diagnosed with diabetes compared to their White counterparts (7%).<sup>14</sup></p>
<p><b>HIV/AIDS</b></p>	<p>African Americans, who comprise approximately 12% of the US population, accounted for half of the HIV/AIDS cases diagnosed between 2001 and 2004.<sup>12</sup> In addition, African Americans were almost 9 times more likely to die of AIDS compared to Whites in 2004.<sup>12,13</sup></p>
<p><b>Tooth decay</b></p>	<p>Between 2001 and 2004, more than twice as many children (2–5 years) from poor families experienced a greater number of untreated dental caries than children from non-poor families. Of those children living below 100% of poverty level, Mexican American children (35%) and African American children (26%) were more likely to experience untreated dental caries than White children (20%).<sup>12,13</sup></p>
<p><b>Injury</b></p>	<p>In 2004, American Indian or Alaska Native males between 15–24 years of age were 1.2 times more likely to die from a motor vehicle-related injury and 1.6 times more likely to die from suicide compared to White males of the same age.<sup>12,13</sup></p>

**Table 1.2: Social Determinants by Populations \***

<p><b>Access to care</b></p>	<ul style="list-style-type: none"> <li>• In 2006, adults with less than a high school degree were 50% less likely to have visited a doctor in the past 12 months compared to those with at least a bachelor’s degree. In addition, Asian American and Hispanic adults (75% and 68%, respectively) were less likely to have visited a doctor or other health professional in the past year compared to White adults (79%).<sup>15</sup></li> <li>• In 2004, African Americans and American Indian or Alaska Natives were approximately 1.3 times more likely to visit the emergency room at least once in the past 12 months compared to Whites.<sup>12</sup></li> </ul>
<p><b>Insurance coverage</b></p>	<ul style="list-style-type: none"> <li>• In 2007, Hispanics were 3 times more likely to be uninsured than non-Hispanic Whites (31% versus 10%, respectively).<sup>15</sup></li> <li>• In 2007, people in families with income below the poverty level were 3 times more likely to be uninsured compared to people with family income more than twice the poverty level.<sup>12</sup></li> <li>• Residents of nonmetropolitan areas are more likely to be uninsured or covered by Medicaid and less likely to have private insurance coverage than residents of metropolitan areas.<sup>12</sup></li> </ul>
<p><b>Employment</b></p>	<ul style="list-style-type: none"> <li>• As of December 2007, the unemployment rate varied substantially by racial/ethnic group (4% among Whites, 6% among Hispanics/Latinos, and 9% among African Americans) and by age and gender (4.5% among adult men, 4.9% among adult women, and 15.4% among teenagers).<sup>16</sup></li> <li>• In 2007, African Americans and Hispanics/Latinos were more likely to be unemployed compared to their White counterparts.<sup>16</sup> Further, adults with less than a high school education were 3 times more likely to be unemployed than those with a bachelor’s degree.<sup>16</sup></li> </ul>
<p><b>Education</b></p>	<ul style="list-style-type: none"> <li>• Since the Elementary and Secondary Education Act first passed Congress in 1965, the federal government has spent more than \$321 billion (in 2002 dollars) to help educate disadvantaged children. Yet nearly 40 years later, only 33% of fourth-graders are proficient readers at grade level.<sup>17</sup> While the reading performance of most racial/ethnic groups has improved over the past 15 years, minority children and children from low-income families are significantly more likely to have a below basic reading level.<sup>18</sup></li> <li>• According to the National Assessment of Adult Literacy, African American, Hispanic/Latino, and American Indian/Alaska Native adults were significantly more likely to have below basic health literacy compared to their White and Asian/Pacific Islander counterparts. Hispanic/Latino adults had the lowest average health literacy score compared to adults in other racial/ethnic groups.<sup>19</sup></li> <li>• The high school dropout rates for Whites, African Americans, and Hispanics/Latinos have generally declined between 1972 and 2005. However, as of 2005, Hispanics/Latinos and African Americans were significantly more likely to have dropped out of high school (22% and 10%, respectively) compared to Whites (6%).<sup>20</sup></li> </ul>



**Table 1.2: Social Determinants by Populations (continued) \***

<p><b>Access to resources</b></p>	<ul style="list-style-type: none"> <li>• Lower income and minority communities are less likely to have access to grocery stores with a wide variety of fruits and vegetables.<sup>21,22</sup></li> <li>• In spite of recent legislation, many teenagers who go to a store or gas station to purchase cigarettes are not asked to show proof of age. African American male students (19.8%) were significantly less likely to be asked to show proof of age than were White (36.6%) or Hispanic (53.5%) male students.<sup>23,24</sup></li> </ul>
<p><b>Income</b></p>	<ul style="list-style-type: none"> <li>• Low socioeconomic status (SES) is associated with an increased risk for many diseases, including cardiovascular disease, arthritis, diabetes, chronic respiratory diseases, and cervical cancer as well as for frequent mental distress.<sup>15</sup></li> <li>• The real median earnings of both men and women who worked full time decreased between 2005 and 2006 (1.1% and 1.2% change, respectively), with women earning only 77% as much as men.<sup>25</sup></li> </ul>
<p><b>Housing</b></p>	<ul style="list-style-type: none"> <li>• In 2005, American Indians or Alaska Natives were 1.5 times more likely and African Americans were 1.3 times more likely to die from residential fires and burns than Whites.<sup>26</sup></li> <li>• Homeless people are diverse with single men comprising 51% of the homeless population, followed by families with children (30%), single women (17%) and unaccompanied youth (2%). The homeless population also varies by race and ethnicity: 42% African-Americans, 39% Whites, 13% Hispanics/Latinos, 4% American Indians or Native Americans and 2% Asian Americans. An average of 16% of homeless people are considered mentally ill; 26% are substance abusers.<sup>27</sup></li> </ul>
<p><b>Transportation</b></p>	<ul style="list-style-type: none"> <li>• Rural residents must travel greater distances than urban residents to reach health care delivery sites.<sup>28</sup></li> <li>• 38.9% of Hispanic/Latinos, 55.2% of African Americans, and 29.6% of Asian Americans live in households with one vehicle or less compared to 24.5% of Whites.<sup>29</sup></li> <li>• Low-income minorities spend more time traveling to work and other daily destinations than do low-income Whites because they have fewer private vehicles and use public transit and car pools more frequently.<sup>29</sup></li> </ul>

\*Social inequities and social determinants refer to the same resources (e.g., health care, education, housing) but social inequities reflect the differential distribution of these resources by population and by group.

## How do social determinants influence health?

Multiple models describing how social determinants influence health outcomes have been proposed.<sup>30-40</sup> Although differences in the models exist, some fairly consistent elements and pathways have emerged. The model presented here contains many of these elements and pathways and focuses on the distribution of social determinants (see Figure 1.1). As the model shows, social determinants of health broadly include both societal conditions and psychosocial factors, such as opportunities for employment, access to health care, hopefulness, and freedom from racism. These determinants can affect individual and community health directly, through an independent influence or an interaction with other determinants, or indirectly, through their influence on health-promoting behaviors by, for example, determining whether a person has access to healthy food or a safe environment in which to exercise.

Policies and other interventions influence the availability and distribution of these social determinants to different social groups, including those defined by socioeconomic status, race/ethnicity, sexual orientation, sex, disability status, and geographic location. Principles of social justice influence these multiple interactions and the resulting health outcomes: inequitable distribution of social determinants contributes to health disparities and health inequity, whereas equitable distribution of social determinants contributes to health equity. Appreciation of how societal conditions, health behaviors, and access to health care affect health outcomes can increase understanding about what is needed to move toward health equity.

**Figure 1.1: Pathways from Social Determinants to Health**

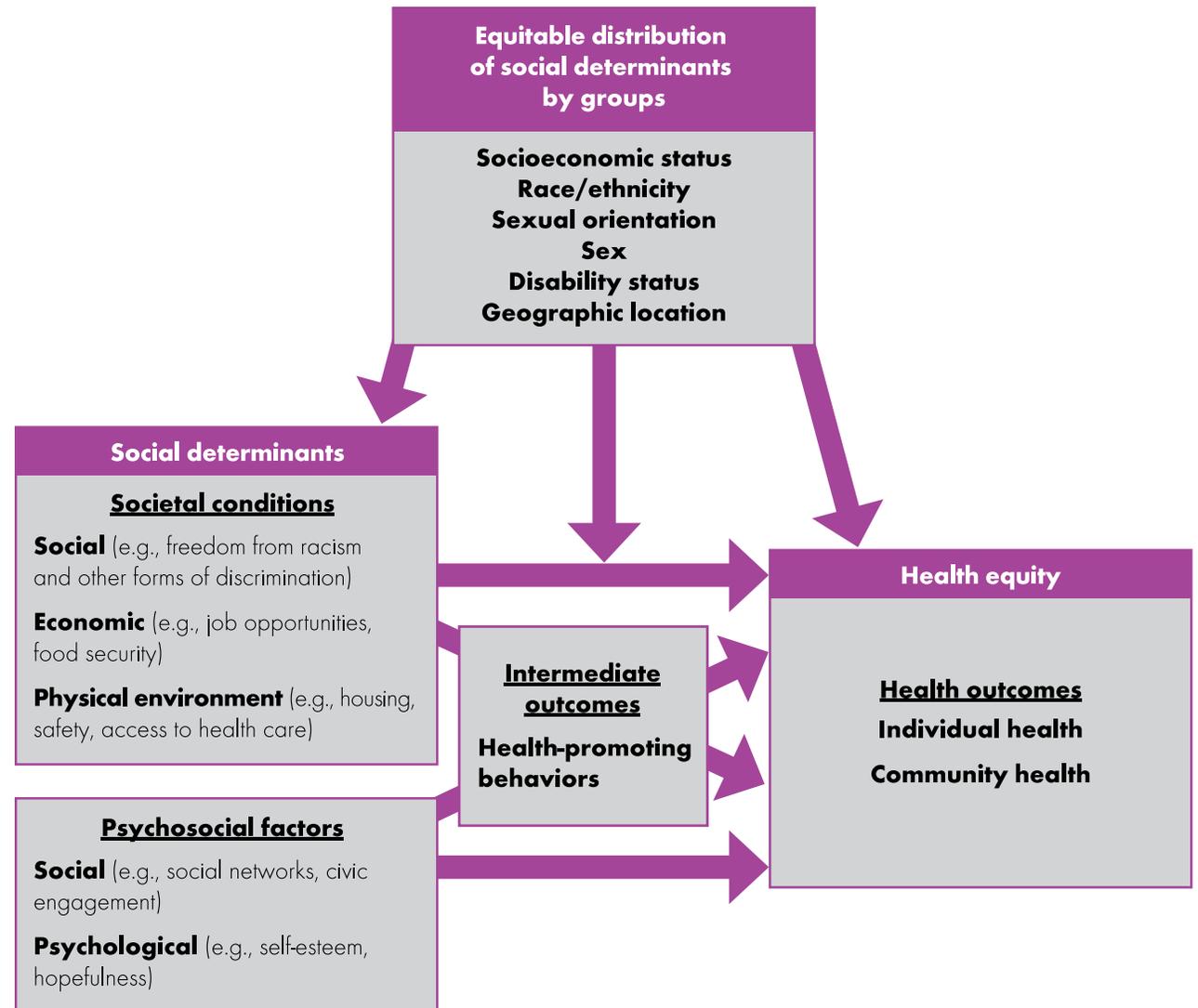


Figure adapted from Blue Cross and Blue Shield of Minnesota Foundation, [http://www.bcbsmnfoundation.org/objects/Tier\\_4/mbc2\\_determinants\\_charts.pdf](http://www.bcbsmnfoundation.org/objects/Tier_4/mbc2_determinants_charts.pdf) and Anderson et al, 2003.<sup>38,39</sup>

## Learning from doing

Chapter 2 of this workbook contains examples of community initiatives that have addressed inequities in the social determinants of health either directly or indirectly through more traditional public health efforts. These examples identify skills and approaches important to developing and implementing programs and policies to reduce inequities in social determinants of health and in health outcomes. After you have seen how other communities have addressed these inequities, Chapter 3 will describe how to develop initiatives to reduce inequities in your community.

**Figure 1.2: Growing Communities: Social Determinants, Behavior, and Health**

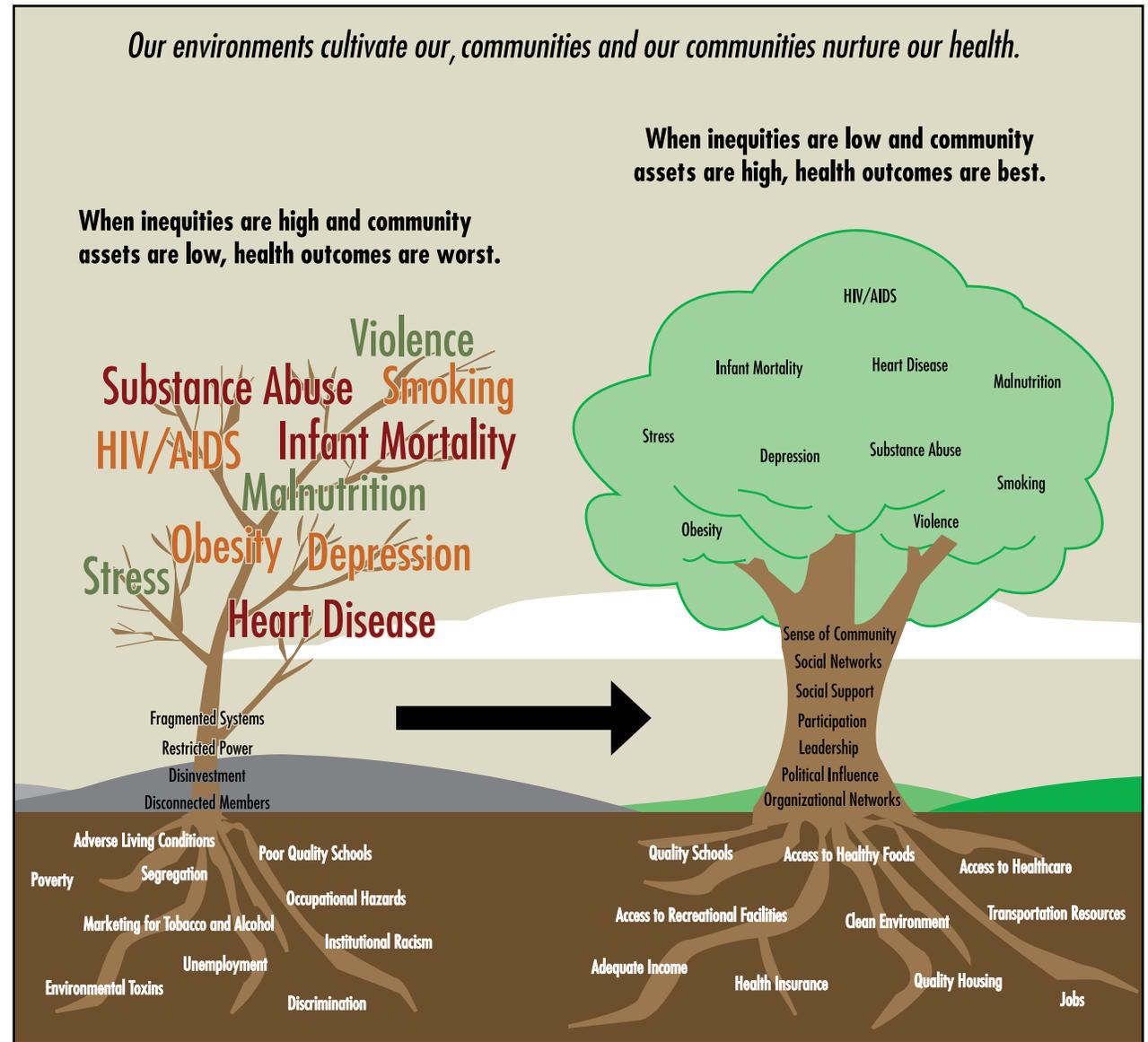


Figure adapted from Anderson et al, 2003; Marmoeetal, 1999; and Wilkinson et al, 2003.<sup>39-41</sup>



# Communities Working to Achieve Health Equity

## Background:

### The Social Determinants of Disparities in Health Forum

The Social Determinants of Disparities in Health: Learning from Doing forum included the presentation and discussion of nine community initiatives that address inequities in the social determinants of health. The forum was intended to allow participants to share their ideas and experiences with ongoing projects and to use these ideas and experiences as a basis for future research and practice. Information from each of the community initiatives is presented here as described by presenters at the forum. These initiatives are examples of what's being done in varying contexts to address a broad range of health and social issues. They were divided into three groups for the panel presentations at the forum, even though most of them shared characteristics with initiatives presented in the other categories. The three categories were:

#### > Small-scale program and policy initiatives

These are local initiatives that either focus directly on social determinants of health or address them through more traditional health promotion or disease prevention projects. See case studies 1-3.

#### > Traditional public health program and policy initiatives

These initiatives illustrate how efforts to address social determinants of health can be incorporated into traditional public health programs, processes, and organizational structures. See case studies 4-6.

#### > Large-scale program and policy initiatives

The first two community initiatives in this group are attempting to directly reduce inequities in social determinants of health caused by factors such as poverty, racism, or an unhealthy physical environment. The third is a historical perspective that provides inspiration and evidence for a multifaceted health care system. See case studies 7-9.





# Project Brotherhood

## Who we are:

A black men's clinic at Woodlawn Health Center, Chicago, Illinois.

## What we want to achieve:

Project Brotherhood seeks to: 1) create a safe, respectful, male-friendly place where a wide range of health and social issues confronting black men can be addressed; and 2) expand the range of health services for black men beyond those provided through the traditional medical model.

## What we are doing:

Project Brotherhood was formed by a black physician from Woodlawn Health Center and a nurse-epidemiologist from the Trauma Department at Cook County Hospital who were interested in better addressing the health needs of black men. Partnering with a black social science researcher, they conducted focus groups with black men to learn about their experiences with the health care system, and met with other black staff at the clinic. As a result of this research, Project Brotherhood uses the following strategic approaches:

- Offers free health care, makes appointments optional, and provides evening clinic hours to make health care more accessible to black men.
- Offers health seminars and courses specifically for black men.
- Employs a barber who gives 30–35 free haircuts per week and who received health education training to be a health advocate for black men who cannot be reached by clinic staff.
- Provides fatherhood classes to help black men become more effectively involved in the lives of their children.
- Discourages violence among the next generation of black men by producing “County Kids,” a comic book that teaches children how to deal with conflict without resorting to violence.
- Builds a culturally competent workforce able to create a safe, respectful, male-friendly environment and to overcome mistrust in black communities toward the traditional health care system.
- Organizes physician participation in support group discussions to promote understanding between providers and patients.

## How we will know we are making a difference:

In January 1999, Project Brotherhood averaged 4 medical visits and 8 group participants per week. By September 2005, the average grew to 27 medical visits and 35 group participants per week, plus 14 haircuts per clinic session. The no-show rate for Project Brotherhood medical visits averages 30% per clinic session compared to a no-show rate of 41% at the main health clinic. To meet the growing needs, additional staff time has been secured and Project Brotherhood clinic hours have been extended. As of 2007, Project Brotherhood has provided service to over 13,000 people since opening.

## Summing up:

By providing a health services environment designed specifically for black men where they are respected, heard, and empowered, Project Brotherhood is helping to reduce the health disparities experienced by black men.

## How to reach us:

Mildred Williamson

Project Brotherhood

(773) 753-5545

ProjectBrotherhood@hotmail.com

<http://www.projectbrotherhood.net>



## What we are learning:

When our patients learn that the health care providers at Project Brotherhood share an interest in many issues that affect them, they gain a sense of social support that becomes a powerful dynamic. Knowing that they will see physicians of their own race and gender increases the level of trust they have in their physician. Originally met with skepticism, most Project Brotherhood activities are now being successfully implemented. This is an excellent environment for more seasoned black male professionals to mentor younger black professionals as well as black high school and college students.



## Who we are:

We are a partnership of the Latino Network, the Emmanuel Community General Services, the Community Capacitation Center of the Multnomah County Health Department, the School of Community Health at Portland State University, the Department of Public Health and Preventive Medicine at the Oregon Health and Science University, and several community and faith-based groups.

## What we want to achieve:

To address social determinants of health and reduce health disparities in black and Latino communities in Multnomah County, Oregon, by increasing social capital, which is a resource available to all members of a community through durable social networks for the purpose of facilitating the achievement of community goals and health outcomes.

## What we are doing:

Our project proposes that health inequities are shaped by fundamental social determinants, including racial discrimination, social exclusion, and poverty. The project, which uses existing resources to enhance residents' access to social and economic resources, explores how racially and ethnically dissimilar communities can use existing social capital to change community conditions.

We rely on three strategies to address social determinants of health:

- We use community-based participatory research to support cross-cultural partnerships in which partners share resources and decision-making power.
- We use popular education, which means teaching through a process of mutual learning and analysis (emphasizing that students need to be active in the learning process and should be considered agents of change rather than receptacles of knowledge) to identify important community health issues and their social determinants, to identify useful expertise among community members, and to develop the community leadership necessary to take action.
- We select community health workers (CHWs) and provide them with specialized training in leadership, local politics, governance structure, advocacy, community organizing, popular education, and health.

We elected to work with five groups: three black faith-based communities, the Comunidad Cristiana (a Latino coalition of five evangelical congregations) and a geographically defined Latino community consisting of four apartment complexes. This decision to work with relatively small groups (40–107 members) helped the steering committee and CHWs address issues of specific concern in these communities instead of broader issues common to all Latino and black community members. In an ongoing process, CHWs use popular education to identify health issues in their communities and to design projects to respond to those issues. Projects have included forming a public safety committee, organizing a community health fair, establishing a diabetes support and information group, and a homework club, and a photovoice project that provides community members with cameras to document community problems and strengths. The photovoice project led community members to develop a campaign to address trash problems and other environmental health issues.

## How we will know we are making a difference:

To determine whether opportunities for building skills, increasing knowledge, and sharing decision making will increase social capital, we administered a baseline survey to 170 adults randomly selected from the communities to assess social capital, general health, and health-related quality of life. We also conducted in-depth interviews with selected community members to help us determine how the development and function of social capital in black communities differs from that in Latino communities. Follow-up surveys showed significant improvements in social support, self-rated health and mental health among community members that participated in the interventions with Community Health Workers who use popular education.<sup>43</sup>

## Summing up:

The data described above were reviewed to identify and prioritize the concerns of participating communities. We found that popular education is an effective tool to encourage members of different communities to talk about and begin to address their unique and common health concerns. Our challenge is to better understand how a person's health is affected by social, economic, and political contexts.

## How to reach us:

*Stephanie A. Farquhar, PhD*  
Portland State University  
(503) 725-5167  
farquhar@pdx.edu



## What we are learning:

We have learned that although Latinos and blacks have a shared interest in reducing health inequities, the ways in which the two groups identify health concerns, create solutions, and think about social capital differ. We embrace these differences and are working with both groups to identify opportunities for cross-cultural collaboration.

Building trust between members of different demographic groups is difficult but essential work. A specific challenge of working across cultures is the language barrier. Popular education, which uses role-playing and other creative learning methods, can help provide a common language and reduce potential divisiveness of language barriers.

# 3 CASE STUDY

## Project BRAVE: *Building and Revitalizing an Anti-Violence Environment*<sup>44</sup>

### Who we are:

Project BRAVE is a school-based intervention developed by Students at the Center, a school-based organization; the Crescent City Peace Alliance, a community-based organization; and a researcher and students from Tulane University School of Public Health to reduce youth violence in New Orleans, Louisiana.

### What we want to achieve:

To reduce the social determinants of violence by changing learning and teaching methods in elementary, middle, and high schools.

### What we are doing:

Project BRAVE classes begin with a “story circle,” where small groups of students tell stories about violence they have experienced or seen. After sharing these stories orally, the students write them down and edit them. In our pilot, a public health researcher helped the students critically analyze their experiences and identify the social determinants of violence in their community. This analysis, based on a technique known as “conscientization” or raising critical awareness, involved a number of steps over several weeks. Relevant themes that emerged during this process included the importance of attending school and increasing the level of social support among students. Participating students came to see themselves as agents of change in the school and in the community with the ability to motivate others to implement solutions to violence. A final theme was that heightened awareness of violence could help prevent it in the future. Artists worked with students to translate their stories into a play that communicated the importance of reducing youth violence to neighborhood members, organizations, and other key stakeholders who might have a role in addressing such violence. Their play, “Inhaling Brutality, Exhaling Peace,” told a student’s story about a murder witnessed at a local park. One of the performances was conducted in the neighborhood next to the park where the events in the story took place. The discussion that followed led some neighbors to express shock at what was happening in their neighborhood park and to begin organizing community efforts to prevent further violence.

## How we will know we are making a difference:

At the end of the semester, project team members tape-recorded group interviews with students, analyzed and coded the content of the interviews, and used these data to identify various themes related to social determinants of violence (e.g., school attendance, social support, self-perceptions as change agents). Interest in the Project BRAVE class has led to an increase in school attendance, an important social determinant of violence and community health. Future evaluation efforts will include school and community surveys to measure change in student-related variables, such as school attachment and social support, and community-level variables, such as collective efficacy and community empowerment. Finally, we will monitor longer-term outcomes such as crime rates, to assess the project's impact on the overall community.

## Summing up:

Project BRAVE builds on existing relationships among schools, community members, community-based organizations, and local researchers to support already-established opportunities for students to share their experiences and to participate in community change to reduce violence.

## Post-Hurricane Katrina update:

Despite the devastation of schools and neighborhoods caused by Hurricane Katrina, the work of Project BRAVE is being continued by Students at the Center. The group is teaching writing classes at McMain Secondary School and in the Douglass community using BRAVE materials and methods, working to publish a collection of student writing on violence, and participating in many efforts to "watchdog" the rebuilding process as it pertains to public schools. Many young people are working to improve education as New Orleans rebuilds.

## How to reach us:

*Jim Randels*

*Students at the Center (SAC)*

*(504) 982-0399*

*jimrandelssac@earthlink.net*



## What we are learning:

We are learning that Project Brave is an effective approach for addressing youth violence but that there are many challenges.<sup>44</sup> These include poor attendance by many students and minimal time available for "special" courses. Securing funding has also been challenging because funders often require school-based projects to use standardized curricula. Unfortunately, due to lack of funding, Project BRAVE is no longer in existence.

# Healthy Eating and Exercising to Reduce Diabetes<sup>45</sup>

## Who we are:

The East Side Village Health Worker Partnership (ESVHWP) is a community-based participatory research effort formed to understand and address social determinants of women's health on Detroit's east side.

## What we want to achieve:

To identify facilitators and barriers to sustained community efforts addressing social factors that contribute to diabetes and to develop a program that reduces the risk or delays the onset of Type II diabetes.

## What we are doing:

The ESVHWP and Village Health Workers (VHWs) work together to identify and develop ways to address health concerns in their communities. VHWs and members of the ESVHWP identified diabetes as a high-priority health concern and developed Healthy Eating and Exercising to Reduce Diabetes, a program that encourages community members to engage in moderate physical activity and healthy eating to reduce their risk for diabetes. The project is built upon the recognition that social and economic policies as well as social and physical environments contribute to the complexity of the disease. The main objectives for this program are to:

- Increase knowledge among VHWs and other community members on the east side of Detroit about how to reduce the risk or delay the onset of type II diabetes.
- Increase resources (e.g., community gardens, cooperative buying clubs, social support for a healthy diet) and reduce barriers (e.g., lack of affordable fresh produce in local stores) to healthy meal planning and preparation.
- Identify and create opportunities for safe, enjoyable, and low-impact physical activities for community members.
- Strengthen and expand social support for practices that help to delay the onset of diabetes or reduce the risk of complications.

## How we will know we are making a difference:

We have conducted both process and outcome evaluations. We used evaluation results from the first training session to modify the training program for subsequent training sessions. We have also tracked participation and sales volume at mini-markets, both to document the demand for fresh produce and to allow the project coordinator to tailor the quantity and types of products to be offered at future markets. We joined forces with another community initiative to expand the mini-markets and food demonstrations and to conduct a more extensive evaluation.

## Summing up:

Healthy Eating and Exercising to Reduce Diabetes (HEED) emerged within the context of an ongoing partnership that had built capacity through collaborative work. These partners worked to develop an analysis of diabetes risk that placed health in the context of their particular community environments. From this analysis, they were able to address barriers to the management of diabetes within their communities. Such partnerships offer a great opportunity for dialogue that increases understanding of diverse perspectives and can provide a foundation for addressing social and environmental factors that affect health. More recent activities from the HEED project include impacting local policies in order to address structural and environmental issues that limit access to healthy food.

## How to reach us:

Amy Schulz, PhD  
University of Michigan  
(734) 647-0221  
ajschulz@umich.edu



## What we are learning:

- > Diabetes-related dialogue, research, and intervention are iterative processes that are informed by and can help inform an understanding of how diabetes risk is affected by social conditions and the social relationships that create them.
- > Community initiatives to address health issues or their social determinants are largely dependent on local funding sources that may or may not support efforts to address these social determinants.
- > The success of collective efforts to address health disparities depends on convincing community members and other stakeholders that these disparities are caused in part by inequities in the social determinants of health.



## Taking Action: The Boston Public Health Commission's Efforts to Undo Racism

### Who we are:

The Boston Public Health Commission (BPHC) in partnership with city agencies, health care organizations, community-based organizations, and community members.

### What we want to achieve:

To determine how a large public health organization can recreate itself to incorporate an anti-racist agenda.

