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Promoting Effective Local Public Health Practice

The Building Networks Project: Aligning Public Health and Community Organizing

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Across the field of public health, widespread conversation occurs about the patterns of health inequity in American society. Evidence shows that health inequities, disproportionate differences in health and mortality that impact populations, result from broader social and economic inequities. Populations that bear the burden of social inequities—typically low-income people and people of color—struggle to access the basic social goods that people and communities need to thrive, including well-paying jobs, good public education, public infrastructure and transit, affordable housing, and safe neighborhoods. The lack of access to basic social goods and political power is why many populations in the United States have significantly worse patterns of health outcomes than their wealthier, whiter counterparts.

But what is the root cause of the inequitable distribution of resources and social goods? Groups of people and communities that have less well-resourced and organized power are less able to ensure the conditions required for health. Power inequities are an obvious but often neglected obstacle to achieving health for all people.

Increasingly, public health officials are recognizing power inequities as a major underlying cause of health inequity. In April 2007, the World Health Organization's Commission on Social Determinants of Health wrote the following:

Health inequities flow from patterns of social stratification—that is, from the systematically unequal distribution of power, prestige and resources among groups in society. As a critical factor shaping social hierarchies and thus conditioning health differences among groups, “power” demands careful analysis from researchers concerned with health equity and social determinants of health.¹

Aligning Two Powerful Disciplines

Public health has a long history and deep roots connecting the field to social movements that have created changes in power relationships and have resulted in increased equity. The Women's Suffrage Movement, the Labor Movement, the Environmental Movement, and many others are examples of public health's past influence. Staging interventions to end the extreme and unacceptable health inequities in American society will require a resurrection of such alliances and a renewed commitment to unleashing communities into a movement for racial and economic equity. Through organizing for a common agenda, people can disrupt the structures of power that inadvertently produce and reproduce the

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unequal distribution of power, resources, and health. The work requires a commitment to deep democracy, building on a large scale, to ensure accountability, transparency, and fully developed participation.

In the last two decades, a growing number of local health departments in the United States have sought to reclaim this legacy and return public health to its social justice roots. Moving beyond the monitoring and regulatory functions customarily associated with the discipline today, public health practitioners have sought ways to expose and eliminate the unhealthy conditions in which people work and live and the unfair policies that create those conditions. The Building Networks Project, funded by the W.K. Kellogg Foundation and the Kresge Foundation, aligns this movement with the discipline and strategies of community organizing in five states in the Midwest: Michigan, Minnesota, Missouri, Ohio, and Wisconsin. The goal over the next three years is to create strong, flexible, and durable statewide teams that will achieve “strategic breakthroughs” toward eliminating health inequities.

For example, in Minnesota, organizers have begun a partnership with public health about work and economic dignity, grounded in the knowledge that income and wealth differentials are major predictors of health outcomes. The first step will be to use an upcoming statewide conversation about raising the minimum wage as the launching pad for advancing a narrative about the connections among income, wealth disparities, and health. Organizations across the state are aligning to push for raising the minimum wage, and public health professionals can project the data and use their expertise to advance a health and income gap narrative. This will provide the opportunity to devise a long-term strategy that can create the structures and vehicles necessary for more low-wage workers across the state to organize and negotiate for better wages and benefits.

In October 2013, teams from the five Midwest states met to imagine possibilities and develop strategies for creating health equity, drawing on the wisdom and traditions of both public health and community organizing. Emerging campaigns include addressing mass incarceration, low-wage work, educational opportunity, financial justice, and access to healthy food. In the next phase of the work, statewide teams will assess which efforts will yield the most powerful outcomes and, in the long term, rearrange and democratize the structures of power that repeatedly generate racial and economic inequity and oppression.

The Emergent Opportunity

Just three weeks after the five-state gathering, 70 organizers and public health professionals from seven counties in Michigan gathered to launch “Michigan Power to Thrive.” The meeting was predicated on conversations begun two years earlier between staff of Ingham County Health Department (ICHHD) and organizers from Gamaliel of Michigan, who had been brought together by the National Association of County and City Health Officials to explore a strategic alignment between the two disciplines. Gradually, actors from both fields came to grasp the potential of working together. Public health staff began to recognize that community organizing, like public health, was its own unique world shaped by decades of tradition, theory, and practice.

At Michigan’s initial gathering in November, participants discovered the resonance between the discipline of organizing and the historical social justice movement within public health. They also explored the tensions between the two disciplines—a process that proved to be just as valuable to collaboration.

Public health professionals entering the world of organizing—some through immersion in that world through weeklong leadership trainings offered by organizations like ISAIAH—come to recognize that real transformation is both personal and institutional and involves fundamental challenges to the way public health

Within communities, many local health departments have raised the consciousness of unjust practices in housing, education, and employment and their impact on health.

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professionals think and act. Aligning with organizers requires much more than sharing data and providing access to people in power. It demands that public health professionals do the following:

- Dispel the illusion of powerlessness that many have come to accept as cogs in a bureaucratic machine, i.e., settling for helping one individual at a time because people are convinced that broader economic and social forces are beyond their influence;
- Expose false narratives of health in the United States, i.e., that *health* is synonymous with *healthcare*, that health is solely the responsibility of the individual, that health is randomly distributed rather than a direct consequence of policies designed to increase corporate profits, cheapen labor, and exploit specific populations through structural racism; and
- Become comfortable with a new framework for action, one that thrives on openly building and using power to confront forces that intentionally limit people's capacity to act in their own self-interest.

Attempts to shift the focus of public health have been diverse and promising, but they have not yet succeeded in changing the frame of public health work. Public health professionals are better today than they were 10 years ago at measuring and explaining health inequity. Within communities, many local health departments have raised the consciousness of unjust practices in housing, education, and employment and their impact on health. Some departments have piloted community-driven initiatives that expose the ways harmful environmental exposures are distributed across geographic areas conspicuously defined by race, ethnicity, and economic status. In a very dynamic time of experimentation and observation, many health departments are attempting to transform their practice beyond mitigation of health inequities toward strategies for acting on root causes. What they have not done, however, and what they need to do, is *build power* in communities to influence the way *all* policy decisions that impact health are made.

Mutual learning and agitation across public health and community organizing has generated tremendous energy and a hunger for deeper engagement between the two disciplines. More important, collaboration has yielded a commitment to ongoing interaction at the local level and to an emerging plan to broaden the power base in the shared pursuit of health equity. 

