A learning exchange between the USA and England:

Racial and Ethnic Approaches to Community Health (REACH)

&

Communities for Health (C4H)

A qualitative analysis

Authors

Trevor Hopkins[1], Michael Grady[2], Martin Gibbs[3], Charmaine Ruddock[4], Claire Blanchard[5], Ginder Narle[6], Jayne Norwood[1], Chris Brookes[7]

1- Asset-based consulting based at Chester le Street, Co. Durham, DH2 1TZ, United Kingdom - www.assetbasedconsulting.net

2- Principal Advisor, Institute of Health Equity, University College London - Department of Epidemiology & Public Health, 1-19, Torrington Place - London - WC1E 6BT, United Kingdom

3- Health Inequalities and Inclusion Health, Department Of Health (DH), Area 311, Richmond House, 79 Whitehall, London, SW1A 2NS, United Kingdom

4- Bronx Health REACH/NY CEED, The Institute for Family Health based at 16 E. 16th St., 6th Floor, New York, NY 10003, USA

5- International Union for Health Promotion and Education (IUHPE), 42 Bd de la Libération, 93203 St Denis cedex, France – cblanchard@iuhpe.org

6- Learning for Public Health West Midlands (LPHWM), Sandwell Primary Care Trust, Kingston House, 438 High Street, West Bromwich, B70 9LD, United Kingdom

7- Health Action Partnership International (HAPI), Tavistock House (Entrance B), Tavistock House North, London, WC1H 9HX, United Kingdom

Suggested citation

Hopkins T., Grady M., Gibbs M., Ruddock C., Blanchard C., Narle G., Norwood J., Brookes C., **A learning exchange between the USA and England: Racial and Ethnic Approaches to Community Health (REACH) & Communities for Health (C4H) - A qualitative analysis**. *International Union for Health Promotion and Education (IUHPE)* 2012.

Partners & Contributors

ADDITIONAL CONTRIBUTORS AND MAIN AUTHORS OF THIS REPORT:

Asset-Based Consulting

Institute of Health Equity, University College London

PROJECT PARTNERS

International Union for Health Promotion and Education (IUHPE)

Learning for Public Health West Midlands (LPH WM)

Health Action Partnership International (HAPI)

Department of Health of England (DH)

US Centers for Disease Control and Prevention (CDC)

Acknowledgements and Disclaimer

ACKNOWLEDGEMENTS

We would like to thank all project partners (US Centers for Disease Control and Prevention (CDC), the International Union for Health Promotion and Education (IUHPE), the Department of Health of England (DH) and Health Action Partnership International (HAPI), Learning for Public Health West Midlands (LPHWM), the Health Inequalities Unit at University College London, the REACH US community programme and the Communities for Health programme) for continued support, engagement and dedication throughout the whole process of this learning exchange in sometimes challenging political and economic contexts and understood the importance of change happening over time. We would like to specially thank Martin Gibbs, Chris Brookes, Leandris Liburd, Pattie Tucker, Claire Blanchard, Mary Hall and Ginder Narle for their incredible efforts that have made the twinning exchange possible.

We would also like to thank all communities and community representatives that took part in the exchange as well as all projects that participated in the qualitative analysis (cited in appendix 1) as well as all individuals, programmes, and partnership organisations visited (also cited in appendix 1) for their passion and leadership over the years to improve the conditions in which their community members are born, *grow*, live, work and age beyond health and well-being towards sustainable and equitable environments and societies that made this learning exchange such an enriching effort.

Special thanks goes to Trevor Hopkins at Asset-Based consulting for his analysis and leadership in developing this qualitative report, Michael Grady from the Health Inequalities Unit at the University College London for his invaluable expertise and contribution on the social determinants of health, Ginder Narle for her practice-perspective, contribution and leadership in making this report a reality, and Charmaine Ruddock and Smiti Kapadia for their REACH US perspective and contribution.

The learning exchange and this qualitative evaluation piece were supported by the International Union for Health Promotion and Education (IUHPE) and the US Centers for Disease Control and Prevention (CDC) through a cooperative agreement CDC RFA DP07-708.

Contents

Introduction

Multi-sectoral and multi-disciplinary approaches are the cornerstone for collaborative efforts to address non-communicable diseases (NCDs).[1]

Community health promotion interventions, targeted at deprived, marginalised and priority populations and focusing on addressing the social determinants of health (SDH) to reduce health inequalities, are an important strategy to prevent and control NCDs and promote the health of the seldom heard and seldom served groups.

Since the Ottawa Charter[2] increasing visibility has been afforded to the SDH and health inequalities in recent years with influential international reports leading the way.[3]

---

[1] United Nations (2011) *Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*, A/66/L.1

[2] World Health Organization (1986)*The Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa*, WHO

[3]* International Union for Health Promotion and Education. *Key Messages from the International Union for Health Promotion and Education on the Social Determinants of Health*. IUHPE; 2012. http://www.iuhpe.org/uploaded/Activities/GWG/SDH/20120718_IUHPE%20Key%20Messages_SDH_FINAL.pdf

* Marmot M et al (2008) *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the WHO Commission on Social Determinants of Health.* Geneva, World Health Organization; 2008. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

** Rio Political Declaration on Social Determinants of Health – World Conference on Social Determinants of Health*. World Health Organization; 2011. http://www.who.int/entity/sdhconference/declaration/Rio_political_declaration.pdf

* Marmot M, Atkinson T, Bell J, Black C, Broadfoot P, Cumberlege J, Diamond I, Gilmore I, Ham C, Meacher M and Mulgan G. *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

* Marmot M. (2012) *WHO European review of social determinants of health and the health divide* Lancet Vol 380 September 15 2012 pp 1011-1029. http://www.instituteofhealthequity.org/projects/who-european-review

While there is extensive documentation on the nature of health inequalities and growing yet limited documentation on 'what works' to reduce inequities, there is an essential need to share and develop a better understanding of strategies for actions that can effectively address the SDH and social injustice.

Background

It is in such a context and to address this need, that in 2008, a partnership between the US Centers for Disease Control and Prevention (CDC), the International Union for Health Promotion and Education (IUHPE), the Department of Health of England (DH), Health Action Partnership International (HAPI), and more recently Learning for Public Health West Midlands (LPH WM), agreed to embark on a learning exchange between Communities for Health (C4H) in England and the Racial and Ethnic Approaches to Community Health across the US (REACH US) communities that are tackling health inequalities.

The learning exchange initiative was developed to:

→ provide an opportunity for community practitioners to learn from the experiences of other similar communities;

→ explore and share knowledge, skills and tools in addressing the social determinants of health;

→ summarise key aspects of what works and doesn't work in reducing disparities and inequities; and

→ disseminate findings that help inform global practice and improve initiatives that promote health, well-being and equity in populations globally.

The exchange comprised a site visit of English community representatives who visited selected REACH US communities in November 2011, a site visit of US community representatives who visited communities in England [4] in June 2012, and then debrief meetings to extract lessons learnt from the visits followed by a conference to enable broader dissemination of efforts in June 2012. The exchange has resulted in the identification of key common themes, along with insight into the fundamentals of the efforts to address health disparities in each country and within

[4] Blanchard C., Gibbs M., Narle G., Brookes C. *Learning from communities in the USA and England to promote equity and address the social determinants of health* - Global Health Promotion (submitted for publication 2013)

the respective communities visited. Some of the key drivers identified are as follows:

- Political context – a driver and determinant;
- community engagement and its impact on sustainability;
- information intelligence (data collection, availability and use);
- collaborative work (working in partnerships);
- time – a factor for change;
- funding and corresponding driving paradigm;
- health - a holistic approach to health and well-being as opposed to disease;
- putting a focus on community assets to build effective interventions; and
- the key role of leadership and the need for building capacity for sustained leadership in communities.

In order to further capture the lessons learned, drivers, factors for success and strategies that work as well as make recommendations for policy and practice at the local, national and global levels, a qualitative exercise was conducted and the results are described in this report.

