The California Endowment

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Research, Practice, and Policy:
Key Strategies to Reduce Health Disparities
Through a Focus on Communities

A Report of a Convening Hosted by
The California Endowment and PolicyLink
Woodland Hills, CA, October 26-27, 2005

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Introduction

Community conditions impact residents' health, and those conditions can be improved through a wide range of public policies that reach well beyond what is often understood as "health care." In recent years, for example, the following physical and economic improvements to communities—and thereby to residents' health—have come about through well-crafted campaigns to change or enact policies:

- Required cleanup of toxic waste dumps in communities;
- Higher minimum wages;
- Improved housing code enforcement;
- Funds for building or cleaning up local parks;
- Improved indoor air quality in schools; and
- Construction of grocery stores in underserved communities.

Achieving these goals depends on the combination of useful research, community-based insights and advocacy, alliances, and well-crafted strategies. But how can researchers, practitioners, and policy advocates work together to reach the goal of a healthy community—a safe environment, access to fresh food, and available neighborhood facilities that promote healthy lifestyles? To answer this question, The California Endowment (TCE) and PolicyLink invited 31 of the country's leading researchers and health practitioners to a day of provocative discussion.[1]

Participants included researchers in the areas of racial and ethnic disparities in health, neighborhood influences on health, racial discrimination, socioeconomic status and health, housing and health, and access to care. The researchers included pioneers in Community Based Participatory Research (CBPR) and others whose epidemiological, sociological, or political analyses have been carried out in a more conventional style. Also present were: leaders of community health clinics and child development programs that have taken a comprehensive view of neighborhood factors;[2] staff members of foundation initiatives that address community factors affecting disparities in asthma, obesity, and employment opportunities; and representatives of California local public health agencies. Many of the participants, researchers and practitioners alike, had extensive knowledge of the process of informing, creating, and implementing public policies. All came prepared to share their insights and to shape the next steps for creating healthy communities.

In his opening remarks, Dr. Robert Ross, President and CEO of The California Endowment (TCE), discussed the foundation's commitment to eliminating health disparities through a variety of approaches, one of the most critical being a focus on changing neighborhood conditions. TCE is funding three initiatives in particular to address this concern, and each was represented at the meeting.[3] The initiatives have been based on the growing body of evidence about social and economic determinants of health and about the influence of community factors. Each supports a place-based approach that relies on coalitions to evaluate environmental conditions and to identify and advocate for policy changes to improve individual and community health. Success depends on organized communities, compelling research, savvy advocacy strategies, and well-crafted policy proposals.

Ross noted, as did Angela Glover Blackwell, Founder and CEO of PolicyLink,[4] the principal facilitator for the convening, that a gathering of researchers, community practitioners, and policy advocates was highly uncommon and held great promise. Working

together, the participants could begin to craft key next steps for research and strategies to create healthier communities.

Four kinds of presentations and discussions occurred throughout the day: a facilitated dialogue among a researcher, practitioner, and policy advocate about the intersection of their respective roles,[5] a presentation about a national research project that epitomized many of the issues under discussion,[6] small groups in which participants defined the elements of a healthy community,[7] and extensive discussions among the entire group about the directions for research and policy change to address health disparities. Participants told success stories about diverse policies —from restrictions on the sale of soda in schools to local regulations to reduce diesel vehicle pollution—to illustrate the role of research in policymaking; in some cases, research had played a pivotal role in policy change efforts. Other examples highlighted challenges such as a lack of conclusive evidence or the lack of opportunities for in-depth discussions of research findings in policy debates. Although no formal consensus was sought, a substantial collection of ideas was generated, from which a productive, rough agenda can be created for The California Endowment, for PolicyLink, and for the participants.

This summary draws from all of the sessions, synthesizing comments on common issues from the day. Although a broad range of issues were discussed, they can be captured in two general themes:

Research efforts are crucial, but limited.
Research on the community factors that affect health

disparities is a critical component of the overall effort to eliminate those disparities. However, the contributions of research to good policies and effective practice have been severely limited by the way most research is conducted; important changes are needed if research is to reach its potential of relevance, responsiveness, and usefulness. The three general areas that need to be strengthened are: support for research on community factors affecting health disparities, collaboration between researchers and community in conducting research, and increased capacity of local practitioners and advocates to obtain and use effectively data and research findings.

A conceptual and linguistic framework is needed. Many of us share a sense of the qualities of a healthy community and of how important community change is to overcoming racial and ethnic health disparities. Despite the growing body of evidence, we lack a common, persuasive language and conceptual framework for acting on these general goals and will need both in order to build the necessary public and political will to generate change. We are faced with two distinct but interconnected challenges: to increase awareness of the centrality of community factors in shaping health outcomes in a society and an economy primarily focused on issues of access to medical care; and to increase public understanding of racial and ethnic health disparities.

Discussion of these themes is followed by five case studies involving or suggested by participants at the convening; they illustrate different aspects of relevant research on community health and its relationship to policy and practice.

Making Research Relevant, Useful, and Engaged with Community

Research on the community factors that affect health disparities is a critical component in eliminating those disparities. There are at least five ways in which research can be instrumental:

- Evidence that defines, measures, and illuminates the health consequences of social, economic, and environmental inequities can focus public attention on those problems.
- This kind of evidence is also central to engaging policymakers and obtaining and supporting their commitment to action.
- Surveys of public attitudes, knowledge, and opinions can be invaluable in framing issues and developing strategies for policy change.
- Analyses that clarify the root causes of health problems and that explain the relationships among community factors can guide practitioners in the design of more effective programs.
- Assessments of whether policies and programs are working and whether community health is improving or deteriorating are essential to making informed judgments about what to do next.

Excellent examples of research exist that have been valuable for practice and policymaking. But the potential assets of research are often not realized. The way much health research is designed and implemented puts it beyond contact with community residents and out of touch with their concerns. The imperatives and incentives that drive much of the funding for research are counter to its usefulness for the policy process.

Making research relevant to struggles for healthier communities requires a more reciprocal and productive relationship between researchers and communities. It must redefine research issues so that they can more effectively address community factors that affect health. That improved relationship starts with building trust with communities where, in many cases, distrust of research has been well-earned by past abuses, neglect, or irrelevance. It also requires a more widely shared understanding in the community about the nature of the research process, from the prerequisites for solid analysis to the practicalities of project funding, support, and time frames. A variety of models for building local capacity and engaging community members in the research process were described and critiqued over the course of the convening.

The participants included many prominent community-focused researchers in public health. Both they and the practitioners highlighted projects where the research process had engendered trust and the results were both rigorous and relevant to the policy process. At the same time, the prevailing sense was that such successes are still relatively uncommon because of the ways in which most health-related research is organized, funded, and carried out. The discussions elicited a set of structural and historical reasons for these limitations, for which solutions were later proposed. First: a brief review of the challenges as outlined by the participants.

Challenges

Funding for research and for community health innovations is not geared to time frames that help to link research with practice and policymaking. Practitioners serve people with multiple, urgent, basic needs and are often working with limited resources and staffing. Policymakers work within tight budget and election cycles. Yearly budgets may change priorities or eliminate funding for entire categories of services. This is not an easy environment in which to make a strong connection with a research project that may take years to complete—primarily because most useful health disparities research involves multiyear studies and long-term funding. The speed with which research results are available can sometimes be influenced by public pressure, as the response to AIDS shows; but the nature of some kinds of research nonetheless causes it to take longer than policymakers or practitioners can afford to wait.

