PREVENTION INSTITUTE

Partnering for Health Equity

Grassroots Organizations on Collaborating with Public Health Agencies

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FUNDING AND AUTHORSHIP

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Written by Prevention Institute.
Principal authors: Juliet Sims, Sandra Viera, and Manal J. Aboelata

Prevention Institute (PI) is a focal point for primary prevention, dedicated to fostering health, safety, and equity by taking action to build resilience and to prevent problems *in the first place*. A national nonprofit with offices in Oakland, Los Angeles, and Washington D.C., we advance strategies, provide training and technical assistance, transform research into practice, and support collaboration across sectors to catalyze innovation, advance policy and systems change, and build momentum for prevention, wellbeing, and health equity. Since its founding in 1997, Prevention Institute has focused on transforming communities by advancing community prevention, health equity, injury and violence prevention, healthy eating and active living environments, health system transformation, and mental health and wellbeing.

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For further information, contact Juliet Sims:
juliet@preventioninstitute.org

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Introduction

With support from the W.K. Kellogg Foundation, Prevention Institute initiated *Partnering for Health Equity: Grassroots Organizations on Collaborating with Public Health Agencies* to better understand community perspectives on the challenges, opportunities, facilitators, and barriers to working with public health agencies to advance health equity. Prevention Institute spoke to organizational leaders working in grassroots, base-building, and community-based organizations, and asked them to share their experiences and ideas about the skills, strengths, and limitations of effectively working with public health agencies on initiatives, campaigns, or broader norms-change efforts aimed at eliminating health inequities through the production of more just systems, institutions, policies, and practices.

We wanted to learn about how features of the political landscape, funding, staff skills, leadership, and partnerships influence the ability of community-based organizations to work effectively with public health agencies to narrow systemic gaps in health fueled by racial injustices and made evident in health inequities.

This report highlights what emerged during our conversations. Our starting point for this project was the recognition that local and state health departments have an important role to play in advancing health equity. These agencies all have a health mandate and we see evidence of local health departments that already fully embrace the charge to undo structural and institutional barriers that stand in the way of all people achieving optimal health. We also knew that there were some places around the country where neither a focus on racial equity nor health equity has taken root within the health mandate of local or state jurisdictions. We wanted to learn about how features of the political landscape, funding, staff skills, leadership, and partnerships influence the ability of community-based organizations to work effectively with public health agencies to narrow systemic gaps in health fueled by racial injustices and made evident in health inequities.

What we heard from the grassroots leaders we spoke to was a tremendous openness to strengthening their own organizations and the public health institutions they partnered with to learn, grow, and become ever more effective in their efforts to achieve fairer and more equitable health outcomes. We also heard about some deep challenges that have impeded the work. Here, we articulate the structural factors, the organizational practices, and ways of navigating partnerships and community engagement that have and haven't worked.

We hope that the issues and ideas discussed below will affirm, bolster, and accelerate the practices that enable public health departments as well as state and tribal jurisdictions to function as effective partners in community-rooted efforts to eliminate racial inequities and achieve health equity. Our hope is that people working in the public health field—in philanthropy, local government, and community-rooted organizations—can use this information to catalyze effective ways of approaching the practice of public health by embracing structural and institutional racism and discrimination as within the purview of public health; foster stronger working relationships that reverse the legacy of historical inequality; forge processes and practices that lead to equitable distribution of opportunities, power, and resources; and produce equitable health outcomes.

Methodology

Informed by project partners and the W.K. Kellogg Foundation, PI identified and selected organizational leaders from across the U.S. that represent grassroots, base-building, and other community-based organizations who were, at the time of the interviews, actively working in partnership with local or state health departments to reduce and eliminate racial inequities in health. Each interviewee had experience working directly with public health agencies to address the policies, structures, and institutions that influence community-level determinants of health. Each interviewee articulated a clear goal of improving health and safety outcomes by focusing on institutional, structural, and systemic drivers of unfair and unjust differences in health outcomes, observable by race / ethnicity. The topical issues included land use and environmental justice, housing, economic opportunity, violence prevention, and criminal justice reform. The fundamental issues identified included community voice and power, resource distribution and definitional questions like "what is or isn't within the purview of public health?" Between September 2016 and January 2017, project staff conducted semi-structured interviews with 20 highly credible equity leaders who are recognized in the health and/or social justice fields for their track records of civic involvement and community-rooted efforts. A subset of these leaders represented organizations that are approaching these community determinants with an explicit focus on achieving racial equity. Appendix A provides a table summarizing interviewees and the focus area of the organizations they represent, and the map below indicates the geographic spread of key informant interviewees.

By design, our research involved speaking with leaders of community organizations actively engaged with their local or state health department.