Methodology

Outline

The purpose of this report is to explore further and capture some of the information that may add to the drivers identified during the exchange visits between the C4H and REACH community representatives and share these across a number of audiences through journals and conferences.

Approach

The research was conducted in four stages:

1. The planning team devised a questionnaire (Appendix 2) for organisations to provide information to highlight some key factors in their projects, including the historical context and their organisational journeys.

   The questionnaire was constructed around themes (which had emerged from the exchange visits) to draw out further information on these key themes, lessons learnt and drivers (see page 4 above)

2. Questionnaires were sent to the REACH US communities and the Communities for Health projects in England (Appendix 1). Sixteen completed questionnaires and one short report were received by the deadline. Two US and two English projects also submitted detailed reports and background information that, while providing contextual information, were not used in conducting the qualitative analysis and preparing this report.[5]

[5] The questionnaire was designed for distribution to the US and English community organizations who participated in the learning exchange to provide information for the qualitative analysis, however the University of Alabama also provided valuable input that was included in the analysis report.

3. A qualitative, thematic analysis[6] of the responses received from the 16 projects was conducted[7] to identify key themes, lessons learned and strategies that worked at both practical and strategic levels.

4. A summary of the analysis and main findings was used to develop conclusions and learning from the analysis to inform policy and practice 'grounded' [8] in the data collected in the responses to the questionnaires.

5. Analytical findings and insights were circulated in a draft report to all participants for comment and review in order to 'triangulate' the results[9] and their inputs informed the present final report.

[6] 'Thematic analysis' is the most common form of qualitative research analysis. It emphasises pinpointing, examining, and recording patterns (or "themes") within data.

[7] The analysis was conducted by a key expert from Asset Based Consulting with extensive experience of working in local government on partnership approaches towards improving health and well-being and challenging health inequalities, an interest in the relationship between connected, cohesive communities and the development of resilience and improved health outcomes from an asset-based perspective.

[8] 'Grounded theory' method is a systematic methodology in the social sciences involving the discovery of theory through the analysis of data. It is mainly used in qualitative research, but is also applicable to quantitative data.

[9] In the social sciences, 'triangulation' is often used to indicate that more than two methods are used in a study with a view to double (or triple) checking results. This is also called "cross examination"

Summary analysis of the questionnaire responses	
1. What is the role and function of your organisation including funding?	• Organisational types were very varied, from English respondents, ranging from grassroots community organisations to statutory services[10] although in many cases the project activities were supported by either the NHS or a local authority (LA). Funding was also a mix of NHS/LA finance through grants or contracts. • Responses from US projects reported the organisations were all community or social enterprises. Some were supported by academic institutions. Many were larger in size and scope than in England. Funding came through a combination of state grants, private finance and (in some cases) revenue generation via trading activity.
2. When was the organisation established and why?	• The organisations in both countries ranged in age from over 100 years to just 1 year old. • The reasons for being established were more varied in England than in the US but all were addressing health inequalities and social determinants of health. • In the US the organisations were in the main delivering primary health/social care services to poor minority communities that were not adequately served by the private health insurance or social services systems.
3. What has changed over the years?	• Across both countries all organisations reported similar changes. • Some projects reported successful performance and outcomes. • Others noted that their work remained stable although activities varied as the community and external environment changed. • A clear outcome for many was that they had developed a better understanding of the community they served and this often led to improved practices. • The organisations universally stated that health inequalities had become worse over time.
4. What would you consider was most helpful to your organisation?	• There was consensus across the organisations that successful partnerships and collaborations were the most helpful factor in achieving outcomes. • This included good community relationships, ranging from good engagement processes to co-production of community services. • Other important factors noted were: leadership, organisational and staff commitment and secure funding.
5. What was considered to be unhelpful?	• The lack of funding or sustainable funding was most frequently cited as being most unhelpful. • A linked issue was that the benefits of community engagement and development work were not well understood and were not valued (in policy making). • Community approaches were marginalised by the dominance of

[10] A statutory service is a service that is essential to the running of the country and is therefore provided by the governement.

	the medical model, academic research and clinical practice.
6. What have been the key drivers for success?	• The majority of the projects stated that strong, effective relationships with communities were a key factor. • Successful engagement relied on the ability to provide culturally appropriate support and to acknowledge that communities were not just deficit ridden but also had many assets. • In addition in many of the responses success is described as the organisation's ability to stay true to community engagement or development principles and practice (often in the context of difficult power relationships)
7. Identify one major challenge and how was this overcome?	• Understandably responses to this question were varied, although the lack of sustainable funding was universally cited as an enduring challenge. • While in England the new commissioning arrangements, resulting from health care reforms in England in 2012[11], were seen as a potential opportunity, in contrast a number of US responses were anxious about further outsourcing of services to larger organisations. • Some interesting solutions were suggested, which included a variety of enterprise models and methods for generating capital resources. e.g. "We need to increase private funding and establish an endowment" Union Settlement Association – East Harlem, US • In addition there was a significant appetite to challenge the dominant models of service delivery and champion the community led approach.
8. Can you share your vision, potential challenges and opportunities?	• Future visions included influencing policy at strategic level and making better use of resources through collaboration and partnership working. • In England there were specific references to using more community assets in the future and local commissioning. • Interestingly insecure funding was the dominant feature in responses on challenges from both English and US organisations. However all organisations stated they would find ways to survive.
9. Is there anything else you want to tell us?	This question yielded some of the most powerful comments in the questionnaire responses as without exception they conveyed the values and principles of the organisations' commitment to their approach to working with communities in the most appropriate and beneficial ways

[11] *Health and Social Care Act 2012* - Conservative-Lib Dem deal - http://news.bbc.co.uk/1/hi/8677933.stm

10. General observations	• We observed that all of the projects state either explicitly *or* by implication that their work is intertwined with power structures. • Power imbalances influence both the need for their services in the communities they serve as well as their status, value and position as organisations in the public health and social care system. • Despite the differences between English and US organisations in terms of their size, type and role, all attribute some of the challenges they and their communities face to the unequal distribution of power and influence over decisions in relation to public health policies and distribution of resource.

Semantics

It is inevitable that a qualitative analysis of written responses across two countries will expose differences in language, with the same words used to describe different things and different words used for the same thing. This is a problem of understanding that comes down to meaning or connotation. This has been the subject of many enquiries most notably in the field of semantics. In linguistics, semantics is the study of interpretation of signs or symbols as used by agents or communities within particular circumstances and contexts.[12] One particular issue in this report is the use of the terms 'community engagement' and 'community development'. These terms are used relatively interchangeably in and between both countries. In this report we have reproduced these phrases as reported in the responses. Further analysis of the use or meaning of these phrases lies outside the scope of this report.

[12] Neurath O, Carnap R, Morris C, (Eds) (1955). *International Encyclopedia of Unified Science*. University of Chicago Press

Main findings

Varying approaches to funding systems

There are a number of similarities between the US and England. In both countries the exchange organisations receive some public funding. In England this funding was a mix of NHS/LA (local authorities) finance through grants or contracts. In the US funding came through a combination of grants from federal and/or state agencies, private philanthropic foundations, and (in some cases) revenue generation via trading activity like pharmacy sales.

Principles and framework

All the responses conveyed a sense of organisations having strong guiding principles; a clear model/framework for community work; a commitment to understand and be led by the community; and above all valuing the individuals and communities they are supporting. Values of social justice and human rights form the bedrock of their action to address health inequities.

Roles of politics and power structures

The view that community development has a strong political dimension seems to be more openly acknowledged and utilised in the US. However, with a few exceptions, there is little opposition or effective challenge to the medical model or current clinical practice from key players reflected in either country's responses to the questionnaire. We suggest that this dominant model and practice may be protected by political, professional and structural power. This power imbalance is highlighted in the WHO Commission Report (2008)[13] and the recent WHO European Review[14]. Both show the 'causes of the causes' of health inequities lie in the conditions in which

[13] Marmot M et al (2008) *Closing the gap in a generation* WHO Commission on the Social Determinants of Health

[14] Marmot M. (2012) *WHO European review of social determinants of health and the health divide* Lancet Vol 380 September 15 2012 pp 1011-1029

people are born, live, grow, work and age. Inequalities in access to and balance of power, money and resources give rise to these conditions and deny political voice and influence.

