community-based public health
POLICY & PRACTICE
Partnership for the Public's Health
a collaboration of The California Endowment and the Public Health Institute
Issue #1

The Partnership for the Public's Health (PPH), a collaboration of The California Endowment and the Public Health Institute, is publishing a series of policy briefs on the various components of Community-Based Public Health (CBPH) *and associated issues. As early as 1988, the Institute of Medicine noted that public health should be "what we as a society do collectively to assure the conditions in which people can be healthy."*[1] *That collective approach drives the PPH Initiative.*

This first issue was co-authored by two representatives of the many kinds of people and organizations involved in CBPH. Wendel Brunner, PhD, MD, Director of Public Health for Contra Costa Health Services (CCHS), and Barbara Becnel, director of the West County Health Collaborative, were invited to write the first brief because as part of the PPH grantee network in Contra Costa County, they both represent organizations that are part of our statewide initiative to support effective partnerships between local health departments and community groups. Our third contributor, Joan Ryan, originally wrote her column for publication in the San Francisco *Chronicle*. The collaboration Ryan describes, between CCHS and several community groups, actually began several years before PPH. We include it here because it shows the actual impact of combining the strengths and resources of a local health department with those of community residents.

The Partnership for the Public's Health believes that *CBPH* improves the physical, social, and economic conditions of a community through *community empowerment and collaboration with health departments and with other public and private agencies and institutions. CBPH is the set of strategies and actions that re-focus the practice of public health towards and with the community.* Public health departments, the principal set of government entities with the mission to protect and improve the health of the community, become more effective at accomplishing mandated functions when communities are true partners in these endeavors.

In the PPH Initiative as a whole, and in this series of policy briefs, we emphasize the definition of community that describes a geographic location, because we know that change in a community has the best chance of being sustained if it is initiated and owned by the residents who live there. PPH chose local public health departments as the partnering agencies with communities because, although they may not be the *only* institutions with a responsibility for improved community health, they are the principal ones. They can provide access and entr e to bring other institutional partners to the collaborative table that represents the larger public health system.

We welcome you to our first issue of *Community-Based Public Health: Policy and Practice*, and we hope that you will be provoked, delighted and inspired by these stories.

COMMUNITY: A group of people residing in the same geographic area

BASED: Referring to the point at which a process is begun

PUBLIC: Of, pertaining to, or affecting the community, or the people as a whole; serving or acting for the community

HEALTH: Optimal physical, mental, social, economic, and spiritual well-being (and for communities, add "environmental")

1 Committee for the Study of the Future of Public Health, Division of Health Care Services, Institute of Medicine. The Future of Public Health. Washington, DC: National Academy Press, 1988.

Community-Based Public Health:
A Model for Local Success

Wendel Brunner, PhD, MD

The mission of local public health is to promote the overall health and well-being of the community, address the causes of disease and disability, and provide ethical and tenacious leadership to implement effective health policies and programs. To realize this ambitious agenda, however, local health departments can't act alone. Health departments need to form partnerships with mobilized neighborhoods and communities, as part of a spectrum of strategies to improve public health.

Involving communities is a new approach for public health. For much of the twentieth century, public health has focused on the control of communicable disease, applying the scientific disciplines of epidemiology, sanitary engineering, and microbiology. Public health nurses promoted maternal and child health, teaching masses of rural immigrants basic hygiene, nutrition, and how to melt into the pot of urban American life. Public health made tremendous strides, but the focus was on the expertise of scientifically trained public health practitioners directed toward pre-defined outcomes and governed by unquestioned social mores.

The public health epidemiologist of the twenty-first century, however, sees that the leading causes of death are now chronic diseases such as cancer, heart disease, and stroke, which disproportionately impact low-income and minority communities. Community public health issues include domestic violence, childhood obesity, drug abuse, and environmental contamination, all entwined in complex ways. In our West County Health Collaborative, an area with major toxic pollution and substandard housing, lead is the leading killer of children. The lead doesn't come from waste sites or paint chips, however. It comes from handguns. Successfully addressing a problem like this involves much more than epidemiology.

"I wish they would leave the politics out of public health," lamented one health officer at the last statewide meeting, "and let public health be directed by scientific expertise." Addressing today's public health problems, however, requires a community as well as a scientific approach. It doesn't work to enter low-income neighborhoods and lecture residents to stop smoking and eat five-a-day servings of vegetables to diminish their chance of getting cancer or heart disease. These messages fail to capture the interest of communities confronting more urgent concerns of violence, drugs, unemployment, and the struggle to hold families together.