For more information, visit www.isaiah-mn.org and <http://mosesmi.org>.

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Tackling Foreclosure and Improving Health through Local Partnerships, Community Organizing, and Policy Change

By Katherine Schaff, Alameda County Public Health Department; Robbie Clark, Causa Justa::Just Cause; Alexandra Desautels, Alameda County Public Health Department; Tammy Lee, Alameda County Public Health Department; Tram Nguyen, Alameda County Public Health Department; and Muntu Davis, Alameda County Public Health Department

The Alameda County (CA) Public Health Department (ACPHD) strives to ensure the optimal health and well-being of all people. However, staggering inequities in health continue along lines of place, race, and class.¹ As an example, by 2006, subprime loans generated one trillion dollars for the banking industry, while people of color experienced a loss in wealth of an estimated \$164 to \$213 billion from 2000 to 2008—the greatest loss of wealth to communities of color in modern U.S. history.² This massive redistribution of wealth portends poorer health for current and future generations.

ACPHD built partnerships with community-based organizations (CBOs) to address local housing and foreclosure policies as one strategy to achieve health equity. This article exemplifies how local health departments (LHDs), CBOs, and residents can influence and draw attention to larger issues that generate health inequities.

Coming Together to Rebuild Neighborhoods, Restore Health

Given the disproportionate impact subprime loans and the foreclosure crisis had in African-American and Latino communities,^{3,4,5} Causa Justa::Just Cause (CJJC), a multi-racial grassroots organization working to achieve justice for low-income San Francisco and Oakland residents, began holding Tenant Rights Clinics to fight illegal evictions



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and utility shutoffs. ACPHD recognized utility shutoffs would directly affect health and partnered with CJJC on the issue.

From this initial collaboration, CJJC and ACPHD released *Rebuilding Neighborhoods, Restoring Health: A Report on the Impact of Foreclosures on Public Health*. Combining primary data collection and stories from community members, the report exposed both individual and community-level health impacts of foreclosure and amplified the voices of residents negatively impacted by foreclosures.^{6,7}

Ongoing Partnering for Success

CJJC and ACPHD sent the report to key allies and policymakers at the local, county, state, and federal levels and coordinated events to draw media attention to the impact foreclosure has on health. The report included 11 policy recommendations that helped guide continued joint work. At the same time, ACPHD launched its “Place Matters” initiative, building staff capacity and infrastructure to address policy.⁸ CJJC and ACPHD stayed connected through the Place Matters Housing and Economics Workgroups even when there was not funding for a specific collaborative project. This partnership led to several significant outcomes:

Local and State Policy on Utility Shutoffs

Rentals account for a substantial number of properties facing foreclosure.⁹ Because landlords and banks stopped making water payments on foreclosed properties, tenants faced water shutoffs. CJJC organized advocacy efforts and ACPHD provided testimony and letters to policymakers, helping enact a local resolution to prevent water shutoffs. CJJC used the report to support organizing at the state level, helping pass SB 1035 in 2010, which supported an end to utility shutoffs by allowing utility companies to place liens on properties for delinquent bills, holding landlords and banks accountable.¹⁰

Vacant Property Registration

The Place Matters Housing Workgroup, CJJC, and other partners collaborated to ensure passage of Oakland’s Vacant Property Registration Ordinance, which netted the city over \$1.6 million in its first 18 months and helped reduce blight by mandating that banks register and maintain foreclosed properties.

Linked Banking Ordinance

CJJC and the Place Matters Economics workgroup collaborated with the City of Oakland to update its Linked Banking Ordinance to include requirements that banks disclose detailed lending data, including any ties to predatory financial services located in Oakland. To highlight the links among banking, foreclosure, and health, ACPHD’s Health Officer and Director, Dr. Muntu Davis, wrote an op-ed about responsible banking and health in the *Oakland Tribune*.¹¹

Virtual Blight and Habitability Tour

In May 2013, CJJC led a “Virtual Blight and Habitability Tour” in front of Oakland City Hall, using ACPHD data and tenant testimonies to highlight the need for resources for housing code enforcement. CJJC, the Place Matters Housing Workgroup, and many partners also released the report *Housing, Health & Habitability in Oakland: A Factsheet for 2011–12*, with recommendations for stabilizing Oakland’s neighborhoods, preserving a healthy housing stock, and ensuring better city services for the residents made most vulnerable by institutional decisions related to foreclosure and banking policy.¹²

Displacement and Health

CJJC and ACPHD are writing a report that examines links between displacement and health and proposes mitigation strategies.

Building Partnerships for Health Equity

Staff from both organizations describe several lessons learned and benefits from the continued partnership to address housing and economic issues that affect health.

Partnerships

LHDs can partner with CBOs to conduct research and advocate for change to address the social issues that affect health. Robbie Clark from CJJC states, “It has been good to use our different

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positions as organizations to advance things from areas of strength.” CJJC brought people power, campaign knowledge, and a deep understanding of housing issues. Engaging local residents to take collective action is essential for moving policy solutions forward, and CBOs, free from the restrictions placed on government, may be better equipped and have more experience in this area. ACPHD staff have data and policy analysis skills, and the health lens brings a sense of objectivity, credibility, and urgency to issues. To engage in partnerships that include policy change and community organizing, LHDs need to develop internal infrastructure and staffing support, including reliable points of contact, clearly stated priorities, and individual relationships with partners. Clark states that “this is how we start to get at the root causes of how our health is being impacted. It’s really through that deeper relationship where you develop that shared assessment of the issues and develop ways to address them.”

Building Trust and Transparency

Partnerships are most likely to succeed when built on trust, mutual respect, and power sharing. Communicating about capacity and process is an important aspect of strong partnerships. Both LHDs and CBOs adhere to internal decision-making processes. LHDs will also have processes for taking a position on a policy, testifying, or speaking to the media. Clark shared that CJJC understands that such processes are part of working with a governmental organization and that ACPHD staff are clear about the processes and ensure that they do not delay action. In addition, coming to consensus about the goal of a collectively created tool or report is an essential step in role clarification.