Health care systems as defining factors driving inequities in health

All the projects in this study are facing challenges arising from race and health inequalities but the implications and responses differ by country. In England the issue appears to be that services exist but some individuals and communities are excluded and marginalised and as a consequence find it hard to access them.

In the US, there is inadequate provision for those who experience socio-economic disparities, despite Medicaid (a publicly financed health insurance for individuals who are at a certain federal poverty level) and not for profit health centres that receive special federal government funding to provide healthcare to those not qualified for Medicaid and without employer sponsored health insurance or private health insurance. This is a key driver of health inequity with evidence of a correlation between levels of spend on social and health care and levels of all cause mortality.[15]

Different perspectives (race and ethnicity vs socio-economic status) – a common goal

There is a further difference in that US projects were much more explicit about race as a key factor. While the Communities for Health Programme was not targeted at black and minority ethnic (BME) populations, the majority of the English projects were working with minority ethnic communities. Despite this they placed less emphasis on race as a primary factor in health inequalities. Race is discussed as one of many issues including disadvantage of gender, sexual orientation, disability, age, religion and belief which are interwoven and overlaid on social status and also linked to gaps in service provision or perceptions about and appropriateness of services.

[15] Stuckler D. ,Basu S.,McKee M (2010) *Budget crisis, health and social welfare programmes*. BMJ 2010 340. C3311

Additionally, the policy recommendations of the English review of health inequalities[16] has influenced the context. The six key policy objectives of that review to address health inequalities in England were:

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all
- Ensure healthy standards of living for all.
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

The report highlighted the social gradient in health identifying that the lower a person's social position the worse his or her health is. This provides a broad context for action and has been broadly adopted by the Government in England. These key drivers are implicit in many of the projects as a holistic response to addressing the social determinants of health rather than focusing on illness.

Funding – a major barrier to project implementation and achieving project objectives

The majority of responses reported a lack of funding as the greatest barrier impacting on the community interventions. This fell into several areas: funding cuts, short-term funding, funding criteria, inflexible funding and bureaucratic funding regimes. Continuity of funding is a pre-requisite of sustainable change in community work but is frequently not addressed.[17]

[16] Marmot M. (2012) *WHO European review of social determinants of health and the health divide* Lancet Vol 380 September 15 2012 pp 1011-1029 .

[17] Hills J., Sefton T., and Stewart K.(2009) *Towards a more equal society* Policy Press, Bristol

Marginalisation of community interventions focused at addressing the social determinants of health (SDH) in marginalised / deprived pockets of the population

If we consider the funding issues alongside other insights gained from the analysis we conclude that community development, its associated methods and the organisations/services that adopt this way of working, remain marginalised within mainstream health and social care systems in both countries.

Despite awareness that health inequity is driven by unequal access to power, opportunities, resources, political influence and voice (all of which deny the basic human right to a healthy life); these issues are not being addressed in high level policy or commissioning structures. Addressing the processes of exclusion is a critical element in addressing health inequity.[18]

Understanding complexity – a must for addressing SDH and reducing social injustice

Frequently projects reported understanding more about the complexity of communities they worked with and how this links to environmental/social conditions and their relationship with health inequalities. The knowledge produced was in some cases used to change the practice of health professionals.

[18] Marmot M et al (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*.

Conclusions and learnings from the analysis

Evaluation of community development programmes needs to factor in the impact of the context and how this interacts with the programme's methodology to generate outcomes. There is a need to use participatory methods and approach evaluation as 'reflective practice'.[19]

Further thinking is needed on one of the key challenges identified in nearly all of the responses – how to fund organisations using the approaches developed by all the projects in the exchange? To develop a basis for commissioning that supports community development and community building, it is important to not only look at how activities are commissioned but also what activities [20] with the aim of empowering individuals and communities to take control over their own health and lives thereby creating opportunities for them to flourish. This requires greater levels of social well-being and social cohesion within communities so as to create the conditions within which individual citizens can thrive.[21]

As public health transfers into top tier Local Authorities in England we have an ideal opportunity to encourage a debate amongst elected decision makers on the politics of health inequalities, and of promoting a human rights approach across the social gradient and across the life course. The hoped for end result is one in which strategies and policies based on the assets and strengths of empowered individuals and local communities is deployed.[22] Similar opportunities could be sought in the US as President Obama's health care reforms are put in place.

---

[19] Davies H (2012) *What do we know about evaluation?* in *What makes us healthy? The asset approach in practice: evidence, action, evaluation* – Foot J (2012)

[20] Foot J & Hopkins T *(2010) A glass half-full: how an asset approach can improve community health and well-being* I&DeA

[21] Marmot M et al (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*

[22] Marmot M et al (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*

It would be useful to examine relationships of power that are implicit within and between organisations, citizens and communities. Understanding these power dynamics, may enable the development of interventions addressing power imbalance - a major social determinant of health and contributor to health inequity. Expanding the examination of power dynamics in both countries to also include that between countries will, undoubtedly not only add insights into some of the efforts described in this report but may influence policies and practices globally for greater equity between high, middle and low income countries.

It would be interesting to conduct a further investigation into the organisational culture of entities that do this kind of work. Is there an empowerment culture in the organisation that matches the community empowerment that they seek to deliver? In this context, an organizational culture that fosters empowerment is defined as one with dispersed leadership and good working conditions which foster control and reduce stress. Is the organisation's driving paradigm a success factor or barrier for sustainability? Is a paradigm shift centered on community assets as opposed to one driven by funding necessary for successful and sustainable efforts?

It would also be interesting to examine the impact of gender as well as leadership characteristics and traits. This was one of the findings from the exchange visits to the USA, most if not all were led by women. Does community development work attract a certain kind of person who has already developed empowering skills? Does a gender difference exist with women demonstrating greater transformational focus than men[23] and are women more nurturing as a consequence of different patterns of socialisation?[24] This was one of the observations reported anecdotally by English visitors to the USA, that most if not all projects were led by women.

[23] Alimo- Metcalfe B. (2007) *Gender and Leadership: Glass ceiling or reinforced concrete*. Research Institute of the Ecole Nationale d' Administration Publique. Quebec ,Canada.

[24] Rosener J.B. (1990) *Ways Women lead.* Harvard Business Review. Nov/Dec pp119-160 cited in Grint (1997) *Leadership*. Oxford University Press UK

Analysis of the questionnaire responses

1. What is the role and function of your organisation including funding?

Role and function

There is a mix of organisational type and role although this was much less the case across the US projects. The English organisations included the statutory sector: the Fire & Rescue Service, Local Authorities and NHS services, as well as a large number of community organisations. In England it was often the case that community organisations were being supported in some way by either the Local Authority or NHS.

With one exception (The University of Alabama) all of the US organisations were voluntary or community organisations. For example Section 303 (a co-operative) or section 501c (similar to a social enterprise)

A range of different functions was reported. These were more diverse in England. Some organisations were broadly providing activities that could be described as addressing health inequalities across the 'Social Determinants of Health'[25], to fill gaps or improve access to mainstream services. Others were addressing specific issues, for example: Female Genital Mutilation (FGM) in a Somali community and men's health in Coventry.

In England funding was a mix of NHS/LA finance through grants or contracts. In the US funding came through a combination of grants from federal and/or state agencies, private philanthropic foundations and (in some cases) revenue generation via trading activity.

[25] Marmot M et al (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*

Funding

Several of the English projects did not comment on their funding sources. The Fire & Rescue Service (FRS) is directly funded from central government but also had additional grants for specific projects. The majority of English projects have been funded via a mix of local authority and NHS budgets. In addition to this, in-kind support (paid workers or co-ordination/advice etc.) were often provided to community organisations. In some cases the funding was via Service Level Agreements[26] or contracts rather than grants. In England this was universally reported as a benefit and a preferred source of funding.

