

## Chapter 7

# Tackling the Root Causes of Health Disparities Through Community Capacity Building

*Anthony Iton*

*“The problems of poor neighborhoods are as much political as they are technical. That fact suggests the need for a new politics of community-building—one with explicit strategies for exerting pressure on the people and institutions who do not naturally serve the interests of disadvantaged people.”*

*- The Aspen Institute*

## WHY WE HAVE HEALTH DISPARITIES IN AMERICA

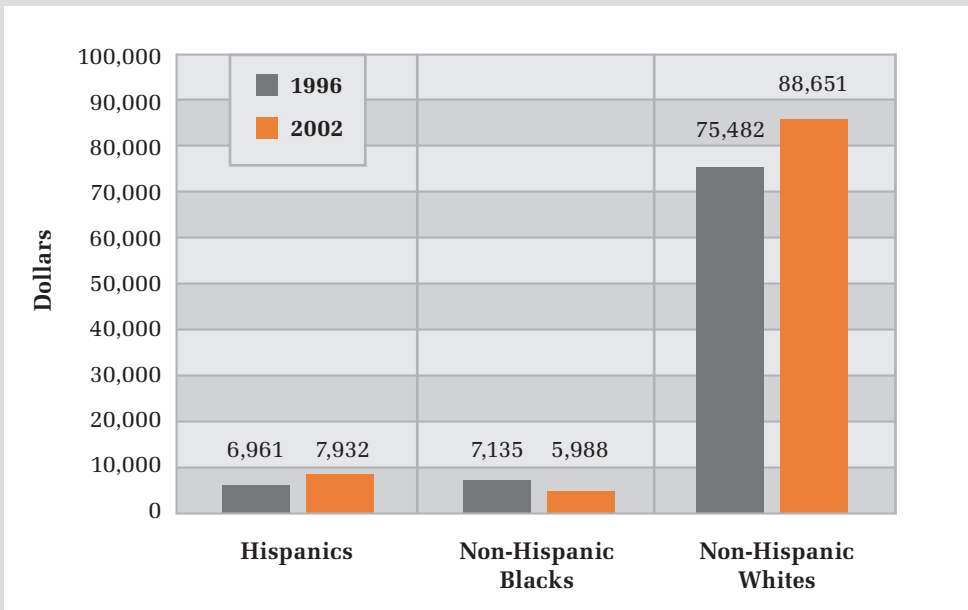
**I**n the United States wealth is the strongest determinant of health. While this phenomenon is by no means unique to the U.S., the strength of this relationship in this country is profound and increasing. In America, wealth equals health.<sup>1,2</sup>

Wealth confers a number of important social benefits that are strongly associated with health outcomes. These benefits include access to a variety of social goods such as high quality education, employment, housing, childcare, recreational opportunities, nutrition, medical care, and safer and cleaner neighborhoods. While this general relationship has been demonstrated in many developed countries, the extent to which access to key social goods is controlled by wealth varies substantially across the developed world. Generally speaking, in countries where there is a well-developed social safety net, there are formal mechanisms designed to facilitate access to key social goods for all economic strata within the society. These mechanisms often include substantial government investments and subsidies for housing, childcare, education, vocational training, employment, medical care, and food access. A direct and intended consequence of these investments is the reduction of the powerful influence of wealth as a determinant of health as a result of conferring independent access to these critical social benefits.

In order to make investments in these critical social benefits, governments generally tax income and effectively redistribute it in the form of greater access to these benefits for lower income groups. As a consequence, in the countries where these investments are in place, there tends to be less inequality in the distribution of income. There is substantial evidence that life expectancy increases and other health indicators improve as the distribution of income and resources in developed countries becomes more egalitarian.<sup>3,4</sup>

In the U.S., wealth is the primary portal through which one accesses a variety of critical social benefits. Further complicating this issue in the U.S. is the enormous disparity in wealth between various racial and ethnic groups and the profound legacy of racial discrimination that is so inextricably embedded in this country's history and political practices, past and present. African-American and Latino households have less than ten cents for every dollar in wealth owned by White households. Approximately one-third of African-American households and one-quarter of Latino households have zero or negative net worth. Nationwide, the percentage of Whites who own their homes is about 75%, whereas homeownership rates for African-Americans and Latinos is about 47%.<sup>5</sup> These racialized patterns of wealth distribution are consistent from community to community across the United States. Furthermore, there is no evidence that this racial wealth disparity is narrowing; in fact, just the opposite appears to be occurring.

**Median Net Worth of Households by Race and Ethnicity in 1996 and 2002 (2003 dollars)**



Source: Pew Hispanic Center tabulations of SIPP data from the 1996 and 2001 panels.

So if in the American context wealth equals health and wealth is strongly correlated with race, then it naturally follows that there will be a strong relationship between health and race in America and that these large inequities in wealth will translate to large racial health disparities.

## CONCENTRATIONS OF RACE AND POVERTY: NEIGHBORHOOD RESIDENTIAL SEGREGATION

In addition to racialized patterns of wealth distribution that lead to a relative concentration of poverty in certain racial groups, the spatial concentration of poverty has also increased sharply in America, creating a *de facto* American apartheid. Between 1970 and 1990, the percentage of urban poor Americans living in non-poor neighborhoods (defined as having poverty rates below 20%) declined from 45% to 31%, while the percentage living in poor neighborhoods (poverty rates between 20% and 40%) increased from 38% to 41% and the proportion living in very poor neighborhoods (over 40% poverty) grew from 17% to 28%. As a consequence, many American neighborhoods are becoming poorer and more segregated. In general in these neighborhoods, poor performing schools are abundant and school dropout rates are high. Additionally, access to transportation, quality affordable housing, adequate parks and recreational opportunities, and grocery stores is often very limited. In addition, these neighborhoods tend to be in closer proximity to sources of environmental pollution. It should then come as no surprise that the risk factors related to chronic disease tend to be found in greater concentration in these neighborhoods. Understanding and illuminating the social, economic and political policies that play a role in creating and reinforcing residential segregation in the U.S. is critical to designing solutions to eliminate health disparities.