Building Staff Capacity and Leadership Support

LHD staff need to be politically savvy to navigate difficult situations and bureaucratic constraints. LHDs can hire staff experienced in or build staff capacity for campaigns and advocacy, policy analysis, community organizing, and social justice work. ACPHD benefitted by having a framework¹³ that includes analysis of the role of power in driving social and health inequities; such frameworks align with those used by many CBOs that are engaged in community organizing, racial justice, and policy change. Having support at a high level within ACPHD has also given validity to the work and

helped advance agendas through bureaucratic processes.

Broadening the Lens

A health lens can broaden the political dialogue and create opportunities to advocate for change from a new, powerful perspective. Clark states that there are “widely held beliefs around health and people’s right to health, as well as the responsibility of our local government and politicians of protecting the health of residents.” Partnering with CJJC has given ACPHD powerful allies who can advocate for the important local government role in addressing health inequities, increasing much needed political support for this type of initiative.

Advancing Goals

CJJC and ACPHD create opportunities to advance both organizations’ goals with joint projects; for example, door-to-door surveys can mobilize and engage residents. In collecting primary data for the report, ACPHD developed a sampling plan that emphasized rigorous scientific standards and provided an opportunity for CJJC to advance its goals while connecting with residents.




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Conclusion

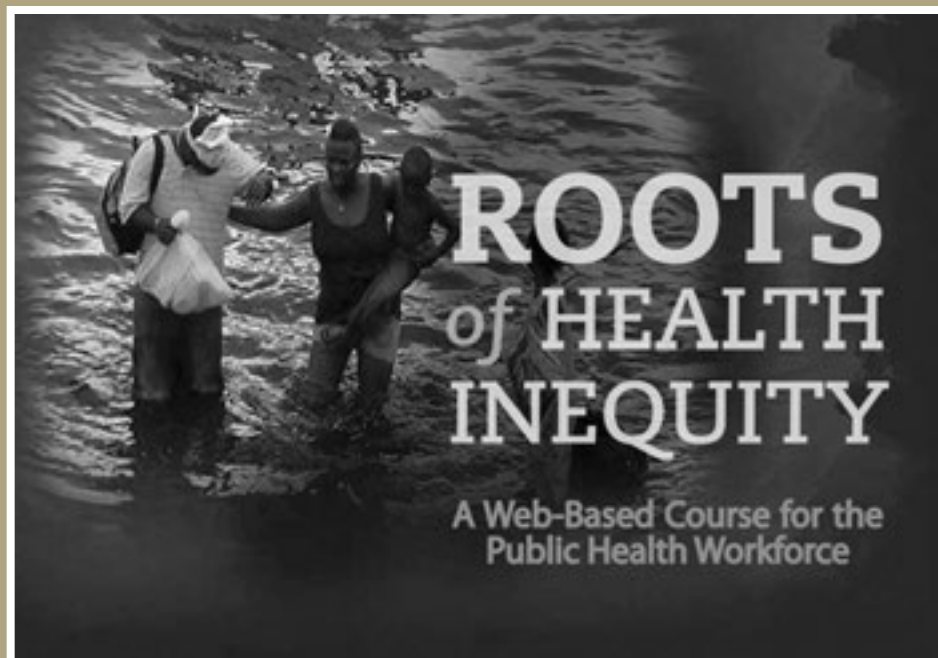
LHDs are charged with examining, maintaining, and protecting the public's health and safety. While the context for each LHD will differ, foreclosure has emerged as a threat to public health in communities across the country. For ACPHD, partnering with local organizations like CJC to explore and address foreclosure and housing through multiple and connected strategies of community organizing, policy change, and strong partnerships has meant winning real policy successes, informing the public of the health impacts of banking decisions, and thereby increasing capacity to tackle health inequities. 

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Roots of Health Inequity: Build Community Capacity to Address Poor Health Outcomes

By Mikhaila Richards, MS, Senior Program Analyst, Health Equity and Social Justice, National Association of County and City Health Officials



About the Course

"Roots of Health Inequity," a transformational Web-based course and learning collaborative, uses a social justice framework to help participants critically examine the core concepts of health equity. Building on the work of *Unnatural Causes*, this free tool features interactive presentations, podcasts, case studies, videos, group-directed discussions, and readings to help participants investigate the following:

- Principles of social justice;
- Impacts of class, race, ethnicity, and gender inequity on health;
- Effective community-engagement methods; and
- Methods to develop and implement meaningful strategies to create health equity.

Collaboratively designed by community and public health leaders, Roots of Health Inequity offers a comprehensive package of multimedia materials that public health agencies, schools, and community-based organizations can use to increase their capacity to address the root causes of health inequities.

Applying experiential education techniques, Roots of Health Inequity uses concrete, real-life examples of community change, actively engages participants in self-reflection, and inspires action.

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“First and foremost, Roots of Health Inequity is raising awareness; it’s about self-reflection and changing a paradigm.”

*—Kimberly Pettiford, MPH, Community Health Promotion Specialist,
The County of San Diego Health and Human*

“Roots of Health Inequity is an exciting resource that supports individuals, small groups, and organizations in advancing public health practice. During these challenging times, this online curriculum ties public health to social change and offers keen insight on the important mission of reorganizing public health practice to eliminate health inequities.”

—Dr. Linda Rae Murray, Chief Medical Officer, Cook County Department of Public Health, and Past President of the American Public Health Association, 2009–2012

Enhance Critical Thinking

As part of Roots of Health Inequity co-learning community, staff and community members can use their experiences and insights to develop new frameworks and knowledge. By helping each other to translate extensive knowledge about their communities’ social and economic inequalities, group members can build innovative, cross-cutting partnerships and action strategies.

Develop Leadership

Roots of Health Inequity encourages group participation and promotes information sharing among a mobilized and motivated team of stakeholders committed to tackling health inequities. By examining the underlying assumptions, features, and values of a social justice approach, the learning groups can determine goals and priorities from which to develop strategic action plans.

Improve Strategic Planning Efforts

To develop processes and strategies for tackling health inequities, organizations are first challenged to rethink the framework guiding the work of public health. This framework can help teams establish a vision for public health practice that includes targeting social injustice. All of the discussion exercises and resources in Roots of Health Inequity create a foundation that a health equity team needs to assess organizational roles, responsibilities, resources, and past performance.

Learn More

Go to www.rootsofhealthinequity.org to learn more about how to register and participate. For more information, including guidance about how organizations can use the course, contact rootsofhealthinequity@naccho.org. 