Instead, health departments must be willing to meet with communities and share the agenda, prioritizing community concerns as well as health department goals. We have to demonstrate to communities that working with the health department will advance their own agendas and improve their lives. If we are successful, we will find that communities bring enormous assets to bear on the health issues that affect their lives. Communities have informal networks; institutions like schools, churches, and neighborhood associations; political will and commitment; and knowledge and expertise about the community and its values. Since the mission of public health is to promote the overall health and well-being of the community, there is certainly a basis for many common goals and priorities. In our experience, communities and the health department do identify goals together that address major health issues.

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Community partnership implies that the health department and the community agencies each bring an important expertise to the table to achieve a common goal. The health department contributes, at minimum, a professional knowledge of public health and health issues of the community. The community partner brings at least a knowledge of the community experience, goals, aspirations, and problems of the residents. Establishing successful partnerships between health departments and communities involves account-

ability and trust, and that takes time. It requires years of consistently keeping promises, demonstrating respect, and producing at least some results.

This partnership can be very uncomfortable for health departments. We are trained as public health professionals to use our scientific knowledge to act on behalf of the community to accomplish goals quickly and efficiently. Engaging in a genuine partnership with communities requires giving up a degree of control over outcomes. Categorical funding is also a barrier. Funders expect regular progress reports with predetermined goals and objectives checked off according to an established timeline. Communities, who are seldom consulted when the grant is written or the program designed, may have other priorities.

Local health departments, along with communities, have the greatest stake in effective community partnerships, and are the institutions best situated to advocate for community priorities. Unlike academic institutions, foundations, or state agencies, local health departments are directly accountable to local communities through the democratic process, to city council members and district supervisors who are grounded in neighborhoods. Health departments must likewise insist on accountability from other agencies that want to partner in our communities. After the research project is over or the grant funding has ended, ethical, tenacious health departments will be working with communities to promote overall health and well-being.

Engaging in a genuine partnership with communities requires giving up a degree of control over outcomes.

Community-Based Public Health:

Lessons on Power, Policy and Grassroots Leadership

Barbara Becnel

Barbara Becnel is the Executive Director of the West County Health Collaborative in Contra Costa County, California. She is a published author, and has more than 20 years of experience as a public policy analyst.

During the summer of 1992, shortly after the civil unrest in Los Angeles provoked by not-guilty verdicts given to police officers accused of the videotaped Rodney King beating, I interviewed several members of the Los Angeles Police Department. I was researching the evolution of LA's youth gangs. In various ways, each of the officers echoed what one police officer explicitly stated in describing the treatment of people residing in low-income southern California communities:

> *When I was about to be transferred from Watts to a well-to-do part of town, I was pulled aside by my Lieutenant and told, `Now don't forget, you're going to a community where people have jobs. So, you have to be careful. You can't talk to those people any old way like you can to the people in Watts.'*

From a grassroots perspective, the lessons this anecdote provides – about power, (informal) policy and resident leadership – are legitimate fodder for a discussion about community-based public health.

Traditionally, community-based public health has stood for community empowerment via the uplifting of the role of residents and local groups so that they can assist in developing the policy and programs that affect the health and well-being of neighborhoods. The community-based public health model also promotes an ultimate equal-leadership endgame that involves two key entities. One is a "professionalized" grassroots community brought about through capacity-building and collaboration – and the other, a body of public and private agencies that have learned how to share power with this newly empowered community and that genuinely values its input.

These would be good results, particularly for a lower income community that has for years been marginalized by its local public and private institutions. But do the anticipated outcomes of a successfully implemented community-based public health model go far enough? In other words, will this model allow a lower income community to achieve what its higher income counterpart has already achieved – to be viewed, as described in the police story, not as an equal partner with law enforcement or other local entities, but as the lead or senior partner?

The Lieutenant in that story instructed his officer about an informal policy – his officer should not dare to speak disrespectfully to more affluent residents. The core lesson was that that community would not tolerate such behavior. Thus, the power and leadership of the community were vested in the residents, not the officers or the institution the officers represented. An omnipotent resident-as-leader public health model informed the politics and policy of "appropriate" law enforcement behavior. Current definitions of community-based public health come close to achieving this resident-dominant model, but miss the mark because of a significant nuance concerning the concept of partnership.

The development of a viable partnership with local institutions is – from the point of view of the grassroots community – not a partnership fashioned of equal leaders, but a partnership of entities that play equally important roles.