## NEGLECTED SCHOOLS IN STRUGGLING NEIGHBORHOODS

The majority of U.S. states provide fewer dollars per student to their highest-poverty school districts than to their lowest-poverty school districts. This educational funding disparity forms a consistent pattern across American communities despite the clear evidence that high-poverty schools need more resources to meet the same standards. This fact is even codified in the No Child Left Behind Act wherein Congress established a standard that states should provide districts with *additional funding* per low-income student equal to 40% of the average per student amount. Despite this awareness, these funding gaps between wealthy and poor districts within states remain, and have even increased in some states. In addition, most states also have a funding gap between schools with the most African-American and Latino students and those with the fewest.<sup>6</sup> Finally, there is also evidence of substantial within district funding disparities favoring wealthier white students at the expense of poorer African-American and Latino students within the same school district.<sup>7</sup>

The largest expense in a school's budget (typically 80-85%) is teacher salaries. Educational research has repeatedly documented that effective teaching is critical to student

achievement, and low-income students and students of color are consistently assigned to the least qualified, and consequently lowest salaried teachers. It is thus not terribly surprising that based on these funding disparities alone, a substantial achievement gap should be expected to exist between wealthy and poor students, and between white students and African-Americans and Latino students. This achievement gap manifests itself through reduced standardized tests scores, promotion rates and high school graduation rates for African-Americans and Latino youth.

### National Graduation Rates by Race and Gender<sup>8</sup>

by Race/Ethnicity	Nation	Female	Male
American Indian/AK Nat	51.1	51.4	47.0
Asian/Pacific Islander	76.8	80.0	72.6
Hispanic	53.2	58.5	48
Black	50.2	56.2	42.8
White	74.9	77	70.8
<b>All Students</b>	<b>68</b>	<b>72</b>	<b>64.1</b>

Nationally, only an estimated 68% of those who enter 9th grade graduate with a regular diploma in 12th grade. In 2001, only 50% of all black students, 51% of Native American students, and 53% of all Hispanic students graduated from high school. Black, Native American, and Hispanic males fare even worse: 43%, 47%, and 48% respectively.<sup>8</sup> Adults need a high school diploma in order to be able to compete effectively for jobs that pay a living wage. Neighborhoods where many residents are high school dropouts are more likely to have higher unemployment, poorer quality housing, poorer schools, and possibly less stable families. Middle and upper class families then point to low test scores and poor quality schools for their decision to move away from these neighborhoods in favor of better schools in the suburbs. Thus, the abysmally poor graduation rates being tolerated in the U.S. for poor African-American and Latino children are contributing greatly to maintaining an American status quo of economically-deprived, racially segregated and generally under-resourced neighborhoods mired in severe social dysfunction. This is the context in which health disparities are created.

## PUBLIC HEALTH AS A SOCIAL JUSTICE ENTERPRISE

Public health practitioners that purport to be committed to “eliminating health disparities” cannot labor in ignorance of the persistent social, political and economic forces that create and reinforce such striking patterns of residential racial segregation, educational disparities and profound wealth gaps. Ultimately, when forced to examine how these rigid, apartheid-like patterns of societal organization are maintained, despite the successful elimination of legalized forms of racism following the civil rights movement, one cannot but conclude that at its very roots, the problem lies with a persistent inequity in the distribution of social, political and economic power among racial groups in the U.S. If one accepts this conclusion, then the relevant question for public health practitioners is how do we build social, political and economic power for low-income communities of color.

Public health practice as a social justice enterprise is a concept of public health that recognizes and targets root causes of social inequity. Social justice is a dynamic concept that takes on many different forms in different settings. Fundamentally though, the need for social justice efforts arises wherever significant power imbalances are found. In settings in which justice is in short supply, power will tend to concentrate according to lines of privilege. In this society, privilege primarily flows according to race, class, gender, and to some extent, immigration status. Consequently, many social, political and economic policies tend to favor whites, particularly wealthy white males. There are numerous specific examples of this including the GI Bill, red-lining practices, welfare policy, urban renewal policies, education funding policies and practices, drug use and incarceration policies, affordable housing policies and health insurance policies. One can easily describe these policies and practices collectively as affirmative action for whites. Cumulatively, these policies and practices have created and continue to reinforce America’s unique form of apartheid. Any general strain on society whether it be economic recession, new drug epidemics such as crack cocaine, communicable disease epidemic such as influenza, or natural disaster such as Hurricane Katrina, will exact its greatest toll on low-income communities of color that are at the very bottom of the American privilege and power totem pole.

Justice has two key ingredients: truth and power. Without either one of these ingredients, there cannot be justice. Public health practitioners are experts at identifying truth. We have innumerable detailed studies published in peer-reviewed journals describing the clear relationship between various “social determinants of health” and health outcomes. In fact we have entire journals dedicated to these topics. Yet despite the truth being out there, we see relatively little evidence of progress in core health measures for our most socially, politically and economically marginalized populations. This is because public health has still largely ignored the issue of power and its skewed distribution throughout our society. Our work in communities tends to focus on individual-level behavioral change models, intensification of service delivery, and issue-specific community mobilization efforts. Rarely do public health agencies focus squarely on building upon indigenous social, political and economic power in low-income communities of color. What follows is a description of one county’s approach.

## THE SITUATION IN ALAMEDA COUNTY

Like many, if not most, American cities and counties, Alameda County faces profound and persistent racial health disparities. While significant health disparities can be found that afflict almost every racial and ethnic group, the magnitude of racial health disparities in Alameda County is most profound for African-Americans, Latinos, Pacific Islanders, and Native Americans. In Alameda County, African-Americans experience striking disparities in virtually all of the major health indicators, including coronary heart disease, diabetes, stroke, AIDS, cancer, asthma, infant mortality, low birth weight, and homicide. In fact, of the 19 key health indicators tracked longitudinally by the Alameda County Public Health Department, African-Americans have the worst outcomes in 16 of them.

Tracking health indicators by race provides important information about the disparate outcomes of people within various racial categories and suggests the potentially powerful role that racism, both present and past, may play in determining health outcomes in this county. Understanding how race and racism may be mediating this powerful influence on health outcomes in Alameda County requires a better understanding of the complex interplay of a variety of social and economic factors and how their distribution across Alameda County may be strongly influenced by race.

