Case Study #1
Poder es Salud (Power for Health)

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:

1. We use community-based participatory research to support cross-cultural partnerships in which partners share resources and decision-making power.
2. 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.
3. 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.

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.

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.

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Case Study #2

Project BRAVE: Building and Revitalizing an Anti-Violence Environment

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.

What we are learning:
We are learning that Project Brave is an effective approach for addressing youth violence but that there are many challenges. 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.

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Case Study #3
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:

1. 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.
2. 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.
3. 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.

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.

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Case Study #4

The Community Action Model to Address Disparities in Health

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.

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.

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.

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Case Study #5

From Neurons to King County Neighborhoods

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:

1. Develop partnerships with early childhood development stakeholders to discuss current and proposed policies to support early childhood development.
2. Build a common knowledge base by developing a document that describes "what we know" about policies that support early childhood development.
3. Develop policy recommendations in 14 areas by working with stakeholders to compare existing governmental policies with proposed policies.
4. Organize support for proposed policy changes through community meetings to disseminate and discuss the policy agenda.
5. 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.

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.

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