President's Column



By Terry Allan, RS, MPH, Health Commissioner, Cuyahoga County (OH)
Board of Health (Serving Greater Cleveland)

*"...A child's course in life should not be determined by the zip code he's born in, but by the strength of his work ethic and the scope of his dreams."—
President Barack Obama*

I recently heard a compelling speech that captured the essence of what has become a growing national public health movement. A line from this pivotal address crystallized the reality that "...a child's course in life should not be determined by the zip code he's born in, but by the strength of his work ethic and the scope of his dreams." Notably, this time, these words did not come from a local health official. They were spoken by the President of the United States, during his recent speech identifying inequality as the defining challenge of our time. This speech was significant because it eloquently captured the ethos of an emerging domestic imperative to address the longstanding social determinants that are the root cause of this chasm.

The urgency of this national movement becomes particularly poignant, given that the U.S. investment in healthcare now approaches 18 percent of our GDP and, yet, Americans have been dying at younger ages than people in almost all other high-income countries. A January 2013 Institute of Medicine (IOM) report titled *Shorter Lives, Poorer Health* found that this disadvantage has been getting worse for three decades. When compared to peer countries in Europe, Canada, Australia, and Japan, the United States ranks at the bottom in health outcomes for many conditions and illnesses, including infant mortality, obesity and diabetes, heart disease, and HIV and AIDS. The report goes further in identifying that, although the income of Americans is higher on average than in other countries, the United States also has higher levels of poverty (particularly among children), income inequality, and lower rates of social mobility. These

complex forces interact with disparities in healthcare access, healthy eating and active living opportunity deficits, adverse economic and social conditions, and environmental factors, as well as public policies and social values that shape those conditions, as described by IOM.

The net effect of these compounding disadvantages is that the deck is particularly stacked against low-income minority children and families hoping for a fair shot at a long, healthy, and productive life. This growing separation is associated not only with race but also with class and has the net effect of sidelining significant human potential.

Life expectancy maps are a useful means to graphically represent these inequities and their impacts to policymakers. In Greater Cleveland, GIS mapping of life expectancy data identified about 10 neighborhoods in Cuyahoga County where residents live 20 years less than the residents of more affluent areas.



These compelling data have propelled a focus on health equity in our health improvement planning work.

In an address at Johns Hopkins School of Medicine, Robert Wood Johnson Foundation CEO Risa Lavizzo-Mourey described compelling evidence of the value of public health interventions in closing the gap. Dr. Lavizzo-Mourey noted, “When people take responsibility for modifying their own behavior and modifying or supporting the modification of the environments in which they live, learn, work, and play—they can alter the health trajectory of an entire society.” Many examples exist in the proliferation of comprehensive smokefree laws and healthy eating and active living programs in high-need neighborhoods that illustrate transformative work currently underway at local health departments across the United States.

We must seize the opportunity to accelerate the reduction of these longstanding inequities. Our success will depend on our ability to integrate public health priorities with allied domains such as planning, development, behavioral health, education, and transportation that alter the social conditions and futures for those that have been left behind.

The W.K. Kellogg Foundation commissioned a paper by the Altarum Institute, which makes a strong business case for the economic and health benefits that would come with a national focus on health equity. The Institute found that disparities in health cost the United States an estimated \$60 billion in excess medical costs and \$22 billion in lost productivity in 2009 and projected that the burden would rise to \$126 billion in 2020. The report also

enumerated that additional economic loss due to premature deaths was valued at \$250 billion in 2009.

This work has become particularly important, given the elevated discussion and growing support for establishing a living wage. The Altarum Institute found that work to close the income gap would have substantial benefits on the GDP and federal tax revenues. Put simply, reducing inequities is good for the economy, for business, and for population health.

We can all do our parts in our own communities to meet this defining challenge by embracing this national movement and working with partners to create the conditions in which all people can be healthy. [📄](#)

Executive Director's Column



By Robert M. Pestronk,
MPH, Executive
Director, NACCHO

Personal circumstance is determined the longer one lives by a combination of privilege, personal choice, and differentials of political power accumulated over time. This has been true since the nation's founding and is not unique to American society.

Personal choice and life course are not under our sole control despite the heroic stories of personal achievement against all odds that form part of America's powerful national mythology. After all, inequity based on race was fundamental to the compromise that produced the Constitution and, ultimately, led to the Civil War. Inequity enabled the early accumulation of wealth and power by those with privilege in colonial America. Many of the nation's first and most prestigious universities are coming to grips with the origin of their wealth and reputations that seeded their growth and prestige. Late 19th century and early 20th century muckraking and calls for women's suffrage responded to conditions of inequity that allowed some people, from a population-wide perspective, although not always for every individual, to unfairly determine another's life course, health, and destiny. Stories are told of those who later in life, having accumulated vast wealth and power, attempted to rebalance societal forces through charitable giving. President Obama's remarks in December 2013 in South Africa highlighted the continuing presence of economic inequity in the United States and its corrosive effect on lives at home and abroad.


Equity requires a continuous societal journey of individual awakening and collective action that repeatedly enables personal opportunity and enhanced outcomes for groups of people rather than distorting them through political and economic power or "isms" (like racism, classism, sexism, chauvinism). Where one lives, learns, earns, or yearns is important.

We are shaped by villages of people, torrents of ideas, and the ever-present force of interests that can determine living and working conditions. The proof of this is never far from each of us if we take the time to reflect critically on our own circumstances and those of others. I am European-American in a nation that granted advantage to this race not always visible to me. I wasn't counseled about the personal threat and jeopardy posed by the color of my skin. My childhood neighborhoods were well-maintained, free of obvious pollution, populated by working adults, and safe for outdoor play from dawn until bedtime. I walked to school on sidewalks. I travelled from suburbia to metropolis on my own without fear. Gunshots at night were unheard of except on TV. Food graced a table not haunted by debt. A veneer of generational

achievement and expectation occluded a history of massive familial holocaust and religious persecution. I know now that my early life was quite different from that experienced by others and from that of the African-American baby, whose crib was the middle drawer of a bedroom dresser, whom I visited with a public health nurse many years ago as I started my work in a local health department.