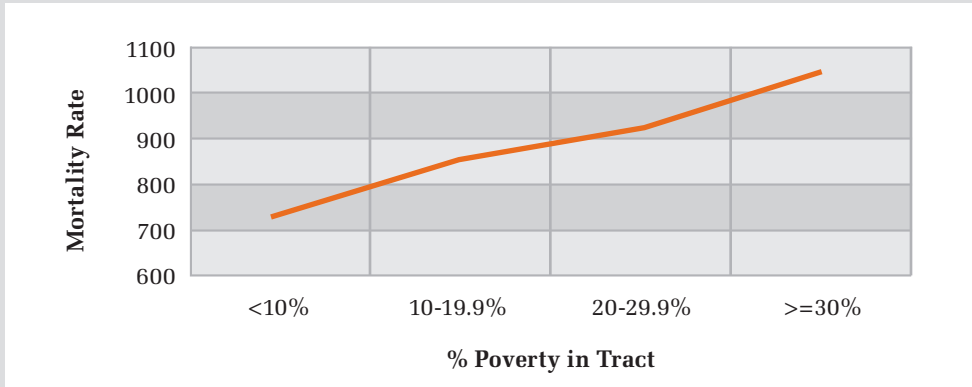
## WHY FOCUS ON NEIGHBORHOODS?

In Alameda County, higher rates of disease are observed in low-income neighborhoods independently of a wide range of demographic, behavioral, social, psychological, and health characteristics. Neighborhood of residence has been linked to all-cause mortality, cause-specific mortality, coronary heart disease, low birth weight, perceived health status and rates of violent crime. In Alameda County, the neighborhood in which one lives serves as a fairly good predictor of one's mortality rate. The graphic below demonstrates the strong association between the all-cause mortality rate and neighborhood poverty in Alameda County. Mortality steadily increases as percentage of neighborhood poverty increases. This so-called "social gradient" is strong suggestive evidence that the quality of the social environment itself may play an important role in determining health outcomes.

When one performs a similar analysis of the same overall mortality data now stratified by race (see figure below), two interesting phenomena appear. The first finding is that there is no evidence of a social gradient for Hispanics and Asians in Alameda County. In fact, one might even argue that the data reveals a slight reverse social gradient for Hispanics. That is that Hispanics living in wealthier neighborhoods actually have slightly higher mortality than those living in neighborhoods with high levels of poverty. The second interesting finding is that in neighborhoods where there is a high proportion of households living in poverty, white mortality rates exceed those of African-Americans.

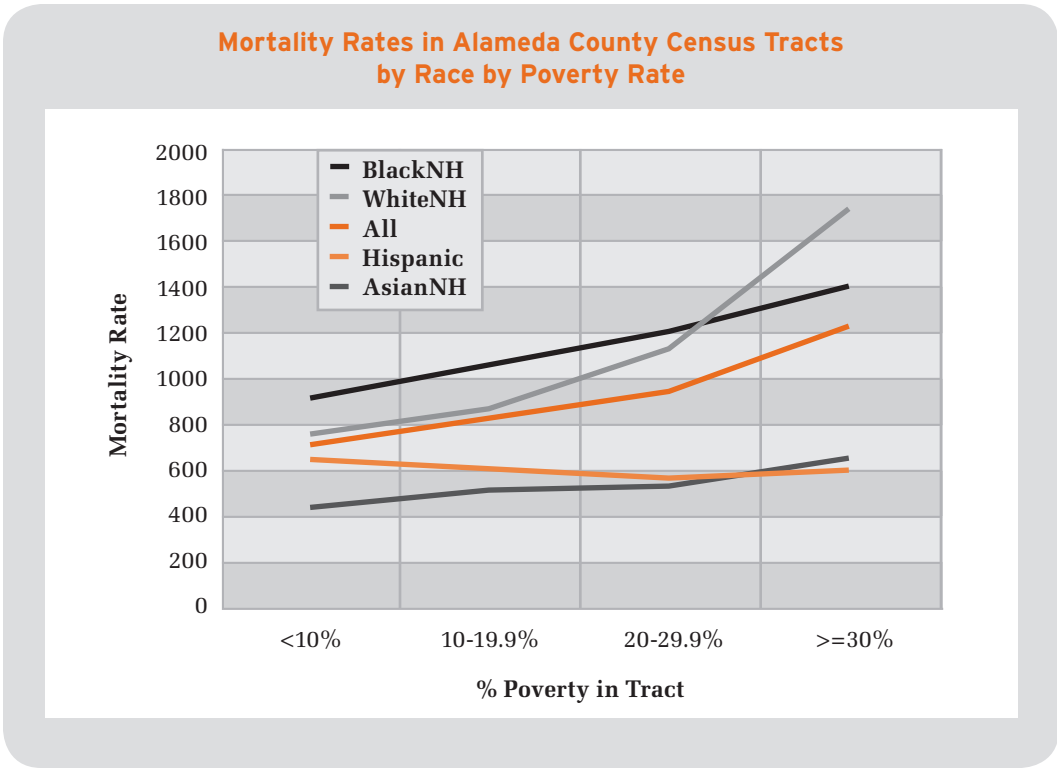
Understanding the underlying causes of these two phenomena may provide some useful insight into the design of public health interventions that can help reduce health

### Mortality Rates in Alameda County Census Tracts Grouped by Poverty Rate: Social Gradient



disparities in Alameda County. Several hypotheses might explain the apparent paradox reflected in the lack of a significant social gradient for Latinos and Asians in Alameda County, including the so-called “healthy-migrant theory” which posits that the immigration process itself may select for a healthier sub-population. Additionally, Latino and Asian immigrants may also have health and social behaviors that are health protective, including healthier diets, greater inclination towards physical activity, and a greater cultural reliance on social and peer networks.<sup>9,10</sup> As immigrants acculturate, there is some evidence that they lose some of these protective health behaviors.<sup>11</sup> Public health interventions that attempt to strengthen and support these protective health and social behaviors may in fact lead to improved health outcomes among all Alameda County residents.

The second phenomenon of the cross-over between White and African-American mortality rates as neighborhood poverty increases above 20% is somewhat more complex. It should be noted that only 4% of Alameda County Whites live in census tracts where >20% of the households are in poverty. In stark contrast, over 40% of Alameda County African-Americans live in census tracts where >20% of households are in poverty. Thus African-Americans in Alameda County are 10 times more likely than Whites to live in neighborhoods where greater than 20% of the residents are poor. The few Whites that live in these high poverty neighborhoods have higher mortality rates than their African-American neighbors. A possible explanation for this phenomenon is the 4% of Alameda County Whites that live in neighborhoods with high poverty may suffer disproportionately from profound health and social burdens such as mental illness, alcohol and drug addiction, and severe family dysfunction. These factors, rather than factors related to race may explain their relatively poor health outcomes. Whereas *compared to* the small number of Whites living in poverty in Alameda County, African-Americans in poverty may be less burdened by alcoholism, mental illness, and severe



family dysfunction. In essence, Whites may be more often consigned to poverty due to severe social dysfunction and poor baseline health status, whereas African-Americans are to a larger extent consigned to poor neighborhoods due to the cumulative impact of racism, including social, political and economic policies that encourage neighborhood racial segregation.

