State of the Health Equity Movement

2011 Update

Part C: Compendium of Recommendations

THE DRA PROJECT
Accelerating Disparity Reducing Advances

Institute for Alternative Futures

State of the Health Equity Movement, 2011 Update
Part C: Compendium of Recommendations

DRA Project Report No. 11-03

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The Disparity Reducing Advances Project (DRA Project) led by the Institute for Alternative Futures periodically releases Health Equity Movement Updates, a set of reports that serve as a resource and provide a window into the growing health equity movement in the U.S. The present report is a component of the DRA Project's 2011 Health Equity Movement Update and presents a compilation of 79 recommendations on health equity from governments, foundations, communities, private organizations, and non-profit organizations.

The DRA Project's 2011 Health Equity Movement Update also includes: "Part A: Overview" (DRA Project Report 11-01), which identifies the patterns and themes from the present report, Part C; and "Part B: Catalog of Activities" (DRA Project Report 11-02), which describes projects, meetings, and publications focused on health equity. All three 2011 reports represent updates of a set of 2009 DRA Project reports that summarize health equity efforts and the movement prior to late 2009 (DRA Project Reports 09-01, -02, and -03). All of the DRA Project reports are available at www.altfutures.org/draproject.

Introduction

The Robert Wood Johnson Foundation's Commission to Build a Healthier America recently published a map detailing Washington, DC's metro lines.[1] Yet, the data on the map is not what a rider would see on a normal basis; rather, it details the life span discrepancy arising between the suburbs of Maryland and Virginia, and Washington, DC. A resident from East Falls Church in Fairfax County, VA (along the Orange Line), for instance, has a life expectancy of 80.1 years. Nine stops, or 10 miles later, the same train arrives at Metro Center in the District, where the average life expectancy drops to 72 years. However, this graphic may be misleading, as it takes the average age of all of the District's regions; it ignores the even larger discrepancies between the District's neighborhoods. It is estimated that people in Georgetown and the affluent areas of Northwest DC live on average 20 years longer than those in the low-income areas of Anacostia. The difference in lifespan characterizing these residential areas reveals the existence of health

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[1] Robert Wood Johnson Foundation. *Commission Metro Map*. Digital image. *Commission to Build a Healthier America*. The Robert Wood Johnson Foundation (RWJF), 2009. Web. 2011. <http://www.commissiononhealth.org/PDF/769f7dcc-46a7-4953-b149-44931d0995e8/CommissionMetroMap.pdf>.

disparities in the United States. The greater awareness of these differences and greater attention to them is one of the indicators of the growth of the health equity movement.

Over the past two years more federal, state, and local governments, as well as private organizations, have recognized and taken action towards eliminating health disparities. Thus, the health equity movement has assumed a broader place in the American political sphere. In 2009, the Institute for Alternative Futures (IAF) identified 28 reports recommending policy changes[2]; in 2011, this increased to 79 reports. These reports are from the Robert Wood Johnson Foundation, Prevention Institute, Centers for Disease Control and Prevention, Policy Link, and many other organizations, foundations, and government institutions. This illustrative collection demonstrates the explosion of interest in the health equity movement, as well as the steps many have taken in order to decrease inequities concerning people's health.

The health equity movement is focused on fairness in health and health outcomes, not merely health care reform. The movement is increasingly recognizing the prominent role that the social determinants of health (SDH) play in health inequity. The Centers for Disease Control and Prevention defines these as, "The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world."[3]

Presently, public health departments and other activists are focusing on the actions that federal, state, and local governments must take in order to create health equity. The following pages present recommendations from 79 reports that serve as indicators of the health equity movement and its expansion. Part C serves as an illustrative look at the movement to combat health inequities. All 50 states have Minority Health Offices and many have Health Equity Offices, which may be the same as or in addition to the Minority Health Office. Likewise, various cities and counties have established Health Equity Offices. IAF has captured recommendations from a small fraction of these. We invite readers to send suggestions of other offices or reports that should be added to future reports on the state of the health equity movement to futurist@altfutures.org.

About The DRA Project

The Disparity Reducing Advances Project (the DRA Project, www.altfutures.org/draproject) is a multi-year, multi-stakeholder project developed by IAF to identify the most promising advances for bringing health gains to the poor and the underserved, and accelerating the development and deployment of these advances to reduce disparities. The DRA Project works to overcome health disparities by targeting the advances with the highest potential for reducing health disparities and then creating a network of organizations committed to accelerating the development and deployment of those advances. The network includes health care systems and local providers, major federal government agencies, technology developers, and consumer and patient organizations. The DRA Project has contributed to and facilitated many initiatives that address health disparities and increase awareness regarding health equity, including

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[2] DRA Project. "Health Equity Recommendations Selected Overview - October 15, 2009". http://www.altfutures.org/draproject/pdfs/Report_09_02_Health_Equity_Recommendations_Selected_Overview.pdf.
[3] CDC. "CDC - Social Determinants of Health - Definitions." *Centers for Disease Control and Prevention*. U.S. Department of Health and Human Services, 2010. Web. 26 July 2011. http://www.cdc.gov/socialdeterminants/Definitions.html.

[reports](#), workshops, and [foresight briefings](#). As part of our commitment, the DRA Project will periodically identify and compile the actions that communities, governments, and others are taking to address health disparities and achieve health equity.

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Health Equity Recommendation Selected Overview - 2011

The table below compares health equity recommendations from 10 leading examples of new or updated reports. Although each report presents different health equity strategies and/or priorities, a number of common categories emerged:

- Early childhood investment
- Education
- Environment, housing, and transportation
- Healthy eating and behaviors
- Employment
- Law enforcement/criminal justice
- Health care

The following 10 reports illustrate the growing activity in the health equity movement and focus on a wide range of policies, all of which affect health:

1. HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Healthcare -The Department of Health and Human Services, 2011
2. Equity, Social Determinants of Health and Public Health Programs – World Health Organization (WHO), 2010
3. Addressing the Intersection Between Preventing Violence and Promoting Healthy Eating and Active Living – Prevention Institute, 2010
4. A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety – Prevention Institute, 2010
5. Working Together for a Healthier Kansas: A Status Report on the Social Determinants of Health in Kansas – Kansas Department of Health and Human Services (KDHHS), 2011
6. F as in Fat: How Obesity Threatens America's Future – Robert Wood Johnson Foundation and The Trust for America's Health, 2011
7. Partners for Public Health: Working with local, state, and federal agencies to create healthier communities, Bay Area Regional Health Inequities Initiative, 2011
8. Health Inequalities – A Challenge for Local Authorities - Marmot Review Fair Society, 2011
9. Health Disparities and Inequalities Report - Centers for Disease Control and Prevention, 2011
10. The Health Disparities of Vermonters- Vermont Department of Health, 2010

Recommendation Categories	Health Equity Recommendations – Selected National, Global, State, or Local Publications									
	DHHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care — DHHS, 2011	Equity, Social Determinants of Health and Public Health Programs — WHO, 2010	Addressing the Intersection: Preventing Violence & Promoting Healthy Eating and Active Living — Prevention Institute, 2010	A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety — Prevention Institute, 2010	Working Together for a Healthier Kansas: A Status Report on the Social Determinants of Health in Kansas — KDHE, 2011	F as in Fat: How Obesity Threatens America's Future — RWJF, TFAH, 2011	Partners for Public Health: (SF Bay Area, CA) — BARHII, 2011	Health Inequalities — A Challenge for Local Authorities — Marmot Review Fair Society, Healthier Lives, 2011	Health Disparities and Inequalities Report — CDC, 2011	The Health Disparities of Vermonters — VDH, 2010
Early Childhood Investments										
Invest in early childhood initiatives and programs, including early childhood education	✓	✓	✓	✓	✓			✓	✓	
Education										
Reform or increase funding for K-12 education		✓		✓	✓			✓	✓	
Equalize access to quality of K-12 education		✓	✓	✓	✓	✓	✓			✓
Advocate for, invest in, and retain high quality teachers, especially in low-income areas				✓	✓			✓		
Increase access and affordability to higher education	✓		✓			✓		✓	✓	
Improve physical education at school, including requiring schools to incorporate physical and nutritional education				✓		✓				
Support of Active Living										
Encourage or ensure safe cities, neighborhoods, communities, streets, recreational areas, and/or buildings	✓	✓	✓	✓	✓	✓	✓	✓		✓
Encourage active transport or design walkable and bikeable communities/complete streets		✓	✓	✓	✓	✓	✓	✓		✓
Increase availability and access to parks, playgrounds, and/or public use of school facilities			✓	✓		✓	✓			
Housing										
Provide access to safe, affordable, and stable housing	✓	✓		✓			✓			✓

	DHHS, 2011	WHO, 2010	Prevention Institute, 2010	Prevention Institute, 2010	KDHE, 2011	RWJF, TFAH, 2011	BARHII, 2011	Marmot Review Fair Society, 2011	CDC, 2011	VDH, 2010
Transportation										
Promote and increase access to affordable public transportation		✓	✓	✓		✓	✓	✓		✓
Increase transportation safety, including traffic safety for pedestrians			✓	✓		✓	✓			✓
Air, Soil, Water										
Improve air, soil, and/ or water quality	✓	✓		✓		✓	✓	✓	✓	✓
Address pollution/climate change, its impacts on health & the poor	✓	✓		✓			✓		✓	
Nutrition										
Promote or ensure availability of fresh, healthy food in all communities, especially underserved ones	✓	✓	✓	✓	✓	✓	✓			✓
Promote access to healthy food, including local healthy food, through tax incentives or programs	✓	✓	✓	✓	✓	✓	✓			✓
Tax unhealthy behaviors					✓	✓	✓			✓
Fresh healthy food should be accessible and incorporated within programs such as WIC/SNAP				✓	✓	✓				
Improve school nutrition	✓				✓	✓				
Healthy foods should be encouraged and promoted in grocery stores and restaurants, one option is menu labeling		✓	✓	✓		✓	✓			
Limit the amount and density of fast food restaurants						✓		✓		
Limit or eliminate junk food advertising, especially to children		✓				✓				✓
Target obesity and create obesity prevention programs	✓	✓			✓	✓			✓	
Encourage Breastfeeding	✓	✓				✓				✓
Reducing Tobacco, Drug, & Alcohol Use										
Implement an outreach regarding the hazards of smoking	✓	✓							✓	
Become a smoke free nation, ban smoking in public		✓			✓		✓			
Incentivize/subsidize, or expand interventions for alcohol/drug abuse	✓	✓	✓	✓	✓				✓	
Limit number and density of liquor stores		✓	✓	✓			✓			

	DHHS, 2011	WHO, 2010	Prevention Institute, 2010	Prevention Institute, 2010	KDHE, 2011	RWJF, TFAH, 2011	BARHII, 2011	Marmot Review Fair Society, 2011	CDC, 2011	VDH, 2010
Employment										
Increase minimum wage		✓	✓	✓	✓			✓		✓
Implement policies that support a living wage		✓	✓	✓			✓	✓		✓
Increase job opportunities	✓	✓	✓	✓	✓	✓		✓		
Support and increase green jobs or green collar jobs			✓	✓	✓		✓			✓
Increase access to and/or provide job skill/ training programs	✓			✓						✓
Increase diversity in the non-healthcare and healthcare job markets				✓				✓		
Law Enforcement/Criminal Justice										
Reduce crime	✓	✓	✓				✓			
Reform or revise criminal laws, especially those that disproportionately target or punish minorities					✓					
Develop and support violence prevention efforts/programs, especially with youth	✓	✓	✓	✓					✓	
Promote and support programs for re-entry into the community for former offenders					✓					
Health Care										
Support or provide universal access to quality health care	✓	✓		✓			✓	✓	✓	✓
Ensure access to culturally and linguistically appropriate health care providers or programs	✓	✓		✓						
Focus on preventative care	✓			✓	✓	✓			✓	
Community and interagency collaboration										
Encouragement of community cohesion, voice, empowerment, and collaboration, especially within the health equity movement	✓	✓	✓	✓		✓	✓		✓	✓
Interagency collaboration between health department and other public departments	✓	✓	✓	✓		✓	✓			
Consider health in non-health planning and policies	✓	✓		✓			✓			
Better data collection methods	✓	✓		✓			✓			

National U.S. Reports

1. **Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations - Joint Center for Political and Economic Studies, July 2010**

To view this report, please click on the link:
http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf

About: This report provides a comprehensive review of general and specific ACA with the potential to significantly improve health and health care for millions of diverse populations and their communities. The narrative that follows identifies these provisions, discusses why they are important, and considers challenges that may lie ahead in implementing them.

Health and Health Care Provisions Specific to Race, Ethnicity, and Language:

- **Data Collection and Reporting by Race, Ethnicity, and Language**
  Improvements in data collection and reporting by race, ethnicity, and language in the ACA have the potential to enhance the evidence-base for new health equity improvement initiatives for diverse communities, while, at the same time, raising awareness about the persistence of health disparities and the urgency for action among policymakers and the public.
  - Require that population surveys collect and report data on race, ethnicity and primary language.
  - Collect/report disparities data to Medicaid and CHIP [Children's Health Insurance Program].
  - Monitor health disparities trends in federally-funded programs.

- **Work Force Diversity:**
  Concordance between patient-practitioner race/ethnicity has long been recognized as a strategy for improving the quality of care. Furthermore, racially and ethnically diverse practitioners are more likely to practice in medically underserved areas and treat patients of color who are uninsured or underinsured.
  - Collect and publicly report data on workforce diversity
  - Increase diversity among:
    - Primary Care Providers
    - Long-term care providers
    - Dentists
    - Mental health professionals
  - Health professions training for diversity
  - Increase diversity in nursing professions
  - Investment in HBCUs [Historically Black Colleges and Universities] and minority-serving institutions
  - Community-based training for AHECs [Area Health Education Centers]

- o Grants for Community Health Workers, providing CLAS [Culturally & Linguistically Appropriate Services]
- o Grants to train providers on pain care, including CLAS
- o Support for low income health profession/home care aid training

- **Cultural Competence Education and Organizational Support:**
Cultural competence training and education for health professionals has gained credibility as a strategy for improving the quality of care delivered to culturally and linguistically diverse patients.
    - o Improves the quality of patient-provider interactions in clinical settings
    - o Assists in deinstitutionalizing racism and guiding culturally competent program development and evaluation.

- **Health Disparities Research:**
    - o PCORI [Patient-Centered Outcomes Research Institute] to examine health disparities through CER
    - o Increase funding to Centers of Excellence
    - o Promote NCMHD [National Center on Minority Health and Health Disparities] to Institute Status
    - o Support collaborative research on topics including cultural competence
    - o Support for disparities research in post-partum depression
    - o Support for disparities research in pain treatment / management

- **Health Disparities Initiatives in Prevention:**
Through innovative health education and preventive programs, health care reform legislation offers the opportunity to stem disparities in premature death, disability, and acute and chronic disease
    - o National oral health campaign, with emphasis on disparities
    - o Standardized drug labeling on risks & benefits
    - o Maternal & child home visiting programs for at-risk communities
    - o Culturally appropriate patient-decision aids
    - o Culturally appropriate personal responsibility education
    - o Support for preventative programs for AI/ANs

- **Addressing Disparities in Health Insurance Reforms:**
While health insurance market reforms and expansions in Medicaid hold promise to substantially reduce disparities in insurance status, targeted efforts are necessary to ensure that culturally and linguistically isolated communities are enrolled and take full advantage of benefits for which they are eligible. Failure to successfully enroll these populations is likely to put additional strain on already stressed safety net clinics and Disproportionate Share Hospitals (DSHs).
    - o Remove cost-sharing for AI/ANs at or below 300% FPL
    - o Enrollment outreach targeting low income populations
    - o CLAS/information through exchanges
    - o Nondiscrimination in federal health programs and exchanges
    - o Require plans to provide information in "plain language"
    - o Incentive payments for reducing health/healthcare disparities
    - o Summary of coverage that is culturally/linguistically appropriate
    - o Claims appeal process that is culturally/linguistically appropriate

General Provisions with Significant Implications for Racially and Ethnically Diverse Populations:

The new health care reform law includes a number of general provisions—concerning health insurance reform, improved access to health care, quality improvement, cost containment, public health initiatives and social determinants of health—which are likely to benefit low income and racially and ethnically diverse communities.

- o Health Insurance Reforms to Expand Coverage and Affordability:
- o Actions to Improve Access to Health Care
- o Quality Improvement
- o Cost Containment
- o Public Health Initiatives
- o Social Determinants of Health

Leveraging the Potential of Health Care Reform to Reduce Disparities

▪ **Advancing the Health of Communities**
- o Leveraging support for community-based strategies and engagement in reducing disparities
- o Promoting integrated strategies across health and social services to improve the health of divers communities

▪ **Health Care Organization-based Initiatives**
- o Developing and testing model programs that link specific organizational efforts to reducing disparities and improving quality of care
- o Documenting and linking non-profit community needs assessment/benefit requirements to health care reform incentives to address disparities
- o Preserving and transitioning the health care safety net

▪ **Individual-level initiatives**
- o Developing effective care/disease management and self-management interventions and protocols for diverse patients
- o Mitigating the effects of overweight/obesity and negative environment factors that may impede progress on reducing disparities

2.	**Why Place & Race Matter - Policy Link and The California Endowment, April 2011**

By Judith Bell (Policy Link) and Mary M. Lee (Policy Link)

To view this report, please click on the link:
http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/WPRM%20FULL%20REPORT%20(LORES).PDF

About: An effective agenda to improve health and prosperity in California and in the nation must consider both race and place. It must embrace comprehensive approaches spearheaded and sustained by many, many stakeholders. Collaborative efforts must include the private sector and involve the voices and experience of people of color…With this report, we hope to further inspire creative thinking, new partnerships, innovative strategies to achieve sustainable change, and continued momentum in the movement to build healthy, opportunity-rich communities.

Taking Action:

1. Establish Strategic Place Targets
   o The initiative provides comprehensive services within a clearly marked geographic area, one with a predominantly African American population.

2. Increase Political Power of People of Color and Immigrants
   o Civic engagement by people traditionally underserved is critical for needed changes. When the civic engagement of diverse communities increases, officials will have to address their concerns with greater focus and resources.

3. Enforce Laws That Prohibit Discrimination
   o Successful enforcement can reduce disparities while increasing awareness of the available legal protections and the consequences of violating these laws. People who know their rights and the procedures to enforce them are less likely to be victimized. Potential violators are put on notice that they will be penalized.

4. Shift Public Perceptions:
   o Mainstream media must recognize that the mainstream is changing—news outlets must be held accountable for coverage that reflects the diversity and the strengths of our increasingly multiracial and multiethnic communities.
   o These [new media] tools should be used to present new, and more accurate, views of people of color. In addition to changing perceptions, these tools offer the possibility of changing opinions that could then be galvanized to build healthy communities.

5. Engage Strongly with Vulnerable Communities:
   o The more that the people hurt by disparities know about the root causes and the possibilities and opportunities to change them, the more likely they are to help rectify the situation.

6. Target Policies That Disproportionately Hurt People of Color
   o Policy goals can and must be accomplished without disproportionately burdening vulnerable groups (for example, zero tolerance policies at schools).

In addition to these six strategies, the movement to build healthy communities needs an action agenda with policy proposals to address issues with local, regional, statewide, and national impacts. Strategies that address both the race and place dynamics should be emphasized. Among the policy issues that should be considered are:

1. *Safe water and Safe Parks.*
2. *Joint use.*
3. *Health-care access.*
4. *Integrated Services.*
5. *Health Impact Assessments (HIAs).*
6. *Health in all policies.*
7. *Access to Healthy Foods.*
8. *Transportation.*
9. *Housing.*

10. *Leveraging federal resources.*

From Local Advocacy to Statewide Change:
▪ The priorities of local communities must anchor an authentic statewide policy agenda to create healthy places for everyone. This is true for every state in America: The experiences and the needs of local communities must be integrated, and local leaders must be fully involved in the process.
▪ Relationships between state and local groups must be frank and genuine. This requires trust on all sides, and a commitment to ensure that state policy proposals and the strategies and decisions to get them adopted are driven by local needs, knowledge, and action.

3.	**The Poor Pay More – Poverty's High Cost to Health – George A. Kaplan, National Conference of State Legislatures, September 2009**

Robert Wood Johnson Foundation

To view this report, please click on the link:
http://www.rwjf.org/files/research/thepoorpaymore2009.pdf

About: The report begins with descriptions of these key determinants of health and the impact they have been shown to have on health. It then offers several policy options that might ease poverty and thereby improve health….The report offers examples of policies that have the potential to break these pathways that connect poverty to poor health.

Initial points of conversation:
▪ Raise the Economic Status of the Poor by:
    o Increasing the minimum wage
    o Extending coverage and improving usability of the earned income tax credit
    o Ensuring access to high quality child care

▪ Invest in early childhood and education
    o Investing in early learning opportunities
    o Ensuring continuity of educational opportunity to increase graduation rates
    o Increasing availability of education, training, and employment programs for poor adults

▪ Reinforce the safety net by:
    o Increasing aid to jobless workers
    o Providing more flexibility in the TANF provisions and expanding training activities
    o Aligning food, housing, and health programs with the needs of the poor

▪ Invest in communities by:
    o Continuing the expansion of neighborhood/community initiatives and their integration with Education, Transportation, and Workforce Programs

4.   **Tackling Health Inequities through Public Health Practice: Theory to Action – 2nd Edition – National Association of County and City Health Officials (NACCHO), 2010**

Oxford University Press, Edited by: Richard Hofrichter and Rajiv Bhatia

To view this report please click on the link: http://www.naccho.org/topics/justice/

About: *Tackling Health Inequities* raises questions and provides a starting point for health practitioners ready to reorient public health practice and address the root causes of health inequities. This reorientation involves restructuring the organization, culture, and daily work of public health. *Tackling Health Inequities* is meant to inspire readers to imagine or envision public health practice and their role in ways that question contemporary thinking and assumptions, as emerging trends, social conditions, and policies generate increasing inequities in health. No predefined set of protocols or tools can eliminate health inequity. It will require reimagining practice, taking risks, and active and strategic engagement of the public health community in the political process. Recent experiences in many jurisdictions suggest that many health practitioners are ready and able to act.

Several chapters focus on racial health inequities and their proposed resolutions are featured below:

CHAPTER 15: Exploring the Intersection of Public Health and Social Justice: The Bay Area Regional Health Inequities Initiative (Page 283)
Bob Prentice and Njoke Thomas

Why a regional collaboration?
- Besides the advantage of consulting with public health colleagues and asserting a collective regional voice, there were other reasons to explore a regional approach.
- Some planning functions, most notably transportation, have regional commissions, and even those that are fundamentally local, such as land use or redevelopment, have obvious regional implications.
- More generally, the regional implications of economic development, labor markets, urban sprawl, and changing demographic composition demand that public health no longer be confined to historical, but increasingly outmoded, city and county boundaries.
- In addition, media markets, which are essential for public advocacy, are mostly regional.

Building an Organization:
- A principle of membership in BARHII is that a public health director and/or health officer must be willing to participate in order to commit the health department as a whole.
- The health official then determines which senior managers best represent their organization's work on health inequities and who should therefore attend the BARHII regular monthly meetings.
- A system of committees, described later, was created to allow staff at varying levels in their respective health departments to collectively consider the issues that confront them in their daily work.
- BARHII has also been a vehicle for collective trainings and presentations on various aspects of public health and health equity, including special sessions on structural racism, land use, transportation, redevelopment, climate change, and media advocacy.

- While BARHII is an important forum for people from different health departments to consult with one another, it also embodies the potential for collective action, particularly related to policy advocacy.
- Sometimes it is more effective to represent the collective voice of senior public health officials in the Bay Area, including some situations in which a collective voice can speak to issues too risky for individual officials accountable to local governing bodies to tackle.

Organizing the work:
- BARHII's work is divided among standing committees where health department managers and staff attempt to define a public health practice that can address health inequities, and define the organizational structure, culture, and staff requirements to support that practice.
- The committees make it possible for staff at all levels of the health department to become active participants in BARHII, so it is no longer a top-down organization made up entirely of senior officials.

Data Committee:
- Establishing the evidence base for work on health inequities.
- Epidemiologists from each health department formed the Data Committee to help guide the evolving practice.
    - o Developed a conceptual framework. Defines the path from mortality, morbidity, and risk behaviors – the common focus of health department programs – to neighborhood conditions, institutional power, and social inequalities, which challenge health departments to shift their attention "upstream."

Community Committee:
- To establish the basis on which health departments work with communities on a multitude of issues over time to address the social and environmental conditions that contribute to poor health.
- To address more effectively the root causes of health inequities, local health departments are trying to adopt a broader perspective on work in communities, looking at the neighborhood conditions that contribute to poor health.
- BARHII provides a forum in which member health departments are attempting to forge new strategies for community engagement and capacity building to address these neighborhood conditions, and to establish relationships that can be sustained over time and across diseases and risk factors.
- Ultimate goal will be to create a clearinghouse of promising practices of health departments working with communities on the social and environmental determinants of health inequities.

Built Environment Committee:
- Recognition of the importance of physical conditions in neighborhoods, buttressed by a burgeoning movement linking public health to land use
- Was established to identify a role for public health departments in influencing the land use and transportation planning decisions that affect neighborhood conditions.
- Has provided an opportunity for local health departments to consolidate their efforts, share promising practices and generate a regional forum for discussion of these issues that seldom restrict themselves to county boundaries.
- The work has focused on establishing a mutually beneficial, cross-disciplinary exchange between planning and public heath, articulating to planning and transportation professionals the health

consequences of their policies and practices and helping public health professionals to consider the best strategies for influencing the planning process.

- Ultimate goal is to make health equity a fixture in land use and transportation planning. BARHII has also developed an initiative to expand the focus of work on the built environment beyond land use and transportation planning to include economic development and redevelopment and more explicitly focus on social and health equity.

Internal Capacity Committee:
- Charged with developing strategies for increasing the capacity of the local health departments to engage in a new kind of public health practice.
- The committee has emphasized a participatory approach to understanding and addressing these issues.

Social Determinants of Health Ad Hoc Work Group
- Analyze the social environment and related strategies for public health practice.

CHAPTER 16: Using Our Voice: Forging a Public Health Practice for Social Justice (page 296)
Rajiv Bhatia, June Weintraub, Lili Farhang, Karen Yu, and Paula Jones

Five strategies for local health equity practice:
1. Establishing a collective responsibility for health and health equity
   o People must first acknowledge that society has failed to provide healthful conditions for all of its members, and that this inequity is unfair.
2. Translating research into policy change
   o Public health research should serve to inform and shape all public policies that impact human health, yet public health evidence on the causes and consequences of health inequities are not routinely integrated into policy deliberation and action.
3. Forging relationships with social movements
   o The goals of health equity reflect the shared values of social justice advocates working to advance a more equitable distribution of social benefits and burdens.
   o When public health develops meaningful relationships with civil society organizations that engage with social justice struggles, all sides can benefit.
   o Effective and inclusive community participation in design and implementation of research and policy helps to ensure that interventions address priority needs, are holistic and culturally appropriate, and are likely to benefit those with the least advantage.
4. Monitoring institutional accountability
   o When failure to implement or enforce policies, rules, and laws results in public health consequences, public health agencies have a responsibility to raise attention to such failures and seek action on the part of sister institutions either directly or indirectly.
   o Public health practitioners who objectively identify consequences for public health, provide constructive solutions, and work collaboratively to mobilize the actions of external interests, can influence the outcome.
5. Facilitating a consensus for change
   o When subpopulations do not have the ability to access or effectively use information, public health can be a resource on the decision-making process and its outcomes and impacts, helping people explore available alternatives to a particular course of action.

    o   By providing expert testimony on the behalf of groups whose perspectives may not be otherwise represented, public health can give marginalized stakeholders the tools and legitimacy needed to ensure their perspectives are considered in a decision-making process.

    o   Public health activities must acknowledge diversity among community needs.

    o   Advancing a health equity agenda involves not only helping marginalized social groups "win" better conditions and a more equitable stake in society but also helping move all people towards a common vision and commitment to equity.

CHAPTER 20: Tackling the Root Causes of Health Disparities through Community Capacity Building (Alameda County) (page 370)
Anthony B. Iton, Sandra Witt, Alexandra Desautels, Katherine Schaff, Mia Luluquisen, Liz Maker, Kathryn Horsley, and Matt Beyers

Why We Have Health Disparities in the United States:

1. Wealth
   - In the United States wealth equals health
   - Wealth confers a number of important social benefits that are strongly associated with positive health outcomes. These benefits include access to a variety of social goods, such as high quality education, employment, housing, child care, recreational opportunities, nutrition, medical care, and safer and cleaner neighborhoods.
   - In the United States, wealth is the primary portal through which one accesses a variety of critical social benefits.
   - As wealth is strongly correlated with race, it follows that a strong relationship would exist between health and race.
   - Large inequities in wealth translate to large racial health inequities in the United States.

2. Neighborhood Residential Segregation and Health: Concentrations of Race and Poverty
   - In addition to racialized patterns of wealth distribution that lead to a relative concentration of poverty in certain racial groups, the spatial concentration of poverty has also increased sharply in the United States, enhancing a de facto residential apartheid.
   - The direct link between wealth and health, neighborhood segregation, and the concentration of poverty into spatial areas provides another pathway from wealth to health.
   - As racial and wealth-based segregation increases, so do the negative health consequences.
   - Segregation by race and income causes a concentration of disadvantage in neighborhoods, including a greater concentration of risk factors for disease and injury.
   - These inequitable neighborhood conditions affect individual and community health. Two pathways through which the neighborhood social and physical environment may produce health disparities are:
     - Shaping individual behaviors – In low-income communities, these neighborhood physical conditions may be operating in a manner that increases the likelihood that certain adverse risk behaviors will be adopted.
     - Increasing individual risk factors – Characteristics of the social environment may produce certain physiological changes in individuals that directly increase their risk of disease.
       - > Weathering and Allostatic Load: link between the cumulative impact of various social and environmental stressors and human physiological

response. Neighborhood-level poverty, racism, crime, lack of education, unemployment, and social isolation act synergistically to produce detrimental physiological changes.

3. Education and Health: Neglected Schools in Struggling Neighborhoods
   o Public health practitioners have consistently illustrated the link between education and health across multiple pathways and for multiple health outcomes.
   o Education correlates with health through multiple pathways.
   o The abysmally poor graduation rates of poor African Americans and Latino children being tolerated in the United States are contributing greatly to maintaining a status quo of economically deprived, racially segregated, and generally under-resourced neighborhoods mired in severe social dysfunction.

Designing Public Health Practice to Achieve Health Equity

▪ **Expanding the Traditional Scope of Public Health Department Work**
   o Levels of intervention are targeted towards: 1) individual, 2) group, 3) neighborhood/community, and 4) larger society/policy area.
   o It is only by eliminating these [social and environmental] forces that health inequities can be eliminated.
   o The question for local health departments is: what effective strategies can be employed to address these underlying structural forces that play such a powerful role in producing and perpetuating health disparities?

▪ **Alameda County's Working Principles and Three-Pronged Approach**
   o Effective strategies to reduce and eventually eliminate health in equities must be multifaceted and long term.
   o They must involve institutions beyond the sectors of public health and medicine. In addition, they must address the power differentials that have contributed to the creation and maintenance of social and health inequalities.
   o ACPHD has recently identified ten principles that guide how and with whom we address the challenge of eliminating health inequities.
      1. *Exploring the historical forces* that have left a legacy of racism and segregation is critical to moving forward with the structural changes needed to provide living wages, affordable housing, excellent education, clean air, and other social conditions in neighborhoods that now experience disadvantage.
      2. *Working across multiple sectors of government* and society is basic to making the structural changes necessary. Such work should be in partnership with community advocacy groups that continue to pursue a more equitable society.
      3. *Measuring and monitoring the impact of social policy on health to ensure gains in equity is essential.* This will include instituting systems to track governmental spending by neighborhood and tracking changes in measures of health equity over time and place to help identify the impact of adverse policies and practices.
      4. Groups that are the most effected by inequities must have a voice in identifying policies that will make a difference as well as in holding the government accountable for implementing these policies. *A high level of public participation is needed with attention to outreach, follow-through, language, inclusion, and*

> *cultural understanding.* Government and private funding agencies should actively support residential capacity to engage.

5. *Acknowledging the cumulative impact of stressful experiences and environments is crucial.* For some families, poverty lasts a lifetime and is perpetuated throughout multiple generations, leaving family members with few opportunities to make healthful decisions.

6. *The developmental needs and transitions of all age groups should be addressed.* While infants, children, youth, adults, and elderly require age appropriate strategies, the largest investment should be in early life because important foundations of adult health are laid in early childhood.

7. *Changing community conditions requires extensive work on land use policy to address the location of toxic sites, grocery and liquor stores, affordable housing and transportation, the primacy of the automobile, access to opportunities for physical exercise and building social supports, and overall quality of life.*

8. *The social fabric of neighborhoods needs to be strengthened.* Residents need to be connected and supported and believe that they hold power to improve the safety and well-being of their families. All residents need to have a sense of belonging, dignity, and hope. Neighborhood assets should be maximized to address this issue.

9. While low-income people and people of color face age-old survival issues, *new challenges* brought on by the global economy, climate change, U.S. foreign policy and the need for immigration reform and energy alternatives are also relevant and should be addressed in the context of equity.

10. Because of the cumulative impact of multiple stressors, our overall approach should shift *toward changing community conditions and away from blaming individuals or groups for their disadvantaged status.* Eliminating inequities in Alameda County is a huge *opportunity to invest in community*. Inequity among us is no longer politically or morally acceptable and we all stand to gain by eliminating it.

1. **ACPHD's efforts address and eliminate health inequities have centered on three main strategies:**
   1. **Building the international capacity of staff and creating an organizational culture that supports staff in addressing health inequities;**
   2. **Working closely with neighborhoods in community-capacity building efforts; and**
   3. **Addressing the root causes of health inequities through local policy work.**
      - These three areas are supported by innovative research and data analysis and in each area, connecting with programs and services.
      - While the three strategies provide a framework for action and day-to-day work, the 10 principles provide guidance for staff in how to approach this work from a social justice perspective.

1. **Institutional Change and Internal Capacity Building**
   - Institutional Change:
     - o This entails an organization that can not only address the needs of individuals, but also enact broader solutions, including community-capacity building efforts and policy change aimed at the fundamental processes of injustice.
   - Internal Capacity Building:

o As staff must address increasingly complex issues, avenues and mechanisms must be in place to increase external capacity.
o To change organizational culture and redefine practice, staff will need opportunities to learn and apply new skills. As organizational culture shifts, staff will need ongoing training and support in order to respond as the organization changes.
o Have created a five-module Public Health 101 training series for all the staff that covers: 1) the history of public health; 2) cultural competency and cultural humility; 3) undoing racism; 4) social and health equity; 5) community capacity building. Training on policy development is offered to staff members who are engaging in more focused policy work.
o By tying workforce development and organizational change to social justice, local health departments can strategically assess needs, create learning opportunities, and develop a staff that is capable and supported in tackling the difficult issues that arise when trying to address root causes of health inequities.

2. **Building Community Capacity**
   - Community capacity has been defined as "the characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems."
   - Community capacity is considered to be a socially protective factor for community residents.
   - It is also a method for combating social inequities such as poverty, racial disparities, unemployment, and other social determinants of health.
   - Certain health protective factors in the culture and social milieu that can be identified and enhanced in a manner that would inure to the benefit of the broader community.
   - Public health departments must become more adept at facilitating ongoing community-level processes that acknowledge cultural strengths and build upon the resiliency factors within each cultural group.
   - It is this "social action that promotes participation of people, organizations and communities toward the goals of increased individual and community control, political efficacy, improved quality of life and social justice" that is key to achieving social and health equity.
   - Overview of the City/County Neighborhood Initiative (ACPHD)
   - The City/County Neighborhood Initiative (CNII), a multiyear intervention, has four main goals on the pathway to reducing violence and health inequities:
     o Empower residents to speak and act effectively on their own behalf.
     o Empower grassroots organizations that can leverage the power of the community.
     o Win concrete improvements in people's lives.
     o Alter the relations of power so institutions are accountable and responsive to the community.
   - **Component 1: Community assessment and issue selection**
     o ACPHD reached out to community partners and conducted a survey.
     o This survey served two purposes: 1) identifying neighborhood assets, needs, and priorities; and 2) mobilizing adult and youth residents to gain awareness of neighborhood conditions that affect their health.
     o They established action teams in the following areas:
       - Improving a local park, Tyrone Carney Park, and the surrounding streetscape;
       - Reducing drug use and dealing; and
       - Increasing positive youth activities.

- **Component 2: Resident Action Council (RAC)**
  - RAC – a planning and organizing decision making body for residents to address neighborhood priorities.
  - Comprised of 20 adult and 20 youth residents.
  - Organized by ACPHD.
- **Component 3: Leadership training:**
  - ACPHD provided RAC members with 16 hours of initial leadership training to develop their practical skills in community organization, neighborhood problem solving, and political advocacy.
  - ACPHD has developed and begun implementing additional training modules including: unlearning oppression and racism, action planning, public speaking, meeting facilitation, asset mapping, media advocacy, and fundraising.
- **Component 4: Community Mini-Grant Program:**
  - To further support leadership development and social cohesion among residents, ACPHD developed a Mini-Grant Program to fund resident initiated community improvement projects.
- **Component 5: Time Bank:**
  - ACPHD collaborated with the RAC and a local church to develop the Sobrante Park Time Bank (SPTB), modeled after the International Time Banking movement.
- **Component 6: Capacity Building with Youth**
  - CCNI engages youth ages 12 to 24 years in programs to improve the social and physical conditions in their neighborhoods.

3. **Public Policy: Tackling Society's Inequities:**
   - Local public health departments can support the righting of this power imbalance by highlighting the health implications of a variety of policy choices.
   - Health agencies can legitimize grassroots community-led efforts through reviews of the research, data analysis, and "health impact assessments" to make tangible the impacts of certain policy choices.

4. **Additional Examples of Ongoing Policy Activity:**
   - Supporting elderly Chinese-American residents seeking rent stabilization.
   - Environmental justice partnerships to hold port accountable.
   - Working with transportation advocates to close gaps in transit services.
   - Including community groups and residents in data collection, analysis, interpretation, and dissemination of results.
   - Assessing the health impact of housing displacement.

CHAPTER 29: Teaching Social Inequalities in Health: Barriers and Opportunities (page 517)
Carles Muntaner and Haejoo Chung

Strategies that Might Help Overcome Barriers in Teaching SIH (Social Inequalities in Health)

In and Around Classrooms	At the Government Level
Teachers' affiliation with working-class unions and participation in collective bargaining.	Increased public funding for universities.

Teachers' engagement with oppressed communities via community-based participatory action research.	Limiting the role of corporate agendas in research and teaching.
Student community projects during SIH course work.	Implementation of egalitarian policies that reduce the elitism in academia.
	Alleviating class inequalities in university credentials.

5. Ten Promising Practices to Reduce Social Inequities in Public Health – National Association of Chronic Disease Directors (NACDD), June 2011

To view this document, please click on the link:
http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/promising-practices-to-reduce-inequity/view

1. Targeting with Universal Approaches
   - Balance of targeted approaches with universal strategies to disproportionately improve the health of more disadvantaged groups while at the same time improving the health of the entire population
2. Purposeful Reporting
   - Relationships between health and social inequities in all health status reporting
   - Evidence about health inequities may be considered part of a strategy for change (finding by SES versus controlling for it)
   - Tracking changes over time (are differences getting better or worse over time)
3. Social Marketing
   - Tailoring interventions to disadvantaged populations
   - Change understanding and behaviors of decision makers and public to take action to improve the social determinants of health
4. Health Equity Target Setting
   - Allow to be a part of community engagement process to connect target setting to other aspects of health equity action
5. Equity-Focused Health Impact Assessment
   - HIA is a structures method to assess potential health impacts of proposed policies and practices
   - HIAs are a tool – interpretation of the evidence lies with the decision makers and their values
6. Competencies/Organizational Standards
   - Individual Level
     - Skills base required to work effectively on social inequities included community planning, partnerships, and coalition building
     - Use skills to inform recruitment, training, professional development, and position descriptions
   - Organizational
     - Make health equity a priority – commit to work intersectorally and with community engagement

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The DRA Project, a project of the Institute for Alternative Futures
www.altfutures.org/draproject | futurist@altfutures.org | 703.684.5880   24

o Need to change the bureaucratic/structural model on which public health is build to one with more community engagement, consultation, and participation

7. Contribution to Evidence Base
   o Intentional distribution of knowledge
8. Early Childhood Development
   o Comprehensive continuum approach
   o Combination of services and policies designed through intersectoral collaboration that involves communities – especially vulnerable communities – in program planning and implementation
9. Community Engagement
   o Key cross-cutting strategies stress importance of consultation, involvement, support, and engagement
   o Need rigorous evaluations of social interventions aimed at reducing health inequities
10. Intersectoral Action:
   o Many solutions to the social determinants of health are outside the health sector (education, income, housing, transportation)
   o Strong and durable relationships between public health and other sectors

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6. Linking Action on Health Inequities with the 10 Essential Public Health Services – Health Equity Council, National Association of Chronic Disease Directors (NACDD), 2011

To view this report, please click on the link:
http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/linking-health-equity-to-10-essential-ph-services/view

1. Monitor health status to identify and solve community health problems/
   o Improve and better coordinate state data systems to track disparities.
   o Make these data more easily accessible, especially to the community.
   o Grown infrastructure and support for community-driven health assessment.
2. Diagnose and investigate health problems and health hazards in the community.
   o Build capacity of state and local health departments to conduct public health. surveillance and epidemiology research with populations experiencing health disparities
   o Develop an integrated environmental public health tracking program.
   o Expand use of health impact assessments to understand how policies outside of the health department influence health inequities.
3. Inform, educate, and empower people about health issues.
   o Expand health education and empowerment efforts by building community partnerships to design, implement, and evaluate communications strategies, by training and fielding peer health educators.
   o Develop and evaluate culturally tailored public health communications messages that are disseminated through new and traditional media.
4. Mobilize community partnerships and action to identify and solve health problems.