Time also presents a challenge to funding community health innovations. Philanthropists are pressed to continually seed new approaches and to turn their attention to new problems. Funding organizations typically operate on two- to five-year cycles. They have to justify to boards of directors the direction

they are taking; they may be unable to award grants to the same organization cycle after cycle. These dueling forces can prevent practitioners from building their capacity to collect, monitor, and maintain data to gauge change over an extended period of time and from building long-term relationships with researchers.

Community conditions and problems change quickly; most research methods do not capture those changes. As one participant observed, "Research provides us with a snapshot and a history, but it doesn't capture changing communities." Practitioners' data and research needs may be difficult to satisfy, especially if community circumstances are in flux. Data can document a point in time, but practitioners need to work in the present as well as with changing circumstances. A typical research project may be complete, with its results interpreted, but then circumstances could change. This can be a problem not only for standard academic research, but for customized, applied data collection efforts as well.

For example, in the Fresno region, the first three years of the California Works for Better Health initiative included needs assessment and capacity building components. However, after data were gathered, while analysis and the programmatic component were getting underway, the community was changing: an additional 2,000 Hmong immigrants moved into the area, and significant data about them were lacking. "We had three years to plan to work in the community, but once we went into implementation, the whole community was different—our research didn't capture that." This problem is one that local data centers such as those in the National Neighborhood Indicators Partnership have tried to address, but their efforts require the resources to collect and manage continually updated information.

Most institutional support for health research still steers away from community factors. Community Based Participatory Research is becoming more accepted, and the links among community, environment, and health outcomes are more commonly acknowledged. Nonetheless, university-based researchers who focus on community factors and health disparities, or on practice- or policy-relevant research in general, can find themselves

professionally in precarious positions. The convening participants elaborated on those perils and disincentives.

Advancement in the research university setting is contingent upon publishing in peer-reviewed journals and obtaining NIH grants. These journals are ranked by impact factor, based on how often other researchers cite the articles that appear in the journals. These types of research projects do not often feature the sort of data or findings that fit in the highest impact or most prestigious journals (e.g., *New England Journal of Medicine, Journal of the American Medical Association,* and *Lancet*). Academic departments tend to assign lesser value to interdisciplinary work or publications that appear outside of the most prestigious journals. The institutional biases toward clinical issues over community factors, as well as the pharmaceutical interventions for specific illnesses over interventions to address environmental or socially determined causes, also skew the research agenda away from a focus on place or on a political and an economic perspective on health disparities.

A "silo" mentality still prevails in most government funding in which research grants are tied to specific diseases or interventions. Typically, attention to practice or policy matters is specifically excluded in research awards[8]; when innovative practices are funded, the evaluation research is usually narrowly defined and highly constrained.

The historical record of harmful research can still present a barrier to building trust.
Researchers must earn the trust of a community in order to conduct quality research on community conditions and to facilitate the use of their research by residents who are working to improve local conditions. The attendees suggested a number of factors that make community residents distrustful of researchers. One noted, "We have to overcome the legacy of abuse and maltreatment by researchers."

Low-income communities of color, in particular, may have had or heard of bad experiences with researchers, or may be skeptical about the capacity for research to bring about change. As a source of distrust, the legacy of the Tuskegee syphilis study still lingers.[9]

Community members have often found research to be a one-way process: researchers arrive, collect information, and leave without sharing their findings or translating their results into practice or policy change, creating a sense of distrust and skepticism. One such example recalled was a school-based research study wherein children's vision, height, weight, and body fat measures were being collected. Yet, the researchers were forbidden to share their data with the families because of ethics rules governing the use of human subjects (put in place, ironically, to prevent abuses such as the Tuskegee study from recurring). Because of this lack of feedback, community members felt alienated from the process. A variation on this theme arises when there is no contact with the researcher and community members learn inadvertently, primarily through news reports, that their community is being "researched."

Practitioners agreed that a long-term commitment to working in the community together is needed. Interested parties from all three sectors—research, community, and public health—must commit to work together over a long period of time and be willing to endure tough times. In the words of one attendee, "This is a marriage, not just a relationship." The need for (1) a substantial investment of time and resources and (2) a capacity to adjust to periods of success and failure over several years presents significant challenges for funding organizations, researchers, practitioners, and policymakers.

Researchers are often reluctant or otherwise unable to make recommendations about practice or policy. A common disconnect was also identified: practitioners want researchers to distill or translate their findings into recommendations, yet researchers shy away from taking this step. The traditional research setting tends to discourage researchers from venturing into practice or policy arenas. Some peer-reviewed journals explicitly forbid policy recommendations in submitted articles. NIH tells grantees not to engage in policy advocacy work.

University-based researchers face other disincentives to making their work directly useful to community practitioners and residents. The peer review journals, in which university-based researchers must focus on publishing, require writing about topics of general—rather than local—applicability, take months if not years in the review process, and push the researcher to move on to the next publication or project even before the results of the previous one are known. These disincentives are handed down to the next generation of professors; the conventional wisdom is to avoid such connections until safely tenured.

Potential Solutions: Community Engagement

The challenges to linking research, practice, and policy are substantial, but substantive solutions were proposed at the convening. The broad notion of an engaged community encompasses a number of key features, including: a population that can actively participate in defining, analyzing, and interpreting its own community health assets and problems; and residents who can speak and act on their own behalf in a variety of policymaking settings as partners, not just clients, of the community-based agencies that serve them.

Participants highlighted the benefits of community engagement in promoting policy change. Community engagement in the research process can help overcome distrust of researchers and ensure that the steps of research—problem definition, data collection, analysis, and presentation—are relevant to community residents' concerns. Participants also noted that community health outreach workers can be a bridge to organizing communities for policy change, effectively reaching residents where they live.

Communities need, and can acquire, policy advocacy skills. In small group discussions about what makes a community healthy, participants in all three groups talked about the need for processes through which communities can become better advocates for the health of their own neighborhoods. Practitioners must secure resources to work with residents to identify and collaborate with critical partners, set priorities, interpret and use data, and build political will for changes in local and state government policy. Building residents' policy advocacy skills was seen as one way to achieve this. The California Endowment supports such training for policy effectiveness in many of its community health initiatives, and a small but growing number of other foundations are assuming a similar agenda.

Communities need, and can acquire, research and data skills. Conventional research is driven by the funder and/or the academic researcher. The researcher frames the question, determines the method by which the question will be answered,

collects data (if necessary), analyzes the data, interprets the results, and writes the report or article describing the conclusions. Conventional research is often criticized for being removed from the reality of neighborhood life or otherwise impractical. One way to overcome such criticism, as well as to acquire better data, is to let community members determine the direction of the research process.

Community Based Participatory Research has recently gained currency, especially among researchers who address health disparities. CBPR is defined as a "collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities."[10] The key principles of CBPR are:

- Recognizing community as a unit of identity;
- Building on strengths and resources;
- Facilitating partnership in all research phases;
- Promoting co-learning and capacity building; and
- Seeking balance between research and action.[11]

The case studies accompanying these proceedings include descriptions of several CBPR projects notable for their impact on policies that affect community factors and health. They are emblematic of this growing arena of research and action. However, participants pointed out that many other kinds of research, such as those involving national studies of large data sets, may be no less valuable to low-income communities or to the overall effort to reduce health disparities, yet do not lend themselves to the same mode of participation and engagement.

Both local health organizations and research institutions will need new sources of flexible, long-term support to implement a community-focused, community-driven research agenda. Greater funding will be needed not only for CBPR endeavors in the formal sense, but also for a broader range of empirical studies, both local and national in scope, that address community factors in health disparities. While it is understandable that researchers will indicate the need for more support, the point made here goes well beyond that. The key to change, our participants said, is for that support to be predicated upon genuine partnerships with community practitioners and clear evidence of how the results could be useful in developing policy. The proposal for next steps at the end of these proceedings elaborates on how those conditions could be met.