The development of a viable partnership with local institutions is – from the point of view of the grassroots community – not a partnership fashioned of equal leaders, but a partnership of entities that play equally important roles. This may mean that grassroots leadership has to wrest the power to define policy and develop programs away from long-time stakeholders and change longstanding policies. But it is possible, as the following tale demonstrates.

Policy Brief Feedback Form

The Partnership for the Public's Health would like to hear your thoughts about our new series of policy briefs. Your feedback is much appreciated, and will help us improve future issues. It should only take about five minutes to fill out this form.

Name_____

Organization _____

Address _____

City _____

State_____ Zip _____

Phone _____

Fax _____

E-mail _____

Please fax this form and any additional comments to: Partnership for the Public's Health
ATTN: Adele Amodeo
Fax number: 510.451.8606

This form will also be available on the PPH website, at www.PartnershipPH.org. If you wish, you may download the form there, and e-mail it to PPH at aamodeo@partnershipPH.org.

Thank you!

1. Did the policy brief cover issues that are of concern to you? ❑Yes ❑No
2. Do you think that you will use the information covered in the policy brief in your work? ❑Yes ❑No
3. Are the resources provided at the end of the brief useful to you? ❑Yes ❑No
4. Do you know of additional resources that are relevant to the topics covered in the brief? ❑Yes ❑No
   If yes, please describe: _____
   _____
5. Do you have suggestions for future topics for these policy briefs? ❑Yes ❑No
   If yes, please describe: _____
   _____
6. Would you be willing to write a future policy brief? ❑Yes ❑No
   If yes, is there a particular topic that you would like to cover?
   Please describe: _____
   _____
7. Further comments (please attach additional sheets of paper if necessary):
   _____
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Best Practices – Grassroots-Style

I am Co-Chair of a Contra Costa County public employment agency that serves youth. I am also Executive Director of the lead organization of a PPH community grantee, the West County Health Collaborative, composed of community-based organizations and residents. In my role as Co-Chair of the county youth agency, I had a decision to make. It was time to renew the contract of the youth agency's sole provider of services for young people – a large public educational institution ("The Institution") that had exclusively received funding from this source for many years. But the law had changed, requiring more emphasis on hard-to-serve, out-of-school youth – most likely ex-offenders.

The Institution was experiencing difficulty recruiting such participants; grassroots groups were likely to do a better job. But it was not eager to give up any portion of its funding to other organizations, and the county youth agency was resistant to changing what had become a systems issue – The Institution applied for funds, provided services and got its contract renewed routinely.

When a political fight ensued over my intention to allocate nearly a third of the overall employment funds to community-based groups, I relied on grassroots leadership and a strategic plan to win a very tough battle. Residents and community-based organizations belonging to all three West, East and Central Contra Costa County Partnership Health Collaboratives recognized that this was an issue that impacted the entire county, so they recruited people from their communities to attend a public meeting where the final decision would be made after a vote. Neither The Institution nor the public employment agency had ever experienced at one of these regularly scheduled meetings a standing-room-only crowd, not to mention a crowd of multi-ethnic residents of all ages who spoke with passion, *instructing* agency members to vote in favor of supporting grassroots groups. It was a stunning moment. The community prevailed.

These days, our community is moving forward with more confidence, as it should. We are motivated by the knowledge that lower-income communities have a right to what higher income communities already experience: entitlement to a leadership role in ensuring the health and well-being of their own residents and neighborhoods.

The Power of Ordinary People

Joan Ryan

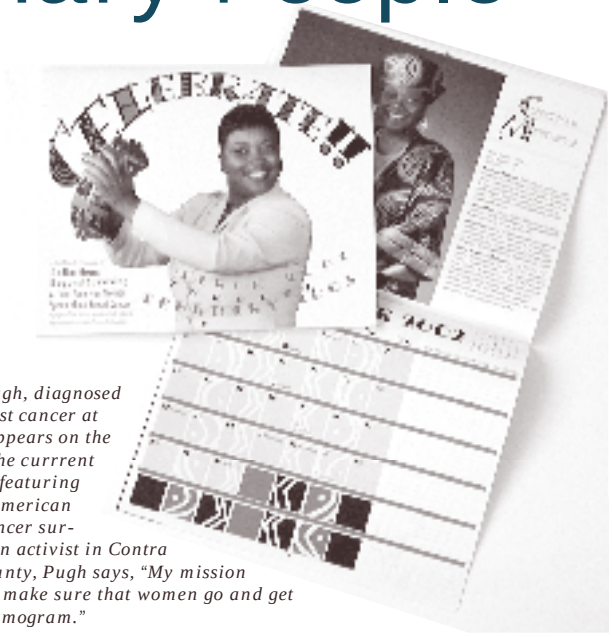
First published in the San Francisco Chronicle *on Friday, June 8, 2001.*

This is the unlikely story about what happens when government officials skip the bureaucratic mission statement to embrace the mission itself.