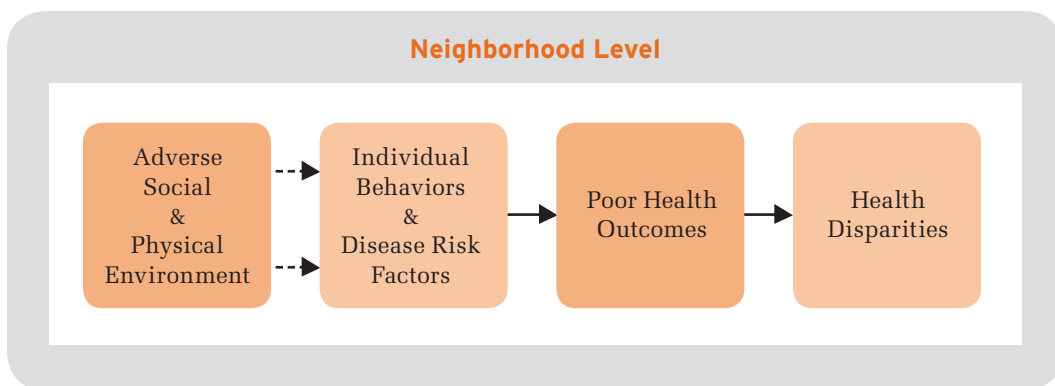
According to standard measures of residential segregation, Alameda County has among the highest levels of residential segregation for African-Americans in the San Francisco Bay Area. Oakland, the county’s largest city, ranks as the second most segregated city for African-Americans in California.

### **HOW DO UNHEALTHY NEIGHBORHOODS CAUSE UNHEALTHY PEOPLE?**

Neighborhoods do not exist in a vacuum, however, for purposes of understanding some of the direct and potent mediators of health disparities, it is initially helpful to artificially isolate the neighborhood context and examine it independent of the larger societal context. What follows is a simplified analysis of the neighborhood-level mediators of health disparities. As stated above, it is clear that factors in the neighborhood social and physical environment are *associated with* disparities in health. However, the extent



to which these factors are *causally related* to health disparities remains poorly understood. In order to better understand how these neighborhood-level factors in the social and physical environment may cause health disparities, it is important to delineate the pathways through which this effect may operate.



The above-simplified graphic should not be read to imply that these relationships are linear or unidirectional nor should it be interpreted to suggest that there is no role of genetics, access to medical services, quality of medical services, or individual choice. However, it does propose a possible pathway through which the neighborhood social and physical environment may produce health disparities.

- **Shaping Individual Behaviors:** Characteristics of the physical environment such as availability of parks, grocery stores, community centers, and public transportation, create the context in which individual behavioral choices are made concerning physical activity, nutrition, tobacco and alcohol use, and other health-related behaviors. In low-income communities, these neighborhood physical conditions may be operating in a manner that increases the likelihood that certain adverse risk behaviors will be adopted.
- **Increasing Individual Risk Factors:** Characteristics of the social environment may produce certain physiological changes in individuals that directly increase their risk of disease. A robust literature base has developed around several proposed theories to explain this including *Weathering*, and *Allostatic Load*.<sup>12</sup> These hypotheses generally propose a link between the cumulative impact of various social and environmental stressors and human physiological response. In this way, neighborhood-level poverty, racism, crime, lack of education, unemployment, and social isolation act synergistically to produce detrimental physiologic changes (hypertension, increased free radical activity, elevated cortisol, impaired immune system responsiveness, etc.).

The existence of protective or resiliency factors in the social environment has also been proposed. These factors include high educational attainment, stable family relationships, positive youth-adult relationships, meaningful opportunities for civic par-

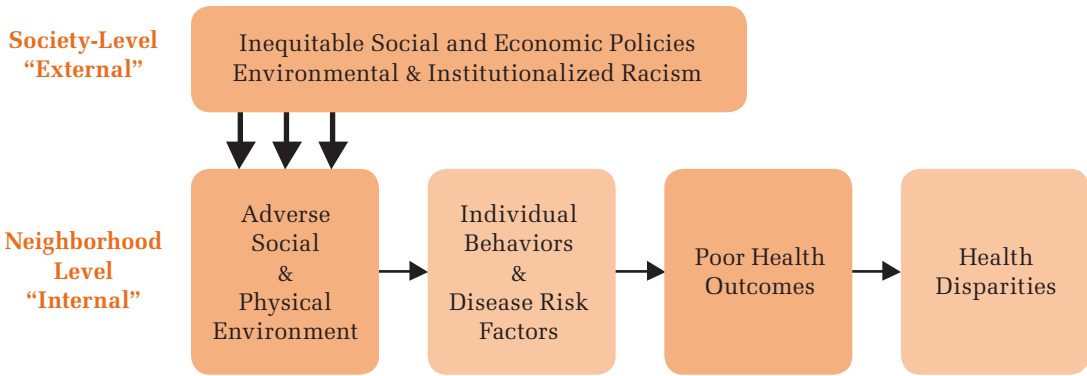
icipation, positive race/ethnic intergroup relations, timely access to appropriate health and social services, and high career/employment expectations. These factors are theorized to act as a buffer against poverty, crime, racism, etc. and reduce Weathering and the Allostatic Load, thus ultimately improving health outcomes. However, limiting one's focus solely to the *neighborhood level* risks missing the powerful influence of social, economic and political policy in creating impoverished, racially-segregated, and unhealthy neighborhoods.

## HOW DOES INEQUITABLE SOCIAL POLICY CAUSE UNHEALTHY NEIGHBORHOODS?

In order to develop successful public health interventions to reduce health disparities one must thoroughly understand the forces that lead to the clustering of health disparities in low-income, minority neighborhoods. The social, political and economic forces that produce these discernible effects in low income communities are identifiable. They include longstanding and pervasive local, regional, state and federal policies that reinforce rigid patterns of social and material disparity between racial and economic groups in this country, ultimately leading to persistent health disparities. Over time these forces have taken many forms including racially-restrictive covenants on property, economic redlining in banking practices, school segregation, housing and urban renewal policies, disinvestment in public transportation, discriminatory zoning practices, law enforcement racial profiling, differential incarceration policies related to drug use and possession, and other deliberate governmental policies and practices. The cumulative impact of these discriminatory policies has created and maintained a well-structured racial and class apartheid in Alameda County and elsewhere in America. While some of these policies and practices have been successfully challenged and reversed, others remain intact. The legacy of decades of these discriminatory policies is indelibly stamped in the health disparities that we are faced with today.