The US organisations were almost always funded via a mix of national/state/city government grants and private non-profit philanthropic organizations. One particularly large organisation (Greater Lawrence Family Health Centre) is part funded through private or state subsidised insurance and revenue generation from an on-site pharmacy. There were some notable differences in the funding obtained by The University of Alabama. It accessed funding through a competitive process that allocated national finance, ring-fenced for research. It also had internal resources to contribute and attracted private donations.

Alabama University is an interesting submission. It clearly has huge resources, including finance, knowledge, systems etc. The length and quality of the response to the questionnaire indicated the significant resource at its disposal. This reveals an interesting perspective on funding issues that provides insights into the ability of powerful organisations like academic institutions, both to access funding and influence community organisations and projects.

Recommendation: If there is to be further research it would be useful to examine relationships of power that are implicit within organisations, between organisations and between organisations, citizens and communities.

[26] A **service-level agreement (SLA)** is a part of a service contract where a service is formally defined. In practice, the term *SLA* is sometimes used to refer to the contracted delivery time (of the service or performance).

2. When was the organisation established and why?

When established?

The projects showed a wide range of organisational age ranging from one hundred and seventeen years (US project – Union Settlement Association established in 1895) to one year (Migrant Listening Event - a short term English project in 2011)

In general the US organisations were established to provide services and support to BME communities. Their activities appear to be much more like the statutory provision in England – providing generic primary health care and social services to communities that lacked the material resources to access these through health or social care insurance systems.

The implications and responses arising from race and health inequalities in each country are different. In England organisations reported that services exist but some communities, disadvantaged and marginalised groups find them hard to access, because of the processes that facilitate exclusion including:

- Cultural appropriateness – many services cannot account for the subtle requirements of many BME people, families and communities
- A connected issue is that, in some communities, people and groups' perceptions (whether correct or not) are that Services will not deal with their problems sympathetically
- In some cases due to the specific cultural nature of the issue as in the example of FGM there is no service response.

Similarly, in the US, despite government provision for those who experience the worst socio-economic deprivation, the organisations reported that adequate services do not exist or are not accessible for much greater numbers of individuals and certain ethnic groups than in England. One effect of this is that the community organisations that fill these gaps are much larger than similar English community organisations, with more resources, staff and bigger client populations.

Why established?

In the English responses to the questionnaire, comments on the need for the project were varied. All, in some way, linked to or were underpinned by an understanding of inequalities in health or social circumstances. It was generally understood that wider determinants affected physical health and often manifested in other problems. Over time the West Midlands Fire & Rescue Service realised that some house fires were related to issues such as alcohol and substance misuse which they came to understand were underpinned by social inequalities.

Even those projects in England that focused on a single issue, such as encouraging breastfeeding, started from the perspective that social and cultural influences underpin health behaviour. This is consistent with the policy direction of many English local health and wellbeing boards that have adopted the six key policy objectives in 'Fair Society, Healthy Lives'[27] Some projects champion this approach more than others. Brighter Futures in England provide a strong political argument for the work they do. In their report they challenge the domination of the medical model in treatment services, especially in the area of mental health and its complex interaction with substance misuse.

Case Study: Brighter Futures (Stoke on Trent)

This project works with people who have complex needs including individuals with multiple diagnoses: mental & physical health issues, coupled with substance misuse to 'self-medicate' – issues frequently associated with homelessness.

The project finds that their service users fall between the services established in response to national policy (especially as this tends to be constructed around single issues), "...single homeless people are excluded from a right to housing under the Homeless Persons Act (1968)" and "The Mental Health Act (date) only provides for people with a 'treatable' condition". Simply addressing the characteristics of such excluded groups is insufficient. The processes which create marginalisation should be

[27] Marmot M (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*

addressed as a response to the social and health issues of a wide range of excluded groups and individuals.[28]

The project faced difficulties in securing recognition for their approach:

"...because we are not medically qualified our opinion is of less value"[29]. However they describe a clarity and belief in their method of support and were able to convince health workers that the approach worked "... based on empowering people (rather) than a medical model that sought to 'treat' people."

Their vision for the future is to get underneath lifestyle issues to really deal with the causes of enduring poor health,

"... the physical aspects of poor health will not work unless we seek to improve well being...behavioural change risks alienating people and increasing their ambivalence."

A final insight from Brighter Futures is that social class is a major influencing factor in determining health outcomes, which they suggest are likely to get worse as the welfare reforms in England are implemented in 2013. This is reinforced by the analysis considering the impact of the economic downturn and the policy changes on health inequalities in London.[30]

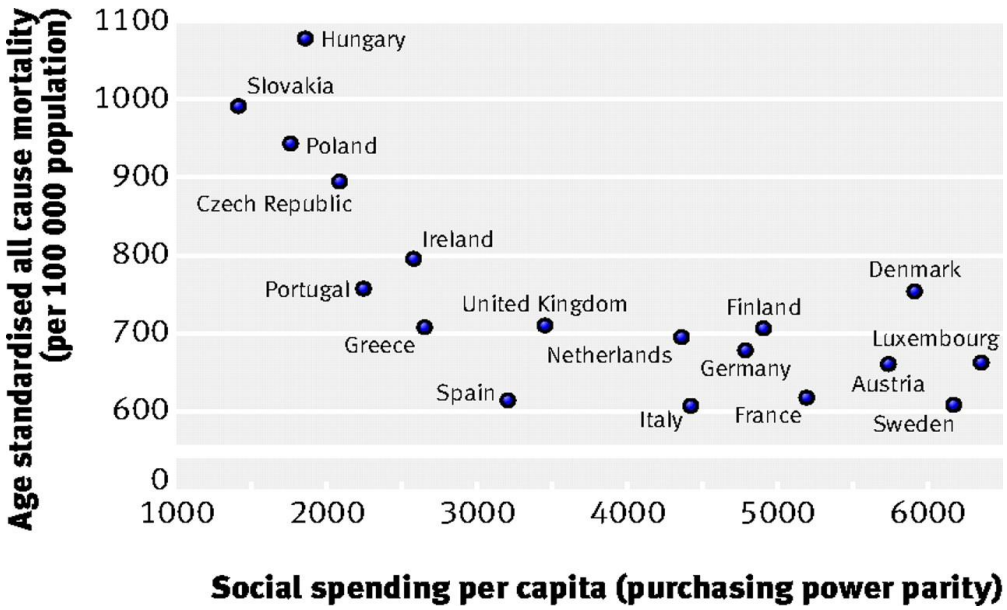
The US responses most frequently stated that they filled a gap in healthcare access rather than being explicit about inequalities and the social determinants of health. It could be concluded that tackling inequalities is implicit in the need for these services because inequalities underlie the inability of many people in poorer and BME communities to access insurance funded health and social care systems.

[28] Marmot M (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*

[29] "By denying public recognition to entities that cannot be measured by science, the call for pure, orthodox, confirmed medical practice shields this practice from all political evaluation." in
Illich I (1976) *Limits to Medicine - Medical Nemesis*

[30] Bloomer E.et al (2012) *The impact of economic downturn and policy changes on health inequality changes in London* at www.ucl.ac.uk/marmotreview.

"Socially cohesive societies …with developed welfare states and high quality education and health services have created the conditions for people to have the freedom to lead lives they have reason to value. Remarkable health gains have been the result." [31] This is illustrated in the table below:



[32]

In the responses to the questionnaires the US projects were much more explicit about race as a factor in health inequalities. While all of the projects (both English and US) worked in support of BME communities and were dealing with some challenges associated with deprivation and inequality, the US examples frequently refer to their response as specifically intended to cope with the scale of both existing, changing and new migrant communities. The English projects place less emphasis on race as a primary factor in health inequalities. In the English responses race is discussed as one of many issues linked to gaps in service provision or perceptions about and appropriateness of services.