Building Public Understanding and Political Will to Reduce Health Disparities and to Emphasize Community

Relevant research and engaged communities are only two of the needed ingredients for meaningful policy change to occur. Participants also acknowledged the importance of building public understanding and political will, recognizing that this starts with such basics as the language with which we speak of health and disparities. They discussed the lack of public awareness about disparities as well as the need to find clear communication that would frame issues in ways that direct attention to disparities.

Language about "place" should be used to help people understand a broader concept of health beyond health care access and quality. One participant framed it simply: "The vast majority of the public thinks of health as clinical care, not healthy people . . . clinical care, not farmers' markets." When thinking about health, the general public will usually focus its attention on insurance or on the access to and quality of medical care. The Centers for Disease Control and Prevention estimate that lack of access to care accounts for only 10 percent of total mortality in the United States. Even within the field of public health research and practice, individual health behaviors receive more attention than social and economic factors. A great challenge in the health disparities field, then, is to increase researchers', practitioners', and policymakers' awareness of the key role that place can play in promoting health and preventing disease.

Participants felt that discussions about place and opportunity could help broaden the public's understanding of health disparities. Neighborhood conditions impact one's access to affordable, nutritious food; safe places to exercise; good air quality; and the degree to which residents feel a sense of safety and connectedness. The concept of

"place" frequently invoked other terms—community, social capital, mutual support, and social networks—that characterized the ways in which people come together in communities. Participants felt these concepts were critical to understanding how policy and practice can jointly promote health or prevent disease.

A campaign must be waged to raise awareness that disparities exist. Professor David Williams of the University of Michigan discussed the need for increasing awareness about disparities, stressing that it would be through this awareness only that meaningful mobilization efforts could occur. He noted a survey conducted by the Kaiser Family Foundation that found that more than half of the adult population is unaware that health disparities exist and that this awareness is not much higher among people of color.[12]

Participants noted that people often take their situation for granted, not realizing things could be better. Betina Jean-Louis from Harlem Children's Zone (HCZ) emphasized the need for practitioners to better inform consumers about health risks in their communities and how health disparities affect them, and mentioned out that "Often people are satisfied with the health care they receive . . . unaware that they are being treated differently." Several participants also pointed out that some community residents do "know there are disparities and know what they are about."

The meanings of the terms we use—health disparities vs. health inequities—must be clear. In raising awareness about health disparities, what language should be used? Some attendees did not like the term *disparities* for several reasons: it

sounds like jargon; it is descriptive, connoting an outcome rather than a process; and it is value-free. More people in communities and the general public, it was suggested, understand *injustice* or *inequities*. These terms connote a normative value and moral standard, building on people's innate sense that the observed differences are inappropriate or unfair. As with other issues of social justice, this awareness can become the basis for deciding that society and government at every level have a responsibility to address the issue.

It was pointed out that both "reducing" and "eliminating" health disparities were being used in the conversation and that the difference might be important. Some participants argued that focused policy change efforts, even those that would improve community environments, can only claim to "reduce" health disparities. "Eliminating" health disparities, it was argued, would require a more fundamental agenda to tackle the root causes of economic and racial injustice, which go beyond most notions of reform. This was not a point that could be resolved at the convening, but it was useful in reminding attendees of the potential depth and scale of the task.

Race is central to the dialogue. "We can't just talk about place; we have to get to racism and structural issues," a participant from the CDC commented. While participants felt that the concept of place could be useful in framing health disparities, there was also recognition that the attention to community factors should not result in forgetting the legacy and continuing impact of structural racism. A concern was raised that place-based strategies to address health disparities could lead to the expectation that solutions to community deficits can be achieved

without reference to race. This would obscure the historic marginalization of people of color, and black people in particular. Racial and economic segregation have deep historical and structural roots and have contributed to the concentration of poverty along racial lines. Given the timing of the convening—shortly after the Hurricane Katrina disaster—participants characterized the graphic suffering of low-income African Americans in New Orleans as a reminder of the interconnectedness of race and neighborhood conditions. Race and ethnicity, it was also noted, were mirrored in the health disparities within Latino and Asian American communities and should be considered in their own right.

Another observation was that many physicians see race as a biological factor, to the exclusion of understanding it as a social phenomenon. According to an online survey of 600 physicians conducted by HCD Research and the Muhlenberg College Institute of Public Opinion, 81 percent of them believed that "race should be used as a biological basis for determining certain ailments or diseases." Race as a biological or genetic factor is heavily contested by social scientists who argue that race is overwhelmingly a socially constructed factor that affects health through perception and prejudice. While there are obviously some genetically specific conditions in talking about race and health disparities, they must be framed as being about social structures and valuing all people equally, rather than dwelling on their genetic or biological differences.

While there was general consensus that race remains critically important, there were varying perspectives about how to ensure that attention is paid in the public discourse. Several attendees pointed out that

race is currently a charged issue. Others did not necessarily see racial/ethnic disparities in health status only as a reflection of poor policy, but rather as in part a reflection of poor choices on the part of minorities. Given this perception, how then should the issues be persuasively framed?

One suggestion was to follow the example of public awareness concerning the negative impacts of smoking: the strongest anti-smoking progress in decades was realized when the impacts of secondhand smoke were widely publicized and understood. The consequences of smoking came to be viewed as more of a *universal* health problem, one needing a *societal* response, rather than consequences confined to individual smokers, requiring a campaign targeted to *individuals* for action. Solutions need to be couched so that the public perceives that "we are all affected by health disparities," regardless of race and economic status. By replicating the secondhand smoke campaign, race must be taken out of the dialogue, or at least out of the headline.

Another perspective presented was that race and racial inequities must be kept in the dialogue, dealing directly with the discomfort they cause. As some participants stated, "If we really want to eliminate disparities, we may have to consider overthrowing the current system (of racial and economic privilege), not just push for incremental changes."

Appealing broadly to the public as opposed to appealing to and organizing specific groups most affected by health disparities surfaced throughout the day. Many participants felt there were opportunities to make broad, universally appealing arguments, the sentiment being that "disparities violate the basic norms of fairness endorsed by most of the population." While health disparities affect large numbers of people, most do not link their plight to the larger issues of social and racial injustice; they may be unaware of how they are impacted by factors that can be prevented. By reframing the issue, broadening the base of support, and increasing general awareness of the sociopolitical forces that unevenly distribute opportunities, the impact of health disparities can be significantly reduced.

Two quotes from the discussion illustrate this line of thinking: "The growing disparity between haves and have-nots cuts across geographic and racial boundaries. Most folks feel they are worse off today than they were 10–20 years ago. People understand haves and have-nots."

Other participants contended that awareness of disparities can be raised by connecting it in the public's mind with the overall crisis in health care. One said, "People who are ill or know someone who's ill, who's had to navigate the health system—doctors are united under this banner." Another mentioned that "Most people in the U.S. are concerned that we have a crumbling health system that is increasingly unsatisfactory for themselves and their families."

The dialogue continued: What is the vehicle with which to increase awareness of the harmful effects of health disparities on everyone, not just the marginalized and deprived? What might be the successful parallel to the secondhand smoking campaign, in which a health issue moved from an individual to a collective problem? One proposal was to determine how to engage and to motivate the middle class in this struggle. The white middle class is shrinking while the African American and Latino middle classes are emerging and need support; they may be open to aspects of the disparities framing.