A useful concept for understanding this legacy is that of “institutionalized racism” put forward by Dr. Camara Jones.<sup>13</sup> Jones defines institutionalized racism as “differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need.” Institutionalized racism *causes* unhealthy neighborhoods by systematically starving certain communities of access to key social goods, such as education, health care, adequate housing, recreational amenities, etc., thereby directly creating adverse social and physical environments within these communities.

Countering these powerful social and environmental forces is unquestionably a daunting task. Nevertheless, it is only by eliminating or counteracting these forces that health disparities can be eliminated. The question for local health departments is: What effective strategies can be employed to address these underlying forces that play such a powerful role in producing and perpetuating health disparities?



## DESIGNING PUBLIC HEALTH APPROACHES TO TARGET HEALTH DISPARITIES

*“Eliminating health disparities will also require new knowledge about the determinants of disease, causes of health disparities, and effective interventions for prevention and treatment. It will also require improving access to the benefits of society, including quality preventive and treatment services, as well as innovative ways of working in partnership with health care systems, State and local governments, tribal governments, academia, national and community-based organizations, and communities.”*

*-CDC Office of Minority Health*

Local public health interventions are generally focused at one of four levels: 1) individual, 2) group, 3) neighborhood/community, and 4) the larger society/policy arena. Individual and group-focused interventions frequently are heavily characterized by specific clinical and preventive services such as risk factor screening, immunization, and targeted educational campaigns. Individual and group level interventions dominate local public health practice in the U.S. in large part due to the programmatic requirements embedded in most of the major federal and state public health funding streams.

Public health interventions that focus on neighborhoods or other “places” are rarer despite the fact that many of the exposures to known social determinants of disease occur at the neighborhood level. It is particularly at the neighborhood level that the physical and social environments manifest their deleterious influence on low-income racial and ethnic communities in Alameda County and elsewhere. This is particularly true for young people living in low income communities for whom travel outside of their immediate neighborhood is often infrequent. Thus effective public health interventions to reduce and eliminate racial health disparities presumably must result in discernible neighborhood level change.

The rarest of all local public health interventions are those that are directed to the larger society and policy arena. However, it is in this arena where public health

interventions probably hold their greatest potential. While there has been substantial support from public health leaders for social policies that have a direct and obvious impact on access to health services, such as universal health insurance, there has been relatively little organized public health efforts to support other equally health-beneficial policies such as universal pre-school access, improved public school funding, living wage efforts, affordable housing, land use planning reform, public transportation, immigration, incarceration and rehabilitation, and employment policy.

Despite a general effort by our national health leadership to acknowledge the role of “social determinants” in influencing health outcomes, the federal perspective on health disparities too often devolves into a discussion of disease-specific remedial strategies.<sup>14,15,16</sup> Many federal public health organizations frequently frame the issue of racial health disparities primarily from a medical perspective. As a result, the solutions proposed often focus primarily on the intensification of individual medical and case management services to the specific population most afflicted. In this framework, “determinants of health” are often limited to those that are perceived as amenable to individual behavior modification approaches such as tobacco cessation and drug treatment, counseling against high-risk sexual behaviors, and education regarding the consequences of poor nutrition and physical inactivity. However, efforts based on this “medical model” have demonstrated limited efficacy. Additionally, such approaches are generally resource-intensive and consequently unsustainable after the initial infusion of resources inevitably begins to dwindle.

Recently, there has been increasing acknowledgement by HHS, CDC, NIH, HRSA and other federal public health leadership bodies of the contribution to health disparities of factors such as housing and educational segregation, the location of sources of environmental pollution, selective marketing practices of alcohol, tobacco, and fast-food companies, access to transportation, and the availability of parks, open-space and other community amenities. Notably, however, discussions about the health consequences of social and economic policies that produce the inequitable distribution of income and resources across racial groups have been virtually non-existent at the federal level.

## **EXPANDING THE TRADITIONAL DISPARITIES FRAMEWORK**

It is clear that effective public health interventions to reduce and eventually eliminate health disparities will need to be multi-faceted and long-term. In a recent speech in Oakland, former U.S. Surgeon General Dr. David Satcher laid out a useful framework for understanding how to intervene to eliminate racial health disparities. The Satcher framework calls for interventions that address the following five key domains: 1) access to and quality of medical care; 2) individual risk behaviors; 3) the physical environment; 4) the social environment; and 5) persistent discriminatory social policies and practices that serve to deprive many low income communities of the assets necessary to build healthy neighborhoods and result in a pervasive sense of hopelessness.

While there are many published health disparities interventions that focus on the first two domains in the Satcher framework, there are very few that focus on the latter three. It is within these latter three domains that the manifestations of the inequitable

distribution of wealth and resources has its most acute impact on racial and ethnic minorities residing in low-income neighborhoods. Examination of the physical environment in these neighborhoods reveals neglected parks, abandoned cars, vacant lots, deteriorated housing, a proliferation of alcohol retail outlets and fast food franchises, a relative absence of grocery stores, and various sources of environmental pollution. The social environment reveals drug dealing, high unemployment, limited business investment, violence, street crime, public intoxication, and general litter. The cumulative effect of various discriminatory social policies and practices creates a spiritual environment that is characterized by hopelessness and a lack of a keen vision for the future, particularly among youth. This sense of *futurelessness* contributes to negative self images and short-term self-destructive behaviors and risk-taking.

## WORKING INTERNALLY VS. EXTERNALLY: SOCIAL CAPITAL AND STRUCTURAL INEQUALITY

There is evidence that at the neighborhood-level these forces are operating both internally (low social cohesion, neighborhood disorganization, and lack of leadership) and externally (political, economic and social policies that lead to an inequitable distribution of important social goods such as employment, education and health care). While these internal and external contexts are closely inter-related, public health interventions designed to reduce health disparities that fail to address both simultaneously are much less likely to succeed. Some researchers have highlighted this internal/external dichotomy in critiquing public health approaches that focus exclusively on working within communities to build social capital. They argue that pure social capital building approaches present “a model of the social determinants of health that excludes any analysis of structural inequalities (e.g. class, gender, or racial/ethnic relations).”<sup>17</sup> Others are critical of approaches that focus primarily on legal efforts designed to dismantle specific policies and practices that have a racially discriminatory effect. Such approaches often fail to directly involve the affected community members and consequently do not lead to a sustained increase in community capacity.