- Mobilize communities experiencing inequities in health outcomes by strengthen community partnerships and developing integrated approaches to community health.
5. Develop policies and plans that support individual and community health efforts.
   - Develop and support individual and community-level inequities elimination efforts by: Develop state-wide action plan.
   - Promote community health planning as a tool to balance allocation of health care resources with community needs.
   - Establish a minority health report card.
   - Establish a statewide interagency and interdepartmental coordinating council to coordinate the work of state agencies to address health inequities.
   - Address upstream determinants of health such as housing, access to healthy foods, transportation, recreation options.
6. Enforce laws and regulations that protect health and ensure safety.
   - Review and evaluate how policies and practices affect the health of communities experiencing inequities in health outcomes.
   - Where necessary, strengthen enforcement of state laws and regulations that protect the health and wellbeing of vulnerable populations.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
   - Measure and expand access to quality personal health care services.
   - Assure access to a coordinated system or quality care and culturally and linguistically appropriate services by:
     - Encouraging health systems to adopt medical home models.
     - Expanding language access.
     - Expanding access to primary care, especially in underserved communities.
     - Including requirements to address health inequities in all state health services contracts.
8. Assure competent public and personal health care workforce.
   - Improve the capacity of health and public health professionals to respond to the needs of communities experiencing inequities in health outcomes by:
     - Requiring cultural competency training of current and future health professionals.
     - Expanding efforts to increase diversity in state health professions workforce.
     - Encouraging training and employment of community health workers.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
   - Evaluate effectiveness of individual and population-based health services in eliminating health inequities and publically report this information.
10. Research for new insights and innovative solutions to health problems.
    - Provide the support and resources needed to ensure that the OMH is able to successfully carry out its legislative charge and coordinate the stat health departments' health inequities efforts.

7.	**National Stakeholder Strategy for Achieving Health Equity – National Partnership for Action to End Health Disparities (NPA), 2011**

U.S. Department of Health and Human Services – Office of Minority Health, 2011

To view this report, please click on the link:
http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

About: The United States recognizes that the social determinants of health are multiple and overlapping, and that disparities not only affect individuals but represent enormous social and financial burdens to society as a whole. Many of the fundamental causes of illness are the result of "the host of interrelated elements that affect individuals across their lifespan, from birth to death," and the determinants of health contribute to the health of individuals and communities alike. The *National Stakeholder Strategy* "provides an overarching roadmap for eliminating health disparities through cooperative and strategic action" and is a key component of the U.S. government's National Partnership for Action to End Health Disparities (NPA). The U.S. government will use the *Strategy* to develop and jointly issue aligned Blueprints for Action and the HHS Action Plan to Reduce Racial and Ethnic Health Disparities.

The **determinants of health** can be divided into four categories (with examples):
1. **Social** determinants of health: gender, SES, employment status, educational attainment, food security status, housing and transportation availability, and health system access and equity.
2. **Behavioral** determinants of health: patterns of obesity, exercise norms, and the use of illicit drugs, tobacco, or alcohol.
3. **Environmental** determinants of health: lead exposure, asthma triggers, workplace safety factors, and unsafe or polluted living conditions.
4. **Biological and genetic** determinants of health: family history of heart disease and inherited conditions (ex: hemophilia and cystic fibrosis).

The NPA prime activity was to establish priorities for a national strategy using a "bottom up" approach. "The intent was to change the paradigm of strategy development by vesting individuals – particularly those at the front line of fighting health disparities – with identifying and helping to shape the core actions for a coordinated national response."

Guiding Principles of the NPA and *National Stakeholder Strategy*
1. **Community Engagement**
2. **Partnerships**
3. **Cultural and Linguistic Competency**
4. **Nondiscrimination**

Mission and Goals of the NPA and the *National Stakeholder Strategy*
1. **Awareness:** Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.
2. **Leadership:** Strengthen and broaden leadership for addressing health disparities at all levels.
3. **Health System and Life Experience:** Improve health and healthcare outcomes for racial, ethnic, and underserved populations.
4. **Cultural and Linguistic Competency:** Improve cultural and linguistic competency and the diversity of the health-related workforce.
5. **Data, Research, and Evaluation:** Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.

Goals and Strategies: The *National Stakeholder Strategy* lays out 20 strategies encompassed by 5 key goals which are intended to act as a framework and "menu of resources for stakeholders to design actions that are achievable through their scopes of influence and expertise."

1. **Awareness:** Despite the longstanding documentation of health disparities among minority populations, the American public and health care providers continue to be largely unaware of these gaps in health outcomes. At the same time, a substantial percentage of racial minorities believe that their race influences their receipt of sub-standard health care. Therefore, it is imperative that all stakeholders understand the health disparities issue and work collaboratively to both enhance its visibility and develop a clear strategy for health promotion and disease prevention.

    a. **Healthcare Agenda**: Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal healthcare agendas.

        i. **Objectives:** Strengthen minority and tribal health entities and develop a health disparities liaison in non-health departments to ensure local, state, and tribal partnerships and decision-making power; foster relationships with non-partisan think-tanks and other policy centers to advance and disseminate disparity reduction and equitable policies; establish and utilize a national minority health information exchange or portal system; develop multi-stakeholder partnerships to advocate for local policies and actions that create and sustain conditions conducive to good health.

    b. **Partnerships**: Develop and support partnerships among public, nonprofit, and private entities that provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan.

        i. **Objectives:** Establish or assess and strengthen formal partnerships at different levels and across sectors that can potentially impact health disparities, create opportunities for new collaboration, and improve prospects for coordination and integration; Identify or create health equity and neighborhood solutions groups to efficaciously apply, implement, sustain and evaluate Blueprints for Action; after identifying and engaging community leaders, relevant funders, coalitions, non-profits and non-traditional partners in neighborhood and health equity solutions groups, provide infrastructure support and activity coordination to minimize duplication of efforts; connect health equity and neighborhood solutions groups, representatives of minority populations, and other stakeholders to the *National Stakeholder Strategy* to adopt joint actions for ending health disparities.

    c. **Media**: Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multi-tier audience – including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically isolated individuals – to encourage action and accountability.

        i. **Objectives:** Encourage public-private partnerships to develop and support a public relations/social marketing infrastructure for addressing health disparities and health equity, which can in turn serve as a wider platform for "mainstreaming" the message; maintain media spotlight on health disparities by supplying information to mainstream and community-based media outlets; create health disparities messages and solutions targeting specific audiences so

that relevant stakeholders (ex: community partners) can adopt and use them effectively with media representatives; strengthen the ability of the media to frame disparities as they relate to societal health impacts, and the social determinants of health, as well as present potential solutions to these disparities.

d. **Communication**: Create messages and use communication mechanism tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health.

   i. **Objectives:** Establish communications-based common messages so that organizations can support the *Strategy*; create, disseminate, and encourage data briefs about different health disparities affecting specific sub-populations; Leverage the power of social media to engage underserved communities in conversations and forums about preventing chronic and infectious diseases; create partnerships to conduct joint information campaigns with heath disparity/equity messages targeting specific populations; engage community leaders to ensure greater dissemination of health equity messages.

2. **Leadership:** Given the multi-faceted nature of the social determinants of health and health disparities, the development of comprehensive solutions requires that current leaders become more engaged and that stakeholders foster a new generation of leaders to carry on the health equity movement in the future. Leadership should be cross-sectoral in nature in order to provide an open forum for the widest array of experiences, ideas, etc. possible.

   a. **Capacity Building:** Build capacity at all levels of decision-making to promote community solutions for ending health disparities.

      i. **Objectives:** Establish and expand access to leadership training and planning and operational tools to equip leaders with the capacity to design and deliver services, foster community engagement, and develop multi-sectoral partnerships to end health disparities; develop a leadership pipeline by creating opportunities for entry- and mid-level professionals; create and implement a system to brain and build the skills of leaders and staff at the public, philanthropic, state, etc. level(s) to support and engage in community-oriented prevention and health equity work; provide resources to improve community organization capacity to leverage data for competitive submissions; create principles so that leaders at all levels can engage community leaders in decisions about population-specific solutions.

   b. **Funding Priorities:** Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services.

      i. **Objectives:** Broaden outreach to include representatives that can act as potential grant reviewers and grant recipients; work with agencies and organizations in the public, private, and non-profit sectors to include representatives from minority and traditionally excluded sub-populations on issues related to funding, programmatic, and research priorities; improve overall coordination of technical and resource assistance to help community-based organizations write/submit quality grant proposals; incentivize larger stakeholders to invest in local health equity efforts and collaborate with community-based organizations; establish regional and national research

consortia that may ultimately use research to develop and implement projects dealing with health disparities; strengthen centers of excellence.

   c. **Youth:** Strengthen and broaden leadership for addressing health disparities at all levels.

        i. **Objectives:** Build adult capacity to engage and support youth from underserved populations as equal partners in decision-making about programmatic and funding priorities and in the design and implementation of community assessments and initiatives; build underserved youth capacity to lead in health disparities reduction efforts; educate and train youth (especially those from traditionally excluded populations) to become peer leaders and advocates for their health and health disparities reduction.

3. **Health System and Life Experience**: The health of individuals and populations is determined by interrelated factors present where they live, learn, work, play, and grow older. Improving health and healthcare outcomes for racial, ethnic and underserved populations will require cross-sectoral and comprehensive solutions complemented by creative and appropriate policies.

   a. **Access to Care:** Ensure access to quality health care for all.

        i. **Objectives:** Support community-driven needs assessments; communicate the expectations and benefits of a health home to underserved groups and health care professionals; improve comprehensive primary health services to ensure support for culturally, linguistically, and geographically isolated communities; develop and strengthen partnerships to improve underserved (currently and historically) populations' access to health care through Medicaid or CHIP; identify the affordability of out-of-pocket health care costs for under-served or low-income populations and create strategies to reduce these costs; incentivize culturally and linguistically competent providers to practice in medically underserved areas (and improve their distribution); incentivize health service providers to adopt and adhere to quality improvement standards.

   b. **Children:** Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care.

        i. **Objectives:** Improve underserved populations' access to maternal, infant, and early childhood support services; collaborate with health providers, educators, and caregivers to assure that children receive proper immunization and have up-to-date and appropriate well-child visits; establish ongoing educative health communication about the impact of nutrition, injury prevention, and physical activity on children's life and functioning; support the establishment of school-based health centers; use child health outcome data to inform quality of care for children; promote linkages and strengthen collaboration among pediatricians, early childhood educators, preventive care services, other health and social service providers, and families to ensure school readiness and access to comprehensive services.

   c. **Older Adults:** Enable the provision of needed services and programs to foster healthy aging.

        i. **Objectives:** Increase older adults' access to and use of preventive healthcare services; establish partnerships between the businesses, medical and health, and community sector(s) to ensure that older adults have access to appropriate services, as well as evidence-based, self-management programs; increase the

number of accessible home and community-based provider and caregiver training programs; increase the number of older adults in living in communities who have access to core services provided by area agencies on aging; support collaboration between entities committed to aiding older adults and/or state and local offices of minority health to ensure access for older adults from racial and ethnic minority groups; incentivize the implementation of naturally Occurring Retirement Communities (NORCs) or similar community aging-in-place models in medically underserved areas (MUAs) and/or health providers shortage areas (HPSAs).

d. **Health Communication:** Enhance and improve health services experience through improved health literacy, communications, and interactions.

  i. **Objectives:** Develop health education materials in primary languages spoken by communities; use culturally and age-appropriate avenues and direct-to-consumer methods to deliver health and safety messages to LEP individuals or persons with marginal literacy skills; leverage social media outlets to engage and communicate information about prevention, health promotion, and health protection; enhance and disseminate guidelines for effective health literacy efforts and support the integration of health literacy training into social support institutions' or network's activities; establish and disseminate guidelines to healthcare and medical training programs and professional health associations for effective encounters and patient-provider communication; promote development of clinical tools to improve identification of and communications with at-risk patients.

e. **Education:** Substantially increase, with the goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits.

  i. **Objectives:** Develop and implement local strategies to reduce conditions affecting school attendance and chronic absenteeism; develop strategies to support parents and caregivers address factors impacting their children's lives; improve school environment, culture and other conditions to produce learning friendly environments; encourage the introduction of concepts about health disparities/equity/determinants as part of K-12 education curricula; improve health career pipeline, especially for persons from underserved groups; increase investment in strategies to decrease academic achievement gaps among students from underserved groups while concurrently increasing their opportunities for higher education or career-oriented alternatives.

f. **Social and Economic Conditions:** Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes.

  i. **Objectives:** Improve healthy food availability, accessibility, affordability and consumption; improve safety of and accessibility to public transportation, walking and bicycling; improve safety and accessibility of transportation for rural or geographically isolated communities; improve housing quality, affordability, stability, and proximity to resources; improve neighborhood conditions; monitor and improve air, water and soil quality in places where people frequent; ensure employment opportunities for persons of underserved or minority groups and enhance their labor market participation; support

programs and initiatives that contribute to the long-lasting financial stability and prosperity of underserved families; expand and strengthen social safety net opportunities; strengthen disaster and emergency plans by taking into account the needs of underserved and vulnerable populations; develop partnerships to help youth and adult learners acquire the skills necessary for greater economic mobility; encourage joint-learning and collaboration.

4. **Cultural and Linguistic Competency**: In order to address the unique health factors weighing on the lives of diverse populations the health care field should strive for greater awareness of cultural values, beliefs and practices. Moreover, increasing the diversity of the health-related workforce will help not only help improve cultural and linguistic competence on the provider side, but also act as guides for sub-populations unfamiliar with negotiating in the healthcare setting.

   a. **Workforce**: Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities.

      i. **Objectives:** Monitor health workforce composition, identify competencies needed, develop appropriate curricula, and enhance recruitment strategies to increase supply of qualified health professionals; collaborate with business and employers to encourage cultural and linguistic competency education for persons who work in the health care field; highlight and disseminate best practices of public health agencies and health organizations to ensure this education; develop and integrate model cultural and linguistic competency training courses and modules into workforce development programs, and undergraduate and graduate programs in health-relevant areas; assist providers to implement effective language access policies, practices, and procedures that comply with Federal civil rights law; use digital methods to deliver services to persons who are geographically isolated or do not have adequate access to transportation.

   b. **Diversity:** Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare, organizations and systems.

      i. **Objectives:** Create a policy agenda which expands health care worker diversity and cultural and linguistic competency; work with medical schools, health associations and businesses to create inclusive organizational structures and processes; develop collaborative relationships with higher learning institutions, including universities traditionally catering to underserved minorities, to increase minority recruitment into public and environmental health-related programs; educate high school and college counselors/teachers about career pathways in the health professions and help them to support early recruitment of youth from minority populations; increase the number of bridge programs between universities and employers in the health sector to create more opportunities for students from minority backgrounds.

   c. ***Ethics and Standards, and Financing for Interpreting and Translation Services:*** Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting

and translation. Encourage financing and reimbursement for health interpreting services.

   i.   **Objectives:** Promote interpreting and translation ethics codes and standards of practice; assist states, healthcare financing entities, and managed care organizations to develop plans to comply with these codes and standards; collaborate with accredited bodies for health organizations to integrate these codes and standards into accreditation requirements; increase the number of interpreters who meet professional standards and certification for health interpretation; encourage financing and reimbursement for medical interpretation services.

5. **Data, Research and Evaluation**: While research documenting health disparities among ethnic, racial and other underserved minorities continues to improve, there are still knowledge gaps, especially in the areas of social and environmental determinants.

   a. **Data:** Ensure the availability of health data on all racial, ethnic, and underserved populations.

      i.   **Objectives:** Promote the inclusion of data on underserved or minority populations in federally and privately conducted or supported health-related programs, activities, or surveys; develop and evaluate a framework and standards for information management and sharing among systems and policy organizations on the collection, reporting and use of this data; establish, support, and disseminate information about publicly available surveillance systems to track the causal, contributory, or protective impact of cultural, linguistic, environmental, and socioeconomic factors on health; improve current systems of data collection, analysis, reporting, and use as it pertains to data about ethnic, racial or other underserved populations; increase and improve the inclusion of community partners in all research and evaluation processes; incentivize reporting of quality of care data stratified by race, ethnicity, primary language, gender, and SES.

   b. **Community-Based Research and Action, and Community-Originated Intervention Strategies:** Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities.

      i.   **Objectives:** Identify and collaborate with community-based organizations and programs to develop and disseminate evidence-based practices for ending health disparities; work with researchers and evaluators to develop models for evaluating community-originated intervention strategies; engage community members and built their capacity to be equal partners in all aspects of public health interventions, programs, and initiatives; strengthen and promote community-based participatory research; ensure non-discriminatory research practices by integrating Title VI-complaint protocols into requests for research proposals and funded projects.

   c. **Coordination of Research:** Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities.

      i.   **Objectives:** Enhance integrated and cross-disciplinary research to comprehend systemic and continuous disparities in specific health conditions; evaluate best

practices to identify practices or policies that have improved health outcomes and reduced health disparities; foster community-based participatory research that draws upon historically excluded communities; develop teaching modules that education stakeholders on how to develop and implement collaborative health promotion and prevention projects while complying with Title VI requirements.

   d. **Knowledge Transfer:** Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity

       i. **Objectives:** Facilitate the translation and dissemination of culturally and linguistically appropriate interventions that have been shown to improve health outcomes; provide training and technical assistance to community stakeholders on data usage, interpretation and transmission; provide training and technical assistance to providers, researchers, and evaluators on community engagement and Title VI requirements; provide training and technical assistance to organizational stakeholders on how to efficiently utilize data to enhance their decisions and programs; promote strategies that make research findings easily understood and useable by the public and policymakers.

Guiding Concepts and the Implementation Framework: These concepts are embodied in the *Strategy*'s 5 goals and 20 strategies. By applying this implementation framework, stakeholders can pursue maximum influence in a manner the produces sustainable and robust changes in health disparities.

1. **Leadership:** This *Strategy*'s implementation framework assumes that all partners will share leadership and act as equal partners; leadership is cross-sectoral, collective, and coordinated. The *Strategy*'s Framework calls for the creation of 10 Regional Health Equity Councils (corresponding with the 10 HHS regions). These independently functioning Councils will include persons from the public and private sectors, community interests, state and local government, and healthcare-related associations, practices and businesses, who will collectively use resources to support NPA goals and establish best practices. The goal is for a "multi-dimensional and multi-level cooperative leadership structure" will help foster an effective movement towards implementing NPA goals.

2. **Ownership:** A participatory process requires that stakeholders learn form one another, establish an open sharing environment, feel included and productive in the process, be able to voice constructive criticism of beliefs and ideas, and work together collectively.

   a. **At the community level:** This ensures a grassroots element to the Councils, facilitating the flow of knowledge to the local level, the development of inclusive and pragmatic solutions, and the catalyzing of community movements, discussions, and interest.

   b. **Within health equity councils:** Independently functioning health equity councils have the freedom and flexibility to define individual partners' roles, assume ownership for national strategies and build upon existing leadership infrastructure.

   c. **Across health equity councils:** Lateral leadership and partnerships will facilitate the development of common objectives and the pursuit investments, as well as ensure that national strategies to combat health disparities are not marred by effort duplication or missed opportunities.

3. **Partnership:** Partnerships make the system of implementation more efficient, create goal orientation, maximize influence for change, and allow for the pooling of resources.
    a. **Awareness:** Given the diverse nature of the partnerships, they can use networks, media outlets, and different media approaches to raise awareness of health disparities issues in efficacious ways.
    b. **Leadership:** Leadership must work together collaboratively to set goals and priorities, leverage resources, facilitate evaluations of their efforts, and lay the grounds for future leaders.
    c. **Health and Health System Experience:** Healthcare systems and providers can provide their expertise, bolster their understanding of cultural circumstances and needs, as well as learn from the underserved communities represented in partnerships to provide more targeted and appropriate care to meet specific health needs.
    d. **Cultural and Linguistic Competency:** All partners can work together to communicate better with diverse cultural communities that have different health needs, cultural necessities, and levels of English proficiency.
    e. **Research and Evaluation:** Evaluation techniques can make partnerships more sustainable over time, increase internal awareness and improve strategy and policy implementation in the long term.

4. **Capacity:** Capacity-building strategies will help the stakeholders seeking to implement the *Strategy* better perform their functions, solve problems, and sustainably achieve their objectives.
    a. **Identify resources to build capacity:** Use these resources to improve leadership, management of programs and finances, assessment and evaluation, grant writing, sustainability, and the ability to provide technical assistance to other partners.
    b. **Assess needs and identify required capacity building support:** These tools specifically tailored to groups combating health disparities can identify partnership and strategy priorities, problems, and possible solutions.
    c. **Leverage capacity development investments:** Utilize strategies such as joint training and funding announcements across local, state and national levels that improve the sharing of investments and coordination of information.
    d. **Build individual capacity:** Empower individuals by creating accessible, inclusive, participatory and accountable plans of action.
    e. **Build organizational capacity:** Improve the day-to-day activities of the organization by progressively developing new leadership, improving program and process management, and creating sustainable shared partnership models.

5. **Communication:** Cross-sectoral and multi-level communication fosters greater efficiency and effectiveness.
    a. **Building communications capacity:** Create core messages and toolkits to facilitate the ability to communicate to leadership about the *Strategy* and the need to end health disparities.
    b. **Developing materials:** Leverage social media and Internet-based resources to spread messages, increase awareness, update partners and the public, and foster sustained engagement.
    c. **Recruiting and engaging partners:** Must bolster the infrastructure necessary to increase awareness and lay the grounds for future action.

d. **Leveraging local, regional, and national media outlets:** Leverage information technology, traditional and new media to reach multiple and diverse populations, including underserved communities, and encourage action and accountability.

e. **Conducting a public information campaign:** Increase awareness and foster continual change by hosting events like town-halls/informational meetings, coordinated forums during National Minority Health Month, a 12-month *Strategy* anniversary event, and concurrently conducting research the effectiveness of such campaign outreach.

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8. **HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care – Department of Health and Human Services (HHS), April 2011**

To view this report, please click on the link:
http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

About: First-ever HHS Disparities Action Plan and the National Partnership for Action (NPA) Stakeholder Strategy, a comprehensive, community-driven approach to reduce health disparities, can be used together to coordinate action that will effectively address racial and ethnic health disparities across the country. Furthermore, the HHS Disparities Action Plan builds on national health disparities' goals and objectives recently unveiled in Healthy People 2020, and leverages key provisions of the Affordable Care Act and other cutting-edge HHS initiatives.

New Opportunities to Reduce Racial and Ethnic Health Disparities:
1. **The Affordable Care Act:**
   - HHS Disparities Action Plan builds upon the Affordable Care Act - the landmark law signed by President Obama last year – that will bring insurance coverage to more than 30 million people;
   - The Affordable Care Act not only includes provisions related broadly to health insurance coverage, health insurance reform, and access to care, but also provisions related to disparities reduction, data collection and reporting, quality improvement, and prevention;
   - The Affordable Care Act will also reduce health disparities by investing in prevention and wellness, and giving individuals and families more control over their own care;
   Important Provisions
   - The National Strategy for Quality Improvement in Health Care, which will include priorities to improve the delivery of health care;
   - The National Prevention and Health Promotion Strategy, which aims to bring prevention and wellness to the forefront of national policy.

2. **HHS Initiatives:**
   - Healthy People 2020:
     - Goal: "To achieve health equity, eliminate disparities and improve the health of all groups."

- o Throughout the next decade, the Healthy People 2020 initiative will assess health disparities in the U.S. population by tracking rates of death, chronic and acute diseases, injuries, and other health-related behaviors for sub-populations defined by race, ethnicity, gender identity, sexual orientation, disability status or special health care needs, and geographic location.
- Let's Move!
  - o First Lady Michelle Obama launched the *Let's Move!* initiative with the goal of solving the challenge of childhood obesity within a generation;
  - o The *Let's Move!* initiative has five key pillars:
    - Creating a healthy start in life for our children, from pregnancy through early childhood;
    - Empowering parents and caregivers to make healthy choices for their families;
    - Serving healthier food in schools;
    - Ensuring access to healthy, affordable food;
    - Increasing physical activity.
- The National HIV/AIDS Strategy:
  - o Released by the President in July 2010;
  - o The National HIV/AIDS Strategy offers a vision that "the United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race and ethnicity, sexual orientation, gender identity, or socioeconomic circumstance, will have unfettered access to high-quality, life-extending care, free from stigma and discrimination."
- HHS Strategic Action Plan to End the Tobacco Epidemic:
  - o Released in November 2010 by the Secretary;
  - o Plan is anchored around the four pillars of:
    - Engaging the public;
    - Supporting evidence-based tobacco control policies at the state and local levels;
    - Having HHS lead by example;
    - Advancing research, especially in the context of new Food and Drug Administration (FDA) authority to regulate tobacco.
- Efforts to Reduce Disparities in Influenza Vaccination:
  - o The HHS Seasonal Influenza Task Force has launched efforts to maximize vaccinations in targeted racial and ethnic minority groups through coordinated Departmental efforts as well as private-public partnerships.
- Interagency Working Groups on Environmental Justice:
  - o Executive Order 12898 directs each federal agency to make achieving environmental justice part of its mission;
  - o HHS and other participating agencies are committed to identifying and addressing disproportionately high adverse human health or environmental effects on minority and low-income populations.

3. **HHS Infrastructure:**
- HHS has not only established offices of minority health in six agencies (AHRQ, CDC, FDA, HRSA, Centers for Medicare and Medicaid Services [CMS], and Substance Abuse and

Mental Health Services Administration [SAMHSA]), but also elevated the National Center on Minority Health and Health Disparities (now NIMHD) to an institute level at the NIH;

- Key action steps for these offices include:
  - o Enhancing the integration of the missions of offices across the Department to avoid the creation of silos;
  - o Aligning core principles and functions with the goals, strategies, and actions presented in the HHS Disparities Action Plan;
  - o The Council will serve as the venue to share information, leverage HHS investments, coordinate HHS activities, reduce program duplication, and track progress on the strategies and actions of the HHS Disparities Action Plan.
- In addition, HHS will reinvigorate and reaffirm its continuing commitment by:
  - o Promoting closer collaboration between operating and staff divisions to achieve a more coordinated national response to health disparities;
  - o Coordinating more effectively its investments in research, prevention, and health care among HHS agencies and across the federal government;
  - o Developing improved mechanisms to monitor and report on progress toward achieving the vision of the HHS Disparities Action Plan; and
  - o Facilitating public input and feedback on Departmental strategies and progress.

4. **Partnerships with Other Federal Departments**:
   - The Department will collaborate with the Federal Interagency Health Equity Team (FIHET). FIHET seeks to facilitate activities of the NPA between federal agencies to increase the efficiencies and effectiveness of policies and programs at the local, tribal, state and national levels.

Vision and Purpose:
1. Vision of HHS Disparities Action Plan: **"A nation free of disparities in health and health care."**
2. The five goals from the HHS Strategic Plan for the Fiscal Year (FY) 2010-2015 provide the framework for the HHS Disparities Action plan. They are:
   - Transform health care;
   - Strengthen the nation's Health and Human Services infrastructure and work force;
   - Advance the health, safety, and well-being of the American people;
   - Advance scientific knowledge and innovation; and
   - Increase the efficiency, transparency, and accountability of the HHS programs.
3. This plan will also serve as guidance for future development, subject to the availability of resources.

Overarching Secretarial Priorities:
Implementation of the HHS Disparities Action Plan will uphold four overarching Secretarial priorities to assure coordination and transformation of both existing programs and new investments. These priorities aim to:
1. **Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities.**
2. **Increase the availability, quality, and use of data to improve the health of minority populations.**
3. **Measure and provide incentives for better healthcare quality for minority populations.**

4. **Monitor and evaluate the Department's success in implementing the HHS Disparities Action Plan.**

Goal I: Transform Health Care:
- Reduce disparities in health insurance coverage and access to care.
- Reduce disparities in access to primary care services and care coordination.
- Reduce disparities in the quality of health care.

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce
- Increase the ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities.
- Promote the use of community health workers and Promotoras.
- Increase the diversity of the healthcare and public health workforces.

Goal III: Advance the Health, Safety, and Well-Being of the American People
- Reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies.
- Conduct and evaluate pilot tests of health disparity impact assessments of selected proposed national policies and programs.

GOAL IV: Advance Scientific Knowledge and Innovation
- Increase the availability and quality of data collected and reported on racial and ethnic minority populations.
- Conduct and support research to inform disparities reduction initiatives.

Goal V: Increase Efficiency, Transparency, and Accountability of HHS programs.
Strategies:
- Streamline grant administration for health disparities funding.
- Monitor and evaluate implementation of the HHS Disparities Action Plan. To assure accountability and a clear focus on performance and outcomes, HHS will employ a multi-level monitoring and evaluations approach to track progress.
- Goal-Level Disparities Monitoring and Surveillance.
- Strategy-Level Evaluations.
- Action-Level Monitoring.

9. Health Disparities and Inequalities Report – Centers for Disease Control and Prevention (CDC), January 2011

To view this report, please click on the link:
http://www.cdc.gov/mmwr/pdf/other/su6001.pdf

About: Key findings from the *CDC Health Disparities and Inequalities Report – United States, 2011* are summarized in the following:

Social Determinants of Health:
- Education and income:
  - The U.S. Department of Education, Institute of Education Sciences, has identified effective interventions that are aimed at reducing the school dropout rate.
    - The Task Force on Community Preventative Services recommends interventions aimed to promote healthy social environments for low-income children and families and to reduce risk-taking behaviors among adolescents.

Environmental Hazards
- Inadequate and Unhealthy Housing
  - Effective interventions to prevent home hazards include improving ventilation, avoiding the use of wastewater system to dispose of toxic chemicals, using integrated pest management, installing grab bars in showers, adding handrails to stairs, installing working smoke and carbon monoxide detectors, and installing four-sided fences around pools.
- Unhealthy Air Quality
  - Public health efforts, including promoting mass transit and reducing emissions from industrial facilities, can help reduce population exposures to these pollutants.

Health-Care Access and Preventive Health Services
- Health Insurance Coverage
  - Insurance coverage is strongly related to better health outcomes. Substantial disparities in uninsured rates were observed among all the demographic and socioeconomic groups.
  - Increased access to health care with or without insurance will reduce the importance of disparities in the uninsured rates.
- Influenza Vaccination Coverage
  - Evidence-based interventions targeted at reaching minority populations – including use of reminder/recall systems, standing orders for vaccination, regular assessments of vaccination, coverage levels among provider practices, immunization registries, and improving public and provider of the importance of immunizations for adults – are needed to eliminate these disparities.
- Colorectal Cancer Screening
  - Coordinated efforts should continue to address barriers and disparities in screening so that the incidence of and comorbidities associated with colorectal cancer can be reduced among all populations.

Health Outcomes – Mortality
- Infant Deaths
  - Prevention of preterm birth is critical to both lowering the overall infant mortality rate and reducing racial and ethnic disparities.
- Motor Vehicle-Related Deaths
  - Effective interventions to prevent motor vehicle-related injury and death are available from *The Guide to Community Preventative Services* and include primary seatbelt laws, child safety seat distribution and education programs, minimum drinking age laws, and sobriety checkpoints.
- Suicides

- o Comprehensive strategies that include a component on developing life skills have been demonstrated to be effective in reducing suicidal behavior among American Indians and other youth and might be useful in reducing suicides among other groups if applied more widely.
  - o Community – and societal – level strategies that address social conditions such as poverty, inadequate social support, and lack of access to jobs might have significant population-level impacts but need further testing and application in specific cultural settings.
- Drug-Induced Deaths
  - o Reducing such deaths will require better adherence to guidelines for cautious use of prescription drugs by prescribers, better enforcement of regulations against abuse of such drugs, and greater use of substance abuse treatment for persons abusing drugs.
  - o Cohort studies have demonstrated the effectiveness of long-term methadone maintenance therapy, but the impact of other interventions is still under study.
- Coronary Heart Disease and Stroke
  - o Premature deaths attributed to CHD and stroke among black adults indicate the need for evidence-based interventions to reduce the prevalence of risk factors for cardiovascular disease among black children and adolescents.
  - o *The Guide to Community Preventive Services* includes recommended interventions to address the primary risk factors for CHD, stroke, hypertension, and cholesterol, including diabetes, nutrition, physical activity, tobacco, and obesity. Promoting interventions in each of these topic areas will have a ripple effect in improving cardiovascular health and reducing deaths caused by heart disease and stroke.
- Homicides
  - o Universal school-based interventions aimed at reducing youth violence have demonstrated promise [in reducing this disparity].
  - o Additional work is needed to build organizational and community capacity, particularly in public health, to implement these strategies within the communities and the populations in greatest need.

Health Outcomes – Morbidity
- Obesity
  - o Dietary modification and increased physical activity are effective.
  - o Education efforts to promote healthy eating and active living, and increase emphasis on policy and environmental strategies can help to reduce disparities in obesity prevalence.
- Preterm Births
  - o Understanding of the causes for these wide disparities preterm risk is limited.
  - o Reported causes include difference in socioeconomic status, prenatal care, maternal risk behaviors, infection, nutrition, stress, and genetics.
  - o Multidisciplinary research into the factors influencing preterm birth is needed for developing effective intervention strategies.
- Potentially Preventable Hospitalizations
  - o Improving care coordination overall and reducing barriers to care for specific groups have been demonstrated to reduce rates of preventable hospitalization and costs of health care.
- Current Asthma Prevalence
  - o 7.8% of the US population had asthma during 2006-2008.

- o Asthma prevalence was higher among the multiracial, Puerto Rican Hispanics, and non-Hispanic blacks than among non-Hispanic whites.
  - o Asthma prevalence was higher among the poor than it was among the non-poor.
- HIV Infection
  - o Reducing the number of HIV infections will require full time implementation of CDC HIV testing recommendations and expanded behavior interventions for populations at high risk.
- Diabetes:
  - o Recommend complementary, effective evidence-based interventions for diabetes prevention and control, for obesity prevention and control, and for the promotion of physical activity.
- Hypertension and Hypertension Control
  - o Hypertension is a serious public health challenge in the US affecting approximately 30% of adults and increasing the risk for heart disease and stroke.
  - o Non-Hispanic blacks have a higher risk for hypertension and hypertension related complications than non-Hispanic whites and Mexican Americans.

Health Outcomes – Behavioral Risk Factors
- Binge Drinking
  - o Screening and counseling for alcohol misuse among adults, including binge drinking, should be implemented as recommended by the U.S. Preventative Services Task Force.
  - o The frequency and intensity of binge drinking should also be monitored routinely to guide development and evaluation of culturally appropriate binge drinking prevention and intervention strategies for groups at greater risk.
- Adolescent Pregnancy and Childbirth
  - o Previous studies have reported that variations in adolescent birth rates reflect differences in interrelated socioeconomic characteristics, including education and income, community characteristics, and attitudes among adolescents toward pregnancy and childbearing, which in turn affect sexual activity and contraceptive use.
  - o Community service coordinated with positive youth development behavioral intervention is an effective approach for reducing sexual risk behaviors among adolescents.
- Cigarette Smoking
  - o The Institute of Medicine's 2007 report, *Ending the Tobacco Problem: A Blueprint for the Nation*, has demonstrated that comprehensive tobacco control strategies that include population-based policies are effective in decreasing smoking behavior. Implementation of these policy strategies should be adapted to address tobacco-related disparities among specific populations.

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10. Toward Health Equity: A Prevention Framework for Reducing Health and Safety Disparities – Rachel A. Davis and Larry Cohen, 2009

By Rachel A. Davis and Larry Cohen with assistance from Sharon Rodriguez
In *New World of Health Promotion: New Program Development, Implementation, and Evaluation*
Edited by Bernard J. Healty and Robert S. Zimmerman Jr.

To view this chapter, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-199/127.html

About: This chapter in the textbook "The New World of Health Promotion: New Program Development, Implementation, and Evaluation," provides a primary prevention framework for thinking about how disparities can be reduced. It begins with an overview of primary prevention, provides a framework for understanding the health disparities trajectory, examines how social determinants enable an **environmental approach** to addressing health disparities, and describes what can be done to help close the persistent gap in health and safety outcomes in the United States.

One Step Back: From Medical Care to Exposures and Behavior:
- Despite the available evidence, prevention efforts focus on behavior change alone, such as through health education and counseling efforts, which ignores the larger environmental factors that can work against the educational message.
- Educational efforts will have a greater impact if they are linked with efforts to change environmental conditions.
- Behavioral change is not only motivated by knowledge but also by a supportive social environment and access to facilitative services, support from other societal mechanisms, and an emphasis on setting up social conditions that promote health.
- Behaviors are shaped and controlled by social, physical, and cultural environments that are associated with socioeconomic status.
- Beyond shaping behavior, the environment also directly affects health.

The Second Step Back: From Exposures and Behaviors to Environment
- Many community leaders and health advocates intuitively understand that the environment is a primary determinant of health.
- **Equitable Opportunity:**
    1. Racial justice, characterized by policies and organizational practices that foster equitable opportunities and services for all; positive relations between people of different races and ethnic backgrounds.
    2. Jobs & local ownership, characterized by local ownership of assets, including homes and businesses; access to investment opportunities, job availability, the availability to make a living wage.
    3. Education, characterized by high quality and available education and literacy development across the lifespan.
- **The People:**
    1. Social networks & trust, characterized by strong social ties among persons and positions, built upon mutual obligations; opportunities to exchange information; the ability to enforce standards and administer sanctions.
    2. Community engagement & efficacy, characterized by local/indigenous leadership; involvement in community or social organizations; participation in the political process; willingness to intervene on behalf of the common good.
    3. Norms/acceptable behaviors & attitudes, characterized by regularities in behavior with which people generally conform; standards of behavior that foster disapproval of deviance; the way in which the environment tells people what is okay and not okay.
- **The Place:**

1. What's sold & how it's promoted, characterized by the availability and promotion of safe, healthy, affordable, culturally appropriate products and services; limited promotion and availability, or lack, of potentially harmful products and services.
2. Look, feel & safety, characterized by a well-maintained, appealing, clean, and culturally relevant visual and auditory environment; actual and perceived safety.
3. Parks & open space, characterized by safe, clean, accessible parks; parks that appeal to interests and activities across the lifespan; green space; outdoor space that is accessible to the community; natural/open space that is preserved through the planning process.
4. Getting around, characterized by availability of safe, reliable, accessible, affordable methods for moving people around, including public transit, walking, biking.
5. Housing, characterized by availability of safe, affordable, available housing.
6. Air, water & soil, characterized by abundant opportunities within the community for cultural and artistic expression and participation and for cultural values to be expressed through the arts or indirectly via behaviors that in turn affect health and safety outcomes.

The Role of Public Health: A New Way of Doing Business
- Apply a Health and Health Disparities Lens
  - Efforts should be undertaken with attention not only to ensuring actions are designed to bolster community factors to improve health but also to ensuring actions are specifically designed to close the health gap.
- Advance Comprehensive Approaches
  - Individuals and coalitions developing comprehensive plans to address health disparities should build upon existing efforts utilizing the Spectrum of Prevention (Cohen & Swift, 1999). The six levels of the spectrum are:
    - Strengthening individual knowledge and skills
    - Promoting community education
    - Educating providers
    - Fostering coalitions and networks
    - Changing organizational practices
    - Influencing policy and legislation.
- Generate Interdisciplinary Approaches
  - As employers, investors, purchasers, providers of services and as prominent facilities within communities, institutions like banks, businesses, government, schools, health care and community groups have a major influence on community environments. Eliminating racial and ethnic health disparities and improving health outcomes requires participation from key public and private institutions working in partnership with communities. Furthermore, communities need to be involved in identifying the health problems of greatest concern, examining the critical pathways to illness and injury, and working to alter these pathways.
- Foster Community Resilience
  - Community resilience is the ability of a community to recover from and/or thrive despite the prevalence of risk factors.
  - Focusing on building community capacity and resilience has three important results:
    - Community members are brought into the process and feel a greater vested interest in successful change.
    - Community members can apply new skills to address health factors outside of the current initiative and are able to respond to advances and emerging practices.

- Community members can gain skills and a sense of efficacy that can permeate many aspects of their lives and improve broad life outcomes.
- Drive Evaluation and Accountability
  - The most comprehensive and valuable reports are able to monitor trends over time and offer some interpretation about the magnitude and direction of any changes.
  - Effective indicator reports frame the information in a way that can lead to action and identify relevant policies and steps that can be undertaken to improve the indicator.
  - Community input ensures that reports and the process of developing reports reflect local priorities and keep the meaning of indicators transparent and clearly understood by populations for whom the report is intended.

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11.   Examining the Health Disparities Research Plan of The National Institutes of Health: Unfinished Business – Institute of Medicine, March 2006

To view this report, please click on the link:
http://www.iom.edu/~/media/Files/Report%20Files/2006/Examining-the-Health-Disparities-Research-Plan-of-the-National-Institutes-of-Health-Unfinished-Business/nihdisparities.ashx

About: This report brief assesses the NIH's response to the Minority Health and Health Disparities Research and Education Act of 2000, which established the NIH National Center on Minority Health and Health Disparities (MCMHD) disparities to, among other things, develop an NIH Strategic Plan on health disparities. Congress passed the law to ensure that NIH's work on health disparities was integrated and inclusive as opposed to broken up into small, independent research projects. The report brief covers the Strategic Plan for FY 2002-2006 and the then-unapproved Plan for FY 2004-2008 and argues that, due to lack of coordination and limited strategic planning, NIH's efforts to combat health disparities and to fulfill the requirements of the Act are unfinished.

