

N A C C H O Exchange

Volume 20, Issue 1
Winter 2021
Health Equity



Promoting Effective Local Public Health Practice

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National Association of County & City Health Officials

The National Connection for Local Public Health



Taking a Public Health Approach to Address Structural Racism and Mitigate Health Inequity

By Lori Tremmel Freeman, MBA, NACCHO Chief Executive Office

In unique—and sometimes fleeting—moments in time, we are compelled to listen closely to what we are seeing and hearing and determine how we will respond as individuals, organizations, communities, and as a country. This moment is upon us. What we are seeing and hearing and experiencing is a clear, pent-up demand for racial justice and equality—a long-time crisis of its own—converging with COVID-19, political unrest, and the need for fundamental social change. This issue of Exchange describes and interprets some of this work and the renewed energy, spurred by recent events, that have catapulted health equity to new levels of awareness and the need for social transformation.

Structural Racism. Racial Equity. Systemic Racism. White Privilege. Institutional Racism. Diversity. Ethnicity. Cultural Representations. National Values. Progress and Retrenchment. These are some of the concepts we should all explore more closely to strategize collectively against structural racism, according to work done by the Aspen Institute Roundtable on Community Change, a group that worked with leading innovators to produce strong and reliable frameworks for successful and sustainable community change and development nearly five years ago, in 2016.

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Shifting and Sharing Power: Public Health's Charge in Building Community Power

By Lili Farhang and Megan Gaydos, Human Impact Partners



Local health departments (LHDs) around the country are making tremendous progress in explicitly committing to end structural racism as a strategy to achieve health equity. Many local and state governments are passing resolutions and training staff on equity, creating and implementing work plans, and shifting organizational policies, practices, and culture to advance equity. This suggests palpable energy and momentum to address the ongoing effects of this country's founding sins of genocide and slavery.

Alongside this progress, LHDs are also growing more curious about the concept of power, especially in light of the strong and well-researched connection between greater levels of democracy and higher life expectancy, and living healthier, more productive lives. Building power at a small scale within historically marginalized communities has the potential to transform how decisions are made, by whom, for whom, and with whom—all of which lead to improved health equity outcomes. Community power building is not only a process to achieving health equity, but is an outcome in and of itself.

Some LHDs have begun to build and share power with communities—a core strategy to achieving health and racial equity goals. Indeed, social justice advocates have long understood that achieving racial equity is necessarily about building power in communities most harmed by inequities, and which have been most disenfranchised from centers of power.

This article describes frameworks to explore the concept of power and its dynamics, and community power building; how health departments' explicit support for power building with grassroots community organizations is a strategy to achieve health equity; and relevant examples and resources for health departments.

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Defining and Understanding How “Power” Operates

The Grassroots Policy Project outlines three distinct, but interrelated, dimensions of power:

- 1. Organizing people and resources for direct political involvement in visible decision-making arenas.** Most campaigns, organizing, and electoral work that we see today focuses on this dimension of power.
- 2. Building durable, long-term political infrastructure—or networks of organizations—aligned around shared goals and ability to shape political agendas.** This is best embodied by issues prioritized for discussion in political and administrative hearings, agendas, and other settings.
- 3. Making meaning on the terrain of ideology and worldview.** This is about shifting narratives and shaping people's conscious and unconscious understanding of the world, especially in ways that change their ability to ask questions and offer ideas about what is possible.

Ultimately, racial, class, gender, and other hierarchies serve to maintain power and privilege for some, at the expense of others. Communities who are politically, socially, culturally, and economically marginalized—including people of color, immigrants, the working class, people with disabilities, women, LGBTQ people, and many others—have less power across all these dimensions.

This is not accidental, but the result of social structures and resources in service of a dominant culture that sustains inequality and hierarchies associated with structural racism, class, and gender oppression, placing economic interests above meeting human needs. When power is grossly out of balance, certain social groups or organized networks have enormous capacity to shape laws, make meaning, and actively suppress interests that threaten their hold on that power. These groups and organized networks are familiar to all of us: trade associations, business roundtables, chambers of commerce, the finance and banking industry, real estate developers, natural resource extraction corporations, and many others.