The question can be simplistically stated as: Are health disparities due to something wrong within low-income minority neighborhoods, or are they due to something wrong with American society that concentrates health disparities in certain neighborhoods? Our contention is that this is not an either-or situation. Eliminating health disparities will require sophisticated public health interventions that simultaneously address both the internal neighborhood context (low social cohesion, neighborhood disorganization, and lack of leadership) and the external context (discriminatory political, economic and social policies).

*Washing one's hands of the conflict between the powerful and the powerless means to side with the powerful, not to be neutral.*

*-Paulo Freire*

## **THE INTERNAL NEIGHBORHOOD CONTEXT: BUILDING COMMUNITY CAPACITY**

Not all poor communities suffer disproportionately bad health outcomes. In Alameda County, there is no better example of this phenomenon than the so-called Latino Health Paradox. As mentioned above, Alameda County's Latinos have lower overall age-adjusted mortality rates than Alameda County whites. This finding would seem to refute the conventional wisdom that health outcomes are inextricably tied to poverty level. At a minimum it would seem that other less well understood factors, in addition to poverty, have the potential to substantially influence the health outcomes of communities. What might these factors be, and how are they health protective? The Latino Health Paradox tells us that there may be certain health protective factors in the social milieu that can be identified and enhanced in a manner that would ensure to the benefit of the broader community. These factors are sometimes referred to as resiliency factors and may include strong social networks, meaningful employment opportunities, positive adult-youth relationships, and accessible venues for civic and political participation. Public health departments must become more adept at facilitating ongoing community-level processes that build upon these resiliency factors.

Alameda County Public Health Department has designed a community-led, multi-component public health intervention designed to build neighborhood-level community capacity. The goal of the intervention is to build political, social, and economic power within low-income communities of color within Alameda County. Our community capacity building approach borrows heavily from popular education principles expounded by Brazilian educator Paulo Freire and builds directly upon existing community assets and strengths. The approach focuses on identifying neighborhood assets, most specifically its leaders, and facilitating a coherent and supportive neighborhood social, economic and political infrastructure that will allow these leaders to enhance the natural resiliency of their communities and thereby improve long-term health outcomes.

## **BRIEF OVERVIEW OF THE COMMUNITY CAPACITY BUILDING STRATEGY**

In conjunction with partners from county, city and community-based agencies and religious and neighborhood improvement organizations, Alameda County Public Health Department (ACPHD) has designed a multi-component, community-level intervention that is targeted at building community capacity in the low-income neighborhoods in Alameda County, thereby supporting and enhancing four key protective/resiliency factors: 1) positive adult-youth relationships, 2) meaningful opportunities for community participation, 3) high career/employment expectations for youth, and 4) improved race/ethnic inter-group relations. The approach is in part based on MAPP, a product of NACCHO, but substantially modified for application to the neighborhood level in a low-income, diverse urban community.

The intervention is three years in duration and has six core components:

1. Conducting a Baseline Door-To-Door Community Survey and Needs/Strengths Assessment (repeated three times during the course of the intervention)
2. Establishing a Resident Action Council
3. Instituting a Leadership Training Program
4. Establishing a Resident-To-Resident Grant-Making (Mini-Grant) Program
5. Establishing a Time Dollar/Neighbor-to-Neighbor Bartering Program
6. Facilitating Youth Economic Development Programs

The multiple components of the intervention are facilitated through the creation of a Resident Action Council (RAC) in the target neighborhoods. A Core Team in each neighborhood, comprised of representatives from local schools, churches, neighborhood associations, community-based associations and from city and county departments, supports the efforts of the respective neighborhood RAC. Meals, childcare, simultaneous translation services and incentives are provided for all intervention activities. Community meetings take place at locations identified by our community partners. What follows is a description of the community capacity building process in Sobrante Park, a low-income, diverse neighborhood of Oakland, California.

### **Component 1: Community Survey Needs/Strengths Assessment and Community Forum**

The first step in the community capacity building process is conducting a survey that focuses on identifying neighborhood assets, needs and priorities. The standardized community survey is designed to measure neighborhood social capital based on existing validated instruments. In Sobrante Park, a youth and adult survey was performed by community residents and volunteers. These surveys served as the baseline assessment for the intervention. A total of 219 adult and 100 youth completed surveys in Sobrante Park. All respondents were asked if they wanted to participate in efforts to improve their community and were invited to provide their contact information (separate from the survey).

A follow-up activity was the hosting of an all-day Community Forum, attended by 61 residents, held in Sobrante Park in September 2004. Results of the community survey were presented and discussed, focusing on the neighborhood strengths and the areas for improvement that survey participants identified. Residents prioritized the top three areas for action from the list of neighborhood areas for improvement compiled from the survey results. They prioritized several physical and social characteristics of their neighborhood for change:

1. Improving the local park to provide safe, supervised recreation for youth;
2. Reducing drug use and dealing; and
3. Increasing positive youth activities.

Participants developed short- and long-term goals for addressing each of the priority issues, and agreed to join the Resident Action Council (RAC).

### Component 2: Resident Action Council

The Resident Action Council (RAC) is the strategic planning and decision-making body where residents address issues related to neighborhood change on an on-going basis. This organized residential structure will remain in place after the completion of the intervention to insure sustainability of the neighborhood changes. Monthly 2.5-hour meetings provide an opportunity for residents to share ideas, bring suggestions, and form subcommittees to develop and implement action plans. Monthly minutes are distributed to the Core Team so that they can better support the resident-driven efforts.

The criteria for participation include living in the neighborhood, reflecting the diversity of the neighborhood, having a sincere interest in improving the neighborhood, and committing to participate for one year. All members participate in 2-3 days of initial leadership training and then receive additional training throughout their involvement in the RAC.

Due to successful recruiting, a total of 60 residents, of whom 40 are youth between the ages of 13 and 21, have joined the Sobrante Park RAC. The RACs will receive facilitation, administrative and technical support in their efforts from key staff of the Alameda County Public Health Department.

### Component 3: Leadership Training

Leadership Training has been provided to the Sobrante Park RAC. This training will prepare local leaders to take a more active role in bringing about change in their community by developing their practical skills in the areas of community organizing, neighborhood problem-solving and political advocacy.