Drawing on our qualitative research experience, project staff developed and tested an open-ended interview guide focused on learning about the roles of each organization; what they were doing to promote health equity; their experiences collaborating with public health agencies; how they saw public health agencies supporting community efforts related to health and/or racial equity; challenges to collaboration to advance community-driven equity priorities; their perspectives on creative approaches public health agencies can employ to overcome barriers to engaging in an equity-focused practice; elements of effective partnerships; ways in which public health agencies sometimes explicitly or

Places represented by those interviewed

implicitly reinforce bias or inequities; and, other learnings interviewees thought we should hear about. Project staff completed a brief review of scholarly and gray literature, policy briefs, and case studies focused on the role of public health agencies in advancing health equity and social justice. Appendix B includes a summary of the literature reviewed.

Upon completion of interviews, project staff conducted a comprehensive, multi-step analysis of the interview recordings and notes to identify and compile recurring themes. We listened deeply for challenges, opportunities, facilitators, and barriers to working with public health agencies to advance health equity. Related issues were clustered into domains that describe roles, practices, and skills that have facilitated public health agencies' ability to advance health equity in partnership with community organizations and leaders, as well as structural challenges to these efforts.

By design, our research involved speaking with leaders of community organizations actively engaged with their local or state health department. We did not investigate the role of public health agencies working explicitly on issues of health equity and/or racial equity in the absence of a strong community–based organization. Nor did we talk to leaders of community-based organizations that had not partnered with a local or state health jurisdiction. Our interviewees skew towards representation of urban and suburban communities, with only a small number representing rural communities. Our interviews were part of a larger effort, including other partners funded independently by the W.K. Kellogg Foundation. Project partners interviewed community leaders in rural areas within New Mexico, Mississippi, Michigan, and tribal communities across the country, and their reports (forthcoming as of this printing) complement this report by bringing in rural advocates' perspectives.

Advancing Health Equity

Why the Role of Public Health Agencies Matters Now

A growing number of public health professionals consider the pursuit of health equity to be central to the practice of public health. Public health professionals are increasingly embracing the idea that eliminating inequities requires understanding and acting upon the underlying reasons for persistent and systemic gaps in health outcomes. An increasing number of health departments and their professional associations are explicitly naming issues like economic inequality, racism and discrimination, and voter exclusion, to name a few, as central to achieving lasting improvements in health and safety for children, families, and the communities in which they live.

The inclusion of health equity in *Healthy People 2020* as one of four overarching goals, along with publications like the World Health Organization's (WHO) *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* and Centers for Disease Control and Prevention's (CDC) *A Practitioner's Guide for Advancing Health Equity,* have strengthened awareness and understanding that public health must go beyond documenting disparities in health and development of programs that focus on populations experiencing inequities. Typically, health departments engaged in the practice of addressing health equity systemically are focused on shifting structural, political, and institutional policies and practices that deny resources and opportunities to marginalized and excluded groups while affording other groups (disproportionately White, wealthy, and heterosexual) greater access to resources, power, and decision-making needed to achieve optimal health and well-being. The health departments on the leading edge of this work are demonstrating how to be effective in improving health outcomes by eliminating

Structural drivers: At the root of inequitable community conditions

The World Health Organization has identified structural drivers—the inequitable distribution of power, money, opportunity, and resources—as a key determinant of inequity in health and safety outcomes. Together, structural drivers "fashion the way societies are organized." They include economic and social policies, and processes and norms, particularly at the national and international levels, that reflect historic and present-day systems of inequality related to class, race, gender, and sexual orientation, among others. Structural drivers not only fuel chronic stress—such as from the stressors associated with living in poverty and with racism—they are also the fundamental root causes of inequities in community conditions and, consequently, health and safety outcomes.

inequities based on race, social status, or economic position in society. Most of the time, they are accomplishing this through deep and embedded partnerships.

As momentum increases to re-orient public health toward racial and health equity, the field is looking for "models" of practice and partnership with groups working at the community and grassroots levels. Where public health has traditionally focused on behavior and outcome data, health education, and access to services to reduce chronic illness and injury, an equity-focused practice includes broader efforts to address inequitable community environments—places in which the surrounding conditions are designed to make illness and injury inevitable—and taking on the decisions, decision-makers, policies, and practices that are responsible for the conditions we see. Equity-focused advocates and practitioners work on addressing power imbalances, social and political hierarchies, and norms and values that perpetuate racism, discrimination, and exclusion.

Over recent decades, a growing number of health departments have been transforming their own practices and influencing the field. Increasingly, these departments approach the communities they work in as equal partners, seeing residents and community-groups as bearers of solutions, ingenuity, and power, rather than as "consumers" of safety-net care, recipients of services, or clients in health education. In this work, public health rarely sees itself 'at the center' of health efforts, but increasingly views itself as lending its resources, skills, and capacity to advance community-defined priorities and strengthen social-justice efforts that take root in (and are defined by) community residents and the groups that work closely with residents. Understanding that change cannot be accomplished through government alone, these health departments are seeking out deeper connections with social-justice organizations and leaders in their communities. Health departments working toward transforming their policies and practices don't abdicate their responsibility to improving health outcomes, but recognize that there are important and valid ways of working with community groups and other governmental departments to make durable, systems-level changes in the institutions and practices that produce health inequities.