Another explanation of power comes from the University of Southern California's Equity Research Institute (USC ERI). *Changing States: A Framework for Progressive Governance* describes six arenas in which ideas, policies, and power are contested, including the electoral, legislative, judicial, administrative, communications, and corporate arenas. Understanding and influencing the rules, structures, and processes in each arena is essential to achieving “progressive governance,” or the ability to implement and sustain long-term systemic change that achieves health and equity for all.

Building Community Power as an Antidote to Health Inequity

Governmental public health must investigate the terrains on which power operates, and to learn strategies to influence that terrain to eliminate inequities. Chief among these strategies is helping to build community power, sharing power with communities experiencing inequities, and using their own power to confront inequities. This requires more than one-off coalitions on single issues; ideally, the creation of permanent alliances should be the goal.

Why do LHDs and their communities need to help build power to achieve health equity? Health and well-being, in its fullest sense, is an emancipatory idea, inescapably political because it is socially and politically produced, not random. Health inequity results from intersecting oppressions, and from antagonistic interests and deep social divisions (i.e., not simple prejudice). Eliminating them cannot happen without struggle, pressure, and organizing. This requires a strategy to build power, as a means to overcome the organized networks that shape laws, make meaning, and oppose social change.

A commitment to sharing power means strengthening democracy. It means widening—and shifting—the circle of people and communities involved in making

“Power properly understood is nothing but the ability to achieve purpose. It is the strength required to bring about social, political, and economic change.”

—Dr. Martin Luther King Jr., *Where Do We Go from Here: Chaos or Community*

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decisions in all arenas, in determining strategies, and in having people most impacted by inequities determine our change processes and choices.

As described by USC ERI in their primer, *Leading Locally: A Community Power-building Approach To Structural Change*, “Community power is the ability of communities most impacted by structural inequity to develop, sustain and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision makers that change systems and advance health equity.” Building community power is an approach to shaping the conditions needed for healthy and equitable communities via the development and implementation of policy, practice, and structural change.

Perhaps the most effective organizations to build community power are grassroots community organizations, also known as community organizing groups, or community power building organizations (CPBOs). These groups explicitly work to transform power—its rules and structures, and decision-making in communities, focusing on those most impacted by structural oppression.

They engage communities, assemble them to make connections across their lived experiences and conditions, and take collective action. They often focus on improving the social, economic, and environmental determinants of health inequity—even if they don't use those words. CPBOs engage impacted communities to set agendas, create and sustain healthy communities, and change systems, while building leadership, skills, and expertise to achieve and oversee that agenda.

As stated by USC ERI, “A guiding principle is that community members are themselves experts in their own lived experiences and problems that their community faces... [CPBOs] place members in control of the design and implementation of collective efforts to improve their day-to-day lives.” Given



this, CPBOs are distinct from general community-based organizations, since the former always have an intentional leadership development or power-building component to their work, beyond services.

Community Power Building Organizations are Natural Allies for Public Health

LHDs have been committed to community engagement for decades, and have many institutional mechanisms to work with communities. Indeed, one of the ten essential public health services is to “strengthen, support, and mobilize communities and partnerships.”

Implicit in these practices is the notion that communities should participate in a department's planning and programming. Much less clear is their authority and power in decision-making. But sharing power with communities in decision-making is, in and of itself, supporting community power building. This is our growing edge in public health—to shift the purpose of our community engagement to be in service of community power building.

CPBOs can be valuable and effective partners for health departments to achieve this goal. The following aspects of CPBOs make them natural allies for local health departments:

- They directly engage, build the leadership of, and are accountable to people and communities most impacted by inequities.
- They bring vision and skills to challenge structural racism and other forms of oppression, and to build power to make long-lasting change.
- They have a structural understanding and experience working to advance equitable policy and systems change at all levels of government.
- They bring experience at applying political pressure and managing the power dynamics inherent in making social change.