### What we have done:

The elimination of racial and ethnic health disparities was determined to be one of our priority areas in response to data showing that blacks in Boston fare significantly worse than whites on 15 of 20 measures of health. Our efforts to understand and eliminate the impact of racism on health are based on the following principles: 1) race is a social and political construct that establishes and maintains white privilege; 2) understanding the role of racism in perpetuating disparities in health requires a common language and contextual framework; and 3) undoing institutional racism requires participatory approaches placing leadership and decision making in the hands of those being served. We focus on lack of equal opportunity, discrimination, and race-related differences in exposure to health risks as well as instituting quality-improvement initiatives within the health care system by adopting three main strategies:

- *Promote a non-racist work environment.* Activities include training BPHC staff and managers, creating executive positions to coordinate these efforts, reviewing and adapting policies and practices to eliminate discrimination, increasing effectiveness in handling complaints about racism, increasing staff diversity, creating performance measures to assess progress in addressing racism, and establishing standards for culturally appropriate materials and compliance mechanisms.
- *Build partnerships.* Activities include training community leaders, employing coalition members, conducting community assessments to document the effects of racism on residents, and sponsoring workshops for community residents.
- *Refocus external activities.* We formed the "Task Force to Eliminate Racial Disparities in Health," which includes hospital CEOs; community health center directors; community coalition chairs and representatives from health plans, businesses, and higher education. The Boston mayor also established a hospital working group to improve the assessment of health disparities, workforce diversity, cultural competence training, and hospital participation in community-based efforts by linking funding to the REACH 2010/Boston Healthy Start Coalition's outreach and education activities.

## How we will know we are making a difference:

Project staff are tracking the impact of efforts to make targeted policy changes. Since its beginning, the BPHC Disparities Project has reached over 6,100 people across Boston through education, training, and planning activities focused on understanding and addressing health disparities. A city-wide blueprint for addressing racial and ethnic health disparities has been developed and, in 2006, the Mayor of Boston was awarded the U.S. Department of Health and Human Services Director's Award in recognition of his leadership on the project. In 2007, BPHC received a REACH US (Racial and Ethnic Approaches to Community Health) cooperative agreement award from CDC to establish a learning collaborative to share this work with other communities.

## Summing up:

The first step in addressing institutional racism is the collection and use of appropriate health disparity data to engage key leaders and encourage community members, health care providers, and elected officials to address health disparities and develop concrete plans for eliminating them. Implementing the BPHC Taking Action initiative has required shifting existing personnel and financial resources as well as identifying new funding sources. Fortunately, we have been able to do both because of the commitment of political leaders and the strength of community coalitions.

## How to reach us:

*Meghan Patterson*  
Boston Public Health Commission  
(617) 534-2675  
MPatterson@BPHC.org  
[www.BPHC.org/disparities](http://www.BPHC.org/disparities)



## What we are learning:

We have found that many people are uncomfortable discussing or unwilling to discuss issues related to racism. In addition, many public health staff members feel a tension between attempting to be service providers and attempting to be "change agents;" many are not trained as organizers, and they do not necessarily have an interest in this role.



# The Community Action Model to Address Disparities in Health <sup>46</sup>

## Who we are:

San Francisco Tobacco Free Project (SFTFP) of the Community Health Promotion and Prevention section of the San Francisco Department of Public Health and local community-based organizations.

## What we want to achieve:

We have two primary goals: 1) to mobilize community members and agencies to change environmental factors that promote economic and environmental inequalities; and 2) to provide a framework for community members to acquire the skills and resources to investigate the health of their community, and then plan, implement, and evaluate actions that change the environment to promote and improve health.

## What we have done:

We designed the Community Action Model (CAM) to increase community and organizational capacity to address the social determinants of health associated with tobacco-related illness. A key component of CAM is helping community members (advocates) identify underlying social, economic, and environmental forces that create health inequities using the following process:

- *Skill-based training.* Train 5-15 advocates in the CAM process, discuss issues of concern, and choose a focus area that has meaning to the community.
- *Action research.* Define, design, and implement a community diagnosis to find root causes of community concerns and discover resources to overcome them.
- *Analysis.* Analyze the results of the diagnosis and prepare findings.
- *Organizing.* Select, plan, and implement an action to address the issues of concern.
- *Implementation.* Enforce and maintain the action to ensure that the appropriate groups will sustain the community's efforts.

Since 1996, SFTFP has implemented the CAM model by funding community-based organizations (CBOs) to work with community advocates to carry out the process above. SFTFP has funded 37 projects, and the following are examples of successful actions accomplished by CBOs:

- San Francisco School Board policies to ban tobacco food subsidiary products.
- Tenant-driven smoke-free policies in multi-unit housing complexes.
- City-wide ban on tobacco ads.
- Enforcement of local and national laws prohibiting bidi tobacco product and cigar use by youth.
- A Good Neighbor program to promote inner city access to healthy alternatives to tobacco food subsidiary products. (See poster on inside front cover of this workbook).

## How we will know we are making a difference:

We are conducting evaluations to determine whether funded projects have completed the five CAM steps, met the criteria for action (i.e., is achievable, has potential for sustainability, and compels people to change the community for the well-being of all), and increased the capacity of advocates/agencies to participate in the CAM process. Preliminary findings suggest that 30 of the projects implemented action plans that met the criteria and 28 of them successfully accomplished the proposed actions themselves. Future evaluations will address long-term sustainability of projects and identification of factors that contribute to a project's success.

## Summing up:

CAM is designed to enhance individual and organizational capacity to address social determinants of health through policy interventions. Helping the community members most affected by health disparities to develop the skills to change social structures underlying health inequities is an important first step. Although we have focused on tobacco-related issues, the skills and capacities developed by participants in the projects we have funded can also be used to address other health issues affecting communities.

## How to reach us:

*Susana Hennessey Lavery*

*San Francisco Department of Public Health*

*(415) 581-2446*

*susana.hennessey-lavery@sfdph.org*

*http://sfhfc.globalink.org*



## What we are learning:

- > Categorical funding sources focused on behavior-change models often lack the infrastructure to coordinate a community-driven advocacy campaign focused on policy development.
- > Projects to make health-related environmental changes require sustained funding and can be labor intensive, limiting the number of such projects that can be funded.
- > Because categorical funding often requires that the Community Action Model process have a predetermined area of focus, making the issue relevant to the community can sometimes be difficult (i.e., tobacco control may not be a priority for the community advocates).
- > To address these funding challenges, we have adopted the following strategies:
  - Require funding applicants to demonstrate that their proposed project is achievable and sustainable and that it will compel a group, agency, or organization to change the specified conditions for the well-being of all area residents.
  - Require funding applicants to be community based, to demonstrate a history of or interest in activism, and to have the infrastructure necessary to support the proposed project.
  - Develop simple work plans and budget processes to alleviate some of the administrative burdens.
  - Address the challenge of working with groups by training and providing technical assistance to CBOs and community advocates.

# New Deal for Communities<sup>47</sup>

## Who we are:

Partnerships between community members, community and voluntary organizations, local authorities, businesses, and the United Kingdom government.

## What we want to achieve:

To reduce health inequities by restructuring local socioeconomic environments.

## What we are doing:

We designed the National Strategy for Neighborhood Renewal (NSNR) to reduce social inequities through the development of healthy communities and neighborhoods. A key element of the NSNR was the New Deal for Communities (NDC) initiative, an area-based regeneration initiative being implemented in 39 of the most deprived communities in the United Kingdom. The initiative supports intensive regeneration of neighborhoods through partnerships among local people, community and voluntary organizations, local authorities, businesses, and government agencies. Each NDC partnership has developed a plan focused on one of four key areas determined to be barriers to lasting change in deprived neighborhoods: unemployment, poor health, crime, and low education levels. They are attempting to overcome these barriers by improving the physical environment; improving neighborhood management; improving local services; creating better facilities for arts, sports, and leisure activities; building the local community's capacity to take action on health-related goals; tackling disadvantages resulting from racial discrimination; and encouraging enterprise to support economic development.

## How we will know we are making a difference:

The NDC has a formal evaluation plan that includes the collection of baseline and follow-up data, though the vast scope of the project makes formal evaluation an extremely complex process. Evaluation activities will focus on three main processes to assess how the initiatives impact health, including how direct or indirect actions contribute to health improvement; how the process of selecting communities for participation impacts health, either negatively, due to identification as a community in need, or positively, due to recognition of unmet needs; and how this approach influences health by increasing the capacity of community members to participate in health enhancing activities. Interim evaluation results, which vary by neighborhood, show increased satisfaction with the neighborhood as a place to live; significant improvements in crime and fear of crime; community elected Boards to oversee neighborhood regeneration activities (average voter turnout 23%); improvements in youth educational attainment and in school retention; and modest improvements in self-rated health.<sup>48</sup>

## Summing up:

There is a great deal to learn about the effectiveness of interventions that seek to modify the macro-socioeconomic environment, though we do know that the active participation of affected community members in all stages of such interventions is essential to their success. Also, the longer the interval between an intervention and an anticipated change in a group's health status, the greater the likelihood that the evaluation will fail to capture an effect.

## How to reach us:

Jayne Parry

University of Birmingham

+44 (0)121 414 3191

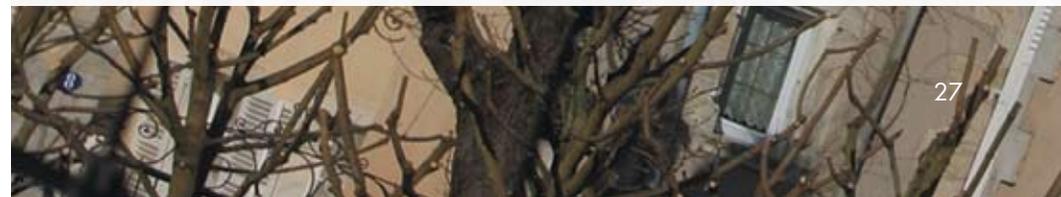
[j.m.parry.1@bham.ac.uk](mailto:j.m.parry.1@bham.ac.uk)

<http://www.neighbourhood.gov.uk/page.asp?id=617>



## What we are learning:

We are learning that implementing the NDC initiative is a complex process with many strengths and challenges. Initiative strengths include: 1) collaboration of intersectoral and multiagency partnerships with community members to identify needs and develop and implement projects designed to meet those needs; 2) an evidence-based approach to demonstrate progress toward stated objectives; 3) a large financial investment over 10 years; 4) strong national leadership; 5) expert and administrative engagement and support; 6) linkages to primary health care; and 7) a history of community development and involvement. Our challenges include: 1) pressure from national leaders to achieve outcomes in a short time; 2) lack of support for health care practitioners engaging in community work; 3) reliance on expert consultants, which, without transfer of skills, minimizes the ability to build community capacity; 4) inexperienced and overworked staff; and 5) conflicts between community groups.



# From Neurons to King County Neighborhoods<sup>49</sup>

## Who we are:

Public Health – Seattle & King County, local and state governments, human services and child advocacy organizations, community residents, and other early childhood development stakeholders.

## What we want to achieve:

To develop a coordinated policy agenda that will strengthen early childhood environments and complement existing efforts focused on families and individuals. Our ultimate goal is to create “universal access” to environments that support healthy development, school readiness, and success in school.

## What we are doing:

We designed a policy-oriented intervention to enhance early childhood environments in King County, Washington. The intervention involves the following five steps:

- Develop partnerships with early childhood development stakeholders to discuss current and proposed policies to support early childhood development.
- Build a common knowledge base by developing a document that describes “what we know” about policies that support early childhood development.
- Develop policy recommendations in 14 areas by working with stakeholders to compare existing governmental policies with proposed policies.
- Organize support for proposed policy changes through community meetings to disseminate and discuss the policy agenda.
- Monitor the 14 governmental policies on the agenda, report progress to stakeholders on a regular basis, and identify opportunities for action.

## How we will know we are making a difference:

We will formally monitor and periodically report to stakeholders on the status of the policies. We conducted interviews to assess stakeholder knowledge on each of the policy areas. The results of these interviews helped us identify opportunities for action (e.g., to help move people out of poverty, stakeholders can advocate for income assistance by enrolling all eligible families in Earned Income Tax Credit/Temporary Assistance for Needy Families/Social Security benefits) as well as the need for more coordinated partner and community support before a proposed policy change could be attempted. The outcome goals of partnerships are also used as a basis for assessment activities. For example, after we selected school readiness as an outcome goal, we conducted a population-based assessment of school readiness among King County kindergarten children in three school districts. The resulting data has been used to mobilize community engagement, funding and action particularly in one neighborhood in King County. We are in the process of conducting a second assessment in these school districts and will have the baseline data against which to compare and track improvement in school readiness.

## Summing up:

We are in the process of developing strategies to promote local, county, and state policies that support environments conducive to early childhood development, school readiness, and success in school. However, ensuring that all American children grow up in such environments will require the ongoing commitment and cooperation of all partners in this endeavor.

## How to reach us:

Sandy Ciske, Regional Health Officer  
Public Health - Seattle & King County  
(206) 263-8686  
sandra.ciske@kingcounty.gov



## What we are learning:

It is difficult to keep partners engaged long enough for them to become fully informed participants in building a policy agenda to support childhood development and to keep them focused on the environment rather than on individuals or families as the unit of change. Although people say they want to change conditions in their community, they may lose interest in the proposed policy agenda before it can be implemented, because the changes necessary can seem daunting and the benefits of such changes seem distant. There is a continuous need for better collaboration among groups, stronger leadership, a commitment to prioritized policies, and the protection of existing funding for early childhood services and programs.



# The Delta Health Center

## Mound Bayou, Mississippi<sup>50</sup>

### A Historical Case Study

#### Who we are:

The Delta Health Center, located in Mound Bayou, Mississippi, was created in 1965 following a year of intensive work to establish 10 local community health associations. These local associations, which modeled themselves on black churches and offered public health and nursing services, eventually merged to form the North Bolivar County Health Council, which became chartered as a community development corporation.

#### What we wanted to achieve:

To develop a health center that provided primary medical services and to change social determinants of health by helping the local community to organize, articulate their health-related needs, and act to meet those needs.

#### What we did:

In addition to providing medical, dental, and nursing care, the health center offered the following services:

- *Environmental services.* Activities included digging a protected well, building sanitary privies, repairing and screening housing, and establishing rodent and pest control.
- *Nutritional services.* Activities included obtaining money for an emergency food distribution program and developing the North Bolivar County Farm Cooperative, in which 1,000 families worked to grow vegetables instead of cotton, sharing the harvest and selling the surplus in local markets.
- *Transportation services.* Activities included creating and operating a bus transportation system that linked the contact centers of the 10 community health association centers to the Delta Health Center.
- *Educational services.* Activities included training community members as medical secretaries, medical librarians, nursing aides, and community health workers/educators/organizers; establishing a General Educational Development certificate program under the credentialing umbrella of a local black community college; operating a college preparatory program; operating a public health sanitarian program; and establishing the Office of Education within the Delta Health Center to assist community members with applications to colleges and to medical, nursing, and other professional schools. Within the first eight years, this program produced seven physicians, five doctors in the clinical sciences, two environmental engineers, more than twelve registered nurses, and six social workers.
- *Financial services.* Activities included establishing a bank branch in Mound Bayou, where local black community members were hired as tellers and supervisors and racial discrimination in mortgage lending was decreased, which led to the construction of new housing and an increase in home ownership; hiring a part-time lawyer to apply for federal and state housing; and establishing economic and community development programs.

In addition, we worked to reduce the social isolation of poor and rural communities by establishing summer internships for students as well as Head start, teen guidance, and counseling interventions.



### **How we knew we were making a difference:**

The success of our efforts has been reflected in the personal commitment of those who received services from the Delta Health Center and then returned to join the Center staff in various positions, including as executive directors, physicians, and nurses.

### **Summing up:**

Community health centers can partner with local communities to function as multidisciplinary community institutions that address a wide range of factors affecting health outcomes. The Delta Health Center, originally sponsored by Tufts Medical School, is now owned and operated by a nonprofit community board in Mound Bayou, Mississippi, and serves parts of three counties in the Mississippi Delta.

### **How to reach us:**

*Seymour Mitchell, Executive Director*

*Delta Health Center*

*(662) 741-2151*

*<http://www.tecinfo.com/~dhc1/history.html>*



### **What we learned:**

After initially resisting many Delta Health Center activities, the state government, state and local medical societies, and other Mississippi resources ultimately cooperated with the Center; some poverty-alleviating interventions led to conflict within the black community because they were perceived as threatening to middle class community members and institutions; and many Center activities fostered important attitudinal and opportunity changes among community members (e.g., educational interventions led to higher levels of educational aspiration and achievement). The Delta Health Center can serve as a model for other federally qualified health centers attempting to increase community capacity to improve the social determinants of health.



# Developing a Social Determinants of Health Inequities Initiative in Your Community

This chapter provides guidelines you can adapt to develop a social determinants of health initiative in your community. As you prepare your initiative, engaging multiple sectors of the community and encouraging active participation in collaborative processes are critical to improving the conditions for health. These processes involve personal and professional commitments to build trust, accept responsibility, listen to new or opposing perspectives, and maintain authenticity.

- Section 1 of this chapter discusses how to enlist participation from members of your community to create partnerships and build capacity.
- Section 2 provides methods for assessing social determinants of health and developing a shared vision for community change.
- Section 3 describes processes for building community capacity to address social determinants as part of your shared mission and vision.
- Section 4 offers approaches useful for focusing your initiative on social determinants of health inequities.
- Section 5 describes how to develop and implement an action plan for your initiative.
- Section 6 discusses how to assess your initiative's progress, make adjustments as needed, and share your results with others.
- Section 7 provides recommendations for how to maintain your initiative's momentum over time.

Sections 1–7 are presented in sequential order, but the framework for developing your initiative illustrates how the information presented in these sections forms a cumulative knowledge base or process for achieving health equity (see Figure 3.1). This framework recognizes that the information presented in each step may be useful to change social determinants of health inequities, whether you are forming a partnership, developing goals and objectives for a program, or evaluating why a program was or was not successful in your community.



Each section provides information, tools, and processes that you can incorporate into your ongoing work or use to start a new initiative. Some of these resources are provided in call-out boxes as follows:

**> Moving Forward**

Includes thoughts and recommendations from others engaged in this work.

**> Forum Spotlight**

Presents work from the community initiatives described in Chapter 2.

**> Example from the Field**

Provides an example adapted from multiple initiatives of how these resources have been applied in diabetes prevention.

**> Perspectives**

Offer insights from experts in the field.

Finally, this chapter presents information and resources that can be used to produce change, whether you are creating a new partnership, transforming an existing partnership, or working on organizational change to address social determinants of health.

**Figure 3.1: Phases of a Social Determinants of Health Initiative**

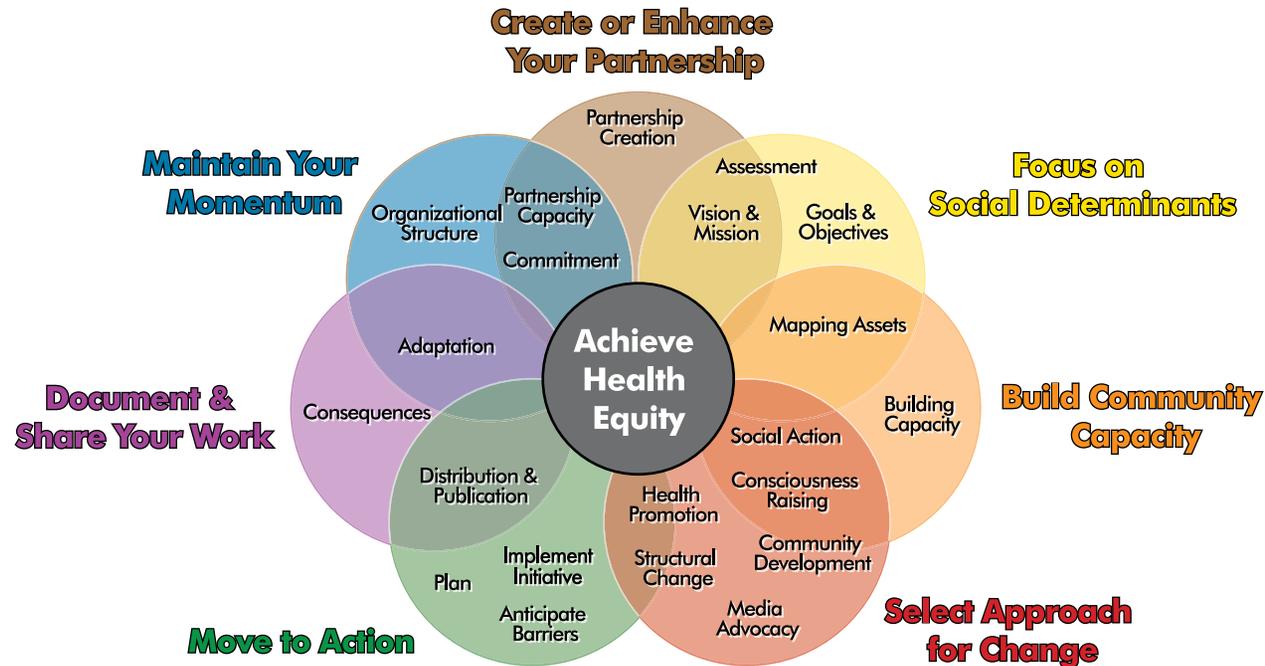


Figure adapted from Brownson et al, 2003 and Green et al, 1991.<sup>51,52</sup>

# Creating Your Partnership to Address Social Determinants of Health

Because social relationships are complex and have varying effects on different members of a community, establishing a broad-based collaborative partnership is fundamental to addressing the social determinants of health inequities. Partnerships can be described both by their structure (the number and types of groups that form the partnership) and by the methods and processes of collaboration they use (the ways partners work together to create change and the degree to which all partners are engaged in the partnership's activities).<sup>53</sup> This section describes how to create a partnership to address social determinants of health within your community.

## Developing the structure and collaborative processes for your partnership

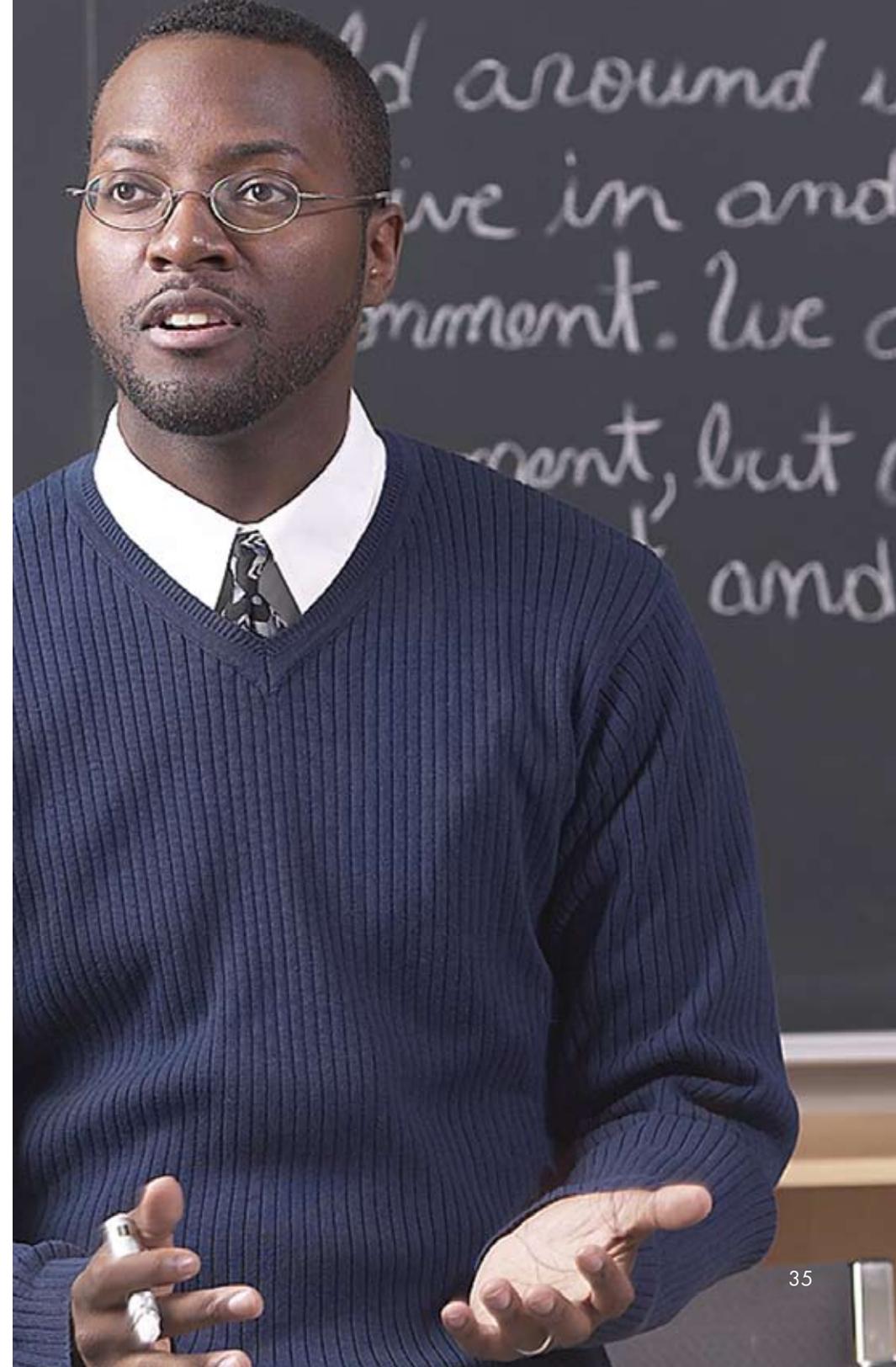
A partnership is a purposive relationship between two or more parties (individuals, groups, or organizations) committed to pursuing an agenda or goal of mutual benefit.<sup>54</sup> Partnerships are formed for many reasons, including to help members of the partnership learn and adopt new skills, gain access to necessary resources, share financial risks and benefits, exchange viewpoints with a broad range of individuals and organizations from the community, and respond to the changing needs of a community.<sup>53</sup> It is essential to build partnerships to address social determinants of health because no

one group, be it health care providers, public health practitioners, or community members, can accomplish the many tasks required for changing social, economic, and environmental conditions that impact health. Partnerships are necessary in order to:

- Pool information.
- Increase understanding of a community's needs and assets.
- Improve public policies and health systems.
- Engage new issues without having sole responsibility for managing or developing them.
- Develop widespread public support for issues or actions.
- Share or develop the necessary resources for action and problem solving.
- Minimize duplication of effort and services.
- Recruit participants from diverse backgrounds and with diverse experiences.
- Promote community-wide change through the use of multiple approaches proposed by representatives from different sectors of the community.
- Improve your chances of making meaningful changes in community conditions by gaining community members' trust in a broad-based coalition of partners.<sup>53-57</sup>

The first step toward creating a successful partnership is to assemble a group of interested community members and organizations to discuss ideas and concerns for the community. In doing so, it is important to recognize that individuals and groups might already be gathering in your community. You may choose to work within existing partnerships to minimize the burden put on them by asking them to join yet another group. These existing partnerships may have helpful knowledge and experience. However, although existing groups are important, they may not address the social determinants of health or include people or organizations from the community who can inform initiatives to address social determinants. Therefore, you might wish to invite others to join your efforts, particularly those who have insight into or experience harm from the political, social, economic, and environmental conditions in your community.<sup>55-59</sup>

Listening to the voices of people and organizations in the community who experience inequitable distribution of social, economic, and environmental resources can help to build a strong partnership to address social determinants of health inequities. Together with other members of your community, you can identify these important nontraditional partners by making a list of the relevant sectors of your community (e.g., government, education, business, public services, faith, funding agencies) and ensuring that your partnership includes representatives from each of these sectors as well as other community members. To effectively identify those who may be interested in the work of your partnership, it may first be necessary to consider how your community is defined.



## PERSPECTIVES — Community

**Yvonne Lewis:** *Faith Access to Community Economic Development; Flint, Michigan (Participant in Learning From Doing forum)*

Involving the community into the decision-making process is critical for ensuring that decisions concerning community health are just and right for all, not only those in charge. People in communities know what their problems are, and researchers can learn from the experiences of community members by talking with them rather than talking about them.

Correcting inequities requires knowledge of how systems work. For example, communities need to understand how the legislature decides to allocate money. Then they can ask questions of the folks saying, “please vote for me,” and work to achieve things that will make a difference in their communities.

Communities have been defined or characterized in a number of ways, including as groups of people who live in a particular geographic area, have some level of social interaction, share a sense of belonging, or share common political and social responsibilities.<sup>60-65</sup> Each community has its own set of structures and norms that govern interactions among its members. A person may be part of many overlapping communities, some of which influence access to social resources more than others. Thus, someone living in a geographically defined community that is economically depressed might have less access to affordable healthy food options (e.g., grocery stores or supermarkets) and medical care (e.g., hospitals or clinics) than someone living in a more prosperous area, even though this individual may have a relatively high personal income.

The following questions can help you think about how to define your community: Who does the community include? Who does it not include? Does the community have definite geographic boundaries? Are there social or cultural ties that link community members? What are some shared characteristics of the community? (See “Example from the Field: Building Community Partnerships.”)

Once your partners have been gathered, consider ways to meaningfully involve this diverse group of community leaders (e.g., businesspersons, clergy,

health care providers) and community members. This may include informal as well as formal strategies. For example, it is often useful to have an informal meeting at a restaurant. Informal activities such as “ice breakers” can encourage members to get to know each other and enable them to learn how to work across inherent power differences within the group.<sup>66, 67</sup> It can also be useful to choose a neutral facilitator or facilitators to help keep the group focused and moving forward. A facilitator recognizes that a group can accomplish more than one person alone because of the varying skills and talents of group members as well as different norms, cultures, and processes of your partners. A facilitator can encourage all partners to take part in the group and help the group address conflict when it arises.

