

## Partnering4Health Addressing Health Equity

As part of the Partnering4Health project, the U.S. Centers for Disease Control and Prevention (CDC) selected three national organizations -- [the American Heart Association](#) (AHA), the [American Planning Association](#) (APA), and the [National WIC Association](#) (NWA) -- to work with 96 communities and address one or two priorities for improving their population's health: improved access to healthy foods and beverages, more access to physical activity opportunities, more smoke-free environments, or improved access to clinical preventive services. The preventable causes of morbidity and mortality communities addressed through this project are more common in populations where environmental conditions and circumstances reinforce unhealthy behaviors. Chronic diseases are often more debilitating, diagnosed later, and associated with worse outcomes in racial/ethnic and low-income communities, which affects the overall health of communities.

Some communities started their health equity work by looking internally, using both bias assessments with staff and equity audits that considered capacity and need at the organizational level. Individually and organizationally, a recognition that "my experience is my experience" and that "good community work was good self-work" made a health equity focus personally and organizationally satisfying.

Although data and mapping helped identify areas of need that coincided with disparate health outcomes, qualitative information was often as important as quantitative in identifying what might most benefit under-resourced communities. Community residents often knew solutions and had assets but had never been given voice to bring those forward. Focus groups were a powerful tool for not only hearing the community voice but also garnering champions within the communities of focus. Storytelling by community members validated data and gave voice to the community. Some coalitions included community influencers who participated fully in discussions and decision making, recognizing that community ownership will create sustainability.

Distribution of resources was a serious barrier in many low income, racially diverse and immigrant communities. Some projects discovered stark contrasts in the county health rankings (from very healthy to very unhealthy) between two adjacent jurisdictions. Without being deliberate about

*"As a Sacramento resident and a D4AS Coalition member I know that our comprehensive approach is what is necessary to empower residents and decision-makers to shift our historic development pattern from segregation and neglect toward health and equity."*

*Katie Valenzuela Garcia, Sacramento  
CA APA coalition member*

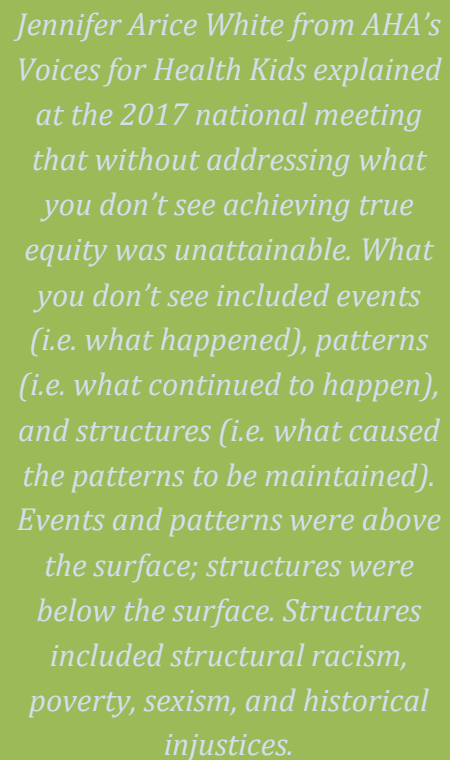
health equity, the result was often what a Crescent City LA staffer called the “anonymous problem” in health disparity where white people accessed the services even though those services were available for all populations. Professionals coming from outside a community were sometimes ignorant about “legacies of oppression” that affected how a community made use of resources and opportunities even when they were available.

Stigma arose as an issue in different ways. Some eligible women avoided WIC because they did not consider themselves “free-loaders.” The Hampton Roads VA coalition scrapped plans for a community garden when a focus group revealed a perception that only low income people would participate and people did not want to be stigmatized as low income.

Some groups that were not identified as ignored and marginalized but that experience poor health included people with mental illness or physical disabilities, the homeless, imprisoned, and drug addicted. Some undocumented people, especially Latinos, feared contact with any governmental programs for fear of deportation.

Selecting PSE approaches that helped the most disadvantaged presented challenges in communities with mixed populations (i.e. home owners, renters in low income housing, and neighborhoods with high crime rates). In Baltimore, the APA-funded community discovered that zoning regulations kept retail and mixed use establishments out of underserved residential communities, so they changed the zoning. Then they used tax incentives to encourage retailers providing healthy foods to move into residential neighborhoods identified as food deserts. Communities that increased availability of nutritious foods found that cooking classes about ways to use fresh produce and taste testing helped drive sales.

To engage community voices and informal community leaders, communities found that they had to show up and be present at gatherings and events outside normal office hours, lead from behind, meet people where they are (farms, stores, bus stops, soup kitchens, clinics, public housing, senior centers, rallies, festivals) don’t expect them to come to you, and utilize assets in communities such as



*Jennifer Arice White from AHA's Voices for Health Kids explained at the 2017 national meeting that without addressing what you don't see achieving true equity was unattainable. What you don't see included events (i.e. what happened), patterns (i.e. what continued to happen), and structures (i.e. what caused the patterns to be maintained). Events and patterns were above the surface; structures were below the surface. Structures included structural racism, poverty, sexism, and historical injustices.*

community health workers and existing programs. Some communities used grant funds to pay people for their time and costs of attending coalition meetings or focus groups. Educated professionals, people from the majority culture, and people with power often needed education about inequities and collective impact (i.e. how issues and conditions interrelate). Data, story-telling, and internships were some educational approaches used in this project.

At the final summative meeting, participants reflected that health equity is a process not an end in itself. Therefore, for sustainability and impact, it had to become a practice not a project.