Justice is a state of affairs in which redress is awarded for harm, where each person's full potential can be expressed, and where collective intent improves the odds for a high quality of life. We create inequity and must take responsibility individually and collectively for eliminating it. We can create conditions that make justice likelier, too. We elect those who can, if *they* choose, support policies that recognize the humanity of us all or not, whose decisions can either enable or disable inequity and justice. Yet those we elect are always subject to the influence of powerful interests that can narrow the possibility of who will represent us, the decisions they make, and the rules for accountability and transparency that affect population health and personal destiny.

Joan Miro defined an artist as "one who, amidst the silence of others, uses his voice to say something." Governmental public health professionals are artists called to use their voices to describe complex and interlocking systems, often invisible to others, which nonetheless enmesh us all. Governmental public health officials are artists who must ask for help to create their very public art every day despite organizational conditions of scarcity. They must lead people adaptively to answer deceptively simple questions (what is the problem, what are its causes, what works to prevent the problem, what action is necessary to establish what works as the precondition for every life¹), sometimes placing themselves at personal risk because efforts to make life equitable and just usually conflict with the interests of powerful groups.

The frontispiece of the Institute of Medicine expresses the following sentiment from Goethe: "Knowing is not enough, we must apply. Willing is not enough, we must do." Science, one of the best current methodologies for knowing, is not enough. Politics and political action are necessary for doing. Proust says, "The only real voyage of discovery consists not in seeking new landscapes but in having new eyes." Let us all have the courage not only to see things anew but to act alone or with others on what we know must be done to ensure equity and justice. Health equity, after all, is a necessary but not sufficient precondition for equity. 

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*We create
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The Raising of America: Early Childhood and the Future of Our Nation

By Larry Adelman, Co-Director, California Newsreel



A glance at all the parenting books and magazines, talk shows, blogs, advice columns, and Web forums makes clear that Americans, like parents and caregivers everywhere, want to give their children a strong start in life. Yet U.S. child well-being has now fallen to 26 of 29 of the richest nations; the United States does beat Latvia, Lithuania, and Romania. Not only do U.S. children fare worse than those in most other rich countries, but when it comes to infant mortality, child mental health, injuries, teenage pregnancy, obesity, substance abuse, education, and other measures, the country makes more children vulnerable and allows those to fall further behind the median.¹ The United States is the richest, most powerful nation on earth. Why is it so difficult for parents, caregivers, and communities to provide the safe, secure, and nurturing environments that young children need to thrive? And how can Americans do better?

The Raising of America: Early Childhood and the Future of Our Nation (www.raisingofamerica.org) is a documentary series and companion digital learning platform to be released in spring 2014 (and tentatively broadcast next fall) that aims to reframe the way Americans view early child health and development. Building on the analysis of health inequities in *Unnatural Causes*, an award-winning documentary series also produced by California Newsreel, *The Raising of America* seeks to tell a new story, one that links a strong start in life not just to better individual outcomes through the life course—learning, earning, and physical and mental health—but also to a healthier, safer, better educated, more prosperous, and more equitable nation.² *The Raising of America* also explores how strong communities and a more equitable nation are key to producing conditions in which more children have the opportunity to thrive.

The documentary series interlaces the stories of families and communities with scientific studies, translating the evidence from neuroscience and other fields that illustrates how the fetal environment and early childhood experience can alter the “wiring” of rapidly developing brains and other bio-regulatory systems—for better or for worse.³ These epigenetic and physiological changes influence not only cognitive function but also the self-regulation of emotions and behaviors, even the susceptibility to chronic diseases as people age—hypertension and heart disease, stroke, obesity, diabetes, substance abuse, and mental illness.^{4,5,6,7}

The real subject of *The Raising of America* is not so much what is on the screen but rather what sits before it, i.e., the audience. The series interrogates widely held default understandings and beliefs that “explain” why some children prosper while others flounder and that hinder efforts to build support for investments in early childhood, especially for those children and families who face the greatest adversities. For example, many assume babies do not “remember” and so believe infancy is not important as long as babies are housed, changed, and fed, but as Jack Shonkoff, MD, director of the Center for the Developing Child, says in *The Raising of America*, “Our bodies remember, our brains remember.” Exposure to nurturing or adverse experiences in the early years can become embodied in many ways, building strong or fragile foundations for life-course outcomes.⁸ Similarly, when children fare poorly, many people are quick to blame “bad” parents who made the wrong choices, which is only a partial truth.

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Increasingly, young families are pressured by limited time, money, and resources. They face wage cuts and split shifts, long work weeks and commutes, stagnant wages, increased debt, little or no paid sick, family, or parental leave, and uncertain futures. The two decades-long Wisconsin Study of Families and Work, chronicled in *The Raising of America*, illustrates how stressors faced by parents during the perinatal period have trans-generational consequences. These stressors can “drip down” on their young children, altering their offspring’s own stress response, impulse control, concentration, working memory, and even brain architecture. The struggles of most young parents and caregivers to provide for their children have become so normalized that few of them can imagine that life might be different, that public policies and economic and racial arrangements can help or hinder child outcomes.

Furthermore, exposures and outcomes get steadily worse step by step down the class pyramid. Today, that gradient is steeper than it has been since the last Gilded Age.⁹ A quarter of children are born into poverty;¹⁰ 61 percent of those babies are black or Latino;¹¹ 46 percent of young children (birth to age three) live in households that are poor or near poor. They and their families face multiple adversities with potential cumulative, life-long consequences for their physical, socio-emotional, and cognitive development.¹²

However, recent scientific findings suggest that bold initiatives offer an extraordinary opportunity not only to transform life prospects for all children, especially those made most vulnerable, but also to build a healthier, more prosperous, and more equitable America. Multiple studies have demonstrated society-wide benefits from high-quality early care, paid parental leave, income supports, home visiting nursing, and other investments in early child health and development: lower chronic disease and healthcare costs; less violence, crime, and substance abuse; and a better educated and more productive workforce.¹³ Despite such evidence, many of these findings and their implications have received little media attention and remain unfamiliar to the public, civic and policy leaders, and even many healthcare providers.

The Raising of America will help change that. It will provide advocates, practitioners, educators, and community organizers a customizable ensemble of multimedia tools to educate and mobilize staff, constituents, and the general public about why investing in young children and their families and caregivers may be the most prudent investment any nation can make.