Key Findings:
NIH ranked health disparities third among its top five organizational priorities and the individual strategic plans of the various Institutes and Centers (ICs) were contained extensive planning. However, there were gaps in the work.

1. Planning: The Act stipulated that the NIH-wide Strategic Plan would be updated annually, but at the time of writing (six years later) NIH had only approved a Strategic Plan for 2002-2006. A follow up Strategic Plan with improvements was yet to be approved.

2. Coordination: There is little evidence that NIH programs across ICs addressing health disparities are centrally coordinated, seen as a part of the overall NIH strategy, or well implemented in terms of priorities and outcomes.

3. Comprehensiveness: Gaps remain in a number of areas of study including: the social and behavioral determinants of health and their interaction with biological factors; the characteristics of populations affected by poor health; the relationship between population disparities in health care and differences in health status; and causes of disparities in health care.

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4. Funding: The authorized funding of up to $100 million included in the Act was not allocated, ensuring that the Strategic Plan was an unfunded mandate. Complete, standardized, and approved budget information was unavailable for the Strategic Plan.

Recommendations:

1. Through the MCMHD, ICs, and when appropriate, collaborating agencies, NIH should undertake research to further refine and develop conceptual, definitional, and methodological issues inherent in health disparities research and understanding the causes of disparities.

2. The NIH director should ensure that the Strategic Plan is reviewed and revised annually.

3. The Strategic Plan's research objectives should assure the integration of research on the multifactorial nature of health disparities. Including non-biological factors and population research et cetera.

4. The Plan should include measurable targets and time periods for research capacity objectives, and NIH should develop methods for measuring, analyzing and monitoring the results of programs that address this capacity.

5. The Plan's communications programs should be set up as a specific trans-NIH effort with centralized coordination. Any initiative should be informed by advisory expertise; develop a surveillance system; and promote the issue of inequities of health communication.

6. The updated Strategic Plan should include assessments of the efficacy of the individual strategic plans of the ICs (whether they reflect the larger goals and objectives of the Strategic Plan). These objectives should be measurably targeted and time-based.

7. NCMHD should designate additional health disparity groups and promote the development of, and access to, a registry of diseases and conditions which are variable by race, ethnicity, SES, geographic locale, and other designated health disparity populations.

8. A clear and timely budget process should be attached to the Strategic plan and updated reliably. Such a budget should include information for NIH as a whole and for the involved ICs and Offices, documenting allocations for Plan goals and objectives.

9. The NIH director should conduct a review of the administrative staffing of NCMHD to ensure that it commensurate with the Center's responsibilities. Moreover, the directors of NIH and NCMHD should increase scientific leadership and presence within NCMHD by appointing eminent scientists in the areas of minority health and health disparities. NCMHD should establish committees and panels with relevant expertise from within and outside NIH.

10. The NIH director, through the authority of the NCMHD director, should assure continuous, effective harmonization of the health disparities research program across the NIH.

12.   NIH Health Disparities Strategic Plan, Fiscal Years 2009-2013

National Institutes of Health – National Center on Minority Health and Health Disparities (NCMHD)

To view the Strategic Plan(s) for Fiscal Years 2002-2006 and 2004-2008, please click on the link:
www.nimhd.nih.gov/about_ncmhd/index2.asp

About: The *NIH Health Disparities Strategic Plan and Budget* sets the overarching principles for the NIH health disparities agenda. It focuses on three goals each NIH IC must strive to achieve: 1.) Conduct and support intensive research on the factors underlying health disparities; 2.) Expand and enhance research capacity to create a culturally sensitive and culturally competent workforce; and 3.) Engage in aggressive, proactive, community outreach, information dissemination, and public health education. The *Strategic Plan* outlines all ongoing and planned projects of each NIH IC and the program offices within the NIH Office of the Director to address minority health and health disparities. The NCMHD leads the development and revision of the *Strategic Plan* in collaboration with the NIH Institute and Center Directors, the NIH Director, the NCMDH Advisory Council, and obtains public input on each version of the *Strategic Plan*. Each plan and budget must: establish priorities among the health disparities research activities for authorized NIH agencies; establish objectives for these research activities; describe the means for achieving the objectives and set dates for these achievements; act as a broad binding statement of policies regarding minority/and other health disparities research activities; and promote coordination and collaboration among agencies conducting research activities.

13.   The National Institute of Drug Abuse, NIH Health Disparities Strategic Plan, Fiscal Years 2009-2013

To view this report, please click on the link:
www.nida.hih.gov/PDF/HealthDisparitiesStrategicPlan_508.pdf

About: While researchers have collectively acknowledged that drug abuse is a medical disease, it is also a stigmatized disease. Racial/ethnic minorities are most adversely affected by this stigma, which in turn leads to misperceptions about drug abuse and addiction in minority communities, as well as differences in consequences for abuse. Therefore, there is a great need to understand the unique prevention, treatment, and health services needs of underserved minority and other communities. NIDA has made sustained efforts to close this knowledge gap, beginning in 1993 with the establishment of a Special Populations Office, and the implementation of over a half-dozen institute-wide initiatives and policies. Since establishing its Health Disparities Committee in 2000, NIDA has been working to develop and further refine its *Strategic Plan to Address Health Disparities* as a part of the overall *NIH Strategic Plan on Reducing Health Disparities*. The *Revised 2009-2013 Strategic Plan* focuses on concerns related to research methodology, diversity, linguistic and cultural differences, support for researchers with diverse backgrounds, and communication with health disparity populations.

Progress in Health Disparities Research: Accomplishments and Lessons Learned

Significant progress has been in addressing the drug abuse and addiction research needs of racial/ethnic minority and other health disparity groups in the areas of research, research capacity and development, outreach and dissemination, and NIDA infrastructure:

- Research
  - Released an RFA on Health Disparities titled "Health Disparities: Drug Use and its Adverse Behavioral, Social, Medical, and Mental Health Consequences" (2001) that supported eight projects. Have subsequently released two additional health disparity-related RFAs.
  - Developed a competitive Health Disparities Supplement program (2002) that supported 28 projects.
  - Ensured the inclusion of racial/ethnic minority populations in the Clinical Trials Network (CTN). Protocols were established to enhance treatment for Spanish-speaking individuals, study on jobs training for American Indians with drug dependence, and other studies addressing drug treatment in minority populations.
  - Increased research findings and publications in the field of drug abuse pertaining to racial/ethnic minority groups.
- Research Capacity Development
  - Capacity development at diversity promoting institutions, co-funding a number of research capacity programs, as well as individual grants focused on minority issues.
  - Intramural and extramural summer research programs for students.
  - The National Hispanic Science Network, established to address addiction issues facing Hispanic populations.
- Outreach and Dissemination – support and participation in:
  - Numerous meetings/conferences sponsored by racial/ethnic minority organizations and organizations focused on health disparities issues.
  - National health disparity conferences in 2001 and 2005.
  - Efforts to make information available to groups in appropriate language and context.
  - Report released and revised titled "Drug Use Among Racial/Ethnic Minorities" (2003).
  - Scientific meetings on health disparities, including "Drug Abuse, HIV/AIDS, and Health Outcomes Among Racial and Ethnic Populations" (2001) and "Advancing Research to Reduce Drug Abuse and HIV/AIDS Health Disparities: Methodological Considerations" (June 2004).
- NIDA Infrastructure
  - Regularly convene expert work groups to advice the Director on research needs.
  - Regularly convenes a cross-division Health Disparities Committee that plans the NIDA-wide Health Disparities Initiative.
  - Established a Minority Interest Groups as part of the CTN.
  - Established an African American Initiative to address the disproportionate impact of HIV/AIDS and criminal justice involvement on African-Americans.

NIDA's Health Disparities Objectives for FY2009-2013
Note: Each objective also includes an Action Plan, Targets and Timelines, Major Performance Measures, Outcome Measures, and a Projected Budget

Areas of Emphasis in Research
- Area of Emphasis 1: Epidemiology of Drug Abuse and its Health Consequences among Racial/Ethnic Minority Populations

- o Objective One: Improve the knowledge base on the origins and patters of drug abuse/addiction in all racial/ethnic populations, and examine risk and protective factors for all minorities.
  - o Objective Two: Identify both the short- and long-term effects of drug use, abuse, and addiction on the overall health and related consequences in racial/ethnic minority populations.
- Area of Emphasis 2: Prevention of Drug Abuse and Addiction
  - o Objective One: Support prevention research focused on racial/ethnic minorities.
  - o Objective Two: Ensure that new directions for prevention research include members of racial/ethnic minority, rural, low-income and other underserved populations. Ensure that new directions in prevention involve the study of health disparity-specific concepts.
  - o Objective Three: Develop effective, culturally specific drug abuse prevention strategies for health disparity populations who are at increased risk for drug abuse.
- Area of Emphasis 3: Addressing Disparities in Treatment and Health Services Research
  - o Objective One: Increase the number of treatment research studies that focus on racial/ethnic minority and rural populations and improve dissemination of the study results.
  - o Objective Two: Determine the factors that contribute to differences, if any, experienced by racial/ethnic minority and rural populations in access to services and outcomes of treatment in managed care and other service systems.
- Area of Emphasis 4: Addressing Racial/Ethnic Disparities in Basic and Clinical Neurosciences
  - o Objective One: Increase the number of neuroscience, epigenetic, clinical neuroscience, and basic behavioral science studies that focus on racial/ethnic minorities, low SES and social stressors.

Areas of Emphasis in Research Capacity

- *Objective One*: Increase and improve drug abuse and addiction research development and training experiences for students, especially students from groups under-represented in science, as a means of attracting and preparing competent, future researchers in addiction and health disparity research.
- *Objective Two*: Establish new and strengthen existing programs to provide research development and support opportunities for faculty and investigators interested in health disparities research related to drug use and addiction.
- *Objective Three*: Increase the capacity of academic institutions to conduct health disparity research in drug abuse and addiction.
- *Objective Four*: Involve the broader professional and lay community in addressing health disparities caused by drug abuse and addiction.

Areas of Emphasis in Community Outreach, Information Dissemination, and Public Health Education

- *Objective One*: Educate racial/ethnic minority populations about drug abuse and addiction prevention and treatment. Identify and improve mechanisms for dissemination of research findings within and across racial/ethnic minority groups.
- *Objective Two*: Put research into practice in health disparity communities by providing science-based prevention and treatment information to service providers serving these populations.
- *Objective Three*: Educate the research and practice community about the state-of-the science in drug abuse and addiction research with health disparity populations.

Areas of Emphasis in Integration of Research, Capacity Building and Outreach Goals
- *Objective One*: Educate the field on strategies to reduce health disparities in addiction and related co-morbidities, including greater risk for criminal justice involvement among minority populations, through coordinated, collaborative approaches.

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14. Partners for Public Health: Working with local, state, and federal agencies to create healthier communities. – Bay Area Regional Health Inequities Initiative (BARHII), California, 2011

BARHII, Public Health Laws and Policy, 2011

To view this report, please click on the link:
http://www.barhii.org/resources/downloads/partners_for_public_health.pdf

About: This guide, funded in part by Robert Wood Johnson Foundation, is intended to provide information to public health department staff and advocates about the many public agencies that make policy decisions and implement projects related to the physical environment.

Action Steps for Public Health Advocates:
- **Air Quality**
    - Map locations of sensitive sites relative to transportation corridors; map problematic traffic patterns and idling issues.
    - Share and research and develop partnerships with community residents and environmental justice groups, as well as regional and state regulatory agencies.
    - Participate in development of local land use, transportation, and climate action plans and policies that impact air quality. Ensure that health-supportive policies are included in local plans.
    - Advocate for implementation of the state's greenhouse gas reduction plan.
    - Ensure health representation on local port commissions as well as regional and state regulatory agencies; work with agencies and ports to enforce cleaner goods-movement and emissions-reduction policies.
    - Participate in the development of regional Air Quality Management District plans; participate in the development of regional greenhouse gas, and ensure that vulnerable communities and those experiencing greater health disparities will not be negatively impacted by GHG reduction strategies.
    - Participating in implementing state legislation that requires coordination of transportation and housing planning in general plans.

- **Business Licensing and Permitting**
    - Work with local agencies responsible for business licensing and permitting to develop programs for health businesses and limit unhealthy businesses.
    - Provide feedback to the state Alcoholic Beverage Control on decisions for new and renewal alcohol retail licenses in your county.

- **Economic Development**

The DRA Project, a project of the Institute for Alternative Futures
www.altfutures.org/draproject | futurist@altfutures.org | 703.684.5880

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- o Use data to demonstrate needs and gaps pertaining to access to healthy businesses (e.g. map food access for all communities).
- o Assess the impact of poor food access on community health and the local economy.
- o Educate policymakers on connections between food access and health and the need for targeted economic development programs that address food access.
- o Work with local and state economic development agencies to develop programs that provide incentives for food retailers to locate and expand in underserved neighborhoods.
- o Evaluate how economic development funds can incentivize greater community benefits, such as living wage or local hire agreements.
- o Advocate for technical assistance and funding programs tailored to meet the needs of local business owners.

- **Housing**
  - o Assess where local communities may be vulnerable to displacement, as well as the health impacts of segregation and sub-standard housing; disseminate findings to decision-makers.
  - o Participate in local planning processes to advocate for integrated housing developments that offer a range of prices as well as rental and ownership options, and that reflect the locality's share of housing needs for all income levels and special populations.
  - o Pursue public-private partnerships with community development corporations and other developers to attract appropriate housing and mixed-use projects.
  - o Work with local code enforcement agencies to develop inspection and code compliance procedures that support healthy housing.
  - o Advocate for state and federal government to restore the U.S. Department of Housing and Urban Development budget and increase affordable housing funding sources.

- **Land Use**
  - o Use health data to inform land use decision-making processes (e.g., map access to and availability of health community infrastructure, such as grocery stores, schools, and transit stops).
  - o Partner with departments and commissions that influence and implement land use decisions. Serve on planning commissions; create opportunities for regular collaboration with planning departments.
  - o Partner with community groups and residents to reach out to populations that may not traditionally participate in land use decisions. Support community outreach efforts, and bring a health lens to the process.
  - o Participate in decision-making; ensure that land use plans and policies include health-supporting policies that reflect local needs and prioritize communities most impacted by health disparities.
  - o Participate in the development of policies and regulations that implement land use plans. Ensure that implementation measures translate health goals into development incentives, standards, and requirements.

- **Parks and Recreation**
  - o Use data to demonstrate the connection between physical activity infrastructure (parks, trails, recreation facilities, etc.) and health. Map where gaps exist, especially for communities most impacted by health disparities.

- o Educate decision-makers about the connections between poor health outcomes and poor access to opportunities for physical activity opportunities.
- o Partner with parks and recreation departments to identify ways to improve access to and maintenance of parks and recreation facilities.
- o Advocate for additional funding for acquisition and maintenance of parks and recreation infrastructure at the state and federal level.

- **Public Utilities**
  - o Advocate for local policies that promote clean water and reduce runoff, such as zoning codes and design standards that require landscaping, green building, and green streets.
  - o Advocate for increasing green energy sources, allowing distributed and community-owned energy generation, and providing affordable energy for low-income consumers.
  - o Advocate for increasing the use of public land for urban agriculture.

- **Public Works**
  - o Use data to demonstrate the connection between active transportation infrastructure and health outcomes; map access to transit, and biking and walking facilities.
  - o Partner with local public works departments to review projects for health impacts; provide input on project proposals and ensure those with the greatest ability to impact health and improve quality of life are prioritized.
  - o Support adoption and implementation of "complete streets" policies that accommodate all users of roadways.
  - o Participate in Metropolitan Transportation Commission (MTC) regional planning processes.

- **Redevelopment**
  - o Participate in redevelopment planning processes to make sure health priorities are in the plan.
  - o Conduct a Health Impact Assessment of the proposed plan to evaluate its potential public health effects.
  - o Partner with other community-based organizations to implement the plan.
  - o Hold the redevelopment agency accountable for supporting health-oriented goals, generate public health data to inform priorities, and communicate progress to the community.
  - o Advocate for the establishment of redevelopment areas in communities most impacted by health disparities.
  - o Encourage residents to join redevelopment oversight committees (PAC/CAC).

- **Schools**
  - o Encourage school districts to partner with public and private organizations to share facilities and open them for community use.
  - o Advocate for school sitting policies that locate schools in the center of communities to maximize community use and accessibility.
  - o Encourage school districts to partner with local planning agencies when making school sitting decisions.
  - o Partner with school districts and local governments to adopt Safe Routes to School policies, improve pedestrian and bicycle safety near schools, and encourage active transportation to schools.

- **Soil Quality**
    - Share information about the health impact of exposure to contaminated soil.
    - Partner with environmental justice groups to map contaminated sites and advocate for their clean-up and reuse.
    - Partner with local planning and redevelopment agencies to apply for federal Brownfield clean-up funding.

- **Transportation**
    - Conduct walkability and bikeability assessments.
    - Educate planners, engineers and decision makers about the link between safe streets, active transportation, and health.
    - Map neighborhoods and transportation access to essential services and daily needs.
    - Participate in the development of city and county general plans to ensure that they include transportation policies that improve safety and promote active transportation.
    - Participate in the development of county transportation plans and ensure that active transportation and improvements to connectivity are priorities.
    - Participate in the development of the Regional Transportation Plan and ensure that active transportation and improvements to connectivity are priorities.
    - Advocate for increased funding for active transportation infrastructure in the federal transportation reauthorization.

- **Water Quality**
    - Advocate for local policies that promote clean water and reduce runoff, such as zoning codes and design standards that require landscaping, green building, and green streets.
    - Partner with agricultural and farm worker groups to promote agriculture practices that require low water inputs, reduce or eliminate pesticide and herbicide use, and reduce runoff.
    - Advocate for strong state standards for water quality.

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15. Mind the Gaps in Measuring Health Care Performance – Robert Wood Johnson Foundation (RWJF), June 2011

National Quality Forum

To view this report, please click on the link:
http://www.rwjf.org/files/research/72501nqf201106.pdf

About: More than one-quarter of Americans – and two out of three older Americans – have multiple chronic conditions, forcing them to spend untold hours seeking care. For many reasons having little to do with patients, the "system" is set up to address their conditions one at a time. As the number of patient's conditions increases, so do the risks of serious complications. Furthermore, the quality of their care will vary widely, depending on where they live, the providers available to them, and the choices they must make with too little information.

Enter three promising strategies with the potential to improve care for all patients: **health information technology, value-based payment, and public reporting of results.** Each strategy represents a pillar supporting better and more consistent health care quality. Each depends on accurate and meaningful measures of performance so patients can identify good care, health plans can pay for it, and providers can deliver it.

National Quality Strategy Priorities
- Making Care Safer
- Ensuring Person- and Family-Centered Care
- Coordinating Care Effectively

- Promoting Prevention
- Supporting Better Health in Communities
- Making Care More Affordable

Health Information Technology
- With the use of good performance measures, health information technology (health IT) has unique power to focus everyone on the same goals and data. That focus can result in better care for individuals and whole populations.
- In the future, the growing use of personal health records (PHRs), maintained by patients themselves, will result in more data about health outcomes, health risk behaviors, adherence to treatment plans, and experience of care.

Pay for Performance
- Soon, ambulatory practice teams might receive payment that vary depending upon the quality of care provided and the outcomes achieved by their patients. They will then have added incentive to coordinate care; provide the most effective services; and eliminate unnecessary tests, drug interactions, and wasted time that cost them resources they could otherwise put toward practice improvements.

Summary of Current and Proposed Performance Measures for Payment Reform Models

	1. Global Payment	2. ACO Shared Savings Program	3. Medical Home	4. Bundled Payment
Care delivery organizations and/or providers that would typically receive payment	Integrated delivery system, multispecialty group practice, other aggregated provider groups and organizations	Integrated delivery system, multispecialty group practice, other aggregated provider groups and organizations.	Ambulatory group practices and/or individual physicians (primary care)	Hospitals, ambulatory group practices, and/or other providers
Types of measures in use in one of more highlighted payment programs	• Mortality • Morbidity (disease and treatment complications) • Safety outcomes • Preventive services • Healthy behaviors • Clinical care process • Care coordination (patient survey) • Safety practices (infection control) • Inappropriate resource use (e.g., imaging, antibiotic prescribing)	• Morbidity (disease and treatment complications) • Clinical care process • Care coordination (patient survey) • Preventive services	• Clinical care process • Preventive services • Access • Patient experience • Patient engagement • Care coordination (survey) • Organizational capabilities, including care management and practices and meaningful use of health IT.	• Episode case (predicted) • Mortality • Morbidity (treatment complications) • Functional status (change) • Safety outcomes • Patient experience • Preventive services • Healthy behaviors • Clinical care process (episode-specific) • Patient engagement • Care coordination (survey) • Safety practices • Service use
Types of measures that have been proposed for use in a highlighted payment program but not used	• Functional status (longitudinal change) • Quality of life (longitudinal change)	• Mortality • Functional status (longitudinal change) • Quality of life (longitudinal change) • Structure (ACO criteria) • Management	• Morbidity (disease complications) • Functional status (change) • Quality of life (change) • Staff satisfaction	• none currently

Public Reporting

- Public reporting creates a feedback loop. Patients ask more questions about providers that look weaker in clearing a common benchmark.
- Board members, attending physicians, and staff themselves unite in asking tough questions when their organizations don't perform as well as others.
- Providers strive to improve their performance as they find themselves compared to their peers. The bar is raised community wide, and patients end up with better, more consistent care.

16. Primary Health Care and the Social Determinants of Health: Essential and Complementary Approaches for Reducing Inequities in Health – Journal of Epidemiology and Community Health (JECH), 2010

By Kumanan Rasanathan, Eugenio Villar Montesinos, Don Matheson, Carissa Etienne, Tim Evans

To view this report, please click on the link:
http://jech.bmj.com/content/early/2010/05/27/jech.2009.093914.full.pdf

About: Reviews the 'sisterhood' between PHC [Primary Health Care] and SDH [Social Determinants of Health], considering their commonalities and differences how they can both coherently contribute to progress in improving health equity.

The primary health care reforms necessary to refocus health systems towards Health for All:
- Universal Coverage Reforms:
    - To improve health equity
- Service Delivery Reforms:
    - To make health systems people-centered
- Leadership Reforms:
    - To make health authorities more reliable.
- Public Policy Reforms:
    - To promote and protect the health of communities.

17. Beyond the Affordable Care Act: Achieving Real Improvements in Americans' Health – Robert Wood Johnson Foundation (RWJF), 2010

To view this report, please click on the link:
http://content.healthaffairs.org/content/29/8/1481.full?ijkey=gSs3Mnbr2fPGk&keytype=ref&siteid=healthaff

About: Recommendations that provide a high-level road map for moving forward.

Recommendations for Policy:

Promoting early childhood education
- Support in Early Childhood:
    o Programs that promote early childhood development and that support of the children and families.
    o Greater support for early childhood development programs could be the most important health policy that the nation could undertake.
- Childhood Obesity:
    o Commission's main recommendation in this area targeted schools because of how much time children spend in school, and because policy makers can influence what goes on at schools.
- Emphasis on Food and Activity:
    o Requiring schools to offer only nutritious food. Junk food should not be available.
    o Schools should ensure that all of the meals they provide meet the Dietary Guidelines for Americans of the Department of Health and Human Services (HHS).
    o Schools must do more to help children increase their physical activity through physical education programs, recess that allows physical activity and movement, and recreational activities during and after school.

Promoting food nutrition for all ages
- Promote Good Nutrition. Two recommendations:
    o Panel advocated for the creation of public-private partnerships to open and manage full service grocery stores in communities without access to healthful food.
    o Special Supplemental Nutritional Program for Women, Infants, and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, meet hungry families' need for nutritious food.
- Public-Sector Initiatives:
    o Funding for these [WIC, SNAP] federal food programs should be expanded to provide benefits to everyone who needs them, to enable people to purchase sufficient nutritious food.
- Public-Private Partnerships:
    o To expand access to healthy food choices, governments and communities can work with private businesses to make fresh and nutritious food more available in poor neighborhoods.
    o Increased access to affordable, nutritious foods at the community level is associated with healthier diets and lower rates of obesity.

Promoting healthy communities
- **Four of the commission's recommendations supported this goal**
    1. Integrating safety and wellness into every aspect of community life including schools, workplaces, religious institutions, and neighborhoods;
    2. Creating "healthy community" demonstration projects to evaluate the effects of a range of policies and programs;
    3. Developing a "health impact" rating system for housing and infrastructure projects that provides incentives for projects to increase community health
    4. Eliminating smoking

Working across agencies:
- Because health is influenced by so many daily choices, it needs to be a factor in all policy making, including decisions about transportation, housing, education, and community planning.
- Working across conventional policy silos to engage in cross-sector partnerships and solutions.
- Local Efforts.
- Smoking Cessation.

18.	**Investing In America's Health: A State-By-State Look At Public Health Funding and Key Health Facts –Robert Wood Johnson Foundation (RWJF), 2011**

To view this report, please click on the link:
http://healthyamericans.org/assets/files/Investing%20in%20America%27s%20Health.pdf

About: Where you live, learn, work, and play make a big difference in how healthy you are. A range of factors, like education, employment, income, family and social support, community safety, and the physical environment, impact our health.

In many communities, healthy choices are easy choices for their residents. In many other American communities, however, there are obstacles to healthy living. In these areas, people look to public health departments to help build a healthy community. This report analyzes the funding of public health departments in order to locate and analyze disparities between areas.

National Prevention Strategy and Prevention Fund as outlined in the ACA:
- The Fund will:
  - Bring common sense into our health care system by helping people to stay healthy and not get sick in the first place.
  - Help Americans to make healthier choices and take personal responsibility for their own health and the health of their families and children.
  - Reduce health care costs for businesses and families; prevent suffering; save millions of lives; keep Americans healthy and at work; and improve the quality of life for all.
- The Fund supports prevention efforts at the community level to:
  - Reduce tobacco use.
  - Expand opportunities for recreation and exercise.
  - Improve nutrition by increasing access to fresh fruits and vegetables and farmers markets, and helping kids to eat healthier meals and snacks in schools.
  - Expand mental health and injury prevention programs.
  - Improve prevention services in low-income and underserved communities.
- The Fund improves state and local health departments to:
  - Provide flu and other immunizations.
  - Protect our food, air, and water.
  - Fight infectious diseases.
- The Fund helps modernize disease outbreak and containment capabilities to:
  - Expand the workforce for public health laboratories.

- o Provide modernized equipment and technology to labs to protect us from disease outbreaks and other threats.
- The Fund supports science and research to:
    - o Develop more and even better ways to prevent disease and keep families and communities safe and healthy.

Recommendations:

In addition to shoring up the core ongoing funds for public health, we need to ensure the new Prevention Fund is used to build upon — and not supplant— and expand existing efforts. If we do not keep the foundation of support intact, we will never advance in the fight to prevent diseases, curb the obesity epidemic, or reduce smoking rates.

TFAH [Trust for America's Health] recommends that:

- Core funding for public health – at the federal, state, and local levels – be increased;
- Funding be considered strategically – so funds are used efficiently to maximize effectiveness in lowering disease rates and improving health;
- The Prevention Fund be implemented quickly and strategically to effectively and efficiently reduce rates of disease; and
- Accountability must be a cornerstone of public health funding – that the use of funds and the outcomes achieved from the use of the funds be transparent and clearly communicated with the public.

19.	**The Need for Prevention-Centered Health Reform – Partnership for Prevention, 2009**

To view this report, please click on the link:
http://www.prevent.org/downloadStart.aspx?id=31

About: While financing and access are, indeed, critical and necessary elements of health care reform, by themselves, they fall short of our ability to achieve the real goal – improving the health of all Americans.

More important than increasing our overall healthcare spending is spending our precious resources on the things that contribute the most to improved health. This means prevention. Delivering preventive services that have been proven effective is essential if we are to optimize the health of our citizens.

Prevention means improving both the quality and quantity of both clinical preventive services and community preventive services

- **Clinical Preventive Services** should be a basic benefit of proposed health financing reform.
    Financing mechanisms should:
    - o Make high-value clinical preventive services accessible to all.
    - o Encourage patients to use preventive services
    - o Offer incentives to healthcare providers to deliver clinical preventive services
    - o Reward employers for their active engagement in employee health promotion
- **Community Preventive services** should be a basic benefit of proposed health financing reform.
    Policies and financing mechanisms should:

- o Create healthy environments and promote healthy lifestyles
- o Offer incentives to organizations that influence the health populations to deliver community preventive services.
- o Encourage Americans to give greater attention to prevention in their own lives.
- ▪ Health Reforms should aim to increase the impact of prevention. **Financing mechanisms should:**
  - o Increase support for research on community-based and clinical prevention.
  - o Support the development and tracking of system performance standards related to prevention.

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20. Community Centered Health Homes: Bridging the gap between health services and community prevention – Prevention Institute, 2011

To view this report, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html

About: Skills needed to engage in community change efforts are closely aligned with the problem solving skills providers currently employ to address individual health needs. It is a matter of applying these skills to communities. Specifically with patients, practitioners follow a three-part process: collecting data, diagnosing the problem and undertaking a treatment plan. The CCHH would function in a parallel manner by developing capacity and expertise to follow a three-part process for addressing the health of the community, classified as inquiry, analysis, and action.

Elements of the Community-Centered Health Home
- ▪ Inquiry Elements:
  1. Collect data on social, economic, and community conditions.
  2. Aggregate symptom and diagnoses prevalence data.

- ▪ Analysis Elements:
  1. Systematically review health and safety trends.
  2. Identify priorities and strategies with community partners.

- ▪ Action Elements:
  1. Coordinate activity with community partners.
  2. Advocate for community health.
  3. Mobilize patient populations.
  4. Strengthen partnerships with local health care organizations.
  5. Establish model organizational practices by:
     - o Creating policies that promote equity: eliminate institutional discrimination, ensure cultural competency of CCHH staff, and ensure workforce diversity.
     - o Ensuring healthy foods and beverages are available and promoted in cafeterias, vending machines, coffee carts, and other concessions.
     - o Encouraging physical activity through building design (e.g., open, inviting stairways), meeting practices (e.g., walking meetings), and incentives for employees to travel to work by active means.

- o   Establishing procurement policies for geographic preference of locally and regionally grown healthy foods.
- o   Implementing policies and practices in CCHH facilities to support initiation and continuation of breast-feeding (e.g., Baby-Friendly Hospitals).

- Capacities needed for effective implementation:
    1. Staff training and continuing education.
    2. A dedicated and diverse team.
    3. Innovative leadership.

- Overarching systems change recommendations:
    1. Structural health care payment systems to support CCHHs.
    2. Leverage current opportunities for government, philanthropy, and community benefits to support CCHHs.
    3. Establish consistent metrics for evaluation and continuous quality improvement.
    4. Strengthen and utilize networks.
    5. Building a cadre of health professionals prepared to work in CCHHs.

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21.   A Healthy Food Financing Initiative: An Innovative Approach to Improve Health and Spark Economic Development – Policy Link, 2010

Policy Link, The Food Trust, and The Reinvestment Fund

To view this report, please click on the link:
http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/HEALTHYFOODFINANCING_2PG.PDF

About: The Healthy Food Financing Initiative (HFFI) is a viable, effective, and economically sustainable solution to the problem of limited access to healthy foods, and can reduce health disparities, improve the health of families and children, create jobs, and stimulate local economic development in low-income communities.

- HFFI would:
    - o   Attract investment in underserved communities by providing critical loan and grant financing.
    - o   Help fresh food retailers overcome the higher initial barriers to entry into underserved, low-income urban and rural communities, and would also support renovation and expansion of existing stores so they can provide the healthy foods that communities want and need.
    - o   Be flexible and comprehensive enough to support innovations in healthy food retailing and to assist retailers with different aspects of the store development and renovation process.

- In the midst of the country's current economic downturn, the need for a comprehensive federal policy to address the lack of fresh food access in low-income communities and communities-of-color is critical.

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o   Evidence strongly shows that when people have access to healthier foods, they make healthier choices—and that securing new or improved local grocery stores can also improve local economies and create jobs.

▪   The federal government should build on these successes so that more communities across America can benefit by funding a Healthy Food Financing Initiative to improve children's health, create jobs, and spur economic development nationwide.

22.	**Fighting Fat at 15: What the Government Can Do to Combat Childhood Obesity – Center for American Progress, 2010**

To view this report, please click on the link:
http://www.americanprogress.org/issues/2010/09/pdf/fighting_fat.pdf
About: Low-income children face especially high barriers to attaining and sustaining a healthy weight, as limited resources make it more difficult to purchase healthy foods and preserve a measure of reliable food security. Families unable to pay for items with higher price tags instead fill up on cheaper and less healthy foods, cementing a link between hunger and unhealthy eating practices. Lower-income communities are also more likely to live in food deserts devoid of nutritious stock items, making it difficult to achieve balanced family diets. In order to be effective, holistic policy solutions addressing childhood obesity in low-income children must be sought in the larger context of malnutrition.

Of children living in poverty, 44.8 percent are overweight or obese, and childhood obesity costs the United States an estimated $14.1 billion per year across income groups. These rates exacerbate and lead to a steady epidemic of adult obesity. Furthermore, 23.5 million people currently live in food deserts and low-income zip codes have 25 percent fewer supermarkets than middle-income zip codes. Inequitable access to healthy food items and sustained food security drives high levels of obesity among poor children.

Recommendations in addition to sustained support for the Child Nutrition Act
80. Develop sustained interagency collaborations: The various federal agencies engaged in the fight to end childhood obesity, including the Department of Health and Human Services and the Department of Education, along with other partners in the White House Task Force on Childhood Obesity must pursue successful, continued, and sustained collaborations in order to set clear goals and benchmarks, efficaciously evaluate progress and foster experimentation.
81. Eliminate food deserts: Build upon the president's Healthy Food Financing Initiative, which combats obesity rates low-income communities by investing $400 million a year to stock corner stores with healthy food items and bring supermarkets into underserved neighborhoods.
82. Improve the Farm Bill: When Congress revisits the Farm Bill it should expand access to fruits and vegetables and facilitate the use of farmers' markets or generally increase the resources available to families for food purchases.
83. Transportation Legislation: People living in low-income communities have less access to vehicles, meaning they are more unable to access supermarkets but also stand to

benefit from improvements to the nation's transportation system. Follow through on President Obama's infrastructure investment proposals and bolster the ARRA-funded Transportation Investment Generating Economy Recovery (TIGER) grant program.

23. The Grocery Gap: Who Has Access to Healthy Foods and Why It Matters - Policy Link, 2010

Policy Link, The Food Trust

To view this report, please click on the link:
http://www.policylink.org/atf/cf/%7B97C6D565-BB43-406D-A6D5-ECA3BBF35AF0%7D/FINALGroceryGap.pdf

About: Existing research provides clear evidence that food deserts exist in numerous low-income communities and communities of color across the country, and that they have significant negative impacts on health, social equity, and local economic development. The balance suggests that making affordable, healthy foods more available to underserved residents will lead to their making healthier choices about what to eat and, ultimately, better health, while contributing to economic and neighborhood revitalization.

Implications for Policy:
While there is general agreement in the literature about the lack of access to healthy foods and increasing evidence about its consequences, fewer researchers have focused on the question of what are the **most effective solutions**. This search has largely been taken up by impacted communities and their advocates and supporters. Across the country, they are:

- Attracting or developing grocery stores and supermarkets;
- Developing other retail outlets such as farmers' markets, public markets, cooperatives, farm stands, community-supported agriculture programs, and mobile vendors (and ensuring public benefits can be used at these venues);
- Increasing the stock of fruits, vegetables, and other healthy foods at neighborhood corner stores or small groceries;
- Growing food locally through backyard and community gardens and larger-scale urban agriculture; and
- Improving transportation to grocery stores and farmers' markets.

24. F as in Fat: How Obesity Threatens America's Future - Trust for America's Health (TFAH) and The Robert Wood Johnson Foundation (RWJF), 2011

To view this report, please click on the link:
http://www.healthyamericans.org/reports/obesity2011/Obesity2011Report.pdf

About: For the past five years, the Robert Wood Johnson Foundation (RWJF) and Trust for America's Health (TFAH) have collaborated to produce the *F as in Fat* report in order to raise awareness, drive action, identify solutions, and reverse the obesity epidemic. RWJF and TFAH recognize the importance of reducing health inequities in order to build a healthier America.

Recommendations:

1. Policy Priorities to Reverse Childhood Obesity
   - Ensure that all beverages and food served and sold in schools conforms to recent Dietary Guidelines for Americans.
     - Implement updated nutrition standards for food and beverages served and sold in schools.
     - Increase federal reimbursement for National School Lunch Program.
     - Expand access to School Breakfast Program.
     - Ensure schools have resources they need to train cafeteria workers to replace outdated or broken kitchen equipment.
   - Increase access to affordable foods through new and improved grocery stores, farmers' markets, or healthy corner stores.
     - Creating incentive programs that attract grocery stores and supermarkets to underserved neighborhoods.
     - Introduce or modify land use policies and zoning regulations to promote, expand and protect potential sites for community gardens, mobile markets, and farmers' markets.
   - Increase time, intensity, and duration of physical activities in both schools and out of school programs.
     - Make physical education (PE) a requirement in schools.
     - Implement a minimum of 150 minutes per week of PE in elementary schools and 225 minutes per week in middle and high schools.
     - Increase opportunities for physical activity in schools outside of PE, such as classroom activity breaks, intramural and inter-scholastic sports.
   - Increase physical activity by improving the built environment in communities.
     - Establish joint use agreements that allow community residents to use school playing fields, playgrounds, and recreation centers when schools are closed.
     - Build and maintain parks and playgrounds that are attractive for playing and located close to residential areas that could be kept safe through community policing strategies.
     - Plan, build, and maintain a network of sidewalks and street crossings.
   - Use pricing strategies—both incentives and disincentives—to promote the purchase of healthier foods.
   - Reduce youths' exposure to marketing of unhealthy foods through regulation, policy, and effective industry self-regulation.
     - Adopt a definition of "marketing" to include marketing via social media.
     - Adopt research-based, industry-wide, front-of-package labeling system.
     - Eliminate advertising and marketing of unhealthy foods near school grounds and in public places frequented by youths and limit the number of fast food outlets near such places.

- o Set nutritional standards for children's meals that include a toy or other incentive item.
- o Limit advertising that directly appeals to children.

2. Strategic Implementation of New Policy Opportunities
   - Support the *Let's Move* initiative.
   - Emphasize Obesity Prevention in a Reforming Health System.
     - o TFAH and RWJF recommend that the Prevention and Public Health Fund not be cut, and that a significant portion be used for obesity prevention.
     - o TFAH and RWJF encourage health departments around the country to work with members of the community to compete for Community Transformation Grants.
     - o TFAH and RWJF recommend that each federal department involved in the National Prevention, Health Promotion, and Public Health Council and the National Prevention Strategy look for ways to improve health through their policies and create an implementation plan that includes measureable goals, a timeline, and description of how the department's budget will fund health-related activities.
     - o The Centers for Medicare and Medicaid Innovation provide a range of opportunities to examine, evaluate, and expand models for treating and preventing obesity. For example, reimbursement of various community-based obesity prevention efforts could provide increased incentive and implementation of these programs.
     - o TFAH and RWJF encourage public health departments to work with care providers and to develop applications that reflect evidence-based, innovative, and high impact approaches to compete for resources provided by the CDC and ACA, and recommend that the departments coordinate the demonstration project with *Let's Move!,* minimize duplication efforts and promote coordinating with existing funding streams, fund grantees to test a variety of methods and strategies across childhood settings, and ensure that adequate funding and compliance measures are used to conduct thorough evaluations.

3. Fully implement nutrition related legislation and programs: the Healthy, Hunger-Free Kids Act, the Agriculture Appropriations Act, and the Healthy Food Financing Initiative.
   - The TFAH and RWJF strongly suggest that the USDA move quickly to fully implement the Healthy, Hunger-Free Kids Act of 2010 to improve the nutritional quality of food and beverages served and sold in schools, to strengthen wellness policies, and the encourage increased physical education and activity.
   - The TFAH and RWJF also suggest that programs in childcare settings and nutrition assistance programs be fully funded and carried out.
   - The Healthy Food Financing Initiative, which provides incentives for new retail food locations in underserved communities, should be supported so that access to healthy affordable foods may be improved.

4. Implement the National Physical Activity Plan
   - TFAH and RWJF recommend full implementation of policies, programs, and initiatives outlined in the National Physical Activity Plan, including grassroots advocacy effort, public

education programs, a national resource center, a policy development and research center, and dissemination of best practices.

5. Be Strategic in Realigning Chronic Disease Programs at CDC
    - TFAH and RWJF recommend that CDC be thoughtful in their leveraging resources during their realigning of the chronic disease programs in order to have maximum impact on reducing disease rates and improving health.

6. Industry should fully implement the IOM Recommendations for food marketing to children
    - TFAH and RWJF suggest that the recommendations from the IOM report on food marketing to children be fully carried out and that industry should adopt strong, consistent standards for food marketing and work to implement the other recommendations set forth in the IOM report.

7. CDC should strengthen the Health and Sustainability Guidelines for federal concessions and vending operations, work with employers to implement wellness programs, and use strong guidelines for federal workplace-based food contracts.
    - Businesses should focus on incentives rather than penalties and should also support disease prevention and health programs in surrounding communities.

8. Improve policies to increase opportunities for physical activity and access to healthy nutrition for people with disabilities
    - Given the high obesity rates within the community of disabled people, health care providers should receive more training and education about how to assist people with disabilities to be more active and improve nutrition.
    - Legislation related to obesity should include implementation and monitoring of already passed legislation that requires the active inclusion and participation of people with disabilities.
    - Also, more research on how gender, age, ethnicity, and income contribute to the high rates of obesity among people with disabilities would remove barriers to healthy choices for the disabled.