[31] Marmot M. (2012) WHO European Review of Social Determinants of Health and the health divide. Lancet.Vol 380 September 15 2012 pp 1011-1029.

[32] Stuckler D. ,Basu S.,McKee M (2010) *Budget crisis, health and social welfare programmes*. BMJ 2010 340. C3311

3. What has changed over the years?

This can be notoriously difficult to evaluate: "To understand the effectiveness of a programme, questions are needed about who it worked for and in what circumstances, as well as how and why it worked or did not work. Many of the interventions are experimental and evolve with learning about what works and what doesn't. This makes it difficult to assess progress against goals when these are adapting to unexpected consequences and outcomes."[33]

In their responses projects did report some changes over time that ranged from health inequalities having gotten worse to projects reporting significant increases in their performance and outcomes. Some projects reported that their work had remained fairly stable although the nature of their activities had varied as the community around them changed.

A number of the projects reported that their work has increased their understanding of a particular community or client group. This knowledge was used in various ways to bring additional benefits or to challenge unhelpful views and models.

Most frequently projects reported understanding more about the complexity of communities they worked with and how this links to environmental/social conditions and their relationship with health inequalities. The knowledge produced was in some cases used to change the practice of health professionals – as in the English FGM project which changed practice in maternity appointments for Somali Women.

Recommendation: Evaluation of community development programmes needs to factor in the impact of the context and how this interacts with the programme's methodology to generate outcomes. There is a need to use participatory methods and approach evaluation as 'reflective practice' alongside quantitative and qualitative approaches.

[33] Foot J (2012) *What makes us healthy? The asset approach in practice: evidence, action, evaluation* http://www.assetbasedconsulting.net/uploads/publications/WMUH.pdf

"The inclusion of explicit corporate strategic objectives for Health & Wellbeing provides an opportunity for West Midlands FRS to demonstrate the links between people's health and fires" (West Midlands Fire & Rescue Service)

"An information card in the form of a bookmark has been produced that women could present ...to indicate they are affected by FGM. The community had a major role in designing the tool. It is hoped that the tool will increase women's choice and involvement in their care" and "there will be increased understanding of women with FGM, from maternity services" (Somali FGM Bookmark Project)

"...evaluation has proven that a community led approach motivates and encourages the community to improve their own health & well-being" and "changing mindsets by using flexible and approachable methods rather than being target driven" (My Health Matters, Stoke-on-Trent)

"Over the years BPN has moved to include a stronger focus on the influences of the social determinants, referencing a Socio-ecological model…" (Brooklyn Perinatal network)

4. What would you consider was most helpful to your organisation?

Without exception all of the projects cited good joint working relationships as a major benefit. This was described in a variety of ways including: 'partnership', 'relationship' and 'collaboration'. In addition all projects discussed a level of community involvement - this ranged from: consultation with communities to establish a basis for work; formal partnership working with communities and community leaders; to co-production[34] with user-led organisations.

Other helpful factors frequently reported were: strong leadership, clear objectives, policy direction, committed, skilled staff and sustainable funding.

[34] "Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and neighbours." in Boyle D & Harris M *(2009) The Challenge of Co-production" NESTA*

We would conclude that the following are desirable attributes for any successful organisation; effective civic, political and executive leadership,[35] clarity of objective and strategic fit of projects,[36] policy alignment and coherence, [37] workforce capacity, [38] and continuity of project funding to deliver long term strategic change.

Recommendation: It would be interesting to conduct a further investigation into the organisational culture of bodies that do this kind of work. Is there an empowerment culture in the organisation that matches the community empowerment that they seek to deliver? Does community development work attract a certain kind of person who has already developed empowering skills? Does a gender difference exist with women demonstrating greater transformational focus than men?

Using a community development approach was not always explicitly mentioned in the responses – however use of this approach is demonstrated in all of these projects and there are many clues to this throughout the responses.

> "Collaborating with community leaders to identify the most effective and appropriate ways to address health issues" (Greater Lawrence Family Health Centre)

5. What was considered to be unhelpful?

With the exception of the projects that are led by local authorities (LA) or Primary Care Trusts[39] (England - PCT) and the largest US project (The Greater Lawrence Family Health Centre), all other responses reported a lack of funding as the most unhelpful.

---

[35] Marmot M et al (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*

[36] Smithies J and Hampson S (1999) *Review of good practice in community participation,health projects and initiatives* Labrynth Consultancy and Training

[37] Cook B (2009) *Health Inequalities* Southern Health Board. Northern Ireland.

[38] Grady M and Goldblatt P (Eds) et al. (2011) *Addressing the social determinants of health ,the urban dimension and the role of local government* WHO Europe.

[39] An **NHS primary care trust** (PCT) is a type of NHS trust in England that commission primary, community and secondary care from providers and provide community services directly.

This included:

- Reductions in funding - from LA/PCT as a result of the recession
- Reductions in funding - due directly to the recession
- Short-term funding – usually one to three years
- Funding criteria – grants are usually available only to fund new activities
- Inflexible funding – often related to achieving outputs in a target driven culture
- Bureaucratic funding regimes - the time & resources involved in bidding for and monitoring grant funding can be greater than the benefits achieved

One or more of these funding barriers was/were experienced across each country and in the majority of projects.

If we consider the funding issues alongside other insights gained from this analysis we conclude that community development, its associated methods and the organisations/services that adopt this way of working, remain marginalised within the health and social care systems in both countries.

Although this applies to all projects we observed some subtle differences between the US and England in the responses to this question, including:

In England substantial and sustained funding for health and social care is allocated to public services and of most relevance to this analysis – the NHS.

There is still little opposition or effective challenge in either country's responses to dominance of the medical model or current clinical practice, which we suggest is protected by professional and structural power.

An exception to this was the response from the 'Brighter Futures' project which challenges assumptions about how the medical professions undervalue the opinions

of community workers. This project concludes that 'rough sleeping/homelessness' is an 'iatrogenic'[40] effect of poor health and ineffective interventions.

From the responses we received it is reported to be unhelpful that funding for community development and community based activity has, for some time, tended to be short-term and vulnerable.

The responses from the US indicate that funding appears to work differently in that country and the problems with funding are described differently in these projects. It is usually made available via competitive tendering through national, regional and local administrations. Its use in smaller projects appears to be threatened by bigger organisations if the commissioners' preference is to contract a large organisation to provide multiple services.

> "Some years ago the Infant Mortality Reduction Initiative (IMRI) citywide community partners funded by the NYC council faced the prospect of the diversion of the funding allocated in the Mayors' Executive budget to the Department of Health and Mental Hygiene for this initiative...(they) had appeared to be more in favor of sending to a few large NGOs the lion share of this pot of money designated by the city council for infant mortality reduction work. The smaller community based organization usually secure this funding support annually for their work. (Brooklyn Perinatal Network)

The result is that smaller organisations, especially those that are the closest to communities can lose out.

> "One of the main challenges has been the limited availability of resources to provide much needed services in the communities being studied." (The University of Alabama)

It might be the case in the US that the population served by these organisations, i.e. those outside of the insurance system, seem negatively regarded in society. We make this assumption because of the language used to describe them. The

[40] Iatrogenesis – an inadvertent adverse effect or complication resulting from medical treatment or advice

connotations of the word 'migrants' are people who are not of the USA and are different or other. "...difference is fundamental to cultural meaning. However, it can also give rise to negative feelings and practices." [41]

Because of the substantial differences in the provision of health and social care systems between the US and England it is difficult to make any comparisons of what is both helpful and unhelpful, although there was more consensus between the two countries on what was helpful. We suggest that a contributing factor in both the US and England is that community development and engagement activity carries less value than clinical or medical care services – no matter how they are funded. However we want to impress that there are some complex underlying issues here – not just simply the allocation of funding – that lie outside the scope of this report.