With a lens on babies and young children, *The Raising of America* can be an effective catalyst for discussion of transformative policy and systems changes. The National Association of County and City Health Officials has received a small grant from the CDC Foundation to develop companion materials that will enable local health departments to use *The Raising of America* in in-service training, community dialogues, and alliance-building to change the conversation and spotlight initiatives that can help *all* young children and their families.

Conditions that nurture or threaten healthy child development do not just happen but are produced and reproduced by public policy, private investments, and decisions that Americans, as a body politic, not just individuals, have made. We can either invest early for success, or pay more for failure later. The choice is ours. 

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Best Babies Zones—A New Approach to Reducing Infant Mortality

By Cheri Pies, MSW, DrPH, Principal Investigator; Wendy Hussey, MPH, Program Manager; Shannon Merrell, Student Assistant; and Carly Strouse, MPH, Graduate Student Researcher; all from University of California, Berkeley



For several decades, interventions aimed at reducing infant mortality have focused on medical and technological innovations. Despite large investments in improving healthcare access and support services for families, mothers, and babies, significant racial-ethnic and socioeconomic disparities in maternal and child health outcomes persist. A focus on the life course perspective and a return to early roots in maternal and child health (MCH) have taught public health practitioners that opportunities to achieve better birth outcomes and improved health for all must begin where community residents live, work, learn, and play. Attending to the range of social, environmental, and biological aspects of people's lives is essential to improving the quality of life in communities. The Best Babies Zone (BBZ) initiative, funded by the W.K. Kellogg Foundation, is a bold national, multi-sector endeavor focused on implementing strategies not only to improve access to quality healthcare but also to align and transform educational, economic, and community systems in specific geographic areas to improve MCH outcomes.

BBZ communities promote good health from one generation to the next. Positive life experiences and increased opportunities such as early childhood education, affordable housing, and a vibrant local economy will help everyone thrive and be healthy.

BBZ is being launched in three zones encompassing small geographic areas

where change is greatly needed and resources are aligned to produce and measure impact. In these zones, BBZ aims to develop, implement, and evaluate a model for cross-sector collaboration to reduce infant mortality and improve birth and early childhood outcomes. The three BBZ communities are Price Hill in Cincinnati, OH; Hollygrove in New Orleans, LA; and Castlemont in Oakland, CA. BBZ teams work with community residents and organizations to establish a broad, cross-sector collaborative to cultivate a public health social movement and address the social determinants of health within each zone.

BBZ is unique in using a place-based, collective impact approach to engage community members in each zone. With the goal of improving social and economic conditions of a neighborhood through community transformation, the community's vision for change guides the BBZ's efforts. Collective impact is a structured approach to collaborative partnerships with a specific focus on working together to solve complex social problems. The collective impact framework defines five conditions that are necessary to achieve collective impact: sharing a common agenda, mutually reinforcing activities, maintaining continuous communication, sharing a system of measurement, and identifying a "backbone" organization.¹

Backbone organizations guide the overall strategy for the initiative, support

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joint activities, create shared measurement practices, build a social movement around the initiative, mobilize funding, and develop policy.² BBZ’s national backbone organization is the University of California, Berkeley. The following national partners and leading MCH consultants provide leadership and technical assistance: Association of Maternal and Child Health Programs, CityMatCH, National Healthy Start Association, Harder and Company (evaluation), Mario Drummonds (development and sustainability), Milt Kotelchuck (strategic direction), Lorraine Lathen (media and marketing strategy), and Amy Fine (place-based efforts and policy).

In addition to the national support, each site has its own backbone organization and additional community partners (see Figure 1).

Figure 1. BBZ Backbone Organizations and Some of the Community Partners

SITE	NEW ORLEANS	OAKLAND	CINCINNATI
Backbone Organization	Healthy Start New Orleans (NOLA), housed in the New Orleans Department of Health	Alameda County Public Health Department (ACPDH). ACPDH work’s with BBZ coincides with two of its broader initiatives: Building Blocks for Health Equity and Building Blocks Collaborative	Cincinnati Children’s Hospital Medical Center (CCHMC), which is building upon the work of its existing Infant Mortality Population Health Team, and the Office of Maternal and Infant Health for Infant Mortality Reduction
Community Partners	Louisiana State University School of Public Health, Dillard University, Hollygrove Community Development Corporation, and Trinity Christian Community Center	Girls Inc., Mandela Marketplace, Oakland Unified School District, Youth UpRising, and the Alameda County Community Food Bank	Santa Maria Community Services, which includes Literacy Center West and Transforming Early Childhood Community Systems

The collaboration among backbone organizations and community partners facilitates work within each zone. These organizations help BBZ connect with community members and engage them in the initiative’s work. Working effectively with and gaining the trust of community members, who are at times wary of outsiders, takes time. The BBZ teams work within each zone to gain a deep and clear understanding of community needs that local residents have identified and to connect the community with resources to help fulfill those needs. Each zone employs different strategies to engage residents; some have gone door-to-door in the zone, while others have used community surveys and attended fairs and community events to speak with

residents. The teams provide a consistent presence and incorporate sustainable solutions in each zone to earn community trust.

Many activities are occurring within the zones to help BBZ establish a presence and work with communities toward their goals. In Hollygrove, the Healthy Start NOLA and BBZ team sets up a table at a local corner store every Friday to talk with neighbors about BBZ and reach out to the community. The BBZ team in Hollygrove has also hosted several community events. With a PlayStreets grant and partnership with other local organizations, BBZ cohosted a PlayStreets event that attracted about 150 families to a community party filled with music, healthy foods, field games for children, and family services presented by Healthy Start, Nurse Family Partnership, and more. The enthusiastic response from community members led to a follow-up event the next month. BBZ Hollygrove partnered with Healthy Start NOLA, March of Dimes, Zeta Phi Beta Sorority, and United Health Care to host a Baby Shower event. The well-attended event provided families with information about local services for pregnant women and families and included a Pregnancy 101 class led by a local nurse practitioner.

In Oakland, ACPHD and BBZ are partnering with BBZ Castlemont’s local high school to host a monthly community market. The market provides an opportunity for community members to sell crafts and artisan products they produce while engaging with other community members. The market coincides with a nearby playgroup to encourage families to come out with their children to play and visit the market. ACPHD is also working with Youth Uprising, an organization committed to transforming Castlemont through personal transformation, systems change, and community economic development, to improve BBZ interaction and engagement with the local community.