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25.   Early Childhood Obesity Prevention Policies – Institute of Medicine, 2011

To view this report, please click on the link:
http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies.aspx

To view this report's Recommendations, please click on the link:
http://www.iom.edu/~/media/Files/Report%20Files/2011/Early-Childhood-Obesity-Prevention-Policies/Young%20Child%20Obesity%202011%20Recommendations.pdf

About: In this consensus report, the IOM recommends actions that healthcare professionals, caregivers, and policymakers can take to prevent obesity in children five and younger. Pediatricians and other healthcare professionals have an important opportunity to make parents aware of their child's excess

weight early on, and the IOM recommends that healthcare professionals measure weight and height or length in a standardized way, as well as pay attention to obesity risk factors, such as rate of weight gain and parental weight, at routine pediatric visits. In addition, the IOM recommends that parents and child care providers keep children active throughout the day and provide them with diets rich in fruits, vegetables, and whole grains, and low in energy-dense, nutrient-poor foods. Caregivers also should limit young children's screen time and ensure that children sleep an adequate amount each day. What happens to children during the first years of life is important to their current and future health and well-being.

Areas and Goals of Recommendations:

- Growth Monitoring
  - Assess, monitor, and track growth from birth to age five.
    - Healthcare providers should measure weight and length or height in a standardized way, plotted on World Health Organization growth charts (ages 0–23 months) or Centers for Disease Control and Prevention growth charts (ages 24–59 months), as part of every well-child visit.
    - Healthcare professionals should consider 1) children's attained weight-for-length or BMI ≥ _85th percentile, 2) children's rate of weight gain, and 3) parental weight status as risk factors in assessing which young children are at highest risk of later obesity and its adverse consequences.
- Physical Activity
  - Increase physical activity in young children.
    - Child care regulatory agencies should require child care providers and early childhood educators to provide infants, toddlers, and preschool children with op-portunities to be physically active throughout the day.
    - The community and its built environment should promote physical activity for children from birth to age five.
  - Decrease sedentary behavior in children.
    - Child care regulatory agencies should require child care providers and early childhood educators to allow infants, toddlers, and preschoolers to move freely by limiting the use of equipment that restricts infants' movement and by implementing appropriate strategies to ensure that the amount of time toddlers and preschoolers spend sitting or standing still is limited.
  - Help adults increase physical activity and decrease sedentary behavior in young children.
    - Health and education professionals providing guidance to parents of young child and those working with young children should be trained in ways to increase children's physical activity and decrease their sedentary behavior, and in how to counsel parents about their children's physical activity.
- Healthy Eating
  - Promote consumption of a variety of nutritious foods, and encourage and support breastfeeding during infancy.
    - Adults who work with infants and their families should promote and support exclusive breastfeeding for six months and continuation of breastfeeding in conjunction with complementary foods for 1 year or more.
    - To ensure that child care facilities provide a variety of healthy foods and age-appropriate portion sizes in an environment that encourages children and staff to

consume a healthy diet, child care regulatory agencies should require that all meals, snacks, and beverages served by early childhood programs be consistent with the Child and Adult Care Food Program meal patterns and safe drinking water be available and accessible to the children.

- The Department of Health and Human Services and the U.S. Department of Agriculture should establish dietary guidelines for children from birth to age two years in future releases of the *Dietary Guidelines for Americans*.

o Create a healthful eating environment that is responsive to children's hunger and fullness cues.

- State child care regulatory agencies should require that child care providers and early childhood educators practice responsive feeding.

o Ensure access to affordable healthy foods for all children.

- Government agencies should promote access to affordable healthy foods for infants and young children from birth to age five in all neighborhoods, including those in low-income areas, by maximizing participation in federal nutrition assistance programs and increasing access to healthy foods at the community level.

o Health adults increase children's healthy eating.

- Health and education professionals providing guidance to parents of young children and those working with young children should be trained and educated and have the right tools to increase children's healthy eating and counsel parents about their children's diet.

- Marketing and Screen Time
  o Limit young children's screen time and exposure to food and beverage marketing.
    - Adults working with children should limit screen time, including television, cell phone, or digital media, to less than two hours per day for children aged two-five.
    - Healthcare providers should counsel parents and children's caregivers not to permit television, computers, or other digital media devices in children's bedrooms or other sleeping areas.
    - The Federal Trade Commission, the U.S. Department of Agriculture, Centers for Disease Control and Prevention, and the Food and Drug Administration should continue their work to establish and monitor the implementation of uniform voluntary national nutrition and marketing standards for food and beverage products marketed to children.
  o Use social marketing to provide consistent information and strategies for the prevention of childhood obesity in infancy and early childhood.
  o The Secretary of the Department of Health and Human Services, in cooperation with state and local government agencies and interested private entities, should establish a sustained social marketing program to provide pregnant women and caregivers of children from birth to age five with consistent, practical information on the risk factors for obesity in young children and strategies for preventing overweight and obesity.

- Sleep
  o Promote age-appropriate sleep duration among children.
    - Child care regulatory agencies should require child care providers to adopt practices that promote age-appropriate sleep durations.
    - Health and education professionals should be trained in how to counsel parents about their children's age-appropriate sleep durations.

26. **Community Action Guide: Changing Food Deserts into Food Oases: A Resource for States and Communities – National Association of Chronic Disease Directors (NACDD), 2010**

To view this report, please click on the link:
http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/food-deserts-to-food-oases/view

- Step I: Data gathering, measurement, and assessment
    - Use online mapping tools to locate food deserts
    - Additional steps:
        - Evaluate food costs, as compared to the income of families, and the percentage of community members under the federal poverty line.
        - Evaluate community rates of obesity and other nutrition related chronic diseases; such as, diabetes and heart disease.
        - Perform an environmental scan to determine what food resources are available in your community, and a market basket analysis to identify the availability, cost, and nutritional value of foods sold at local stores.
        - Determine if healthful food locations are within one block of bus stop routes.
        - Evaluate the food environment as a whole, factoring in fast food restaurants, and other related food sources.

- Step II: Define audience/Identify Partners
    - Define the stakeholders in the community: policymakers, agencies, organizations, community members that can partner to develop solutions based on your community's specific needs.

- Step III: Action-Policy Development & Community Solutions
    - Attracting or developing grocery stores and food markets;
    - Developing other retail outlets such as farmers' markets, public markets, cooperatives, farm stands, community supported agriculture programs, and mobile vendors (and ensuring public benefits can be used at these venues);
    - Increasing the stock of fruits, vegetables, and other healthy foods at neighborhood corner stores or small groceries;
    - Growing food locally through backyard and community gardens, and larger scale urban agriculture; and
    - Improving transportation to grocery stores and farmers' markets.

27. **The Transportation Prescription: Bold New Ideas for Healthy, Equitable Transportation Reform in America – Policy Link, Prevention Institute, Convergence Partnership, 2009**

To view this report, as well as associated files, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-107/127.html

About: The goal is to improve transportation for everyone while delivering other important payoffs, including better respiratory and cardiovascular health; improved physical fitness; less emotional stress; cleaner air; quieter streets; fewer traffic injuries and deaths; greater access to jobs; nutritious foods, pharmacies, clinics, and other essentials for healthy, productive living.

A Foundation for 21st-Century Transportation Policy:
Healthy, equitable transportation policy is grounded in four principles. These may also serve as benchmarks to assess the impacts of transportation plans on public health, equity, and environmental quality.

1. **Develop transportation policies and plans that support health, equity, and environmental quality.** Federal, state, and local transportation should be aligned with the top health and environmental goals of federal departments and agencies.

2. **Prioritize transportation investments in distressed regions, low-income neighborhoods, and communities of color.** Federal, state, and local transportation agencies should emphasize projects that will revitalize the economy of struggling communities, lower health disparities, and will connect vulnerable populations to jobs, business opportunities, healthy food outlets, medical services, and other necessities.

3. **Emphasize accessibility, instead of simply mobility, in transportation policies and programs at all levels of government as well as across sectors and policy silos.** Transportation systems should give communities wider access to all the things that are not necessary for a good life, not to move people faster and further.

4. **Ensure transparency, accountability, and meaningful participation by all residents, advocates with diverse interests, and experts from different fields.** State and regional transportation officials and private developers must engage new partners in decision making and provide the data, training, and resources to allow full, informed participation by the people affected most by the decisions and investments.

Policy and Program Priorities to Improve Health and Equity
1. Prioritize investment in public transportation.
2. Prioritize investment in bicycle and pedestrian infrastructure.
3. Encourage equitable transit oriented development by creating incentives for integrated land use and transportation planning.
4. Create incentives and accountability measures to ensure that transportation plans account for their impacts on health, safety, and equity.
5. Give state, regional, and local government agencies and organizations more flexibility to move dollars among funding categories to target spending to meet local needs.
6. Prioritize transportation investments in communities with high unemployment and poverty rates to stimulate economic growth and provide access to jobs.
7. Make sure that jobs and contracts created by federal transportation investments reach low-income people and communities of color.

8. Support the development of cleaner bus and truck fleets and invest in freight rail infrastructure to reduce greenhouse gas emissions, improve local air quality, promote health, and foster energy independence.
9. Advance safety for all travelers.
10. Support policies and programs that increase access to healthy foods.
11. Give low-income rural communities greater access to public transportation funds from the surface transportation bill providing the opportunity for access employment and education opportunities.

28. Residents Live in Communities with Health-Promoting Land Use, Transportation, and Community Development - The California Endowment and the Prevention Institute, 2010

To view this report, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-288/127.html

About: "Residents Live in Communities with Health Promoting Land Use, Transportation, and Community Development," is based on the conclusion that conditions in our physical surroundings (environment) where we live, work, play, learn, and shop; how we travel and transport goods; and everywhere our food comes from, all impact our health and well-being.

Promising Strategies and Practices:
1. Walkable and Bikeable Neighborhoods
   o Complete street polices. *Complete streets is a regulatory strategy to ensure that all roads provide routine accommodation for all users, including bicyclists, transit users, and pedestrians of all ages and abilities, by including or enhancing pedestrian and bicycle infrastructure during road maintenance, repair, new construction, and redesign.*
     • Widening sidewalks
     • Raising medians
     • Narrowing roadways
     • Placing bus stops in safe and convenient locations
     • Making various improvements (e.g., refuge medians) for disabled travelers.
   o Safe routes to School
   o Connect roadways to complementary systems of trails and bicycle paths
   o Adoption of pedestrian and bicycle master plans
   o Renovate or rebuild schools in locations that encourage walking, bicycling, and use of public transit and that minimize exposure to hazards such as air pollution

2. Public Transit
   o Affordable reliable multi-modal public transportation options
   o Transit-oriented development

3. Parks, Recreation, Open Space

- o Provide local parks, playgrounds, and recreation facilities in currently underserved residential areas
- o Joint use agreements
- o Require new housing developments to incorporate recreation and open space for activity
- o Offer parks and recreation programming that encourages and supports physical activity
- o Increase access to national and state park systems among people from low-income communities and communities of color

4. Safety: Violence and Perceived Violence
   - o Eyes on the street. *Natural surveillance*
     - Building must be facing the street.
     - There should be eyes upon the street from buildings lining the street.
     - The sidewalk should be used continuously, at nearly all hours.
     - Children are able to play on sidewalks and streets.
     - Neighborhood streets should be as narrow as possible and accommodate only slow-moving traffic.
     - A large number of shops and public places, particularly those that are bustling at night, should be sprinkled throughout the neighborhood.
     - Good lighting.
   - o Safe community places for youth
   - o Reduce density of alcohol outlets
   - o Blight reduction/public art
   - o Neighborhood focal points

5. Healthful Food Environments
   - o Offer retailers incentives from local government
   - o Support corner stores to provide more healthful options
   - o Establish restrictions on sales and marketing of unhealthy food
   - o Preserve farmland on the urban and suburban fringes and in prime growing areas
   - o Expand community gardens and urban agriculture
   - o Ensure that grocery stores and small stores are equipped to accept the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits
   - o Accessing grants or loans to improve distribution of local foods to stores
   - o Invest in fresh food financing initiatives for grocery stores and small stores
   - o Expand access to farmers' markets
   - o Food policy councils

6. Land Use Policy
   - o Health elements in general plans
   - o Zoning Codes
   - o Redevelopment Funds
   - o Business Improvement Districts (BIDs)
   - o Mixed-use/mixed-income developments
   - o Health impact assessment

7. Current Political Opportunities

o   Growing awareness of the importance of improving health by addressing the built environment, as well as awareness of the potential return on investment of community-level chronic disease prevention efforts and growing political will to take innovative and far-reaching steps to mitigate and reverse the potential impact of climate change, present multiple opportunities.

8. Climate Change
    o   State legislation
    o   Strategic Growth Council
    o   Regional Blueprint Planning

9. Stimulus Funding
    o   Prevention and wellness community funds
    o   Infrastructure funds

10. Other Federal Funding Sources
    o   Transportation reauthorization

Measures of Progress:
▪   Walkable and Bikeable Neighborhoods
    o   Establish polices that support complete streets and safe routes to schools.
    o   Local business groups organize to invest in streetscape amenities that enhance safety and walkability and keep the neighborhood clean and attractive to local shoppers.
    o   More children and families have safe options to bike or walk to school, parks, and neighborhood shopping corridors.
    o   Traffic-calming measures are employed on neighborhood streets.
    o   Reduce the number of pedestrians and bicycle injuries and fatalities.
    o   Residents walk or bike for leisure and for transportation to destinations.

▪   Public Transit
    o   Public transit options connect community members to employment, commercial, and recreations opportunities.
    o   Public transit is affordable.
    o   Transit facilities with disability access are within safe walking distance to households.

▪   Parks, Recreation, and Open Space
    o   Shared and multipurpose facilities (e.g., family resource centers, schools, and parks) are safe and accessible for community use.
    o   Local parks and playgrounds are safe and offer activities for children, youth, and families.
    o   Neighborhood parks and/or recreational facilities should be within a safe walking distance (e.g., quarter-or half-mile) to households.
    o   Parks, open space, and recreation facilities should be equitably distributed throughout all communities.
    o   Parks, playgrounds, and schools should not have liquor stores and junk food outlets within a quarter-mile.

▪   Safety: Violence and Perceived Violence

- o   Neighborhood physical infrastructure encourages eyes on the street.
- o   All communities should have adequate physical infrastructure to support safe walking and biking (e.g., sidewalks, bike lanes, lighting, etc.).
- o   Graffiti, trash, and other forms of blight are limited.
- o   Public art is highly visible throughout the community.
- o   Arts and recreational opportunities are available to youth of all ages after school and on the weekend.
- o   Communities should enhance personal safety in areas where people are or could be physically active.

- ■   Healthful Food Environments:
    - o   Incentives are provided to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas.
    - o   Small neighborhood grocery stores carry a wide variety of fresh fruits and vegetables and other healthy and culturally appropriate food items that are fairly priced, and displayed and advertised in a manner that attracts neighborhood customers.
    - o   Local policies encourage square footage of grocery stores and convenience stores to be dedicated to fresh foods.
    - o   Policies restrict marketing and access to unhealthful foods and beverages, such as alcohol and items containing trans fat.
    - o   Land use policies encourage farmers' markets and produce stands in residential neighborhoods and near community gathering places.
    - o   Neighborhood stores increasingly become WIC vendors; upgrade their offerings in accordance with the new, healthier WIC food packages; and improve infrastructure of their stores to stock and sell affordable, quality fruits and vegetables.
    - o   Neighborhood residents are increasingly growing their own food in backyards and in community gardens.

- ■   Land Use Policy
    - o   Land use planning decisions condor health through tools such as health impact assessments.
    - o   Schools are built and maintained as environmentally healthy buildings and property (e.g., asbestos-safe, lead-free, hazard-free, adequate playgrounds, etc.).
    - o   Schools are built in locations that maximize walking and biking to school and access to physical activity while minimizing exposure to air pollution and other toxins.
    - o   Noise is controlled in indoor and outdoor environments consistent with World Health Organization guidelines for community noise.
    - o   Access to unhealthy products such as tobacco, alcohol, and fast food should be limited through planning mechanisms.

- ■   Overarching
    - o   Local government strives to incorporate policies and programs that prioritize the physical well-being of community residents while simultaneously encouraging the economic health of the community.
    - o   Development and investment should be prioritized to create neighborhood conditions that reduce avoidable injury and disease in communities with the greatest need – especially low-income populations and communities of color.

o   Mechanisms for community input on built environment planning and decision-making are in place and accessible.

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29.   Addressing the Intersection: Preventing Violence and Promoting Healthy Eating and Active Living – Prevention Institute, 2010

To view this report, as well as an executive summary, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-267/127.html

About: *Addressing the Intersection: Preventing Violence and Promoting Healthy Eating and Active Living* deepens the understanding of the inter-relationship between violence and healthy eating and physical activity and provides guidance on identifying and promoting intersecting strategies. It highlights cross-disciplinary strategies that are being successfully implemented across the country today.

Emerging Strategies for Making the Connection between Preventing Violence and Promoting Healthy Eating and Active Living:

Understanding a community-wide approach for preventing violence – especially in highly impacted neighborhoods

- **Prioritizing Key Risk & Resilience Factors:** Communities working to prevent chronic disease can prioritize important local risk factors as well as community assets related to preventing violence and chronic disease.
- **Convening Partners from Institutions and the Community:** Collaboration among community partners helps forge a shared vision and enhances buy-in to selected strategies. *Collaborative efforts should rally broad community participation.*
- **Developing a Multifaceted Plan**: Past campaigns to prevent violence have too often focused solely on individual skill-building or educational approaches; but sustainable success also requires addressing broader environmental and systems-level issues through a well-structured plan.
- **Ensuring Adequate Funding**
- **Applying a violence prevention lens to environmental and policy change strategies to promote healthy eating and active living efforts.**
- **Creating Safe Spaces**: Enables residents to maximize use of community resources, including those that support good nutrition and physical activity. Factors such as the availability of safe, open space for play and the "walkability" of neighborhoods influence the choices residents make in their daily lives.
- **Promoting Community Development and Employment:** Efforts should ensure that all members of a community have equitable access to opportunities and resources-including quality education, living-wage jobs, and environments free of racism, sexism, and other forms of oppression or bias.
- **Fostering Social Cohesion:** Encourages feelings of inclusion, social order, ownership, and community participation. Social networks foster mutual trust and increase residents' willingness to intervene on behalf of each other and to get involved in community-building activities.
- **Elevating the role of healthy eating, active living practitioners in fostering safer communities through advocacy and partnerships.** As local leaders working to build healthier communities, practitioners focused on healthy eating and active living can be:

- o **Bold Spokespeople**
- o **Catalysts**
- o **Coordinators**
- o **Integrators**

30. Strategies for Enhancing the Built Environment to Support Healthy Eating and Active Living – Healthy Eating Active Living Convergence Partnership, 2008

Prepared by the Prevention Institute

To view this report, please click on the link:
http://www.convergencepartnership.org/atf/cf/%7B245a9b44-6ded-4abd-a392-ae583809e350%7D/CP_BUILT%20ENVIRONMENT21-07.11.11.PDF?msource=cp15&tr=y&auid=8729239

About: This report outlines a range of organizational practices and public policies being considered to improve the built environment in support of healthy eating and regular physical activity. Prevention Institute developed this document based on key informant interviews and a scan of policy and research reports. Moreover, the report is intended to serve as a resource to identify target policies and opportunities towards building healthy environments.

Characteristics of the Built Environment:
- Walkable and bikeable neighborhoods
- Public transit
- Parks, recreation facilities, and open spaces
- Healthy food environments
- Safety

Strategies and Policies
- Active Transportation and Public transit
  - o Strategies and Policies
    - Implement complete streets policies to provide for the safe and convenient travel of all users of the roadway, including pedestrians, bicyclists, public transit users, motorists, children, seniors, and people with disabilities.
    - Connect roadways to complementary systems of trains and bicycle paths that provide safe places to walk and bicycle for children, seniors, and the general public.
    - Encourage the adoption of pedestrian and bicycle master plans, which can be incorporated into city general plans and capital improvement programs.
    - Invest in public transit to provide affordable and reliable multimodal transportation options for all neighborhoods.
    - Ensure that children can walk and bicycle safely to school, including Safe Routes to School (SRTS) non-infrastructure activities and infrastructure improvements to provide sidewalks and bicycle paths.
    - Increase federal funding sources for active transportation and public transit.
  - o Political Opportunities
    - There is a need for leadership from different sectors and constituencies, including

seniors, education, and public health.
- There needs to be more advocacy support from local and state constituencies to influence decisions at higher policy levels (e.g. for state and federal funding).
- To achieve complete streets policies, pressure must be brought to bear on state departments of transportation by both grassroots advocates and from the federal level.
  > Increase public support by implementing a complete streets promotional campaign to education the community, local elected officials, media, and other professionals.
- Programs funded by the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU) (2009) need to be successful enough to warrant further funding allocations in the future.
- Connect the built environment to efforts to combat the climate change crisis.

- Activity-Friendly Recreation Environments
  - Strategies and Policies
    - Provide local parks, playgrounds, and recreation facilities in currently underserved residential areas.
    - Require new housing developments to incorporate recreation and open space for activity.
    - Offer parks and recreation programming that encourages and supports physical activity.
    - Establish joint use agreements that allow use of public schools and facilities for recreation by the public.
    - Increase access to national and state park systems among people from low-income communities and communities of color.
    - Increase federal funding sources for parks, playgrounds, and open space.
  - Political Opportunities
    - Local finance measures are the most viable way to cover costs of maintenance and programming.
      > In this strong "anti-tax" climate, federal resources need to reprioritize how general funds are allocated to localities to increase levels of steady funding for local parks.
    - Reinvigorate the Urban Park and Recreation Recovery Program operated by the National Park Service.
    - Find better mechanism for funding allocations to states and local parks other than the Land and Water Conservation Fund (LWCF).
    - Emphasize the links between parks and health.

- Land Use Planning.
  - Strategies and Policies
    - Integrate health and smart growth considerations, including infill development; compact, transit oriented development; mixed-use buildings, walkable, bikeable neighborhoods; and green building practices into general plans, area specific plans, and zoning decisions.
    - Establish development requirements that give priority to created transit oriented

development.
- Support the development of mixed-income housing to provide affordable options in convenient locations and avoid concentrations of poverty.
- Stimulate economic development and revitalize communities by providing a mix of retail, housing, and transit in underserved communities.
- Renovate or rebuild schools located in neighborhoods that students can easily walk or bicycle to and from, or when building new schools ensure that they are located in areas that are easily accessible by walking, bicycling, or public transit.
- Refine and promote the use of health impact assessments for development decisions.
- Expand access to retail establishments that provide healthy food options.
- Establish restrictions on sales and marketing of fast food and alcohol.
- Preserve farmland on the urban and suburban fringes and in prime growing areas.
- Expand community gardens and urban agriculture.

o Political Opportunities
- Compact, mixed-use developments, inclusionary zoning, and transit oriented developments are viewed by advocates as key strategies to ensure more livable and walkable communities.
- Push for legislation around "school siting."
- Use land use and zoning decisions to improve access to healthy foods and reduce exposure to unhealthy foods.
- Consider the implications that land use decisions have on health.
- Obtain and draw upon the support of non-traditional partners such as the building and construction industry by creating a comprehensive agenda that frames issues broadly enough to give everyone a stake while simultaneously creating healthier communities for all persons to live, work, play, and learn.

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31. Creating a Healthy Environment: The Impact of the Built Environment on Public Health – Centers for Disease Control and Prevention (CDC), 2010

To view this report, please click on the link:
http://www.cdc.gov/healthyplaces/articles/Creating%20A%20Healthy%20Environment.pdf

About: In order to address these critical health problems (diabetes, depression, anxiety, obesity, etc.) we must seize opportunities to form coalitions between doctors, nurses, and public health professionals and others such as architects, builders, planners and transportation officials, so that we are all 'at the table' when environmental decisions are made. This means thinking about what constitutes safe and affordable housing, safe neighborhoods, providing green space for others to enjoy where they live and work, and rethinking how we travel from one place to another.

- **Specific Actions from the public health sector to address these issues** (integrating physical activity into our daily lives; cleaning up and protecting the environment; recognizing the contributions to mental health to overall health and well-being; reducing the toll of violence in society) **might include the following:**

- Supporting research to determine the impact that changes in the built environment can have on public health, such as the addition of green space, sidewalks, and bikes paths, and the reduction in impervious surfaces.
- Participating in local planning processes, such as comprehensive planning meetings, zoning hearings, and urban planning workshops known as charrettes (intense, community-based, local planning and problem solving workshops where local leaders and decision-makers develop consensus vision about the desired future of their community).
- Working with planners and other land-use professionals to provide them with the strong public health arguments they need to support "street-growth" designs and initiatives.

- **To reclaim their role as public health protectors the planners and urban designers might take the following actions:**
  - Balancing the potential public health consequences of their choices with other considerations.
  - Designing communities around people rather than automobiles.
  - Changing existing zoning codes so to encourage multiuse land-development patterns that make it possible to work, shop, and go to school within walking distance of people's homes.
  - Changing existing building codes to encourage building and site design that is accessible to people who have various degrees of mobility.
  - Encouraging green space development that promotes community, reduces violence, and improves mental health.

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32.   Education Matters for Health – Robert Wood Johnson Foundation (RWJF), 2009

Commission to Build a Healthier America

To view this report, please click on the link:
http://www.rwjf.org/files/research/commission2009eduhealth.pdf

About: Education can influence health in many ways. This issue brief examines three major interrelated pathways through which educational attainment is linked with health: health knowledge and behaviors; employment and income; and social and psychological factors, including sense of control, social standing, and social support.

Improving health through educational policies and programs:
- Provide knowledge and skills necessary to fully participate in the labor force.
- Education can be key in promoting social mobility and breaking the cycle of intergenerational disadvantage and related health disparities.
- Investments to promote and increase educational attainment could have both human and economic benefits.
- One of the most effective strategies for reducing health disparities in this country could be to take steps to close the gaps in educational attainment.

33.	**Fostering Physical Activity for Children and Youth: Opportunities for a Lifetime of Health - Healthy Eating Active Living Convergence Partnership, 2010**

Prepared by the Prevention Institute and Policy Link

To view this report, please click on the link:
http://www.convergencepartnership.org/atf/cf/%7B245A9B44-6DED-4ABD-A392-AE583809E350%7D/Convergence_Physical%20Activity_final.pdf

About: With a focus on values of social justice and equity, Fostering Physical Activity outlines a range of organizational practices and public policies to improve environments for regular physical activity among children and youth. It reflects diverse perspectives of professionals and advocates working on various aspects of physical activity.

Opportunities for Improving Physical Activity:
1. **Physical Activity in School:**
   o **The Institute of Medicine recommends that schools ensure that all students participate in at least 30 minutes of moderate-to-vigorous physical activity during the school day** to help reach the recommended daily levels.
   o The National Association for Sport and Physical Education (**NASPE**) **recommends** that a comprehensive school physical education program include **high-quality physical education (PE), school based physical activity opportunities, school employee wellness and involvement, and family and community involvement.**
   o The **CDC** [Centers for Disease Control and Prevention) **recommends that trained specialists teach PE classes**. PE specialists teach longer and higher-quality classes in which students spend more time being physically active.

   ➢ **Examples of Strategies and Policies:**
      Strategies:
         o Develop local and state standards that reflect the National Standards for Physical Education
         o Fund school wellness policies
         o Implement comprehensive school physical activity programs
         o Integrate physical activity into academic lesson

      Policy Opportunities:
         o States should set PE requirements to signal support for promoting physical activity among children and youth, but also ensure adequate enforcement and accountability.
         o A state-level policy that allocates funding to school districts is necessary for effective implementation and monitoring.
         o The *No Child Left Behind Act* (**NCLB**) is a key piece of legislation that can enhance physical activities in schools and after-school programs.
            ▪ Several organizations have made compromises, hoping to get physical activity addressed in the bill.

- Advocates seek improvements in PE standards, support for professional development of PE teachers, and initiatives to integrate physical activity into the school day.
  - The ***Fitness Integrated with Teaching (FIT) Kids Act*** [2009] was proposed to improve standards for physical education.
    - Would promote high-quality PE for all public school children and promote physical activity in after-school programs
    - Physical activity advocates would like to see the funding for Carol M. White Physical Education Program (PEP) increased, ideally to $100 million.

2. **Physical Activity in Early Childcare and Education Settings**
   - Time spent playing outdoors
   - Staff capacity building should include training to competently deliver physical activity program components and to encourage providers to model the healthy behaviors they promote.

   ➢ **Examples of Strategies and Policies:**
      Strategies:
      - Establish state licensing and accreditation requirements/health codes and support implementation of policy change.
      - Invest in staff wellness and training to support the integration of physical activity.
      - Provide resources to Head Start programs for physical activity.

      Policy:
      - ***Improving Head Start for School Readiness Act of 2007***
        - Increasing funding for Head Start programs is vital to ensure that the needs of all Head Start children are met.
        - *American Recovery and Reinvestment Act of 2009*
      - **Childcare licensing requirement and state and city health codes** are also mechanisms to introduce or improve physical activity standards.

3. **Physical Activity in Out-of-School Time Programs**
   - **After-School Programs:**
     - Programs should make physical activity an integral component.
     - Federal, state, and local assistance programs can provide funding support to mitigate transportation barriers.
   - **Youth Sport and Recreation Programs**

   ➢ **Examples of Strategies and Policies:**
      Strategies:
      - Increase funding for integrating physical activity into the 21st Century Community Learning Centers program
      - Provide state funding for after-school programs
      - Establish policies for improving the quality of and access to affordable extracurricular youth sports

- Offer physical activity programming that encourages family participation
- Changes in after school programs:
  - Providing time for both structured and unstructured physical activity
  - Encouraging enjoyable, non-competitive activities
  - Reducing television and computer use
  - Training providers and wellness staff

4. **Physical Activity in Communities:**
   - **Active Commuting**

   ➢ **Examples of Strategies and Policies:**
     - Promote active transportation policies, including infrastructure improvements and programming, to encourage bicycling and walking.
     - Ensure that children can walk or bicycle safely to school.
     - Form walking clubs and walking school buses.
     - Renovate or rebuild schools in neighborhoods so students can easily walk or bicycle; locate new schools in areas that are accessible by walking, bicycling, and public transit.
     - Incorporate physical activity components into the Safe and Drug-Free School and Communities Act (SDFSCA).

5. **Safe and Accessible Play Areas:**

   ➢ **Examples of Strategies and Policies:**
     - Establish joint use agreements.
     - Ensure that land use and transportation planning supports physical activity.
     - Support action included in the Promoting Lifelong Active Communities Every Day Act (the Play Every Day Act).
     - Increase federal funding sources for parks, playgrounds, and open space.
     - Offer parks and recreation programming that supports physical activity.

6. **Safe Places Preventing Violence**

   ➢ **Examples of Strategies and Policies:**
     - Promoting Safety through Liquor Store Closures
     - Transforming Schoolyards into Vibrant Community Spaces
     - Building Violence Prevention into Safe Routes to School (SRTS) Improvements

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34. **Two sides of the same coin: Hunger and obesity in early childhood-Center for American Progress (CAP), 2010**

By Alexandra Cawthorne

To view this report, please click on the link:
http://www.americanprogress.org/issues/2010/12/pdf/child_hunger.pdf

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About: The rate of obesity among low-income children and families is on the rise. The USDA reported in 2009 that one in five homes with a baby or toddler was food insecure, exposing the access barriers to nutritious foods that are especially high for economically impoverished communities. This statistic has far-ranging and costly public health implications: According to the National Cancer Institute and the University of Calgary, children that go hungry at least once in their lives are more than twice as likely as children from food secure homes to have poor health outcomes 10-15 years later. Obesity and food insecurity are greatly interrelated: poor children are more likely to be overweight and less likely to consume adequate levels of nutritious items like fruits and vegetables. Given that clinicians have seen an upward trend in weight among children under the age of two, this report seeks to both chronicle the connections between hunger and obesity in poor families with babies and toddlers. The author then provides recommendations about how to improve access to adequate nutrition among low-income families and leverage existing policies and programs to improve disparate health outcomes.

In low-income households, obesity is quickly becoming an alternative to starvation. Many families cannot afford to fill their refrigerators and pantries with nutritious foods, and thus they will rely upon unhealthy low-cost, high calorie and imperishable items to fill out their diets.

Background

1. **Prevalence of obesity and food insecurity among low-income women and their children**. There is a strong correlation between lower incomes and higher obesity rates, especially among women from minority backgrounds. Over a third of homes headed by unmarried women are food insecure, and children from these settings are more likely to be obese than in intact homes.

2. **Pre-pregnancy weight and child obesity**. A mother's weight before pregnancy is an important factor for maternal and child health, and overweight women are more likely to require cesarean sections and suffer from pregnancy complications and neonatal problems. Food insecurity perceptibly increases a woman's risk of obesity during pregnancy and contributes to higher than average health care costs.

3. **Breastfeeding and early eating habits.** Breastfeeding may reduce the likelihood of child obesity by as much as 22 percent and is associated with lower stress levels and less depressive symptoms among mothers. However, the prevalence and duration of breastfeeding is low in the United States, especially among low-income and black babies. This has drastic consequences for a child's development. More must be done to understand the root causes of what could be a possible multigenerational cycle of obesity among economically impoverished parents and children.

4. **Poverty inhibits the ability of poor parents and young children to develop and maintain**

   o **Limited access to healthy affordable food.** Lack of access to fresh produce and affordable, nutritious groceries in less affluent communities influences obesity rates. When neighborhood carries these items the foods are often more highly priced than they would be in higher-income neighborhoods.

   o **Inadequate food knowledge and exposure.** Low-income families are overexposed to targeted marketing of high-calorie processed foods and often lack knowledge of the necessary foods composing adequate children's nutrition. Moreover, access to nutritious

food is not associated with higher consumption and purchase rates in low-income neighborhoods because such rates are influenced by an individuals' familiarity with the foods and their nutritional value.

o **Cycles of food deprivation and overeating.** Families that skip meals or reduce the size of them for economic reasons may eat more than normal when food dollars are plentiful. Such fluctuating cycles of food nutrition contribute to family obesity.

o **High Stress levels and emotional eating.** Lack of reliable economic stability is associated with high stress levels in low-income families, which are a key determinant of obesity.

o **Imbalance of work and family life.** Inflexible work schedules, job instability and low wages impede upon a family's ability to shop for and prepare nutritious meals, as well as a mother's capability to breastfeed her child.

o **Fewer opportunities for physical activity.** A family's home environment, surrounding neighborhood and physical activity patterns are determinants for a child's later exercise habits. Low-income families often have limited access to safe play spaces, exercise resources and may live in violent neighborhoods not conducive to active lifestyles.

Recommendations

1. **Existing Programs.** Food assistance, nutrition, health care and anti-poverty programs are all necessary elements in efforts to prevent and combat childhood obesity, as well as enable families to provide healthy lifestyles for their children.

    a. **Supplemental Nutrition Assistance Program (Formerly Food Stamps Program).** Half of all children in this nation live in households that will rely on SNAP at some point in their childhood. Benefit increases and sustained political support for these increases are necessary, especially in times of financial upheaval.

    b. **Special Supplemental Assistance Program for Women, Infants, and Children.** WIC provides nutritional assistance, education and support to low-income pregnant and postpartum women and their preschool age children. The Healthy, Hunger-Free Kids Act ("Act") increased support for breastfeeding WIC mothers, and advanced strong nutrition and physical activity policies and practices in schools and childcare programs. Policymakers must work diligently to implement these principle portions of the Act.

    c. **Child and Adult Care Food Program.** CACFP improves the quality and affordability of day care for low-income children, and importantly ensures that these children receive consistent nutritious meals and snacks throughout the school week. Funds from CACPF are also used to provide meals to families in homeless shelters. The Act improves access to the Program and improves the nutritional standards of the meals served through the Program.

    d. **Affordable Care Act.** Besides making health insurance more affordable to women of childbearing age, ACA contains a number of provisions that emphasize the prevention of

obesity. It includes a home visitation program bringing nurses into homes to aid new mothers – who can also promote healthy breastfeeding practices – and mandates that employers provide accommodations for breastfeeding.

e.   **NEWBORN Act.** Creates a national pilot program focusing on providing prenatal care and community outreach, and educating at-risk and potential mothers about healthy pregnancies. Moreover, the act expands access to nutrition and physical activity programs. Congress should work to advance this initiative.

f.   **Baby Friendly Hospital Initiative.** Originally sponsored by the WHO and UNICEF, the Initiative assists hospitals in supporting mothers to initiate and continue breastfeeding their babies. Policymakers and community stakeholders should expand this program to under-served low-income communities in order to increase the prevalence and duration of breastfeeding practices.

g.   **Temporary Assistance for Needy Families reauthorization.** The structure of a state's work requirements effect the balance of work and family life among TANF recipients, and thus a family's ability to manage its health outcomes as well. Policymakers should examine the ways in which TANF intersects with opportunities to improve health outcomes for disadvantaged families.

h.   **Early Childhood Programs.** Policymakers should use funds allotted to programs such as Early Health Start and the Child Care and Early Development Block Grant to develop evidence-based policies and practices related to child nutrition and physical fitness, as well as improve access to these programs as a whole.

2.   **Other Recommendations**
   a.   Develop and/or support programs that help low-income parents meet their financial and familial needs.
   b.   Expand access to accommodating and predictable work schedules so that parents can provide for their families without fear of being fired or needing to quit.
   c.   Policymakers should incentivize the creation of a community-building agenda which develops family-friendly physical and social infrastructure, especially in current low-income neighborhoods.

U.S. Local and State, in General

35.   In the First Place: Community Prevention's Promise to Advance Health and Equity – Prevention Institute, 2011

To view this report, as well as associated files, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-302/127.html

About: This paper defines community prevention, describing its role as a cornerstone in achieving health equity and social justice both in the United States and internationally.

Taking Two Steps to Prevention:
1. From the health issues to the behaviors and exposures
2. To the community environment

The Spectrum of Prevention:
1. **Strengthening Individual Knowledge and Skill:**
   o Emphasizes enhancing the skills that are essential for healthy behaviors.
      • New and expectant mothers, for example, must understand the importance of breastfeeding and know how to address breastfeeding challenges in order to initiate and maintain breastfeeding.
2. **Promoting Community Education:**
   o Second level moves to educating larger communities.
3. **Educating Providers:**
   o Reaching and educating providers is necessary because they often serve as the conduit to communities and individuals and they help to shape the standards and norms.
   o The notion of who is a provider should be approached broadly, extending beyond the "usual suspects" to anyone who is in a position to share information or influence the opinion of others.
      • Faith leaders; postal workers and other public servants; employers; business, union, and community leaders.
4. **Fostering Coalitions and Networks:**
   o Emphasizes that one can accomplish more and have a greater impact working together than working alone.
   o Fostering collaborative approaches brings together the participants necessary to ensure an initiative's success and increase the "critical mass" behind an effort.
5. **Changing Organizational Practices:**
   o Reshaping the general practices of organizations and institutions can affect both health and norms.
   o Changes reach the members, clients, and employees of the organization as well as the surrounding community and serves as a model for all.
      > Government, health institutions, workplaces, media, sports, faith organizations, and schools
6. **Influencing Policy and Legislation:**
   o The sixth level of the spectrum has the potential for achieving the broadest impact.
   o By mandating what is expected and required, sound policies can lead to widespread behavior change on a communitywide scale that might ultimately become a social norm.

Collaboration Multiplier:
▪ **Collaborating across sectors generates broad-based support for prevention efforts.**
▪ Diverse stakeholders working together can share information and resources, consider an issue from different angles, and combine forces to resolve it.
▪ Must be a working knowledge of how other agencies, sectors or disciplines think, function and define success.

- They also must understand how their actions impact health, an approach known as, Health in All Policies.
- Developed specifically to foster meaningful and impactful cross-sectoral collaboration
- Each sector in the collaborative shares key information according to a common set of categories. Specific categories vary based on the particular collaboration; however typical examples include:
    o Definition of problem: What language does each sector use to define the issue?
    o Key Issues: What are each sector's priorities relating to the issue?
    o Data: What information does each sector collect, and how does it collect it?
    o Funding: What funding sources and other resources does each sector bring?
    o Training: What expertise can each sector share with other participants; who does each sector typically train?
    o Partners: With what other types of groups is each sector connected?
    o Solutions/Outcomes: What specific objectives has each sector set in relation to the issue?

Conclusion:
- Communities across the globe are developing quality prevention approaches based on a new way of thinking, one that examines the underlying causes of illness and injury.
- Health advocates and local leaders...are starting to define health more broadly.
- **Embracing a community prevention approach allows advocates, community leaders, and health practitioners to keep people healthy *in the first place.***

36.	Local Government Actions to Prevent Childhood Obesity- National Collaborative on Childhood Obesity Research (NCCOR), 2009

Committee on Childhood Obesity Prevention Actions for Local Governments

To view this report, please click on the link:
http://www.rwjf.org/files/research/20090901iomreport.pdf

About: The National Collaborative on Childhood Obesity Research (NCCOR) is dedicated to providing brief, succinct information on childhood obesity prevention specifically for policy makers.