Opportunities for Advancing Equity-Focused Public Health Practice

"Through collaboration with community partners, [the local health department] has been able to advance its thinking and work on the governmental systems and structures that challenge people's ability to live healthy lives. […] Together, we've named eliminating structural racism as a priority goal in our strategic plan."

- Interviewee

In our interviews with equity-focused community organizations and leaders, we learned about some of the roles and practices that public health agencies are engaged in that have been particularly supportive of community-led efforts. We have organized what we heard into three categories and include examples from the interviews to inspire further transformations:

1. Bringing intentionality to health equity efforts;
2. Valuing community experience and capacity;
3. Aligning health department functions with equity goals.

1. Bringing Intentionality to Health Equity Efforts

In the context of public health agencies, a critical precursor to strengthening health equity practice is intentionally broadening the individually-focused programmatic approach that has come to characterize the practice of public health in the last half-century, toward a systems-level orientation.[1] Nearly every interviewee mentioned the importance of focusing on policy and systems change to improve the health and safety of residents facing inequitable conditions and experiencing poor health outcomes. One interviewee, however, noted that "focusing efforts on the 'root causes' of health inequities is not woven into the fabric of core public health practice. It needs to be intentional." Among the people we spoke to, several described working with public health agencies to incorporate systems-level approaches to advancing health equity. The following ideas emerged in our discussions:

Systemic change—fundamental change in policies, processes, relationships, and power structures as well as deeply held values and norms—allows communities to address the structural factors that have caused health inequities to be produced.

By placing health equity at the center of public health efforts, governmental agencies can make addressing structural racism, discrimination, and bias part of their mandate.

Some public health agencies have sought to foster greater intentionality by embedding equity goals into strategic plans, organizational budgets, engagement processes, and evaluation plans. A small number of interviewees talked about their work to embed equity goals into community health assessments, community health improvement plans, and departmental strategic plans required for accreditation. They said that this was an opportunity to strengthen and codify health equity as a priority focus, and to elevate policy and systems change objectives.

As one example, one interviewee described how through a prioritization process with community partners, the local board of health named *elimination of structural racis*m as a priority. The inclusion of this root cause of poor health then helped to open the door to strategies and activities focused on eliminating racial bias across institutions and society, including: developing a community-level understanding of the historical forces involved in creating current inequities; using health equity data to illuminate how race-based policies and practices created opportunities for some and restricted possibilities for others; supporting organizational, institutional, and community leaders to work closely with community members to create awareness of how and why assumptions about racial and ethnic populations can impact their thinking, feeling, and actions; and using an equity-focused approach to develop policies that increase social and economic opportunities for racial and ethnic minorities.

Supporting the advocacy power and voice of communities experiencing inequities makes local health departments more accountable to those communities and advances equitable health and safety outcomes.

Public health agencies receive a significant portion of their funding through categorical federal grants to administer programs, with some additional philanthropic funding. In terms of funding, accountability is shaped by grant activities and reporting requirements, and often centers on services delivered or education provided. Some of the community-leaders we spoke to said that they thought governmental public health partners cared deeply about health inequities, but that the

benchmarks tied to public health funding didn't necessarily align with systemic change strategies supported by equity-focused community organizations and residents.

Some interviewees said that shifting accountability toward community meant recognizing that building power within communities and movement-building are fundamental to systemic change. One interviewee emphasized that public health leaders needed to be aware of power and politics coming into play, without letting fear or risk-aversion get in the way of work to advance health equity. Government-wide capacity-building initiatives, such as the Government Alliance for Racial Equity (GARE), were highlighted by several individuals we interviewed as helpful in creating greater institutional momentum for addressing racial equity within local governments.

To work within the real and perceived boundaries of government, including limits on lobbying, several interviewees described adopting an "inside-outside" strategy to leverage and align strengths of government with those of organizers, advocates, and community partners. This approach can add particular value to community-led policy efforts because public health agencies have access to useful data, knowledge of various policy processes and levers, and expertise on power dynamics within government—all of which can help inform strategy.

One person described to us how the local health department had established a leadership academy for youth and residents to build civic engagement skills. Support for the academy—combined with deeper relationship- and trust-building with grassroots organizations and residents—enabled the health department to support systemic changes without overstepping its own advocacy limits.

Public health agencies can use their standing and credibility to build relationships with other governmental agencies whose policies, practices, and funding streams significantly impact health and safety.

A growing number of local and state health departments have embraced the importance of partnerships with other governmental agencies whose decisions greatly impact social determinants of health, such as affordable housing, safe places to be physically active, equitable education and employment opportunities, and availability of healthy food retail options.

One interviewee noted that in their experience working with different government agencies, public health stood out because of its more nuanced and holistic understanding of how health inequities are created and perpetuated. The frameworks that public health has developed to organize its work around determinants of health and the methodological approach that focuses on moving upstream to address inequities establishes a model for a shift in governmental practices across sectors.