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Last year, Human Impact Partners published, *Building Power to Advance Health Equity: A Survey of Health Departments About their Collaborations with Community Power Building Organizations*, as part of the Robert Wood Johnson Foundation-funded project, Lead Local. The report summarizes findings from a survey of staff at 29 health departments about their experiences working with CPBOs. It offers valuable insights into why health departments should collaborate with CPBOs, and concrete suggestions for how to do so.

The report profiles numerous HD-CPBO collaborations that sought to improve the social, economic, and political conditions that create health and exacerbate inequities. For example:

Kansas City (MO) collaborated with Communities Creating Opportunity and others to:

- Increase healthcare funding for the uninsured
- Remove mandatory disclosure of criminal history on job applications
- Provide paid parental leave
- Increase the number of banks providing reasonable small loans
- Include life expectancy as a measure of success in the city's business plan

Cook County (IL) partnered with the Collaborative for Health Equity, Restaurant Opportunities Center, and other CPBOs to:

- Support the passage of a city living-wage ordinance
- Adopt a welcoming village ordinance
- Limit collection of information about immigration status
- Work to address wage theft

Alameda County (CA) collaborated with Causa Justa: Just Cause and other CPBOs to help pass:

- An ordinance to cap rent increases
- Just-cause eviction protection and other renters' protections
- An affordable housing bond
- A policy requiring banks to abate blight in foreclosed properties or pay a fine
- Proactive code enforcement inspections to address health-related housing complaints

In each of these partnerships, the health department leveraged their power as a government agency to provide data and information, respond to community requests, testify when requested, and elevate the health impacts of policy decisions. CPBOs brought community members together and assumed more explicit advocacy roles to support policy change.

These roles represented unique contributions that matched each organization's institutional strengths and cultures. Their partnerships resulted in transformative improvements in the living and working conditions of communities disproportionately harmed by inequities. To learn more about how these institutions worked together and how they achieved their goals, see the above-referenced report.

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Local Health Department Strategies and Actions to Support Community Power Building

There are countless ways to get started on this work. Here are a few ideas based on our survey of health departments, as well as our own experience supporting HD-CPBO collaborations:

- 1. Identify local CPBOs you want to connect with:** Check out this list of organizations (<https://bit.ly/3aN4PXU>) to find CPBOs in your area. Seek out new relationships, besides those you know.
- 2. Learn about them:** Before connecting, read about their work. Research recent reports, strategic plans, and/or social media, and notice the organization's priorities, commitments, and with whom they are engaging or partnering.
- 3. Be flexible and persistent in communication:** Organizers often have very busy and evolving schedules, and health departments can sometimes move slower than CPBOs. Accommodate their priorities as you schedule meetings, and know that connecting via text or social media may be better than email.
- 4. Intentionally pursue activities together that build and deepen trust:** It takes time to build a trusting relationship, especially in communities harmed by inequities, which may have made them wary of government. Trust is built by sharing values; being transparent about limitations and capacities; and showing willingness to commit, follow through, and receive feedback about the effects of one's actions to improve collaboration.
- 5. Start with small, concrete collaborations:** Establish short-term goals to help create small wins that build trust and support for a longer-term relationship. This can include inviting organizers to staff meetings, sharing health data relevant to their policy priorities, and/or inviting organizers to provide input on community health plans or reports.
- 6. Mobilize public health resources, such as data and evidence, to advance CPBO goals:** Health departments often have abundant data and evidence at their fingertips. Identify the demographic, health, social determinants, or other data that might be helpful in advancing organizing goals, and share it in ways that meet their needs and narrative.
- 7. Do a power analysis together and understand structural reforms that CPBOs are prioritizing:** Analyze who holds power over decision-making, and strategize how to influence those decisions and the process by which they are made in ways that achieve community-identified policy and systems change.