Actions for Healthy Eating [including "most promising action steps"]**:**
- **Improve Access to and Consumption of Healthy, Safe, and Affordable Foods**
    o *Retail Outlets*:
        - Improve community access to healthy foods throughout supermarkets, grocery stores, and convenience/corner stores.
        - Create incentive programs to attract supermarkets and grocery stores in underserved neighborhoods.
    o *Restaurants*:
        o Improve the availability and identification of healthful foods in restaurants.
        o Require menu labeling in chain restaurants to provide consumers with calorie information on in-store menus and menu boards.
    - *Community Food Access*:

- Promote efforts to provide fruits and vegetables in a variety of settings, such as farmers' markets, farm stands, mobile markets, community gardens, and youth-focused gardens.
  - *Public Programs and Worksites*:
    - Ensure that publicly run entities such as after-school programs, child-care facilities, recreation centers, and local government worksites implement policies and practices to promote healthy foods and beverages and reduce or eliminate the availability of calorie-dense, nutrient-poor food.
    - Mandate and implement strong nutrition standards for foods and beverages available in government-run or regulated after-school programs, recreation centers, parks, and child care facilities.
  - *Government Nutrition Programs*:
    - Increase participation in federal, state, and local government nutrition assistance programs.
  - *Breastfeeding*:
    - Encourage breastfeeding and promote breastfeeding-friendly communities.
  - *Access to Drinking Water*:
    - Increase access to free, safe drinking water in public places to encourage consumption of water instead of sugar-sweetened beverages.
    - Adopt building codes to require access to, and maintenance of fresh drinking water fountains (e.g. public restroom codes).

- **Reduce Access to and Consumption of Calorie-Dense, Nutrient-Poor Foods:**
  - *Policies and Ordinances:*
    - Implement fiscal policies and local ordinances that discourage consumption of calorie-dense, nutrient-poor foods and beverages.
    - Implement a tax strategy to discourage consumption of foods and beverages that have minimal nutritional value, such as sugar-sweetened beverages.

- **Raise Awareness About the Importance of Healthy Eating to Prevent Childhood Obesity:**
  - *Media and Social Marketing:*
    - Promote media and social marketing campaigns on healthy eating and childhood obesity prevention.
    - Develop media campaigns, utilizing multiple channels to promote healthy eating (and active living) using consistent messages.

Actions for Increasing Physical Activity:

Encourage Physical Activity:
  - *Built Environment:*
    - Encourage walking and bicycling for transportation and recreation through improvements in the built environment.
    - Plan, build, and maintain a network of sidewalks and street crossings that create a safe and comfortable walking environment and that connect schools, parks, and other destinations.
  - *Programs for Walking and Biking:*

- Promote programs that support walking and bicycling for transportation and recreation.
- Adopt community policing strategies that improve safety and security of streets, especially in high crime neighborhoods.
- Collaborate with schools to develop and implement a *Safe Routes to School* program to increase the number of children safely walking and bicycling to schools.

- *Recreational Physical Activity:*
  - Promote other forms of recreational activity.
  - Build and maintain parks and playgrounds that are safe and attractive for playing, and in close proximity to residential areas.
  - Adopt community policing strategies that improve safety and security for park use, especially in higher crime neighborhoods.
  - Collaborate with school districts and other organizations to establish joint use facilities agreements allowing playing fields, playgrounds, and recreation centers to be used by community residents when schools are closed; if necessary adopt regulatory and legislative policies to address liability issues that might block implementation.

- *Routine Physical Activity:*
  - Promote policies that build physical activity into daily routines.
  - Institute regulatory policies mandating minimum play space, physical equipment, and duration of play in preschool, after-school, and child-care programs.

Decrease Sedentary Behavior:

- *Screen Time:* Promote policies that reduce sedentary screen time.

Raise Awareness of the Importance of Increasing Physical Activity

- *Media and Social Marketing:* Develop a social marketing campaign that emphasizes the multiple benefits for children and families of sustained physical activity.

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37. A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety – Prevention Institute, 2010

To view this report, as well as an executive summary and report brief, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-81/127.html

About: Along with national policy change, the local arena has emerged as an ideal setting for reducing inequities in health and safety and for promoting good health. Local policy solutions are the emphasis of this brief.

Remedying inequitable health and safety outcomes requires a four-pronged solution:
1. Strengthen communities where people live, work, play, socialize, and learn;
2. Enhance opportunities within underserved communities to access high-quality, culturally competent health care with an emphasis on community-oriented and preventive services;
3. Strengthen the infrastructure of the health system to reduce inequities and enhance contributions from public health and health care systems; and

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4. Support local efforts through leadership, overarching policies, and through local, state, and national strategy.

Local Solutions for Advancing Equity in Health and Safety:
- Account for the historical forces that have left a legacy of racism and segregation.
- Acknowledge the cumulative impact of stressful experiences and environments.
- Encourage meaningful public participation with attention to cultural differences.
- Focus overall approach on changing community conditions, not assigning blame.
- Strengthen the social fabric of neighborhoods' sense of belonging, dignity, hope.
- Respond to climate change, global economy, foreign policy, and fostering equity.
- Address the developmental needs of all age groups, especially children and youth.
- Make structural changes via cross-sectoral partnerships-nonprofits, government.
- Measure, monitor social policy impacts on health and equity over time and place.
- Empower groups most affected by inequity to have a voice in policy change.
- Invest deeply and broadly in community as part of designing equitable solutions.

Community Recommendations:

- **Build the capacity of community members and organizations:**
  - Train public sector staff to empower residents to partner with local government and community-based organizations;
  - Foster structured community planning and strategies for prioritizing goals and efforts.
- **Advance housing and safety through land use, transportation, and housing decision making and planning:**
  - Engage residents in priority setting and decision making;
  - Adopt complete street policies that promote walkability and bikeability;
  - Implement high density, mixed-use zoning and interconnected streets strategies;
  - Prioritize accessibility of public transportation, walking, bicycling;
  - Ensure safe, healthful housing standards and materials;
  - Train public health and health care practitioners to advocate for built environment policies that support health and safety.
- **Support healthy food systems by enhancing the availability of healthy products, reducing exposure to unhealthy products, and encouraging sustainable agriculture:**
  - Develop processing and distribution infrastructure for small to midsized farms;
  - Expand organic farming;
  - Provide incentives to support minority farmers;
  - Protect occupational health and safety of farm workers;
  - Incentivize neighborhood stores and farmers' markets;
  - Adopt preferential purchasing policies for local and sustainably produced foods;
  - Restrict liquor stores and fast food restaurants;
  - Promote acceptance of SNAP and WIC benefits.
- **Encourage opportunities for physical activity from an early age to prevent chronic illnesses and promote physical and mental health:**
  - Provide safe, easy access to parks, open space, and recreational facilities;
  - Promote joint-use agreements;
  - Require school recess and regular quality physical education.

- **Prevent violence using a public health framework:**
  - o Invest in coordinated citywide, cross-sector planning;
  - o Implement strategies in highly impacted neighborhoods;
  - o Support street violence interruption;
  - o Change norms and practices to help prevent intimate partner and family violence.

Health Care Services Recommendations:

- **Provide health care resources in the heart of the community:**
  - o Support community-based and school-based clinics;
  - o Reform reimbursement policies;
  - o Expand business hours;
  - o Provide resources and help groups to support individual behavior change;
  - o Promote community health workers.
- **Promote a medical home model and ensure patients and community participation in health care-related decisions:**
  - o Provide coordinated services to incorporate detection, prevention, counseling, and management of chronic disease in a central location;
  - o Provide multi-disciplinary, family, and patient-centered, linguistically and culturally versatile services;
  - o Ensure effective communication and patient-system concordance for patient adherence and safety;
  - o Engage community residents in health care planning, evaluation, and implementation.
- **Strengthen the diversity of the health care workforce:**
  - o Train clinical providers to conduct culturally appropriate outreach and services;
  - o Offer incentives to work in underserved communities;
  - o Diversify through community health workers.
- **Provide high quality, affordable health coverage for all:**
  - o Equalize public/private domains;
  - o Ensure access to SCHIP, dental, and mental health services;
  - o Support safety net hospitals and community clinic leadership;
  - o Streamline public health insurance enrollment;
  - o Increase affordability.

Systems Recommendations:

- **Collaborate with multiple fields and diverse government agencies to ensure health, safety, and health equity are considered in every relevant decision, action, and policy:**
  - o Establish health impact analyses;
  - o Evaluate potential policies and funding streams through a "health lens."
- **Enhance leadership at state and local levels and develop clear strategy direction to reduce inequity in health and safety outcomes:**
  - o Engage in high-level civic leadership to elevate health equity as a priority, coalesce partners, and ensure accountability;
  - o Develop state and local plans that identify prioritized actions to achieve health equity.
- **Establish sustainable funding mechanisms to support community health and prevention:**
  - o Educate the broad public about savings cost via prevention;

- o Create a wellness trust to collect and manage prevention funding and index prevention to health care costs;
  - o Reinvest prevention savings in further prevention efforts.
- **Build the capacity of state and local health agencies to understand and lead population-based health equity work:**
  - o Retrain, re-pool, and recruit diverse staff to understand the social health determinants and health equity;
  - o Work with diverse sectors and departments.
- **Provide technical assistance and tools to support community-level efforts to address determinants of health and reduce inequities:**
  - o Provide training in planning, implementation, and evaluation;
  - o Develop standards for local indicator projects;
  - o Link environmental determinants to patterns of disease distribution;
  - o Merge mapping of medical and community conditions;
  - o Enable access to indicators report cards, maps, and community assessment tools.

Overarching Recommendations:

- **Develop a national strategy to promote health equity across racial, ethnic, and socioeconomic lines, with attention to preventing illness and injury in the first place:**
  - o Embed health equity into priorities, practices, and policies of the government and private entities.
- **Provide federal resources to support state and local community-based prevention strategies:**
  - o Align existing strategies and policies with those of other federal agencies;
  - o Give regulatory waivers for financial incentives;
  - o Reimburse community based prevention.
- **Tackle inequitable distribution of power, money, and resources – structural drivers of conditions contributing to inequitable health and safety outcomes:**
  - o Delineate strategies to address racism and discrimination in institutional practices and policies;
  - o Address socioeconomic segregation and conditions;
  - o Reform criminal justice laws
- **Improve access to quality education, and improve educational outcomes:**
  - o Reform school funding to equalize access;
  - o Invest in recruiting, training, and retaining teachers;
  - o Provide need-based supports;
  - o Facilitate positive interventions for at-risk youth.
- **Invest in early childhood:**
  - o Provide high quality, affordable childcare and preschools;
  - o Ensure equitable distribution of and access to preschools**;**
  - o Provide subsidies;
  - o Invest in home-visiting initiatives and in child-care providers;
  - o Encourage breast-feeding;
  - o Provide opportunities for safe physical activity from an early age to prevent chronic disease and to promote physical and mental health.

38. A Road MAPP to Health Equity – National Association of County & City Health Officials (NACCHO), 2010

Authored by Julia Joh Ellingers

To learn more about NACCHO's MAPP, please click on the links:
http://www.naccho.org/topics/infrastructure/mapp/
http://www.naccho.org/topics/infrastructure/mapp/upload/goals_and_strategies.pdf

About: Mobilizing for Action through Planning and Partnerships (MAPP) is "A community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems."

Applying an Equity Lens to Public Health Work

Traditional	Social Justice
Personal responsibility and individual behaviors	Social responsibility to protest common good
Causes of inequity: genes, bad behavior, accident	Causes of inequity: racism, class and gender exploitation
Resolution: behavior change; treatment of symptoms	Resolution: tackling racism, class and gender exploitation through political action
General approach: acceptance of risk as fact of life	General Approach: activist perspective to creating conditions for good health.

Changing the Questions

Instead of Only Asking:	Perhaps we should also ask:
Who lacks health care coverage and why?	What policy changes would redistribute health care resources more equitably in our community?
How can we create more green space, bike paths, and farmers' markets in vulnerable neighborhoods?	What policies and practices by the government and commerce discourage access to transportation, recreational resources, and nutritious food in neighborhoods where health is the poorest?
Why do people smoke (drink)?	What social conditions and economic policies predispose people to the stress that encourages smoking (drinking)?

Mobilizing for Action Through Planning and Partnerships
- A community-wide strategic planning process for improving public health.
- Methods to help communities prioritize public health issues, identify resources for addressing them, and take action.

Paradigm Shift in Practice

From:	To:
Operational Planning	Strategic planning
Focus on the agency	Focus on community & entire public health system
Needs assessment	Emphasis on assets and resources
Medically oriented model	Broad definition of health
Agency knows all	Everyone knows something

MAPP Model

Partnerships
- Establish a health equity team of core, diverse, cross-disciplinary members that would lead the effort to identify the root cause of health inequity.
- Build strategic alliances with partners in the social justice community.
- Develop interagency/multidisciplinary coordination.

Workforce
- Assess staff understanding of health equity.
- Identify how the workforce can more systematically respond to the root causes of health inequity.
- Raise awareness and encourage dialogue about health inequities.

39.   Public Health and Democracy: The Unique Authority of State and Local Health Departments to Address Obesity – Yale RUDD, 2011

Yale RUDD, American Public Health Association

To view this report, please click on the link:
http://www.yaleruddcenter.org/resources/upload/docs/what/law/HealthDepartmentAuthority_AJPH_5.11.pdf

About: The United States has 51 state health departments and thousands of local health agencies. Their size, structure, and authority differ, but they all possess the unique abilities to address obesity. Because they are responsible for public health, they can take various steps themselves and can coordinate efforts with other agencies to further health in all policy domains. Health departments have many options to effect change but need the support of other government entities and officials.

- State and local health departments can work independently and in concert with other agencies and nongovernmental entities to effectuate change within their communities.
- Many suggested strategies [to combat childhood obesity] are directed at correcting disparities in community food environments where the lack of access to affordable healthy food has been shown to contribute to obesity rates for the entire community.
- The state can:
    o Offer incentives for restaurants and food stores to carry and promote healthier options.
    o Mandate strong nutrition standards for food and beverages in government run and maintained facilities and programs.
    o Increase participation in government nutrition assistance programs.
    o Allow farmers' markets to accept government benefits.
    o Coordinate cross-agency conversations and policy making; health departments can insert health concerns into a vast range of policymaking activities within their jurisdiction. This approach called **health in all policies** brings health issues from the traditional health sector into other government entities.
    o Educate policymakers on the cost savings and social gains that stem from promoting prevention and health policy across sectors.
    o Incentive programs to attract supermarkets to underserved areas.
    o Enact zoning or land-use regulations to enable healthy food providers to locate in underserved neighborhoods.
    o Prevent vendors of unhealthy foods from locating near schools and playgrounds
    o Adopt building codes that require clean and accessible water fountains.
    o Enact planning guidelines for the creation, maintenance, and security of sidewalks, parks, and playgrounds.
    o Educate the private sector and insurance companies about the potential cost savings, increased productivity, and reduced absenteeism that reward promotion of wellness and prevention.
- Locally:
    o Regulate retail environment by restricting unhealthy foods in checkout lines.
    o Setting default nutritional standards for restaurant food that comes with toys or other incentives.
    o Collaborate with employers to develop and implement wellness plans to advance obesity prevention and control measures.

Health Department Rulemaking:
- In the past, health department used **rulemaking** to regulate a wide range of issues.
- In locations where rulemaking authority does not exist to address long-term health concerns, agency officials can publicly call for increased authorities over such issues and grassroots movements can urge their legislators to grant it.
- **Agency rulemaking has certain advantages over the legislative process**:
    o **Regulation is relatively quick and does not require multiple levels of action**

- The legislative process is effective; it often takes years for a bill to become law.
  - o **Regulatory action is grounded in the expertise of the agency.**
    - Agency officials can consider competing interests but can act to further the general purpose of the agency: protecting and advancing public health.
  - o If an agency acts within its authority, judicial deference to the agency's action can be quite strong, so if such action is challenged in court, the **judiciary frequently gives the agency the benefit of the doubt on certain issues.**

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40.   **Recipes for Change: Health Food in Every Community – Convergence Partnership, 2010**

Convergence Partnership, Prevention Institute, Policy Link

To view this report, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-266/127.html

About: A broad movement to make healthy foods available to everyone provides a focal point for activism that can strengthen our community and improve the health of all Americans.

1. **Healthy Food Retail Environments - Strategies:**

   - o **Grocery Stores and Small Stores:**
     - Invest in fresh food financing initiative, which provide grants, low-interest loans, training, and technical assistance to improve or establish stores in underserved areas.
     - Promote community engagement to support healthy food retail**.**
     - Utilize federal resources to support healthy food retail**.**
     - Offer retailers incentives from local governments such as site assistance, streamlines development processes, and tax exemptions; balance incentives with requirements for devoting shelf space to healthy foods.
     - Consider healthy food retail in general plans and land use decisions.
     - Ensure that grocery stores and small stores are equipped to accept SNAP and WIC benefits.
     - Provide grants or loans to allow local and regional farms to market and distribute their products to grocery stores and small store owners.
   - o **Restaurants and Street Vendors:**
     - Collaborate with restaurants to offer healthy foods and beverages.
     - Provide incentives for street vendors to sell healthy foods.
   - o **Farmers' Markets:**
     - Designate land and other municipal resources for farmers' markets**.**
     - Leverage federal programs, including WIC and SNAP benefits, to support farmers' markets.
   - o **Transportation Access:**
     - Provide public transportation to connect neighborhoods to grocery stores and other food establishments.
     - Collaborate with food retailers to provide transportation for customers.

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2. **Institutions and Healthy Foods - Strategies:**

    o **Healthcare Settings:**
        - Support successful initiation and continuation of breastfeeding.
        - Encourage hospitals to purchase foods that promote health, nutrition, and the environment.
    o **Preschool, School, and After-School Environments:**
        - Set nutrition standards for foods and beverages sold at school that are not part of a federally reimbursable school meals programs, including items sold a la carte, in vending machines, at snack bars, and at fundraisers.
        - Establish farm-to-school programs to provide students with foods grown locally and regionally.
        - Improve the nutritional quality of meals and snacks served in early childhood and after-school settings.
    o **Governmental Institutions:**
        - Establish nutrition standards for foods sold in vending machines on government-owned property (libraries, recreation centers, and government work sites).
        - Implement laws that guarantee breastfeeding mothers in the workplace regular breaks, a private place to pump, and refrigerated storage for breast milk.
        - Establish healthy food procurement policies that encourage government agencies and institutions to purchase foods that promote health, nutrition, and the environment.

3. **Federal Food and Nutrition Assistance Programs:**
    o Improve benefits offered through the Supplemental Nutrition Assistance Program (SNAP).
    o Expand outreach and simplify application procedures to increase participation in SNAP.
    o Establish incentives to encourage SNAP participants to buy healthy foods.
    o Ensure Electronic Benefit Transfer (EBT) access at farmers' markets.
    o Expand access to federal nutrition programs, including School Breakfast, National School Lunch, Summer Food Service, and Child and Adult Care Food programs.
    o Improve the nutritional quality of meals served through child federal nutrition programs.
    o Maintain the quality and effectiveness of WIC.
    o Leverage WIC food package changes to support greater access to healthy foods.

4. **Regional Food Systems and Agriculture:**
    o Invest in processing and distribution for regional food systems.
    o Support small and mid-sized farmers, particularly farmers of color and women, through grants, technical assistance, and help in marketing and distribution.
    o Establish incentives and resources for growers to produce healthy products, including fruits, vegetables, and foods produced without pesticides, hormones, and antibiotics.
    o Conserve agricultural land.
    o Support community gardens and urban farms by providing municipal land and water, funding and technical assistance, and government oversight.
    o Create local or state food policy councils to develop strategies that focus attention on the entire food system.
    o Establish policies that support the health and wellbeing of farm workers.

41. Assessing the Costs of Racial and Ethnic Health Disparities: State Experience – Healthcare Costs and Utilization Project, 2011

Agency for Healthcare Research and Quality

To view this report, please click on the link:
http://www.hcup-us.ahrq.gov/reports/CostsofDisparitiesIB.pdf

About: This issue brief details state efforts to identify and quantify the human and financial costs associated with racial and ethnic disparities in health status and health care. Included is a description of how state officials measure these costs, the challenges they face in doing so, and potential strategies to ameliorate these challenges. The authors include new state publications in Rhode Island and Virginia about the associated costs of health disparities. Finally, the text lists a number of useful tools and resources that researchers can use to learn more about the topic.

According to the Joint Center for Political and Economic Studies, racial and ethnic disparities cost the nation $1.24 trillion between 2003 and 2006 – about $229.4 billion in direct medical care expenditures and $1 trillion in indirect costs. If non-Hispanic Blacks had the same adjusted rate of preventable hospitalizations as non-Hispanic Whites, it would have resulted in about 430,000 fewer hospitalizations for the former and $3.4billion in total savings (2004-2007 data).

Why is it important to understand and document the costs of health disparities?
- By identifying populations with the poorest outcomes States can target resources and interventions for quality improvement and cost savings.
- It may be easier to interest important stakeholders (state and local policymakers) if they see the immediate cost benefits (in terms of excess costs, spending and lost lives) of combating health disparities.
- Cost or impact estimates are a tool by which states can evaluate their progress in implementing improvement initiatives or interventions for vulnerable sub-populations.

States' Approaches to Measuring Costs
States can measure costs in three ways: in financial terms; in terms of excess deaths or human life lost; and in terms of lost productivity.

84. States can determine the number of "excess" admissions among racial and ethnic minority population(s) with higher rates of hospital admissions compared to those populations with lower rates of admissions. Using this data, States can determine the cost savings that would arise if the former population(s) had the same admissions rate as the latter.

85. States calculate human costs by either: determining the number of deaths that could be prevented if one racial or ethnic minority population had the same death rate as another (typically White); or by calculating years of potential life loss (YPLL, or premature mortality).

86. States can calculate the number of excess days away from work resulting from work-related illnesses/injuries to determine lost productivity among members of racial or ethnic minority populations.

Measurement Challenges and Lessons
- If there is insufficient data or the percentage of people who are members of racial or ethnic minority populations is small, states can aggregate data over several years to increase sample size.
- In the event that States are drawing upon data that includes a high number of admissions where the patients' race/ethnicity is either unknown or undocumented, states can use less suspect race/ethnicity data (ex: excess death) to describe comparative mortality. Moreover, States can work in tandem with hospital associations and communities to improve the collection of race/ethnicity data.
- States can emphasize the distinction between disparities in the frequency of hospital admissions and disparities in the *severity* of admissions.

Rhode Island and Virginia
Both states have undertaken new reports that include a greater emphasis on the costs of disparities in health and health care. Rhode Island 's report explores excess morbidity, mortality and hospitalization, presenting data by population and underscoring the importance of "place" in determining poor outcomes, health problems and lack of access. Virginia has chosen to aggregate its data by focusing on human costs in terms of life expectancy because it is a figure widely understood by the general public.

Recommendations from State Reports
1. **Determine up front what story you want the data to tell and to whom.** Be clear about the purpose of the cost report and the intended audience, including this information in the final report to ensure the reader comprehends the significance and potential uses of the cost data.

2. **Consider the importance of "place" on disparities.** Location and environmental factors contribute to and may exacerbate health disparities: States can use geomapping and geo spatial analysis to present cost data by geographic location, show variations in community by location and pinpoint places with the greatest need.

Specific State and County Reports

Specific State Reports

42. **Our Health Is California's Health:** *Setting the Agenda for 2010 and Beyond -* **Prevention Institute, 2010**

Center for Health Improvement, Prevention Institute, Public Health Institute

To view this report, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-284/127.html

About: The recent passage of national health reform legislation and the subsequent need for implementation in California creates an opportunity to develop a comprehensive approach to improve the health and safety of all Californians. A healthy population is more productive, reduces the burden on the health and social service systems, and is better able to take advantage of the opportunities California affords.

Three core principles should be considered in examining all policies, decisions, and opportunities in order to maximize effectiveness and positive impact on health and safety:
1. Equity and Fairness
2. Effective Governance
3. Health in All Policies

These principles are embedded in specific recommendations for actions across three areas of health:
1. Promoting safety in homes and communities
2. Preventing chronic disease
3. Health care access and quality

Recommendations:

Promoting Safety in Home and Communities
1. Invest in the development, implementation, and coordination of sustainable approaches to preventing violence that will have the greatest impact in neighborhoods, schools, and homes.
    o Strengthen community-building efforts in neighborhoods, particularly where violence is pervasive.
    o Support prevention efforts by instituting violence prevention programs in all schools; reducing young children's exposure to violence in homes and communities; increasing the availability of meaningful and safe work; improving the built environment to increase social and commercial activity and "eyes on the street" throughout the day; and reducing the availability of unhealthy and unsafe products – including weapons, tobacco, and alcohol – through zoning and advertising restrictions.
    o Strengthen intervention efforts through increased outreach in highly impacted neighborhoods, support for treatment and mental health and substance abuse problems, and programs to promote mental health and prevent substance abuse among youth.

- o Provide violence prevention training service providers, as well as state and local government officials.

2. Address leading causes of unintentional injury and align state action in support of prevention efforts.
   - o Develop interagency strategic plans and benchmarks to reduce injuries including burns, falls, drowning, and workplace safety.
   - o Promote safe travel for all by reducing speeding limits, advancing Complete Street policies, and reducing reliance on automobiles by promoting alternative modes of transportation (public transit, walking, bicycling).
   - o Support expanded data and regulations related to drug, chemical, and environmental protections including increasing awareness of risks, promoting safer chemical alternatives for industrial and consumer use, and increasing restrictions on leading causes of poisoning (including prescription drugs).
   - o Support health hazard assessments and actions on known and probable hazards (e.g. pesticides, lead paint, workplace exposures).

3. Enhance state government support of efforts to prevent all injuries.
   - o Establishing a mechanism for multi-sector collaboration in state government to address priority injury issues.
   - o Increase flexibility of funding streams in support of local injury prevention efforts.
   - o Establish a statewide multicultural and multilingual communications campaign to help build and sustain injury prevention efforts.

Preventing Chronic Disease:
1. Promote effective government practice to foster health community environments.
   - o Support efforts of the Strategic Growth Council and its Health in All Policies Task Force to implement collaborative state agency and department actions to support environmental, equity, and health goals.
   - o Build local public health infrastructure and capacity to work collaboratively and innovatively.

2. Expand access to healthy foods and beverages and reduce the harmful impact of highly processed foods.
   - o Ensure all Californians have access to safe drinking water including making free tap water available during meal service at all schools and using state resources to provide safe tap water to low-income communities.
   - o Simplify the Supplemental Nutrition Assistance Program application and retention process in California, including promoting out-of-office reporting systems and eliminating mandatory fingerprinting, to increase the percent of eligible households participating and bring more federal dollars to the state.
   - o Institute healthy food and beverage standards and expand access to childcare, school, and after-school food programs.
   - o Advance strategies, including fees and taxes, to reduce the consumption of sweetened beverages.
   - o Establish a Healthy Food Financing Fund to support grocery stores, farmers' markets, and other healthy food retail in underserved communities.

- o Support sustainable, local, and regional food systems by preserving farmland, creating regional infrastructure for processing and distribution, and investing in new and existing farmers to get healthy products to market.

3. Support increased physical activity for children, adults, and seniors
    - o Facilitate shared use of public facilities (e.g. school playgrounds, parks) and implement strategies to make parks, routes to school and communities safe so that all community members have opportunities to engage in safe physical activity.
    - o Support the implementation of Complete Street policies to promote public transportation, walking, and bicycling as accessible means of transportation.
    - o Ensure that all schools meet or exceed requirements for minutes of quality physical education; encourage the recruitment of qualified physical education teachers.

4. Improve air quality.
    - o Support AB 32, SB 375, and ambitious targets for greenhouse gas reduction.
    - o Implement regulatory action and other incentives to reduce exposure to diesel emissions, ozone, nitrogen dioxide, sulfur dioxide, and other pollutants, especially in communities disproportionately affected by environmental toxins.
    - o Reduce tobacco use and exposure to secondhand smoke by increasing tobacco tax revenue, regulating advertising (particularly to minors and in low-income communities), and restricting tobacco use in workplaces and public venues.

Health Care Access & Quality
1. Expand access to coverage and strengthen the delivery system to ensure access to quality services for Californians
    - o Support a new health insurance exchange that is transparent, consumer friendly, culturally and linguistically acceptable, and structured to negotiate for the best value (price and covered benefits).
    - o Expand eligibility for children, adults, and aging adults through the Medi-Cal and Healthy Families programs.
    - o Support community clinics, public hospitals, and other safety-net providers of care for the uninsured and the underinsured.

2. Make strategic investments in health information technology.
    - o Ensure that all components of the health system are able to monitor quality and health disparities.
    - o Support information being available across providers to improve quality, safety and efficiency, and chronic disease management.

3. Ensure that the future health workforce reflects California's languages and cultures, includes a wide range of primary care providers, and is distributed according to need and available throughout the state.

4. Build on the premise that everyone should have access to primary care and a medical home.
    - o Support appropriate referrals to specialty and acute care.

- o Embrace a comprehensive view of health that includes mental health, dental and vision, complementary health, chronic-care management, reproductive health and contraception, and home, work, and community-based care.
- o Improve integration of the continuum of care and caregiver support for aging adults.

5. Encourage health care organizations to adopt practices and policies that promote prevention (e.g., healthy campuses, supporting the initiation and continuation of breastfeeding, and following Preventive Services Task Force guidelines).

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43. 2010 Annual Report: Achieving access to health for all Coloradans - The Colorado Trust, 2011

To view this report, please click on the link:
www.coloradotrust.org/attachments/.../TCT_AnnualReportComp_051911.pdf

About: The Colorado Trust is committed to work with others to ensure that all Coloradans, regardless of socioeconomic status, have health coverage and access to a responsive and comprehensive health care system, including an adequate supply of health care providers who deliver quality, affordable health care services. To achieve this vision, The Trust supports grantees in developing and implementing policies, programs and services that expand health coverage and improve and expand health care.

Four Program Areas:
1. **Expand Health Coverage**
   - Research, develop and implement policies that control cost and increase access.
   - Strengthen and align diverse voices for health reform, including consumers, providers, and business and policy leaders.
   - Increase public awareness and build a strong base of support for access to health.
2. **Increase Outreach & Enrollment:**
   - Simplify and streamline eligibility and enrollment processes for public insurance programs
   - Develop and implement systems and policies to support continuous enrollment programs.
3. **Improve Health Systems:**
   - Provide comprehensive preventive services in a timely manner.
   - Align coordinated chronic disease care with financial incentives for providers.
   - Strengthen the ability of health care sites and providers to meet quality standards of care.
4. **Increase Availability of Care:**
   - Strengthen the viability of health care delivery sites and providers to serve the uninsured, and publicly and privately insured Coloradans.
   - Ensure adequate points of access across the state for preventive, primary, oral and behavioral care.

- Expand education, recruitment and retention programs and policies to increase the number of health care providers able to serve rural Coloradans.

44. Community Health Data Scan for Connecticut - Connecticut Health Foundation, 2009

To view this report, please click on the link:
http://www.hartfordinfo.org/issues/wsd/Health/CT_Health_Scan.pdf

About: The *Data Scan* suggests six focus areas to improve the health of the people in Connecticut by: increasing access to and quality of care; promoting disease prevention, wellness and management of chronic health problems; and encouraging improvements of health outcomes and wise use of resources.
1. Focus on the health reference groups, and racial/ethnic groups in the greatest need.
2. Focus on diabetes and other conditions in the metabolic syndrome.
3. Focus on enduring a medical home for all Connecticut residents.
4. Focus on the binge drinking and smoking culture.
5. Focus on youth risks and opportunities.
6. Improve the community health data system.

45. Working Together for a Healthier Kansas: A Status Report on the Social Determinants of Health in Kansas – Kansas Department of Health and Environment, 2011

Kansas Department of Health and Environment

To view this report, please click on the link:
http://www.healthdisparitiesks.org/download/DisparitiesReport.pdf

About: This report utilizes the best available knowledge to identify specific actions that can be taken by government, the private sector, community organizations, and private citizens to improve health.

Steps to a Healthier Kansas:

- **Adequate Income:**
  - What the Government and Public-Private partnerships can do:
    1. Ensure that every worker in Kansas receives adequate income to choose a healthy lifestyle. This can be accomplished through living wage laws and minimum wage laws.
    2. Ensure that every citizen of Kansas who is able to work can find a decent job.
    3. Provide adequate assistance to vulnerable social groups such as the elderly, the disabled, and newborns.
    4. Create incentives to encourage savings.
    5. Provide earned income tax credits to low-income individuals.

- o What churches and community organizations can do:
    1. Advocate for policies that would ensure adequate income for all.
    2. Offer programs and outreach services to low-income individuals to ensure that they receive all of the government benefits to which they are entitled.

- o What every citizen can do:
    1. Volunteer to work with the national, state, community, and faith groups that provide advocacy and support services for the poor.
    2. Write your elected political leaders about the relationship between adequate income and health and enlist their support for new initiatives to improve health.

- **Education:**
    - o What the Government and Public-Private partnerships can do:
        1. Provide access to high-quality early childhood education enrichment programs for every child.
        2. Provide prenatal and postnatal support services for vulnerable parents and ensure all parents have knowledge and skills to provide safe, supportive and nurturing environments for their children.
        3. Reform school financing so that every school has the financial and manpower resources to ensure that each child has the opportunity for high-quality experiences from kindergarten through college.
        4. Increase opportunities and reduce financial barriers so that every student who wants to can afford a community or 4-year college.
        5. Provide incentives so that every school can become a center of wellness for its students, staff and the surrounding community.

    - o What churches and community organizations can do:
        1. Offer classes and programs that would enable every parent to become competent in nurturing children.
        2. Advocate for investment in high-quality early childhood enrichment programs and an academically rigorous and welcoming school system.

    - o What every citizen can do:
        1. Become a mentor for children who are at risk for academic failure. This group includes children:
            - Whose first language is not English
            - Who are being raised by a single parent
            - Who have at least one incarcerated parent
            - Who are falling behind in school

    - o What every parent can do:
        1. Make early and regular contact with your child's teacher.
        2. Advocate for high-quality teachers. Teacher quality is the most important factor in student achievement.

- **Housing and Neighborhoods:**
    - o What Government and Public-Private partnerships can do:

1. Ensure that everyone has access to affordable housing.
2. Implement policies and programs to limit exposure to factors such as lead, radon, asbestos, cockroaches, and ensure access to smoke detectors, safe housing conditions (e.g. stairs), help with utility bills, and well-functioning heating and cooling systems.
3. Ensure that every family has access to a neighborhood that is supportive of good health and provides the opportunity to make healthy choices. This will require support for:
   - Strong crime prevention policies
   - Zoning policies that reduce noise and pollution
   - Initiatives that support adequate access to healthy foods and restrict access to fast food, alcohol and tobacco
   - Programs and a built environment that encourages physical exercise and recreation.

- o What Churches and Community Organizations can do:
  1. Advocate for policies that support healthy homes and neighborhoods.
  2. Offer programs and services that increase awareness of how health is affected by where we live, learn, work, play and worship.
  3. Refer people to resources that exist for help with low cost housing, home repairs and safety, emergency shelters, and other neighborhood problems.

- o What every citizen can do:
  1. Volunteer for programs that address housing issues, such as fair housing agencies, Habitat for Humanity, emergency shelters, and other community housing programs.
  2. Develop and support crime watch programs; look out for your neighborhood.
  3. Work closely with community-based organizations and neighborhood groups to give them an active voice in working with government entities and the business sector in designing local solutions to neighborhood problems.

- **Nutrition:**
  - o What Government and Public-Private partnerships can do:
    1. Expand access to healthy foods:
       - Increase support for the SNAP (formerly Food Stamp) program.
       - Provide grants and loans to foster the development of supermarkets and grocery stores in underserved areas.
    2. Provide incentives for schools and workplaces to do more to enhance people's knowledge of food and nutrition and encourage healthy food choices.

  - o What Churches and Community Organizations can do:
    1. Support the development of farmer's markets and community gardens to improve access to fresh fruits and vegetables.

  - o What every citizen can do:
    1. Eat more fruits and vegetables.
    2. Use whole grain breads and cereals as the foundation of your diet.
    3. Use low-fat or non-fat milk, cheese, and yogurt.

4. Read food labels.
5. Use less salt.
6. Reduce calories and fat.
7. Skin chicken and turkey to reduce fat content.

- **Stress:**
  - What Government and Public-Private partnerships can do:
    1. Improve work and residential environments to reduce levels of stress. These include:
       - Enhancing employee control over work.
       - Providing more opportunities for advancement.
       - Ensuring appropriate compensation and rewards.
       - Strengthening leave policies and worker protections.

  - What Churches and Community Organizations can do:
    1. Offer programs that help individuals manage stress and support their access to services that provide resources to reduce levels of stress.

  - What every citizen can do:
    1. Make time in your life for regular exercise.
    2. Take time to relax.
    3. Learn your signs of stress and take a break when they occur.
    4. Talk to a friend.
    5. Avoid debt.
    6. If you are still having trouble, get help.

- **Social Support:**
  - What government and Public-Private partnerships can do:
    1. Workplaces, residential area and public facilities should be designed to encourage social interaction.
    2. Develop policies that build support at the local level by strengthening social networks, fostering economic development and empowerment and increasing civic participation and trust.
    3. Develop policies that strengthen opportunities for relationships at work.

  - What churches and other organizations can do:
    1. Ensure that organizational norms and practices communicate inclusiveness and equality regardless of an individual's personal or social background.
    2. Facilitate a community organization (and churches) becoming an important source of friendships for many individuals.

  - What every citizen can do:
    1. Spend more time with people in distress. Be patient, sensitive, and understanding.
    2. Volunteer to work for a crisis hotline or intervention center in your community.
    3. Get to know your neighbors.

- **Personal Behaviors:**

- o What Government and Public-Private Partnerships can do:
    1. Implement policies and programs that reduce barriers for engaging in healthy behaviors and provide incentives and opportunities to make healthy choices. Examples include:
        - Reducing the number and density of fast food restaurants, particularly in low-income areas.
        - Restrict access to alcohol in low-income areas: limit the number of retail outlets, the hours of operation and the sale of inexpensive, higher alcohol content beverages.
        - Ban the sale of soft drinks and junk foods in schools and workplaces and replace them with healthier options.
        - Increase taxes on alcohol, tobacco, and junk foods and earmark this revenue to support programs that encourage healthy choices.
        - Provide incentives for persons to enroll in smoking cessation and drug and alcohol abuse programs. Expand the number of such programs.
        - Increase access to facilities for physical activity by creating new facilities (parks, playgrounds) and encouraging the creative use of existing ones, such as the after-school use of schools, and the early morning use of indoor shopping malls.

- o What Churches and Community Organizations can do:
    1. Model healthy behaviors in all programs and services, such as serving healthier lunches at meetings or at church-sponsored functions.
    2. Make facilities available after hours for exercise classes and health promoting activities for local community residents.

- o What every citizen can do:
    1. Become informed regarding the multiple behaviors that affect health.
    2. Volunteer with groups and organizations that are working to create healthier communities.
    3. Take care of your own health.

- **Medical Care:**
    - o What Government and Public-Private Partnerships can do:
        1. Ensure that everyone has access to high quality care.
        2. Provide for the psychosocial and material needs of individuals in the health care context.

    - o What every health care facility can do:
        1. Provide culturally appropriate programs and translation services to meet the needs of specific populations. Particular attention should be given to low- income and lower literacy groups.
        2. Give emphasis to prevention in the delivery of care.
        3. Provide effective treatment.
        4. Develop incentives to reduce social inequalities in the quality of care.
        5. Provide care that addresses the social context. This will involve consideration of extra-therapeutic change factors: the strengths of the client, the support and

barriers in the client's environment and the non-medical resources that may be mobilized to assist the client.

- o What Churches and Community Organizations can do:
    1. Advocate for health care coverage for all.
    2. Provide information and resources on health care rights and link local residents to programs that provide access to those who lack insurance.

- o What every citizen can do:
    1. Get medical, dental and eye checkups.
    2. If you lack insurance, seek to identify community clinics that serve everyone.
    3. Do not hesitate to go to an emergency room if your life or someone else's life is at risk. By law, emergency rooms have to treat you if your life is at risk, even if you do not have insurance and you cannot afford to pay.

Keys to Success:
   1. Advocacy
   2. Raising Awareness
   3. Working Together

46.	**Eliminating Health Disparities: From a Grass-roots Perspective, 2009 (Louisiana)**

Bureau of Minority Health Access, State of Louisiana Department of Health and Hospitals

To view this report, please click on the link:
http://www.dhh.louisiana.gov/offices/miscdocs/docs-90/Health%20Disparities%20Report2008-09.pdf

About: This program will provide hard-to-reach populations a point of contact during natural disasters or pandemic flu outbreak and make available resources to assist them with relief and recovery efforts specific for their communities.

Action Steps to Address Health and Educational Disparities

- **Focus Programmatic Efforts:**
    - o Analyze data to identify which groups of youth are at high risk for targeted problems or risk behaviors.
    - o Target efforts and resources to support policy and programmatic efforts that address the needs of youth in high-risk groups.
    - o Support the design and implementation of evidence-based, culturally- and linguistically-appropriate interventions and programs that focus on youth at high risk.
- **Raise Awareness:**
    - o Learn more about the causes of disparities and about evidence-based strategies for effectively addressing specific issues among specific groups of youth at high risk.

- o   Educate policy makers, the public, and other agencies and organizations about health and educational disparities, their causes, and evidence-based strategies for effectively addressing specific issues among specific groups of youth at high risk.
- ▪ **Build Partnerships:**
  - o   Strengthen and sustain partnerships with agencies and organizations serving youth at high risk.
  - o   Participate in broad coalitions that work to address the root causes of health and educational disparities (e.g. poverty, access to health care, discrimination).
  - o   Actively involve youth at high risk in advisory boards or youth councils that plan programs to address health and educational disparities
- ▪ **Document Impact:**
  - o   Monitor health outcomes and behaviors among youths at high risk and, if possible, policies and programs that address these outcomes and behaviors among these youth.
  - o   Evaluate activities and programs that focus on youth at high risk, and use these findings to improve programs.
  - o   Document and share broadly the successes, challenges, and lessons learned in reaching youth at high risk.