A second, more specific idea was to calculate and publicize what the costs of health disparities are to

the economic competitiveness of the nation. This would include the long-term costs of increased chronic conditions, such as diabetes and obesity, which result in part from unevenly distributed community factors. Another suggestion was to calculate and publicize the costs of government disability payments (supplemental security insurance, or SSI), which, in effect, are a tax all citizens pay in a society that, in numerous ways, causes premature disability, thereby losing a significant portion of its productive work force.

The "universalist" approach was not shared equally by all participants. Some saw value in targeting groups affected by health disparities, mirroring the community organizing and consciousness raising of the Civil Rights Movement in the 1950s and '60s. Others stated that health disparities framing should move toward an "identity/protest direction," as summed up by attendee Camara Jones: "Should we wait for a society that's historically turned its back on so many citizens to come to a place where it'll value everyone? How many families are we ready to sacrifice while we're waiting?"

While there is potential for universal arguments to work, many felt that, historically, programs designed to be universal have put black people at a disadvantage. These participants warned that universal policies must ensure that residents in

low-income communities of color will lead better, healthier lives. Several participants believed that casting a civil rights perspective on disparities would be fighting against a common perception that society has made great strides, people have equal opportunity based on ability, and "problems just reflect individual choices."

Dr. Ross concluded that while these issues of framing are important, they must be placed in perspective so that they do not stifle the work that needs to be done. "We can end up falling into a trap if we get too caught up in the language. It's about the work," he stated. "There are a variety of audiences we need to engage on the issue, and we need to use a variety of different kinds of language, depending on what we need strategically to get out of that interaction and situation and not feel disingenuous about it."

Next Steps

The day ended with participants suggesting next steps for research, community health practice, and policymaking. Seven specific ideas were offered:

1. Research: Summarize and/or translate research known to academics for practitioners, policymakers, and journalists. Approximately 100 journal articles are published monthly featuring social inequalities or health disparities. While those in the field may know a lot about these issues, others who need to know may not, and would greatly benefit from such information. Research articles may also be hard to access and difficult to understand because of the jargon used. Translating or summarizing research findings into practitioner or policy language would be a significant contribution.

A related idea is to have an ongoing project monitor research literature and highlight key findings. The Center for the Advancement of Health (www.cfah.org) summarizes key research findings for media sources. This suggestion is similar, but would target practitioners or policymakers.

2. Funding: Issue grants to community organizations and let them find the researchers, rather than giving grants to researchers and asking them to work in the community. Whoever controls the money ends up guiding the project because fiscal control usually is equated with the final say-so in decision making. Even if recipients say they are sharing leadership, whoever is the named grantee and assumes the ultimate fiscal responsibility has the greater influence. More often funding organizations issue grants to universities, sometimes with the proviso that they have a community partner. Researchers attending the convening suggested that grants should be awarded to community organizations, with the caveat that they partner with a research team.

3. Policy and Practice: Assemble a compendium of best practices on health disparities policies and programs. One attending researcher mentioned that a delegation of researchers and policy leaders from Brazil visited him. They are starting to pay attention to racial/ethnic disparities in their country, and asked him for a summary of success stories or best practices on how health disparities are addressed in the United States. Regrettably, he was unaware of any such collection.

4. Practice: Conduct an area-focused intervention and carefully evaluate it. Invest a large sum (e.g., $100 million) in one or two communities to change the opportunity structures. Monitor those areas with an appropriate number of comparison or control areas, document everything, and evaluate changes, circum-stances, and health status among the residents.

5. Practice: Develop state or federal-level programs and policies for specific conditions that occur in many communities. Identify problems prevalent in numerous communities and develop programs or policies to address them. An effective case in point is the ban on junk food and soda in schools, highlighted in one of the case studies at the end of these proceedings. Another community challenge would be to help develop regulations about building materials in schools.

6. Research, Practice, and Policy: Document and disseminate individual success stories. TCE and PolicyLink have been gathering information about where some combination of research, policy, and practice has come together successfully. There are many individual champions and success stories that need to be documented and disseminated.

7. Research: Assess the effectiveness of existing policies. Use participatory research to empower community members and keep the research relevant to local circumstances. Be sure to distinguish between policies that are about individual behaviors and those that change institutions or how resources are allocated. Ensure that research is used to document, validate, or better understand community problems. Researchers must see policy outcomes as part of their agenda and commit to stay involved for extended periods.

The convening generated exchanges that were provocative, thoughtful, and enlightening, and from which several important themes emerged. Attendees shared success stories and ongoing challenges and barriers that they struggle to overcome in their work. There are tensions inherent in efforts to integrate research with practice or research with policy, and the exploration of these tensions was a useful part of the day's conversation.

In summary: a potentially powerful agenda emerged for steps that leaders in research, practice, and policy advocacy can take now—and that foundations can support—to reduce and ultimately to eliminate health disparities through a focus on communities. The dialogue among the three groups mirrored, indeed foreshadowed, the kinds of collaboration that will be needed to bring this agenda to fruition.

Case Studies

The participants in the convening had a vast collective knowledge of innovative activities in research, policy development and advocacy, and the design and implementation of community strategies to reduce health disparities. They made reference to these experiences throughout the day, and their publications represent some of the best information available about these projects and campaigns. We have selected five diverse examples of community-based research, practice, and policy advocacy for brief profiles as part of these proceedings—cases that were referred to directly or which embody the principles described in the discussions. Each case represents a different aspect of the issues raised during the day, including how to conduct collaborative, community-focused research, how to build public will and legislative action, and how to highlight new dimensions of health disparities and place-based factors.

Harlem Children's Zone Asthma Initiative

Overview

The Harlem Children's Zone (HCZ), a pioneering, community-based organization working to improve the quality of life for children and families in some of New York City's most devastated neighborhoods, joined forces with local health organizations to create the Harlem Children's Zone Asthma Initiative (HCZAI) to attack the huge public health problem posed by childhood asthma. Data gathered through the HCZAI have helped Harlem Hospital develop an agreement with a major managed-care insurer to pilot a home health aide program and have armed a U.S. Senator with enough valuable information to champion his efforts to secure federal funding for asthma.

The following case study not only details the methods HCZAI uses to expand knowledge about this epidemic; it also presents the multiple ways clinical specialists and policymakers have used the results to advance changes in their respective fields.

Harlem Children's Zone Asthma Initiative

Dates	2001 – Present
Collaborators	*Community*
	Harlem Children's Zone
	Volunteers of Legal Services
	Brazelton Touchpoints Center
	Local Institutions
	Harlem Hospital
	New York City Department of
	Health and Mental Hygiene
	Columbia University Urban
	Planning Program (of the
	Graduate School of
	Architecture, Planning, and
	Preservation)
	Research
	Columbia University's Harlem
	Health Promotion Center
	(of Mailman School of Public
	Health)
Funders	Dyson Foundation
	National Institute of
	Environmental Health Sciences
	Robin Hood Foundation
	Spunk Fund

Issue: Asthma in Harlem

An HCZAI survey found that 31 percent of children under the age of 13 in Central Harlem have asthma, compared to six percent of children with asthma in this age-group nationwide.[13]

Interventions

Parents or guardians are invited to fill out a screening questionnaire about their children. The questionnaire helps the program identify children who may be suffering from asthma. Initially, the questionnaire offered families the opportunity to have their child examined by a doctor or nurse from the Harlem Hospital pediatric asthma team; this offer was later discontinued. Families who report that their children have asthma or asthma-like symptoms and families whose children are determined to have asthma through a medical examination are invited to participate in the program. Once a family is enrolled, a community health worker visits the home and completes a baseline assessment.