We heard from several people that public health agencies can use their connection and credibility with other governmental departments and agencies to provide education and technical assistance about the impact of other agencies' policies on health and safety outcomes. One person we interviewed described how, for her community partners, "it is often more strategic to have [the health department] connect with

Community Profile: King County, Washington

In King County, Washington, the King County Health Department seeks to embed equity principles—such as diversity, equity, social justice, and inclusion—throughout the county. King County is geographically large in size, encompassing Seattle, 38 other cities, and a large rural area. Many residents enjoy a high quality of life, which includes high income and an unemployment rate below 3.5 percent. However, the benefits enjoyed by some are not enjoyed by all. Low-income communities of color disproportionately face challenges that lead to poorer than average economic, social, and health outcomes.[2] In 2013, the median net wealth gap between communities of color and White communities in King County was $123,900.[3]

In 2010, the public health department and other government agencies sought the input of several thousand residents and county employees to create the county's Strategic Plan. The public health department's data and mapping, which depicted how disparities were correlated with place and race, were critical to launching King County's equity work. Based on community input, the plan included an Equity and Social Justice Guiding Principle that shapes the county's decisions, organizational practices, and community engagement.

The Equity and Social Justice Guiding Principle facilitates further analysis of the systemic causes of inequities in the county—such as housing and education policies—and encourages the prioritization of departmental resources aimed at reducing inequities. This has allowed equity to be factored into funding decisions. For example, park use, social equity, and geographic value, became considerations in transportation and parks allocations.

Moving forward, King County is exploring ways to deepen their equity efforts across sectors with the goal of institutionalizing equity principles such as diversity, equity, social justice, and inclusion so that the work continues beyond any one person in King County for years to come.

a partner county agency to work through policy issues because they are peers." Another emphasized that in communities in which racial equity is a central focus, it can be valuable for the health department to collaborate with community partners to help surface the multi-sector "systems and structures that influence opportunities and barriers [for health and wellbeing] by race."

2. Valuing Community Experience and Capacity

"Health departments should aim for transformational engagement rather than transactional engagement."

– Interviewee

Public health agencies have made progress in incorporating community voices within processes and plans like community health needs assessments and health improvement plans, striving to ensure that residents are part of each step along the way. As public health agencies deepen their work to focus on the root causes of inequities, an opportunity exists to shift their level of community engagement activities so as to better contribute to meaningful, sustainable community leadership. A long-time community leader working with community residents shared that when health departments come into communities and provide information about an issue simply to collect feedback on their own terms and then return to their offices, it can lead to a transactional versus transformational community engagement experience. Transactional community engagement can result in disconnection from community members and frustration with pre-determined limitations on the type of input, feedback, and leadership community members can provide.

Transformational community engagement, on the other hand, seeks to positively change the dynamics between public health agencies and community members. Rather than a singular focus on outcomes, it prioritizes an equitable process that challenges power imbalances and centers the voices of the people most impacted. Transformational engagement efforts make space for opportunities for residents to lead and co-lead sustainable initiatives that impact residents' own livelihoods. Building skills, carving out leadership and decision-making roles, and creating opportunities for deep listening about residents' experiences and priorities can support a shift from one-dimensional, transactional engagement to transformative community engagement.

One interviewee noted that community organizers often feel tension with public health initiatives because public health is tied to strategies and actions that seek measurable results, without fully considering how that paradigm in itself can reinforce damaging dynamics. She

described how, in her experience, increased attention and resources for health issues like obesity led the health department to focus on healthy eating and active living interventions, with individual behavior change and improved weight status as benchmarks. That narrow focus didn't leave room to address the community's primary concerns. Community partners saw inequities like the need for living wages and safety from violence as critical determinants of health, yet the health department felt limited in its capacity to address these factors and partner with community to address them. The health department's benchmarks weren't measuring those outcomes that mattered most to the community.

The following have been successful elements of public health institutions' efforts to engage with community to create transformative change:

Partnerships with communities experiencing health and safety inequities are strengthened by prioritization of an equitable process, in addition to seeking more equitable outcomes.

When it comes to achieving equitable health and safety outcomes, community organizers emphasized that an equitable process that builds leadership and power in community members is at least as—if not more important—than proximal measures of behavior change and improved health status are. In other words: both process and outcomes matter, and a good process in and of itself can be a benefit to health.

Public health agencies have recognized issues of linguistic accessibility, physical locations, timing of community meetings, and provision of child care. But many times, their engagement strategies are oriented toward bringing together residents, providing information, and then collecting feedback to strengthen public health agencies' pre-existing priorities. In these cases, a key opportunity exists for community-based organizations that typically bring a robust set of enduring engagement strategies and skills, to be established as a co-designer and implementer along with public health agencies. When public health agencies invested in more meaningful mechanisms for community engagement—empowering the community to establish priorities, determine approach and strategies, and lead implementation efforts—interviewees indicated that public health agencies had positively contributed to changing leadership and power dynamics that had impact beyond any one initiative or project.