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47.   Michigan Health Equity Roadmap: A vision and framework for improving the social and health status of racial and ethnic populations in Michigan – Michigan Department of Community Health Division of Health, 2010

Michigan Department of Community Health Division of Health, Wellness and Disease Control Health Disparities Reduction and Minority Health Section

To view this report, please click on the link:

http://www.michigan.gov/documents/mdch/MI_Roadmap_FINAL_080310_revised_PRINT_VERSION_pdf_329423_7.pdf

About: As a part of the ongoing mission of the Health Disparities Reduction and Minority Health Section (HDRMH), this report – the *Michigan Health Equity Roadmap* – outlines a vision and plan to significantly reverse the negative health trends that have plagued racial and ethnic populations for decades.

Recommendations:
1.   Improve Race/Ethnicity Data Collection/Data Systems/Data Accessibility.
2.   Strengthen the capacity of the government and communities to develop and sustain effective partnerships and programs to improve racial and ethnic health inequities.
3.   Improve social determinants of racial/ethnic health inequities through public education and education-based community interventions.
4.   Ensure equitable access to quality healthcare.
5.   Strengthen community engagement, capacity, and empowerment.

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48. Plan to Address Health Disparities and Promote Health Equity in New Hampshire – The New Hampshire Department of Health and Human Services, 2011

The New Hampshire Department of Health and Human Services (DHHS) Office of Minority Health, the New Hampshire Minority Health Coalition, the Endowment for Health, the Foundation for Healthy Communities, and the New Hampshire Institute for Health Policy and Practice at the University of New Hampshire

To view this report, please click on the link:
http://www.dhhs.state.nh.us/omh/documents/disparities.pdf

About: This public-private partnership was formed to identify priorities for action to work towards health equity for racial, ethnic, and linguistic minorities in New Hampshire (NH). This plan will serve as a basis for collaboration between diverse stakeholders, public and private, to achieve this goal.
Priority and Recommendations:

1. **Access to Care:**
   - Healthcare Access:
     o Expand access to high quality and affordable healthcare.
       ▪ Expand access to health insurance coverage.
       ▪ Develop high quality patient centered health care for all.
       ▪ Address transportation needs to enable access to healthcare service providers.
         o Promote an integrated, holistic health perspective to include physical, mental and oral.
         o Develop community members' health literacy and capacity to navigate healthcare system.
   - Cultural Competence:
     o Support efforts to improve providers' capacity to serve diverse populations.
       ▪ Require training on cultural competence and on all forms of discrimination as part of training, licensure, and continued credentialing of all health professionals.
       ▪ Promote cultural change within healthcare organizations to improve the delivery of culturally responsive care.
     o Improve the education that providers receive on patient-centered, culturally responsive care.
   - Communication:
     o Advocate for funding streams tied to culturally and linguistically appropriate healthcare.
       ▪ Support efforts to improve organizations' capacity to serve linguistic minorities.
       ▪ Work to improve access to ASL/English interpreters in medical settings.
   - Workforce Diversity:
     o Diversify the healthcare workforce to better reflect the population served.

- Expand the pool of diverse healthcare workers through proven practices such as pipe line initiatives and utilizing the skills of foreign-trained health workers.

2. **Environments Where We Live, Learn, Work and Play**
   - Built Environments:
     - Increase opportunities for physical activity, access to healthy foods, and safety in neighborhoods in which minorities live, learn, work, and play.
   - Expand transportation options to improve use of existing options:
     - Connect individuals to transportation for health visits, including chronic care treatment.
     - Connect individuals to transportation for job interviews, regular employment, childcare, food shopping, ongoing education, and other activities that promote and maintain a healthy lifestyle.
   - Education and Workforce Development:
     - Improve early childhood development and school-based programs' cultural effectiveness.
       - Integrate culturally competent programming into early childhood development and school-based programs to improve integration for racial, ethnic, and linguistic minorities and their families.
     - Expand accessibility and effectiveness of education and training opportunities for minorities.
       - Reach out to and include minority residents in education and training opportunities including post-secondary education and vocational training programs.
     - Encourage employers and labor unions to dedicate resources to recruitment, training, and retention of racial, ethnic, and linguistic minorities for staff and leadership positions.
   - Social Inclusion:
     - Support initiatives that encourage minority groups to build networks.
       - Encourage networking and community building within ethnic groups, and deaf and hard of hearing communities to address issues of isolation.
       - Encourage networking and community building between minority groups and the general population to foster integration.

3. **Awareness and Promotion of Health Equity**
   - Education and Outreach:
     - Educate and involve partners outside the health sector who impact where we live, learn, work, and play in improving health equity.
       - Develop materials and approaches to educate professionals, leaders, and decision-makers about cultural competence, the social determinants of health, and health equity.
       - Encourage collaboration with new partners who influence community-level factors and systems that impact health.
     - Incorporate concepts of civil and social responsibility in health and health equity discourse.
   - Funding:

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o Identify and pursue funding opportunities to support the priorities of this plan.
- Coordinate funding initiatives across sectors to focus efforts and avoid duplication, and to address health inequities and social determinants system-wide.

o Encourage public, private, and nonprofit organizations to prioritize and budget for health equity.
- Examine current operations and budgets to seek ways to promote health equity within existing, routine activities.
- When distributing funding throughout the state, require applicants to demonstrate their commitment to health and equity in response to RFPs.

- Infrastructure and Policy:
  o Build and maintain collaborative public-private partnership structure to implement the plan.
  o Influence and create public policy that supports health and equity.

4. **Data:**
- Guidelines and Systems
  o Establish NH DHHS guidelines and policy for the collection of race, ethnicity and language data as a model for other organizations and state agencies.
  o Identify resources for electronic data system improvements and quality assurance.
- Training and Education:
  o Train collectors and submitters of race, ethnicity and language data to use the NH DHHS policy.
  o Educate the public about the collection of race, ethnicity, and language data.
- Data Use:
  o Work with data stewards to stratify their data to identify disparities.
  o Develop an equity index reflecting data from health and other sectors.

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49. Moving Towards Health Equity in New York: State Strategies to Eliminate Health Disparities – The New York State Department of Health, 2009

By Brian D. Smedley, for the Minority Health Council

To view this report, please click on the link:
http://www.health.state.ny.us/community/minority/docs/moving_toward_health_equity.pdf

About: This paper attempts to identify promising practices to address health disparities and offer a set of recommendations for New York State action. This paper also examines how state health departments have structured minority health and health disparities entities and identifies characteristics of successful offices.

State Strategies to Eliminate Health Disparities: Research Evidence and Expert Opinion:

Essential Public Health Services and State Strategies to Eliminate Health Disparities:
1. **Monitor Health Status to Identify Community Health Problems**
   - Assess and improve the state's capacity to identify and track disparities.

- Coordinate and integrate state data systems across all health-related agencies and programs.
- Improve public accessibility of data.

2. **Diagnose and Investigate Health Problems and Health Hazards in the Community:**
   - Improve population-based screening and epidemiology in health disparity populations.
   - Promote the use of Health Impact Assessments (HIAs).
   - Strengthen the state infrastructure to investigate health hazards, such as environmental and occupational health risks, that disproportionately affect communities of color.

3. **Inform, Educate, and Empower People About Health Issues:**
   - Build and/or strengthen culturally and linguistically appropriate health programs.
   - Develop, disseminate, and evaluate health promotion messages.
   - Evaluate and tailor emergency preparedness messages for communities of color and linguistic minorities.

4. **Mobilize Community Partnerships to Identify and Solve Health Problems**
   - Build and/or strengthen community partnerships for health.
   - Develop integrated approaches in community health that coordinate programs across a variety of settings.

5. **Develop Policies and Plans That Support Individual and Community Health Efforts:**
   - Develop, implement, and evaluate a statewide health disparities plan.
   - Establish a statewide Interagency and Interdepartmental Coordinating Council to establish and coordinate a statewide response to health disparities.
   - Promote community health planning.
   - Enhance the potential power of Certificate of Need (CoN)
   - Address upstream determinants of health, such as housing, the retail food environment, and environmental living conditions.
   - Establish a state minority health policy "report card."

6. **Enforce Laws and Regulations That Protect Health and Ensure Safety:**
   - Evaluate the impact of existing laws and regulations, such as those regarding environmental and occupational exposures, violence, and injury prevention, and firearms access, on the health of disparity populations.
   - Assess and, if needed, improve enforcement of state laws

7. **Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable**
   - Assess health insurance coverage, particularly among underserved populations, and expand public health insurance programs with the ultimate goal of achieving 100% coverage among state residents.
   - Encourage health systems to adopt "medical home" models.
   - Support safety net institutions and quality improvement initiatives in these settings.
   - Enhance primary care, particularly in communities with high rates of ambulatory-care sensitive conditions.
   - Expand language access programs.
   - Include requirements to address health care disparities in all state contracts.

8. **Assure a Competent Public and Personal Health Care Workforce**
   - Continuing education in cultural competence, management, and leadership development.
   - Promoting diversity in the public health and health professions workforce.
   - Encourage the training and employment of community health workers.

9. **Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services:**
    - New York State should evaluate the effectiveness of individual and population-based health services in eliminating health disparities, and it should publicly report this information.
10. **Research for New Insights and Innovative Solutions to Health Problems:**
    - Support community-based participatory research (CBPR).
    - Assess and address state and local health department research capacity
    - Form partnerships with higher education and research institutions focused on health disparities.

Findings and Recommendations:

1. Leverage and Expand Core System and Mission Functions to Assure an Integrative Approach for Addressing Health Disparities.
2. Improve Data Collection, Data Systems, and Mechanisms for Monitoring and Reporting Disparities.
3. Develop, Implement, and Evaluate Disparities Interventions.
4. Ensure Leadership and Stakeholder Support for Coordination of Effort and Institutionalize Disparities-Reduction Work.
5. Promote Thoughtful and Ongoing Communication Between State Agencies and Health Disparity Communities, the Public Sector, and the Private Sector to Address Health Disparities.

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50. Food Security and Health – Oklahoma Health Equity Campaign, 2011

To view this report, please click on the following link:
http://www.oklahomahealthequitycampaign.com

About: A community is food secure when,
- There are adequate resources from which people can purchase foods.
- Available resources are accessible to all community members.
- Food available in the community is sufficient in quality, quantity, and variety.
- There are adequate food assistance programs to help low income people purchase and prepare nutritious foods.
- Locally produced food is available to community members.
- There is support for local food production.
- Every household is food secure within the community.

Oklahoma ranks very high for food insecurity.

Policy Recommendations:

- **Goal: Increase food security in Oklahoma by making fresh, affordable locally-grown food more available to all Oklahomans.**
    - Support Healthy Corner Store, Farm to School, and farmers' market initiatives at local and state levels.

- o Encouraging more Oklahoma farmers to produce health home-grown food for consumption by local residents and institutions.
  - o Increase the affordability of nutritious foods by eliminating the state sales tax on fruits and vegetables.
- **Goal: Link Oklahoma-grown foods with good taste and health. The health of Oklahomans can be improved if Oklahomans increase their consumption of farm-fresh fruits, vegetables, whole grains, and lean meats.**
  - o Promote gardening, healthy cooking institutions, nutrition education and eating local, in schools, households, and communities.
  - o Limit the abundance of unhealthy foods in communities and require nutritional information by provided to fast food customers.
  - o Establish local food policy councils in cities and counties to explore ways to increase production, consumption, and overall availability of healthy local foods.
- **To increase food security in your own backyard**
  - o Find and shop at a farmer's market to support your local farmers.
  - o Join the Oklahoma Food Co-op.
  - o Start a small garden and plant a row for the hungry.

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51.   Literacy and Health Equity – Oklahoma Health Equity Campaign, 2011

To view this report, please click on the following link:
http://www.oklahomahealthequitycampaign.com

About: How does literacy impact health?
- Health literacy is defined in *Health People 2020* as: "The Degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."
- Health literacy requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations.
  - o People with limited health literacy skills are more likely to skip important preventive measure such as mammograms, Pap smears, and flu shots.
  - o Patients with limited health literacy skills enter the healthcare system when they are sicker.
  - o Persons with limited health literacy skills make greater use of services designed to treat complications of disease and less use of services designed to prevent complications. Consequently, there is a higher rate of hospitalizations and use of emergency services among patients with limited health literacy skills. This higher use is associated with higher healthcare costs.
  - o Low health literacy has negative psychological effects. Those with limited health literacy skills reported a sense of shame about their skill level as a result; they may hide reading or vocabulary difficulties to maintain their dignity.
- The primary responsibility for improving health literacy lies with health professionals in both healthcare and public health. However, we must work together to ensure that health information and services can be understood and used by all Oklahomans.

Policy Recommendations:

- **Goal: Oklahomans will possess the literacy skills they need to fully function in their community, workplace, and family.** Health literacy efforts must target:
  - **Children:**
    - Introduce coordinated school education including health literacy concepts for children enrolled in P – K in Oklahoma public schools.
    - Implement Health and Safety education in all OK schools, complying with PASS requirement for K – 12 with emphasis on health and safety literacy.
    - Offer corresponding health and safety literacy education for parents of children enrolled in P – K – 12 public schools of Oklahoma.
  - **Adults:**
    - Oklahomans with limited literacy and/or English skills will realize the impact that improved literacy can have in their workplace, family, health, community, and general welfare.
    - Individuals will low literacy skills will be aware of literacy resources available in their community including library, community based, and adult education programs.
    - Local literacy and adult education programs will have the resources they need to meet the needs of the community.
- **Goal: Low literate Oklahomans will have access to accurate, easy to read and understandable health information, and will be able to use the information to make informed decisions about their health and medical care.** Health literacy efforts must target:
  - **Children:**
    - Introduce coordinated school education including health literacy concepts for children enrolled in P – K in Oklahoma public schools.
    - Implement Health and Safety education in all OK schools, complying with PASS requirement K – 12 with emphasis on health and safety literacy.
    - Offer corresponding health and safety literacy education for parents of children enrolled P – K – 12 public schools of Oklahoma.
  - **Adults:**
    - Accurate health information will be available in formats suited to adults with limited literacy and English skills.
    - Local literacy and adult education programs will be available health related resources, referral organizations, instructional resources, and health literacy.
- **Goal: Health professionals will have resources available to address barriers to effective patient communication including literacy and English competency.** Health literacy efforts must target:
    - ALL health professionals.
    - Continuing education for ALL health professionals.

52. Request for Proposals (RFP) for Health Equity Project – Texas Health and Human Services Commission, 2010

To view this report, please click on the link:

http://www.hhsc.state.tx.us/contract/529100101/529100101.pdf

About: HHSC's missions for this procurement are: to reduce health disparity by improving efficiency of health promotions and health literacy programs to underserved communities; to enhance the Texas infrastructure supporting stronger efforts and better communication to eliminate health disparity.

HEP with support organizations or groups, with a focus on health and human service, including state agencies, community-based organizations, faith-based groups, and non-profit entities that employ community-based practices to reduce health disparities and enhance health literacy.

Goals:
- Expand and accelerate efforts in Texas to eliminate health disparities.
- Increase the capacity and leadership of "special and underserved" communities to address health disparities through the development and implementation of projects employing collaborative, evidence-based strategies.
- Identify, test, and disseminate innovative community-based approaches to health literacy and reduction of health disparities.

Preferred Approaches:
- Interventions based on community –agency partnerships that focus on connections between Social Determinants of Health (SDOH) and health disparities, especially in underserved populations, minority communities, and those of low socioeconomic status.
- Health Education that relies on community generated standards, language, and perspectives and applies National Standards for Culturally and Linguistically Appropriate Services (CLAS) methods.
- Interventions that specifically demonstrate effective coalition building or broad-based collaborations between community-based groups and health delivery and education agencies.
- Projects that demonstrate innovative application of health disparity research to community-driven projects, e.g. Community-Based Participatory Research (CBPR).

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53. **The Health Disparities of Vermonters – Vermont Department of Health, 2010**

To view this report, please click on the link:
http://www.healthvermont.gov/research/documents/VTDisparitiesRpt2010.pdf/

About: The following pages present information, maps, data and trends that highlight health disparities as they exist today in our state, as well as recommended actions that can be taken to reduce these disparities. This is the true calling of public health, and we ask our government, communities and individuals to continue to work together toward our common goal: to better health of *all* Vermonters.

Recommendations to Reduce Health Disparities:
- **Income -** *A healthy standard of living for all:*
  - Tailor effects to address obesity, smoking, and inadequate prenatal care among people with lower incomes.

- o   Increase use of preventive health services among people with lower incomes.
- o   Make state/federal assistance programs more accessible to low-income Vermonters
- o   Raise the state's minimum wage to more closely match the Vermont Livable Wage
- **Education & Occupation** – *Well educated citizens with opportunities to earn a living wage*
  - o   Focus on improving education as a means of reducing health disparities.
  - o   Continue to expand access to higher education.
  - o   Make health materials easier to comprehend.
  - o   Provide job-seeking assistance for Vermonters looking for work.
  - o   Promote safety in the workplace.
- **Housing & the Built Environment** – *Everyone has a safe, healthy place to live*
  - o   Develop affordable housing for low-income Vermonters.
  - o   Expand access to affordable fresh fruit and vegetables.
  - o   Raise awareness about health effects related to living in substandard housing.
  - o   Help families improve indoor air quality and reduce exposure to lead.
  - o   Expand support for communities to develop safe bike and walking paths.
- **Access to Care** – *Equal access to quality health care*
  - o   Continue the upward trend in Vermonters with health insurance.
  - o   Ensure an adequate supply of primary care doctors and dentists across the state.
  - o   Improve transportation systems for accessing health care.
  - o   Raise awareness about the importance of culturally appropriate health care.
  - o   Increase use of cultural and linguistic translators in the health care setting.
- **Race, Ethnicity & Cultural Identity** – *Better health for all Vermonters*
  - o   Improve reporting of racial and ethnic data by federally defined categories, and by more distinct populations.
  - o   Make schools safer for students who belong to a racial or ethnic minority.
  - o   Address factors that contribute to suicide attempts by young Vermonters who belong to a racial or ethnic minority.
  - o   Increase the number of Vermonters who belong to an ethnic or racial minority who have access to health insure and have a primary care provider.
  - o   Increase efforts to prevent chronic diseases and sexually transmitted diseases among racial and ethnic minority groups.
- **Stress, Disability, & Depression** – *Overcome the health toll of chronic stress:*
  - o   Improve recognition of chronic stress and depression.
  - o   Promote screening and treatment for depression among all Vermonters, especially young adults, people with a disability, and people who have chronic diseases.

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54. **State Policy Action Plan to Eliminate Health Disparities – Governor's Interagency Council on Health Disparities, 2010 (Washington)**

To view this report, please click on the link:
http://healthequity.wa.gov/About/docs/ActionPlan.pdf

About: One of the Council's responsibilities is to gather information to understand how the actions of the state government ameliorate or contribute to health disparities. Toward this goal, the Council has

considered models to promote policies, programs, and procedures to ensure equal access to goods, services, and opportunities by people of color so all residents have an equal chance at health.

Key Recommendations:
▪ Develop the capacity for state agencies to create policies, programs, and procedures to endure equal access to goods, services, and opportunities by people of color so all Washingtonians have an equal chance at health. The Council can facilitate capacity building by:
  o Providing technical assistance to state agencies in creating and implementing health equity training for agency staff.
  o Compiling and making available model health equity-related policies, such as language access and public engagement policies.

Selected City, County & Regional Reports

55.	**The Unequal Distribution of Health in the Twin Cities - Wilder Research, 2010**

Commissioned by the Blue Cross and Blue Shield of Minnesota Foundation

To view this report, please click on the link:
http://www.bcbsmnfoundation.org/objects/Publications/F9790_web%20-%20Wilder%20full%20report.pdf

About: This report looks at links between health outcomes and race, income, education and neighborhood conditions in Saint Paul and Minneapolis, Minnesota.

56.	**Achieving Health Equity: Can Silicon Valley become the healthiest region in America? – Health Trust, 2010 (California)**

To view this report, please click on the link:
http://www.healthtrust.org/pdf/HealthTrustNewsletterSpring2009.pdf

About: Research and experience shows that communities can take effective steps to reduce and eliminate health inequality through institutional and policy changes that impact how we live, learn, work, and play. Actions by individuals in the Silicon Valley community can help ensure optimal health for every resident.

▪ **Support Education**
  o Support the efforts of school districts to reduce the dropout rate while increasing test scores, with benchmarks reached for all ethnicities and income levels.
  o Support the establishment of new innovative charter schools focused on getting low-performing children on to a college track.

- o   Advocate for school districts in Santa Clara County Office of Education to create more alternative schools and programs for children who do not succeed in traditional public schools.
- ▪ **Support Preventive Health Care:**
  - o   Support the fluoridation of the water supply for the entire Silicon Valley region, as a way to prevent dental caries and insure optimal oral health for all area residents.
  - o   Support efforts to reduce Santa Clara County's black infant mortality rate by promoting health education and services to pregnant women and infants.
- ▪ **Support Coverage Expansion:**
  - o   Support Working Partnerships and the Santa Clara Family Health Plan's community outreach efforts to provide Healthy Workers information to small businesses employers and workers throughout Santa Clara County that may be eligible.
- ▪ **Support Home Ownership, Prevent Foreclosures:**
  - o   Encourage Congress to use some of the federal bailout money to modify bad loans so that people can stay in their homes.
  - o   Encourage the State of California to put a six-month moratorium on foreclosures and put pressure on banks to modify bad loans.
  - o   Encourage the City of San Jose and other municipalities to increase the counseling available to homeowners who are at-risk of losing their homes, as this kind of counseling is often effective at preventing foreclosure.

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57.   Health and Social Inequity – Santa Clara County, 2011 (California)

Santa Clara County Public Health Department

To view this report, please click on the link:
http://www.sccgov.org/sites/sccphd/en-us/Partners/Data/Documents/SHIPExecSummlowrespdf.pdf

About: This report is intended to be the first step and can be used as a tool in which to begin community-wide dialogue about the root causes of health inequities.

The Public Health Department and Community Benefits Coalition will use this information (statistics and facts about health care in Santa Clara County) in four key ways:
1.   As an integral part of our overall mission to monitor and communicate the health status of our community to the general public, community-based organizations, healthcare providers, and policymakers;
2.   To mobilize new and existing community partners around common priority areas aimed at improving the health of our residents;
3.   To further align our services with key health priorities and apply strategies that address all levels of prevention;
4.   Together with our community partners and leaders, to begin a comprehensive assessment of the social determinants of health and forge a long-term commitment to achieving health equity for every resident of Santa Clara County.

58. **The Community-Driven Eden Area Livability Initiative – Prevention Institute, 2009 (Alameda County, California)**

To view this report, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-82/127.html

About: Improving community environments requires a comprehensive approach that creates bridges across sectors. Over a period of roughly two years, stakeholders in the western unincorporated area of Alameda County (also called "The Eden Area") in California came together to identify, discuss, and debate the most important issues facing their communities and to develop a collective vision of livable communities and a prioritized set of actions.

THRIVE Livability Factors:
Place:

1. **What's Sold & How It's Promoted**

    Characterized by the availability and promotion of safe, healthy, affordable, culturally appropriate products and services (e.g. food, books, recreational items) and the limited promotion and availability, or lack, of potentially harmful products and services (e.g. tobacco, firearms, alcohol, other drugs).

2. **Look & Feel**

    A well-maintained, appealing, clean, and culturally relevant visual and auditory environment.

3. **Safety**

    Characterized by elements that support and enhance public safety presence through collaborative efforts that promote safe routes throughout the neighborhood, blight removal, adequate lighting, quality of life concerns, and overall well-being.

4. **Parks & Open space**

    Safe, clean, accessible parks; parks that appeal to the interest and activities of all age groups; green space; outdoor space accessible by the community; natural/open space that is preserved in the planning process.

5. **Getting Around**

    The availability of safe, reliable, accessible, and affordable methods for moving people around. This includes public transit, walking, and biking.

6. **Housing**

    Characterized by the availability of safe and affordable housing to enable citizens from a wide range of economic levels and age groups to live within its boundaries.

7. **Air, Water, & Soil**

    Safe and non-toxic water, soil, indoor and outdoor air, and building materials. Community design should help conserve resources, minimize waste, and promote a healthy environment.

8. **Arts & Culture**

    A variety of opportunities within the community for cultural and creative expression and participation through the arts.

9. **Preserve Resources/Natural Terrain**

The preservation of the historical character and resources, natural terrain, drainage, and vegetation of the community.

10. Defined Communities

Characterized by the preservation of signage, public art, agricultural greenbelts, wildlife corridors, community gardens, and other such unique community elements.

11. Public Places

Design that encourages the attention and presence of people of all ages and interests.

Equitable Opportunity:

12. Racial Justice

Policies and organizational practices in the community that foster equitable opportunities and services for all. It is evident in positive relations between people of different races and ethnic backgrounds.

13. Jobs & Local Ownership

Characterized by local ownership of assets, including homes and businesses, access to investment opportunities, job availability, and the ability to make a living wage.

14. Education

High quality and available education and literacy development for all ages.

People:

15. Social Networks & Trusts

Characterized by strong social ties among people in the community – regardless of their role. These relations are ideally built upon mutual obligations, opportunities to exchange information, and the ability to enforce standards and administer sanctions.

16. Participation and Willingness to Act for the Common Good

Characterized by local leadership, involvement in the community or social organizations, participation in the political process, and a willingness to intervene on behalf of the common good of the community.

17. Norms/Expected Behaviors & Attitudes

Characterized by community standards of behavior that suggest and define what a community sees as acceptable and unacceptable behavior.

Cross Cutting:

18. Planning integrated communities

Communities containing housing, shops, work places, schools, parks, libraries, cultural art venues, and civic facilities essential to the daily lives of residents.

19. Community Focal Points

Have a combination of commercial, civic, cultural, and recreational uses.

20. Health Care Access and Treatment

Characterized by preventative services, access, treatment quality, disease management, in-patient services and alternative medicine, cultural competence, and emergency response.

59. The Bay Area Network for Positive Health (California), 2010

To view this report, please click on the link:

http://www.healthequity.sfsu.edu/our-work/research.html#BANPH

About: The Bay Area Network for Positive Health (BANPH) is a consortium of several agencies from the Oakland/San Francisco Bay Area committed to reducing the number of local HIV-positive persons who are not in care. The goal of the consortium is to reduce this number by 15% in the first year through a coordinated.

Recommendations: Through
- Locating individuals who test positive for HIV.
- Strengthening their support networks that link these individuals to care.
- Reducing provider based barriers.

BANPH intends to reduce the number of HIV positive individuals who are not in care by 15%. Through their efforts, the BANPH has been able to reach those most marginalized victims including those in extreme poverty, people of color, transgendered individuals, those transitioning out of jail or prison, and substance abusers.

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60. Health Access – Sedgwick County, 2010 (Kansas)

Sedgwick County Health Department

To view this report, please click on the link:
http://www.sedgwickcounty.org/healthdept/fact_sheets/access%20fast%20fact.pdf

About: Affordable health care is essential for all Sedgwick County citizens. Tens of thousands of Sedgwick County's neighbors, friends and family members are uninsured. The impact of this problem does not just affect those individuals; it affects individuals, businesses, and our entire health care system.

Three main barriers:
1. Coverage – To evaluate the current health delivery system for capacity, deficiencies, and potential improvements.
2. Coordination – To create a coordinated system for community health care access.
3. Navigation – To improve communications and accessible information on health care options.

Final Recommendations and Updates:
1. **Enhance Publicity of United Way's 2-1-1 System:** 2-1-1 publicity is now incorporated into all outreach of the Health Department's Center for Health Equity. Health-related 2-1-1 calls are monitored monthly to examine trends.
2. **Community Health Coverage Plan**
3. **Build relationships with Kansas Health Policy Authority (KHPA):** Recently, Oversight Committee members have been placed on numerous state-level strategy teams, which will nurture and support on-going communication with KHPA.
4. **24/7 Nurse Call Line:** A feasibility study was conducted in 2009. The committee concluded that a nurse call line would not be an ideal strategy to pursue at this time.

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5. **Outreach:** The Health Department's Center for Health Equity launched the Community Health Navigator Project in 2009 to maximize outreach to promote affordable healthcare options in our community.
6. **Shared Health Information**
7. **Extending Clinic Hours of Access:** Due to funding constraints, clinics have refrained from extending hours of operations.
8. **Research Data on Emergency Room Usage:** An ER from one for the largest health care entities in our community examined trend data in 2009. The next step is to increase data collection by collaboration with other ER providers in our community to see if the trends are the same between hospitals.
9. **Transportation Plan:** The City of Wichita is currently working on a transportation improvement plan. The results will determine Health Access participants' next steps.

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61.   **Louisville Department of Public Health & Wellness Center for Health Equity: Health Equity Dialogue Facilitator's Guide – Prevention Institute, 2009**

To view the facilitator's guide, please click on the link:
http://www.preventioninstitute.org/component/jlibrary/article/id-80/127.html

About: The objective of the community focus discussion series is to engage Louisville community residents in a dialogue about elements of the social and community environment that can be addressed to enhance quality of life and improve health behaviors and outcomes.

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62.   **AAHP Strategic Plan 2009-2014 – Toward Health Equity, 2009 (Montgomery County, Maryland)**

African American Health Program
Montgomery County Department of Health and Human Services

To view this report, please click on the link:
http://www.onehealthylife.org/sites/default/files/AAHP_StrategicPlan_web.pdf

About: There is now more emphasis on the contribution of social forces to individual health, movement away from conceptualizing health in terms of the absences of specific diseases and conditions in favor of an approach based on wellness, and a growing awareness of the critical role that can be played by cultural competence regarding health care.

- **Social Determinants of Health:**
  - Focus the discussion
    - Both the general public and providers lack sufficient awareness of disparities. AAHP will increase efforts to educate all constituencies in the county about the disparities that continue to affect the health of our Black residents.

- o Support community organization to empower neighborhoods
- o Collaborate with other jurisdictions, initiatives, and community groups
- o Political Advocacy
- ▪ **Access to Culturally Competent Health Care**
  - o Provider education
  - o Translation and internal cultural competence
  - o Cultural competence requirements and assessments
  - o Advocate for increased access and quality in all areas
  - o Increase the number of Black health professionals
  - o Increase health literacy
    - • Health literacy includes the skills that patients need to communicate with providers, read medical information, make decisions about treatments, carry out care regimens, and decide when to seek health.
  - o S.M.I.L.E.
    - • Start More Infants Living Equally healthy. Program offers culturally competent nurse case management to women with high-risk pregnancies.
  - o Create an Executive Board workgroup to focus on increasing access.
- ▪ **Wellness**
  - o Integrate wellness into all programs.
  - o Locate wellness programs in target communities.
  - o Enhance wellness education.
  - o Advocate for provider accountability for wellness.
  - o Emphasize the importance of oral and dental care.
  - o Focus on obesity/advocate for healthy environments.
  - o Advocate for increased funding for health promotion.
- ▪ **Community/Stakeholder Involvement and Collaboration:**
  - o Restructure the AAHP executive committee.
  - o Bring in Black immigrants.
  - o Participate in faith- and community-based outreach.
  - o Establish interactive feedback.
  - o Enhance Health Promoter capacity.
  - o Develop public-private partnerships.
  - o Encourage collaboration among all the health minority initiatives.
  - o Enhance advocacy skills.
- ▪ **Data Collection and monitoring:**
  - o Advocate for local primary data collection.
  - o Advocate for the disaggregation of national data.
  - o Internal program data and program evaluation.

| **63.** | **Buncombe County 2010: Community Health Assessment, 2010 (North Carolina)** |

Toe River Health District/ Avery County Health Department

To view this report, please click on the link:
http://www.buncombecounty.org/common/health/cha/cha2010.pdf

About: Throughout 2010, a team of 68 community leaders from Buncombe County came together to chart a course for making our community a healthy, vibrant, high-quality place to live, work, and play. By creating a community health vision to focus our efforts, leaders can draw attention to the issues that we care enough about to want to create improvements in our community.

Six Priority Areas:
1. Promote Healthy Weight Through Healthy Living
2. Improve Women's Health During Childbearing Years
3. Improve Children's Health Outcomes through a focus on Family Support and Education
4. Increase Readiness of All Students to Learn and Succeed in School
5. Access t o and Continuity of a Mental Health Home (medical home)
6. Access to and Continuity of a Primary Care Home (medical home)

Each of these health priorities is also complemented by five guiding principles or "overarching themes" that will shape the development of specific strategies to address each of the priorities.
▪ Equity / Parity: focus on addressing racial, ethnic, income, and other disparities.
● Access to Resources: focus on strategies that enable access to various kinds of resources.
● Prevention: Focus on creating opportunities to help people stay well.
● Assets-based Approaches: Build on existing strengths and assets.
● Results, impact, and outcomes: Seek to be strategic about which interventions or combination of interventions are more likely to achieve the most impact and create positive health outcomes.

Programs:
1. Obesity Network - Connecting all local providers and non-profit working to prevent or reduce obesity through promoting healthy eating and increased physical activity.
2. Coordinating health care providers and partners who make up the safety net system of care for the uninsured. Coordinate both a point-of-service level group and a leadership, visionary group that focuses on collaborative strategy to improve our system.
3. Building awareness of health inequities and encouraging action and advocacy.
4. Informing our community about options for health care reform and advocacy opportunities.

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64. Status Report on Efforts to Advance Health Equity in Clinical Care and Health Outcomes in Memphis and Shelby County, Tennessee - Healthy Memphis, 2011 (Tennessee)

To view this report, please click on the link:
http://healthcarequalitymatters.org/assets/2011_HMCT_Equity_Report.pdf

The following systematic, community-based and individual-level steps are necessary to pursue health equity in both clinical care and community settings:
1. Standardize the collection of REL data as region wide initiative, including establishment of a policy for hospitals and physicians to adopt as part of their daily practice.

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2. Provide education and community forums to move toward an expansive and progressive conversation and implementation strategy on health equity.
3. Evaluate existing measures to address health disparities in all AF4Q Steering Committees and Workgroups and integrate a shared vision of health equity.
4. Collaborate with the local health information exchange and review national emerging data collection and performance measurements tools.
5. Identify the utilization and availability of mammography testing at the local level.
6. Convene meetings with the Shelby County Health Department, University of Tennessee's Center for Health Education, Economic Empowerment and Research, and the University of Memphis's Center for Health Equity Research and Promotion.
7. Partner with all hospitals in the community regarding results of REL data collection and strategies for quality improvement.
8. Activate a "color conscious" rather than a "color neutral" approach to race, ethnicity, and language awareness.
9. Organize forums and discussion groups to explore the concept of privilege and the impact on target non-dominant groups.
10. Recommend local residents attend "Common Ground – Conversations on Race" offered by the YWCA of Greater Memphis and other forums that support communication, listening, and understanding.
11. Collaborate with local literacy organization(s) to support the development of health literacy for non-English speaking community members.
12. Adopt the National Stakeholder Strategies launched by the U.S. Department of Health and Human Services as a support to our local efforts to address a future state of health equity.

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65.   King County Equity & Social Justice Initiative: Working toward fairness and opportunity for all, 2008 (Washington)

King County

To view this report, please click on the link:
http://your.kingcounty.gov/exec/equity/Equityreport08.pdf

About: Embracing the principles of equity and social justice can lead to a future where all residents of King County have real opportunities for quality education, livable wages, affordable housing, health care, and safe and vibrant neighborhoods.

Now Is the Time to Act:

Moving forward with an initiative focused on promoting equity and social justice will present many practical challenges and barriers. The set of principles listed below can help guide groups around these barriers.
- Move "upstream" to address the root causes of inequity.
- Actively seek out and promote decisions and policies aimed at equity.
- Empower communities.
- Work across agencies and departments.

- Recognize and honor cultural differences.
- Aim for long-term permanent change.

Next Steps and Actions [regarding public health and health –related sectors]:
- **County policy development and decision making**
  - King County will develop and test and equity impact assessment and review tool and the associated process for incorporating the tool in decision-making.
  - Create equity and social justice curriculum for managers, as well as short curriculum for new employees.
  - Create and internal mechanism for support and oversight to ensure that promoting equity is an integral part of doing business.
  - Collect and publish measures to highlight inequities and to mark progress on correcting them.
  - Ensure that county decision-making processes incorporate meaningful input from potentially impacted communities, particularly those facing the greatest inequities by improving internal capacity to work with communities.
- **Community and human services:**
  - *Mental health and substance abuse*: The Department of Community and Human Services will increase its knowledge and understanding of disproportionate access to mental health and substance abuse services through better identification of affected populations, measurement of appropriate levels of service, and determination of whether outcomes are equally effective across population groups.
  - *Prevention and early intervention:* With its partners, the Department of Community and Human Services will review its services for inequities related to prevention and early intervention for the population birth through age three and, where they exist, craft and implement mitigation strategies.
  - *Homelessness:* Under guidance of the DCHS, King County will use Safe Harbors data, program generated data and the Committee to End Homelessness' Strategy Recommendations to link people of color, immigrants and refugees with homeless housing and services and understand barriers in accessing and succeeding in housing.
  - **Development and environmental services:**
    - The Department of Development and Environmental Services will rewrite the zoning code to allow maximum development flexibility in exchange for the provision of public benefit, and it will review and revise comprehensive plan policies to encourage vibrant, mixed-use neighborhoods that are diverse and integrated.
    - The department will create an interagency team to coordinate the siting, funding, permitting, and development of infrastructure to partner and/or support and facilitate affordable housing projects in unincorporated King County and on King County surplus properties.
  - **Public Health:**
    - Apply the Equity Impact Assessment tool and review process in decision-making within each public health function area: protection, promotion, provision and organizational attributes. Public Health will identify a menu of proposed actions and policy decisions and determine impacts on equity as well as mitigation options. Public Health will use this information to select the most promising strategies for further development in a business plan.

- Public Health will work with external partners to achieve equitable access to health care for uninsured and underinsured residents in King County.
- In order to promote fair and equitable access to public health information produced for people with limited English proficiency, Public Health will create a system for translation services to make the process more efficient and produce translations that are of a consistent high-quality.
    - **Transportation:**
        - The Transportation Department will develop a tool to prioritize potential non-motorized transportation improvements based on transportation, health, and air quality and equity outcomes.
        - It will implement the HealthScape principle based on sustainable changes to the built environment to achieve the goals of efficient transportation, improved air quality, healthier communities and reduced greenhouse emissions in a disadvantaged neighborhood.
        - It will work to expand the supply of affordable housing within close proximity to transit, housing, recreation and employment centers through public/private partnerships for transit oriented development.

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66. **2009 Equity and Social Justice Commitments by Department Year End Tracking (King County, Washington)**

King County

To view this report, including the progress update, please click on the link:
http://docs.google.com/viewer?a=v&q=cache:o4FyfQszRv0J:www.kingcounty.gov/exec/~/media/exec/equity/documents/2010EquityCommitments.ashx+2009+Equity+and+Social+Justice+Commitments+by+Department+Year+End+Tracking&hl=en&gl=us&pid=bl&srcid=ADGEESiRrw2v2oU5APEXmEVHmV6kZbtYIFzjip-IoVBB-tg4mYDYjL22J2KTlxgMPWTWr26Yff6o6IcXnvUWyA0pzHq0mFIp6djSTwtcc8-7iFYk7gmgOsFsI5WGs_H9NDUQtBWY1Gvs&sig=AHIEtbRBe3RYK92acefrYIljEeA7kYU1VA

About: The report consists of a chart outlining the departments, the stated department's commitments, the determinant of equity that is addressed, and a progress update.

- **DAJD:**
    - Build internal awareness and education about equity through communication with senior and the health diversity committee. In addition, DAJD will work to include an ESJ component to our New Employee Orientation program.
    - Form disproportionate minority contact group similar to Juvenile Criminal Justice Council for adults.
- **DCHS:**
    - Mental Health and Substance Abuse:
        The DCHS will increase its knowledge and understanding of disproportionate access to mental health and substance abuse services through better identification of affected populations, measurement of appropriate levels of

service, and determination of whether outcomes are equally effective across the population groups.

- o Prevention and Early Intervention:

  With its partners, the Department of Community and Human Services will review its services for inequities related to prevention and early intervention for the population birth to age three and, where they exist, craft and implement mitigation strategies.

- o Homelessness:

  Under guidance of the DCHS, King County will use Safe Harbors Homeless Management Information System (HMIS) data, program generated data, and the Committee to End Homelessness (CEH) in King County Strategy recommendations to link people of color, immigrants and refugees with homeless housing and services and understand barriers in accessing and succeeding in housing. The DCHS will use the understanding gained through such investigation to identify strategies that can be implemented through its programs that will increase access to and success in housing for those populations.

- ▪ **DDES**
  - o Form Based Zone Code:

    Project goal is to develop a code that creates healthy environments in all neighborhoods by focusing on public space – streets landscaping, open space – while encouraging important objectives such as improved walkability and the creation of mixed use neighborhoods.

  - o Affordable/workforce housing project:

    The department created an interagency team (DDES Facilities and Housing Community and Human Services) to coordinate the siting, funding, permitting and development of infrastructure to facilitate affordable and workforce housing projects on King County surplus properties. Sites have been selected and an RFP is under way in order to select developers.

    - • Our new 2009 proposal is to establish a fund to supplement permitting costs for qualified low-income proposals and/or individuals. An example is for a low-income individual that needs to construct an access ramp to their home though they cannot afford the permitting fees. We are in the beginning stages of seeing if the proposal is feasible and can be implemented.