6. What have been the key drivers for success?

In their responses, almost all the projects described the strong and effective relationships that had developed in and with the communities they served as one of their main successes. Frequently the responses highlighted their ability to provide culturally appropriate support and services. However this may not be as straightforward as it seems.

The US projects mostly provide services for BME communities that are extremely economically disadvantaged – described in their responses as the "poor" and "underserved". They are meeting a need that is not provided for elsewhere. Success is often described in terms of meeting these needs by providing basic services.

> "More than 51 percent of Lawrence residents live below the federal poverty levels and nearly 60 percent of the population is Latino – the city has the largest proportion of Hispanics of any Massachusetts community… (Our) presence in the city of Lawrence has ensured that the indigent minorities and working poor have access to quality primary healthcare." *(Greater Lawrence Family Health Centre)*

[41] Stuart Hall cited in Wetherell M, Taylor S & Yates SJ (eds) (2001) *Discourse Theory and Practice*

The services that English projects deliver respond to the perception that health services, particularly the NHS, are hard to access for some communities or are culturally inappropriate. It's not that economic disadvantage isn't a factor for English BME communities but that the projects' successes are often described as improving access to services.

> "The project brought together health professionals and women from the Somali community to share information and communication... with the overall aim of providing culturally sensitive maternity services...If no intervention had taken place many women from this community would continue to avoid antenatal appointments, many presenting late to maternity services" (The Sandwell Somali Bookmark Project)

All projects cite success in terms of delivering strong community engagement and development principles, such as trust, involvement and community led initiatives. Some of the projects were able to demonstrate such a level of benefit that statutory providers were willing to become involved, for example,

> "Initially there was some reluctance to change within community practices however this was short lived as staff became aware of the value of the service in complementing their role" (Coventry Infant Feeding Team)

> "…there is strong evidence that community led and community based efforts, informed by rigorous evaluation have had marked success in making changes at the system and environmental levels…" (The Institute for Family Health)

Generally all the responses conveyed a sense of having strong guiding principles, a clear model/framework for community work, a commitment to understanding and being led by the community and above all to value the individuals and communities they are supporting.

7. Identify one major challenge and how was this overcome?

There were varied responses to challenges faced amongst the English projects, however some similar experiences, including:

- Funding frequently featured as an enduring challenge – projects rarely offered any ideas for how to solve the problem although the new commissioning arrangements in the NHS are seen as an opportunity.

  "The development of the Community Health Network[42] (will)... hopefully make it easier for member organisations to access statutory funding through the commissioning process." (Sandwell Irish Society)

- Several English projects cite problems in resolving relationships between General Practitioners (GPs) and patients as a challenge – one response commented that you need to be persistent and have to demonstrate the added value/benefits of community-led approaches when building relationships with GP practices.

  "The issue between patient complaints against a doctor's surgery, it has been raised many times, however no strict action was taken." (Sandwell - Community Connect Foundation)

- Several English projects describe initial mistrust of them in communities and how the credibility of any new service or community organisation needs to be earned

  "In the very early days there were lots of suspicions and rumours among some of community members as to the motive of establishing the group." (Sandwell - Yemeni Community Association)

The US projects unanimously cited reduced funding or lack of sustainable funding as the main challenge. In particular the preference for outsourcing services to larger organisations was detrimental to many projects.

Some interesting solutions offered were for organisations to establish a philanthropic fund or an endowment. The largest US organisation seemed able to demonstrate a level of success that encouraged them to collaborate with the other REACH Communities to advocate nationally for their work and working practices,

[42] Sandwell Community Health Network is a public health programme targeted at the Black and Minority Ethnic (BME) communities in Sandwell that was established to improve the health and wellbeing of BME communities in Sandwell.

> "The goal of the new coalition was to help shape the national dialogue on the role that communities must play in efforts to address racial and ethnic health disparities" (The Institute for Family Health/Bronx)

8. Can you share your vision, potential challenges and opportunities?

All projects stated that future funding was a constant issue and a concern. All projects suggested that they would keep going somehow and would make the best use of the resources available to them. In the US these solutions tended to be more strategic, for example, to find ways to influence policy. Most US projects seem well informed how policy influences their work and their clients.

The English projects also expressed concerns about future funding but seemed more optimistic with many suggesting that they would work with their communities to find solutions – usually by releasing more community assets.

A number of projects also commented on strategic activities that might help them in the longer term, especially better and different forms of collaboration and resource sharing across organisations and sectors. The transfer of public health back to Local Authorities was seen as an opportunity as was the development of local commissioning to replace grant funding.

9. Is there anything else you want to tell us?

The replies to this question gave us some of the most powerful quotes on principles and values of community development that we have identified:

> "The organisation does not have 'workers' or 'trustees' but has passionate, forward thinking community members…" (Sandwell - Yemeni Community Association)

> "Always respect and speak to the people who live in the area and don't assume you know what their needs are" (Stoke on Trent - My Health Matters)

> "Good work done in the past should not be overhauled and changed if there is no need. Keep what is working well." (Sandwell – The Bangladeshi Islamic Association)

> "Patience is a key virtue when it comes to building social capital and trusting relationships." (The Brooklyn Perinatal Neywork)
>
> "...to identify what works and what doesn't is critical." (The Bronx - Institute for Family Health)
>
> "The exchange has brought a new wealth of knowledge to our work and at the same time has provided validation of our models that are being adopted and successfully implemented." (The University of Alabama)

Additional comments made by the US projects all relate to power:

> "There is power in numbers/collective action… When you have a strong 'why' you will always find a 'how'." (Brooklyn Perinatal Network)
>
> "It has been most rewarding observing thousands of individuals finding ways to improve their own health…truly powerful" (Greater Lawrence Family Health Centre)

General observations

We share the view acknowledged by many others that community development has a strong political dimension:

"Government remains the essential, accountable focal point of power but its job is changing to some degree from delivery to enabling. Of course, no government wants to – or simply can let go of the power it has, or can avoid being held accountable for its actions and the delivery of public services.

So the shift to an enabling role requires a complex, paradoxical, partial transfer of power and responsibility. Inevitably this can face resistance and tensions. Community development helps people and public institutions to respond positively to this transformation by creating additional avenues for participation and releasing new energies from below. It can also assist more traditional forms of government to adapt to change and disperse power"[43]

[43] CDX, CDF, FCDL for UK Department of Communities and Local Government (2007) *The Challenge of Community Development* CDX, CDF, FCDL for UK Department of Communities and Local Government

What was clearly important was being explicit about roles and responsibilities, negotiating on issues of power and control which created an empowering focus within projects with a culture of working 'with' not 'for' disadvantaged communities.[44]

Imbalances in power and control seem to be more openly acknowledged and reported in the US projects. We would suggest this may be attributable to the different service system in the US compared to the public sector in England. Community development projects (and workers) that are aligned to, or funded by public sector organisations will always need to balance their political views. Community development workers employed by public services in England must remain politically neutral.

Recommendation: As public health transfers into top tier Local Authorities in England we have an ideal opportunity to encourage a debate amongst elected decision makers on the politics of health inequalities and the benefits of "empowering individuals and local communities." [45] Similar opportunities could be sought in the US, following President Obama's health care reforms.

As previously noted the US organisations are larger and have been in existence for longer than those in England and seem to be relatively robust organisationally and administratively. Many of the English projects are relatively recent and smaller, some are short-term or time limited and most receive support from the public sector.

The extent and quality of the submission made by the University of Alabama deserves particular comment. It clearly has substantial financial, human and intellectual resources. This is of particular interest when considered in the context of

[44] Weller G. and Grady M.(2012) *Community Development and health improvement in a deprived metropolitan area in Northern England: A case study*. Work based Learning e-journal International Vol 2. Issue 2- March 2012.

[45] Marmot M et al (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*

comments by several projects on the need to demonstrate effectiveness via evaluation in relation to evidence required to attract funding.