Community engagement efforts that provide space for health departments and residents alike to identify root causes of inequities—including unequal distribution of power and historical trauma—build trust and foster long-term relationships.

A legacy of overt discriminatory actions and present-day policies and practices that perpetuate inequities in health, safety, and justice can mean that at times government agencies—including public health agencies—are viewed by communities as part of the problem. At the same time, public health agencies are often seen as an integral part of the solution. Interviewees emphasized that, to take on structural drivers of inequities and community-level determinants, community members and organizations should play central roles in identifying and addressing the most important underlying issues.

Many interviewees highlighted that collaboration is an iterative and challenging process that requires all parties to acknowledge historic dynamics and power imbalances, and that moments of tension can be used as learning opportunities to transform the way everyone interacts.

Building and nurturing trust was identified by a majority of interviewees as a key element in establishing successful partnerships. Interviewees expressed that, due to historical traumas and continued imbalances in racial and class power, inherent distrust between community members and public health agencies exists. Long-time organizers emphasized the need to develop a shared understanding of this context and make space to name the tensions and conflict before attempting to jump into any exchange.

One interviewee expressed that—while it's important for public health to be proactive in showing up for communities—public health shouldn't always lead the dialogue or even be present in the space at all times. Sometimes, what's needed is for public health to convene a series of community listening sessions and create opportunities for the initial sessions to occur without them, so communities can feel safe in naming their needs and frustrations. Then, public health can join the conversation through an initial listening role—continuing to prioritize those most impacted by structural inequities to voice their experiences, identify the issues at hand, and share their recommendations. Once that foundational work has been laid down, public health can take a more active role in the discussion.

Many interviewees highlighted that collaboration is an iterative and challenging process that requires all parties to acknowledge historic dynamics and power imbalances, and that moments of tension can be used as learning opportunities to transform the way everyone interacts. As one interviewee stated, "we're learning to lean into discomfort."

Collaboration that identifies and compensates community partners, fairly acknowledging contributions, helps build equity into institutional practices.

Public health funding streams from federal agencies, such as the Centers for Disease Control and Prevention, are often allocated to governmental health institutions to re-grant to local and nongovernmental groups. This approach can help to strengthen ties between the groups, however, several interviewees described how at times, this could reinforce the perception of a top-down approach to partnership in which the governmental agency is in charge while the community-based organizations are grantees. Many interviewees described the importance of equitable partnership—including funding and resources—to strengthen the capacity of community organizations to work with residents to advance health equity priorities. Ensuring that partnerships are resourced both in terms of skills and funding to establish infrastructure, practices, and policies that treat each partner as equals in design and decision-making institutionalizes community leadership as a practice, not just in principle.

One interviewee described how in the low-income African American neighborhoods he worked within, public health funding was directed to community-based organizations that provided services to the community but whose staff and leadership weren't representative of the community they served. From the perspective of organizers invested in building power within community, these seemingly benign practices can amplify power imbalances and miss opportunities to build community capacity for change that can outlast any single health and safety issue. Interviewees emphasized that public health agencies were valued partners when they served as co-strategists with community—in a supporting role when the community is prepared to take the lead and leading when community capacity is limited.

Allocating funding to organizations that represent the community helps establish a more equal partnership, creates greater transparency, and lays the groundwork for sustainability. In granting or re-granting funds to community-based organizations and partners, public health agencies and other funders should consider providing resources for these partners and their constituents to build capacity in the areas of health equity and racial justice as well as non-monetary resources like physical space, facilitation support, data capacity, etc.

One interviewee also recommended that public health agencies should create strategic opportunities for community partners to co-design collaborative structures and communicate opportunities and challenges, even when those challenges are connected to governmental practices.

Community profile: Cuyahoga County, Ohio

In Cuyahoga County, Ohio, the Cuyahoga County Board of Health has taken a multi-sector approach to partnership—collaborating with community organizations, local government, and healthcare to strengthen collective capacity to advance health equity. Thirty percent of Cuyahoga County residents are African American, many of whom live in the county's urban core, where poverty is high and community conditions create barriers to health.[4,5] Life expectancy in some neighborhoods is 20 years less than in more affluent parts of the county.[6] In this environment, health equity efforts unfold within a racial equity context.

Through participation in the Center for Achieving Equity—a local nonprofit established to empower leaders and communities to identify and address the conditions that shape health and opportunities—the Board's staff, community partners, and governmental partners were able to open a dialogue on how systemic and institutionalized racism and unfair public and organizational policies have produced inequities in health. The Center also participated in the national network, Collaboratives for Health Equity, in which they learned about how other health departments were addressing health inequities.