- ▪ **DES**

  Develop and present a two tiered training program:

  - o Tier 1: Equity and Social Justice Awareness training curriculum. Participants will:
    - • Learn the equity & social justice vision, mission & guiding principles;
    - • Explore the underlying concepts of equity & social justice and how it applies to their work in King County;
    - • Understand the importance of equity & social justice in King County; and
    - • Understand how equity & social justice principles apply to county policies, delivery of services and community engagement in their work.
  - o Tier II: a specific class focused on social justice and public sector decision-making.
    - • Establish yearly reviews of ESJI principles and critical county policies for all DES employees.

- Continue toward the goal of higher participation at the "gold" level in the Health Reform Initiative using new tools to reach groups with high bronze or silver levels of participation.

- **DNRP**
  - Solid waste – apply an equity lens in decisions for solid waste plan (school dumping litter, rate setting, siting facilities) for NE Lake WA & South Co.
  - Parks – capital improvement equity review. Work with PH related to physical activity access.
  - Waste water – consider equity in reclaimed water long range plan.
  - Water/land resources – incorporate economic considerations in flood control district to protect family wage jobs in Kent Valley.

- **DPH**
  - Continue translation policy implementation and pursue county- wide policy
  - DSJG cultural competence training module will add components on Institutionalized Racism & Equity and Social Justice (aligning with DES on training, prioritizing supervisors and managers)
  - Access to health services

- **DOT**
  - Develop a tool to prioritize non-motorized transportation improvements based on transportation, health, and air quality and equity outcomes.
  - Implement the HealthScape principles based on sustainable changes to the built environment to achieve the goal of efficient transportation, improved air quality, healthier communities and reduced greenhouse emissions in a disadvantaged neighborhood.
  - White Center –DOT will work to expand the supply of affordable housing within close proximity to transit, housing, recreation and employment centers through public/private partnerships for transit oriented development.
  - Outreach to SE Seattle and SW King County to prepare communities for Link Light Rail and a new fare card – ORCA.

- **Executive Office**
  - Transmit and advocate for a piece of legislation that places the principles and work of the Equity and Social Justice initiative into King County Code.

- **OSPPM**
  - Building on the community enhancement initiative's work in 2008 to improve Skyway Park, the focus of the 2009 commitment is to develop a community-driven action plan for the revitalization of Skyway.

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67. King County Equity& Social Justice Initiative – January 2009 Update Report (King County, Washington)

King County, 2009

To view this report, please click on the link:
www.kingcounty.gov/exec/equity.aspx

About: In February 2008, King County launched the Equity and Social Justice Initiative, to eliminate long-standing and persistent inequities and social injustices. The goal of the Initiative is for all King County

residents to live in communities of opportunity. To reach this goal, all communities must be equipped with the means to provide individuals with access to livable wages, affordable housing, quality education, quality healthcare, and safe and vibrant neighborhoods. King County is applying the principles of equity and social justice in its actions, decisions, and policies.

2008 Accomplishments: Success through Education, Leadership, and Long-Term Commitment

- **Education:**
    - Hundreds of people attended three Town Hall meetings with elected officials and community leaders, moving towards a common understanding of equity and social justice and jointly searching for solutions.
    - Thousands of community members and county employees held dialogues about the underlying causes of inequities, and discussed how they could each make a difference in creating a more fair and just society.
- **Leadership:**
    - In 2008 county leadership made commitments and took specific steps to address equity and social justice.
    - King County also established an interdepartmental team to champion this work, and is forming a community advisory group that will provide leadership and vision.
    - King County Executive Ron Sims spoke in numerous occasions to local and national groups, sharing out region's groundbreaking activities to comprehensively address the root causes of inequities.
- **Long Term Commitment:**
    - In 2008 King County laid the groundwork to assure future success and long-term commitment to equity and social justice. With the help of the W.K. Kellogg Foundation, the county is developing a strategic plan to guide the Initiative's work in future years.

2008 Highlight:
By assessing equity impact, King County can determine whether policies and programs advance a shared agenda of fairness, spread burdens fairly, and help address historic patterns of institutional bias and discrimination.

Delivery of County Services – 2008 Highlights
Adult & Juvenile Detention:
- Adult & Juvenile Detention along with the Department of Community and Human Services revised information and assistance provided to incarcerated women about available services.

Community & Human Services:
- With its partners, Community and Human Services has been reviewing its prevention and early intervention services for the population birth to age three, crafting and implementing strategies to mitigate inequities in these early childhood services.
- The department developed culturally and linguistically appropriate outreach materials for Somali, Spanish, and Vietnamese families in response to data on utilization of birth to three prevention services for children with developmental disabilities.

Development and Environmental Services:
- Development and Environmental Services has begun the process of rewriting the zoning code.

- o This goal is to allow for greater flexibility for developers and encourages more vibrant, mixed-use neighborhoods in return for providing public benefit such as mixed income housing, walkability, and sustainability.

Executive Office:
- o The Executive Office coordinated the launch of Opportunity Greenway Summer 2008, offering court-involved young adult students the changes to learn about and train for high wage and high demand "green jobs."
- o Approximately 50 high school students were introduced to green jobs in three six-week educational internships programs operated through YouthSource.

Executive Services:
- o To determine if the new Healthy Incentives (SM) employee benefits program was having inequitable impacts on county employees, staff collected information on employee positions with lower participation rates among jobs lacking regular access to computers such as road crews, carpenters and maintenance workers.
- o As a result, the benefit staff developed and implemented an outreach plan to those employees with lower health participation with the goal of decreasing their health expenses and encouraging participation in interventions to improve health. Data show that the plan was successful in increasing participation in most cases.

Management & Budget
- o To promote engagement and leadership from underrepresented groups in neighborhood revitalization activities, the Office of Management and Budget supported the design and facilitation of an inclusive public process to create a community vision for Skyway Park through the county's inter-departmental Community Enhancement Initiative.
- o Encouraged by strong participation and successful implementation of early action items in the park, this project has been expanded to produce a wider community agenda for neighborhood revitalization, addressing the root causes of long standing and persistent inequities.

Natural Resources & Parks:
- o Natural Resources and Parks conducted a GIS-based equity assessment which mapped benefits and burdens related to demographic variables such as race, income, and language.
- o This analysis helped to identify and promote action on potential areas of disproportionality in the department's facility locations and service delivery.

Public Health
- o To increase availability of health information for people with English proficiency, Public Health developed a translation policy and system.
  - The policy includes processes for creating translations of consistent high quality, and has innovative translation guidelines, resources, and best practices.
  - Included are language maps for King County, priority language tiers with 20 languages, quality translation vendors chosen in a competitive process, and a translation worksheet to guide the translation process.

Transportation:
- o Transportation has been actively engaged with community organizations, schools, businesses, and residents to elicit feedback about possible changes to bus routes in the southeast Seattle area and southwest King County in light of Link light rail services and RapidRide starting in 2009.
- o Activities have included over a dozen sounding board meetings, mailings to over 92,000 addresses, a multi-lingual hotline, questionnaires and other materials translated into seven

languages, and numerous community discussions, public speaking engagements and other intensive community outreach activities.

International Reports

68.   **Millennium Development Goals Report – the United Nations (UN), 2011**

To view this report, please click on the link:
http://www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf

About: Developed in 2000 as the framework for the development activities of the United Nations, the Millennium Development Goals (MDGs) include the following objectives to be completed by the year 2015: eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability; and develop a global partnership for development. While much progress has been made towards achieving the targets laid out at the Millennium Summit, the distribution of positive outcomes is not evenly disseminated across all economic ladders, and bypasses other disadvantaged populations due to urban or rural geographic locale, race, ethnicity, sex or disability. Achieving the MDGs will require equitable and inclusive economic growth among all populations and enduring efforts to protect the ecosystems that support such growth.

Goal 1: Eradicate extreme poverty and hunger:

1. **Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day**
   a. Strong growth in the first five years of the new century reduced the number of people in developing countries living on less than $1.25 a day from 1.8 billion in 1990 to 1.4 billion in 2005. Despite the global recession of 2008, the world is on track to reach its poverty-reduction target, with the World Bank currently forecasting that overall poverty rates in the developing world will drop below 15 percent by 2015.
   b. Lack of good quality surveys carried out at regular intervals and hampered access to underlying survey microdata make monitoring progress on poverty reduction more difficult and must be improved moving forward.

2. **Target 2: Achieve full and productive employment and decent work for all, including women and young people**
   a. While global economic growth has rebounded since the 2008 recession, this has not translated into employment generation, and the employment-to-population ratio dropped two percent between 2007 and 2010. Developing countries are not able to produce employment opportunities to keep up with the growth of their working-age populations. Progress in reducing vulnerable employment has also come to a halt, and one in five

workers and their families are living in extreme poverty – amounting to $40 million people more than expected prior to the recession.

3. **Target 3: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.**
   a. The proportion of people in developing countries that are undernourished has plateaued at 16 percent, making it difficult for the world to meet its hunger-reduction target. There are wide disparities in access to food within and among regions.
   b. And while there has been a successful reduction in reducing the proportion of children under five who are underweight, nearly a quarter of children in the developing world are undernourished.
      i. Children are underweight due to a combination of factors:
         1. Lack of quality food
         2. Suboptimal feeding practices
         3. Repeated attacks of infectious disease
         4. Pervasive undernutrition.
            a. Which may be exacerbated by poor sanitation practices.

      ii. Nutrition must be a greater priority in national development strategies and can incorporate simple, cost-effective measures in the key stages of the life cycle (especially conception to two years of age) including, inter alia:
         1. Improved maternal nutrition and care
         2. Breastfeeding within one hour of birth
         3. Exclusive breastfeeding for the first six months of life
         4. Timely, safe, adequate and appropriate complementary feeding and micronutrient intake between 6 and 24 months of age.
   c. Children from poorer households are more likely to be underweight than those children brought up in wealthy homes, and in developing regions children are twice as likely to be underweight if they live in rural rather than urban areas.
   d. Humanitarian crises and conflict continue to turn out a steady stream of refugee populations across the international arena, hindering poverty reduction efforts.

Goal 2: Achieve universal primary education:

1. **Target: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.**
   a. Enrollment levels in the developing world have been slow since the dawn of the new century, rising 7 percent since 1999 to a cumulative 89 percent in 2009. Sub-Saharan Africa has produced the most promising outcomes, with enrollment rising 18 percent between 199 and 2009.
   b. To make progress in this area, efforts must focus on ensuring that children complete a full cycle of primary schooling, as more than 20 percent of primary-age students in developing countries are excluded from full education. Being female, being poor, and living in a country affected by conflict are three of the most important factors in keeping children out of school. Refugee populations are especially vulnerable, with stigmatization, discrimination, language differences, and unqualified teachers acting as barriers to education. Many children who are out of school from an early age will never enter a classroom. The abolition

of school fees can greatly aid progress in this area, as well as the increased funding for education during emergencies.

   c. While the literacy rate of youth (aged 15 to 24) has increased from 83 percent to 89 percent between 1990 and 2009, wide differences exist between continents and regions in terms of rates of children's proficiency in reading and writing skills.

Goal 3: Promote gender equality and empower women:

1. **Target: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.**
   a. In developing regions, 96 girls were enrolled in primary and secondary school for every 100 boys in 2009, a vast improvement over the course of a decade. However, while the gender parity index for the whole developing world is highest at the tertiary level of education, it is also the area where there is the great disparity.
   b. The share of women engaged in non-agricultural paid employment has increased by five percent to 40 percent between 1990 and 2009, but progress has slowed due to the global financial recession. The unemployment rate as a result of the recession has come down faster for men than it has for women, which has entrenched the employment gap between men and women in the developing world that much further. Improvement in employment ratios is greatly variable depending upon continental locale.
   c. Women's participation in government has steadily increased but representation gender parity is far off, and in 2010 female gains were registered in just half of all parliamentary elections or renewals.
      i. Quota arrangements – at the legislative and party level – are key predictors of success, as well as the existence of gender-sensitive electoral arrangements, including in the areas of media exposure and public appearances.

Goal 4: Reduce child mortality:

1. **Target: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.**
   a. Globally, child mortality rates have dropped by a third between 1990 and 2009, and all regions except for Sub-Saharan Africa, Southern Asia and Oceania have seen declines by 50 percent or more.
      i. This MDG Target can only be reached with substantial and accelerated action to eliminate the leading killers of children, including pneumonia, diarrhea, malaria and undernutrition.
   b. Across all regions, rates of child mortality are higher in rural households. Moreover, children from the poorest fifth of the population are nearly twice as likely to die before their fifth birthday as children who grow up in affluent households.
   c. Expanded coverage of immunization against measles (both doses) has increased worldwide and accounts for one quarter of the decline of under-five child mortality rates. Routine immunization and campaigns are necessary to bring down the disparity existing among hard-to-reach children, and political commitments must be made to counter reduced funding measles and streamline implementation.

Goal 5: Improve maternal health:

1. **Target 1: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.**
    a. In the developing regions as a whole, the maternal mortality ratio dropped by 34 percent between 1990 to 2009, but the target is threatened as an increasing number of women enter their prime reproductive years in countries struggling to meet current demands for improved maternal health and reproductive health care.
        i. Although the majority of maternal deaths are avoidable, the largest causes of these deaths are:
            1. Obstetric hemorrhage, mostly during or just after delivery
            2. Eclampsia
            3. Sepsis
            4. Complications of unsafe abortion
            5. Indirect causes, such as malaria and HIV

        ii. The likelihood of maternal mortality increases among women who:
            1. Have many children
            2. Are poorly educated
            3. Are very old or very young
            4. Are subjected to gender discrimination

    b. Studies show that the presence of a trained health-care worker during the delivery process is a crucial strategy to reduce maternal mortality, allowing for the detecting and managing of pregnancy and childbirth conditions.

2. **Target 2: Achieve, by 2015, universal access to reproductive health**
    a. Increased efforts must be placed on ensuring that women are able to have a minimum of four antenatal visits in order to prevent or manage complications. By providing basic antenatal care women will receive nutritional advice, aid in safe childbirth, and alerts about pregnancy threatening impediments. In the case of malaria presence or a mother's HIV-positive status, health workers can provide appropriate preventive treatment.
    b. Globally, increased access to safe, affordable and effective methods of contraception – which contributes to more positive maternal and infant health outcomes – has provided women with greater decision-making power over reproduction.
        i. As the number of women of childbearing age increases family planning programs and health care services must invest more money and resources to ensure equitable and reliable access and to meet the unmet needs for family planning, especially in sub-Saharan Africa and the Caribbean.
            1. Levels of unmet need are especially high among women aged 15 to 19 and have changed little since early data periods. Access to contraceptives for adolescents must be improved in order to improve maternal and child health, reduce poverty, achieve gender equality, and improve the changes of women attending school and gaining paid employment.
    c. Funding for family planning has dropped off in virtually all recipient countries despite demand for contraceptive methods. Increased funding for family planning services is necessary in order to meet this demand and reduce the long-term costs of maternal and newborn healthcare by preventing unintended pregnancies.

Goal 6: Combat HIV/AIDS, malaria and other diseases:

1. **Target 1: Have halted by 2015 and begun to reverse the spread of HIV**
   a. Between 2001 and 2009 the incidence rate of HIV/AIDS declined by nearly 25 percent worldwide and rates of new infections have dropped by 21 percent since 1997. However, the distribution of positive disease reduction is variable across different regions, with an especially troubling rise in infections in Eastern Europe and Central Asia.
   b. The number of people receiving anti-retroviral treatment (ARVs) increased by a measure of 13 from 2004 to 2009, bringing down the number of AIDS-related deaths by 19 percent. Despite leading the world in declining HIV infection rates, Sub-Saharan Africa still harbors the highest number of AIDS-related deaths as well as the highest rates of persons living with HIV.
   c. Women and young people are becoming the most vulnerable sub-populations for new infections. This can be partly ascribed to a lack of knowledge about how HIV spreads, and, although many young people are aware of how to reduce their risk, women and rural youth are less likely to know about preventive measures.
   d. Condom use remains dangerously low among young men and women in developing countries, and disparities in use are visible along the fissures of household wealth and the urban-rural divide.
   e. By 2009 16.6 million children worldwide were estimated to have lost one or more of their parents to AIDS. Education is a vital method by which to provide AIDS orphans with structured environments, emotional support and supervision.
      i. Governments should consider policies including the elimination of school fees, an emphasis on child-sensitive social protection and targeted educational assistance to orphans and other vulnerable children.

2. **Target 2: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it**
   a. Universal access is defined as coverage of at least 80 percent of the population in need of ARVs and/or interventions to prevent mother-to-child transmission (PMTCT) of HIV. Higher initial costs of providing these treatments will be fully compensated by bringing down future hospitalization, morbidity and mortality rates. Overall ARV coverage is variable among men and women, and in-need children in low- and middle-income countries are receiving, as a percentage, less coverage than their adult counterparts.
   b. Without continued efforts to provide ARVS to expectant mothers who are HIV positive up to one third of children born to these women will be infected with the virus.

3. **Target 3: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases**
   a. Increased funding for and attention to malaria control methods such as insecticide-treated mosquito nets and artemisinin-based combination therapies have substantially reduced the number of malaria cases and deaths by an estimated 20 percent between 2000 and 2009. Policymakers and stakeholders must maintain control programs rigorously, even in countries that have previously reported reductions in malaria cases and deaths.
   b. Between 2000 and 2009 the surge in production, purchase and distribution of mosquito nets have brought down the number of malaria deaths, especially in children under five. This is particularly observable in data from Africa, where policymakers have dramatically reduced disparities in access along rural-urban divides by creating nationwide campaigns to distribute free nets.

    c. In 2010, the WHO declared that everyone with suspected malaria has a right to diagnostic tests before treatment instead of presumptive treatment based on their presented symptoms. Sparse data about the use of combination therapy in Africa shows that children are receiving the recommended medicines, but policymakers must work to ensure that health care workers are pursuing accurate diagnoses within the WHO guidelines.

    d. The incidence rates of tuberculosis (TB) are decreasing, bringing the MDG target into view. Moreover, mortality from and prevalence rates of TB are dropping in all regions around the world and deaths have decreased by as much as a third since 1990. The success of the international community in halting the progress of TB can be attributed to wholehearted efforts since 1995 to implement the "DOTS" and Stop TB strategies.

        i. However, the international community must work towards improving the planning, financing and implementation of a range of interventions in order to meet the targets established in the Global Plan to STOP TB, 2011-2015. These interventions include:

            1. Making sure that all patients have access to the recommended treatments, as well as ensuring that persons with multidrug-resistant TB are being diagnosed and treated according to international guidelines.

            2. Ensure that persons with HIV and TB know their HIV-positive status and receive concurrent ARV therapy.

Goal 7: Ensure environmental sustainability:

1. **Target 1: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources**
   a. Deforestation accounts for up to one sixth of all human-induced greenhouse gas emissions. Since 1990, the rate of deforestation has been slowing, but biodiverse forests in the tropics are experiencing disproportionately large net losses.
   b. Troublingly, global carbon dioxide emissions are rising and the decade 2001-2010 was the warmest on record since 1880. Policymakers must elaborate upon the decisions agreed upon at the December 2010 UN Climate Change Conference in Cancun, Mexico, in order to drive national plans to combat greenhouse gas emissions before the next major climate change conference in December 2011. Moreover, countries should continue to build upon the current success of the Montreal Protocol so that the substances targeted by the Protocol continue to decline rapidly.

2. **Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss**
   a. Although there has been an overall increase in protected ecosystems, biodiversity is declining due to inadequate management of existing sites and gaps in the protection of areas prioritized for conservation. Furthermore, the global surge of extinctions has continued uninterrupted, fish stocks continue to be exploited and depleted, and the limits of sustainable water resource use has been exceeded in a number of regions across the globe.

3. **Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation**
   a. Efforts to improve access to clean drinking water have been remarkably successful since 1990 and if current trends persist the world will meet (and surpass) the MDG drinking water

target of 89 percent coverage by 2015. 92 percent of developing countries in this time period increased access to clean water, but in all regions coverage of rural area residents lagged behind that of cities and towns. Even in urban settings, poor households still do not have equitable access to and obtain the associated health benefits of having a piped drinking water supply on premises.

b. The world is still far from meeting the sanitation goal (flush toilets and other forms of improved sanitation), and if current trends persist it will take until 2049 to merely cover 77 percent of the world's population. Close to half of the population of developing regions still did not have access to improved sanitation in 2008, and rural populations are disproportionately disadvantaged in this regard (although this particular disparity has been decreasing over the past decade).

   i. Lack of sanitary facilities leads to inadequate waste disposal and enormous health risks, especially for poor segments of the population who are most exposed to unsanitary disposal sites.

4. **By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers**

   a. Between 2000 and 2010, more than 200 million urban residents living in developing world slums gained access to either improved water, sanitation or durable and less crowded housing. However, the number of individuals moving to urban areas and taking up residence in slums has increased faster than the international community can implement slum improvements.

   i. States should follow the guidance of the Governing Council of the UN Human Settlements Program by enumerating their slum populations and re-setting national, regional and local targets for improving the lives of slum dweller through the prioritization of:
      1. Housing and basic services
      2. Infrastructure (especially water and sanitation facilities)
      3. Transport
      4. Energy
      5. Health
      6. Education
      7. Providing access to affordable land with secure tenure.

Goal 8: Develop a global partnership for development:

As a percentage of the combined national income of developed countries, net aid disbursements are at an all-time high. However, countries are still falling short of the benchmarks put in place at the Gleneagles Group of Eight (G8) Summit in 2005, which can be partly blamed upon the economic recession at the latter part of the decade but also ascribed to underperformance by some donors.

1. **Address the special needs of the least developed countries, landlocked countries and small island developing states**

   a. While most OECD donors plan on increasing aids throughout the coming three years, the allotment of this aid will occur at a slower pace. At this time, least developed countries (LDCs) are receiving about one third of donors' total aid flows.

2. **Develop further an open, rule-based, predictable, non-discriminatory trading and financial system**

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      a. Despite worries that the 2008 global economic crisis would lead to a wave of protectionism, cooperation between the G8 and in other multilateral arenas has prevented such a phenomenon and most exports from LDCs still receive true preferential duty-free status. Moreover, applied tariffs on agricultural products from the developing world have continued to fall after the global recession, allowing LDCs to especially focus on importing to large emerging countries.

3. **Deal comprehensively with developing countries' debt**
      a. As the export earnings of developing earnings declined after 2008, the ratio of public debt service to exports increased for almost all developing regions, interrupting a positive trend of declining debt. Those countries involved in the Heavily Indebt Poor Countries (HIPC) initiative have debt burdens that have fallen below the after for all LDCs.
4. **In cooperation with the private sector, make available the benefits of new technologies, especially information and communications**
      a. By the end of the decade, 90 percent of the world's population was covered by mobile cellular signal, 76 percent of individuals were using these devices and almost one third were online. These services have also reached rural populations, allowing millions to join the information society and have access to innovative applications addressing issues of business, health and education. Such applications can help the world work towards achieving the other MDGs.
      b. At the same time that, in absolute numbers, the percentage of Internet users in the developing world surpassed that in the developed regions, Internet penetration levels remain low in the developing world as a whole, especially in LDCs.
      c. An increasing number of states are creating national broadband plans to bring their populations online, but fixed broadband penetration in the developing world is still about one eight of that in the developed world. Mobile broadband has become an alternative to fixed broadband, but two-thirds of subscriptions remain in the developed regions.

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69. **Reducing Health Inequities through Action on the Social Determinants of Health – the World Health Organization (WHO), 2009**

To view this report, please click on the link:
http://apps.who.int/gb/ebwha/pdf_files/EB124/B124_R6-en.pdf

Urges member states to:
1. To develop and implement goals and strategies to improve public health with focus on health inequities;
2. To take into account health equity in all national policies that address social determinants of health and to ensure equitable access to health promotion, disease prevention, and health care;
3. To ensure dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies;
4. To increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;

5. To contribute to the improvement of the daily living conditions contributing to health and social well-being across the lifespan by involving all relevant partners including civil society and private sectors;

6. To contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their behavior;

7. To generate new, or make use of existing methods and evidence tailored to national contexts in order to address the social determinants and social gradients of health and health inequities;

8. To develop, make use of, and if necessary improve health information systems in order to monitor and measure the health of national populations, with data disaggregated according to the major social determinants in each context so that health inequities can be detected and the impact of policies monitored in order to devise appropriate policy interventions to minimize health inequities.

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70. Equity, Social Determinants, and Public Health Programs – the World Health Organization (WHO), 2010

To view this report, please click on the link:
http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf

About: The priority public health conditions analytical framework has three dimensions of activity – to analyze, intervene, and measure – and five levels of analysis. The top level relates to the structure of society, the second to the environment, the third to population groups, and the last two to the individual.

The five levels can briefly be described as the following:

1. **Socioeconomic Context and Position**
   o Factors defining position include social class, gender, ethnicity, education, occupation, and income.
   o The relative importance of these factors are determined by the national and international context, which includes governance, social policies, macroeconomic policies, public policies, culture, and societal values.
2. **Differential Exposure**
   o Exposure to most risk factors (material, psychological, and behavioral) is inversely related to social position.
   o Many health programs do not differentiate exposure or risk reduction strategies according to social position; though analysis by socioeconomic group would clarify which risk factors were important to each group, and whether these were different from those important to the overall population.
   o Understanding these "causes behind the causes" is important for developing appropriate equity-oriented strategies for health.
3. **Differential Vulnerability**
   o The same level of exposure may have different effects on different socioeconomic groups, depending on their social, cultural, and economic environments and cumulative life course factors.

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4. **Differential Health Care Outcomes**
    o   Equity in health care ideally implies that everyone in need of health care receives it in a form that is beneficial to him or her, regardless of social position or other socially determined circumstances.
    o   Result should be a reduction of all systematic differences in health outcomes between different socioeconomic groups in a way that levels everyone up to the health of the most advantaged.

5. **Differential Consequences**
    o   Poor health may have several social and economic consequences, including loss of earnings, loss of ability to work and social isolation or exclusion.
    o   Further, sick people often face additional financial burdens that render them less able to pay for health care and drugs.
    o   While the advantage population groups are better protected, for example in terms of job security and health insurance, for the disadvantages, ill-health might result in further socioeconomic degradation, crossing the poverty line and accelerating downward spiral that further damages health.

Implementing such action may be the responsibility of public health programs, the wider health sector or sectors beyond health. The upstream levels of the framework, namely context and position, differential exposure and differential vulnerability, can be usefully considered in relation to the classification of structured interventions.

▪   **Interventions that acknowledge** health as a function of social, economic, and political power and resources, and thus seek to manipulate power and resources to promote public health;
▪   **Interventions based** on the assumption that health problems result from deficiencies in behaviors, settings, or the availability of products and tools, and thus seek to address those deficiencies;
▪   **Interventions that recognize** that the health of a society and of its members is partially determined by its values, cultures and beliefs, or those of subgroups within it, and thus seek to alter those social norms that are disadvantageous to health.

The analysis and proposals for each of the conditions have value in their own right and are presented in separate individual chapters of this volume as follows:
▪   Alcohol
▪   Cardiovascular disease
▪   Health and nutrition of children
▪   Diabetes
▪   Food safety
▪   Mental disorders
▪   Neglected tropical diseases
▪   Oral health
▪   Unintended pregnancy and pregnancy outcomes
▪   Tobacco use
▪   Tuberculosis
▪   Violence and unintentional injury

1. **Alcohol**
    Possible interventions to impact:

- Socioeconomic context and position:
    - Enhancing and protecting the ability of governments at various levels to act to reduce alcohol problems
    - Shaping norms and place of alcohol in the culture to decrease the stigmatization
- Differential vulnerability:
    - Community mobilization and empowerment
    - Enhancing access to services for groups of low socioeconomic status
- Differential exposure
    - Controls on alcohol quality
    - Using contextual controls to limit the harm from a given level of drinking

2. **Cardiovascular Disease**

   Possible interventions to impact:
    - Socioeconomic context and position:
        - Universal primary education
        - Programs to alleviate under nutrition in women of childbearing age and pregnant women
        - Tax-Financed public services including education and health
        - Multifaceted poverty reduction strategies at country level, including employment opportunities
    - Differential exposure
        - International trade agreements that promote availability and affordability of healthy foods
        - International agreements on marketing foods to children
        - Use of tobacco tax for promotion of health of the population
        - Develop urban infrastructure to facilitate physical activity
        - Government legislation and regulation
        - Voluntary agreement with industry (e.g. trans fat and salts in processed foods)
        - User-friendly food labeling to help customers make healthy choices
    - Differential vulnerability:
        - Provide healthy meals free or subsidized to school children
        - Subsidize fruits and vegetables in worksite canteens and restaurants
        - Facilitate price structure for commodities to promote health (e.g. lower price for low fat milk) vulnerable groups in health
        - Improve early case detection of individuals with diabetes and hypertension by targeting vulnerable groups (e.g. slum dwellers)
        - Improve population access to health promotion by targeting groups in health ed. programs
        - Combine poverty reduction strategies with incentives for utilization of preventive services (e.g. vouchers)
        - Provide social insurance and fee exemptions for basic preventative and curative health interventions
        - Education and employment opportunities for women
    - Differential health care outcomes:
        - Increase awareness among providers of ethical norms and patient rights
        - Provide universal access to a package of essential CVD interventions through primary care approach

- o   Provide incentives with the public and private health systems to increase equity in outcomes
- o   Provide dedicated services to particular groups (e.g. smoking cessation programs for people in deprived neighborhoods
- Differential consequences:
  - o   Policies and environments in worksites to reduce differential consequences
  - o   Increase access of services for people with specific health conditions (e.g. cardiac rehabilitation)
  - o   Improve referral links to social welfare and education services
- Reducing inequities in cardiovascular health is an ethical imperative that can best be achieved through a public health approach. The components of such an approach are:
  - o   A life course approach to prevent CVD risk factors and their social determinants, promoting cardiovascular health by supporting the health of pregnant women, early child development, universal primary education, healthy behaviors, fair employment conditions and social protection for the elderly;
  - o   Improvement of health status of the whole population through health promotion and upstream policies that address the needs of those at high risk with CVD through health care systems that focus on equity through a primary care approach;
  - o   Balanced investment in prevention and curative care;
  - o   Ensuring equity and social justice in the utilization of limited public sector resources through fair financing, good governance, attention to social norms, and policies and actions that enable equitable allocation of resources to prevention and control of CVD;
  - o   Recognition of the participatory role of patients with CVD and the community in general, and their empowerment to participate in health decisions by giving them educational and economic opportunities and removing barriers to healthy choices;
  - o   Intersectoral collaboration and partnerships to address social determinants outside the health sector that drive the CVD epidemic;
  - o   Public sector leadership and commitment of government to place equity and health at the center of all government policies across education, finance, housing, employment, industry, urban planning, and agriculture;
  - o   Regulation of goods and services that have a negative impact on cardiovascular health, and monitoring the social responsibility of pharmaceutical and technology companies in the private sector.

3. **Health and Nutrition of Children**
   Possible interventions related to
   - Socioeconomic context and position:
     - o Laws that regulate availability of breast-milk substitutes, baby bottles, etc.
     - o Legislation for food fortification with micronutrients.
     - o Laws that regulate maternity and paternity leave.
     - o Regulation of health services, e.g. universal care.
     - o Promote human rights, etc.
     - o Equal rights/preferential treatment, e.g. for ethnic minorities, girls.
     - o Universal women's education.

- o Voluntary industry codes of conduct, e.g. for breast-milk substitutes.
- o Redistribute resources, e.g. through tax, minimum wages, welfare systems or direct cash transfers.
- o Redistribute power, e.g. through land reforms, title deeds.
- o Microcredit for women.
- Differential exposure:
  - o Elimination of malaria vectors.
  - o Avail/subsidize means e.g. for indoor pollution control.
  - o Provide sanitation and clean water.
  - o Improved housing to prevent crowding.
  - o Targeting availability of tools and means, e.g. antimalarials, oral rehydration treatment, antibiotics for sepsis/pneumonia.
  - o Standards for improving specific products, e.g. infant foods.
  - o Reversal of the burden of proof, e.g. with respect to foods marketed for children.
- Differential vulnerability:
  - o Budgeting health services and interventions according to burdens of disease.
  - o Threshold coverage of e.g. insecticide-treated mosquito nets, micronutrients, and immunizations.
  - o Social marketing for soap, insecticide-treated mosquito nets.
  - o Dedicated maternal and child health services near to where disadvantaged population groups reside, e.g. outreach facilities, community health workers, nongovernmental organizations.
  - o Provision of referral care facilities.
  - o Availability of contraception.
  - o Work with community and religious leaders etc. to change health-damaging norms and practices particularly in vulnerable population groups.
  - o Infant and young feeding education and promotion.
  - o Promotion of early child development.
  - o Improving care-seeking behaviors.
  - o Counter-advising.
  - o Role modeling, portraying of conducive norms, e.g. on television.
  - o Hygiene education.
  - o Empowerment of e.g. women in families or communities to make better health choices, such as improved diets.
  - o Targeted social and health services based on need.
  - o Interventions that combine economic and behavioral interventions, e.g. making cash transfers conditional on utilization of maternal and child health services.
  - o Improved transportation systems for ensuring access to maternal and child health services.
- The emerging lessons from this review, directed to health sector managers and policy-makers, are summarized below. Innovative approaches are required to ensure that programs effectively promote equity.
  - o Prioritize diseases of the poor.
  - o Consider the pattern of inequity.
  - o Deploy or improve services where the poor live.
  - o Employ appropriate delivery channels.

- o   Reduce financial barriers to health care.
- o   Monitor implementation, coverage, and impact with an equity lens.

4. **Diabetes**
    Interventions
    - o   At the level of society:
        - o Policy –type interventions.
        - o Agreements within and between governments regarding the primary upstream determinants of inequities in diabetes risk and diabetes care.
            - ▪ May take the form of noble targets or more forceful national or international law aimed at limiting the availability of unhealthy food or environments, and increasing the availability of healthy choices.
    - •   At the level of exposure:
        - o   Mostly address the obesogenic environment.
        - o   Changes on a large but manageable scale.
        - o   Measures to address the social norms regarding body size, changing urban infrastructures to promote physical activity, and changing local food environments so that they promote healthy food options.
    - •   To address inequities in vulnerability:
        - o   Include improved access to health care.
        - o   Reduction or removal of patient-borne costs.
        - o   Improve early life experiences for those who are currently disadvantaged.
        - o   Gene profiles to identify those at high risk.
    - •   Health care outcome interventions to improve compliance and adherence are supported by reasonably good evidence could include increased screening of those at high risk, use of folk media to reach the disadvantaged, culturally and linguistically appropriate health education, and improved self-help and follow-up.

5. **Food Safety**
    - •   Contemporary trends have led to the development of a conceptual model for long-term policy-making and food safety risk management consisting of four phases:
        - o   Identification of a food safety issue, gathering scientific information and aggregating it into a risk profile.
        - o   Identification and evaluation of a variety of possible options for managing the risk.
        - o   Implementation by relevant stakeholders of the preferred risk management options.
        - o   Carrying out monitoring and reviewing activities.
    - •   "Risk analysis" has been introduced as a means of improving food safety decision-making, encompassing three interacting activities:
        - o   Quantitative risk assessment, the scientific process that addresses the magnitude of the risk and identifies factors controlling it.
        - o   Risk communication, a social and psychological process that promotes dialogue between the different parties with an interest in managing the risk.
        - o   Risk management, which combines science, politics, economics and other relevant social factors to arrive at a decision regarding what to do about the risk.
    - •   Strengthening food safety systems:

- o Development of food safety goals.
- o Planning and implementation of food control and food inspection activities.
- o Incorporation of the tenet of risk analysis.
- o Development, updating, and effective enforcement of food legislation, regulation, and standards.
- o Building and maintaining food safety from production to consumption.
- o Implementation of good hygiene practices.
- o Provision of adequate infrastructures and use of appropriate technologies in production, processing, manufacturing, retail sale, transportation, and preparation and handling of tools.
- o Response and adaptation to new technologies and to changing consumer needs.
- o Advocacy, information, and education.
- o Monitoring and surveillance.
- o Science-based research and development.
- o Appropriate capacity building.
- Health Communication:
  - o Health communication is a key element in addressing the lack of knowledge on the part of food handlers or consumers and negligence in safe food consumption and handling.
  - o Education of consumers gives them the knowledge to be selective when choosing their food and to refuse food that is of doubtful hygienic quality, encouraging good manufacturing and hygiene practices and playing a role in improving food safety standards.
  - o Empowerment with regard to securing food safety is an important outcome of education.
- Regulation and control of food handling:
  - o Effective control needs to be supported by appropriate inspection services responsible for the enforcement of food safety legislation and for the inspection of premises, processes and foods to prevent unsafe food entering the food chain at any level.
- Trade Regulations:
  - o The resulting policies and standards are indispensable elements of the infrastructure for ensuring the safety of internationally traded food.
  - o As far as possible they should also apply to food for local consumption, thus making it easier for countries to meet standards for export and keep their share of global food markets.

6. **Mental Disorders**
   Interventions targeting:
   - Socioeconomic Context and Position:
     - o Mental health policy, legislation and service infrastructure to coordinate service provision.
     - o Alcohol and drug policies to reduce substance-related disorders.
     - o Economic policies promoting financial security of populations, funding for key services.
     - o Labor policies promotion employment and protection against stress.
     - o Welfare policies protecting the disabled, sick and unemployed.

- o   Education policies that provide basic education and cater to special needs.
- Differential Exposure:
    - o   Providing safe home and community environment for children.
    - o   Prevention of injury, violence, and crime.
    - o   Provision of adequate housing.
    - o   Relocation of people with mental disorders to less adverse neighborhoods.
    - o   Improved antenatal and obstetric care.
    - o   Employment creation and skill development.
- Differential Vulnerability:
    - o   Early childhood development programs targeting impoverished populations, mother-infant interventions, parent training.
    - o   Depression prevention programs.
    - o   Targeted screening programs, e.g. following head injury.
    - o   Provision of adequate nutrition.
    - o   Antidiscrimination programs targeting racism, gender discrimination, stereotyping.
    - o   Access to financial facilities for the poor.
- Differential Mental Health Care Outcomes:
    - o   Provision of affordable treatment.
    - o   Integration of mental health services with routine health care.
    - o   Provision of evidence-based mental health care and rehabilitation.
    - o   Provision of culturally and linguistically acceptable care.
    - o   Improved accessibility to series, e.g. through provision of affordable transport.
    - o   Anti-stigma campaigns.
    - o   Effective services to treat substance abuse.
- Differential Mental Health Consequences:
    - o   Caregiver support.
    - o   Promotion of social networks and skills training.
    - o   Disability allowances and sickness benefits.
    - o   Health promotion to encourage healthier lifestyles.
- Practical steps for the design and implementation of a mental health information system:
    - o   Needs assessment: identifying what information is needed to monitor the interventions that have been selected.
    - o   Situation analysis: identifying what information is already being collected, analyzed and used, and how this may be adapted for use in the planned system.
    - o   Implementation: finalizing the indicators and minimum dataset, mapping the information flow, establishing frequency of data collection, identifying roles and responsibilities, designing and distributing materials, training of staff, addressing practical barriers, building data quality checks, conducting a pilot project and rolling out the system.
    - o   Evaluation: establishing how well the information system is working by developing a framework and criteria for evaluation, determining the frequency of data collection, and collecting baseline and follow-up data.

7.   Neglected Tropical Diseases
- o   Recommended Action:

- o Addressing water, sanitation, and household-related factors (the "preventive package").
- o Reducing environmental risk factors.
- o Improving health of migrating populations.
- o Reducing inequities due to sociocultural factors and genders.
- o Reducing poverty in NTD-endemic populations.
- o Setting up risk assessment and surveillance systems.

8. **Oral Health**

   Interventions targeting:
   - Socioeconomic Context and Position:
     - o Legislate local production of quality, affordable oral health products (e.g. toothpaste, toothbrushes).
     - o Removal of taxes for oral health products.
     - o Placing oral health within the primary care approach.
     - o Fair and equitable policies.
     - o Develop infrastructure for oral health services and population-based interventions.
   - Differential Exposure:
     - o Regulation on tobacco ban, fluoridation, better labeling amount of fat, sugars and salt in foods and drinks, access use of alcohol advertising.
     - o Promote the use of mouth guards and safety helmets.
     - o Encourage interventions that adopt a common risk factor approach (tobacco, diet, alcohol, stress, and personal hygiene).
     - o Support health physical and psychophysical environments: e.g. roads; living environments; schools; workplace; sanitation facilities and safe water supply.
     - o Encourage optimal exposure to fluorides: support implementation of fluoridation programs (water, milk, salt, toothpaste) and, in some areas where necessary, defluoridation programs.
     - o Promote oral health through general health prevention, health promotion, and education.
     - o Promote oral health though "healthy setting" initiatives and encourage them to be a part of a larger network such as health-promoting schools networks.
   - Differential Vulnerability:
     - o Greater availability of sugar-free alternatives and medicine.
     - o Support interventions and make tools available for breaking poverty and social inequities.
     - o Support measures that promote healthy eating and nutrition and reduce amount of sugars, salts, and fats in foods and drinks.
     - o Reorient oral health services, including capacity building and community-based oral health care provision to improve access and availability.
     - o Promote availability of quality affordable oral health products, subsidized oral health products, and health food and drinks.
     - o Regulate sale of harmful or unhealthy products to certain high-risk groups in certain settings.
     - o Promote oral health through chronic disease prevention, health promotion and education.