Depending on any given family's needs, it receives an overview of asthma, common triggers, asthma monitoring, symptom management, and asthma care. The family and community health worker, together with doctors and nurses, create a family asthma action plan.

Families may receive dust covers for mattresses and pillows, High Efficiency Particulate Air (HEPA) filters and vacuum cleaners, dehumidifiers, and plastic food-storage containers that discourage pests. In cases where roach, rat, or mice infestation is severe, professional crews may be brought in to exterminate the pests. Medications prescribed by doctors to treat asthma are often administered through "pump" inhalers, which are difficult for young children to use. The program provides families with spacer devices that allow children to use their inhalers more easily and effectively. Peak flow meters—small, hand-held devices distributed to families through the initiative—allow parents to monitor their child's lung function daily.

In some instances, identification of environmental triggers is not enough; even with effective advocacy, some families have tremendous difficulty getting their

landlords to address persistent and serious problems in the home. Pro bono legal assistance has been tremendously helpful to families in such circumstances..

Outcomes

Decreased hospitalizations, emergency room visits, and school absences for children enrolled in the program.

Policy and Practice Changes

Using data from the HCZAI, Harlem Hospital is brokering a deal with Metroplus, a Medicaid/managed-care insurer, to pilot a program in which home health aides will provide home care and education relating to asthma.

Senator Charles Schumer's office sought the guidance of HCZAI staff related to his efforts to expand funding for the Centers for Disease Control and Prevention's Inner-City Asthma Intervention Program. The New York Democrat has conducted media outreach and sought a range of opportunities to address the asthma problem highlighted by HCZAI.

HCZAI's model is spreading. The State University of New York Training Strategies Group invited Harlem Children's Zone to participate in a videoconferenced training for child care workers on how to serve children with asthma. An HCZAI member also helped to shape a new training guide on asthma for medical doctors that was developed by The National Environmental and Educational Training Foundation. This document can be found at www.neetf.org/Health/asthma_guidelines.pdf.

HCZAI actualizes the importance of a comprehensive approach to managing chronic disease. The asthma initiative extends beyond education to provide social, environmental, medical, and legal supports.

References

Harlem Children's Zone, "The Harlem Children's Zone Asthma Initiative." *A Look Inside*, Spring 2005. New York, NY: Harlem Children's Zone, 2005.

Nicholas, S.W., Jean-Louis, B., Ortiz B., Northridge, M., Shoemaker, K., Vaughan, R., Rome, M., Canada, G., and Hutchinson, V. "Addressing the Childhood Asthma Crisis in Harlem: the Harlem Children's Zone Asthma Initiative." *American Journal of Public Health,* vol. 95, no. 2. Washington, DC: The American Public Health Association, 2005.

California Junk Food and Soda Ban: Healthier Foods in California's Schools

Overview

The following case highlights some of the activities that led to the passage of three bills designed to slow the obesity epidemic among school children in California. These bills ban access to junk foods and introduce fresh fruits and vegetables to school food programs.

This example illustrates how the work of advocacy organizations, researchers, a school board association, and a foundation successfully led to these positive and substantial statewide policy changes.

This is an abbreviated version of a complicated story involving many organizations—from the grassroots to the state government level. The following examples of actions addressed food in schools and childhood obesity issues; the actions resulted in the passage of three bills in the fall of 2005.

California Junk Food and Soda Ban

Dates	1997–2005
Collaborators	California Center for Public Health Advocacy California Food Policy Advocates California Project LEAN California School Boards Association Samuels & Associates Strategic Alliance for Healthy Food and Activity Environments (formed in 2001)
Funder	The California Endowment (TCE)

Issue: Childhood Obesity in California

One in three children is considered overweight, and in some California school districts, nearly half of all children are overweight.

Interventions

National consensus panels. In August 1999, the California Center for Public Health Advocacy (CCPHA) was awarded a grant from TCE to educate policymakers in California about the importance of nutrition and physical activity for children and adolescents. As part of that effort, CCPHA established a panel of respected state and national experts to develop recommendations for nutrient standards for foods sold in California schools. In March 2002, this panel produced a report, *National Consensus Panel on School Nutrition: Recommendations for Competitive Food Standards in California Schools.*

Media advocacy. California Project LEAN released the results of a fast-food survey in 2000. Through targeted outreach, those results were distributed to a range of state and national print, radio, and television media: National Public Radio, The Associated Press, the Sacramento Bee, the Los Angeles Times, the San Diego Union-Tribune, U.S. News and World Report, and La Opinion. CNN, the Wall Street Journal, and the New York Times also developed stories about the Los Angeles Unified School District's (LAUSD's) soda ban, which was instituted on all campuses in 2004.

Information dissemination to policymakers. In March 2004, California Project LEAN distributed several policy briefs to state and local policymakers. Among the topics: *Are Nutrient Standards for Competitive Foods Feasible?; Food Advertising and Marketing to Children and Youth; Food Fundraising at School;* and *Is Physical Activity by Itself the Answer?* A year later, California Food Policy Advocates published a report, *State of the Plate: California School Meal Primer*, about the National School Lunch Program and the School Breakfast Program in California, for policymakers, schools, parents, and students.

Research

The 2000 *California High School Fast-Food Survey* was produced by California Project LEAN, with research conducted by Samuels and Associates. Food service directors in all districts in the state with at least one high school were surveyed. The poll found that 95 percent of responding districts sold fast foods as à la carte items. The most common foods sold were pizza, cookies, chips, and burritos.

In April 2002, *Prevalence and Specifics of District-wide Beverage Contracts in California's Largest School Districts* was produced by the Public Health Institute, with funding from The California Endowment. This qualitative analysis examined the beverage contracts for provisions that could potentially affect children's health: financial incentives that promote student soda consumption, advertising and promotion of soda products, limited school district control over beverage selection and sales locations, and contract administration by non-nutrition personnel.

An October 2003, Field Poll by the Field Research Corporation, with funding from TCE, assessed Californian adults' perspective on childhood obesity. The survey revealed that Californians believe, second only to illegal drug use, that unhealthy eating habits are the greatest health risk to Californian children today. Nearly all residents (92 percent) saw the problem of obesity as very or somewhat serious.

The November 2004 *Soda and Health Fact Sheet,* compiled by CCPHA, assembled health research that documents how much soda children drink, how many calories soda has per serving, and known links among soda, obesity, and diabetes. This information was distributed to local and state policymakers.

The April 2005, *Linking Education, Activity and Food (LEAF) Fiscal Impact Report,* developed by the University of California at Berkeley Center for Weight and Health, with funding from the California Department of Education, reported the results of a multi-component, cross-site evaluation of the LEAF program. This program was created by the California

Department of Education Nutrition Services Division, with funding from the California Department of Food and Agriculture, to implement SB19 and SB56, also known as the "Pupil Nutrition, Health and Achievement Act of 2001." LEAF awarded grants to 16 middle and high schools. In addition to implementing SB 19/56, the schools were instructed to implement policies to promote the consumption of California-grown fresh produce. The schools were also encouraged to develop and implement an array of related policies to improve student nutrition and fitness. The implementation period was January 2003–September 2004.

The evaluation compared year 1 (September 2002–June 2003) with year 2 (September 2003–June 2004). In terms of fiscal impacts, most food service operations experienced increases in the gross revenues. Qualitative data gathered from all sites indicated that increased costs associated with greater fruit and vegetable purchases, packaging, and storage were offset, in large part, by increased meal sales and other measures that increased the efficiency of the food service operation.