All RAC members participate in 16 hours of initial leadership training, for which the ACPHD has already piloted a curriculum. Additional training will be provided to the RAC on an on-going basis. Staff experienced in both youth- and adult-focused training will develop additional modules incorporating field-tested curriculum that will cover the following topics:

Community Organizing Skills	Problem-Solving Skills
<ul style="list-style-type: none"> <li>■ Unlearning Oppression &amp; Racism Training</li> <li>■ Conflict Mediation</li> <li>■ Recruitment Techniques</li> <li>■ Issue Identification and Prioritizing</li> <li>■ Action Planning</li> <li>■ Public Speaking</li> <li>■ Meeting Facilitation</li> </ul>	<ul style="list-style-type: none"> <li>■ Community Assessment</li> <li>■ Assessing and Using Data</li> <li>■ Asset Mapping</li> <li>■ Policy and Advocacy</li> <li>■ Campaign Management</li> <li>■ Media Advocacy</li> <li>■ Fund Raising and Grant Writing</li> </ul>

### Component 4: Community Mini-Grant Program

A committee of 10-12 youth and adults will be recruited from the RAC membership in each neighborhood intervention site to develop and implement the Mini-Grant Program



for their respective neighborhood. The program provides mini-grants ranging from \$250-\$1000 that the resident-led committees award to fellow residents who have initiated community improvement projects.

The program will support the leadership development and social integration and cohesion of multiple levels of participants: committee members, grantees and project participants. The resident granting committees will help plan and implement the program and make all funding decisions. Committee members will benefit from in-depth leadership development opportunities, enhanced relationship-building and mentoring. Grantees will not only receive financial support for their projects—they will also be assisted in developing project ideas, writing proposals and implementing project activities. Community members who are reached through the granted projects will make new relationships and have further opportunities to get involved in their neighborhood. ACPHD staff who have experience implementing this program throughout Alameda County will provide training, technical assistance and mentorship to participants.

### **Component 5: “Neighbor to Neighbor” Time Dollar Exchange**

A Time Dollar Exchange (TDE), the “Neighbor to Neighbor” program will be established in Sobrante Park. Time Dollars are a type of community currency that is earned by helping others and is spent by getting help from others. They can be exchanged for goods and services among a network of people and organizations. The TDE creates a reciprocal multi-ethnic, cross-generational network within the community where every member is respected and valued for their time and talents. Community members are able to trade their time, providing each other with valuable services such as care for the elderly, tutoring or home repair. In turn, community relationships and interdependency are enhanced.

In October 2004, co-founders of the Time Dollar Institute, Edgar Cahn and Chris Cahn, provided orientation and training to 25 participants who are working or living in Sobrante Park and other parts of Oakland. Our “Neighbor-to-Neighbor” program will be a member of the Time Dollar Institute, which nurtures the network of independent Time Dollar Initiatives throughout the world through its publications, annual conferences, ongoing trainings and evaluation services.

### **Component 6: Youth Employment & Career Development Strategy: Developing Skills, Experiences, Jobs, Career Paths and Enterprises**

Unemployment, underemployment and the explosion of youth participation in underground economies are widely regarded as factors contributing to community deterioration. The Youth Economic Development Program, provided by our collaborating partner, Project YES!, is designed to address these issues by both preparing participants for jobs in the labor market and creating new jobs and internships. Beyond offering traditional vocational educational services, the program will address the severe shortage of viable economic development opportunities available to these communities by building social capital, creating jobs through the operation of innovative social enterprises, and actively partnering with the City of Oakland to leverage labor market attachment opportunities inherent in their community revitalization efforts. This program will be

offered to all community residents who are under twenty-five years of age and who have completed the Leadership Development Training. The four interdependent components of the program are as follows:

### **JOB TRAINING AND SKILL DEVELOPMENT**

Youth participants will be placed in the job training and skill development component, which will provide employment training, case management and coaching as the first step in facilitating their attachment to the labor market. Participants will receive training on time management, teamwork, conflict resolution, money management and job search skills. Participants will also receive customized training targeted to Alameda County's strongest labor market sectors, including health, food services, retail and professional services. Project YES! staff will provide on-going coaching for one year following placement through intensive case management.

### **INTERNSHIPS AND CAREER TRACKING: HEALTH FIELD**

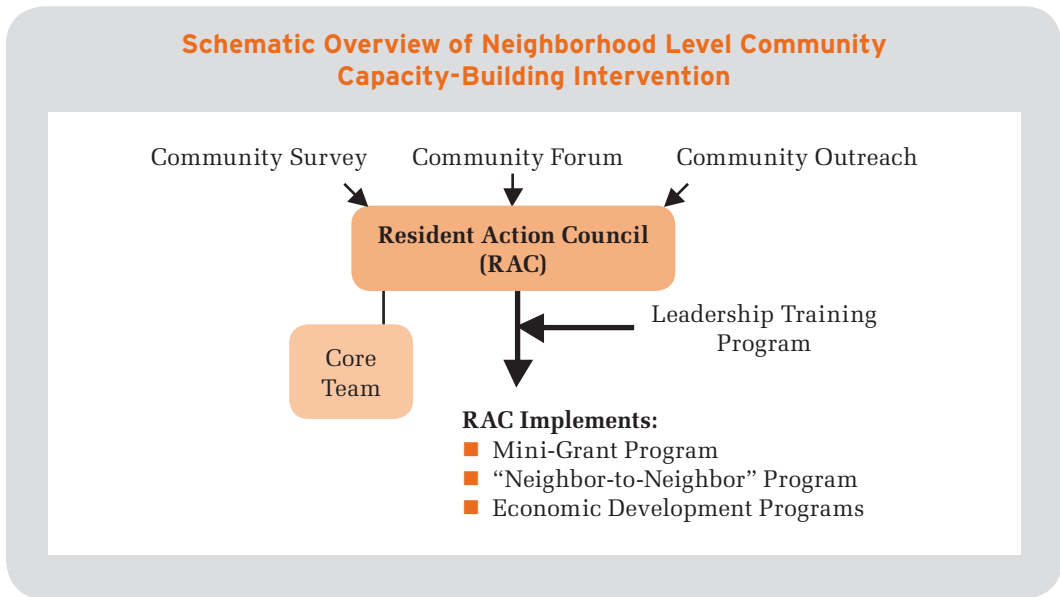
Youth interested in the health field will be enrolled in one of two health internships offered through the Project YES! Teen Clinic programs operated by Children's Hospital Oakland (CHO). Each year these programs will offer twenty paid health educator positions, one operated by Health Information For Youth (HIFY) and the other by CHO's nationally renowned Faces for the Future (FF) program. Youth participating in both programs will serve as paid peer health educators and will be supported in providing trainings and presentations in schools and community forums, as well as producing various public information campaigns using youth-appropriate social marketing health materials. In addition, the FF program places participants in a three-year internship program which introduces underrepresented minority high school students to health professions through "mini residencies" within the hospital and provides intense case management to facilitate movement into health professions.