An important formal strategy is to establish guiding principles for partnership interaction. These principles can include how partners agree to interact within the partnership and how information is shared within the partnership and with those outside the group. Some principles to consider are listed in “Moving Forward: Partnership Principles.” You and your partners can use these to guide the development of your own principles. Once agreed on by all partners, your principles can be posted at meetings and referred to when necessary. To sustain the partnership, it is useful to revisit and modify your principles as new partners join your group.

## EXAMPLE FROM THE FIELD

### Building Community Partnerships

A local public health agency has just received funding for a community-based initiative to address diabetes, a growing community health concern. Evidence suggests that at least 10%-15% of adults in this community have diabetes (note: this does not include people with undiagnosed diabetes) and this number continues to rise. Local hospitals report an increase over the past year in the number of people coming to their emergency departments seeking care for uncontrolled diabetes, including high blood glucose levels, foot infections, high blood pressure, and vision problems. Doctors advise the patients to eat healthy, be physically active, and take their medications. However, many of these individuals lack access to medications or health insurance. In addition, living conditions, such as inadequate housing or homelessness, lack of resources or places to purchase healthy foods, and an absence of employment opportunities, make it difficult to eat healthy or be physically active. For these reasons, the agency decided it was important to focus on the social determinants contributing to diabetes and overall health. To get started, agency representatives began within their own organization and listed partners as follows:

- Someone with community health assessment experience.
- An epidemiologist.
- Someone who knows about health surveillance.
- Someone with community outreach experience.
- Someone with health education experience.

Next, they identified potential partners in their community, including:

- Nurses, doctors, or other health care providers, particularly those who treat people with diabetes.
- Hospital and health clinic administrators.
- Individuals from volunteer agencies.
- Representatives from local businesses (e.g., pharmacies, recreational facilities, and grocery stores).
- Representatives from local homeless shelters and food pantries.
- Faith-based organization leaders and members.
- Local media representatives.
- Policy makers and local government officials.
- Community members who know the history of the community, including those with diabetes and those who care for people with diabetes.
- Local school administrators.
- Funding agency representatives.

## MOVING FORWARD

### Sample Partnership Principles

Convene a meeting with your partners to agree on a set of principles for all members to adhere to during meetings and other interactions. These principles are based on the premise that all members seek, as a partnership, to create initiatives that build on the unique strengths and assets of the local community. To do so, all partners agree to respect the beliefs and cultural norms of others and to build trust and mutual respect to ensure that programs will be maintained and enhanced over time. The following principles may help to start your discussion:

#### **We are committed to equity, collective decisions, and collective action.**

- Knowledge originates and resides in all members of a group.
- All partners are encouraged to participate in all phases of the process.
- Information is shared among all partners.
- Differences in interpretation are addressed with respect for all partners.
- Efforts are made to ensure that the language used is heard and understood by all partners.
- Partners will recognize and honor that each partner brings different assets and different needs to the partnership.

#### **We are committed to high-quality, ethical initiatives.**

- We are committed to ensuring that no harm, including emotional and physical harm, is done to anyone affected by the initiative.
- We are committed to full and total disclosure of all information related to risk.
- Informed consent protects the initiative partners and participants as well as the affected community.

- Confidentiality will be maintained.
- Partners agree to act in a manner that is respectful to other partners, to the community, and to the organizations they represent.
- Partners will obtain appropriate human subjects review or approval prior to the collection of qualitative or quantitative data.
- Partners will obtain approval from the partnership to use data or publish findings.

#### **We are committed to addressing social inequities that affect health, including those that constrain the meaningful participation of individuals and communities in the decision-making process.**

- We are committed to processes that foster inclusion and will work against all forms of exclusion, such as racism, sexism, or homophobia.
- We are committed to ensuring all partners have an opportunity to participate in local governance, such as membership on city councils or school boards.

#### **We will maximize opportunities for learning within the local community and associated organizations.**

- We encourage shared leadership (i.e., decision making, meeting facilitation, direction and management of the partnership).
- We encourage shared input into the development, implementation, evaluation, and dissemination of partnership initiatives.
- We will actively seek financial and other resources that can benefit the community. This includes working with local partners to develop applications for funding.

## Assessing partnership resources and building capacity

It is helpful to take an inventory of the individual, organizational, and structural resources that influence your partnership's capacity to carry out its activities. When considering your partnership's capacity, it is useful to ask your partners the following questions:

- What is the demographic makeup of the partnership (e.g., gender, race/ethnicity, religion, age)? Is there a variety of groups within your partnership? Who is missing? How will this influence your ability to create change in your community?
- Do all partners feel they have a voice? Are all opinions and ideas taken into consideration and respected?
- Are meetings held in a place and at a time that encourages participation by multiple groups within your community?
- Have you and your partners clearly described what you want to do?
- Do you have processes in place for shared decision making?
- Do you have processes in place for managing conflict when it arises? (See "Anticipating challenges" on page 79)

## PERSPECTIVES — Funding

**Alicia Lara:** *California Endowment; Woodland Hills, California (Participant in Learning From Doing forum)*

For funders, the two most important elements in improving the social determinants of health at the community level are achieving balance between individual and social responsibility for health and understanding the power dynamics of community interventions. Funders should be prepared to:

- Ensure that the projects they support strive to achieve a balance between individual and group responsibility.
- Support changing the power dynamic by helping community based organizations access and manage resources.
- Accept that creating sustainable change in a community requires a long-term commitment from funders.
- Learn to work collaboratively with other funders.

- Does your partnership speak with a unified voice?
- Do several individuals help with day-to-day operations?
- Do you have shared leadership?
- Do leaders have the skills necessary to facilitate a meeting? Do you share information from the meeting with those who were and were not present (e.g., minutes)?
- Do current leaders know how to mentor new leaders?
- Do members trust the partnership leader?
- Does your partnership influence events outside your group?
- Does your partnership have physical space and other resources (e.g., facilities, equipment, supplies) for day-to-day activities?

## EXAMPLE FROM THE FIELD

### Identifying Partnership Assets<sup>68</sup>

To identify partnership assets, the community partnership to address the social determinants of diabetes decided to engage partners in the following discussion:

- Who are the individuals, organizations, and institutions that make up this partnership? Are people with diabetes involved?
- Do our partners represent the people living in this community in their race/ethnicity? Gender? Income? Education? Age? Ability status? Sexual orientation?
- What individual and organizational assets do partners bring to the table? These might include, for example, the capacity to provide health services; relationships to policy makers, health care administrators, or the media; connections to other important sectors, such as social services, education, jobs, or housing; community organizing skills; office experience; research or evaluation skills; places to meet; and resources such as computers or copy machines.
- Have we established communication and decision-making processes?
- What is currently being done to prevent the onset of diabetes in our community? What is being done to address the diagnosis and management of diabetes? What is being done to address social determinants that contribute to diabetes? Who is doing this? Can we partner with them?

## Building partnership capacity

Responses to these questions will help point to areas where the partnership is doing well and areas that need improvement. This inventory can lead to changes in where and how often the partners meet, how long meetings should last, decision-making processes, conflict-management strategies, and the roles and responsibilities of individual partners.

In addition to your partnership principles, it is important to create and agree upon ground rules for running partnership meetings. Ground rules are a set of standards for group behavior that establish a safe and comfortable environment and may include sharing information, respecting others' opinions, refraining from dominating the discussion, correcting misperceptions and maintaining confidentiality. For further information and assistance with creating partnerships, see "Moving Forward: Partnership Meetings" below.

## MOVING FORWARD

### Partnership Meetings<sup>69</sup>

- Convene your partners to discuss a proposed agenda.
- Build social time into your gatherings for networking or just getting to know each other.
- Prepare an invitation with a catchy slogan and reading materials to attract community members to the discussion.
- Consider inviting a neutral facilitator for the discussion.
- Agree upon, post, and revisit as needed a set of ground rules for the meeting.
- Develop, post, and revisit as needed a set of principles to guide the partnership.
- Meet on a regular basis with a clear purpose; start and end meetings on time.
- Define roles and responsibilities for all partners (e.g., appoint someone to take notes and prepare meeting minutes).
- Preserve shared leadership and responsibility by delegating meaningful tasks to small groups or subcommittees and devising realistic timelines. Form active committees that allow partners to be involved in issues of concern to them.
- Prepare to engage partners using multiple methods of communication (e.g., oral, written, pictorial) to ensure that people understand information and feel comfortable expressing themselves.
- Avoid conversations about strategies for addressing problems until you have jointly defined the nature of the problems.
- Create an atmosphere in which participants feel comfortable expressing contradictory opinions.
- Focus on common ground but don't be afraid to address conflicts.
- Be prepared to deal with conflict as it arises. (See Section 5 for more information on conflict resolution)
- Prepare meeting summaries and share them with all partners.
- Establish consensus on the financial responsibilities of members and develop a budget for the partnership.
- Build relationships with elected officials and other key community leaders to gain support for the partnership.
- Ensure consistent and clear communication among all partners. Consider creating a newsletter to keep everyone informed.
- Seek technical assistance and support if resources are needed from outside the partnership. This may include recruiting people with needed skills to become members of the partnership or asking outsiders to help (but not necessarily join) the partnership.
- Recognize hard work and dedication through celebrations and fun activities.

Your partnership will likely include a wide range of individuals and groups (e.g., members, researchers, health care professionals, counselors, educators, community activists, community planners), so you may want to consider dividing partners into smaller, more focused subgroups to enable the partnership to function more efficiently (e.g., finance committee, executive committee, youth committee, senior committee). The structure of the partnership should specify how these committees are to coordinate their efforts with the entire partnership. For example, you may decide to have committees report to the larger group on a regular basis.

Establishing strong relationships among partners and ensuring that each partner has clear roles and responsibilities are essential to the success of your partnership. Carefully consider whom to invite into a partnership, how information is to be shared, and how inherent power structures already operate within the partnership. As you move toward defining which social determinants of health you want to focus on and the approaches you want to use, you may need to consider adding new partners to enhance the group's resources and capacity. Highlighting the benefits of participation for each member of the partnership and ensuring that the partnership is structured in a way that maximizes these benefits for each partner are also important.<sup>66</sup>

## PERSPECTIVES — Research

**Susan Tortolero:** *University of Texas Health Science Center; Houston, Texas*  
(Participant in Learning From Doing forum)

Academic and public health researchers need to adapt training, evaluation, and research approaches to support and develop the relatively new field of social determinants intervention research. For example:

- Public health models that hold individuals solely responsible for their poor health need to begin incorporating systemic factors that affect health, such as racism and poverty.
- Developers of interventions to address social determinants of health need to conduct appropriate evaluations of the interventions and publish the results to build a scientific basis for this work.
- Researchers and community partners need to be trained in conducting community-based participatory research. Training should include leadership, participation in the policy-making process, communication skills, community organizing skills, and quantitative and qualitative methods for data collection and analysis.
- Academic institutions need to be more flexible in supporting this type of research and sharing resources with the community.

## FORUM SPOTLIGHT

### How to Use Partnership Capacity to Enhance Programming

*The following example illustrates how existing partnership resources were used to develop a social determinants of health initiative and how partnership capacity was strengthened as part of the initiative.*

The East Side Village Health Worker Partnership (ESVHWP), established in 1996, conducts community-based participatory research to understand and address social determinants of women's health (see pages 20-21). The ESVHWP is guided by a steering committee made up of representatives from community-based organizations and academic institutions, as well as health care providers and community members known as Village Health Workers (VHWs). The steering committee decided to focus on diabetes in women residing in Detroit's east side, because the Detroit VHWs deal with diabetes in their own lives and the lives of their friends, families, coworkers and community members. Given the benefits of having an existing partnership (e.g., people with a working relationship, resources, skills, and experiences), the VHWs were able to develop the Healthy Eating and Exercising in Detroit (HEED) initiative. As the ESVHWP members worked together to develop, implement, and sustain the HEED project, the VHWs were also able to attract individuals with other resources, skills, and experiences to enhance their capacity to reach community members and influence their behavior.

# Focusing Your Partnership on Social Determinants of Health

With your partners around the table and principles and ground rules established, you are now ready to identify and discuss the social determinants of health inequities in your community.

## Assessing social determinants of health

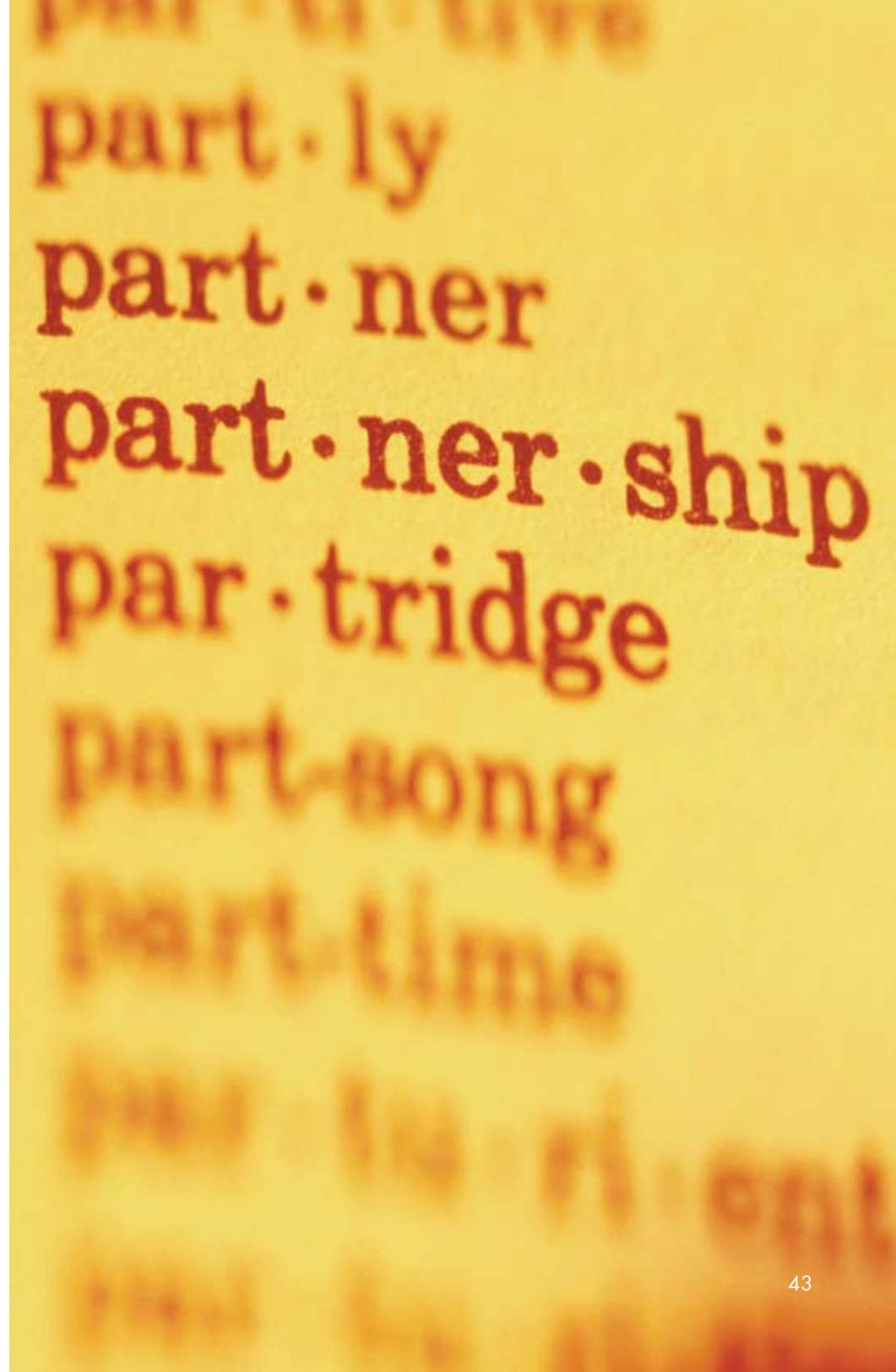
The first step in assessing social determinants of health is to conduct a community assessment. Community assessments are important for several reasons. First, an assessment can provide insight into the community context and ensure that interventions will be designed, planned, and carried out in a way that maximizes benefits to the community. Partnerships can use assessments to make decisions about where to focus resources and interventions. A community assessment

also helps to ensure that all members of a partnership understand of the relationship between the social determinants and the health behaviors or outcomes of interest. Information from a community assessment can encourage others in the community to provide support or resources for the intervention efforts. Lastly, a community assessment can be used to understand where your partnership is starting and what kinds of things you want to track along the way in order to determine how your efforts are contributing to change. A community assessment is considered more comprehensive than the more traditional “needs assessment” because it assesses not only the challenges and needs of the community but also the resources and strengths of the community.

There are many ways to identify and assess social determinants of health. Your partnership can choose one or several, depending on the interests and skills of your partnership members and on resource availability. Below are a series of steps to consider as you conduct your community assessment.

### 1. Consider what you and your partners want to assess.

In some communities, it may be helpful to gather support for addressing social determinants by identifying the leading causes of morbidity (sickness) and mortality (deaths) for the community. Partners can then assess the extent to which the social determinants influence morbidity and mortality, as illustrated in Chapters 1 and 2. Other communities may choose to identify the social determinants first and then examine the extent to which each contributes to causes of morbidity and mortality. Both approaches can be helpful for narrowing in on your partnership's priority areas. Remember, some social determinants have a direct impact on health whereas others influence health through behaviors or psychosocial factors (see Figure 1.1 on page 10). In addition, some social determinants can have a positive influence on health (e.g., support, resources) whereas others have a negative influence. Lastly, once your partnership has chosen a priority area, it may be useful to reflect with community members on current and past programs that have been conducted to address this area, if any (e.g., policy development, environmental change, social marketing campaigns, education programs). Once an inventory has been created, document what about these prior efforts did or did not work, what challenges were faced, what was not addressed in previous approaches, and whether efforts worked for the entire community or only for specific populations.<sup>51,70</sup>



## 2. Talk to other community partners and members who represent the population or communities of interest.

From these conversations, try to determine perceptions of the needs, resources, and challenges in the community. These individuals may be interested in collaborating on the community assessment and cultivating a working relationship to support intervention planning, implementation, and evaluation activities.

## 3. Think about the types of information that will be useful for understanding your community.

There are multiple sources of information that can be assessed. The community initiatives presented in Chapter 2 suggest that a combination of information sources may provide the most complete perspective of the community. In general, it is useful to consider sources in the scientific literature as well as local, state, and national Web-based data systems. The following existing sources of information may be of use:

- **Morbidity/mortality.** Numerous data systems are available to evaluate the rates of morbidity (sickness) and mortality (deaths) within your community. To the extent possible, it may be useful to examine these data by race, income, or other characteristics to better understand how social determinants could be influencing health disparities in your community. For example, you can view the National Health and Nutrition Examination Survey data (NHANES, <http://www.cdc.gov/nchs/nhanes.htm>), National Health Interview Survey data (NHIS, <http://www.cdc.gov/nchs/nhis.htm>), and National Vital Statistics System data (NVSS, <http://www.cdc.gov/nchs/nvss.htm>).
- **Behavioral factors.** Various groups in your community might have different rates of health-related risk behaviors. Even if you wish to focus on the social determinants of health, it may be useful to have information about health-related behaviors among different groups in your community.

These data may be important in understanding the extent to which social determinants influence health behaviors and health outcomes. For example, you can visit the Behavioral Risk Factor Surveillance System (BRFSS, <http://www.cdc.gov/brfss>) and Community Health Status Indicators (CHSI, <http://communityhealth.hhs.gov>, available Spring 2008).

- **Social indicator data.** A number of sources can give information on various social, economic, and environmental conditions in your community, including employment, education, housing, transportation, and parks and recreation. It may be useful to have a researcher or other partner familiar with how to access and work with such data (through Web sites or other sources). The benefit of these data is that they provide information about places or communities on a wide variety of indicators. For example, these data sources may provide information on employment (e.g., job growth, discrimination, affirmative action policies), housing (e.g., residential patterns, costs, mortgage lending practices), environmental hazards (e.g., air quality, hazardous waste), and education (e.g., graduation rates, dropout rates, literacy rates) as well as individual-level information (e.g., percent of families living below poverty in your county). Multiple useful resources are available on the Web at [http://www.cdc.gov/dhdsp/library/data\\_set\\_directory/pdfs/data\\_set\\_directory.pdf](http://www.cdc.gov/dhdsp/library/data_set_directory/pdfs/data_set_directory.pdf) (data set directory of social determinants of health at the local level).

Each of the data sources described above may be helpful for determining the best starting point to understand how social determinants contribute to health disparities in your community. By reflecting on them together you may gain a better sense of the specific social determinants you want to address. For example, your community may have high rates of morbidity and mortality associated with high rates of obesity (e.g., cardiovascular disease, diabetes) and lower rates of fruit and vegetable consumption in areas with fewer grocery stores. These findings might lead your partners to consider developing community produce markets.

#### 4. Determine what information you need to collect to better understand your community.

The community initiatives presented in Chapter 2 suggest that a combination of assessment methods works best. Your partnership may find existing sources of information useful, but there may be limited existing data sources that can provide insight into the resources, services, and other types of support in your community. You may want to gather additional information before deciding, but this can be costly and time consuming. In this case, guidance from someone with research experience will increase the quality of the data and the likelihood of getting the information your partners are seeking. Below are some methods your partners might want to consider when gathering data for your community. Community asset mapping may also be helpful and is discussed on page 55.

► **Review of existing data sources.** One aspect of community assessment is an assessment of existing resources and programs. This includes an assessment of policies, programs, services, and resources of community agencies and organizations to assess interaction among these groups, duplication, overlap, gaps, emerging issues, and new resources. It may be helpful to list the existing sectors of your community and the specific agencies or individuals your partners consider important in each area. These might include health care, policy makers, social service agencies, civic and neighborhood associations, educational institutions, businesses, faith-based organizations, community members, and media representatives. Identify the resources that each entity can contribute, including personal skills such as counseling or public speaking, funding, meeting space, equipment, supplies, programs, publicity, tools, or information. Describe how these entities and resources can have a meaningful impact on your partnership's area of interest. Finally, identify strategies for recruiting entities that are not already part of your community partnership (i.e., determine what might motivate them to get involved). It may also be useful to identify how, or if, various sectors contribute to the social determinants that influence health. For example, there may be institutional policies that

influence who gets hired or city policies that influence whether or not certain businesses decide to provide services in a particular area.

- **Survey data.** Several data sources have public use instruments that can be used within your community. Your partners may want to use these instruments to gather information about morbidity, mortality, behavioral risk factors, psychosocial factors, and social determinants. These data may be available through the Centers for Disease Control and Prevention (<http://www.cdc.gov>) and include BRFSS, the Youth Risk Behavior Surveillance System and the Global Youth Tobacco Survey, among others. Alternately, you may want to collect survey data that is not typically part of existing data sources. For example, it may be important to assess your community capacity for engaging in change efforts (e.g., civic engagement, organizational belonging, interorganizational networks, and community values). Several researchers have considered ways to capture these characteristics and have made tools and instruments available (e.g., <http://ctb.ku.edu> and <http://wonder.cdc.gov>).<sup>71</sup> There are also various instruments for assessing experiences of racism and discrimination and socioeconomic status that may be useful.<sup>72-74</sup>
- **Brainstorming.** Brainstorming is a way of generating ideas from a group of individuals. You may want to ask members of your partnership to list the social determinants they think have a significant impact on the health of their community. You can do this verbally, asking people to discuss or call out the concerns in their community, or visually, asking individuals or groups to create posters or collages that picture the health concerns in their community. The benefit of this process is that you can learn about community perceptions of what is most important. If your partnership represents a small group of individuals within your community, you may need to get input from other community members and organizations in order to capture the range of issues most important to the entire community.

- **Qualitative interviews or focus groups.** Qualitative interviews, or guided discussions, can occur with individuals or with groups. Such interviews allow you to ask specific questions about social determinants of health, including current or historic experiences. Developing an interview guide with an outline of questions and probes (follow-up or clarifying questions) to be asked of each individual or group will increase the quality and amount of information gathered from participants. One benefit of this method is that it allows you to obtain more in-depth information than you might from a brainstorming process while still providing a community perspective. You can also identify additional groups in your community and ensure that individuals from each of these groups are interviewed, allowing for a wider range of perspectives than you might get from brainstorming.<sup>75,76</sup>
- **Photovoice.** Photovoice is a way of conducting a community assessment through still photographs or video. The photography may be conducted by members of the community or by outsiders. Typically, the images collected are used to generate dialogue among community members or community agencies about the conditions in the community.<sup>77</sup>
- **Community observation and audits.** Community audits are tools that can be used to systematically track various social and physical structures as well as individual behaviors in a geographic location. Audits may, for example, be checklists that indicate whether there are sidewalks or streetlights in a particular location. Audits can also be used to identify the presence or absence of merchants who sell fruits and vegetables as opposed to snack foods and alcohol. Alternately, audits can be used to assess the number of vacant lots, playgrounds (with and without equipment), or graffiti. Community audits may be used with geographic information systems software to create maps indicating the presence or absence of various structures in different areas. Printed poster-sized maps and pushpins can also be used to indicate the presence or absence of various structures.<sup>78-81</sup>
- **Concept mapping.** Concept mapping is a process that uses complex qualitative data to engage participants in the definition and measurement of key determinants. In addition, it provides participants with the opportunity to develop conceptual frameworks of how the determinants relate to each other and to health and behavior. Concept mapping includes six overall

steps: preparation (select a group of participants and determine focus), group brainstorming to generate statements, structuring statements through a sorting process to create clusters, representation of the statements/ clusters using a map, interpretation of the maps and utilization of the maps. This process is considered particularly appropriate for obtaining information regarding group-level definitions and perceptions as opposed to individual conceptualizations.<sup>82-84</sup>

- **Health impact assessment (HIA):** HIA is a combination of procedures, methods, and tools by which the potential impact of a policy, program, or project on the health of a population can be assessed. It is similar to an environmental impact assessment, though the emphasis with HIA is the impact on humans rather than the environment. HIA can range from simple, fairly easy-to-conduct analyses to more in-depth, complex analyses. HIA is a broad concept often interpreted in different ways by different users, but there are common elements that can provide a framework for common action among multiple users. Some of these common elements include: social impact assessment, epidemiological assessment, retrospective evaluation of community interventions, health inequalities impact assessment, and hazard mapping. While retrospective analyses are possible, HIA is considered most effective when used prospectively, or before deciding upon and implementing a course of action.<sup>85</sup>
- **Appreciative inquiry. (AI)** AI is a change strategy that identifies existing strengths in a community, group, or system and then actively builds on these strengths to improve a situation. AI often begins by asking such questions as “What is working well here?” and “Why is this working well?” Rather than focusing on problems, AI uses positive words, stories, and images to describe conditions that currently exist and then positively describes conditions the group would like to create. Steps in the process often include discovery, visioning, designing, and creating/sustaining. Capturing and enhancing positive aspects can access untapped potential, which can then be directed toward positive change.<sup>86</sup>

**Table 3.1: Applying Assessment Methods to Different Types of Social Determinants**

<b>Method</b>	<b>Context</b>	<b>Example measures</b>
<b>Review of existing data</b>	<b>Social</b>	<ul style="list-style-type: none"> <li>➤ Crime rates.</li> <li>➤ Housing patterns.</li> <li>➤ Law enforcement policies.</li> </ul>
	<b>Economic</b>	<ul style="list-style-type: none"> <li>➤ Poverty rates.</li> <li>➤ Local tax dollars spent on health, education, transportation, etc.</li> <li>➤ Policies on government spending.</li> </ul>
	<b>Environment</b>	<ul style="list-style-type: none"> <li>➤ Land-use policies (e.g., commercial, residential, parks).</li> <li>➤ Industry standards (e.g., pollutants).</li> <li>➤ Maintenance policies and procedures (e.g., trash, playground equipment).</li> </ul>
<b>Surveys, qualitative interviews, focus groups, appreciative inquiry, concept mapping</b>	<b>Social</b>	<ul style="list-style-type: none"> <li>➤ Perception of racism and discrimination.</li> <li>➤ Perception of a sense of community.</li> <li>➤ Feeling safe from interpersonal crime.</li> </ul>
	<b>Economic</b>	<ul style="list-style-type: none"> <li>➤ Perception of job availability.</li> <li>➤ Perception of local businesses' financial contributions to the community.</li> <li>➤ Attitude toward policies on public spending.</li> </ul>
	<b>Environment</b>	<ul style="list-style-type: none"> <li>➤ Knowledge of environmental hazards in the community (e.g., pollution, illegal dumping).</li> <li>➤ Perception of access to places and resources to maintain health.</li> <li>➤ Attitude toward policies related to the environment (e.g., pollutants).</li> </ul>
<b>Brainstorming</b>	<b>Social</b> <b>Economic</b> <b>Environment</b>	<ul style="list-style-type: none"> <li>➤ Community list of priority concerns.</li> <li>➤ Perception of strengths and weaknesses of previous efforts to address concerns.</li> <li>➤ Identification of innovative ways to address concerns.</li> </ul>

<b>Photovoice</b>	<b>Social Economic Environment</b>	<ul style="list-style-type: none"> <li>➤ Pictures of people, places, or events that can be used to describe or tell a story about the community, such as: <ul style="list-style-type: none"> <li>• People talking or greeting one another; people arguing or acting hostile to one another.</li> <li>• Closed schools or businesses, building remodeling, or construction.</li> <li>• Trees, art or cultural decoration; abandoned cars or litter.</li> </ul> </li> </ul>
<b>Community audits</b>	<b>Social Economic Environment</b>	<ul style="list-style-type: none"> <li>➤ Documentation (e.g., checklists, inventories) of observations of people, places, equipment, maintenance, or aesthetics in the community environment, such as: <ul style="list-style-type: none"> <li>• People engaging in physical activities; people driving in cars.</li> <li>• Absence of grocery stores, supermarkets, and produce markets; presence of fast food restaurants and convenience stores.</li> <li>• Parks with paved, marked, multi-use trails; playgrounds with broken swings or rusty equipment.</li> </ul> </li> </ul>
<b>Health impact assessment</b>	<b>Social Economic Environment</b>	<ul style="list-style-type: none"> <li>➤ Existing evidence: published reviews, gray literature, and views and opinions of people and organizations affected by the issue.</li> <li>➤ Identification of health relevance of a policy or project of interest.</li> <li>➤ Estimation of the size of health impact of the policy or project of interest.</li> <li>➤ Identification of key health issues and concerns.</li> </ul>

## MOVING FORWARD

### Identifying Social Determinants of Health

- Ask partners to think 20–25 years into the future and imagine how they would like life to be different in their community.
- Invite outside speakers who can help inform the partnership about social determinants of health and how they contribute to health inequities in the community.
- Take a walking tour of different areas of the community and ask partners to take pictures that represent conditions or social determinants they would like to address in the community.