Since its formation, the work of the Center has strengthened capacity for health equity in Cuyahoga County in a number of ways. For the Board of Health, participation in the Center has marked a strategic shift from prevention approaches centered on behavior modification and access to healthcare to those focused on socio-economic factors, institutional decision-making, and policies that can improve community conditions.[7] The Board of Health also serves as the backbone organization for the Health Improvement Partnership (HIP)-Cuyahoga, a consortium of over 100 community partners committed to improving health for all Cuyahoga residents. Charged with developing the county's Community Health Improvement Plan, HIP-Cuyahoga successfully named the "elimination of structural racism" as a priority goal. Martha Halko, HIP-Cuyahoga Partnership Coordinator for the Board of Health, described how, "during our Community Health Improvement Planning process, we recognized that for our plan to truly impact inequities, we needed to build the case for equity among all our partners. We moved beyond a data-driven approach that appeals to the mind only, to a community-driven approach guided by shared values—moving both hearts and minds towards improved health for all in Cuyahoga County."[8]

Community profile: Monterey County, California

In Salinas, California, the Monterey County Health Department works to unite government agencies and community leaders in building racial equity and healing. Salinas Valley is home to booming farming and prison industries, resulting in two economic engines: agriculture and incarceration. About 75% of Salinas residents identify as Latino, with the low-income, largely farmworker, population residing predominantly in East Salinas. Racial and economic segregation between East and West Salinas is palpable. In 2014, East Salinas was the site of four fatal officer-involved shootings of young Latino men within six months, leading to distrust, anger, and frustration toward police and government agencies among community members. [9]

Understanding this, and with the guidance of Race Forward and the National Compadres Network, East Salinas Building Healthy Communities—a place-based initiative focused on policy and systems change grounded in a healing-informed racial justice framework that improves health outcomes for residents—and other local leaders co-developed a training and convening on governing for racial equity, where they sought to surface and begin to address the harmful effects of systemic racism. Salinas initiated a novel approach, employing a healing-informed framework and committing as many resources to training community leaders as city leaders and staff. Carmen Gil, a community organizer who helped develop the training expressed, "I wanted to bring people to a point where both sides could see the other side as vulnerable... Even the police chief—I said to him, you have to come as who you are as a father, a son, not just in your uniform... We [also] needed to train all these community leaders and really make them key partners in the process. We need the community to understand what we are doing is moving toward systemic change."[10]

And systemic change is underway for Monterey County. The training was followed up by creation of a steering committee where residents and local leaders continue their commitment to engaging in difficult conversations, providing space for healing, and changing allocation of resources for East Salinas residents. New developments include the Alisal (East Salinas) Vibrancy Plan, which creates a framework for sustained economic opportunities that foster a vibrant cultural district for residents and visitors. The Health Department has been a valuable partner, providing data and innovative strategies to support the development of the plan. To date, the city has set-aside $750,000 to support its creation.[11] The Department has also served as an ally in advancing efforts at the county government level, including helping to facilitate a conversation on racial equity and healing with the Board of Supervisors. In addition, the Health Department also hosts a transformative Health Equity Scholars Academy—a facilitated, capacity-building process where department staff are empowered to approach health in the context of social inequity. The Academy provides space for conversations about race and experience across bureaus and helps build capacity among staff and community residents to navigate complex systems and use their voices to create a healthier and safer Monterey County.

3. Aligning Health Department Functions with Equity Goals

The institutional assets and core functions of public health agencies—including community health data and monitoring, analysis of the health impacts of proposed and existing policies, and evaluation and research—can be leveraged in support of community priorities around health equity. Interviewees offered examples of public health agencies' strategic use of their core capacities to support community-led equity efforts:

Public health plays a uniquely valuable role and helps to "shift the narrative" when it uses its expertise and data to educate non-health sectors and policymakers about the role of structural factors and community conditions in creating and perpetuating racial and health inequities.

"The health department has a particular perspective that is needed in urban planning discussions…. It needs to explore and quantify the health outcomes related to land use—where people live, and how nearby industry and traffic affect people—and stand up in meetings with industry and city, county, etc. and address it."

– Interviewee

A number of interviewees described the technical knowledge and credibility public health agencies have in conveying information about the factors that shape population health, health behaviors and outcomes, and solutions to address health and safety problems.

One interviewee who works to elevate solutions to poverty described how important it is for public health agencies to "broaden the frame from the individual to the conditions and systems that shape individual behaviors." Another interviewee reinforced this notion by cautioning that public health "hinders the work when the narrative isn't focused on a strengths-based model that addresses structural drivers and social determinants of health." In addition to shifting the focus toward community conditions and underlying systems, several interviewees emphasized that public health is well positioned to describe how residents of communities that experience inequities face multiple, intersecting challenges to health and safety. For example, in communities that lack access to healthy food and safe places to play, exposure to violence and community trauma can increase risk for chronic illness and reduce the effectiveness of efforts to improve nutrition and increase activity.