"The partnership allows us to be involved in issues without overstepping our bounds as a government agency. The activities that we would be prohibited from doing can be taken on by the organizers, and we can leverage their work by offering supporting data and information related to their priorities."

—Health Department
Staff Responses to HIP
Survey

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The Time to Invest In Power Building is Now

Although partnerships between health departments and CPBOs constitute a relatively new field of practice, a good foundation and numerous examples exist to build from. These collaborations have tangible impacts both to improve the conditions of people's lives, as well as to transform governance in enduring ways.

Anecdotally, we have heard that health departments who already had relationships with community power-building organizations have been able to leverage those relationships in their COVID response to more quickly target and support communities impacted by COVID.

This included the ability to quickly receive on-the-ground insights about needs for testing, care, and vaccination options; to quickly disseminate information in culturally appropriate and language-accessible ways; and to have the community contribute different COVID response options and allocation of resources.

Collaborations between health departments and CPBOs are an opening to transform public health and government more broadly, ultimately undoing the deep power imbalances that motivate and manifest in health inequities. Undoing these imbalances means undoing inequitable power dynamics, reshaping governance and governing systems, especially with respect to who can participate and who is accountable, and setting the rules of political engagement so no one class or group dominates.

As always, but particularly in this moment of racial reckoning, health departments must develop these kinds of strategies to share and build power—widening the range of people and communities involved in decision-making in all our arenas of influence, and in driving our processes and choices. Nothing short of this kind of transformational change is needed.

The following are resources to learn more about the concepts of power, community power building, and achieving health equity:

- Building Power to Advance Health Equity: A Survey of Health Departments About their Collaborations with Community Power Building Organizations, Human Impact Partners (<https://bit.ly/3aSbgsG>)
- Changing States: A Framework for Progressive Governance, USC Dornsife Equity Research Institute (<https://bit.ly/2MPRXZ8>)
- Power and Social Change, Grassroots Policy Project (www.grassrootspolicy.org/)
- Health Equity Guide, Human Impact Partners (www.humanimpact.org)
- Leading Locally: A Community Power-building Approach To Structural Change, USC Dornsife Equity Research Institute (www.lead-local.org/findings)
- The Lead Local Collaborative: Exploring Community-Driven Change and the Power of Collective Action (<https://www.lead-local.org/>)
- Power Moves Assessment Guide, National Committee for Responsive Philanthropy (<https://bit.ly/3cYJbTf>)
- Ten Essential Public Health Services, de Beaumont Foundation (www.debeaumont.org/10-essential-services/) 

"[Collaboration with community organizers] has helped to create urgency around our work. It has created a healthy tension for us to take positions on issues that matter to our constituents. It has also pushed us to engage more with policies that affect our constituents... [and] understand how we can be relevant to communities that are oppressed."

—Health Department Staff
Responses to HIP Survey



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National Health Observances

March: National Nutrition Month

April: World AIDS Day & National Influenza Vaccination Week






May: National Birth Defects Prevention Month

Special Thanks

NACCHO thanks all the contributing authors for their involvement in this issue. Thanks also go to the NACCHO staff members responsible for making this issue a success: Chris Aldridge, Anna Clayton, Ashley Edmiston, Tahlia Gousse, Andrea Grenadier, Kellie Hall, Richard Hofrichter, Peter Holtgrave, Taylarr Lopez, Sara Lyons, Geoffrey Mwaungulu, Lucy Slater, Pooja Verma, and Alix Ware.

ENVIRONMENTAL IMPACT STATEMENT

1225 LBS OF PAPER MADE WITH 25% POST CONSUMER RECYCLED FIBER SAVES...

-  1,242 lbs wood A total of 4 trees that supplies enough oxygen for 2 people annually.
-  1,814 gal water Enough water to take 105 eight-minute showers.
-  1mln BTUs energy Enough energy to power an average American household for 5 days.
-  377 lbs emissions Carbon sequestered by 4 tree seedlings grown for 10 years.
-  110 lbs solid waste Trash thrown away by 24 people in a single day.