We suggest that further thinking needs to be done on one of the key challenges identified by nearly all the projects – how to fund organisations that are using the type of approaches developed by all the projects in the exchange? "To develop a basis for commissioning that supports community development and community building, not just how activities are commissioned but what activities are commissioned." [46]

One project in England (Brighter Futures in Stoke on Trent) deserves particular comment. It demonstrated a great deal of insight and ability to present an intellectual argument for its practice. The project challenges the dominance of the medical model and its inappropriateness in their field of work.

Most of the other English projects demonstrate an equally valid but different kind of knowledge. Their responses reflect a deep, local and culturally specific understanding of the communities they work with and are part of.

As has been noted by a number of the projects in both countries informal, local and often tacit knowledge of communities is often marginalised by the preference of commissioners for the more dominant epidemiological models of evidence and data that underpins much of mainstream services and practice. To be effective community health development needs a balance of both: "The role of community development is often overlooked at the higher levels of policy, although there is wide reliance on its methods at the level of implementation. This reliance is largely hidden from view because it takes place in detailed local situations. Community Development's own ethos of stressing its role in providing background support rather than leadership reinforces this low profile" [47]

[46] Foot J & Hopkins T (2010) *A glass half-full: how an asset approach can improve community health and well-being* I&DeA

[47] CDX, CDF, FCDL for UK Department of Communities and Local Government (2007) *The Challenge of Community Development* CDX, CDF, FCDL for UK Department of Communities and Local Government

Much of the work in the English projects is reported as having lower status and is perceived as 'marginal' or low profile in comparison with commissioned mainstream community services.

Appendix 1

LIST OF PROJECTS THAT PROVIDED INFORMATION FOR THE QUALITATIVE ANALYSIS

ENGLAND	
Making West Midlands Safer	Coventry
Coventry Men's Health Forum	Coventry
The Infant Feeding Team	Coventry
Bangladeshi Islamic Association	Sandwell
Community Connect Foundation	Sandwell
Migrant Listening Events	Sandwell
Sandwell Irish Society	Sandwell
Smethwick Pakistani Muslim Association	Sandwell
The Yemeni Community Association	Sandwell
The Somali FGM Bookmark Project	Sandwell
My Health Matters	Stoke on Trent
Brighter Futures	Stoke on Trent
UNITED STATES	
Brooklyn Perinatal Project	Brooklyn, NY
The Institute for Family Health	Bronx, NY
Union Settlement Association	East Harlem, NY
The Greater Lawrence Family Health Centre	Lawrence, MA
Korean Community Services	Manhattan, NY
MHRC, The University of Alabama	Birmingham, AL
New York University Center for the Study of Asian American Health & Health Promotion and Prevention Research Center	New York City, NY

ENGLAND

Coventry

- Jean Arrowsmith, Coventry City Council

Nottingham

- Councillor Eunice Campbell, Portfolio Holder for Adult Services and Health
- Sharan Jones, Health and Wellbeing Manager

Sandwell

- Ginder Narle, Sandwell Primary Care Trust & Learning for Public Health West Midlands – LPHWM
- Paul Southon, Sandwell Primary Care Trust

Stoke-on-Trent

- Councillor Gwen Hassall - Stoke-on-Trent City Council
- Judy Kurth - NHS Stoke-on-Trent Public Health Department and Stoke-on-Trent City Council Healthy City Programme

UNITED STATES

Birmingham, Alabama

- Amber Anderson, University of Alabama Minority Health and Health Disparities Center
- Mona Fouad, University of Alabama Minority Health and Health Disparities Research Center
- Eric Jack, University of Alabama at Birmingham School of Business
- Maria Morena, University of Alabama Minority Health and Health Disparities Center
- Joanice Thompson, University of Alabama Minority Health and Health Disparities Center

Bronx, New York

- Joyce Davis, Bronx Health REACH Coalition Member and Leader of Faith-based Outreach Initiative
- Carlos Devia, Program Manager for Research and Evaluation at Institute for Family Health
- Charmaine Ruddock, Project Director, Bronx Health REACH/NY CEED

Brooklyn, New York

- Ngozi Moses, Brooklyn Perinatal Network, Inc.

Lawrence, Massachusetts

- Jean Lussier, Self Management Education/Nutrition Education Director, Latino CEED REACH New England based at the Greater Lawrence Family Health Center, Lawrence, MA USA
- Martha Velez, City of Lawrence Council on Aging.

New York

- Ashley Fox, Lead Evaluator, Communities IMPACT Diabetes Center, Mount Sinai School of Medicine
- Carol Horowitz, Associate Professor and Principal Investigator, Communities IMPACT Diabetes Center, Mount Sinai School of Medicine
- Michelle Ramos, Program Manager, Communities IMPACT Diabetes Center, Mount Sinai School of Medicine

New York

- Kay Chun, Director, Korean Community Services Public Health & Research Center
- Smiti Kapadia, Project Coordinator, New York University Health Promotion & Prevention Research Center
- Simona Kwon, Director, New York University Center for the Study of Asian American Health

LIST OF INDIVIDUALS, PROGRAMMES AND PARTNERSHIP ORGANISATIONS VISITED DURING THE LEARNING EXCHANGE

ENGLAND

Coventry

Coventry City Council - Partnership Organisations Visited *(shown in order of programmed visits)*

Coventry City Council, Chief Executive and Management Team

Citizen's Advice Bureau

Leigh Church of England Primary School

Food Dude Programme

West Midlands Fire Service

Coventry Operational Command Team

Radford Children's Centre

Coventry Breast Feeding Team

'Cook and Eat Well' Programme

Stoke Aldermoor School

Coventry Healthy Weight Programme

MAMTA (dedicated women's group)

University Hospital of Coventry & Warwickshire (UHCW) – Midwifery Team

Coventry Director of Public Health and Team

The Way of the Spirit Warriors (Martial Arts Group)

The POD – NHS Mental Health and Wellbeing Centre

Coventry City Council Neighbourhood Action Team

UHCW – Meeting with Clinical Director and tour of Wisdem Centre and Human Metabolism Research Unit – Professor Kumar and team

Meeting with local GP's and NHS District Nurse manager (George Eliot Practice)

Visit to Gurdwara Temple

Nottingham

Nottingham City Council - Individuals, Programmes and Organisations Visited *(shown in order of programmed visits)*

Nottingham City Council's Health and Wellbeing Team
Communities for Health and East Midlands Communities for Health Network
Workplace Weight Management Programme
Early Intervention Team
Mary Potter Joint Service Centre
Family Nurse Partnership
Forest Outdoor Fitness Centre
Chief Executive Officer and Management of Nottingham City Council
TunTum Housing Association
Changemakers Volunteers
Big Health Day for Adults with Learning Disabilities
Wollaton Hall
Chair of Health Scrutiny
Diabetes Unit at Nottingham University Hospital
Specialist Midwifery Team for Homelessness and Substance Misuse
Children and Families Trilogy of Risk Lead
Nottingham Castle
Nottingham's Healthy Weight Strategy
Juggle Diabetes
Family Intervention Project
Neighbourhood Working
Bright Ideas – Champions for Change

Sandwell

Sandwell – Partnership Organisations Visited

Sandwell Director of Public Health and public health team

Sandwell Metropolitan Borough Council – Service Director Commissioning

The Public Gallery

Sandwell Cares and Sandwell Carers organisations

Smethwick Friends and Neighbours

Bangladeshi Islamic Centre

Brushstrokes

Sure Start Smethwick Cape Hill and Windmill Area Children's Centre

Sandwell Community Health Network

- Indian community in Sandwell
- African Caribbean Health Improvement Service (ACHIS)
- Pakistani community in Sandwell
- Community Connect Foundation (Bengali)
- Bangladeshi Men's Health Project
- Sandwell Irish Health Steering Group
- Sandwell Irish Society

Sandwell Time Bank

Sandwell South Asian Targeted Health Initiative (SSATHI)

Sikh Health Improvement Group

Sandwell Multi Faith Network

Sandwell Yemeni Community Association

UHCW – Meeting with Clinical Director and tour of Wisdem Centre and Human Metabolism Research Unit – Professor Kumar and team