## 5. Develop a work plan that identifies tasks to accomplish, partner roles and responsibilities, and a time frame for completion.

It is often helpful to lay out a specific plan for conducting the community assessment that includes:

- The information to be collected and the questions you hope to answer. This will help the individuals collecting the data to be sure that what they are collecting will be useful. For example, the partnership may want to know morbidity and mortality rates in general or by certain population subgroups (e.g., race/ethnicity, age).
- The potential data sources to examine for this information (See Step 4 for data sources).
- The individuals responsible for exploring these data sources.
- A timeline for completion and reporting back to the partnership that is flexible.

## 6. Collect and organize information so it can be shared with all partners, community organizations, and community members.

Develop a table of indicators related to various diseases, behaviors, psychosocial factors, social determinants, and any other relevant information that was gathered about your community. The Internet and other technologies have made information easier to access than ever before. However, it is important to focus on the data that are most useful to your partnership and to present these data in ways that allow all partners to understand the relationship between social determinants and health. Consider comparing the information your partners have gathered with that collected for other communities or counties or the state or nation as a whole (e.g., high school dropout rates, median income among various groups, percentage of population below poverty, unemployment rates, business census data indicating changes in the number of grocery stores in your community). This comparison can help identify high-priority considerations for your community relative to other communities. It is easy to be overwhelmed by too much data. If possible, have someone who is familiar with accessing and summarizing data help you in this effort. Remember that some people are better able to process data when it is presented visually in maps, graphs, and, to a lesser extent, tables.\* It may also be useful to consider pros and cons of more simple data collection and methods (e.g., counting the number of vacant lots and indicating their location by putting pushpins on a map) versus more complex and costly data collection and methods (e.g., extensive community audits and geographic information systems software).

\* For maps, the data must be geographically referenced so they can be displayed with mapping software.

## 7. With information gathered and summarized, partners can prioritize issues to address.

After you have completed your community assessment, ask partners to decide on the most important issues to address first. This may be done in partnership meetings or through meetings with various community agencies and organizations. Alternately, it may make sense to hold a community forum to present your findings. A community forum is an opportunity to bring together individual community members, partnership members, agency representatives, elected officials, and other interested and influential groups to present the findings from the assessment and move toward prioritization and intervention development. The methods used should incorporate the process the community members and organizations have used for decision making in the past. Regardless of the mechanism chosen, it may be useful to consider the following in your discussion of priorities:

- Which determinants affect the largest number of people in your community?
- Which determinants are most important to your community?
- Why are these determinants important to your community?
- Which determinants have the greatest positive or negative impact on the health of the community?
- Which determinants are easiest to change?
- Which determinants are your partners most willing to work to change?
- What is the expertise of your partners?
- What are the barriers to addressing these determinants?
- What resources are available to address these determinants?

There are four basic principles or lessons learned that others who have conducted community assessments have found helpful in guiding discussions.<sup>87</sup>

- No matter how much time is available to the partnership, there will never be enough time to examine everything.
- Make intentional and open choices about what to assess and what not to assess.
- Be clear about the purposes of the assessment. Make choices about the methods you will use, what information will be shared, who the information will be shared with, and how it will be communicated.
- Be sure the assessment promotes the interests of the community members and that findings are not used against them.

Once you have conducted your community assessment, this information can be helpful in determining priority areas to focus on, setting goals and objectives for your intervention (see page 52), and determining a baseline to assess the progress you are making toward achieving your desired outcomes (see page 82).

## Identifying a vision and mission for the partnership

Increasing agreement to focus on the social determinants, psychosocial factors, health behaviors, and health outcomes of interest is part of the process of building partnership cohesiveness. Partners can begin to define a general direction for the partnership through a decision-making process that gives all participants an active role in creating a shared vision and mission. Because social determinants of health inequities may not be the primary focus of your partnership, you may need to remind your partners about ways in which social determinants affect their ability to improve the health of the community.

To address the social determinants of health inequities, you may need to challenge partners to identify larger, system-level concerns.<sup>67</sup> As covered in the previous section, try to hear from a range of people and organizations and create a balance between groups already involved and those new to the

discussion. Remember to work from the list of determinants, factors, behaviors, and outcomes already generated (see page 52).

If you attempt to change the social determinants of health within a community by working within an existing organization, you may find that the organization has already defined a vision or mission that does not include social determinants of health. If so, you can either build on what exists by highlighting additional actions that could address social determinants of health inequities or suggest modifying the vision to better meet the needs of people and organizations in the partnership.

*Please see the “Suggested Readings and Resources” section for references on assessing social determinants of health and writing a shared vision and mission statement for your partnership.*

## EXAMPLE FROM THE FIELD

### Assessing Social Determinants of Inequities in Diabetes

Once they had invited key partners to meet, the public health agency identified some questions to help focus the discussion on the social determinants of diabetes. These included:

- According to statistics, diabetes is a significant problem in this community. Do you agree? Why? Why not?
  - How has diabetes affected this community? Please identify specific examples.
  - Are some community members more likely to get diabetes than others? Why? Why not?
  - Are some community members with diabetes able to manage their diabetes better than others? Why? Why not?
  - Does the history of this community influence who gets diabetes and how it affects their lives? How?
  - Do the values of this community influence who gets diabetes and how it affects their lives? How?
  - What other factors influence who get diabetes and how it affects their lives?
- What characteristics of this community support people who have diabetes?
  - What are the obstacles to preventing, treating, or managing diabetes for people in this community?
  - What are the social, economic, and environmental conditions that influence the prevention, treatment, or management of diabetes in this community?
  - Do other communities in this area experience the same problems with diabetes? Why or why not?
  - Do the other communities work with this community to address diabetes? If so, how?
  - What are the most common problems faced by people with diabetes in this community?
  - How do these problems relate to other challenges faced by community members?

## EXAMPLE FROM THE FIELD

### Creating a Mission and a Vision<sup>67</sup>

After the partners met and agreed on some key social, economic, and environmental concerns related to diabetes to address in their community, they were ready to discuss their mission and vision. They organized their discussion using the following questions:

- What are the three most important social determinants of diabetes in our community?
  - Partners used a group process in which participants wrote down what they thought were the most important social determinants related to diabetes. The meeting facilitator then asked each person to read one of these determinants out loud. The determinants were written on an easel or large piece of paper taped on the wall so that the group could see the list. Once everyone had had an opportunity to add one determinant to the list, the facilitator went around the group again, asking people to add any determinants that had not yet been listed.
  - Of the determinants listed, the group was asked to identify the top priorities for the community. Partners were asked to pick and rank the three determinants they thought were most important from the list generated. Then the participants stated their top three determinants, and the facilitator indicated their votes with stickers (i.e., blue sticker for #1, red sticker for #2,

and green sticker for #3). By doing this, the group was able to see which determinants most people thought had the highest priority.

- The group was asked to decide which of the determinants with greatest priority could be more readily changed in the short term and which of the would require long-term initiatives. The facilitator then asked each partner to rank the determinants, this time by the ability to create change, identifying those that could be changed in the short term and those that can be changed in the long term. A different color scheme was used to identify the changeability rankings (i.e., purple for short-term change, and orange for long-term change).
- What does this partnership need to look like in order to address these priority social determinants of diabetes? Do others need to be invited to join the effort?
- What does our community need more of and less of to reduce inequities in social determinants that impact who gets diabetes and how it affects their lives?
- How will our community look different if these social determinants of diabetes are addressed? What can be done in 1 year? 5 years? 10 years? 20 years?

## Identifying and prioritizing goals and objectives

Goals and objectives can help you stay focused on activities that enable you to achieve your mission and vision.<sup>70,79</sup> Goals are defined as the long-term outcomes that you hope to achieve. Objectives are concise, time- and action-specific, measurable statements that describe how a goal will be reached. Objectives specify what needs to occur, the time it will take to achieve the desired result, the specific approaches you will use to address your determinants, and how much of a change you anticipate will be required

to reach your goal. Typically, numerous objectives must be accomplished to achieve your goal.

Each objective may also require multiple action steps. To identify and prioritize goals, objectives, and action steps, you can revisit your partnership's vision and mission. Specific goals, objectives, and action steps can be derived from these consensus-driven statements.

An initiative planning model<sup>70,79</sup> can be very useful as you organize your goals, objectives, and action steps and prioritize your objectives. This model can be used to inform your planning process by guiding your community to understand current needs and to plan for the future. To develop an initiative planning model, outline your overall long-term goal and a series of objectives that will help move you toward achieving this goal. These objectives can be used to identify the specific action steps necessary to create change and benchmarks to determine your progress. In developing this model, be sure to include who will be responsible for each action step and the time frame for the steps completion.

Combined into a model, these goals, objectives, and action steps provide the sequence of necessary actions. From this information, you and your partners can prioritize activities according to the timeline laid out in the plan. For example, community awareness and support may be needed before you can secure resources to create structural changes.

In addressing social determinants of health inequities, you may decide to focus on one specific determinant (e.g., housing, racism) within an initiative or specific health outcomes and the social determinants that influence them.

## EXAMPLE FROM THE FIELD

The partnership to address the social determinants of diabetes met to create an initiative planning model. They began by discussing their population. Using data, evidence-based recommendations (e.g., the Community Guide – <http://www.thecommunityguide.org>), their knowledge of the community, and group discussion, the partnership developed an implementation strategy for reducing diabetes in their community. They defined the goal, objectives, approach, action steps, and costs as follows:



# Building Capacity to Address Social Determinants of Health

## Assessing community capacity

“Community capacity,” as used in this workbook, refers to the resources, infrastructures, relationships, and operations that enable a community to create change. Using and increasing community capacity, also often referred to as the “assets” of a community, is an essential step in improving the health of community members.<sup>63,88,89</sup>

Assessing community capacity helps you think about existing community strengths that can be mobilized to address social, economic, and environmental conditions affecting health inequities. In general, you should look at the places (e.g., parks, libraries) and organizations (e.g., education, health care, faith-based groups, social services, volunteer groups, businesses, local government, law enforcement) in various sectors of the community. It is also important to identify the nature of the relationships across these sectors (e.g., norms, values), with the community (e.g., civic participation), and among various subgroups within the community (e.g., distribution of power and authority, trust, identity).<sup>81,82</sup> For more information on assessing and mapping community assets, see “Moving Forward: Mapping Community Assets” (page 55).

## MOVING FORWARD

### Mapping Community Assets<sup>68</sup>

- Begin by defining community assets so that everyone understands what resources are already available in the community. These can include people, organizations, or places and their associated resources (e.g., knowledge, skills, meeting space).
- Discuss the importance of identifying community assets, including how these assets can help move a project forward even when funding is limited or unavailable. Community members feel a greater sense of control over their lives and their communities when involved in the process, and efforts are likely to last longer when they use existing resources.
- Work with partners to identify the purpose(s) for creating an inventory of community assets, because you may not know what resources you have in your community. For example, community members' talents might be underutilized, so you may have to find alternative ways to encourage a sense of pride and ownership or build trusting relationships.
- Outline a process for collecting information, including what will be collected (e.g., historical information; demographic information; awareness of social determinants; information on social, economic, and environmental conditions; infrastructures; facilities); how the information will be collected (e.g., telephone interviews, group discussions or brainstorming, face-to-face interviews); what and how many people, organizations, and places will be inventoried; how long it will take to collect the information; how much it will cost; and how you will use the information once it has been collected.
- Decide on roles and responsibilities for conducting the inventory, including who will lead, who will collect and store the information, and who will analyze and present information to the partners.
- Develop and pilot test interview questions with your partners to make sure you are capturing all the information you need.
- Develop a map of your community's assets such as parks and community centers in one of several ways: find a large street map and mark assets with a dot, tag, or pushpin (maybe color coded by type); use a computer software program (e.g., geographical information systems); or draw your own map to illustrate the locations of various assets.
- Use the map to identify places in the community with and without resources. This information will be helpful as you think about what locations are in greatest need and what resources are available in or around them.



## EXAMPLE FROM THE FIELD

### Mapping Community Assets<sup>68</sup>

To map community assets, the community partnership to address social determinants of diabetes discussed the following questions and came up with some ideas for each question:

**What are the relevant skills, capacities, and experiences of community members and organizations that can help address the social determinants of diabetes? (Make a note of those not included among your partners).**

- Health care environment (e.g., hospitals, clinics, insurance companies, pharmacies)?
- Food environment (e.g., produce markets, quick shops, fast food restaurants)?
- Active living environment (e.g., sidewalks, parks, recreation centers)?
- Community services (e.g., employment assistance, housing, transportation)?
- Other public institutions (e.g., schools, libraries)?
- Private businesses?
- Nonprofit organizations?
- Community or neighborhood organizations?

**How can these skills, capacities and experiences be used to address the social determinants of diabetes? Some examples include changes in environments, policies, and practices, such as:**

- Doctors, nurses, and support staff from a local clinic could donate time in the evenings or weekends to ensure those without health insurance have an opportunity to access health care services.
- Community members could educate other community members about the harmful effects of fast food, including the lack of nutrition, the large serving sizes, and the unhealthy preparation of the food.

- Local parks and recreation departments could build or maintain parks, playgrounds, or greenways to support active living.
- Housing officials could create programs to offer more subsidized housing to people with low income.
- Schools could provide information to students through health education classes on places to access healthy foods (e.g., produce markets, restaurants) and to be physically active (e.g., parks, community recreation centers) and encourage students to share the information with their family members.
- Small retail businesses could receive tax incentives for selling and advertising healthy food alternatives.
- Nonprofit organizations could work with local media to inform members within the community and those in surrounding communities about the significant impact of diabetes on community members' health.
- Community groups could provide support to those with language barriers or low literacy levels to ensure that health information is received by all members of the community.

**What skills, capacities, and experiences are missing?**

- Multilingual individuals.
- Media personnel.
- Evaluators.
- Individuals with knowledge of the community's history.
- Community role models.
- Policy makers.

## Building community capacity

One of the most important capacities to develop is a shared language and common understanding of how social determinants influence health. Once people and organizations in the community have a common understanding, they can work to improve the conditions that affect the health of community members.

Much of the work to increase community capacity relies on processes that you will develop working in and with your community. The following recommendations provide some guidance for developing these processes.

- Encourage broad community participation in planning, organizing and implementing projects. One way to do this is to start with existing social groups such as those in schools, work sites, service organizations, volunteer organizations, and places of worship. Individuals within these groups often share a sense of belonging with other group members and have some trust in the processes that the group uses to reach its goals – both of which are critical to the enthusiastic participation of individuals in group projects. Experiences with these groups can be stepping stones to future collaboration.
- Identify existing social relationships and use them to solicit participation from other people and organizations, share information, build unity and solidarity among community members, and open doors for individuals and groups.
- Identify useful assets of people and organizations in the community. These assets may include experience with strategic planning, the ability to facilitate meetings or mobilize people and efforts, or the ability to provide funding, space, and other necessities for carrying out the project.

- Conduct regular conversations to share information with community members and engage them in making decisions through consensus-based, collaborative processes. Build on existing social networks such as workplaces, schools, place of worship, and clubs and keep all community voices involved by attempting to address everyone's interests and needs.

Ensure that your group's leaders are representative of the community, that they understand its needs, and that they can engage all community representatives in identifying problems and devising solutions that will have broad support. You should also establish mechanisms to ensure that leadership roles and responsibilities are widely shared. These may include mentoring new leaders or creating bylaws that require periodic changes in leadership. Attempt to understand how the beliefs, perspectives, and histories of people and organizations in the community influence their willingness to participate in efforts to change community conditions and encourage them to consider alternative ways of thinking.

*Please see the "Suggested Readings and Resources" section for more information on assessing and building partnerships and community capacity and on establishing goals and objectives for your partnership.*

# Selecting Your Approach to Create Change

Once your partnership has developed a mission and vision, assessed partnership and community capacities, identified needed resources, and decided on goals and objectives, you are ready to develop interventions to address social determinants of health programs or policy initiatives intended to move your community closer to your vision. You may use a wide variety of approaches. These include raising awareness or increasing knowledge of social determinants of health inequities and their influence on health, building skills and capacities to change a social determinant or its influence on health; or altering social, economic, or environmental conditions through policies and infrastructure changes. These approaches are complementary; using them in combination increases the likelihood that changes will lead to the desired goal. In other words, although raising awareness and building capacity are critical, it is likely that changes in skills and policies and infrastructures will also be required to alter health inequities. Similarly, changes in skills, policies, and infrastructures are less likely to occur without increased awareness and capacity.

Section 2 suggested that different approaches can be used to create the changes specified in your objectives. Section 4 describes six approaches to changing community conditions that others have found useful: consciousness raising, community development, social action, health promotion, media advocacy, and policy change. The best approach depends on what your partnership wants to accomplish and your comfort level with the strategies used in each approach. In some cases, the decision to incorporate certain approaches may be partially determined by funding guidelines or other restrictions based on work already occurring in your community or organization. The following descriptions of these approaches will help you select those that best meet the needs of your partnership.

## Consciousness raising

### *What is consciousness raising?*

Consciousness raising is a process through which people come together to discuss the relationship between individual or group experiences or concerns and the social or structural factors that influence them.<sup>90-92</sup>

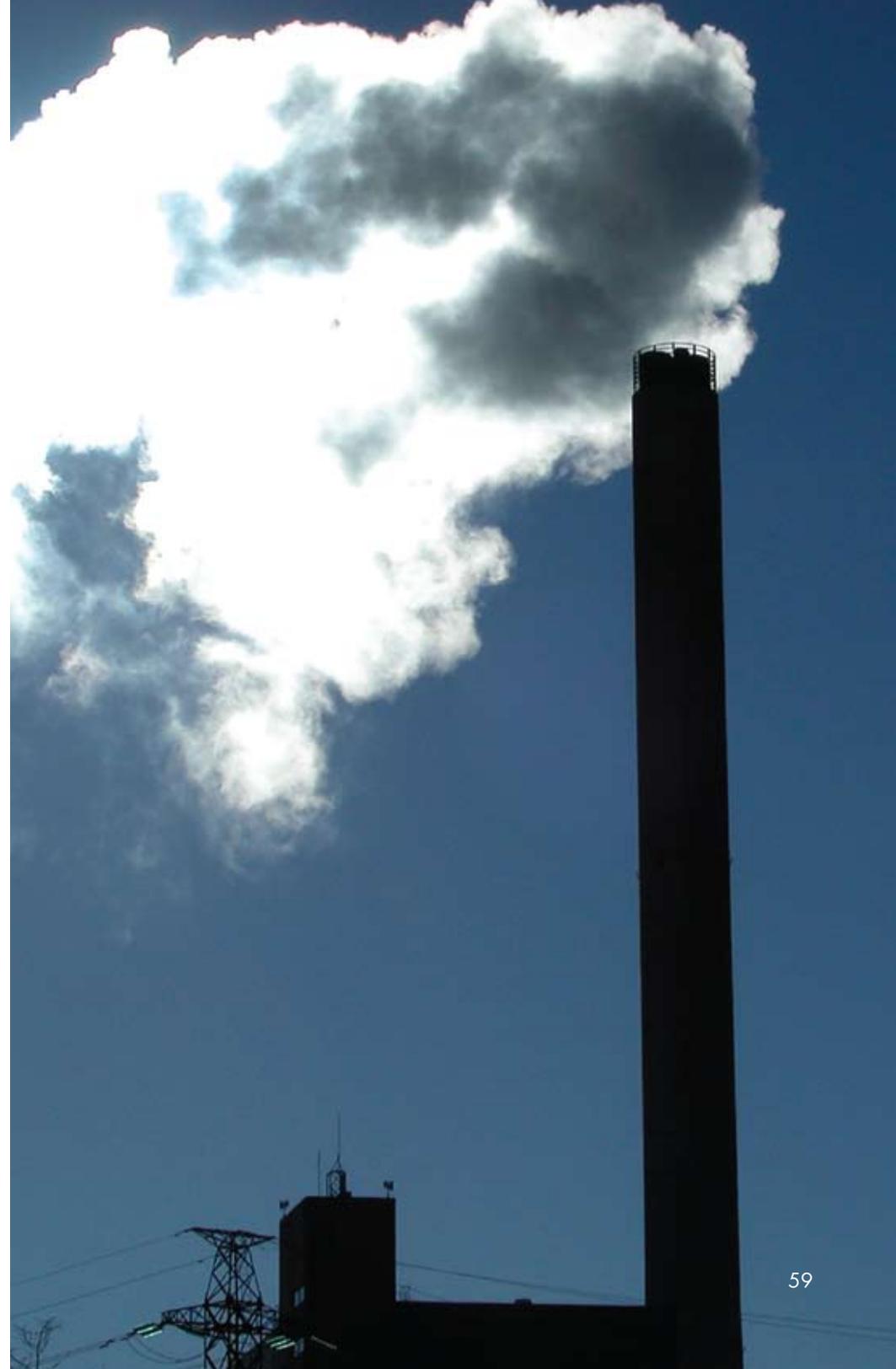
Consciousness raising can be useful both in creating a coalition or partnership and in working with an existing partnership to increase community-wide support for addressing specific inequities in the social determinants of health.

### *When do you use consciousness raising?*

This approach is useful for ensuring that both “insiders” and “outsiders” develop a common understanding of issues and concerns, stimulating discussion and motivating partners to address the issues and concerns. Consciousness raising is a good approach when some people in a group do not see or understand how social and structural factors influence health. It also helps individuals and groups identify specific social determinants or structural factors that influence current inequities to develop goals and objectives for change. In addition, this approach can help the partnership frame issues in ways that bring groups together for action rather than creating factions that lessen the ability to create change.

### *How do you use consciousness raising?*

Some methods used to raise consciousness include generating discussion by asking individuals to share their experiences, presenting hypothetical vignettes, having the group discuss responses to a picture or photograph, or reading a story or poem. Encourage critical reflection by asking individuals to describe what they saw or heard as the major issue, followed by asking “but why does this happen?” or “why is this the situation?”



## EXAMPLE FROM THE FIELD

### Selecting Your Approach to Create Change

The community partnership to address social determinants of diabetes inequities decided it would be useful to generate deeper understanding of the social determinants, as opposed to individual determinants, of diabetes. They looked in the local newspaper and found a story about a homeless person who had recently died at a nearby shelter due to complications from diabetes. They copied this story and shared it with the members of the partnership. Next, they had a partnership member facilitate a discussion focused on gaining a better understanding of how this could happen in their community. This generated a list of key factors associated with diabetes among people with limited resources.

#### List of key factors associated with diabetes among people with limited resources

- Lack of access to healthy food (e.g., not enough money to buy healthy food, fast food is available and cheap, food pantries and soup kitchens cannot afford to provide fresh fruits and vegetables).
- Lack of places or time to exercise.
- Limited access to health care and inability to afford medications, cultural factors associated with seeking health services and late diagnosis.
- Chronic stressors (e.g., family, living conditions, employment status).

The facilitator then asked the group to focus on the social determinants, or root causes, of these factors and diabetes through addressing the question, “but why does this situation exist?” This led to the reasons listed below.

#### “But why does this situation exist?”

- Lack of good jobs for those with limited education or no previous job experience.
- Many neighborhoods lack grocery stores that provide affordable fresh fruits and vegetables.
- New development has increased the cost of housing over the past few years, causing many people to become homeless or to move away from their neighborhoods; these moves may prevent people from accessing public transportation to get to health clinics or jobs.
- Feelings of discouragement and that “the system” (e.g., health care providers, employers, policy makers) doesn’t care what happens to people who are “down and out.”

## FORUM SPOTLIGHT

### Consciousness raising

*The following example illustrates how consciousness raising was used to draw attention to community problems.*

This New Orleans school- and neighborhood-based intervention is working to reduce violence and its social determinants as experienced by youth (see pages 18-19). Teachers worked with 15 students to write stories about violence in their lives or in their community. A local actor worked with the students to turn their stories into monologues. The actor and students

then added movement and sound (e.g., poetry, rap music) to the monologues to create a living backdrop meant to evoke the locations of violent events. They developed a list of people and organizations to invite to their performance and held the performance at a local park. Following the performance, the students and attendees talked about how violence was affecting the teens’ lives and discussed strategies for reducing violence.

## Community development (sometimes called locality development)

### *What is community development?*

Community development is a set of processes or efforts to create community change at the local level through strengthening social ties, increasing awareness of issues affecting the community, and enhancing community member participation in addressing these issues.<sup>90-92</sup> With respect to the social determinants of health inequities, this involves bringing together individuals affected by a particular health inequity so they can cultivate a shared group identity and develop a specific set of processes for addressing their common purpose. Though it is important for all work in this field to engage partners to determine processes, define problems, and identify approaches for change, community development is unique in that those who experience the problem are the leaders. The focus is on using existing and new individual and community capacities to increase control over the events that occur in the community.

Community development seeks to enhance or establish a group of individuals who share a common purpose: the desire to increase their abilities to work together to create changes in health or the social determinants of health. With other change strategies, the focus may be on implementing a particular health education program or policy or environmental change, and capacity building is seen as important but secondary to these outcomes. In community development approaches, the goal is to use the community capacities and strengths to increase community control.

As stated in the Ottawa Charter, a document produced by the World Health Organization's first International Conference on Health Promotion in response to growing expectations for more comprehensive, ecological approaches to public health:

"To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment... People cannot achieve their fullest health potential unless they are able to take control of those things that determine their health. At the heart of this process is [communities taking] ownership and control of their own endeavors and destinies."<sup>93</sup>

As this suggests, setting priorities, making decisions, and planning strategies are some of the main health promotion action areas; the process of problem solving is seen as health promoting in and of itself. Building and using existing capacities for problem solving can directly and indirectly improve health equity.

This approach may sound similar to community capacity building. These strategies share several common characteristics. However, the processes and outcomes may look very different. Community development seeks to establish an empowered group of individuals who share a common purpose as the primary outcome through which changes in social determinants of health inequities are created. Capacity building may involve processes that increase funding, enhance skills, or make other types of improvements but do not necessarily build on and enhance the power of those most affected by the inequity.

### *When do you use community development?*

Community development may be useful when you first develop a partnership or later when the partnership has accomplished other goals. The process encourages partners to develop a shared group identity that relies on understanding, trust, acceptance of differences, and cohesive relationships, in addition to the partnership-building activities described in Section 1 (e.g., inviting stakeholders, identifying social and health inequities in the community, deciding on a shared vision and mission). Community development is useful because it can enhance the processes by which community partners work together to define their concerns. It can also motivate partners to act on behalf of their mutual interests.<sup>90</sup> This approach may be useful when an existing partnership decides to use a more participatory approach as opposed to one that relies on public health or other experts taking the lead.

### *How do you use community development?*

Community members should take the lead roles in community development efforts. Others, such as public health practitioners, researchers, and community organizers, can assist community members by presenting processes for facilitating meetings, problem solving, and consensus building. It is important to ensure that the models and processes suggested can be modified by community members as needed. It also could be helpful to engage community members in consciousness-raising processes before, or as part of, community development to increase their awareness of the social determinants of health.

In addition to representatives from the community, partnerships should include community agencies or organizations that will be asked to help implement change. Organizations are more likely to take part in changing social determinants of health if they have been included in the discussions and have worked with the community from the start, rather than just being asked to implement a solution.

## MOVING FORWARD

### Community Development Meeting Preparation

#### Preparing to gather:

- Clarify the purpose of the meeting. This is important so you can clearly articulate the purpose to others who may be interested in working with you.
- Start by inviting community members affected by the social determinants of health in your community.
- Invite key people, including those who know about, work in, or are affected by the social determinants of health (e.g., transportation, education, economic development) in your community.
- Select a time, day, and place to meet that fits into the schedules of a majority of community members and representatives of community-based and other, more formal organizations.
- Create a clear agenda for the meeting. Ask individuals as you invite them if there is something in particular they want addressed during this first meeting.
- Ensure that everyone's specific needs are met (e.g., childcare, transportation, interpreters) so they can participate actively.

#### Facilitating discussion:

- Establish roles for ensuring that the group functions smoothly, including a neutral facilitator, note taker, and timekeeper.
- Ask participants to introduce themselves.
- Establish ground rules for the meeting.
- Agree upon and post the vision and mission statements for your group.
- Establish clear decision-making processes that encourage everyone to participate in the discussion.
- Conduct meetings in an organized fashion:
  - Review minutes or proceedings from the previous meeting.
  - Assess progress members have made in carrying out assignments from the previous meeting.
  - Determine items to be addressed at the current meeting and set priorities for discussion.
  - Reserve time on the agenda for information sharing and discussion of key topics.