The August 2005 *Overweight Children by Assembly District* report was produced by CCPHA using data from the California Department of Education's 2004 Physical Fitness Test. To determine whether there have been changes in the epidemic of overweight children, CCPHA compared the 2004 findings to those published in 2001. Findings were reported for each state Assembly district to provide policymakers and the general public with a clear picture of the extent to which this epidemic affects their communities.

Policy

In 2002 and 2003, the School Board of the Los Angeles Unified School District unanimously passed a Healthy Beverage Resolution, banning the sale of carbonated beverages on all school campuses K–12, and an Obesity Prevention Motion, setting nutrition standards for all foods sold on all school campuses, expanding access to the school breakfast program, and taking other steps to strengthen the school nutrition program. Though not the first school district in California to ban soda and junk food sales, because of its size, LAUSD's decision helped encourage other districts to establish their own nutrition policies.

In September 2005, SB12 and SB965 were signed into law. These bills established rigorous nutrition standards for foods and beverages sold on public school campuses K–12. SB12 establishes nutrition standards for all foods sold à la carte, including in vending machines, in school stores, or as part of a school fundraiser. The bill established limits on fat and sugar content, calories, and portion size.

SB965 defined school beverage standards for high schools, eliminating the sale of soda and other sweetened beverages on high school campuses in California. (Similar standards had already been established for elementary and middle schools through SB677.)

In September 2005, SB281, which provides fruits and vegetables for school breakfast programs, was signed into law.

References

Agron, Peggy. personal communication, November 2, 2005.

California Center for Public Health Advocacy, *California SB677, The California Childhood Obesity Prevention Act of 2003*.

California Center for Public Health Advocacy, *Fact Sheet: Soda Consumption Puts Kids at Risk for Obesity, Diabetes, Osteoporosis, and Cavities*. 2004.

California Center for Public Health Advocacy, *The Growing Epidemic: Childhood Overweight Rates on the Rise in CA Assembly Districts.* 2005.

California Center for Public Health Advocacy, *National Consensus Panel on School Nutrition: Recommendations for Competitive Food Standards in California Schools.* 2004.

The California Endowment, "Preventing Obesity in California: A Call for Policy and Community-based Approaches." *Health . . . in Brief. Policy Issues Facing a Diverse California,* vol. 4, no. 1. Los Angeles, CA: The California Endowment, 2005.

California Project LEAN. "A Behind-the-Scenes Look: What it Took to Ban Soft Drinks in the LAUSD." *Lean Times.* Sacramento, CA. November 2002.

Canter, M., Hayes, G., Korenstein, J., *Motion to Promote Healthy Beverage Sales in LAUSD.* 2003.

Canter, M., Korenstein, J., *LAUSD Obesity Prevention Motion.* 2003.

Field Research Corporation. "A Survey of Californians About the Problem of Childhood Obesity, Conducted for The California Endowment." November, 2003.

Goldstein, Harold. Personal communication. November 29, 2005.

Public Health Institute, "Food Fundraising at School," *California's Obesity Crisis Focus on Solutions - What Schools Can Do.* Policy Brief 4. 2004.

Reich, Jessica. Personal communication. December 1, 2005.

Reich, Jessica. *State of the Plate: A School Meal Primer for California.* 2005.

Samuels, Sarah. "Fact Sheet - 2000 California High School Fast Food Survey." 2000.

Woodward-Lopez, G., Vargas, A., Kim, S., Proctor, C., Hiort-Lorenzen Diemoz L., and Crawford, P. *LEAF Cross-site Evaluation: Fiscal Impact Report.* University of California, Berkeley: Center for Weight and Health, 2005.

Reading, Writing, and Breathing: School-Air Toxics and Environmental Justice in California

Overview

Three researchers— Manuel Pastor, Jr., James Sadd, and Rachel Morello-Frosch—investigated the impact of respiratory hazard exposure on health and academic performance for school-aged children in California. This case highlights one approach to integrating researchers and community practitioners in order to ensure that research results are accurate and framed in a way that is helpful to community advocates. It demonstrates the value of including community organizations and government agencies' voices in understanding and framing research results.

Issue: Environmental Conditions in California Schools

This investigation was taken to ascertain the associations among neighborhood respiratory hazards, asthma hospitalization rates, school demographics, and school academic performance.

Research

The research team used U.S. Environmental Protection Agency (EPA) National Air Toxics Assessment (NATA) data for the State of California, which estimates outdoor concentrations for diesel particulates and 32 air toxics. Air toxics concentration estimates were then assigned to local neighborhoods. The team used these data to generate estimates of total respiratory hazard for every neighborhood (census tract).

The team then combined these respiratory hazard estimates with school information on demographics and academic scores, discovering that respiratory hazards are not distributed equally: the schools in areas with higher respiratory hazards contained a substantially higher proportion of Latino, African American, and Asian Pacific Islander students, and a slightly higher percentage of students qualifying for the free or reduced price school lunch program.

The researchers then set out to investigate the impact of respiratory hazard exposure on health and academic performance. For health, they examined asthma hospitalization rates by zip code for Los Angeles County, portions of the Bay Area, the San Joaquin Valley, and San Diego and Imperial counties. They found a significant correlation between the respiratory hazard measure and the incidence of hospitalization, after taking into consideration neighborhood level of income, value of housing, population density, and race. For academic performance, they used the school rank, a number from 1 to 10 based on the school's Academic Performance Index (API) (higher ranks mean "better" schools in this system). Looking only at the 10 largest school districts in California, the researchers found that, in nine of the districts, schools with higher respiratory hazards had lower state ranks.

Reading, Writing, and Breathing: School-Air Toxics and Environmental Justice in California

Dates	2003–2005		
Collaborators	**Researcher**	**Organization**	**Role**
	Manuel Pastor, Jr.	Center for Justice, Tolerance, & Community, University of California, Santa Cruz	project coordination and statistical analyses, including multivariate and spatial modeling
	James Sadd	Environmental Science, Occidental College	developing and maintaining geographic information systems (GIS)
	Rachel Morello-Frosch	Department of Community Health, School of Medicine, Center for Environmental Studies, Brown University	statistical analysis, health end-points, and estimates of risk
Funder	The California Wellness Foundation		

Community Input

The research team wanted to know how this work would serve community organizations and what they might do with the information. Before the team documented its findings, it organized two convenings, one in Northern California and one in Southern California. In Northern California, staff from 13 community organizations and government agencies attended. In Southern California, staff from 11 community organizations and government agencies attended. The research team presented its findings, answered questions, and listened to concerns and suggestions.

Two important issues were raised in these discussions. First, advocates and practitioners pointed out that other environmental hazards are in the school setting, such as pesticides and toxic particulate matter, which could influence health and academic performance. Second, participants cautioned that the recommendations arising from the report could not simply be that schools need to be built in suburbs away from traffic and factories. Schools currently located in poor quality environmental settings need to be "cleaned up" so that students are exposed to lower levels of toxics.

Policy Recommendations

After the convenings, the research team reported its findings and policy recommendations. Briefly, they were:

- Improve data on air quality. We need data to document the distribution of particulates, criteria air pollutants, and agricultural pesticides.
- Improve program on clean school buses. Diesel-related emissions are a major contributor to respiratory hazards.
- Enhance indoor air quality at schools.
- Focus on remediation as well as new siting. Recent legislation has prohibited new school construction within 500 feet of busy roads but does not address those schools built before the regulations.
- Enhance school-based health services.
- Take a comprehensive approach to school environmental quality. This study focused on air toxics, but there are other environmental health

concerns, ranging from pesticide use to chemicals used in school cleaning to the proximity of schools to landfills, transfer stations, brownfields, and other perceived hazards.
- Continue efforts at source reduction. A main goal should be to continue to prevent and reduce pollution at its various sources.