Several interviewees highlighted the value of public health agencies using their expertise and credibility to provide analysis and education about the health impacts of proposed development projects and local policies. For example, an interviewee described the power of the message when the local health officer came to speak to community partners and business and industry leaders about the striking disparities by zip code in chronic illness and life expectancy that stemmed from industrial pollution in the neighborhood—home to a large number of African

American residents. "The zip code study stunned people—industry couldn't minimize it. It's important that public health leaders step up in that way, use data to describe the environmental pollution crisis, and its effects on morbidity and mortality." The data provided crucial context for negotiations between the community and industry leaders.

When collection, analysis, and dissemination of data is done in partnership with community, it strengthens community leadership and establishes pathways toward more effective strategies for action.

Through their core functions, public health agencies undertake regular assessments of community health and often engage community residents and organizations to gather information and input about health issues, challenges, and solutions needed to improve health status. The information is collected, shared with city and county agencies, health systems, elected officials, and used to inform broader health processes, such as community health improvement plans or public health strategic plans. But it is not always shared back with community residents or organizations.

Data is a valuable tool for communities to have as they make the case for changes in systems and environments, and track and monitor progress of those agencies and elected bodies that are responsible for ensuring health in their communities. Interviewees in both rural and urban communities underscored how co-ownership of efforts to collect, analyze, and share data can help to build ongoing capacity and skill within communities. Bringing community residents into the data-gathering process means empowering residents to shape the scope of inquiry, collect data in a culturally effective way, and analyze the data so it serves the priorities of the community as well as those of the institution gathering the data. One interviewee recounted how the county health department made a valued practice of "sharing data and engaging in research with [community partners]. This has included survey development and data collection, co-creation of survey tools, training of [community] partners on community research and how to conduct it, and provision of data to help make the case to key decision-makers."

Interviewees who worked with local health departments in both suburban and urban regions underscored the value of public health's capacity to responsively analyze census and GIS (Geographic Information Systems) data quickly, or to share relevant community health data in response to community requests. One interviewee recounted how a health department GIS mapping specialist was made available to

community partners to help map data that residents had gathered during a neighborhood assessment of land use and economic opportunity. By leveraging the department's GIS capacity, residents and community partners were able to create neighborhood maps that helped to inform their plan for equitable community development and revitalization.

Community Profile: Minnesota Department of Health

In Minneapolis, the Minnesota Department of Health is working to transform their data collection and reporting systems to improve health equity by making existing racial, ethnic, and socio-demographic inequities more visible. Inequities in Minnesota, like in other U.S. states, highlight the need to better prioritize care, healing, and primary prevention. State data shows that poverty rates are twice as high for Asian children, three times as high for Latino children, four times as high for American Indian children, and nearly five times as high for African American children when compared to White children.[12]

In 2014, the department released Advancing Health Equity in Minnesota—a report to the state legislature that identified several conditions that produce these inequities and made recommendations to advance health equity. The report demonstrated the need to move upstream and focus on structural factors: "achieving health equity requires valuing everyone with focused and ongoing efforts to address avoidable systematic inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[13] The report also spoke to the role of the health department and the need to develop commitments, structures, and practices to support health equity and address structural racism. One recommendation in particular sought to begin operationalizing this by engaging community partners more equitably in the department's efforts, including the development of reports and recommendations.

An opportunity emerged to put the recommendation into action with the development of a plan for improving the collection, analysis, reporting, dissemination, and use of health equity data.[14] The Department contracted with Voices for Racial Justice—a community-based nonprofit that works to advance racial, cultural, social, and economic justice in Minnesota—to develop a report focused on advancing health equity through Minnesota's Health Care Quality Measurement System.

Voices for Racial Justice would work with the health department to undertake a more culturally-appropriate process for obtaining the perspectives of those most impacted by inequities to guide the development of the report. The approach Voices for Racial Justice took was guided by the input of community leaders who had provided valuable insight that, in order to appropriately heal inequities, health data needed to be collected in a culturally-humble way, broken down to show health impacts for their respective communities, and owned by the people impacted.

Since the report's publication and with the guidance of Voices for Racial Justice and their community partners, the Department has committed to further transforming their approach to relationship-building and data collection, analysis, and sharing. They are working to better support culturally-humble and genuine community engagement, more accurately quantify and disaggregate data for affected communities, co-develop sustainable health equity initiatives with community leaders, and establish a state health equity data plan.[15]

Systemic challenges to strengthening the capacity of public health to collaborate for health equity

In addition to hearing a lot about shared approaches to racial equity and health equity practice that bridges the skills and priorities of community-rooted organizations with their local or state health department, our interviews also illuminated the local experience of systems-level challenges within public health.

Public health funding is largely focused on service and program delivery: Federal public health funding streams are often limited in scope, focusing on the delivery of services and programs and emphasizing education, early intervention, or treatment as mechanisms for reducing risk factors for illness and injury. Several interviewees described how this approach does not foster more equitable health outcomes because it does not address the systems or conditions that have caused inequities to be produced. A interviewee working in a predominately African-American community described how, when funds are passed to communities, they go to providing services, rather than to building capacity or giving communities the chance to execute solutions to underlying health inequities. The categorical nature of public health funding streams—in which dollars are dedicated to reduce the incidence or prevalence of single diseases or risk factors—also makes it difficult to develop a public health practice that focuses on the structural drivers and unhealthy conditions that contribute to a broad range of illnesses and injuries in communities facing health inequities.