#### After the gathering:

- Share handouts, minutes, and task assignments with all members, including those who were unable to attend the meeting.

## FORUM SPOTLIGHT

### Community Development

A small group of community members decided that they wanted to improve health in their community. They realized that to do so they needed to enhance their own capacities to define the key issues in their community and increase their collective ability to create solutions. The small group invited several community members and leaders (e.g., pastors from churches) to work with them to learn together how to identify health problems that threatened the community (e.g., diabetes, cardiovascular disease) and to create solutions. They spent a good deal of time talking about the underlying social, economic, and environmental problems contributing to these community health concerns. The group worked together to learn different ways of defining health and a healthy community. For example, participants were asked to respond to the following questions:

- > What do you know about health?
- > What does health mean to you?
- > What are the causes of good health and poor health?

The group then met with other community leaders to identify strengths and needs in the community and create a list of specific goals and solutions. These processes helped people already involved feel even more committed; it also engaged some of those who were not originally interested. Committees were formed to carry out the tasks identified. Some of the key social determinants identified were lack of health insurance and lack of jobs and employment security. Solutions identified included creating a formal cooperative that provided members with health insurance, small business loans, and job opportunities. Overall, those who participated felt they had contributed in a meaningful way, learning new skills and using existing skills, so that they were able to take the lead in creating change.

## Social action

### *What is social action?*

Social action is an approach that focuses on altering social relationships or resources.<sup>90-92</sup> This strategy spotlights how social factors can affect people's health and how inequities in the social determinants of health can be influenced. Social action often includes activities that explicitly highlight an issue. For example, a group of community members might join together to light a candle for each person in their community injured by an alcohol-impaired driver in the past five years as a way to encourage the enforcement of laws that prohibit driving while under the influence of alcohol.

### *When do you use social action?*

Social action can be used to help raise awareness of issues and to increase community participation in efforts to address them. It can be especially useful at the beginning of change efforts; later in the process, social action can sometimes get people's attention when other approaches have failed. Though this strategy can help define and bring attention to a problem, it does not necessarily identify effective solutions.

### *How do you use social action?*

Health practitioners can take part in social action in a variety of ways. For example, they can provide current, relevant information and data to help develop the messages conveyed through social action activities. They can also help identify appropriate audiences for a particular message (e.g., an elected official, the public at large). Health practitioners can assist the partnership in determining how to convey the message from the data to the audience in a way that will capture its attention. This is usually a public action involving a large number of people. Because the intent of social action is to make a public statement, it is often useful to organize media coverage of the event and ensure that public officials are aware of it.

## EXAMPLE FROM THE FIELD

### Social Action

The partnership to address diabetes wanted to show community members the number of people affected by diabetes in their community and how social determinants influenced these peoples' lives. They decided to hold a march with people carrying body bags, each representing a person in their community who died from diabetes at an early age because they didn't have access to resources to prevent or limit the impact of diabetes.

These individuals were followed by a group suffering from or representing those living with diabetes who lacked the resources to take care of their health. Another group followed, carrying posters highlighting the social determinants associated with diabetes, including statistics about funding for education, unemployment rates, health insurance rates, housing, and access to affordable places to eat healthy foods or exercise.

## Health promotion

### *What is health promotion?*

Health promotion refers to activities designed to help people improve their health or prevent illness through changes in environments, lifestyle, and behavior.<sup>52</sup> Health promotion includes efforts to reach individuals or families, activities in the workplace to reach employees, and community initiatives focused on larger populations. Traditionally, health promotion in the United States has focused on changing individual knowledge, attitudes, and skills to encourage particular behaviors. These promotional, informational, and skill-based messages are often conveyed in individual participants' homes, at schools or in the medical providers' offices; communicated through campaigns (e.g., distribution of generic, targeted or tailored information); or transmitted at community sites (e.g., health fairs). Health promotion efforts may also include organizational, policy, or environmental changes that facilitate positive health outcomes. These health promotion efforts are more likely to address social determinants of health, such as increased access to quality fruits and vegetables through development of community gardens or reduced exposure to environmental toxins through policies supporting improved air quality.

### *When do you incorporate changes in social determinants to enhance your health promotion programs?*

Within community settings, it is not unusual for organizations and individuals to want to focus on the behavioral determinants of health and well-being. However, even when the partnership is interested in addressing a particular health or risk behavior, it is possible to address social determinants of health equity. It is useful to incorporate program elements that address social determinants in order to create desired behavior changes. For example, educating people about the health benefits of eating fruits and vegetables is important. However, people must have access to affordable produce if they are to incorporate it into their diets. Thus, increasing access to affordable food (the social determinant), in conjunction with knowledge and skill development, is more likely to create the desired change in behavior and thus the change in health outcomes.

### *How can social determinants be incorporated into your health promotion efforts?*

Health promotion efforts may attempt to improve health by creating individual, social, organizational, community, or governmental changes. For example, individual change efforts could focus on altering knowledge, skills, attitudes, or behaviors. Such an intervention might include working to educate community members on the benefits of exercise. An examination of the social determinants that influence this behavior might uncover a number of barriers to exercise, such as a lack of recreational facilities or the requirement of fees or an annual membership to use those that are available. Your health promotion effort might incorporate attention to social determinants by working with a local recreational facility to create a sliding scale for fees or alternative payment plans for those who cannot afford the usual fees or arrangements. Similarly, your efforts to improve dietary patterns might include not only information and skill-building activities but also working with local government officials to increase access to healthy food options through tax and zoning policies that encourage the development of full-service grocery stores in neighborhoods where they are lacking.

When working to incorporate changes in social determinants into health promotion programs, especially programs in communities that experience multiple disadvantages (e.g., residential segregation due to race, ethnicity, and income), it is important to:

- Consider the quality of the existing social ties among individuals and organizations and how new social ties can be created and supported.
- Consider the physical or built environment, including:
  - Access to grocery stores with affordable fresh fruits and vegetables.
  - The availability of safe neighborhoods and sidewalks in good repair for walking.
  - Access to affordable facilities such as gyms and pools.

- Consider the availability of resources (e.g., transportation, jobs, housing, schools).
- Work with partner organizations to provide opportunities for economic development, including healthy jobs with livable wages.
- Enhance cultural competency among health educators and increase access to interpretive services.
- Use participatory approaches to work with community members and different sectors of the community to create these changes.

## FORUM SPOTLIGHT

### Health Promotion Approach that Incorporates Social Determinants

*The following example illustrates how social determinants were incorporated into a more traditional health promotion effort.*

In 1998, a group of health professionals at the Cook County Health Department in Chicago opened a walk-in clinic to address the health needs of black men (see pages 14-15). These professionals recognized the need to address health in the context of men's lives in the community. The clinic provided free health services; expanded after-hours care; provided fare cards for public transportation to the clinic and to job interviews; provided technical assistance on preparing résumés and interviewing for jobs; and offered fatherhood and parenting courses, a manhood development course, social support discussion groups and youth initiatives for sexual health education. The health professionals also developed community outreach strategies to encourage black men in the community to visit the

clinic. Once at the clinic, this connection was reinforced by a predominantly black male staff, physicians who participated in support group discussions, and courses and programs tailored to black male adult and youth cultures. This project demonstrates how health promotion efforts can be effective by increasing access to health care and by reducing barriers that reinforce social inequities, including:

- Cost of health care.
- Lack of trust for medical staff who do not understand the social context (e.g., lack of similarities with clients, including appearance, language, history, or culture).
- Flexible in appointment times.
- Assistance with obtaining employment and social support.

## Media advocacy

### *What is media advocacy?*

Media advocacy is the strategic use of media coverage to encourage social, economic, or environmental change.<sup>94</sup> Media coverage is an excellent approach for reaching large populations and capturing the attention of decision makers who influence policy. Mass media campaigns reach people through newspapers, radio, television, and other means (e.g., billboards, posters, brochures, e-mail alerts). Historically, mass media campaigns in public health have focused on encouraging individual behavior change. Alternatively, media advocacy can be designed to influence norms, policies, and collective responses by the community.

### *When do you incorporate social determinants into your media advocacy?*

Mass media campaigns have been used to increase public understanding of specific health issues, such as how individuals can change their own or their loved ones' behavior to improve health outcomes. To address social determinants of health, it is important to shift the focus to help the public understand how health outcomes are influenced by broader social, economic, and environmental conditions. This type of media advocacy campaign can help reframe certain public health concerns as the result of community rather than individual causes or problems. This can help initiate collective community responses to create change. Media campaigns are most useful when high visibility is desired and debate or discussion is useful in reframing the issue and providing support for initiatives to create social or organizational change.

### *How do you use media advocacy?*

Begin by referring to your partnership's vision and mission. Decide on the goals and objectives of your media campaign and identify your main audience.

Once you have chosen your audience, invite media representatives to become involved with the planning, implementation, and evaluation of your media campaign if they are not already part of the partnership. In addition, consider the most appropriate media outlet for delivering your message (e.g., newspaper, radio) and make sure that a representative of that medium is included in your partnership.

Next, plan your message. Identify the problem and offer solutions. Consider how to frame the problem and the solution to attract the interest of your audience and ensure the message is culturally sensitive. For example, if your objective is to increase access to health care through improved transportation opportunities, you may want to direct your media campaign toward local decision makers, transportation planners, and other influential individuals or organizations in the community. Messages may emphasize increased funding for public transportation, expansion of existing transportation infrastructure or service routes, improved hours of operation, or other changes to transportation opportunities in the community.

Decide on the best media outlet to use based on your audience. Media outlets may include television (PSAs, news, public affairs, popular culture, paid advertising), newspapers (editorials), radio, billboards, interactive media (chat rooms, bulletin boards, Web sites), or public information forums (news releases, special events, town meetings). In addition to discrete media spots, the message must be part of an ongoing community dialogue to be effective. This can be done through letters to the editor, editorials, and public hearings or community meetings.

Be sure to frame your message in a way that moves the focus for change away from individual behavior and toward social, economic, or environmental conditions. Work with local media representatives to learn how to develop a marketable story, create sound bites, and determine who will be the public spokesperson.

Additional points to keep in mind:

- Messages should be simple and clear. State the issue and why the intended audience should be concerned. Provide potential solutions, be powerful and compelling, and speak directly to your audience.

- Be sure your data are accurate, up-to-date, and easy to understand.
- Develop a media list and become familiar with local media. Find out which reporters cover which issues. Think about the audience each media outlet (e.g., newspaper, radio station) reaches.
- Work with media specialists so that your message is in the proper format for the media outlet you have chosen.
- Piggyback onto breaking news by highlighting local stories related to health and social issues.

## FORUM SPOTLIGHT

### Use of Media Advocacy to Influence Policy

*The following example illustrates how media advocacy was used to influence policy changes.*

In 2002, the Girls After School Academy (GASA), a program primarily serving African American girls aged 8-18 years, received a grant from the San Francisco Department of Public Health Tobacco Free Project to implement a smoke-free policy at the Sunnydale Housing Project (see pages 24-25). Sunnydale Housing is a 767-unit public housing project made up of 91 buildings and has been described as the largest, most isolated, and most underserved public housing development in San Francisco.<sup>92</sup> Approximately 70% of the community members are African American. Seven girls in GASA were recruited as youth advocates to research, develop, and advocate for a smoke-free policy for one of the Sunnydale buildings. After comprehensive training, the youth advocates:

- Developed a pamphlet on the harmful effects of tobacco, which included the focused targeting of African Americans by the tobacco industry.
- Conducted a survey of tenants to assess the level of interest in developing smoke-free areas at Sunnydale.
- Created a petition and collected signatures to support smoke-free buildings in Sunnydale.
- Worked with the tenants to pass an initiative to phase in a smoke-free policy.

## PERSPECTIVES — The Media

**Gregory V. Button:** *University of Michigan; Ann Arbor, Michigan (Participant in Learning From Doing forum)*

To ensure that the media will provide the coverage needed to advance the public health message from one that places sole responsibility for health on the individual to one that also questions how social factors affect health, it is important to:

- Have a clear message.
- Be armed with facts, not just assertions.
- Be prepared to discuss the solution as well as the problem.
- Build all of the elements of a good news story into presentations.
- Be tenacious and willing to undergo repeated rejection to get the message to the public.

## EXAMPLE FROM THE FIELD

### Media Advocacy

The community partners discussed a newspaper article about a person with diabetes who had died at a local homeless shelter. The article highlighted the person's life as an individual but didn't mention any of the broader social issues that influence who gets diabetes, such as high rates of diabetes among African Americans and Hispanics or high school graduation rates or health literacy levels among people with diabetes. The partnership had been exploring these issues and decided to work with local media outlets, particularly radio and local television stations, to encourage the community to consider the ways these issues influenced the health of their community. Their main goal was to shift attitudes away from "what is wrong with these people" to the social challenges faced by people with or at risk for diabetes and how a lack of choices and access to resources can make their diabetes worse. They started by considering the following: many community members may be concerned about their own health and the health of those they care about, but they may not really understand the health of other people, saying it is a choice not to be healthy. Some, such as those who work in social service agencies, may want support for their clients so they can be healthier and more effective at getting jobs, finding housing, or participating in the community in other ways. Some employers said they didn't want to hire people with diabetes because they missed too much work and because it raised the cost of insurance premiums. Once these different responses to diabetes were identified, different messages were created to reach different audiences.

**What are the key messages that we want to convey?**

**What local data support these claims?**

➤ **Message 1: Save our Community!**

*Data:* African Americans in our state are five times more likely to have diabetes than whites.

*Report or Web site:* Centers for Disease Control and Prevention, <http://www.cdc.gov/diabetes/statistics/prev/state/index.htm>

*Year published:* 2005

*Data Source:* State-specific Estimates of Diagnosed Diabetes Among Adults

*Years data were collected:* 1994–2004

➤ **Message 2: Stay in School, Stay Healthy**

*Data:* High school graduation rates are lower among African Americans than whites (10% of African Americans and 6% of whites in the U.S. do not complete high school reducing their chances for meaningful employment, which limits their ability to buy healthy foods or live in adequate housing, as well as limiting understanding of health issues).

*Report or Web site:* Kids Count, <http://www.kidscount.org/sld/databook.jsp>

*Year published:* 2004

*Data source:* National Center for Education Statistics, Dropout Rates in the United States, 2000

*Year data were collected:* 2000

### What is the right media outlet?

➤ *Who do we want to hear our message?*

- Policy makers – city council, county and state legislatures.
- Employers.
- School administrators.
- Grocery and convenience store owners.
- Neighborhood organization leaders.
- Community members.

➤ *What media outlets does our intended audience use?*

- Radio – soft rock, public radio, R&B stations, classical stations, gospel stations.
- TV – nightly local news.
- Newspaper – local newspaper – living section, business section.
- Other – shopping cart placards, billboards.

## Policy and environmental change

To achieve community-wide changes in health equity, community members can engage in decision-making processes within their community. This may require learning new skills or strategies to gain active participation of people and organizations in the community and key decision makers from different sectors. Local decision makers include elected and appointed officials, institutional or organizational leaders, and other individuals or groups involved in policy making in your community.

Using this approach, your partnership may focus on policy initiatives (e.g., zoning regulations, tax policies, worksite or school policies) or changes to the built environment (e.g., creating equitable access to affordable transportation, education, employment, recreation facilities, healthy food).

**According to the Institute of Medicine, public health agencies and community coalitions have a special role to play in policy development and implementation. “[They] must raise crucial questions that no one else raises; initiate communication with all affected parties, including the public-at-large; consider long-range issues in addition to crises; plan ahead as well as react; speak on behalf of persons and groups who have difficulty being heard in the process; build bridges between fragmented concerns; and strive for fairness and balance.” (pg. 45)<sup>2</sup>**

### *What is policy and environmental change?*

A policy is a plan or course of action intended to influence and determine decisions, actions, and rules or regulations that govern our collective daily life.<sup>95</sup> Policies can be created and enforced by organizations, communities, or the government at local, state, or federal levels. One purpose of creating new or changing existing policies is to change the social determinants that influence health equity (e.g., tax incentives for the food service industry to provide healthy foods, combine state taxes for education and distribute across districts to ensure equitable access to public education).

Changes to the environment include facilities (e.g., buildings, roads, schools, parks), amenities (e.g., benches, trash bins, streetlights), cultural or artistic events or enhancements (e.g., statues, festivals, murals), and social support and networks (e.g., block groups, charettes, community forums). Changing the

environment requires informed decision making about urban design, land use, transportation, and political and social services and systems and their relationships to health outcomes.

### *When do you use policy and environmental change?*

This approach is useful when you want to create or change existing policies or environments to promote health equity. People and organizations in the community may consider using policy change to affect groups of people instead of or in addition to individual-level strategies (e.g., brochures, posters). Policy changes can be designed to regulate the behavior of individuals (e.g., smoking bans), organizations (e.g., flex-time), or communities (e.g., housing codes for maintaining rental property). Policy changes can also affect the built environment, such as zoning related to new grocery stores or fast food restaurants, maintenance of sidewalks and streetscapes, or architectural design features such as neighborhood signage addressing the history and culture of the community.

### *How do you use policy and environmental change?*

Health practitioners, researchers, and other people and organizations in the community can be active players in the policy-making process by educating decision makers about how changes to policy or the environments can promote health equity. For example, your partners can provide current health or social determinants data, information about existing policies, examples of policies that have worked well in other communities, or other information on an issue as it is experienced by your community. Your partners can also help by developing a list of key decision makers to contact based on their interest in the issue or their position on certain decision-making bodies (e.g., committees, boards). See “Moving Forward: Ways to Support Policy Change” (page 72) for more ideas on how to engage in policy-change work.

Your partnership may also consider engaging in policy change by connecting to larger organizations that can help define concerns and develop potential solutions. A well-structured, well-positioned organization can support policy change by defining a problem that affects many individuals or communities (e.g., consumer legislation, air quality), and it can also help unite voices and actions to create change. Larger organizations can also work with local organizations to obtain support to implement these strategies. Some groups may work directly on health-related topics (e.g., land-use policies to increase parks and greenways), whereas others may work on policies that influence the social determinants of health even if they are not explicitly focused on health (e.g., housing, air quality).

**NOTE:** If your partnership is considering policy-change strategies, be aware that most organizations that receive public funds or have 501(c)3 status cannot participate in lobbying activities. Lobbying activities include letter or phone campaigns, petition drives, promoting a position on a specific legislation, or endorsing a position to a legislator. These rules are updated regularly. For more information, go to AR-12 at <http://www.cdc.gov/od/pgo/funding/ARs.htm>.

If your partnership receives public funds, many activities are allowed that support policy change. You can provide current data or other educational information on an issue as it is experienced in your community. You can also help by developing a list of legislators to contact based on their interest in the issue or their position on certain legislative committees. See “Moving Forward: Ways to Support Policy Change” (page 72) for more ideas on how to engage in policy-change work.

## PERSPECTIVES — The Role of Policy in Community Matters

**Angela Glover Blackwell:** *President, PolicyLink Institute, Oakland, CA*  
Keynote Address, *Social Determinants of Health Disparities: Learning from Doing*, Atlanta, GA, October 28, 2003

“Across America, people are creatively solving local problems by taking advantage of the wisdom of those who are working for change at the community level as well as that of those working for change at the policy level. The experiences and wisdom of people working at the local level are integral to solving problems in ways that are meaningful and sustainable.

There has been an explosion of exciting activities in local communities that cross lines of race, class, and profession; people are organizing, building networks, and finding solutions to problems within their communities that will ultimately lead to an improved quality of life for all community members. However, it is impossible to talk about quality of life without considering the need for policies to improve overall public health and to reduce health disparities among different segments of the population.

A major factor in reducing health disparities is recognizing how place matters - i.e., how where a person lives is associated with disparities in disease incidence, mortality rates and other health indicators. The physical, social, and economic environments of a community, including air and water quality, housing conditions, and access to resources and services, determine the daily advantages or disadvantages community members face in trying to survive and prosper. For example, someone who lives in an environment of concentrated poverty will likely have little or no access to full-service grocery stores with fresh produce, limited access to transportation (personal or public) to get to a store, a clinic, or a health center, and few community health programs in local public schools. One’s address should not determine one’s destiny.

We have many exciting examples of how community members can produce meaningful improvements in their community by analyzing strengths and problems, recognizing opportunities, overcoming differences, and working together as a disciplined team of community partners.

To create needed changes, we must use approaches that encourage cooperation among public health professionals, community partners (e.g., transportation, parks and recreation, policy makers, businesses, schools), and the community members they serve. Community members offer practical

experience in solving real-life problems, while public health professionals bring a different perspective and a theoretical basis for changing community conditions: both sets of assets are vital to community-based efforts to improve factors affecting the health of community members. To overcome what may seem like intractable problems, we must work together to strengthen existing organizations or build new institutions to create new standards and expectations for community life. By building coalitions, community members and public health officials can gain the strength and breadth of support necessary to address issues whose ultimate solution can best be achieved through policy change. The key to success for these coalitions is realizing that community members must be full partners.

Multiple strategies are needed to improve quality of life in our communities. Key among these must be strategies that emphasize policy development designed to help local communities achieve local level change. Why policy development? Local, state, and federal policies influence the way society organizes its resources, conducts its business, and expresses its values. In a democracy, all people have a right to participate meaningfully in policy making. The use of successful local projects to inform policy agendas acknowledges the authenticity of a community-centered approach to change.

Everyone benefits when communities are organized, responsive to local needs, supportive of residents input to policy change, and active in creating policies to protect community members from harmful conditions. Establishment of these conditions will not only help improve community health, but communities that do so will become stronger, because their members will have the information and skills needed to sustain such gains.

Unfortunately, significant barriers have existed and communities of color and low-income communities have frequently been excluded from discussions of the health-related policies that affect them. The development of successful health-related policies depends on the participation of a broad, representative coalition of community members so that the policies created represent the needs or experiences of all community members.

Public health can support the use of innovative approaches with communities, to improve the health and quality of life. To create a strong, healthy, and equitable world, we must identify and replicate successful community-based projects that harness our collective wisdom and experience.”

## MOVING FORWARD

### Ways to Support Policy Change

- Provide current local statistics on health issues of concern to increase awareness of the problem.
- Work with community groups to develop simple, to-the-point statements about the issue and specific strategies to implement that can be shared with decision makers and the media.
- Provide a list of local decision makers with contact and background information.
- Assist community groups with setting up times to meet local decision makers.
- Build community capacity to communicate with decision makers by building partnerships with other groups that have similar interests.
- Translate academic and policy reports for use by public health practitioners and community groups to make them locally relevant.
- Work with community groups to develop an agenda for action at the local, state, or national level.

## FORUM SPOTLIGHT

### Recruiting Partners to Work for Policy Change

*The following example illustrates how advocacy was used to develop a policy agenda.*

Public Health - Seattle & King County (PHSKC) designed an intervention to bring attention to environmental policies focused on families and individuals (see pages 28 - 29). Through a coordinated policy agenda and strengthened advocacy, partners focused on building public will to address the environmental factors that shape the lives of young children. The ultimate goal was to create universal access to environments that support school readiness and other indicators of healthy child development. PHSKC produced a 75-page child development resource to engage partners in discussions of issues considered crucial for healthy childhood development (e.g., nurturing relationships, family resources, child care, neighborhood, access to early interventions). Approximately 60 partners were asked to read the resource before meeting to generate policy recommendations for healthy early childhood environments. Obtaining additional support for these policy changes from communities in King County is one of the group's next steps.

## PERSPECTIVES — Policy

**Jim Kreiger:** *Public Health - Seattle & King County; Seattle, Washington*

To make change on a large, community scale, public health needs to influence changes at the policy level. Suggestions for ways to accomplish this include:

- Assess the situation and consider policy implications up front.
- Bring the issue to policy makers' attention.
- Provide the technical background policy makers need in a clear and concise manner.
- Mobilize constituencies to ensure genuine participation and power sharing by all groups involved.

## Selecting your approach

Your partnership may feel overwhelmed by the wide range of ways to address the social determinants of health inequities in your community. Consider this an asset rather than a barrier, because it allows you to try a variety of approaches to find out what works best for your partnership and your community. If possible, use multiple approaches to increase the likelihood of reaching different groups in your community. There is no right or wrong approach, but there are several factors that might influence your decision about which approach to use to achieve your goals and objectives. These include:

- The experience and expertise of your partners.
- The nature of the social determinants you plan to address.
- The availability of financial and other resources.
- Funding restrictions or guidelines for the initiative.
- The existence of policies that are not being enforced.
- Whether you are working to create community change or organizational change.
- The political and social buy-in of the community.
- The relative success or failure of similar approaches in the past.

Although these factors can help guide your decision-making process, it is important to trust the intuition and experience of your partners, particularly the community members. Your partners could decide it is time for a new and different approach. They could also suggest that you modify one of the suggested approaches or choose another alternative. For many issues, it might be necessary to use more than one approach to create the changes desired. In such cases, it may be useful to determine the benefits and challenges of implementing these approaches simultaneously or sequentially. You may want to consider, for instance, the resources required, the extent to which one approach lays the groundwork for the other, and the readiness of the community to engage in these approaches. The important thing is that the group agrees on the best way to proceed. Some additional questions that might help you determine the best next step for you are found in “Example from the Field: Selecting Your Approach” (page 74).

*Document your decision-making process to develop support for the selected approach. Remember to consider new partners who can support your use of different approaches. Be willing to modify your approach as you track your successes and challenges. This is the learning-from-doing model. Several sources of information on these approaches are available in the “Suggested Readings and Resources” section.*

## FORUM SPOTLIGHT

### The Use of Multiple Approaches

*The following example illustrates how multiple approaches can be used to address the same issue.*

The Boston Public Health Commission (BPHC), the city’s health department, has identified the elimination of racial and ethnic disparities in health as one of its top priorities (see pages 22–23). An analysis of routinely collected health outcomes demonstrated that black community members in Boston fared significantly worse than white community members on 15 of 20 measures. BPHC determined that the most effective strategies for addressing disparities would focus on understanding and eliminating the impact of racism on health. Health inequities are associated with a variety of factors, including unfair environmental exposures, unequal access to care, and bias or discrimination by health care providers. Interventions were designed to

be population-based, with an emphasis on improving access to care, linking clients to social services, and addressing institutional policies and norms considered racist. To address these factors, BPHC selected multiple approaches, including:

- Promoting an anti-racist work environment by establishing an internal team to guide ongoing anti-racism dialogues (consciousness raising).
- Creating a position in the executive office to coordinate the BPHC’s anti-racism work (policy change).
- Documenting and disseminating information on racial disparities (media advocacy).
- Redirecting funds to support initiatives that addressed documented racial disparities (policy change).

## EXAMPLE FROM THE FIELD

### Selecting Your Approach

The community partnership to address diabetes knew it wanted to focus on social determinants, but partners were not sure where to begin or how to proceed. The following questions were useful in helping them decide what to do:

#### Which of the approaches described in Section 4 are particularly appealing?

- One of our objectives was to increase community awareness of social determinants of diabetes inequities. Media advocacy seems like a good way to do this.
- We like the idea of health promotion programs.
- Maybe we could work on policy-level issues – a good amount of this requires changes in policies.

#### What is the benefit of using the media advocacy approach?

- Media advocacy would be good to start with, because until we increase awareness, we won't have the support to make other kinds of changes.
- Media advocacy might also help us get more people interested, broadening the range of ideas and support we can use to make other kinds of changes.

#### What are the potential drawbacks to using this approach right now?

- Support is nice, but it doesn't really change the things we need to change. It may be okay if we start there but commit to move beyond just getting support.

**What social determinants of diabetes do we plan to address in our community? What approaches seem to have a "good fit" with the outcomes we hope to achieve?**

- We really need to work on increasing access to affordable, healthy food and places to be active; improving housing and health care; and increasing jobs. Media advocacy doesn't really do much for us in this area.
- Maybe media advocacy will mobilize support from people on the local business council, and maybe businesses will see that influencing social determinants of diabetes among all community members, not just their employees, is in their best interest and then work with us to develop ways to increase jobs for people living with or at risk for diabetes.

**Consider the experiences, resources, and other supports that exist in the partnership. Do they help us with one approach rather than another?**

**Consider any funding restrictions we might have.**

- We have some help from the local newspapers and some people who know radio personalities.
- We need to get local businesses involved and probably someone from the local hospital, housing coalition, and food pantries.
- We have a limited budget for this, and media advocacy would fit within the guidelines for how we can and cannot use the money. We might want to check with the funding agency to be certain.

**Finally, work with the group to prioritize the approaches so you can allocate your resources according to your priorities.**



At this stage, you have formed your partnership, developed a common understanding of the social determinants of health inequities in your community, reached a consensus on your partnership's mission and structures for working together, inventoried partnership and community capacities, identified goals and objectives, and selected one or more approaches that best meet the needs of your community. You are now ready to learn from doing by developing and implementing an action plan. In addition to discussing how to form an action plan, this section describes how to anticipate possible barriers to fulfilling your plan.

### Getting started

#### Developing an action plan

An action plan describes the specific steps necessary to meet clearly defined goals and objectives. Begin to develop an action plan as soon as your partnership's vision, goals, objectives, and approaches have been determined. The initiative planning model described at the end of Section 2 (page 53) provides an outline of the components to include in your action plan.

# Moving to Action

An action plan is important not only to keep your partnership on track toward meeting its goals but also to demonstrate to community members and other stakeholders that you are making tangible progress toward improving social, economic, and environmental conditions. Keep in mind, however, that you may need to modify your action plan to meet changing conditions in your community over time. An action plan should not be viewed as a static document. To be effective, an action plan should include the following key elements:

- Your partnership's goals and objectives.
- Who is responsible for the completion of activities.
- The time frame for completion of activities.
- How you will assess progress.
- How you will assess impacts and outcomes.