In Cincinnati’s Price Hill BBZ, CCHMC is working with partners that support

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A focus on the life course perspective and a return to early roots in maternal and child health (MCH) have taught public health practitioners that opportunities to achieve better birth outcomes and improved health for all must begin where community residents live, work, learn, and play.

local families. CCHMC works with a community engagement specialist in outreach efforts. This specialist, who knows the community well, is committed to, and has been successful in, engaging members of the community, especially mothers in the zone, in activities that help to support families. CCHMC supports a mother-led group that meets monthly in Price Hill and provides parenting education and resources to new parents. The involvement from the community in both leading and attending the group is helping to support BBZ community-development efforts.

Over the next year, the zones will start integrating the work being accomplished across the sectors to create community-wide improvements. This holistic approach, combined with authentic community connection, will pave the path toward community transformation across the zones.

BBZ represents a paradigm shift from traditional MCH approaches to improving infant, maternal, and family health outcomes. The work highlights the importance of improving community health through collaboration among community residents, community-based organizations, local businesses, schools, parks and recreation centers, transportation alliances, and city, state, and federal agencies. By the end of the current grant period (2012–2015), the work of these initial sites will serve as a blueprint for future BBZ site development and implementation in other U.S. cities to improve health outcomes within communities. 📄

For more information, visit www.bestbabieszone.org.

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Improving Health through the Lens of Race, Place, and Policies

By Kimberlee Wyche Etheridge, MD, MPH, Tennessee State University; Former Director, Bureau of Family, Youth and Infant Health, Metro Public Health Department



Figure 1: Jefferson Street with I-40 Overlays, 2010 (Source: Racial Healing Project 2011, MPH D)

Focusing on a community-driven approach, the Metro Public Health Department (MPHD) led several initiatives to promote health equity within disparate communities in the North Nashville area. Residents there carry a disproportionate burden of chronic diseases like asthma, diabetes, obesity, hypertension, cancer, heart disease, and stroke. In addition to these health disparities, over two-thirds of children live below the federal poverty rate. One critical disparity in the community, which represents a convergence of the environment, the experiences, and the health of the population, is an excessively high infant mortality rate. To address the long-standing health disparities in this community, MPHD engaged the North Nashville community to learn about the community's history, key events that shaped neighborhoods, and people's understanding and interpretation of these events. MPHD believes it is essential that residents who have a stake in the community participate in decision-making to address health disparities and equity in their neighborhoods.

In 2011, through the Racial Healing Project, a team of public health experts from MPHD partnered with academic institutions, community leaders, and historians to study North Nashville's history and identify critical periods over the last 100 years that could help to explain factors contributing to such persistent health disparities. The team identified the 1950s as a critical period and a turning point in North Nashville's history. Prior to the 1950s, many residents had considered North Nashville to be an opportunity-rich community with a stable population of working class African-American families, profitable local businesses, and a strong sense of community. However, several key events and policies had a negative impact on the growing urban area.

The most significant event was the 1967 Sixth Circuit Court of Appeal ruling in the case of the Nashville I-40 Steering Committee vs. Ellington.¹ The case focused on the construction of a 3.6-mile section of Interstate 40 along a planned route through the predominantly African-American community of North Nashville.

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A steering committee comprising teachers, ministers, civic and professional leaders, and racially diverse business owners was heavily involved in organizing opposition to the planned construction but did not have a voice early in the planning process. The steering committee argued that building the interstate would be detrimental to the community,² yet others viewed the interstate as a lifeline with national and economic implications. The committee lost an appeal to the Supreme Court, and the injunction that halted construction of Interstate 40 was lifted. When the interstate was completed, it transected Jefferson Street, which had been identified as the heart of the North Nashville community (Figure 1). Many cross streets became dead ends, movement in the community became difficult, and residents became cut off from businesses and neighbors. The social cohesion that was once the strength of the community eroded, leaving concentrated poverty, waning opportunities, crime, and a sense of disenfranchisement that contributed to high rates of illness and disparate health conditions.

In addition to the construction of Interstate 40, several key policies negatively impacted or compounded the disparities in North Nashville (see Table 1).

Table 1. Policies Affecting North Nashville

LEGISLATION	IMPACT ON THE NORTH NASHVILLE COMMUNITY
Home Owners Loan Act of 1933	This act was intended to provide relief for nearly 20 percent of families across the county; however, only one percent of the funds was granted to African-American homeowners. As a result, many African-Americans in North Nashville lost ownership of their homes during this time period.
Federal Housing Act of 1949	This act set the stage for the leveling and displacing residents of an impoverished North Nashville African-American community that sat at the base of the capitol, replacing the neighborhood with the James Robertson Parkway. Families were often relocated to low-standard housing stock farther north, away from the growing downtown area.
Pyramidal Zoning	According to historical accounts provided by the Nashville Civic Design Center in its Urban Design/Policy Brief, ⁴ this zoning ordinance negatively affected the community during this same time period. The ordinance was instituted to protect suburban land owners from commercial growth and mixed land use, but North Nashville properties were excluded. The ordinance sanctioned the building of many types of businesses next door to established residences, which ultimately decreased property values.

To better understand lasting community views on the impact of the interstate, and other policies or laws, MPH, through the Racial Healing Project, conducted a series of informant interviews and focus groups with long-time residents in North Nashville. Many respondents viewed the interstate as an example of how decision-makers had ignored the community. The impact of the interstate on the neighborhood was compounded by experiences of discrimination and a legacy of mistrust. MPH also found that North Nashville residents believed that most community partnerships and improvement programs quickly came and went, often tied to short-term funding. The interventions typically targeted individuals and did not impact the community as a whole, nor achieve long-term sustainability.

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Through the Racial Healing Project, MPHD understood that, to achieve equitable health, change must be multifaceted and community-driven and must address contributing factors at the policy, systems, environmental, and individual levels, while acknowledging historical contributions to health disparities. MPHD also believed in the importance of establishing and nurturing community relationships long before funding opportunities arose. This philosophy led MPHD to apply for new funding to work differently with the community (see Table 2). Gaining a better understanding of the community’s history enabled MPHD to strengthen its funding applications by purposefully including the targeted communities early in the planning process.