References

Pastor, M., Sadd, J., Morello-Frosch, R. *Reading, Writing, and Breathing: Schools, Air Toxics, and Environmental Justice in California.* University of California, Santa Cruz: Center for Justice, Tolerance & Community, 2005.

Pastor, M., Sadd, J., and Morello-Frosch, R. "Reading, Writing, and Toxics: Children's Health, Academic Performance, and Environmental Justice in Los Angeles." *Environment and Planning C: Government and Policy,* vol. 22, no. 1. Brondesbury Park, London: Pion Ltd., 2004.

Pastor, M., Sadd, J., and Morello-Frosch, R. "Who's Minding the Kids? Pollution, Public Schools, and Environmental Justice in Los Angeles." *Social Science Quarterly,* vol. 83, no. 1. Ames, Iowa: Blackwell Publishing Inc., 2002.

Concerned Citizens of Tillery and Partners at the University of North Carolina School of Public Health

Overview

This case documents a landmark example of Community Based Participatory Research (CBPR) concerning a critical rural environmental health issue and the impacts on policy that the research and related advocacy have achieved.

Residents were involved in each stage of the work, from identification and specification of the problem onward. The findings have been used to establish better local health policies; the experience has helped to increase the capacity of the organized residents. The work performed by the residents and their partners at the University of North Carolina was later documented for a national comparative study of the policy impacts of CBPR, based at the University of California, Berkeley School of Public Health.

Concerned Citizens of Tillery and Partners at the University of North Carolina School of Public Health

Dates	1996–present
Collaborators	Concerned Citizens of Tillery University of North Carolina at Chapel Hill faculty and students
Funders	National Institute of Environmental Health Sciences (NIEHS) North Carolina State Health Department

Issue: Proliferation of Large-scale Industrial Hog Operations in Rural North Carolina

Large-scale hog operations are disproportionately located in low-income, African American communities. Residents are concerned about such operations' odor problems, their contribution to the loss of small family farms, and their perceived negative health effects through water and air contamination. Residents who frequently suffer irritated eyes, sore throats, and other respiratory ailments attribute these conditions to industry practices.

Research

University of North Carolina at Chapel Hill faculty were funded to conduct research that, using official records, could quantify systematically the extent to which hog confined animal feeding operations (CAFOs) and their potential impacts on health and quality of life disproportionately affected low-income communities and people of color (primarily African Americans) in the state. The aims were to evaluate data for local communities, to consider possible alternative explanations for observed patterns, and to consider data on household water sources (well or municipal), because groundwater contamination is an important public health concern. Although data analyses were conducted at the university, the study questions originated in the exposed communities. Community members participated in evaluating data quality through their knowledge of local CAFOs.

Hog CAFOs, the members discovered, were far more common in poor communities and communities of people of color and that this concentration was more extreme for integrator-owned or contracted CAFOs than for independent operations. Furthermore, they found that hog operations were concentrated in areas where most people depend on household wells for drinking water.

In 1998, with support from the North Carolina State Health Department, researchers initiated a survey of rural residents in eastern North Carolina. Reports of odor problems and respiratory effects had been coming in from hog CAFO neighbors across eastern North Carolina, and the State Health Department was interested in obtaining more information. In consultation with the community partners and staff from the health department, they designed a survey to compare health and quality of life of residents of three communities—one in the neighborhood of a hog CAFO, one in the neighborhood of a dairy operation that used a liquid waste management system, and a third with no intensive livestock production.

Policy

Three key policy outcomes of this work are listed here, and then described with more context and detail below:

- Helped secure passage by Halifax County commissioners of intensive livestock operation ordinance (following adoption of similar ordinance by Department of Health), 1997;
- Secured creation of a local fire district; and
- Led in the creation of the North Carolina Environmental Justice Network, stirring a statewide environmental justice movement.

One of the most important outcomes for the community was that in January 1997, the county commissioners passed an intensive livestock operation (ILO) ordinance, making Halifax the first county in the state to adopt such an ordinance by both its board of health and commissioners. Halifax County was recognized in 1997 for its effort to regulate ILOs by the North Carolina Association of County Commissioners. This positive outcome had followed many years of grassroots activism and organizing; it built upon the successes in getting: a county-level Health Rule and Ordinance in April 1992, a statewide moratorium on corporate hog industries in 1997, and a four-year moratorium on any new or expanded farms passed by the General Assembly and enacted in 1995.

Another outcome was establishing a fire district—one of the unintended but quite welcomed consequences of community organizing. The fire district is an area close to a fire station. Its creation had other consequences, such as lowering insurance rates for businesses and homes and providing opportunities for several young men to become volunteer firemen. This in turn built community capacity, resulting in other activities yielding desirable outcomes for all community members.

The activities supported by the NIEHS contributed to the creation of a climate that raised consciousness about environmental justice issues in general, and hog issues in particular, at many levels and circles— from county and regional to state and national levels, and from legislators and academicians to professional and public circles. This contribution to consciousness-raising is highlighted in several statements made by various partners during interviews conducted for the University of California, Berkeley comparative study.
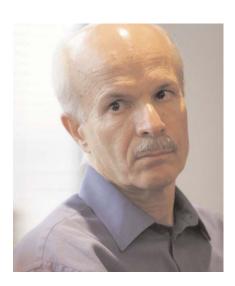
For example, the research partner mentioned how the partnership's "report generated newspaper articles, other media accounts that in turn increased awareness" and promoted the "discussion of environmental justice issues in the rural South" among the public. By creating a statewide network— the North Carolina Environmental Justice Network (NCEJN), which was in part a result of the NIEHS-supported project—the partnership was able to build a coalition among various communities across the state with the specific goal of raising communities' consciousness around environmental justice issues.

References

Minkler, Meredith. 2006. Personal correspondence and forthcoming publications with Victoria Breckwich-Vasquez and Mansoureh Tajik. From the Project on Policy Impacts of Community Based Participatory Research. School of Public Health, University of California, Berkeley. Funded by the W.K. Kellogg Foundation.

Wing, S. "Social Responsibility and Research Ethics in Community-Driven Studies of Industrialized Hog Production." *Environmental Health Perspectives*, vol. 110, no. 5. Cary, North Carolina: National Institute of Environmental Health Sciences, 2002.

Wing, S., and Wolf, S. "Intensive Livestock Operations, Health, and Quality of Life Among Eastern North Carolina Residents." *Environmental Health Perspectives*, vol. 108, no. 3. Cary, North Carolina: National Institute of Environmental Health Sciences, 2000.

Research on Housing Mobility and Health: Moving to Opportunity

Before the October 27th convening, participants were provided with an article by Professor Dolores Acevedo-Garcia and her colleagues at Harvard University, "Does Housing Mobility Policy Improve Health?," which appeared in 2004 in *Housing Policy Debate.* The article provides a summary of research focused on investigating health effects on public housing residents who were provided different types of opportunities to relocate. Professor Acevedo-Garcia described the findings of the research during the convening, providing an overview of the lessons that can be derived from research on health effects of housing mobility programs or efforts to deconcentrate poverty.