Before writing your action plan, you will need to organize a planning group, which should include people and organizations in the community that you identified when creating your partnership. Some of these groups or individuals may be part of your existing partnership, whereas others may be invited because they bring a different perspective or experience. After the planning group has been organized it should meet to determine what action steps are necessary. Once these steps have been developed, assign specific roles and responsibilities to partners and devise a timeline for all action steps. A good action plan:

- Describes each action step clearly and specifically. The plan should be easy to understand and in a format useful to all partners.
- Assigns responsibilities for each action step. This determination should be made following a group discussion about who should be responsible for what.
- Provides a timeline for completion of the action steps. The group will need to estimate the time needed for each action step and be sure the times are reasonable for everyone involved. Some steps will need to be completed before others can begin. Be sure to identify this in your action plan.
- Outlines what resources will be necessary to successfully implement each action step, including finances, staff, space, and equipment. The group will need to identify existing resources first and then determine whether additional resources will be required. You might want to create a mini action plan for obtaining additional resources.
- Includes a list of other community members who may be potential collaborators and involves them in your project as necessary. This may also help increase community awareness of your project.



## MOVING FORWARD

### Developing Your Action Plan<sup>67,69</sup>

When developing an action plan, ask partnership members the following questions and incorporate their agreed-upon answers into your plan:

- What is the purpose of this action plan?
- Why do we think the plan is achievable?
- How does the plan address our partnership's goals and objectives?
- How will we know if we are achieving our objectives?
- What are the specific action steps?
- Who is responsible for each action step?
- When will the action steps take place? Will they be completed by a specific date, or will they be ongoing?
- Who else in the community should know about or can help with the plan?
- What resources (e.g., money, space) are necessary to implement the plan?
- What resources does the planning group have now to complete the action steps?
- What additional resources are needed? Where and how will these resources be obtained?

## MOVING FORWARD

### Implementing Your Action Plan<sup>67,69</sup>

- Review the action plan: is it complete, clear, and current?
- Follow through with action steps.
- Does the action plan reflect the goals and objectives as well as the roles and responsibilities of all partners?
- If volunteer or paid staff are required, is there a plan to train them? Do they have clear roles and responsibilities?
- Discuss the plan and the activities with all partners to ensure the timeline and roles are realistic for everyone.
- Work to identify potential barriers and challenges and strategies to address them.
- Check in with all partners during the implementation process to see whether the partnership is making progress.
- Refine the action plan as necessary.
- Discuss the possibility of unanticipated challenges the partners may encounter while attempting to implement the action plan, and document discussions.
- Keep partners informed about progress.
- Keep track of what has been accomplished whether it is what was intended, and, if not, what changes should be made to the plan.
- Celebrate small and large accomplishments.<sup>96</sup>

Continually monitor your group's progress toward completing the action plan. Once an action plan has been formulated that meets the criteria above, revise it as needed to maximize your chances for success. Meet regularly and use the set of questions in "Developing an action plan" (page 76) as the basis for a status report to be discussed at your meetings. The group can acknowledge and celebrate what has been completed, assess challenges, and revise the action plan accordingly.

## Implementing your action plan

As you move from the planning stage to the action stage, be sure that all partners have a copy of the action plan and understand their roles and responsibilities. Your first step in implementing your action plan is to obtain the resources identified as necessary for moving forward. Make sure these resources are in place before you begin to implement your action plan. Also, be sure that your group has a backup plan in case promised resources are not provided or in case additional resources become necessary.

Carrying out your plan may be challenging at times, and progress may sometimes be difficult to recognize. Take time to appreciate what has been accomplished and to publicly recognize what people have contributed. Doing so will help reenergize your group and strengthen relationships among group members.

## Anticipating challenges

Any partnership working to change conditions within a community should expect to face challenges of various sorts and should, as much as possible, develop strategies for addressing potential problems before they occur. The following are challenges you may encounter in working with your partners.<sup>66,96</sup>

- Maintaining effective communication. One challenge is to ensure that group members are communicating effectively with one another. It is important when addressing social determinants of health inequities to invite groups that historically have not been part of public health initiatives. Based on different experiences, some groups may use language that other groups in your partnership have trouble understanding, and each group will come into the partnership with different expectations and priorities. It is important to work together to develop a common vocabulary and to reassure the members of the partnership that differences actually make the partnership stronger.
- Dealing with conflict among partnership members. Conflict is inevitable and is not necessarily a bad thing if handled well. Conflict due to power imbalances within the community or among members of the partnership is important to address openly and honestly. These imbalances may become apparent as the group forms or during consciousness raising when partners are discovering and discussing issues of concern. Although recognition of such imbalances can create tension and discomfort among partnership members, you can use the tension to your advantage by discussing differences in access to social resources among various groups in your community and the potential implications of these differences.
- Adhering to partnership principles. If this is a problem, review each principle and determine challenges to adherence. Post the principles at each partnership meeting and review and revise them as needed.

- Addressing unrealistic expectations of various partners. Partners may become impatient or dissatisfied with the direction of the partnership or the time it takes to make decisions and implement actions. For example, some people find the community development approach frustrating due to the focus on process rather than on tasks. You may need to remind them that the focus on process is an effort to promote participation of all partners and build trust among them, thus improving your partnership's chances of accomplishing its goals. As noted earlier, including short-term achievable action steps in your action plan should help reduce the frustration of partners eager for immediate change and give them a sense of accomplishment that will help them stay in the partnership for the long haul. You should continuously monitor the energy level of the partnership and allow opportunities for members to shift the direction of the partnership as needed.
- Resolving conflicts between partners' roles and responsibilities within the partnership and their roles and responsibilities within the community, their organizations, or their home environments. For example, if a partnership is developed to reduce infant mortality rates in the community and a local foundation decides to grant money to a single organization, the partnership may be at risk due to the potential for competition among partnership members established by the grant opportunity. Even if the organization that receives the grant money is successful in reducing infant mortality rates, community partnerships could feel negative impacts due to unresolved conflicts. It is important that the partnership develop mechanisms to overcome such tensions and promote understanding among members of the community.

You can help prevent conflicts from damaging the partnership by encouraging members to openly discuss actual or potential conflicts, modifying the action plan if necessary and feasible and ensuring that community members help define the actions most appropriate for their communities. This will help the members better understand and respect the roles their partners have outside of the partnership. Also, it is important to recognize that representatives from agencies and organizations are often limited by their organizational roles or policies. For example, agencies or organizations that receive public funding may be prohibited from participating in certain policy activities. However, even those agencies can play some role in policy change (see page 70). Working collaboratively to determine the most appropriate role for each partner will strengthen the overall process and improve outcomes.

Other problems your partnership may need to address include members' perception that the partnership threatens their autonomy, disagreement about community needs, conflicts over funding decisions, lack of consensus about membership criteria or coalition structure, lack of leadership, competing interests, and failure to include relevant constituencies.

To overcome these problems, the members of the partnership must work together to identify expected challenges, prepare for unexpected challenges, agree to disagree, and create strategies to overcome both expected and unexpected challenges. If challenges prohibit progress of the partnership, it may be useful to seek assistance from an outside consultant.

*Please see "Suggested Readings and Resources" for more information on coping with challenges and resolving conflict.*



# Assessing Your Progress

It is important to incorporate ways to assess or track the steps your partners make from the beginning of your efforts. This process is a bit like drawing a map of the efforts your partners will make to reach your goals and objectives. In Section 2, you began this process by creating and implementing your community assessment. The findings from your assessment were used to determine your priorities, goals, and objectives and actions to be taken. The next steps involve documenting the progress your partnership has made toward meeting these goals and objectives. It is valuable to record intended and unintended actions taken by the partnership as well as intended and unintended consequences of those actions. A responsive initiative will likely change the action plan many times in the course of doing its work, so it is necessary to provide evidence of the barriers or challenges that led to these changes and how the partnership adapted to improve the initiative. By tracking its progress this way, your partnership will be able to see whether the initiative has met its goals and objectives. Although each initiative is unique, the information your partners collect can help the partnership determine whether the action plan has been successful or a new plan will need to be developed. Information your partners collect on this initiative can provide information for others engaged in similar work, and your partners can share this information with people and organizations in the community who are interested in your progress.

All partners should be actively involved in tracking your progress,<sup>69,96,97</sup> which should include steps to define the questions to address, collect and track information, assess and interpret findings, and report findings to others.

## Evaluating your efforts

Even with the best intentions, your efforts to track your partners' decision making processes; the challenges that emerged; and notes, pictures, or recorded conversations about the initiative aren't helpful unless you organize and annotate (i.e., interpret and make notes on items) so you can remember how each item relates to your progress. Evaluation questions, tools, and methods help you track your progress and organize the information you collect. Identifying and organizing the evaluation at the beginning of your initiative can ensure that the right questions are asked and the answers are documented along the way. The nature and complexity of your initiative will help determine the types of evaluation your partnership chooses. In general, the tools and methods described in Section 2 on community assessment are the same tools and methods that can be used to track progress throughout your initiative. However, when evaluating your initiative, there are several questions your partners may want to consider. Some of these questions follow along with some tools and methods your partners might want to use to help answer them.

► How is your partnership working?

One of the first things to consider is how to evaluate the processes used to develop and carry out your initiative. This involves examining the processes used within the partnership itself. To assess your partnership, your partners should discuss what to document, with whom the information should be shared, and how it is to be used. For example, your partners might want to document satisfaction with what has been accomplished to gauge continued interest in participating in the project. It might also be useful to document the extent to which partners feel they have been involved in decision making and their comfort with conflict management strategies. Partners may also choose to review the minutes from meetings to ensure that activities are being carried out as agreed upon by the group. The accomplishments and challenges documented will help guide future partnership initiatives. This learning-from-doing approach can strengthen and maintain your partnership by reinforcing accomplishments and revising or eliminating what isn't working so that all partners feel they are making a meaningful contribution to the project. "Moving Forward: Evaluating Your Process" (page 84) provides specific questions to consider as you evaluate your partnership. In addition, many resources exist to guide the development and implementation of partnership evaluation plans. For more detailed information about designing and conducting evaluations of partnerships, see "Evaluation" in the "Suggested Readings and Resources" section.<sup>71</sup>



## MOVING FORWARD

### Evaluating Your Process

#### Partnership

- What about your partnership works well (e.g., decision making, conflict management, leadership, ability to move forward, location, time of meetings, length of meetings, balance of tasks, time for social interaction)?
- What about your partnership has not worked well?
- How can you make the partnership work better?

#### Community capacity

- Has your partnership successfully reached out to the community? How?
- What has been challenging about assessing community strengths?
- What resources have been helpful?
- What resources are still needed? Are these resources available within the community? Are there costs associated with securing them?

- How well has your action plan worked?

The next consideration is the extent to which your partnership has implemented the action plan as intended. Explore changes that have been made and document why these changes were considered appropriate (referred to as “process evaluation”). For example, your partners may have decided to use a media advocacy approach and work with a particular radio station. After several months of planning your media events, the person your partners have been working with at the station let them know that she was moving to another city. In such a case, you could begin working with a new contact person or use a different media outlet (e.g., another radio station, a local newspaper). Another example based on the media advocacy approach is to ask community members to listen to the media messages created and determine whether they understood the messages as intended. Community members might recommend changes that could enhance your ability to get your message across. By tracking these types of changes and their rationales, your partners can document choices, allowing them to recognize the types of things that facilitate or hinder their momentum.

- Are your partners making progress toward their goals and objectives?

It is also useful to document the extent to which your partners are accomplishing their objectives (referred to as “impact evaluation”) and goals (referred to as “outcome evaluation”). Below are some questions to consider as part of your evaluation process:

- What was your intention? What did partners hope to accomplish? Your partners can answer these questions by recording and reviewing meeting minutes and referring to the mission statement, goals, and objectives.
- What did the partnership do to accomplish these goals and objectives? To answer this, your partners might again review your meeting minutes or notes. Other strategies include documenting stories and conversations with other partners and keeping any photographs, illustrations, or records of media coverage or speaking engagements that highlight the social and economic determinants of health inequities that your partnership has chosen to address.

- If the partnership were starting the initiative over, what would your partners do the same or differently? To help answer this, keep a record of discussions among partners about the process and action steps carried out. It may also be helpful to ask people who took part in the process what they thought worked well and what they would like to see done differently in the future. These questions can be asked through a questionnaire or a group discussion. Be prepared to review your goals and objectives and make changes as needed.
- What were some of the intended consequences of your actions? The intended consequences are the changes in the objectives and goals the partnership laid out. In terms of your initiative, this might involve tracking the programs and policy or environmental changes planned and implemented by your partners, any money generated for these initiatives, and any changes that have occurred as a result of your activities, including changes in employment opportunities; changes in structures, such as new sidewalks, community centers, or grocery stores; and changes in people's behaviors, such as increased physical activity or increased use of preventive screening.
- What were some of the unintended consequences of your actions? It is also important to document unexpected changes, including changes in your partnership, your objectives, or your goals and outcomes. For example, partners may record new partnerships or initiatives that have formed or a change in how the media portrays community health issues in response to your initiative (e.g., more focused on social responsibility as opposed to individual responsibility). In some instances, it may be the change in the action plan that enables you to reach the goals or objectives (i.e., creating change in one or more social determinants).

## Linking your evaluation to your community assessment and action plan

To answer many of these questions, partners need to have considered what they hoped to accomplish through the partnership (mission and vision), where it started (community assessment), and where partners wanted to go (goals and objectives). Therefore, it is important to link your evaluation activities to the specific data collected as part of your community assessment, including indicators of behavior; health; and economic, environmental, and social status in your community (i.e., the data you collected and assessed in Section 2). To track changes in your activities as well as social determinants of health, you can include aggregate assessments of individuals (e.g., community-based surveys, existing surveillance data) and systemic social, economic, and environmental assessments. These indicators provide the opportunity to not only identify areas for change and illuminate trends (e.g., to develop appropriate new initiatives) but also evaluate the impact of your current initiative (i.e., whether you are reaching your objectives). Although many community groups can access these data through public use data sets to see whether these changes are significant, you may consider obtaining technical assistance from local organizations with evaluation expertise or from researchers at local colleges or universities. Such technical assistance can also be useful if your partnership chooses or your funding guidelines require you to link your activities and community indicators of change to health outcomes.

In addition, partners can discuss the information gathered in surveys, interviews, or meeting minutes (i.e., the data you collected and assessed, as discussed in Section 2). Whereas existing indicators can help to track changes in health and social determinants of health over time, feedback from the community (positive and negative responses) can provide insight into how the changes have affected the community and pinpoint specific activities that worked well and those that did not.

It is important to note that most changes in social determinants of health take time. Moreover, it is often difficult to pinpoint a single action or initiative that caused a change in social determinants of health. Rather, it is likely that many different initiatives and actions will act together or synergistically to create changes. It is, therefore, very important to:

- Develop appropriate expectations among your partners and community members.

- Track what you have done so others who may follow will know the cumulative effect of the various steps you took.
- Identify small, short-term milestones on the road to achieving your long-term goal. See the “Suggested Readings and Resources” section.

## EXAMPLE FROM THE FIELD

*Instructions:* First discuss your partnership and how partners individually feel about the collaboration and look at the effectiveness of the group process. Second, examine the action plan, how it was changed, and how well it worked. Finally, evaluate how much progress you have made with your goals and objectives and assess any unintended consequences of your actions.

### Outcome Evaluation

Was the goal reached?

### Impact Evaluation

Was the objective reached?

What were the unintended consequences?

### Process Evaluation

How is the partnership working?

Were the tasks and timelines appropriate?

Did the approach work for the community?

### Goal: To improve social determinants to reduce diabetes in the community

#### Objective (individual):

By next year, increase awareness of social determinants of diabetes.

#### Documentation:

Attendance at the media event and changes in knowledge among attendees

#### Approach:

Consciousness raising

#### Documentation:

Partners included in development  
Partner satisfaction with event content and messages  
Community perceptions of event

#### Objective (organizational):

By year two, support economic development through microenterprise.

#### Documentation:

New resources and services available in the community and the number of new microenterprises created

#### Approach:

Community development

#### Documentation:

Minutes of meetings with local entrepreneurs  
Types of financial services offered and method of delivery  
Entrepreneur satisfaction with participation in decision making

#### Objective (community):

By year three, increase access to affordable, healthy food.

#### Documentation:

New tax incentives to grocery stores to offer healthy foods and increase in availability of foods

#### Approach:

Policy change

#### Documentation:

Provide information to decision makers  
Responses from owners and managers of grocery stores  
Community awareness of changes in healthy foods

## Sharing your work

Some of the products of your work should be shared only among your group's partners. These confidential work products can include:

- Strategies to improve or change goals, objectives, or the action plan.
- Plans to address barriers or conflict within the partnership.
- Methods to rally more support for the project.

Information shared among partners should remain confidential unless all partners agree otherwise. A lot of information, however, is appropriate to share with all community members and with other groups engaged in efforts similar to yours. Such information sharing among groups is vital to the success of local, regional, or national efforts to eliminate health disparities. This workbook, in fact, is largely the product of information sharing by participants in the "Learning from Doing" forum. Your partnership can share

information with the community and with others interested in addressing the social determinants of health inequities in a variety of ways. These include:

- Newsletters.
- Community forums.
- Internet outlets such as Web sites or chat rooms.
- Local newspapers, professional journals, or magazines.
- Local, state and national conferences.
- Informal networks, such as those that operate through libraries, schools, colleges or universities, parks or recreation centers, faith-based organizations, small businesses, and word of mouth.
- Flyers distributed in various ways, including door-to-door, at meetings, and at tables set up in public locations such as supermarkets or on sidewalks.<sup>69</sup>

## FORUM SPOTLIGHT

### Evaluation Strategies

*This example illustrates how an evaluation plan was developed to track outcomes for a very comprehensive initiative.*

The New Deal for Communities initiative is an area-based regeneration initiative being implemented in 39 of the most deprived communities in England (see pages 26–27). The initiative supports the intensive regeneration of neighborhoods through the creation of partnerships between local people, community and voluntary organizations, local health authorities, businesses, and government agencies. Each community receives financial support to address a number of key issues, including those related to community health and the social determinants of health. Action plans include:

- Addressing worklessness (i.e., unemployment or underemployment).
- Improving health.
- Reducing crime.
- Improving educational achievement.

Evaluation of the impact of this multifaceted policy program is complex and guided by theory-driven evaluation strategies, evaluation findings from other effective approaches, and experiential evidence from the community. This evidence can be documented and incorporated into frameworks, such as individual or organizational theories of change (i.e., reflecting readiness to change and processes of change). Participants are asked to articulate how and why they think the actions they are taking will lead to the outcomes they desire (i.e., pathways of change). Participants' responses begin to define the types of data needed to establish whether the pathways are being followed and whether expected short- and intermediate-term outcomes are being achieved.

# Maintaining Momentum

Eliminating inequities in the social determinants of health will likely require long-term commitment and the use of several approaches. With a variety of approaches, community partnerships allow their individual members to become involved in ways that work best for them. In addition, by mixing and phasing in various approaches, different partners can be engaged and energized at different times. Your partnership should consider flexibility one of the most important characteristics of its process. A willingness to adapt (e.g., to abandon strategies that don't work and to try new unconventional strategies) will help your group sustain its work over time and ultimately accomplish its goals.

To maintain momentum, your partnership will need to be responsive to changes in social, economic, and environmental conditions and in the needs of community members. This responsiveness may involve changes in the configuration and focus of the partnership. Making changes can be challenging, in part because long-time members may feel their concerns are being minimized as the partnership incorporates new perspectives.

To keep from losing valuable partners during periods of transition, you may need to make a special effort to convince them of both the importance of modifying the group's focus and their continued value to the group, rather than allowing them to feel they are being replaced. It can also be helpful to create subcommittees through which some members of your group engage in new ventures while others continue to carry out ongoing activities and to focus on building and maintaining relationships during group meetings. The latter is particularly important as new members join the group.

Community fatigue is a challenge that all long-term partnerships must address to maintain momentum and keep the partnership healthy and strong. The capacity of your partnership to be flexible and

respond effectively to transitions can help minimize the fatigue of partners and community members. However, you may also encounter exhaustion and burnout in partners who have been engaged in community work for a long time. An understanding of community history is essential to sustaining your partnership and your initiatives over time. Some partners and community members may have made several past attempts to create change in the health of or social, economic, and environmental conditions in the community with varying degrees of success. Because of barriers they might have encountered during these attempts, these individuals may feel that their energy and efforts were in vain.

To keep energy and enthusiasm high, continue to encourage participation by all partners and ensure their perceived ownership of partnership activities. Be sure that each partner has realistic roles and responsibilities so that no individual or organization feels overburdened. In addition to attempting relatively ambitious long-term actions, try to develop easily completed, shorter-term activities that can be expected to produce "small wins" that will keep the partners motivated and optimistic. You can also anticipate and plan for training and resources needed in your partnership or the community to enable you to accomplish your initiative.

The information presented in Chapter 3, Section 1, applies to the establishment of an informal partnership. At some point, however, members may decide to formalize the partnership and may require legal advice to help determine the most appropriate organizational structure (see "Moving Forward: Maintaining and Sustaining Your Partnership" on page 89). This could lead you and your partners to consider hiring management and administrative staff to assist with planning, implementation, and evaluation activities. Hiring paid staff may require additional funding as well as other resources, such as office space and equipment.

In summary, keeping your partnership and the initiatives you sponsor alive and thriving requires your group to be flexible in its response to changing conditions without losing its capacity to harness the collective expertise its members

have gained working together. Remember to celebrate your partnership's accomplishments and to recognize the contributions of each member.

## MOVING FORWARD

### Maintaining and Sustaining Your Partnership

#### Maintaining Your Partnership<sup>98</sup>

- Develop a formal organizational structure when you are ready. The following are examples of types of organizations and possible advantages of structuring your partnership in each way:
  - A government-sanctioned organization. Structuring your partnership as an organization that has been authorized by executive or legislative action of state or local government might increase your group's credibility in the community and could give it the legal authority and fiscal status to conduct certain activities.
  - A community network or coalition. This form of organizational structure may allow you to more accurately identify community needs and to gain greater community support for your group's activities. In addition, structuring your group in this way could allow you the flexibility to engage in a variety of activities without being restricted by any one organization's rules and regulations. If your group is organized in this fashion, it might be useful to have a memorandum of understanding that outlines the expectations of each partner. It can also be helpful to establish bylaws for more formal partner interactions.
- Create local awareness of and support for the partnership.

- Bring in new partners.
- Ensure that all members are participating in partnership activities.
- Encourage shared leadership and decision making.
- Develop a strong sense of group identity.

#### Sustaining Your Partnership's Initiative

- Increase community awareness and understanding of the initiative.
- Help partners develop the skills and resources necessary to carry out the initiative.
- Build the initiative on existing efforts when possible.
- Identify potential funding opportunities, such as grants from government agencies or foundations. If you are part of a non-incorporated coalition, you may need to find a fiscal agent or partner that will permit you to access these funding streams.
- Reflect on mission, goals, and objectives to determine necessary changes.
- Revisit your partnership principles often and revise them as necessary.
- Change strategies as necessary and appropriate.

# Closing Thoughts

Since the [Social Determinants of Health Disparities: Learning From Doing](#) forum in October 2003, the community initiatives presented in Chapter 2 have evolved and new lessons learned have emerged. The information presented in this workbook provides only a snapshot of the impressive efforts that have taken place in our example communities and elsewhere. One of the best ways to understand the process of developing social determinants of health initiatives is through regular, ongoing observation of those engaged in these initiatives; here we have provided only a glimpse of their efforts.

We recognize that there are many other promising interventions, tools and resources in communities across the globe. As we begin to work with new partners across different sectors of the community, we can learn from alternative approaches to influencing the social, economic, and environmental conditions that influence health. For example, we can find meaningful interventions in public policy (e.g., educational policies that ensure equal access to educational opportunities regardless of student residence), economic development (e.g., microfinance, individual development accounts), or information technology (e.g., computer and Internet connectivity support).

As noted earlier, most communities have long histories of improving conditions that, in the long run, also improve health and minimize health disparities. There seems to be growing appreciation of such initiatives for their potential public health impact. Such initiatives provide public health agencies and community organizations with potential new partners. Community initiatives bring interested citizens, local knowledge, and other resources to such efforts. Public health agencies and community organizations can bring an emphasis on addressing health disparities, evaluation strategies, and other resources.

As the breadth of local initiatives addressing health disparities grows, so does the depth. Many communities are developing multicomponent initiatives with the understanding that many factors affect health. For example, job training programs can have a positive health effect on participants through increased self-esteem and income from a new or better job. There is a growing understanding in some communities that job training programs are most likely to be successful when combined with other initiatives, such as financial literacy programs, job placement programs, and improved primary and secondary education programs.

These complex initiatives require time and substantial effort to build sustainable partnerships, share resources, develop systems of communication, and minimize the competitive environment many organizations have been exposed to in order to acquire funding.

It is by sharing challenges and successes in the efforts to change social determinants that communities can learn from each other how to work to achieve health equity. Each initiative brings new information about strategies that can be used to improve social determinants of health. We hope that you will join the many others working toward health equity, some of whose efforts we have highlighted in this workbook, so we can all learn by doing.

Tell us your story about the work your community is doing to achieve health equity. You may email us at [CCDinfo@cdc.gov](mailto:CCDinfo@cdc.gov), attention social determinants of health. Include your contact information in your email if you would like a reply.



## Suggested Readings and Resources

### Chapter 1: Achieving Health Equity

#### Health Equity

- Braveman P, Gruskin S. Defining equity in health. *Journal of Epidemiology and Community Health* 2003;57:254-258.
- Braveman P. Monitoring equity in health and healthcare. *Journal of Health Population and Nutrition* 2003;21(3):181-192.
- Commission on social determinants of health. Achieving health equity: from root causes to fair outcomes. Interim statement. London (UK): Commission on Social Determinants of Health, World Health Organization; 2007. [http://www.who.int/social\\_determinants/resources/interim\\_statement/en/index.html](http://www.who.int/social_determinants/resources/interim_statement/en/index.html).
- Dahlgren G, Whitehead M. *Policies and Strategies to Promote Equity in Health*. Copenhagen: World Health Organization; 1992.
- Evans T, Whitehead M, Diderichsen F, Abbas B, Wirth M, editors. *Challenging Inequities in Health: From Ethics to Action*. Oxford and New York: Oxford University Press; 2001.
- Flournoy R, Bell J, Bell JD, Blackwell AG, Colmenar R, Fox R, et al. *Regional Development and Physical Activity: Issues and Strategies for Promoting Health Equity*. Oakland, CA: PolicyLink; 2002.
- Kosny A, Ennis G. The social determinants of health: equity across the lifespan. Proceedings of Made to Measure: Designing Research, Policy and Action Approaches to Eliminate Gender Inequality, National Symposium; 1999 Oct 3-6; Halifax, Nova Scotia.
- Rifkin SB. A framework linking community empowerment and health equity: it is a matter of CHOICE. *Journal of Health Population and Nutrition* 2003;21(3):168-180.

#### Health Inequalities

- Daniels N, Kennedy B, Kawachi I. *Is Inequality Bad for Our Health?* Boston: Beacon Press; 2000.

Ibrahim SA. Eliminating health inequalities. *American Journal of Public Health* 2003;93(10):1618.

Raphael D. Health inequities in the United States: prospects and solutions. *Journal of Public Health Policy* 2000;21(4):394-425.

Singh GK. Area deprivation and widening inequalities in US mortality, 1969-1998. *American Journal of Public Health* 2003;93(7):1137-1143.

Woodward A, Kawachi I. Why reduce health inequalities? *Journal of Epidemiology and Community Health* 2000;54(12):923-929.

#### Health Disparities

- Applied Research Center. *Closing the Gap: Solutions to Race-Based Health Disparities*. Oakland, CA: Arc Publications; 2005.
- Artazcoz L, Benach J, Borrell C, Cortes I. Unemployment and mental health: understanding the interactions among gender, family roles, and social class. *American Journal of Public Health* 2004;94(1):82-88.
- Davis R, Cohen L, Mikkelsen, L. *Strengthening Communities: A Prevention Framework for Eliminating Disparities*. Oakland, CA: Prevention Institute; 2003.
- Hillmeier MM, Lynch J, Harper S, Casper M. Measuring contextual characteristics for community health. *Health Services Research* 2003;38(6 pt 2):1645-1717.
- James SA. Social determinants of health: Implications for intervening on racial and ethnic health disparities. Proceedings of the Minority Health Conference; 2002 Mar 1; University of North Carolina.
- James SA. Confronting the moral economy of US racial/ethnic health disparities. *American Journal of Public Health* 2003;93(2):189.
- Johnson JC, Smith NH. Health and social issues associated with racial, ethnic, and cultural disparities. *Generations* 2002;Fall:25-32.