It begins in 1992 in an office in Contra Costa County. The public health department staff was reviewing yet another sobering study. It showed that African Americans still received significantly poorer health services than Caucasians. The disparity was starkest in the breast cancer statistics.

In Contra Costa County, white women had a much higher incidence of breast cancer than black women: 154 per 100,000 for whites compared to 110 per 100,000 for blacks. But black women were more likely to die from the disease: 35 deaths per 100,000 vs. 26 per 100,000 for whites.

One reason, the staff concluded, had to be early detection. They knew from the 1992 statistics that 71 percent of white women but only 44 percent of black women were diagnosed at an early stage of the cancer. Chances of survival diminish the later the cancer is detected. If



Jackie Pugh, diagnosed with breast cancer at age 27, appears on the cover of the currrent calendar featuring African American breast cancer survivors. An activist in Contra Costa County, Pugh says, "My mission now is to make sure that women go and get that mammogram."

they could close this gap, they could close the gap in the mortality rate.

No county in California, and perhaps in the nation, had brought about parity in breast cancer survival rates between white and black women. But that's what Contra Costa County set out to do. They knew it would mean chipping away at cultural beliefs, economic barriers and government intransigence. They knew they would have to mobilize an army of activists and health care professionals.

"There was a sense that these disparities were some inevitable fact of nature," said Dr. Wendell Brunner, Contra Costa County's director of public health. "But we knew the cause could be identified, addressed and eliminated."

By the end of that year, the University of California at San Francisco was regularly sending a mammography van into Contra Costa neighborhoods. The county held the first in a series of Women's Health Days at Martin Luther King Jr. Health Center in Richmond, offering uninsured and underinsured women free breast and cervical screenings.

Local groups, including the school districts, hospitals and American Cancer Society, introduced a breast health education project at Contra Costa high schools in 1994. The following year, the county procured funding through a new state tobacco tax for the Breast Cancer Early Detection Program, which provided free breast exams and mammograms.

By 1996, health advocates were out talking one-on-one with women and driving them to health centers for breast exams and pap smears. By 1998, office walls all over the county were decorated with calendars featuring 19 local African American breast cancer survivors. Wanna Wright was the cover girl.

"A lot of African Americans saw what happened to women with breast cancer. They not only died, but they died an agonizing death," said Wright, a 22-year survivor. "There was a feeling that there was nothing anybody could for them, so why find out?"

The results of the county's work arrived this year in a packet of the latest statistics: 71 percent of BOTH white and black women with breast cancer were diagnosed at an early stage. It will be a few years to gather mortality rates, but the expectation is that the gap will be considerably narrowed.

Breast cancer isn't the only health disparity between blacks and whites. But by conquering this one, Contra Costa showed that the disparities can be closed. It also showed the power of ordinary people — even government people — to bring about revolutions.

For More Information

The Partnership for the Public's Health website – Information about the Partnership, and links to the following community resources and useful documents. http://www.partnershipPH.org

Community Toolbox – website through the University of Kansas which is available for community organizers to share their work. It offers how-to materials, guides for community problem solving and a general store with recommendations of books and products. http://ctb.lsi.ukans.edu/

Community-Based Public Health Caucus, APHA – http://www.sph.umich.edu/cbph/caucus

The Mobilizing for Action through Planning and Partnerships (MAPP) Website – Tools, references and resources, and case vignettes are available on the National Association of County and City Health Officials (NACCHO) website. Access to the website is free. http://www.naccho.org/project77.cfm

The MAPP Field Guide – a 24-page booklet will provide an easy-to-read overview of the MAPP process and point readers to the website for more information. Contact NACCHO's publications office or visit http://www.naccho.org/prod102.cfm for ordering information.

McKnight, JL and Kretzmann, JP. **Mapping Community Capacity**. Evanston, IL: Institute for Policy Research, Northwestern University, 1996. Available at http://www.northwestern.edu/IPR/publications/mcc.html

About this Series

The policy brief series is part of PPH's commitment to its grantee partners; the California Endowment (which supports PPH); and the larger public health world. Each brief will define terms, identify challenges, share success stories and best practices, indicate issues for policy and systems change, and point towards key sources of further information. We encourage feedback and suggestions from our readers (please email Adele Amodeo at aamodeo@partnershipPH.org).

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