Context: The Intentional Deconcentration of Low-Income Public Housing Families

Housing mobility strategies started being used extensively during the 1990s as a means of poverty deconcentration or racial/ethnic desegregation. In some cases, these policies were created in response to legal cases begun decades earlier, successfully arguing that public housing was a form of racial discrimination. The most well-known case of such litigation was the Gautreaux case, in which public housing residents sued the U.S. Department of Housing and Urban Development (HUD) for racial discrimination in the administration of the Chicago public housing program. The U.S. Supreme Court ordered the City of Chicago to racially desegregate its public housing and to offer placements to black families in private units located in other parts of the metropolitan area. Many HOPE VI projects, which depopulated large public housing projects so that they could be rebuilt at lower densities with mixed-income populations, similarly provided displaced residents with housing vouchers that could theoretically be used anywhere that would accept them. However, such changes represented moves to "opportunity" for the families only when the new locations were appreciably less poverty-stricken neighborhoods, something not designed into HOPE VI as it was into the following demonstration project.

The Research Strategy and Findings

The source of most of the highest-quality research on social and health effects of housing mobility strategies is the HUD-supported Moving to Opportunity (MTO) program, begun in 1994. Central-city public housing residents in Boston, New York, Chicago, and Los Angeles were randomly assigned to treatment and control groups. Treatment group members were offered housing counseling and a Section 8 housing voucher that could be redeemed only in a low-poverty neighborhood. (This group was also called the experimental group.) A second treatment group was offered a Section 8 voucher with no geographic restrictions. The control group did not receive a voucher. Two to three years after the groups were randomized, they were assessed for their housing circumstances and a variety of outcomes, including physical and mental health measures. Some of the notable findings included:

- **Mental health.** Moving into low-poverty neighborhoods resulted in large improvements in mental health for girls and no significant changes for boys.
- **Injuries.** In Boston, children in treatment group families experienced fewer injuries or accidents.
- **Smoking.** Girls who moved into lower-poverty areas did better; boys who moved did worse. Teen girls in the experimental group reported lower use of marijuana and of smoking tobacco. Teen boys in both treatment groups reported significantly higher rates of smoking tobacco than controls.
- **Adult health outcomes—observed effects.** Adults in both treatment groups had lower obesity than the control groups. Adults in the experimental group had lower prevalence of psychological distress and depression.
- **Adult health outcomes—no effects.** No differences between groups of adult participants were observed for asthma, self-reported health, high blood pressure, smoking, drinking alcohol, or activities of daily living.

Among the more curious findings from the MTO studies is that boys do not improve and, in some cases, experience more negative effects (e.g., more arrests, more smoking) after moving compared to girls. Professor Xavier de Souza Briggs of MIT and his colleagues are analyzing data from an extensive

ethnographic study to find out why this might be. One hypothesis is that boys maintain ties to their friends in their previous neighborhoods and continue to be negatively influenced by these peers, not "benefiting" from the better influences of new peers in the new lower-poverty area. Another hypothesis is that African American or Latino young men may stand out more in lower-poverty areas that presumably have higher proportions of whites. Yet another assumption is that the police may easily target them, presuming that they are more likely to commit crimes. Finally, it is known that African American youth do not smoke as much as white youth, so the increase in smoking behavior could be the result of new influences in the new settings.

Housing and Health: New Areas for Research that Crosses Boundaries

Professor Acevedo-Garcia made several overarching points about research on housing mobility and health and on viewing housing and neighborhood characteristics as important social determinants of health in their own right.

The MTO study presented a relatively rare opportunity for housing and health researchers to work on the same issues and the same database. Collaboration and interaction among the two disciplines should be encouraged. The intertwined origins of public health and urban planning in the United States lie in century-old tenement and sanitation reforms, and the linkage between housing and health is being rediscovered.

Ethnicity and culture cannot be separated from the study of individual and neighborhood poverty. One cannot draw specific conclusions about Latino communities from studies of only African Americans, for example. Understanding important historical settling differences between African Americans (the history of slavery and forced migration) and Latinos (immigration) and how they came to live in segregated settings could offer interesting research data. Some research shows that Mexican Americans who live in segregated, all-Mexican enclaves have better health status than Mexican Americans who live in integrated or ethnically heterogeneous settings.

There are two contrasting general policy motivations for and implications of this kind of housing-health research: (a) focus on neighborhoods and work to improve them or (b) facilitate people moving out of "bad" neighborhoods into "good" ones. A focus on the neighborhoods and improving people's lives should include improving not only housing, physical conditions, safety, and education, but also social capital and employment opportunities. Concentrating on enhancing mobility focuses on safeguarding and enhancing the immediate well-being of children and on the assets of racial and economic integration. Mobility strategies beg questions such as what happens to the people who cannot move? What happens to the "bad" neighborhood when those who can move have left? Neither strategy has yet been fully implemented in all of its dimensions, leaving most studies and social experiments short of the full-scale transformations that would allow us to definitely assess the impact of neighborhood change on health.

Notes

[1] Participants were invited to an informal dinner the evening prior to the full day's discussion. During this preliminary networking and relationship building period, an important foundation was established that contributed to the convening's overall success.

[2] Harlem Children's Zone from New York and Codman Square Health Center from Boston.

[3] Healthy Eating, Active Communities (HEAC) is a four-year initiative to address the childhood obesity epidemic in California. This broad-based strategy, targeting six California communities, aims to increase opportunities for healthy foods and physical activities. Community Action to Fight Asthma (CAFA) works to implement local and statewide policy changes to improve neighborhood conditions that contribute to childhood asthma. California Works for Better Health (CWBH) is a 10-year commitment in three regions to build local capacity to connect people in low-income areas with good jobs, understanding that jobs are the primary source of income and health insurance, and that income is one of the most important determinants of health.

[4] In addition to a five-year collaboration with TCE, PolicyLink has been working with diverse partners—researchers, policymakers, academics, and practitioners—to identify community-level strategies to improve health. The organization's conceptual framework for understanding the role of community factors on health was distributed to participants.

[5] David Williams, Professor of Sociology, University of Michigan; Betina Jean-Louis, Director of Research, Harlem Children's Zone; and Marion B. Standish, Program Director for Health Disparities, The California Endowment.

[6] Dolores Acevedo-Garcia, faculty member in the Harvard School of Public Health, presented a summary of the findings on the health impacts of neighborhood mobility for low-income families, from the Moving to Opportunity social experiment.

[7] Each breakout group was asked to answer the question, "How do you use research, practice, and policy to achieve a healthy community?" Common threads ran through many of the responses.

[8] The National Institutes of Health were identified in the meeting for this approach, though other agencies also take this stance.

[9] The study was conducted by the U.S. Public Health Service and the Tuskegee Institute to see what syphilis does to the body. In 1932 almost 400 poor black men with syphilis in Alabama were enrolled; they were never told they had syphilis nor were they treated for it—even after 1947, when penicillin became a standard treatment. This is an example of egregious abuse on the part of researchers. In poor and non-white communities, the legacy of Tuskegee is powerful; people do not want to be guinea pigs.

[10] W.K. Kellogg Foundation Community Health Scholars Program, 2001.

[11] N. Wallerstein, *Community Based Participatory Research Workshop,* PowerPoint presentation. American College of Epidemiology, Albuquerque, NM. September 22, 2002.

[12] According to a Kaiser Family Foundation survey, over two-thirds (67 percent) of whites say they believe African Americans get the same quality of care as they do; 61 percent of whites, compared to 41 percent of blacks, thought the following statement was true: "African Americans with heart disease are just as likely as whites who have heart disease to get specialized medical procedures and surgery."

[13] Harlem Children's Zone, "The Harlem Children's Zone Asthma Initiative." *A Look Inside,* Spring 2005. New York, NY: Harlem Children's Zone, 2005.

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