### **JOB CREATION THROUGH ENTERPRISE DEVELOPMENT: COMMUNITY OWNED AND OPERATED BUSINESSES**

Project YES! has committed to link job-ready participants to all four of its community owned and operated businesses, which include an Internet café, a graphic design business, a recording studio, and a social marketing company. These businesses, which will employ approximately fifty youth at any point in time, will exist as private not-for-profit entities that re-invest excess revenue in businesses expansion and the development of an employee base from within the two communities. Participants in all three enterprises will receive business-specific training, externships in related businesses, paid employment within the business, and support in pursuing continuing education in their fields through a network of relationships with colleges and advance trade institutions.

## LABOR MARKET ATTACHMENT AND COACHING: LINKAGE TO EXISTING AND PLANNED REVITALIZATION PROJECTS

The City of Oakland has committed to partner with Project YES! to link our program participants actively to the employment opportunities created by the more than \$3 billion in community revitalization efforts in the Council Districts encompassing Sobrante Park and other areas of Oakland. This represents hundreds of employment opportunities within the retail, construction, and professional services fields for the participants of the Youth Economic Development Program.



## THE EXTERNAL CONTEXT: BUILDING SOCIAL, POLITICAL AND ECONOMIC POWER

Politics is the struggle over the allocation of scarce and precious social resources. Counteracting the forces that control the distribution of social goods and create the conditions in neighborhoods that lead to health inequities is a daunting task for local public health departments. This is particularly true when local public health agencies are confronted with the neighborhood level consequences of these broader societal and political forces. In addition, while many of the more potent discriminatory forces have been struck down in law, their long term legacy remains, for example, in profound residential racial segregation. While there is some evidence that residential racial segregation is improving for some groups, that improvement is very modest and gradual in pace. It is therefore often difficult to observe progress in undoing these effects in the timeframe of most public health interventions.

Nevertheless, there are many examples of disease-specific public health interventions that target the broader social, economic and political spheres such as tobacco control, and automotive safety efforts (e.g. changes in laws relating to seatbelts, motorcycle helmets, and drunk-driving). However, public health efforts that target broader determinants of health such as education, land-use planning, wages, benefits and employment, transportation, affordable housing, etc. are rarer. If one adopts the position that health disparities ultimately emanate from the fundamental power imbalances that are consciously maintained in our society, then one must conclude that efforts to build social, political and economic power within those communities that suffer most from health disparities is the only sustainable long-term solution.

Local public health agencies can provide considerable support to righting this power imbalance by striving to highlight the health implications of a variety of policy choices. Health agencies can legitimize grass-roots community-led efforts around living wage campaigns, environmental justice, and benefits for low-income workers such as janitors, nursing home aides, and hotel workers. Local health agencies can also become adept at conducting “health impact assessments” to make tangible the impacts of certain policy choices. Furthermore, local health departments can demand a role at the table in various local and regional policy-making tables such as those of land-use planning and transportation agencies, criminal justice and corrections boards, and boards of education.

One recent example was the Department’s efforts to support the cause of a group of low-income, elderly Chinese residents of rent stabilized housing in downtown Oakland. A wealthy real estate developer and generous political contributor had sought to interpret a ten year-old affordable housing agreement between his real estate company and the City of Oakland in a manner that permitted him to evict these elderly long-term renters from a building in order to convert it to market rate condominiums. In response to a request from neighborhood activists, ACPHD weighed in on the part of the elderly renters noting the well documented public health literature that illustrates the deleterious impact of the disruption of neighborhood social networks on the health outcomes of elderly communities of color. This testimony served to bolster and legitimize the position of neighborhood advocates who benefited from the credibility of the health department in what might otherwise have been perceived as a purely political struggle. Other examples include efforts to support the rights of striking nursing home workers and janitors, advocacy for improved grocery store presence in low income neighborhoods, supporting the closure and mitigation of environmental sources of pollution in communities of color, and support for litigation against regional transit agencies whose funding practices disadvantage disproportionately non-white bus ridership versus heavily white train ridership.

Public Health departments can also sustain efforts to address health inequities by building the capacity of community groups and residents to collect data, analyze, interpret, understand, and disseminate results so communities themselves can better advocate and represent their interests in the policy arena. An example of this is the support that ACPHD gave to a youth community group that had advocated for a free and reduced-price student bus pass that was threatened with elimination by the trans-

portation commission. The youth were interested in surveying their peers to document how the increase in the student bus pass prices would affect the lives of area youth and to examine the local experience of being bus riders. They requested and received assistance from ACPHD to help develop a survey results database, including training in inputting surveys results and help conducting simple statistical analysis. The youth group administered surveys to over 1000 middle and high school transit riders. The findings of the survey were used to mobilize the broader community to successfully advocate for the continuation of the discounted student bus pass.

Alameda County Public Health Department has endeavored to assert the public health interests of our low-income residents of color in each of these venues when possible. Most often this is done in partnership with community-based organizations in order to maximally leverage our credibility. However, the vast array of different venues for protecting these interests makes this approach very challenging.

## SUMMARY

In virtually every public health area of endeavor, be it immunizations, chronic disease, HIV/AIDS, STDs, obesity, or even disaster preparedness, local public health departments are confronted with the consequences of structural poverty, institutional racism and other forms of systemic injustice. Disproportionate amounts of public health resources are expended in neighborhoods where unhealthy social and physical environments reflect the cumulative impact of profound and unjust social, political and economic forces. By designing approaches that are specifically designed to identify existing assets and build social, political and economic power among residents of afflicted neighborhoods, local public health departments can begin to sustainably reduce and move towards eliminating health inequities in low-income communities of color. Additionally, local public health agencies must simultaneously seek opportunities to strategically partner with advocates for affordable housing, labor rights, education equity, environmental justice, transportation equity, prison reform, and other disciplines to change norms regarding the distribution of those critical social goods that have a powerful influence on health outcomes. Without such a focus, local health departments will most likely only succeed in tinkering around the edges of health disparities at a cost too great to justify.

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