- Keppel K, Pamuk E, Lynch J, Carter-Pokras O, Kim I, Mays V, et al. Methodological issues in measuring health disparities. *Vital and Health Statistics. Series 2, Data Evaluation and Methods Research* 2005;2(141):1-22.
- Krieger N, Rowley DL, Herman AA, Avery B, Phillips MT. Racism, sexism and social class: implications for studies of health, disease and well-being. *American Journal of Preventive Medicine* 1993;9 (6 Suppl):82-122.
- LaVeist T, editor. *Race, Ethnicity and Health: A Public Health Reader*. San Francisco: Jossey-Bass; 2002.
- Levy BS, Sidel VW. *Social Injustice and Public Health*. New York: Oxford University Press; 2005.
- Livingston IL. *Praeger Handbook of Black American Health: Policies and Issues Behind Disparities in Health*. 2nd edition. Westport, CT: Praeger Publishers; 2004.
- Mays VM, Yancey AK, Cochran SD, Weber M, Fielding JF. Heterogeneity of health disparities among African American, Hispanic, and Asian American women: unrecognized influences of sexual orientation. *American Journal of Public Health* 2002;92(4):632-639.
- Mikkelsen L, Cohen L, Bhattacharyy K, Valenzuela I, Davis R, Gantz T. *Eliminating Health Disparities: The Role of Primary Prevention*. Oakland, CA: Prevention Institute; 2002.
- National Institutes of Health. NIH Addressing Health Disparities: The NIH Program of Action. Available at <http://healthdisparities.nih.gov/whatare.html>.
- PolicyLink. *Reducing Health Disparities Through a Focus on Communities*. Oakland, CA: PolicyLink; 2002.
- The Prevention Institute. *Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities*. Oakland, CA: California Campaign to Eliminate Racial and Ethnic Disparities in Health; 2003.
- Provider's Guide to Quality and Culture. A Resource for Providing High Quality, Culturally Competent Services to Multi-Ethnic Populations. Available at <http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>.
- Redmond LJ, Bowman BA, Mensah GA, compilers. *Health Disparities: A Selected Bibliography from the National Center for Chronic Disease Prevention and Health Promotion. January 2000-January 2005*. Atlanta, GA: Centers for Disease Control and Prevention; 2005.
- Schulz AJ, Israel BA, Parker EA, Lockett M, Hills Y, Wills R. The East Side Village Worker Partnership: integrating research with action to reduce health disparities. *Public Health Reports* 2001;116(6):548-557.
- Williams DR, Collins C. US socioeconomic and racial differences in health: patterns and explanations. *Annual Review Sociology* 1995;21:349-386.

### Defining Social Determinants

- Barnett E, Casper M. A definition of "social environment." *American Journal of Public Health* 2001;91(3):465.
- Berkman LF, Kawachi IE. *Social Epidemiology*. New York: Oxford University Press; 2000.
- James SA. Social determinants of health: implications for intervening on racial and ethnic health disparities. Proceedings of the Minority Health Conference; 2002 March 1; University of North Carolina.
- Kosny A, Ennis G. The social determinants of health: equity across the lifespan. Proceedings of Made to Measure: Designing Research, Policy and Action Approaches to Eliminate Gender Inequality, National Symposium; 1999 Oct 3-6; Halifax, Nova Scotia.
- Krieger N. A glossary for social epidemiology. *Journal of Epidemiology and Community Health* 2001;55(10):693-700.
- Marmot M. Introduction. In: Marmot M, Wilkinson R, editors. *Social Determinants of Health*. Oxford: Oxford University Press; 1999:1-16.

- Miringhoff M, Miringhoff, ML. *The Social Health of the Nation*. New York: Oxford University Press; 1999.
- Queensland Health. Integrating Public Health Practices: A Position Statement on Community Capacity Development and the Social Determinants of Health for Public Health Services. Queensland Government; 2003. Available at <http://www.health.qld.gov.au/phs/Documents/shpu/20426.pdf>.
- Wilkinson R, Marmot M. *Social Determinants of Health: The Solid Facts*. Copenhagen: World Health Organization; 2003.
- World Health Organization. Action on the social determinants of health: Learning from previous experiences. Proceedings of the First Meeting of the Commission on Social Determinants of Health; 2005 Mar; Geneva. Available at [http://www.who.int/social\\_determinants/strategy/CSDH\\_socialdet\\_backgrounder.pdf](http://www.who.int/social_determinants/strategy/CSDH_socialdet_backgrounder.pdf).

### Examples of Social Determinants

- Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE. The Community Guide's model for linking the social environment to health. *American Journal of Preventive Medicine* 2003;24(3 Suppl):12-20.
- Baker E, Williams D, Kelly C, Nanney MS, Vo H, Barnidge E, et al. Access, income and racial composition: dietary patterns aren't just a personal choice. Proceedings of the American Public Health Association Meeting; 2003 Nov; San Francisco.
- Berkman L, Kawachi I. *Social Epidemiology*. New York: Oxford University Press; 2000.
- Davis R, Cook D, Cohen L, Baxi S. A community resilience approach to reducing ethnic and racial disparities in health. *American Journal of Public Health* 2005;95(12):2168-2173.
- Evans RG, Barer ML, Marmor TR. *Why are Some People Healthy and Others Not: The Determinants of Health of Populations*. New York: Aldine de Gruyter; 1994.
- Findley SE, Irigoyen M, See D, Sanchez M, Chen S, Sternfels P, et al. Community-provider partnerships to reduce immunization disparities: field report from northern Manhattan. *American Journal of Public Health* 2003;93(7):1041-1044.
- Flournoy R, Yen I. *The Influence of Community Factors on Health: An Annotated Bibliography*. Oakland, CA: PolicyLink; 2004.
- Gunn SWA, Mansourian PB, Davies AM, Piel A, Sayers B. *Understanding the Global Dimensions of Health*. New York: Springer; 2005.
- James SA. Social determinants of health: implications for intervening on racial and ethnic health disparities. Proceedings of the Minority Health Conference; 2002 Mar 1; University of North Carolina.
- Kawachi I, Kennedy BP. Health and social cohesion: why care about income inequality? *BMJ*. 1997;314:1037-1040.
- Kingsley GT. Housing, health, and the neighborhood context. *American Journal of Preventive Medicine* 2003;24(3 Suppl):6-7.
- Kosny A, Ennis G. The social determinants of health: equity across the lifespan. Proceedings of Made to Measure: Designing Research, Policy and Action Approaches to Eliminate Gender Inequality, National Symposium; 1999 Oct 3-6; Halifax, Nova Scotia.
- Krieger J, Allen C, Cheadle A, Ciske S, Schier JK, Senturia K, et al. Using community-based participatory research to address social determinants of health: lessons learned from Seattle Partners for Healthy Communities. *Health Education and Behavior* 2002;29(3):361-382.
- Krieger N. A glossary for social epidemiology. *Journal of Epidemiology and Community Health* 2001;55(10):693-700.
- Link BG, Phelan J. Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior* 1995;Spec No:80-95.
- Marmot M. Introduction. In: Marmot M, Wilkinson, R, editors. *Social Determinants of Health*. Oxford: Oxford University Press; 1999:1-16.

Needle RH, Trotter RT, Singer M, Bates C, Page B, Metzger D, et al. Rapid assessment of the HIV/AIDS crisis in racial and ethnic minority communities: an approach for timely community interventions. *American Journal of Public Health* 2003;93(6):970-979.

Ramos IN, May M, Ramos KS. Environmental health training of promotoras in colonias along the Texas-Mexico border. *American Journal of Public Health* 2001;91(4):568-570.

Raphael D. Addressing social determinants of health in Canada: bridging the gap between research findings and public policy. *Policy Options* 2003;35-40.

REACH 2010. Atlanta: National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Available at <http://www.cdc.gov/reach2010>.

Schulz A, Northridge ME. Social determinants of health: implications for environmental health promotion. *Health Education and Behavior* 2004;31(4):455-471.

Schulz AJ, Parker EA, Israel BA, Allen A, DeCarlo M, Lockett M. Addressing social determinants of health through community-based participatory research: The East Side Village Health Worker Partnership. *Health Education and Behavior* 2002;29(3):326-341.

Singh GK. Area deprivation and widening inequalities in US mortality, 1969-1998. *American Journal of Public Health* 2003;93(7):1137-1143.

Singh GK, Miller BA, Hankey BF. Changing area socioeconomic patterns in U.S. cancer mortality, 1950-1998: Part II - Lung and colorectal cancers. *Journal of the National Cancer Institute* 2002;94(12):916-925.

Singh GK, Siahpush M. Increasing inequalities in all-cause and cardiovascular mortality among US adults aged 25-64 years by area socioeconomic status, 1969-1998. *International Journal of Epidemiology* 2002;31(3):600-613.

Syme L. Social determinants of health: the community as an empowered partner. *Preventing Chronic Disease* 2004;1(1):1-5.

Wilkinson R, Marmot M. *Social Determinants of Health: The Solid Facts*. Copenhagen: World Health Organization; 2003.

Williams DR, Collins C. US socioeconomic and racial differences in health: Patterns and explanations. *Annual Review of Sociology* 1995;21:349-386.

### Health Impact Assessment

Harris-Roxas B, Simpson S, Harris L. *Equity-Focused Health Impact Assessment: A Literature Review*. Sydney: Centre for Health Equity Training Research and Evaluation; 2004. Available at [http://chetre.med.unsw.edu.au/files/Harris-Roxas\\_B\\_\(2004\)\\_Equity\\_Focused\\_HIA.pdf](http://chetre.med.unsw.edu.au/files/Harris-Roxas_B_(2004)_Equity_Focused_HIA.pdf).

IMPACT: International Health Impact Consortium. Liverpool, England: Department of Public Health at the University of Liverpool; 2001. Available at <http://www.ihia.org.uk>.

Mindell J, Boltong A. Supporting health impact assessment in practice. *Public Health* 2005;119(4):246-252.

National Institute for Health and Clinical Excellence. London: National Institute for Health and Clinical Excellence; 2006. Health Impact Assessment Gateway. Available at <http://www.publichealth.nice.org.uk/page.aspx?o=HIAGateway>.

World Health Organization. Health Impact Assessment. Geneva: World Health Organization; 2006. Available at <http://www.who.int/hia/en>.

### Inequalities by Race

Cutting H, Themba-Nixon M. *Talking the Walk: A Communications Guide for Racial Justice*. San Francisco: We Interrupt This Message; 2003.

Glover-Blackwell A, Kwoh S, Pastor M. *Searching for the Uncommon Ground: New Dimensions on Race in America*. New York: W.W. Norton & Company, Inc; 2002.

- James SA. Confronting the moral economy of US racial/ethnic health disparities. *American Journal of Public Health* 2003;93(2):189.
- Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health* 2000;90(8):1212-1215.
- Krieger N, Rowley DL, Herman AA, Avery B, Phillips MT. Racism, sexism and social class: implications for studies of health, disease and well-being. *American Journal of Preventive Medicine* 1993;9 (6 Suppl):82-122.
- LaVeist T, editor. *Race, Ethnicity and Health: A Public Health Reader*. San Francisco: Jossey-Bass; 2002.
- Massey DS, Denton NA. *American Apartheid: Segregation and the Making of the Underclass*. Cambridge, MA: Harvard University Press; 1993.
- One America In the 21st Century: The President's Initiative on Race*. Washington, DC: White House: 1998.
- The Prevention Institute. *Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities*. Oakland, CA: California Campaign to Eliminate Racial and Ethnic Disparities in Health; 2003.
- Williams DR. Race, socioeconomic status, and health: the added effects of racism and discrimination. *Annals of the New York Academy of Sciences* 1999;896:173-188.
- Williams DR, Collins C. US socioeconomic and racial differences in health: patterns and explanations. *Annual Review of Sociology* 1995; 21:349-386.

### Community

- Fellin P. Understanding American communities. In: Rothman J, Erlich J L, Tropman J E. *Strategies of Community Organization*. Itasca, IL: Peacock; 1995.
- Hunter A. The loss of community: an empirical test through replication. *American Sociology Review* 1975;40(5):537-552.

- Israel BA, Checkoway B, Schulz A, Zimmerman M. Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational and community control. *Health Education Quarterly* 1994;21(2):149-170.
- Israel BA, Eng E, Schulz AJ, Parker EA, editors. *Methods in Community-Based Participatory Research for Health*. San Francisco: John Wiley & Sons; 2005.
- McKnight JL. Redefining community. *Social Policy* 1992; Fall/Winter: 56-62.
- Minkler M, Wallerstein N. *Community Based Participatory Research for Health* San Francisco: Jossey-Bass; 2003.
- Patrick DL, Wickizer TM. Community and health. In: Amick IBJ, Levine S, Tarlov AR, Chapman Walsh D, editors. *Society and Health*. New York: Oxford University Press; 1995:46-92.
- Steuart GW. Social and cultural perspectives: community intervention and mental health. *Health Education Quarterly* 1993;20(1 Suppl): S99-S111.

### Public Health

- Brownson RC, Baker EA, Leet TL, Gillespie KN. *Evidence-Based Public Health*. New York: Oxford University Press; 2003.
- Hofrichter R, editor. Tackling health inequities through public health practice: a handbook for action. *The National Association of County and City Health Officials*. 2006.
- Institute of Medicine. *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press; 2003.
- Stokols D. Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion* 1996;10(4):282-298.
- Tarlov A, St. Peter R. Introduction. In: Tarlov A, St. Peter R, editors. *The Society and Population Health Reader: A State and Community Perspective*. New York: New Press; 2000:ix-xxv.

## Chapter 2: Communities Working to Achieve Health Equity

- Becker AB, Randels J, Theodore D. Project BRAVE: Engaging youth as agents of change in a youth violence prevention project. *Community Youth Development Journal* 2005 Fall; Available at [www.cydjournal.org/contents.html](http://www.cydjournal.org/contents.html).
- Geiger HJ. Community-oriented primary care: a path to community development. *American Journal of Public Health* 2002;92:1713-1716.
- Michael YL, Farquar SA, Wiggins N, Green MK. Findings from a community-based participatory prevention research intervention designed to increase social capital in Latino and African American communities. *Journal of Immigrant and Minority Health* In press.
- Office of the Deputy Prime Minister. Research report 17. New deal for communities 2001-2005: an interim evaluation. Sheffield Hallam University; 2006 November. Available at <http://www.neighbourhood.gov.uk/publications.asp?did=1625>.

## Chapter 3: Developing a Social Determinants of Health Inequities Initiative in Your Community

### Assessing Social Determinants

- Amick BC, Levine S, Tarlov AR, Chapman Walsh D. *Society and Health*. New York: Oxford University Press; 1995.
- Berkman LF, Kawachi IE. *Social Epidemiology*. New York: Oxford University Press; 2000.
- Centers for Disease Control and Prevention. Data Set Directory of Social Determinants of Health at the Local Level. Atlanta: Centers for Disease Control and Prevention. Available at [http://www.cdc.gov/cvh/library/data\\_set\\_directory/index.htm](http://www.cdc.gov/cvh/library/data_set_directory/index.htm).
- Corin E. The cultural frame: context and meaning in construction of health. In: *Society and Health*. New York: Oxford University Press; 1995:272-303.
- Davis R, Cook D, Cohen L, Baxi S. A community resilience approach to reducing ethnic and racial disparities in health. *American Journal of Public Health* 2005;95(12):2168-2173.
- Flournoy R, Yen I. *The Influence of Community Factors on Health: An Annotated Bibliography*. Oakland, CA: PolicyLink; 2004.
- James SA. Social determinants of health: implications for intervening on racial and ethnic health disparities. Proceedings of the Minority Health Conference; 2002 Mar 1; University of North Carolina.
- Labonte R. *How Our Programs Affect Population Health Determinants: A Workbook for Better Planning and Accountability*. Regina, Saskatchewan, Canada: Health Canada; 2003.
- Marmot M. Introduction. In: Marmot M, Wilkinson R, editors. *Social Determinants of Health*. Oxford: Oxford University Press; 1999:1-16.
- Miringoff M, Miringhoff ML. *The Social Health of the Nation*. New York: Oxford University Press; 1999.
- Miringoff ML. Toward a national standard of social health: the need for progress in social indicators. *American Journal of Orthopsychiatry* 1995;65(4):462-467.
- Raphael D. Addressing social determinants of health in Canada: bridging the gap between research findings and public policy. *Policy Options* 2003;24(3):35-40.
- Raphael D. Barriers to addressing the societal determinants of health: public health units and poverty in Ontario, Canada. *Health Promotion International* 2003;18(4):397-405.
- Syme L. Social determinants of health: the community as an empowered partner. *Preventing Chronic Disease* 2004;1(1):1-5.
- Weissman E, editor. *Using Performance Monitoring to Improve Community Health: Conceptual Framework and Community Experience*. Washington, DC: National Academy Press; 1996.
- Wilkinson R, Marmot M. *Social Determinants of Health: The Solid Facts*. Copenhagen: World Health Organization; 2003.

## Partnerships

- Alter C, Hage J. *Organizations Working Together*. Newbury Park, CA: Sage Publications, Inc.; 1992.
- Baker EA, Homan S, Schonhoff R, Kreuter M. Principles of practice for academic/practice/community research partnerships. *American Journal of Preventive Medicine* 1999;16(3 Suppl):86-93.
- Berkowitz B. Collaboration for health improvement: models for state, community and academic partnerships. *Journal of Public Health Management and Practice* 2000;6(1):67-72.
- Clark NM, Community/practice/academic partnerships in public health. *American Journal of Preventive Medicine* 1999;16(3 Suppl):18-19.
- Cohen L, Aboelata MJ, Gantz T, Van Wert J. Collaboration Math: Enhancing the Effectiveness of Multidisciplinary Collaboration. Oakland, CA: Prevention Institute; 2003.
- Findley SE, Irigoyen M, See D, Sanchez M, Chen S, Sternfels P, et al. Community-provider partnerships to reduce immunization disparities: field report from northern Manhattan. *American Journal of Public Health* 2003;93(7):1041-1044.
- Gamm LD. Advancing community health through community health partnerships. *Journal of Healthcare Management* 1998;43(1):51-66.
- Green L, Daniel M, Novick L. Partnerships and coalitions for community based research. *Public Health Reports* 2001;116(1 Suppl):20-30.
- Israel BA, Lichtenstein R, Lantz P, McGranaghan R, Allen A, Guzman JR, et al. The Detroit Community-Academic Urban Research Center: development, implementation, and evaluation. *Journal of Public Health Management Practice* 2001;7(5):1-19.
- Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: assessing partnership approaches to improve public health. *Annual Review of Public Health* 1998;19:173-202.
- Johnson K, Grossman W, Cassidy A. Collaborating to Improve Community Health: Workbook and Guide to Best Practices in Creating Healthier Communities and Populations. San Francisco: Jossey-Bass; 1997.
- Lantz PM, Vruell-Fuentes E, Israel BA, Softley D, Guzman R. Can communities and academia work together on public health research? Evaluation results from a community-based participatory research partnership in Detroit. *Journal of Urban Health* 2001;78(3):495-507.
- Lasker R. Promoting collaborations that improve health. Proceedings of the Community-Campus Partnerships for Health's 4th Annual Conference The New York Academy of Medicine Division of Public Health; Apr-May 2000; New York.
- The Lewin Group, Inc. *Communities Sustain Public Health Improvement Through Organized Partnership Structures*. Battle Creek, MI: W.K. Kellogg Foundation; 2004.
- Mattessich PW, Murray-Close M, Monsey BR. Collaboration: What Makes it Work. Saint Paul: Wilder Publishing Center; 2001.
- Metzler MM, Higgins DL, Beeker CG, Freudenberg N, Lantz PM, Senturia K, et al. Addressing urban health in Detroit, New York City and Seattle through community-based participatory research partnerships. *American Journal of Public Health* 2003;93(5):803-811.
- Nelson JC, Rashid H, Galvin VG, Essien JD, Levine LM. Public/private partners: key factors in creating a strategic alliance for community health. *American Journal of Preventive Medicine* 1999;16(3 Suppl): 94-102.
- Richter D, Gimarc J, Preston G, Williams A. Implementing community-campus partnerships in South Carolina: collaborative efforts to improve public health. *Public Health Reports* 2003;118:387-391.
- Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health* 2000; 21:369-402.

Schulz AJ, Israel BA, Parker EA, Lockett M, Hill Y, Wills R. The East Side Village Worker Partnership: integrating research with action to reduce health disparities. *Public Health Reports* 2001;116(6):548-557.

Seifer SD, Krauer P. Toward a policy agenda for community-campus partnerships. *Education for Health* 2001;14(2):156-162.

Sullivan M, Kone A, Senturia KD, Chrisman NJ, Ciske SJ, Krieger JW. Researcher and researched-community perspectives: toward bridging the gap. *Health Education and Behavior* 2001;28(2):130-149.

Syme L. Social determinants of health: the community as an empowered partner. *Preventing Chronic Disease* 2004;1(1):1-5.

Turning Point: Collaborating for a New Century in Public Health. Seattle: The Robert Wood Johnson Foundation. Available at [http://turningpointprogram.org/Pages/New\\_TP\\_brochure.pdf](http://turningpointprogram.org/Pages/New_TP_brochure.pdf).

### Community-Based Participatory Research

Green L, Daniel M, Novick L. Partnerships and coalitions for community based research. *Public Health Reports* 2001;116(1 Suppl):20-30.

Israel BA, Eng E, Schulz AJ, Parker E, editors. *Methods in Community-Based Participatory Research for Health*. San Francisco: John Wiley & Sons; 2005.

Lantz PM, Viruell-Fuentes E, Israel BA, Softley D, Guzman R. Can communities and academia work together on public health research? Evaluation results from a community-based participatory research partnership in Detroit. *Journal of Urban Health* 2001;78(3):495-507.

Metzler MM, Higgins DL, Beeker CG, Frudenberg N, Lantz M, Senturia K, et al. Addressing urban health in Detroit, New York City and Seattle through community-based participatory research partnerships. *American Journal of Public Health* 2003;93(5):803-811.

Minkler M, Wallerstein N. *Community Based Participatory Research for Health*. San Francisco: Jossey-Bass; 2003.

Schulz AJ, Parker EA, Israel BA, Allen A, Decarlo M, Lockett M. Addressing social determinants of health through community-based participatory research: the East Side Village Health Worker Partnership. *Health Education and Behavior* 2002;29(3):326-341.

### Community Coalitions

Butterfoss F. *Coalition Effectiveness Inventory Self Assessment Tool*. Charleston, SC: Center for Pediatric Research, Center for Health Promotion; 1998.

Butterfoss F, Goodman R, Wandersman A. Community coalitions for prevention and health promotion: factors predicting satisfaction, participation and planning. *Health Education Quarterly* 1996;23:65-79.

Butterfoss FD, Goodman RM, Wandersman A. Community coalitions for prevention and health promotion. *Health Education Research* 1993;8(3):315-330.

Cohen L, Baer N, Sattenwhite P. Developing effective coalitions: an eight step guide. In: Wurzbach ME, editor. *Community Health Education and Promotion: A Guide to Program Design and Evaluation*. 2nd edition. Gaithersburg, MD: Aspen Publishers, Inc.; 2002:144-161.

Cohen L, Gould J. *The Tension of Turf: Making it Work for the Coalition*. Oakland, CA: Prevention Institute; 2003.

Feighery E, Rogers T. *Building and Maintaining Effective Coalitions*. Palo Alto, CA: Stanford Health Promotion Resource Center; 1990.

Green L, Daniel M, Novick L. Partnerships and coalitions for community based research. *Public Health Reports* 2001;116(1 Suppl):20-30.

Kegler MC, Steckler A, McLeroy K, Malek SH. Factors that contribute to effective community health promotion coalitions: a study of 10 Project ASSIST coalitions in North Carolina. *Health Education and Behavior* 1998;25(3):338-353.

Wolff T, Kaye G. *From the Ground Up! A Workbook on Coalition Building and Community Development*. Amherst, MA: AHEC/Community Partners; 1997.

### **Community Capacity**

Aspen Institute. *Measuring Community Capacity Building: A Workbook in Progress for Rural Communities*. Queenstown, MD: Aspen Institute: Rural Economic Policy Program; 1996. Available at <http://www.aspeninstitute.org/bookdetails.asp?i=59&d=60>.

Chavis D, Wandersman A. Sense of community in the urban environment: a catalyst for participation and community development. *American Journal of Community Psychology* 1990;18:55-81.

Cottrell, L. The competent community. In: Kaplan BH, Wilson RN, Leighton AH. *Further Explorations in Social Psychiatry*. New York: Basic Books; 1976.

Easterling D, Gallagher K, Drisko J, Johnson T. *Promoting Health by Building Community Capacity: Evidence and Implications for Grantmakers*. Denver: Colorado Trust; 1998. Available at <http://www.coltrust.org/repository/publications/pdfs/ComCapEvid.pdf>.

Fawcett S, Francisco V, Hyra D. Building healthy communities. In: Tarlov AR, St. Peter RF. *The society and population health reader*. New York: New Press; 2000:75-96.

Freudenberg N, Eng E, Flay B, Parcel G, Rogers T, Wallerstein N. Strengthening individual and community capacity to prevent disease and promote health: in search of relevant theories and principles. *Health Education Quarterly* 1995;22(3):290-306.

Goodman RM, Speers MA, McLeroy K, Fawcett S, Kegler M, Parker E, et al. Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior* 1998;25(3):258-278.

Israel BA, Checkoway B, Schulz A, Zimmerman M. Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational and community control. *Health Education Quarterly* 1994;21(2):149-170.

Kretzmann JP, McKnight JL. *A Guide to Capacity Inventories: Mobilizing the Community Skills of Local Residents*. Chicago: ACTA Publications; 1997.

Lasker RD, Weiss ES. Broadening participation in community problem solving: a multidisciplinary model to support collaborative practice and research. *Journal of Urban Health* 2003;80(1):14-60.

McLeroy K. Community capacity: What is it? How do we measure it? And what is the role of the prevention centers and the CDC? Proceedings of the Sixth Annual Prevention Centers Conference – Centers for Disease Control and Prevention, National Center for Chronic Disease Control and Prevention; Feb 1996; Atlanta.

Norton B, McLeroy K, Burdine JN, Felix MRJ, Dorsey AM. Community capacity: concept, theory and methods. In: DiClemente RJ, Crosby RA, Kegler MC. *Emerging Theories in Health Promotion Practice and Research*. San Francisco: Jossey-Bass; 2002:194-227.

Poole DL. Building community capacity to promote social and public health: challenges for universities. *Health and Social Work* 1997; 22(3):163-170.

Rifkin SB. A framework linking community empowerment and health equity: it is a matter of CHOICE. *Journal of Health, Population and Nutrition* 2003;21(3):168-180.

Queensland Health. *Integrating Public Health Practices: A Position Statement on Community Capacity Development and the Social Determinants of Health for Public Health Services*. Queensland, Australia: Queensland Government; 2003. Available at <http://www.health.qld.gov.au/phs/Documents/shpu/20426.pdf>.

## Consciousness Raising

Freire P. *Pedagogy of the Oppressed*. New York: Continuum Publishing Corporation; 1970.

## Community Development

Dewar T. *A Guide to Evaluating Asset-Based Community Development: Lessons, Challenges and Opportunities*. Chicago: ACTA Publications; 1997.

Garkovich L. Local organizations and leadership in community development. In: Christenson JA, Robinson JW. *Community Development in Perspective*. Ames, Iowa: State University Press; 1989.

Hope A, Timmell S. *Training for Transformation: A Handbook for Community Workers*. Volumes 1-4. London: ITDG Publishing; 1995.

Kingsley GT, McNeely JB, Gibson JO. *Community Building: Coming of Age*. Washington, DC: Development Training Institute and the Urban Institute; 1997.

Kretzmann JP, McKnight JL. *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. Chicago: ACTA Publications; 1993.

Kretzmann JP, McKnight JL. *A Guide to Mapping and Mobilizing the Economic Capacities of Local Residents*. Chicago: ACTA Publishing; 1996.

Kretzmann JP, McKnight JL. *A Guide to Mapping Consumer Expenditures and Mobilizing Consumer Expenditure Capacities*. Chicago: ACTA Publications; 1996.

Kretzmann JP, McKnight JL. *A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities*. Chicago: ACTA Publications; 1996.

Kretzmann JP, McKnight JL. *A Guide to Creating a Neighborhood Information Exchange: Building Communities by Connecting Local Skills and Knowledge*. Chicago: ACTA Publications; 1998.

Mattessich P, Monsey B. *Community Building: What Makes it Work?* Saint Paul: Wilder Publishing Center; 1997.

Minkler M, Wallerstein N. Improving health through community organization and community building. In: Minkler M. *Community Organizing and Community Building for Health*. New Brunswick, NJ: Rutgers University Press; 1997:30-52.

Minkler M, Wallerstein N. Improving health through community organization and community building. In: Glanz K, Lewis FM, Rimer, BK, editors. *Health Behavior and Health Education*. San Francisco: Jossey-Bass; 1997:241-269.

## Community and Social Health Indicators

Centers for Disease Control and Prevention. Data Set Directory of Social Determinants of Health at the Local Level. Atlanta: National Center for Chronic Disease Prevention and Health Promotion, Cardiovascular Health. Available at [http://www.cdc.gov/cvh/library/data\\_set\\_directory/index.htm](http://www.cdc.gov/cvh/library/data_set_directory/index.htm).

Childstats.gov. American Children: Key National Indicators of Well-Being. Washington DC: Federal Interagency Forum on Child and Family Statistics. America's Children: Key National Indicators of Well-Being. Available at <http://childstats.gov>.

Communityindicators.net. Available at <http://www.communityindicators.net>.

Communityphind.net. Baltimore MD: Public Health Indicators and National Data; 2005. Available at <http://www.communityphind.net>.

Emerine D, Feldman E. *Active Living and Social Equity: Creating Healthy Communities for All Residents: A Guide for Local Governments*. Washington, DC: International City/County Management Association; 2005. Available at [http://bookstore.icma.org/obs/showdetl.cfm?&DID=7&Product\\_ID=1247Active](http://bookstore.icma.org/obs/showdetl.cfm?&DID=7&Product_ID=1247Active).

Global Equity Gauge Alliance. Monitoring Health Inequalities and Promoting Equity Within and Between Societies. Available at <http://www.gega.org.za>.

Kingsley GT. *Building and Operating Neighborhood Indicator Systems: A Guidebook*. Washington, DC: The Urban Institute; 1999.

KnowledgePlex.org. Washington, DC: Fannie Mae Foundation; 2006. Available from: <http://www.knowledgeplex.org>.

Miringhoff M, Miringhoff ML. *The Social Health of the Nation*. New York: Oxford University Press; 1999.