MPHD’s efforts emphasize the community’s desire to achieve health and acknowledge the past while improving the present and future. MPHD established strong relationships with community leaders and stakeholders, which made the initiatives possible. Preexisting partnerships were the foundation for program planning and sustainability. Any work that will affect a community must be done in concert with that community and not in isolation based solely on the impressions and decisions of leaders on the outside. Partnerships must be symbiotic, and partners must be willing to alter course based on both the short- and long-term needs of the community. If this step of engaging in community dialogue is missed, skipped, or avoided, residents might rightfully challenge the role of government and offer resistance that might take generations to dismantle.

Table 2. MPHD Initiatives in North Nashville

FUNDING	NEW INITIATIVES IN NORTH NASHVILLE
Communities Putting Prevention to Work (CPPW) Initiative	In 2010, the Centers for Disease Control and Prevention awarded Nashville \$7.5 million to develop and implement policy, systems, and environmental changes to decrease obesity in the jurisdiction.
Federal Healthy Start Grant	In 2008, the federal government offered grants for place-based projects to address disparities in infant mortality. The MPHD initiative “Music City Healthy Start” brought \$3.5 million over five years to Davidson County. This data-driven, comprehensive community-based initiative focuses on high infant mortality rates in the North Nashville area.
New Life Project (NLP)	In 2011, NLP brought an additional \$7.5 million to Davidson County over five years. NLP aims to identify and respond to policies and systems that discourage men from caring for their families.

For more information, visit www.nashville.gov/health-department.aspx.

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A Brief Reflection on the Critical Role of Race and Ethnicity Data in Public Health Policy

By Amaal V.E. Tokars, EdD, Executive Director/Public Health Administrator, Kendall County (IL) Health Department

As the United States has become more diverse, both race data and ethnicity data must begin to reflect this diversity. While race and ethnicity are interrelated complex constructs that can readily be misapplied in research, accurate and complete race and ethnicity data can also play a critical role in meaningful research. Data can powerfully inform policy and practice, so national “big data”¹ must be planned for with care, collected with care, charted with care, mapped with care,² and analyzed with care.

The changing demographics in the United States makes the limited categories on race and ethnicity categories developed to reflect the population half a century ago out of date.³ Without data integrity, current invisible disparities will remain invisible. “The current system may be masking disparities in health behaviors and outcomes...”⁴ Improved data-collection methods may lead to more accurate and complete data. To obtain more accurate data and more complete data in future census work, the United States Census Bureau plans to recommend tracking some races now not specifically included by adding a write-in category for race.⁵

Public health leaders have made the case that an unequal burden of illness,⁶ income inequality,⁷ structural inequality,⁸ health disparities,⁹ and social inequality¹⁰ so often carry a positive correlation specific to race or ethnicity. Public health leaders must not truncate potential implications of data by describing a deficit discourse centered on any particular race or ethnicity. Analysis of both formal policy and polity practices are necessary to describe fully the implications of data related to race and ethnicity. Health prevention and intervention strategies that are data-informed depend upon fully informed data and thoughtfully generated research questions.

Public health leaders must go further and carefully develop research questions about the relevance of the cultural-historical (convergence of a collective consciousness and social-political lived experience), about social segregation, about socioeconomic status, about place-based disparity, and about vulnerability to violence. They must ground themselves thoughtfully in data analysis that includes all precious peoples in the community. Public health research intends to inform public health policy and practice. Public health policy and practice intends to improve the health of the population. Public health policy and practice also has an integral role in contributing to a civil society that is committed to the complete health and well-being of all peoples. ☒

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Conversations for Change: The Integration of Health Equity Concepts into Maternal and Child Health

By the National Preconception Health and Health Care Initiative's Public Health Workgroup

Today's most persistent public health challenges are greatly influenced by the physical, social, and economic environments in which people live. Access to resources and opportunities to support optimal health are absent in some communities, resulting in a disproportionate burden of poor health. This issue is paramount in the field of maternal and child health (MCH). For example, in the United States, African-American infants are more than twice as likely to die before their first birthday as are white infants.¹ Data show that traditional MCH approaches (e.g., ensuring access to early and regular prenatal care) have not ameliorated the black/white gap in birth outcomes. New approaches to these longstanding issues have included preconception health promotion to resolve health and social issues before pregnancy, should it occur, and embracing new theories such as the life course perspective, which explains how accumulated social determinants, the deprivations, and chronic stresses "get under the skin," creating health inequities at critical developmental periods (i.e., infancy, early childhood, adolescence) and across generations.

Expanding the traditional MCH approach begins with the vision that all people have the social, political, and economic power necessary to make decisions about their own health, reproduction, and future. Achieving this vision requires collaborating within and outside of public health to eliminate inequities in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable.² By addressing the social and structural conditions associated with poor physical and mental health (e.g., poverty, substandard education, exposure to violence and trauma, and structural racism), public health can have a direct impact on reproductive health and the health of children, youth, and families, which at the most basic level, are the foundation of a healthy community.

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Preconception Health+Health Care Initiative

A National Public-Private Partnership

However, in many instances little synergy exists between MCH leaders advancing the life course perspective and public health professionals who champion health equity approaches. Segregation of MCH and health equity work within public health agencies limits dialogue about equity as it relates to reproductive health and the health of children, youth, and families. Further, the theoretical concepts guiding this discussion remain abstract for many practitioners and for women and men of reproductive age.

Creating the conditions for healthy reproduction and well-being across the lifespan, starting with the earliest stages, can have implications for the majority of the population and future generations. Having conversations about this vision and its obstacles may disrupt, reinvent, and widen the lens through which this work is done. Public health must create space for a more collective approach and a new language that unites and advances a vision for healthy women, men, youth, children, families, and communities.

The following questions can help start the conversation:

- What is provocative about this vision? What is missing?
- How does this vision relate to real experiences?
- What obstacles might exist?
- What tools are needed to start a new conversation in the community?
- What difference could starting a new conversation make in the community? 

Join the conversation by sharing your responses to these questions and ideas with the National Preconception Health and Health Care Initiative's Public Health Workgroup (sarahv@med.unc.edu).

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NACCHO Exchange, the quarterly magazine of the National Association of County and City Health Officials (NACCHO), reaches every local health department in the nation. It presents successful and effective resources, tools, programs, and practices to help local public health professionals protect and improve the health of all people and all communities.

Mailing and Contact Information

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