Stoke on Trent

Stoke-on-Trent City Council - Partnership Organisations Visited *(shown in order of programmed visits)*

Lord Mayor's Office Stoke on Trent
Stoke on Trent Director Public Health & Team
Voluntary Action Stoke on Trent (VAST)
Stoke on Trent YMCA
Brighter Futures
North Staffordshire Mind
Changes Stoke on Trent
Stoke City Football Club
Staffordshire University
NHS Staffordshire
Staffordshire County Council
Keele University
My Health Matters Team
Redeeming Our Communities (ROC) at Cobridge Community Centre
St Maria Goretti Primary School
Townsend Community House
Professor Hugh Barton
Integrated Sexual Health Centre – Cobridge
Emma Bridgewater Factory
Stoke on Trent City Council Officers
NHS Stoke on Trent Officers

UNITED STATES

New York

Mount Sinai School of Medicine - Partnership Organisations Visited

Bethel Gospel Assembly
Fire Department, City of New York, Engine 53, Ladder Company 43
Little Sisters of the Assumption Family Health Services
Union Settlement Association
Yorkville Common Pantry

New York

New York University Center for the Study of Asian American Health & Health Promotion and Prevention Research Center - Partnership Organisations Visited

NYU B Free CEED (Center of Excellence in the Elimination of Hepatitis Disparities)
Bellevue Hospital Center
Charles B. Wang Community Health Center
Korean Community Services of Metropolitan New York, Inc. -KCS Public Health and Research Center
NYC Hepatitis B Coalition
Manhattan Sikh Association

Bronx, New York

The Institute for Family Health – Partnership Organizations Visited

The Institute for Family Health
MARC Academy & Family Center
Walker Memorial Baptist Church
Morrisania Women, Infant, and Children (WIC) Center

Other Organizations that presented at the meetings

New York Lawyers for the Public Interest
New York City Coalition Against Hunger
New York Academy of Medicine
New York City Department of Education
New York City Department of Health

Brooklyn, New York

Brooklyn Perinatal Network, Inc. – Partnership Organizations Visited

Brooklyn Perinatal Network and The Brooklyn

BACHE Project

Task Force on Infant/Maternal Morality and Family Health

Borough of Brooklyn and City of NY Perspectives on Partnerships for Health Improvement

Brownsville and Community Collaboration

Local Health Department Community Partnership Initiatives

New York City Department of Health and Mental Hygiene

The Brooklyn DPHO

Brownsville Heritage House

East New York Diagnostic Center, Brooklyn, NY

Birmingham, Alabama

University of Alabama at Birmingham (UAB) – Partnership Organizations & Community Partners Visited

UAB Division of Preventive Medicine

UAB School of Business (Project: Summer Enrichment Program in Wilcox County for Economic Development)

UAB Minority Health & Health Disparities Research Center (MHRC)

UAB HealthSmart (innovative model for prevention)

Friends of West End Community Garden

Norwood Resource Center

Dunbar Abrams Bessemer Community Center

Lawrence, Massachusetts

Latino CEED REACH New England based at the Greater Lawrence Family Health Center & City of Lawrence Council on Aging - Partnership Organizations & Community Partners Visited

Merrimack Valley AHEC (Area Health Education Center)

Greater Lawrence Family Health Center

Latino CEED REACH New England

City of Lawrence Council on Aging - Lawrence Senior Center

Heritage State Park Museum, Lawrence, MA

Greater Lawrence Family Health Center, Lawrence, MA- Mammography Working Group

City Planning Office, Lawrence, MA

Appendix 2

REACH/Communities for Health Learning Exchange 2011/12

Community Questions

1. What is the role and function of your organisation? You may wish to highlight the organisation's structure identifying type and specifying allocated funding streams?

2. When was the organisation established and why? Please include a brief summary of the historical context the organisation was set up in, identifying the original vision. The health & social care needs the organisation was originally set up to meet in response to what was happening at the time the organisation was established?

3. What has changed over the years in terms of community health needs and the organisation's response?

4. During this period of establishment what would you consider was most helpful to your organisation? This may be in the form of internal and/ or external support.

5. What was considered to be unhelpful? This may be specific intervention from internal or external agencies and specific policy directives. Can you state how this has changed overtime?

6. What are the main principles and factors that in your opinion have been the key drivers for success, enabling your organisation to deliver specific public health activity? This may be key champions, leaders, access to resources etc

7. As an organisation please can you identify one major challenge the organisation has encountered? How was this overcome? What/who was helpful and what was the key learning?

8. For the future can you share your vision, potential challenges and opportunities ahead? What is needed to guarantee success? Is there anything you would like to do differently if you had the opportunity?

9. Is there anything else you want to tell us about your experiences?

Appendix 3

Sources

Alimo-Metcalfe B. (2007) *Gender and Leadership: Glass ceiling or reinforced concrete*. Research Institute of the Ecole Nationale d' Administration Publique. Quebec, Canada.

Blanchard C., Gibbs M., Narle G., Brookes C. *Learning from communities in the USA and England to promote equity and address the social determinants of health* - Global Health Promotion (submitted for publication 2013)

Bloomer E.et al (2012)*The impact of economic downturn and policy changes on health inequality changes in London*

Boyle D & Harris M *(2009) The Challenge of Co-production" NESTA*

Cook B (2009) *Health Inequalities* Southern Health Board, Northern Ireland.

CDX, CDF, FCDL for UK Department of Communities and Local Government (2007) *The Challenge of Community Development*

Foot J (2012) *What makes us healthy? The asset approach in practice: evidence, action, evaluation*

Foot J & Hopkins T (2010) *A glass half-full: how an asset approach can improve community health and well-being* I&DeA

Grady M and Goldblatt P (eds) et al. (2011) *Addressing the social determinants of health, the urban dimension and the role of local government*. WHO Europe.

Grint (1997) *Leadership* Oxford University Press UK

Health and Social Care Act 2012 - Conservative-Lib Dem deal - http://news.bbc.co.uk/1/hi/8677933.stm

Hills J, Sefton T, and Stewart K. (2009) *Towards a more equal society* Policy Press, Bristol

Illich I (1976) *Limits to Medicine - Medical Nemesis*

International Union for Health Promotion and Education. *Key Messages from the International Union for Health Promotion and Education on the Social Determinants of Health*. IUHPE; 2012.

http://www.iuhpe.org/uploaded/Activities/GWG/SDH/20120718_IUHPE%20Key%20Messages_SDH_FINAL.pdf

Marmot M. (2012) *WHO European review of social determinants of health and the health divide* Lancet Vol 380 September 15 2012 pp 1011-1029. http://www.instituteofhealthequity.org/projects/who-european-review

Marmot M et al (2008) *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the WHO Commission on Social Determinants of Health.* Geneva, World Health Organization; 2008. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

Marmot M, Atkinson T, Bell J, Black C, Broadfoot P, Cumberlege J, Diamond I, Gilmore I, Ham C, Meacher M and Mulgan G. *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010*. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

Rosener J.B. (1990) *Ways Women lead.* Harvard Business Review Nov/Dec 1990

Smithies J and Hampson S (1999) *Review of good practice in community participation, health projects and initiatives* Labrynth Consultancy and Training

Stuckler D, Basu S, McKee M (2010) *Budget crisis, health and social welfare programmes*. BMJ 2010 340. C3311

United Nations (2011) *Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*, A/66/L.1

Weller G. and Grady M. (2012) *Community Development and health improvement in a deprived metropolitan area in Northern England: A case study* Work based Learning e-journal International Vol 2. Issue 2

Wetherell M, Taylor S & Yates SJ (eds) (2001) Discourse Theory and Practice

World Health Organization (1986) *The Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa*

World Health Organization (2011) *Rio Political Declaration on Social Determinants of Health – World Conference on Social Determinants of Health*. http://www.who.int/entity/sdhconference/declaration/Rio_political_declaration.pdf