Miringhoff ML. Toward a national standard of social health: the need for progress in social indicators. *American Journal of Orthopsychiatry* 1995;65(4):462-467.

Mohan J, Barnard S, Jones K, Twigg L. Social capital, place and health: creating, validating and applying small-area indicators in the modelling of health outcomes. Wetherby, Yorkshire: National Institute for Health and Clinical Excellence; 2004.

Urban.org. Democratizing Information. Washington, DC: The Urban Institute National Neighborhood Indicators Project. Available at <http://www.urban.org/nnip>.

### **Community Organizing**

Bobo KA, Max S, Kendall, J. *Organizing for Social Change: Midwest Academy Manual for Activists*. Santa Ana, CA: Seven Locks Press; 2001.

Hunter D, Bailey A, Taylor B. *The Art of Facilitation: How to Create Group Synergy*. Cambridge, MA: Fisher Books; 1995.

Kahn S. *Organizing: A Guide for Grassroots Leaders*. Revised edition. Washington, DC: National Association of Social Workers Press; 1991.

Kahn S. *How People Get Power*. Revised edition. Washington, DC: National Association of Social Workers Press; 1994.

Rothman J. Three models of community organization practice. In: Cox F, Erlich JR, Rothman J, Tropman J. *Strategies of Community Organization: Macro Practice*. Itasca, IL: Peacock Publishers Inc; 1970:20-35.

Stoecker R. *Crossing Development-Organizing Divide: A Report on the Toledo Community Organizing Training and Technical Assistance Program*. Toledo, OH: Toledo Community Foundation, University of Toledo Urban Affairs Center; 2001.

Warren RB. *The Neighborhood Organizer's Handbook*. Notre Dame, IN: University of Notre Dame Press; 1977.

### **Social Action**

Economos CD, Brownson RC, DeAngelis MA, Foerster SB, Foreman CT, Gregson J, et al. What lessons have been learned from other attempts to guide social change? *Nutrition Reviews* 2001; 59(3 Pt 2):S40-S56; discussion S57-S65.

Kahn S. *How People Get Power*. Revised edition. Washington, DC: National Association of Social Workers Press; 1994.

Scott JC. *Domination and the Arts of Resistance*. New Haven, CT: Yale University Press; 1990.

Shaw R. *The Activist's Handbook: A Primer*. Updated edition. Berkeley: University of California Press; 2001.

Speeter G. *Power: A Repossession Manual - Organizing Strategies for Citizens*. Amherst, MA: University of Massachusetts at Amherst; 1978.

### **Social Capital**

Harwood Group. *Public Capital: The Dynamic System that Makes Public Life Work*. Bethesda, MD: The Kettering Foundation; 1996.

National Civic League. *The Civic Index: Measuring Your Community's Civic Health*. Denver, CO: National Civic League; 1999.

Saguaro Seminar. *The Social Capital Community Benchmark Survey: Executive Summary*. Cambridge, MA: John F. Kennedy School of Government, Harvard University; 2001.

Sampson RJ, Raudenbusch SW, Earls F. Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science*. 1997; 277(15):918-924.

Van Kemenade S. *Social Capital as a Health Determinant: How Is it Defined?* Ottawa, Ontario, Canada: Health Canada; 2002.

## Health Promotion

Adler NE, Newman K. Socioeconomic disparities in health, pathways and policies. *Health Affairs* 2002;21(2):60-76.

Anderson LM, Fielding JE, Fullilove MT, Scrimshaw SC, Carande-Kulis VG. Methods for conducting systematic reviews of the evidence of effectiveness and economic efficiency of interventions to promote healthy social environments. *American Journal of Preventive Medicine* 2003;24(3 Suppl):25-31.

Butterfoss FD, Goodman RM, Wandersman A. Community coalitions for prevention and health promotion: factors predicting satisfaction, participation and planning. *Health Education Quarterly* 1996;23:65-79.

Davis R, Cook D, Cohen L, Baxi S. A community resilience approach to reducing ethnic and racial disparities in health. *American Journal of Public Health* 2005;95(12):2168-2173.

Findley SE, Irigoyen M, See D, Sanchez M, Chen S, Sternfels P, et al. Community-provider partnerships to reduce immunization disparities: field report from northern Manhattan. *American Journal of Public Health* 2003;93(7):1041-1044.

Israel BA. Social networks and social support: implications for natural helper and community level interventions. *Health Education Quarterly* 1985;12(1):65-80.

Johnson K, Grossman W, Cassidy A. *Collaborating to Improve Community Health: Workbook and Guide to Best Practices in Creating Healthier Communities and Populations*. San Francisco: Jossey-Bass; 1997.

Kaye G, Wolff T. *From the Ground Up: A Workbook on Coalition Building and Community Development*. Amherst, MA: AHEC/Community Partners, Inc; 1997.

Littlefield D, Robison C, Engelbrecht L, Gonzales B, Hutcheson H. Mobilizing women for minority health and social justice in California. *American Journal of Public Health* 2002;92(4):576-579.

Metzler M, Higgins D, Beeker CG, Freudenberg NL, Paula M, Viruell-Fuentes EA, et al. Addressing urban health in Detroit, New York City and Seattle through community-based participatory research partnerships. *American Journal of Public Health* 2003;93(5):803-811.

Morland K, Wing S, Diez Roux A, Poole C. Neighborhood characteristics associated with the location of food stores and food service places. *American Journal of Preventive Medicine* 2002;22(1):23-29.

Morland K, Wing S, Diez Roux A. The contextual effect of the local food environment on residents' diets: the atherosclerosis risk in communities study. *American Journal of Public Health* 2002;92(11):1761-1768.

Needle R, Trotter R, Singer M, Bates C, Page JB, Metzger D, et al. Rapid assessment of the HIV/AIDS crisis in racial and ethnic minority communities: an approach for timely community interventions. *American Journal of Public Health* 2003;93(6):970-980.

Norris T. *The Community Indicators Handbook: Redefining Progress*. Boulder, CO: Tyler Norris Associations; 1997.

The Prevention Institute. *Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities*. Oakland, CA: California Campaign to Eliminate Racial and Ethnic Disparities in Health; 2003.

Provan K, Nakama L, Veazie MA, Teufel-Shone NI, Huddleston C. Building community capacity around chronic disease services through a collaborative inter-organizational network. *Health Education and Behavior* 2003;30(6):646-662.

Ramos IN, May M, Ramos KS. Environmental health training of promotoras in colonias along the Texas-Mexico border. *American Journal of Public Health* 2001;91(4):568-570.

Stokols D. Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion* 1996;10(4):282-298.

### **Community-Wide Media Advocacy**

Altman DG, Balcazar FE, Fawcett SB, Seekins T, Young JQ. *Public Health Advocacy: Creating Community Change to Improve Health*. Palo Alto, CA: Stanford Center for Research in Disease Prevention; 1994.

Bryant C, Forthofer M, McCormack Brown K, McDermott R. Community-based prevention marketing. *American Journal of Health Behavior* 2000;24(1):61-68.

Goldman KD, Zasloff KD. Tools of the trade: media do's and don'ts. *SOPHE News and Views* 1994; 6-7.

Kansiss P. *Making Local News*. Chicago: University of Chicago Press; 1991.

Kickbusch I. *Action on Health Promotion: Approaches to Advocacy and Implementation*. Copenhagen: World Health Organization; 1989.

National Cancer Institute. *Media Strategies for Smoking Control: Guidelines*. Bethesda, MD: National Cancer Institute; 1988.

Olien CN, Tichenor PJ, Donahue GA. Media coverage in social movements. In: Salmon CT, editor. *Information Campaigns: Balancing Social Values and Social Change*. Newbury Park: Sage Publications; 1989:139-163.

Perschuk M, Wilbur P. *Media Advocacy: Reframing Public Debate*. Washington, DC: The Benton Foundation; 1991.

Ryan, C. *Prime Time Activism*. Boston: South End Press; 1991.

Wallack L. *Mass Media and Health Promotion: Promise, Problems, Challenges*. *Mass Communication and Public Health: Complexities and Conflicts*. Newbury Park, CA: Sage Publications; 1990.

Wallack L. Two approaches to health promotion. *World Health Forum*. 1990;11(2):143-154; discussion 155-164.

Wallack L. Media advocacy: a strategy for empowering people and communities. *Journal of Public Health Policy* 1994;15(4):420-436.

Wallack L, Dorfman L, Jernigan D, Themba M. *Media Advocacy and Public Health: Power for Prevention*. Newbury Park, CA: Sage Publications; 1993.

Whitman A. *Changing the Media's Perspective on Public Health*. Lawrence, KS: University of Kansas; 1999. Available at [http://ctb.ku.edu/tools/en/section\\_1276.htm](http://ctb.ku.edu/tools/en/section_1276.htm).

### **Structural Change (Policy and Built Environment)**

Aboelata M. *The Built Environment and Health*. Oakland, CA: Prevention Institute; 2004.

Acosta C. *Improving public health through advocacy policy*. Oakland, CA: Public Health Institute; 2003.

Alinsky SD. *Rules for Radicals*. New York: Random House; 1989.

Brenner M. Political economy and health. In: Amick BC, Levine S, Tarlow AR, Chapman Walsh D. *Society and Health*. New York: Oxford University Press; 1995:211-245.

Flournoy R. *Regional Development and Physical Activity: Issues and Strategies for Promoting Health Equity*. Oakland, CA: PolicyLink; 2002.

Frank LD, Engelke PO, Schmid TL. *Health and Community Design: The Impact of the Built Environment on Physical Activity*. Washington, DC: Island Press; 2003.

Northridge ME, Sclar ED, Biswas P. Sorting out the connections between the built environment and health: a conceptual framework for navigating pathways and planning healthy cities. *Journal of Urban Health* 2003;80(4):556-568.

Speeter GL. *Power: A Repossession Manual - Organizing Strategies for Citizens*. Amherst, MA: University of Massachusetts at Amherst; 1978.

## Evaluation

- Eng E, Parker E. Measuring community competence in the Mississippi Delta: the interface between program evaluation and empowerment. *Health Education Quarterly* 1994;21(2):199-220.
- Fawcett SB, Paine-Andrews A, Francisco VT, Schultz JA, Richter KP, Lewis RK, et al. Empowering community health initiatives through evaluation. In: Fetterman DM, Kaftarian SJ, Wandersman A. *Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability*. Thousand Oaks, CA: Sage Publications; 1996.
- Fetterman D. Steps of empowerment evaluation: from California to Cape Town. *Evaluation and Program Planning* 1997;17(3):305-313.
- Fetterman DM, Kaftarian SJ, Wandersman A. *Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability*. Thousand Oaks, CA: Sage; 1996.
- Israel BA, Lichtenstein R, Lantz P, McGranaghan R, Allen A, Guzman JR, et al. The Detroit Community-Academic Urban Research Center: development, implementation, and evaluation. *Journal of Public Health Management Practice* 2001;7(5):1-19.
- Kegler MC, Twiss JM, Look V. Assessing community change at multiple levels: the genesis of an evaluation framework for the California Healthy Cities Project. *Health Education and Behavior* 2000;27(6):760-779.
- Kreuter M, Lezin N, Young L. Evaluating community-based collaborative mechanisms: implications for practitioners. *Health Promotion Practice* 2000;1(1):49-63.

## Additional Resources

- Beverly SG, Moore A, Schreiner M. A framework of asset-accumulation stages and strategies. *Journal of Family and Economic Issues* 2003;24(2):143-156.
- Bhatia R, Katz M. Estimation of health benefits from a local living wage ordinance. *American Journal of Public Health* 2001;91(9):1398-1402.

CGAP.org. Washington, DC: Consultative Groups to Assist the Poor; 2003. Available at <http://www.cgap.org/index.html>.

Microfinancegateway.org. Washington, DC: Consultative Group to Assist the Poor; 2006. Available at <http://www.microfinancegateway.org>.

Schreiner M. *A Framework for Financial Benefit-Cost Analysis of Individual Development Accounts at the Experimental Site of the American Dream Demonstration*. Saint Louis, MO: Research Design, Center for Social Development, Washington University; 2000.

Schreiner M, Sherraden M. Drop-out from individual development accounts: prediction and prevention. *Financial Services Review* 2005;14(1):37-54.

Schreiner M, Sherraden M, Clancy M, Johnson E, Curley J, Zhan M, et al. Asset accumulation by low-resource people: evidence from individual development accounts. In: Blanton JL, Williams A, Rhine SLW, editors. *Changing Financial Markets and Community Development. Proceedings of the Federal Reserve System Community Affairs Research Conference*; Richmond, VA: Federal Reserve Bank of Richmond; 2001:183-216.

Vonderlack R, Schreiner. Women, microfinance, and savings: lessons and proposals. *Development in Practice* 2002;12(5):602-612.

## References

1. Institute of Medicine. *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press; 2003.
2. Institute of Medicine. *The Future of Public Health*. Washington, DC: National Academies Press; 1988.
3. Nadakavlikaren A. *Our Global Environment: A Health Perspective*. 5th edition. Prospect Heights, IL: Waveland Press, Inc.; 2000.
4. Berkman L, Kawachi I. *Social Epidemiology*. New York: Oxford University Press; 2000.
5. Braveman P, Gruskin S. Defining equity in health. *Journal of Epidemiology and Community Health* 2003;57:254-258.
6. Baker E, Metzler M, Galea S. Addressing social determinants of health inequities: learning from doing. *American Journal of Public Health* 2005;95(4):553-555.
7. National Association of County and City Health Officials Health and Social Justice Committee. *Creating Health Equity Through Social Justice*. National Association of County and City Health Officials. Available at <http://archive.naccho.org/documents/healthsocialjusticepaper5.pdf>.
8. Mann J, Gruskin S, Grodin M, Annas G. *Health and Human Rights: A Reader*. New York: Routledge; 1999.
9. Braveman P. Health disparities and health equity: concepts and measurement. *Annual Review of Public Health* 2006;27:167-194.
10. Whitehead M, Dahlgren G. *Levelling Up (Part 1): A Discussion Paper on Concepts and Principles for Tackling Social Inequities in Health*. World Health Organization. Available at <http://www.euro.who.int/document/e89383.pdf>.
11. James S. Social determinants of health: implications for intervening on racial and ethnic health disparities. Paper presented at: Minority Health Conference, 2002; University of North Carolina.
12. National Center for Health Statistics. *Health, United States, 2007 With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2007.
13. National Center for Health Statistics. *Health, United States, 2006 With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2006.
14. Pleis JR, Lethbridge-Çejku M. Summary health statistics for U.S. adults: national health interview survey, 2005. *National Center for Health Statistics. Vital Health Statistics* 2006;10(232). Available at <http://www.cdc.gov/nchs/nhis.htm>.
15. Pleis JR, Lethbridge-Çejku M. Summary health statistics for U.S. adults: national health interview survey, 2006. *National Center for Health Statistics. Vital Health Statistics* 2007;10(235). Available at <http://www.cdc.gov/nchs/nhis.htm>.
16. United States Bureau of Labor Statistics. *Labor Force Statistics from the Current Population Survey*. United States Department of Labor. Available at <http://data.bls.gov/cgi-bin/surveymost?ln>.
17. Lee J, Grigg W, Donahue P. *The Nation's Report Card: Reading 2007*. Washington DC: United States Department of Education, Institute of Education Sciences, National Center for Education Statistics; 2007. Available at <http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2007496>.

18. United States Department of Education. National Assessment of Educational Progress: 1992, 1994, 1998, 2000, 2002, 2003, 2005, and 2007 Reading Assessments. Washington DC: United States Department of Education, Institute of Education Sciences, National Center for Education Statistics. Available at [http://nationsreportcard.gov/reading\\_2007/data.asp](http://nationsreportcard.gov/reading_2007/data.asp).
19. Kutner M, Greenberg E, Jin Y, Paulsen C. The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy (NCES 2006-483). Washington, DC: U.S. Department of Education, National Center for Education Statistics; 2006.
20. Laird J, DeBell M, Kienzl G, Chapman C. Dropout Rates in the United States: 2005. Washington DC: United States Department of Education, Institute of Education Sciences, National Center for Education Statistics; 2007. Available at <http://nces.ed.gov/fastfacts/display.asp?id=16>.
21. Morland K, Wing S, Diez Roux A, Poole C. Neighborhood characteristics associated with the location of food stores and food service places. *American Journal of Preventive Medicine* 2002;22(1):23-29.
22. Baker E, Schootman M, Barnidge E, Kelly C. Access to foods that enable individuals to adhere to dietary guidelines: the role of race and poverty. *Preventing Chronic Disease* 2006;3(3):1-11.
23. Centers for Disease Control and Prevention. Tobacco Information and Prevention Source: Minors' Access to Tobacco Fact Sheet. National Center for Chronic Disease Prevention and Health Promotion. Available at [http://www.cdc.gov/tobacco/sgr/sgr\\_2000/factsheets/factsheet\\_minor.htm](http://www.cdc.gov/tobacco/sgr/sgr_2000/factsheets/factsheet_minor.htm).
24. Centers for Disease Control and Prevention. Tobacco use, access, and exposure to tobacco in media among middle and high school students, United States, 2004. *Morbidity and Mortality Weekly Report* 2005;54(21):297-301.
25. DeNavas-Walt C, Proctor BD, Smith J. Income, Poverty, and Health Insurance Coverage in the United States, 2006. Washington DC: United States Census Bureau; 2007.
26. Centers for Disease Control and Prevention. WISQARS Injury Mortality Reports, 2005. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Available at [www.cdc.gov/ncipc/wisqars](http://www.cdc.gov/ncipc/wisqars).
27. National Coalition for the Homeless. How Many People Experience Homelessness? National Coalition for the Homeless; 2007. Available at <http://www.nationalhomeless.org/publications/index.html>.
28. Agency for Healthcare Research and Quality. Health Care Disparities in Rural Areas: Selected Findings from the 2004 National Healthcare Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; 2005. Available at <http://www.ahrq.gov/research/ruraldis/ruraldis.par.htm>.
29. Battelle. Travel Patterns of People of Color. Washington, DC: U.S. Department of Transportation, Federal Highway Administration; 2000. 2010. Volume II. Conference Edition. Washington, DC: U.S. Department of Health and Human Services; 2000.
31. Solar O, Irwin A. Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health. Available at <http://ftp.who.int/eip/commission/Cairo/Meeting/CSDH%20Doc%202%20-%20Conceptual%20framework.pdf>.
32. Schulz A, Northridge M. Social determinants of health: implications for environmental health promotion. *Health Education & Behavior* 2004;31(4):455-471.
33. Lynch J, Kaplan G. Socioeconomic position. In: Berkman L, Kawachi I, editors. *Social Epidemiology*. New York: Oxford University Press; 2000.

34. Hertzman C, Power C, Matthews S, Manor O. Using an interactive framework of society and lifecourse to explain self-rated health in early adulthood. *Social Science in Medicine* 1999;53:1575-1585.
35. Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001.
36. Evans RG, Barer ML, Marmor TF. *Why are Some People Healthy and Others Not? The Determinants of Health of Populations*. New York: Aldine de Gruyter; 1994.
37. Dahlgren G, Whitehead M. *Policies and Strategies to Promote Social Equity and Health*. World Health Organization. Available at [http://whqlibdoc.who.int/euro/-1993/EUR\\_ICP\\_RPD414\(2\).pdf](http://whqlibdoc.who.int/euro/-1993/EUR_ICP_RPD414(2).pdf).
38. Blue Cross and Blue Shield of Minnesota Foundation. *Determinants and Critical Pathways Charts*. Blue Cross and Blue Shield of Minnesota Foundation. Available at: [http://www.bcbsmnfoundation.org/objects/Tier\\_4/mbc2\\_determinants\\_charts.pdf](http://www.bcbsmnfoundation.org/objects/Tier_4/mbc2_determinants_charts.pdf).
39. Anderson L, Scrimshaw S, Fullilove M, Fiedling J. The Community Guide's model for linking the social environment to health. *American Journal of Preventive Medicine* 2003;24(3S):12-20.
40. Marmot M, Wilkinson R. *Social Determinants of Health*. New York: Oxford University Press; 2005.
41. Wilkinson R, Marmot M. *Social Determinants of Health: The Solid Facts*. Copenhagen: World Health Organization; 2003.
42. Farquhar S, Michael Y, Wiggins N. Building on leadership and social capital to create change in 2 urban communities. *American Journal of Public Health* 2005;95(4):596-601.
43. Michael YL, Farquar SA, Wiggins N, Green MK. Findings from a community-based participatory prevention research intervention designed to increase social capital in Latino and African American communities. *Journal of Immigrant and Minority Health*. In press.
44. Becker A, Randels J, Theodore D. Project BRAVE: Engaging youth as agents of change in a youth violence prevention project. *Community Youth Development* 2005;Fall:39-52.
45. Schulz A, Zenk S, Odoms-Young A, Hollis-Neely T, Nwankwo R, Lockett M. Healthy eating and exercise to reduce diabetes: exploring the potential of social determinants of health, frameworks within the context of community-based participatory diabetes prevention. *American Journal of Public Health* 2005;95(4):645-651.
46. Lavery S, Smith M, Esparza A, Hrushow A, Moore M. The community action model: a community-driven model designed to address disparities in health. *American Journal of Public Health* 2005;95(4):611-616.
47. Parry J, Judge K. Tackling the wider determinants of health disparities in England: a model for evaluating the new deal for communities Regeneration Initiative. *American Journal of Public Health* 2005;95(4):626-632.
48. Office of the Deputy Prime Minister. *Research report 17. New deal for communities 2001-2005: an interim evaluation*. Sheffield Hallam University; 2006. Available at <http://www.neighbourhood.gov.uk/publications.asp?did=1625>.
49. Horsley K, Ciske S. From neurons to King County neighborhoods: partnering to promote policies based on the science of early childhood development. *American Journal of Public Health* 2005;95(4):562-567.
50. Geiger H. Community-oriented primary care: A path to community development. *American Journal of Public Health* 2002;92(11):1713-1716.

51. Brownson RC, Baker EA, Leet TL, Gillespie KN. Evidence-Based Public Health. New York: Oxford University Press; 2003.
52. Green LW, Kreuter MW. Health Promotion Planning: An Educational and Environmental Approach. Mountain View, CA: Mayfield Publishing Company; 1991.
53. Alter C, Hage J. Organizations Working Together. Newbury Park, CA: Sage Publications, Inc.; 1992.
54. Nelson J, Rashid H, Galvin V, Essien J, Levine L. Public/private partners: key factors in creating a strategic alliance for community health. *American Journal of Preventive Medicine* 1999;16(3 Suppl):94-102.
55. Berkowitz B. Collaboration for health improvement: models for state, community and academic partnerships. *Journal of Public Health Management and Practice* 2000;6(1):67-72.
56. Butterfoss F, Goodman R, Wandersman A. Community coalitions for prevention and health promotion: factors predicting satisfaction, participation and planning. *Health Education Quarterly* 1996;23(1):65-79.
57. Green L, Daniel M, Novick L. Partnerships and coalitions for community based research. *Public Health Reports* 2001;116(1 Suppl):20-30.
58. Lasker R. Promoting collaborations that improve health. Paper presented at: Community-Campus Partnerships for Health's 4th Annual Conference, 2000; New York.
59. Roussos S, Fawcett S. A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health* 2000;21: 369-402.
60. MacQueen K, McLellan E, Metzger D, Kegeles S, Strauss R, Scotti R, et al. What is community? An evidence-based definition for participatory public health. *American Journal of Public Health* 2001;91(12):1929-1938.
61. Hunter A. The loss of community: an empirical test through replication. *American Sociology Review* 1975;40(5):537-552.
62. Fellin P. Understanding American Communities. In: Rothman J, Erlich JL, Tropman JE, editors. *Strategies of Community Organization*. 5th edition. Itasca, IL: Peacock; 1995.
63. Eng E, Parker E. Measuring community competence in the mississippi delta: the interface between program evaluation and empowerment. *Health Education Quarterly* 1994;21(2):199-220.
64. Israel BA, Checkoway B, Schulz A, Zimmerman M. Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational, and community control. *Health Education Quarterly* 1994;21(2):149-170.
65. McKnight JL. Redefining community. *Social Policy* 1992;23(2):56-62.
66. Feighery E, Rogers T. Building and Maintaining Effective Coalitions. 2nd edition. Palo Alto, CA: Stanford Health Promotion Resource Center; 1990.
67. Kaye G, Wolff T. From the Ground Up: A Workbook On Coalition Building and Community Development. Amherst, MA: AHEC/Community Partners, Inc.; 2002.
68. Kretzmann JP, McKnight JL. Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets. Evanston, IL: ACTA Publications; 1993.
69. Johnson K, Grossman W, Cassidy A. Collaborating to Improve Community Health: Workbook and Guide to Best Practices in Creating Healthier Communities and Populations. San Francisco: Jossey-Bass; 1996.
70. Timmreck T. Planning, Program Development, and Evaluation: A Handbook for Health Promotion, Aging, and Health Services. Boston: Jones and Bartlett; 1995.

71. Granner ML, Sharpe PA. Evaluating community coalition characteristics and functioning: a summary of measurement tools. *Health Education Resources* 2004;19(5):514-532.
72. Krieger N, Smith K, Naishadham D, Hartman C, Barbeau EM. Experiences of discrimination: validity and reliability of a self-report measure for population health research on racism and health. *Social Science Medicine* 2005;61(7):1576-1596.
73. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health* 2000;90(8):1212-1215.
74. Williams D, Collins C. US socioeconomic and racial differences in health: patterns and explanations. In: LaVeist T, editors. *Race, Ethnicity and Health*. San Francisco: Jossey-Bass; 2003:391-431.
75. Ulin P, Robinson E, Tolley E. *Qualitative Methods in Public Health: A Field Guide for Applied Research*. San Francisco: Family Health International; 2005.
76. Krueger R. *Focus groups: A practical guide for applied research*. 2nd Edition. Thousand Oaks, CA: Sage Publications; 1994.
77. Wang C, Burris MA. Photovoice: concept, methodology, and use for participatory needs assessment. *Health Education and Behavior* 1997;24(3):369-387.
78. Baker E, Schootman M, Barnidge E, Kelly C. The role of race and poverty in access to foods that enable individuals to adhere to dietary guidelines. *Preventing Chronic Disease* 2006;3(3):1-11.
79. Brownson R, Hoehner C, Brennan L, Cook R, Elliott M, McMullen K. Reliability of two instruments for auditing the environment for physical activity. *Journal of Physical Activity and Health* 2004;1:189-207.
80. Pikora T, Bull F, Jamrozik K, Knuiaman M, Giles-Corti B, Donovan R. Developing a reliable audit instrument to measure the physical environment for physical activity. *American Journal of Preventive Medicine* 2002;23(3):187.
81. Sampson R, Raudenbush S. Systematic social observation of public spaces: a new look at disorder in urban neighborhoods. *American Journal of Sociology* 1999;105(3):603-651.
82. Trochim WMK. An introduction to concept mapping for planning and evaluation. *Evaluation and Program Planning* 1989;12:87-110.
83. Trochim W, Cook J, Setze R. Using concept mapping to develop a conceptual framework of staff's views of a supported employment program for individuals with severe mental illnesses. *Journal of Consulting and Clinical Psychology* 1994;62(4):766-775.
84. Johnsen J, Biegel D, Shafran R. Concept mapping in mental health: uses and adaptations. *Evaluation & Program Planning* 2000;23(1):67-75.
85. Kemm J, Parry J, Palmer S. *Health Impact Assessment: Concepts, Theory, Techniques and Applications*. Oxford: Oxford University Press; 2004.
86. Barrett F, Fry R. *Appreciative Inquiry: A Positive Approach to Building Cooperative Capacity*. Chagrin Falls, OH: Taos Institute Publications; 2005.
87. The Synergy Project. *APDIME Toolkit: Resources for HIV/AIDS Program, Version 2.0 Managers*. Social and Scientific Systems, Inc. Available at <http://www.synergyaids.com/APDIME/index.htm>.
88. Goodman R, Speers M, McLeroy K, Fawcett S, Kegler M, Parker E, et al. Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior* 1998;25(3):258-278.

89. Cottrell L. The competent community. In: Kaplan B, Wilson R, Leighton A, editors. *Further Explorations in Social Psychiatry*. New York: Basic Books; 1976.
90. Minkler M, Wallerstein N. Improving health through community organization and community building: a health education perspective. In: Minkler M, editors. *Community Organizing and Community Building for Health*. New Brunswick, NJ: Rutgers University Press; 2002:30-67.
91. Rothman J. Three models of community organization practice. In: Cox F, Erlich J, Rothman J, Tropman J, editors. *Strategies of Community Organization: Macro Practice*. Itasca, IL: Peacock Publishers Inc; 1970:20-35.
92. Speeter G. *Power: A Repossession Manual - Organizing Strategies for Citizens*. Amherst, MA: University of Massachusetts at Amherst; 1978.
93. First International Conference on Health Promotion. The Ottawa Charter for Health Promotion. First International Conference on Health Promotion. Available at <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html>.
94. Wallack L, Dorfman L, Jernigan D, Makani T. *Media Advocacy and Public Health: Power for Prevention*. Newbury Park, CA: SAGE Publications; 1993.
95. Harrington C, Estes C. *Health Policy*. 4th Edition. Boston: Jones & Bartlett Publishers; 2004.
96. Kreuter M, Lezin N, Young L. Evaluating community-based collaborative mechanisms: implications for practitioners. *Health Promotion Practice* 2000;1(1):49-63.
97. Dewar T. *A Guide to Evaluating Asset-Based Community Development: Lessons, Challenges and Opportunities*. Evanston, IL: ACTA Publications; 1997.
98. The Lewin Group I. *Communities Sustain Public Health Improvement Through Organized Partnership Structures*. Battle Creek, MI: W.K. Kellogg Foundation; 2004.