Addressing structural drivers and community conditions requires the field to reconcile the political nature of public health: Bio-medical sciences have increasingly shaped the modern practice of public health, yet progress in population health has failed to close the gap in health disparities and the inequities that underlie them. At the same time, public health has distanced itself from the work of policy change and advocacy.[16] For health departments seeking to re-orient their work toward health equity, recognizing structural drivers—the inequitable distribution of power, money, and resources—and resulting community conditions as fundamental factors of health and safety means stepping into a political space. One interviewee who worked as a grassroots organizer described how health department meetings with community advocates to discuss priorities like fair wages and paid family leave were often seen as political. As a result, the department was hesitant about seeking a role for itself in advancing economic policy priorities of the community. The persistence of health inequities, however, means that the field must recognize, speak out about, and champion solutions that are grounded in the evidence base and aligned with the public health field's mission and mandate. Yet for many public health agencies and employees, this level of political engagement marks a significant shift from today's dominant practice.

Conclusion

By building on promising local practices, systemic change in the health system will ultimately open the door to greater impact and facilitate the kinds of effective practices and partnerships highlighted by the community-rooted leaders with whom we spoke.

The ideas that surfaced in our conversations offer a window into the approaches that some health departments have taken and how these approaches are perceived by community partners working to advance health equity. In exploring this topic from the vantage point of community organizations, the report offers valuable insights that build on, and in many ways reinforce, a growing body of literature focused on the role of public health in advancing health equity and taking on the root causes of inequity in health and safety.

As the field of public health moves forward, there is still much more that can be done to advance racial equity and health equity. Representatives of the community organizations that we spoke with highlighted challenges they observed locally, and their observations shed light on the field of public health as a whole. Their insights help us to see that not only do individual departments have work to do to orient their work toward health equity, but the field as a whole will need to confront the systems-level issues that impede their movement toward a health equity and social justice orientation. Tackling these systems issues will require organizational leadership and collaboration across health departments, as well as full participation of the professional organizations that represent public health departments and public health leadership. Together, health department leadership and the governmental leaders that oversee them—such as boards of supervisors, boards of health, health agency leaders, and governors—can examine and reform codes, financing guidelines, policies, and practices that hinder efforts to partner successfully with communities to achieve racial equity and health equity. By building on promising local practices, systemic change in the health system will ultimately open the door to greater impact and facilitate the kinds of effective practices and partnerships highlighted by the community-rooted leaders with whom we spoke.

APPENDIX A: PARTNERING FOR HEALTH EQUITY INTERVIEWEES

Job Title	Location of Organization	Focus Area of Community Organization, Community Leader, or Initiative
Executive Director	Cincinnati, Ohio	Racial Equity; Criminal Justice Reform; Poverty
Principal	New Orleans, Louisiana	Racial Equity; Education; Economic Inclusion
Executive Director	Austin, Texas	Mental Health
Director	Cuyahoga County, Ohio	Health Equity; Social Determinants of Health
Manager	Salinas, California	Health Equity; Criminal Justice Reform; Education; Land Use
Founder	Tyler, Texas	Social Determinants of Health
Healthcare Lead	Tyler, Texas	Social Determinants of Health
Executive Director	Cleveland, Ohio	Environmental Justice
Director of Affordable Housing	Cleveland, Ohio	Environmental Justice
Program Director	Denver, Colorado	Violence Prevention
Executive Director	Grand Rapids, Michigan	Healthcare Parity
Director	Oakland, California	Food Systems; Built Environment
Executive Director	St Paul, Minnesota	Education; Economic Inclusion; Health Equity; Housing; Immigration; Transportation
Principal	St. Louis, Missouri	Racial Equity
Executive Director	Cleveland, Ohio	Racial Equity
Equity Organizer	Minneapolis, Minnesota	Racial Equity
Executive Director	New York, New York	Environmental Justice
Co-Director	Oakland, California	Environmental Justice
Executive Director	Milwaukee, Wisconsin	Immigration; Economic Inclusion; Transportation; Housing
Director	Detroit, Michigan	Racial Equity; Violence Prevention; Maternal and Child Health

APPENDIX B: SELECTED SCHOLARLY AND GRAY LITERATURE, POLICY BRIEFS, AND CASE STUDIES

To inform our landscape assessment and provide greater context for our interviews, Prevention Institute conducted a scan of the literature related to public health agencies' efforts to advance racial and health equity. Our scan includes authoritative reports and peer-reviewed research that provide theoretical and conceptual frameworks, reflect the state of practice, and establish an evidence base for public health agencies' role in advancing racial and health equity.

The evidence base

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