- o Integrate oral health into community, local, national and international health programs.
- o Work in collaboration across government departments and with local communities, other sectors, agencies, and nongovernmental organization and other organizations to promote oral health.
- Differential Health Care Outcomes
  - o Target resources that support the disadvantaged or high-risk groups such as children, older people, people with HIV/AIDS, and people with oral cancer.
  - o Improve early detection of oral cancer and offer timely treatments and referrals.
  - o Tobacco cessation services in dental practices.
  - o Include oral health training of members of the primary care team.
- Differential Consequences:
  - o Regulate sale of harmful or unhealthy products to certain high-risk groups in certain settings.
  - o Encourage healthy diets and moderate consumption of alcohol.
  - o Outreach oral health care towards vulnerable and poor populations groups.
  - o Third-party payment systems reducing inequity use of oral health service.

9. **Unintended Pregnancy and Pregnancy Outcome**
   Interventions:
   - Macro-level Approaches:
     Policies can improve the accessibility and acceptability of services by protecting reproductive rights and expanding knowledge of sexual and reproductive health. Also, communities can reduce gender inequity by ensuring equal access to educational and financial opportunities for women.
     - o Redistribution of health sector resources.
     - o Community-based insurance.
     - o Ensuring sexual and reproductive rights.
     - o Raising awareness through mass media.
     - o Empowering women and communities.
   - Micro-level Programs:
     Altering provider–client interaction by eliminating provider-imposed barriers, ensuring financial accessibility of products and services, and equalizing the power balance between providers and clients can reduce barriers to services.
     - o Eliminating provider-imposed barriers.
     - o Ensuring financial accessibility.
     - o Accommodating service delivery approaches.

10. **Tobacco Use**
    Structural interventions addressing:
    - Socioeconomic context and position in society:
      - o Reducing availability of tobacco and tobacco products:
        - Price and tax measures to reduce the demand for tobacco.
        - Elimination of illicit trade in tobacco products.
        - Prohibition of sales to minors.
      - o Increasing the acceptability of tobacco control as a global public good.
      - o Enhancing accessibility to tobacco control.

- Differential Exposure:
    - Increasing the availability of environments supportive of tobacco control.
    - Reducing the social acceptability of tobacco use:
        - Banning tobacco advertising, promotion, and sponsorship.
        - Packaging and labeling of tobacco products.
        - Other interventions to reduce the acceptability of tobacco use: promoting tobacco-free role models and counter-marketing.
    - Regulating tobacco product disclosures.
    - Increasing accessibility to cessation support.
- Differential Vulnerability:
    - Increasing availability of information.
    - Reducing the acceptability of tobacco use within populations.
    - Trying tobacco control interventions into community development and empowerment initiatives.

11. Tuberculosis

- Preventing TB through addressing downstream risk factors.
- Addressing upstream social determinants.

12. Violence and Unintentional Injury

For interventions on injury to make a significant difference both to inequities and to the global toll of death and disability they need to act on:

- Upstream measures, addressing transport policies, including those relating to vehicle use and speed; housing policies, with the aim of turning the idea of the home as a safe haven into a reality;
- Alcohol policies, giving due regard to the supply end of the problem as well as problem drinkers.

Putting the emphasis, as is often currently the case, on behavioral interventions directed towards individuals, and, in wealthier nations, secondary and tertiary care of the injured, will further widen inequities.

13. Synergy for Equity - Entry-points and interventions

At the Socioeconomic context and position level*:*

- Define, institutionalize, protect and enforce rights; and empower to exercise:
    - Strengthen goof and responsible national and international governance.
    - Improve legislation, policy and enforcement, including with regard to basic human rights and reproductive rights.
    - Put in place universal education of girls.
- Redistribute and regulate power and resources within and between two countries:
    - Implement progressive taxes with redistribution and tax-financed public services.
    - Carry out cash transfers.
    - Ensure that trade agreements encourage fair and socially responsible trade, and that production and regulatory infrastructures promote public health.
- Capitalize on positive and counteract negative effects of modernization and global integration:
    - Enhance and develop healthy urban planning.

- Create international and national basis for regulation of availability and marketing products.
- Encourage international knowledge sharing, solidarity, and transfer of good practices.

Three actions public health programs could take to effect change:
1. Provide setting-specific, timely and relevant evidence at global, national and subnational levels on the relationship between determinants and outcomes (magnitude and distribution).
2. Undertake, individually and jointly, nationally and internationally, health impact assessments, research and analyses; provide examples of good practices; and review and propose options before and during policy development processes.
3. Support advocacy and action groups to engage in public debate and convince politicians, regulators and legislators, including within the health sector, to address the social determinants of health and incorporate health equity issues into economic and social strategies and plans.

At the differential exposure level:
- Social institutions: norm-setters and keepers:
    o Carry out community education and sensitization programs to address gender norms, alcohol marketing and availability, attitudes towards violence.
    o Implement school attendance and health programs, including physical activity and nutrition.
    o Encourage peer-focused interventions using role models.
- Community infrastructure development (roads, transport, water, sanitation, waste management, electricity):
    o Improve infrastructure design to encourage physical activity, heighten safety and security and serve the needs of vulnerable groups.
    o Improve housing, living and working conditions, water and sanitation, venues for physical activity.
- Availability of products for consumption including diversity, security, safety, and marketing
    o Enforce government regulation, including tobacco advertising, sponsorship and promotion bans, food production, and handling safety standards.
    o Introduce watchdog and voluntary agreements with industry, counter-advertising.
    o Tax unhealthy foods, alcohol and tobacco and provide incentives for healthy food and products availability.

Three Actions Public Health Programs Could Take to Effect Change:
1. Provide a lead role in generating evidence and identifying and advocating appropriate interventions to address social norms.
2. Work with and support civil society groups and public opinion makers to focus debate and action at the three entry-points; influence the health ministry to shift more of its attention to upstream policies and what produces good of ill health in the population.
3. Encourage direct and active participation by individual or collective public health programs in such areas such as community education, regulation, infrastructure planning and design, taxation, and advertising.

At the differential vulnerability level:

- Empower: offer social, structural and economic opportunities, educate:
    - Reduce and deconcentrate poverty and address to access to and control over wealth at the family level in particular for women.
    - Implement home visitation programs for high-risk children and parental training programs.
    - Improve population access, targeting and relevance of promotional and preventive measures, and provide means to empower vulnerable groups to take responsibility and act.
- Compensate, target, subsidize
    - Promote interventions that combine poverty reduction with increased utilization of health and educational services, for example conditional cash transfers, vouchers.
    - Provide free or subsidized healthy food.
    - Provide social insurance so that providers do not suffer losses due to fee exemptions etc.
- Public Health reach-out; use of health services, co-conditions, health product stimulants:
    - Improve individual case detection, targeting vulnerable groups such as slum dwellers, the homeless, migrants, drug abusers, prisoners, and people living with HIV.
    - Increase coverage and integration of services, organize quality services close to an appropriate to disadvantaged population groups and diversify delivery channels.
    - Capitalize on interlinkages with other conditions in addressing common root causes, for example tobacco use, alcohol, indoor air pollution, malnutrition.

    Three Actions Public Health Programs Could Take to Change Effect:
    1. Individually and collectively take the lead to identify vulnerable populations and groups and the specific causes of differential vulnerability; work with other sectors to address the social determinants causing differential vulnerability.
    2. Work with communities to ensure that health delivery systems are in line with cultural and social contexts and to sensitize vulnerable populations to the health benefits of program activities.
    3. Take the lead in working with health service providers and other programs to extend coverage and reduce the barriers preventing vulnerable populations from accessing health services (preventive, curative, and rehabilitative).

At the differential health care outcomes level:
- Medical and administrative procedures (patient adherence):
    - Simplify, package, and standardize procedures.
    - Organize group-based education and support sessions.
    - Provide individual system coaching.
- Provide behaviors and practices (provider compliance):
    - Educate and sensitize providers to comply with ethical norms, non-discriminatory practices, and institutional policies.
    - Make health systems accountable to citizens, communicate and enforce patients' rights, ease compliant procedures, include social determinants in clinical audits.
    - Within the public and private health sector ensure incentives, for example fees, bonuses, compensations, and enhanced career paths, to encourage work with the disadvantages and increase equity in outcome.

- Compensate (target, dedicate):
  - Provide dedicated health services for particular groups, for example migrants and minority populations.

Three Actions Public Health Programs Could Take to Effect Change:
1. Take the lead to identify the sources and causes of differential health care outcomes for treatment and care within health care services.
2. Act in partnership to review and influence priority-setting and service provision, financing and organization within the health care system and revive primary health care.
3. Work with the media, public opinion-makers and action groups to create awareness of and demand for equitable health care.

At the differential consequences level:
1. Coping: compensate and empower (social welfare, rehabilitation, etc.)
   - Improve ability to gain income, for example through vocational training, microcredit, social welfare.
   - Provide psychosocial support, including promotion of social networks for people affected by certain health conditions.
   - Provide social safety net and education and vocational opportunities for affected family members, with particular focus on children.
2. Defining, institutionalizing, and protecting rights
   - Educate the public through campaigns to reduce stigmatization and discrimination.
   - Take regulatory measures to address differential consequences of health conditions, including stigma, discrimination, access and loss of insurance coverage.
3. Social and physical access (transport, institutions, workplaces, etc.)
   - Introduce worker-friendly policies, environments and practices to reduce differential consequences.
   - Increase access and affordability for people with specific health conditions.
   - Improve referral services not just for health care services but also for social welfare, education, etc.

Three Actions Public Health Programs Could Take to Effect Change:
1. Individually and collectively take the lead in analyzing and identifying differential consequences of the public health conditions and resulting needs.
2. Develop or strengthen standard referral and follow-up procedures in health and across social systems.
3. Collectively work with patient groups and other partners, including nongovernmental organizations, the media, industry, and insurance companies, to facilitate appropriate responses.

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71. Social Determinants Approaches to Public Health: From Concept to Practice – the World Health Organization (WHO), 2011

World Health Organization (WHO), TDR, HRP, Alliance for Health Policy and Systems Research

To view this report, please click on the link:
http://whqlibdoc.who.int/publications/2011/9789241564137_eng.pdf

About: The primary objective of undertaking these case studies was to review their processes of implementation and draw lessons that can be learned by others embarking on the difficult path of correcting inequities in health by addressing the social determinants. It was thus not an objective to evaluate the outcomes of these programs.

Synthesis of Findings
Collectively the 13 case studies address four of the five levels of the PPHC [Priority Public Health Conditions] framework, all the five themes, and cover a variety of public health challenges through a range of different interventions:

- **Policy/Legislation:**
    - Intervening to regulate availability and control of services, resources, and commodities such as alcohol and tobacco with an aim of modifying the *context and position* determinants of health.
- **Norm Change:**
    - Addressing *differential exposure* by modifying what the society formally or informally encourages and discourages, for example, in terms of what you can eat, what women can or cannot do, and what young people value and do.
- **Community Empowerment:**
    - Handing over control of institutions and/or public funds in full or in part, for example, from civil service structures to communities, thus involving some transfer of power and control with potential to reduce *differential exposure*.
- **Community Development**:
    - Releasing the potential within communities to make them take things in their own hands and thereby reduce the group or individual *differential vulnerability*.
    - Involved provision of information and training, and in some cases, load opportunities and direct injection of resources.
- **Commodity Access:**
    - Reducing the barriers to access of commodities such as healthy food and insecticide nets (ITNs) and thus aiming to modify the *differential vulnerability*.
    - Reducing Includes making these [ITNs] available at subsidized prices or for free.
- **Service Access:**
    - Barriers to access of selected health-care services for certain population groups in order to reduce their *differentiable vulnerability*.
- **Service Responsiveness:**
    - Modifying the way that pregnancy, delivery, and general PHC services are provided in order to make these better correspond to the needs of and the usability for certain population groups with the aim of reducing the differential in health care outcomes experienced by these groups.

72. Compendium of OECD well-being indicators – OECD Better Life Initiative, 2011

> Organization for Economic Co-operation and Development

To view this report, please click on the link: http://www.oecd.org/dataoecd/4/31/47917288.pdf

About: Macroeconomic statistics do not portray a complete picture of the well-being of populations, and therefore well-being indicators should be used to assess the state of life in developed and selected emerging economies. This Compendium is a contribution to this discussion and a preview to OECD's report "How's Life?", to be released in October 2011, which will look at issues including, inter alia, people's health, their education, the quality of their daily work life, their personal security, and their community's cohesiveness. The Compendium's framework distinguishes between current material conditions and quality of life, on one hand, and the conditions required to sustain them over time, on the other.

Framework: The OECD Better Life Index and Initiative (www.oecd.org/betterlifeinitiative) allows citizens to compare well-being across 34 countries, based on 11 essential dimensions in the areas of material living conditions and quality of life.

1. **Material Living Conditions**: 'Economic well-being' determines a person's consumption possibilities and their command over these resources. While it is affected by GDP it is also a function of one's activities that don't contribute to their personal well-being ("regrettables"). It includes:
    a. Income and wealth.
    b. Jobs and earnings.
    c. Housing.

2. **Quality of life**: A set of non-monetary attributes of individuals that shapes their opportunities and life chances, and is contextually and culturally relative. It Includes:
    a. Health status.
    b. Work and life balance.
    c. Education and skills.
    d. Social connections.
    e. Civil Engagement and Governance.
    f. Environmental Quality.
    g. Personal Security.
    h. Subjective well-being.

3. **Sustainability of Well-Being Over Time**: The ability to sustain the socioeconomic and natural systems where people live and work is dependent upon how a person's activities impacts stocks of different types of capital. These types are:
    a. Natural capital.
    b. Economic capital.
    c. Human capital.
    d. Social capital.

Material Living Conditions

1. Income and Wealth

a. These two measures are essential to the well-being of individuals and populations, improving consumptions patterns immediately and over time. Provides access to other non-economic benefits such as better health status and education, higher life satisfaction and better living arrangements.

b. The two best measureable indicators of income and wealth are: household net adjusted disposable income and net financial wealth.

c. Inequalities in the distribution of household wealth are typically twice as high as income and household income is generally lower for youths and the elderly. Employment is a major determinant of household income.

2. **Jobs and Earnings**

a. Societies with high levels of employment are more economically wealthy, politically stable and healthy. The availability of jobs and earnings increases a person's command over resources, allowing them to fulfill their ambitions and feel useful in society. Unemployment is one of the strongest factors contributing to negative subjective well-being.

b. The two best measureable indicators for jobs and earnings are: 1) the share of the working age population (aged 15-64) currently employed in a paid job; and 2) the number of persons who have been unemployed for one year or more as a share of the labor force.

c. Long-term unemployment is higher for youth, individuals with lower educational attainment, and immigrants. Employment rates are higher for prime age men and much lower for youth, women, and persons nearing retirement age. Persons with more education and a cleaner bill of health have a higher likelihood of participating in the labor market.

3. **Housing**

a. Adequate housing is the foremost human material need. Housing makes up the largest portion of household expenditures and is a determinant of a person's ability to meet his/her needs. Poor housing affects health status, family functioning, and social capital.

b. The two best measurable indicators for housing are: 1) whether or not a person is living in a crowded dwelling; and 2) two facilities for personal hygiene. These facilities are:
   i. Lack of indoor flush toilet.
   ii. Absence of bathroom.

c. People with lower incomes are more likely to have poorer housing conditions and live in a dwelling without a flush toilet. Increased age is correlated with better housing conditions.

Quality of Life

1. **Health Status**

a. A person's health status, along with his or her employment situation, is at the top of what affects his or her living conditions. Health status is a determinant of employment, income, and one's ability to maintain social networks and obtain an education.

b. The two best measurable indicators for health status are: 1) life expectancy; and 2) self-reported satisfaction with health status.

c. Women live longer than men but report less personal satisfaction with their health status. Statistics consistently show that, regardless of a country's economic and political

development, persons with lower income or education have higher morbidity and mortality rates.

    d. Countries where SES factors less in life expectancy tend to be those where individuals live the longest.

2. Work and Life Balance

    a. The way a person allocates his or her time is determined by work commitments. A person who works too little will not be able to obtain a certain standard of living, while overwork can delete from an individual's health and personal relationships.

    b. The three best measurable indicators for work and life balance are: 1) the proportion of employees who work more than 50 paid hours per week; 2) hours devoted to leisure and personal care in a typical day for the population aged 25-64; and 3) the employment rate of mothers with children aged 6-14 years.

    c. Age and gender are key determinants of work and life balance inequalities.

3. Education and skills

    a. Persons with higher education earn higher wages, live longer lives, report better health status (and lower occurrence of chronic diseases and disabilities), and are more politically and communally engaged. Moreover, countries with better education levels experience higher GDP growth, higher tax revenues and lower social expenditures.

    b. The two best measurable indicators for education and skills are: 1) percentage of the adult population holding at least an upper secondary degree; and 2) the capacity of 15 year-old students to understand, use, reflect on, and engage with written texts to achieve their life goals, in order to develop their knowledge and potential.

    c. OECD women are more educated than men, and display higher reading skills but perform lower in math competencies. Immigrant children display lower competencies than native-born children. Cognitive skills are strongly influenced by household background and SES. Societies with higher levels of achievement also display higher levels of educational equity.

4. Social Connections

    a. The frequency of a person's contacts with others (family, friends, colleagues or community) and the quality of their relationships are key determinants of well-being. Social networks provide material and emotional support, improve individuals' health statuses and provide access to jobs and other opportunities.

    b. The two best measurable indicators for social connections are: 1) proportion of people who report socializing with friends and relatives at different frequencies (i.e. once a month, once a week, and every day); and 2) the share of people in OECD and selected non-OECD countries who say that, in times of need, they can count on someone to help.

    c. Men are more likely to have contacts with friends once per weak, whereas women are more likely to have contact with relatives. Persons with higher education and income are more likely to enjoy robust social networks and more frequent contact with social contacts. Age and income especially affect the frequency of social contacts.

5. Civil Engagement and Governance

a. Freedom of political speech and participation are fundamental components of individual well-being. Strong civil engagement creates pressure on stakeholders to develop public policy that provides individual benefits such as public services, the justice system, etc. Community participation also fosters a sense of social belonging and trust.

b. The two best measurable indicators of civil engagement and governance are: 1) the extent of electoral participation in major national elections; and 2) the extent to which formal consultation processes are built-in at key stages of design of regulatory proposals, and whether mechanisms exist for the outcome of that consultation to influence the preparation of draft primary laws and subordinate regulations.

c. Education and income level are strong predictors of political participation. Older persons are more likely to turn out to vote. Furthermore, the open consultation process results in design of policies that benefit all citizens in a given jurisdiction, although some individuals may not be able to ultimately take advantage of these policies.

6. **Environmental Quality**

a. Environmental quality drastically affects health statuses: One fourth of the global burden of diseases is associated with poor environmental conditions. Different individual subjective importance is ascribed to environmental quality in terms of beauty and cleanliness.

b. The three best measurable indicators of environmental quality are: 1) the population-weighted average concentrations of fine particles (PM10) in the air a population breathes; 2) the quality of different environmental media (soil, water, air) and people's access to environmental amenities, as well as people's subjective appreciations of the environment where they live; 3) and, ideally, several measures of air quality grouped together to from a composite air quality index.

c. The risk and severity of adverse consequences due to exposure to air pollutions differs depending on their characteristics (ex: age), preexisting conditions, biological susceptibility and capacity to cope with risks and outcomes. Persons with lower SES are more likely to experience severe effects from PM due to poor access to health care, poorer health in general and an increased likelihood of living in environmentally polluted dwellings.

7. **Personal Security**

a. Personal security is a key component of social and individual well-being. Crime can diminish health outcomes, and damage property, social networks and social functioning.

b. The two best measurable indicators of personal security are: 1) the number of police-recorded intentional homicides reported each year, per 100,000 people; and 2) the percentage of people who declare that they have been victim of an assault crime in the last 12 months.

c. With the exception of intimate killings and sex-related homicide, men are more likely to be victim of violent crime. Socio-economic inequality plays a central roe in the occurrence of criminal victimization (for less extreme forms of crime).

8. **Subjective Well-Being**

a. Notions of "happiness", "utility", or "welfare" are part of conceptions of a good life and how specific sets of life circumstances impact how people feel about their lives. Assessment can focus on which life circumstances and objective conditions are important for subjective well-being.

b. The best measurable indicator for subjective well-being is the Cantril Ladder (Self-Anchoring Striving Scale), which measures overall life satisfaction by asking individuals to rate how they value their life in terms of the best possible life through the worst possible life. However, individuals' responses are affected by personality, mood, cultural norms and relative judgments. Therefore, OECD is working with Eurostat and a number of national statistical agencies and researchers to develop additional guidelines on the collection and the use of measures of subjective well-being.

c. Countries with less equal distribution of life satisfaction tend to have a lower average level of life satisfaction. Life satisfaction is higher among educated individuals and higher-income people. Women tend to be more satisfied than men, and unemployed individuals and persons with health problems report lower life satisfaction.

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73. Urban Health Equity and Response Tool (HEART) – the World Health Organization, 2010

To view this report, please click on the link:
http://jech.bmj.com/content/early/2010/05/27/jech.2009.093914.full.pdf

About: Urban HEART provides an opportunity for policymakers from different sectors, and communities, to cooperate in using evidence to identify and prioritize interventions for tackling health inequities. Importantly, the tool empowers local communities to use evidence and take action on their priorities with the support of the local and national authorities.

Three Main Approaches to Reduce Health Inequities:
1. Targeting disadvantaged population groups or social classes.
2. Narrowing the health gap.
3. Reducing inequities throughout the whole population.

1. Targeting disadvantaged population groups or social classes:
- This approach measures progress in terms of an improvement in health for the targeted groups only, for example people living in poverty.
- Any improvement in health of the targeted population can be considered a success.
- In this approach the policy-makers would focus on improving the health status of the most disadvantaged group (for example the poorest 20%).
- However, this approach may not always lead to a reduction in health inequities.

2. Narrowing the health gap:
- The approach takes as its starting-point the health of disadvantaged groups relative to the rest of the population.
- The focus of this action in this category is to reduce the gap between the worst off in society and the best off – the inequity in health status between the extremes of the social scale.
- The goal of this approach is to close the gap in life expectancy between the richest (best off) and the poorest (worst off) 20%.

3. Reducing inequities throughout the world population:
- This approach recognizes that health status tends to decrease with declining socioeconomic status and is not just an issue of a gap in health between the rich and the poor.

- The whole population is taken into consideration, including the middle-income groups
- The goal is to reduce inequities in health among high-, middle-, and low-income groups by equalizing health opportunities across the socioeconomic spectrum.

Tackling Health Inequities in Urban Areas

Urban Heart: The adoption of Urban HEART by national and local governments, community organization and urbanized or rapidly urbanizing communities is intended to:
- Guide policy-makers and key stakeholders to achieve a better understanding of the social determinants of health and their consequences for people living in a city.
- Stimulate policy-makers, program managers and key stakeholders to make strategic decisions and prioritize specific actions and interventions that are tailored to the needs of vulnerable and disadvantaged groups in cities.
- Assist communities to identify gaps, priorities and required interventions to promote health equity.
- Support program managers in improving intersectoral collaboration and communication strategies relating to the social determinants of health.

Urban HEART is expected to achieve the following:
- Local and national authorities equipped with relevant evidence to inform important decisions related to prioritization and resource allocation.
- Communities mobilized and empowered to promote health equity.
- Multiple sectors engaged in addressing common goals, including the promotion of health equity.
- People living in cities with better health and social status, and reduced inequities in health between population groups.

Core Elements of Urban HEART: A process for complex problems such as reducing health and social inequities: will not be a one-size-fits-all prescription; will involve consideration of existing ongoing interventions; will follow cyclical rather than linear processes; and will be determined by engaging all local stakeholders. However three core elements should form the basis of Urban HEART implementation: (a) sound evidence; (b) intersectoral action for health; and (c) community participation.
- **Sound Evidence:**
    o A key criterion for selecting indicators in Urban HEART is to determine those that are most likely to have impact on health inequities.
        - Important to focus on those indicators that have available data to reflect equity.
        - The quality and reliability of the available data should be determined; data quality and validity should be ascertained throughout the process of Urban HEART, as poor-quality data are not appropriate for decision-making.
        - A decision needs to be made on how to address the indicators for which no data are available:
            - Use of alternative data that are already available.
            - Generation of new data.
        - Key issues to consider while collecting data are:
            - Disaggregation.
            - Validation.
            - Consistency.
            - Representativeness.
            - Confidentiality, data security and data accessibility.

- Adjustment methods.
- **Intersectoral action for health:**
  - Involves building upon constructive relationships with people and agencies from outside the health sector in an effort to influence a broad range of health determinants.
  - These include other sectors in the government, such as education, transport and public works, and community groups and nongovernmental organizations addressing relevant issues.
    - First, the nature of the problem that Urban HEART is trying to address is such that the actions cannot be taken within the health sector alone.
    - Second, sharing of information and data resources across sectors is essential to the successful implementation of Urban HEART.
    - Third, the interventions and actions proposed through the implementation of Urban HEART will require intersectoral action through the close engagement of all relevant sectors.
- **Community Participation**:
  - Community participation should be a process that involves community members in all aspects of the intervention process, including planning, designing, implementing, and sustaining the project.
  - It enables the community to become active participants in decisions concerning their health, and promotes simultaneous use of community resources.
    - First, it is important to recognize that social exclusion is a key determinant of health inequalities.
    - Second, empowering communities to identify priorities using evidence, and then initiating actions to address these priorities ensures sustainability of the broader objective of addressing health inequities in urban areas.

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74. Environmental burden of disease associated with inadequate housing – World Health Organization (WHO), 2011

Edited by: Braubach, M., Jacobs, D.E., Ormandy, D.
World Health Organization – Regional Office for Europe

To view this report, please click on the link:
http://www.euro.who.int/__data/assets/pdf_file/0003/142077/e95004.pdf

About: Housing conditions are a key environmental and social determinant of health, and policy makers can enact multi-sectoral reforms that double as primary disease prevention. This report describes methods by which to estimate the disease burden caused by inadequate housing and selected housing risk factors on population health. The researchers apply the environmental burden of disease (EBD) approach, looking at twelve specific risk factors and the impacts of housing renewal. Finally, they offer a case study of England to underline the economic costs of inadequate housing.

Selection of Risk Factors, Policy Implications and Recommendations

1. **Indoor dampness and mold problems and asthma onset in children**: A significant percentage of childhood asthma in the European regions can be attributed to indoor mold and dampness. Exposure is a problem that originates from issues of building construction, building use and functions, and/or building maintenance.
   a. **Previous Interventions:** Previous interventions show that remediation of indoor mold problems have produced positive results on occupants' respiratory health, decreasing symptoms and the severity of asthma.
   b. **Recommendations:**
      i. Awareness of the deleterious health effects of indoor mold and dampness, as well as implications for structural building integrity, must be raised among designers, building and maintenance professionals, society and urban planning, environmental and health care professionals. Information should also be made available to the general public.
      ii. Health care professionals should be briefed on the links between indoor dampness and mold and respiratory problems, including asthma. These professionals should be encouraged to ask asthma patients about potential exposures and give advice about the necessity of home remediation.
      iii. The development of indoor mold and dampness can be minimized through good design, construction and maintenance of buildings. Housing improvement programs can prevent dampness through adequate insulation, ventilation, and moisture control.
2. **Housing conditions and home injury:** Injuries include burns, poisonings, ingestion of foreign objects, and fire-related injuries (including smoke inhalation), drowning, falls, cuts and collisions with objects. Fatalities from home/leisure injuries kill more people per year in Europe than road fatalities and disproportionally affect children. This report looks at the burden of home injury by focusing on fire and falls. Although this approach makes it difficult to estimate the overall burden of injuries, the exposure data for these two modifiable factors is the more robust.
   a. **Policy Implications:**
      i. Fitment of window guards on second floor and higher windows and widespread installation of smoke detectors would prevent about 7500 deaths per year. Where possible, regulation should enforce these standards.
      ii. Provide fencing for private swimming pools and reduce the excessively hot water temperatures in domestic residences.
3. **Household crowding and tuberculosis**: There are about 9 million new cases of TB each year, making it a major contributor to global morbidity and mortality. This disease especially affects lower-income individuals, who live in conditions that make them more susceptible to inhaling the airborne droplets carrying TB mycobacterium. Previous studies show that as many as three-quarters of TB cases are attributable to household contacts, and therefore crowding (as a cofactor) exacerbates this risk.
   a. **Policy Implications**
      i. Advanced TB control programs can reduce the 'necessary cause' of the illness, which is exposure to an infectious case. Reducing home crowding is therefore an integral part of a larger population health strategy.
      ii. Efforts should focus on populations with both high rates of TB and high rates of household crowding (e.g. persons with a lower SES, migrants). Housing policies should promote sufficient supply of sizeable and affordable homes

        iii. It is important to note that reducing household crowding is a method by which to combat all infectious diseases including, inter alia, meningococcal disease, pneumonia, bronchiolitis, enteric diseases, and infections transmitted through direct skin contact.

        iv. Reducing household crowding also lowers population risk for pandemics (particularly influenza).

4. **Indoor cold and mortality**: In Europe alone, there is an estimated one-quarter of a million excess winter deaths per year. These deaths are attributable to not only outside climate but indoor temperatures and inadequate housing design. Low household income, combined with high fuel prices, can also make it more difficult to heat homes.
   a. **Policy Implications**
      i. Improve domestic insulation.

5. **Traffic noise exposure and ischaemic heart disease**: Biological reaction models relating to noise exposure have shown that general stress raises blood pressure, blood lipids, glucose levels, and blood clotting factors and cardiac output. Researchers find here that risk increases when the average noise levels are greater than 60 dB(A) during the day and greater than 50 dB(A) at night.
   a. **Policy Implications**
      i. Transport policies and regulations:
         - Transit reduction in city and residential centers, around schools and other noise-sensitive areas.
         - Lower speed limits.
         - Promote public transportation.
         - Limit heavy vehicles, e.g. during night-time.
         - Rigorously regulate the noise that can come from motorcycles and cars.
         - Limit the amount of time that cars can stay in the city centers.
         - Traffic zoning.
         - Provide incentives for car producers to manufacture quieter cars.
         - Use economic tools to reduce external costs of noise exposure.
      ii. Introducing technical measures:
         - Use quieter road surfaces.
         - Use less noisy tires.
         - Technically control vehicles.
      iii. Housing modifications:
         - Install noise-insulation for certain housing elements or materials (e.g. windows).
         - Put sound barriers along heavily trafficked areas.
      iv. Long-term land use measures:
         - Plan to move traffic away from noise-sensitive areas.

6. **Indoor radon and lung cancer**: Radon, a noble gas product of decaying Uranium, can be found in soils and rocks, but can also exist in unhealthy quantities in indoor spaces due to underlying geological formations, building structure, and ventilation etcetera. Research studies show that lung cancer is strongly associated with radon exposure.
   a. **Policy Implications**
      i. Enact comprehensive radon programs, which would:
         - Promote prevention (in new homes) and mitigation (in existing homes)
         - Provide guidance on surveying
         - Provide guidance on measures

- Provide guidance on radon risk communication and evaluation.
  - ii. Expand existing local, national and European radon projects to better protect population health.
7. **Residential second-hand smoke exposure and lower respiratory infections, asthma, heart disease and lung cancer**: Tobacco smoke contains 4000 chemical compounds, including 50 carcinogens and dozens of irritant and toxic substances. Second-hand smoke (SHS) is a combination of sidestream smoke, which is released into the environment from the burning end of a cigarette, and exhaled mainstream smoke. The presence of cotinine, a metabolite of nicotine, has been found in the body fluids of non-smokers exposed to SHS and is associated with elevated risk for and rates of respiratory and cardiovascular diseases, contributing to 65,000 annual deaths in Europe.
   - a. **Policy Implications**
     - i. Tobacco-free workplace legislation has been shown to reduce SHS exposure efficiency at work, and possibly in the home as well.
     - ii. Home SHS exposure can be reduced through
       - General tobacco control laws
       - Awareness education on the health risks related to SHS exposure, especially for children.
     - iii. Housing policies
       - Set apartment buildings/housing maintenance charges higher for smokers.
       - Landlord's renting houses or apartments should include a no-smoking inside element to their signed agreements.
       - Design buildings so that smokers have easy access to the outdoors and don't have to smoke near intake vents (e.g. provide a balcony for each floor).
       - Indoor smokers could have to pay extra taxes or higher insurance premiums due to increase fire risk.
       - Reduce general home overcrowding conditions (particularly among lower-income persons) through improved housing standards.
8. **Health effects of lead in housing**: Numerous studies have shown that even "low" levels of lead exposure can have measurable deleterious effects for human health, including but not limited to neurological, cognitive, behavioral, cardiovascular, and developmental (children) functions. Lead has also been classified as a human carcinogen by both the U.S. Environmental Protection Agency (EPA) and the International Agency for Research on Cancer, and in 2000 the WHO showed that 0.9% of the global disease burden is attributable to the mild mental retardation and cardiovascular effects of lead exposure. Housing exposures through the ingestion of lead in paints, dust and soil may actually result in higher exposure in general.
   - a. **Policy Implications:**
     - i. Clean, cover and/or remove lead painted or other contaminated surfaces in housing to reduce exposure to lead-based paints, dust, and soil.
       - These efforts should be integrated into existing housing finance, maintenance, rehabilitation, and property turn-over and construction systems.
     - ii. Nations should continue to study which housing poses the greatest risk to children.
     - iii. As the American Public Health Association has already recommended, primary prevention efforts should include eliminating all non-essential uses of lead.
9. **Household carbon monoxide poisoning:** Elevated carbon monoxide (CO) levels can occur in homes due to inappropriate or faulty heating, cooking, or other combustion appliances, or due to exhaust

from attached garages. If inhaled, exposure can lead to CO poisoning, resulting in tissue hypoxia and toxicity, and, at times, death. Gas heating and cooking in particular, especially in inadequate housing conditions (e.g. space), makes CO a potential household hazard.

    a. **Policy Implications and Prevention Measures:**
        i. Prevention measures at policy level
- Laws and economic incentives favoring the placement and maintenance of CO detectors in residential units
- Periodic testing and maintenance of combustion-powered heating systems and home appliances which can emit CO

        ii. Prevention measures at household level
- Qualified technicians should service the heating system, water heater, and other gas, oil or coal burning appliance annually
- CO detectors should be placed in homes (check battery twice per year), and, if the alarm goes off, all residents should leave immediately
- Upon suspicion of CO poisoning, seek care immediately
- Never use a generator, charcoal grill, camp stove, or other gasoline or charcoal-burning device inside the home, basement, garage or near a window
- Never run a car or truck inside a garage attached to a home
- Never burn anything on a non-vented stove or fireplace
- Never heat your house with a gas oven.

10. **Formaldehyde and respiratory symptoms in children:** Indoor exposure to formaldehyde has been associated with acute respiratory symptoms in infants and young children. Researchers find here that it may account for between 0.30% and 0.62% of wheezing in children.

    a. **Policy Implications:**
        i. Precautions should be taken to limit exposure to formaldehyde in children, especially asthmatics.
        ii. More research must be done to assess concentrations of formaldehyde in homes, and the association between exposure and risk for lower respiratory symptoms in children.

11. **Indoor smoke from solid fuel use:** Burning solid fuels (biomass like wood and charcoal) indoors for cooking or heating purposes, especially on open sources with poor ventilation, can generate high concentrations of air pollutants. Globally, this indoor smoke exposure kills 1.5 million individuals each year, and can result in health problems such as pneumonia in children, lung cancer and chronic obstructive pulmonary disease (in adults). The use of biomass for cooking and heating is higher in rural and poor urban areas, especially in low- to middle-income countries.

    a. **Policy Implications:**
        i. Use of "cleaner" liquid or gaseous fuels such as kerosene, or biogas
        ii. Introduction of cleaner cooking stoves or good ventilation (e.g. flues with chimneys or hoods)
        iii. Efforts to encourage behavioral changes (e.g. encouraging mothers to keep their children way from the fire) should accompany interventions.
        iv. Strategies must account for the place of traditional cooking practices in local cultures
        v. Strategies must take into account various other factors which lead to the use of solid fuels for cooking and heating purposes, including local circumstances of:
- Income

- Housing
- Availability of and access to different fuel types
- Climate

12. **Housing quality and mental health:** Poor housing, which produces hazards, increased maintenance necessities, and financial worries, and can disrupt a family's cohesiveness and individual enjoyment of leisure, weighs heavily on levels of stress and mental health. Chronic stress is associated with anxiety, depression and hostility and frustration. Moreover, the stigmatization of inadequate housing can isolate individuals or foster feelings of inadequacy. Researchers find that inadequate housing often comes with poverty and the physical (pollutions, toxins) and social (family instability, violence) risk factors arising from poverty.

    a. **Policy Implications:**
        i. Housing policy needs to expand the definition of health outcomes to include mental health.
            - Measures of housing quality should consider mental health.

General Housing Interventions to Improve Health

1. **Warmth and Energy Efficiency Improvements**
    a. Insulation (cavity wall, loft insulation, hot water tank)
    b. Installation/repair/upgrading of heating system
    c. Installation of double glazing
    d. General repair needs, including energy efficiency appliances, security measures, safety equipment (e.g. smoke alarms)
2. **Housing-led neighborhood renewal**
    a. Rehouse or partially/totally retrofit homes (e.g. kitchen, bathroom) while conducting a policy of wide neighborhood improvement. This should be accompanied by cross-sectoral socio-economic initiatives in the areas of employment, health promotion, and benefit uptake. Rehousing and retrofitting should be complemented by the warmth and energy efficiency improvements listed above.
3. **Reduce exposure to specific indoor hazards**
    a. Reduce risks of house dust mites.
    b. Prevent unintentional injuries, fires, and falls through the installation of safety equipment, and smoke alarms, as well as education, promotion campaigns, and balancing training for 'at-risk' senior-citizens.
    c. Reduce lead exposure through removal and public awareness campaigns.
    d. Reduce unnecessary noise exposure.

Recommendations for Policymakers and regulators

1. Set quantitative and specific standards referring to the characteristics of housing features that should and should not be present.
2. Set qualitative standards stating what should be taken into consideration when designing or assessing housing features to mitigate health threats.
3. Current building codes and regulations should be reviewed critically and regularly, taking into account modern construction techniques, the use of the buildings, and available health evidence.

75. **Health Inequalities– A Challenge for Local Authorities – Marmot Review Fair Society, Healthy Lives, 2011**

To view this report, please click on the link:
http://www.thehealthwell.info/search-results/health-inequalities-challenge-local-authorities

To view the Coalition Government's proposals, please click on the link:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

About: This press release outlines the challenges facing local authorities across England in reducing health inequities. In response to the Coalition Government's proposals about local authorities and public health responsibilities, the Marmot Review team commissioned the London Health Observatory to provide charts showing key indicators for monitoring health inequalities and the social determinants of health for all 'upper tier' local authorities in England.

Main Policy Recommendation from *Fair Society, Healthy Lives:*
1. Giving every child the best start in life (highest priority recommendation)
   - Review proposes a rebalancing of public spending towards the early years, more parenting support programs, a well-trained early years work force, and high quality early years care.
2. Enabling all children, young people, and adults to maximize their capabilities and have control over their lives.
   - Evidence suggests that families rather than schools have the most influence on educational attainment, and therefore building closer links between schools, the family, and the local community are important to reducing educational inequalities.
3. Creating fair employment and good work for all
   - Employment is protective of health; conversely unemployment contributes to poor health.
   - Jobs need to offer:
     - A decent living wage
     - Opportunities for in-work development
     - Good management practices
     - The flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health.
4. Ensuring healthy standards of living for all
   - Having insufficient money to lead a healthy life is a highly significant cause of inequalities.
   - Standards for a minimum income for healthy living (MIHL) need to be developed and implemented.
5. Creating and developing sustainable places and communities
   - Many policies—such as creating more opportunities for walking, cycling, and green spaces—which would help mitigate climate change would also help reduce health inequalities.
   - The review proposes common policies to reduce the scale and impact of climate change and health inequalities. Good quality neighborhoods can make a significant difference in achieving better health and higher quality of life.
6. Strengthening the role and impact of ill-health prevention

- Many of the key health behaviors important for the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition and drug misuse.
- The Review argues for more funding to prevent ill health and action to treat drug misuse as a medical problem.

76. Improving Urban Health Equity through Action on the Social and Environmental Determinants of Health – Global Research Network on Urban Health Equity (GRNUHE), 2010

Global Research Network on Urban Health Equity (GRNUHE), University College London, The Rockefeller Foundation

To view this report, please click on the link:
http://www.ucl.ac.uk/gheg/GRNUHE/GRNUHEPublication/grnuhefinal

About: Urban development that places health equity as a central policy will improve health, reduce social inequity and support communities to cope with, and avert further, global environmental change.

Section 1: Urbanization and global health inequities. Section 1 of the report provides an overview of the nature of 21st century urbanization globally. It describes how urbanization sits within the context of globalization and how the combination of these two large global processes has contributed to urban health inequities, particularly in LMICs.

Section 2: The Determinants of Urban Health Inequity. Section 2 demonstrates the plausible causal relationship between the four themes of GRNUHE (urban planning and design, social environment, climate change, and urban governance) and urban health inequities. In Section 2 and again in the final section of the report we identify data issues relevant to the social and environmental determinants of urban health inequities.

Section 3: Urbanization for Health Equity in the 21st century. Section 3 of this report argues that urbanization can, and must, take place in such a way that improves human health and reduces health inequities. It lays out what GRNUHE considers to be essential component parts of urban management, if it were to be based on principles of health, equity, and environmental sustainability. It offers suggestions for actions that can be taken to reduce urban health inequities through policy and programs aimed at improving the social and environmental determinants described in section 2. Central to action in these areas is monitoring of urban health inequities and evaluation of action.

Action to Reduce Urban Health Inequities:
The health and social inequities described in this report need not exist. Over the past 25 years, two complementary urban concepts – Healthy Cities and Sustainable Cities – have emerged, showing us what a healthier, more equitable and more sustainable city would look like. Over the same period, the world-wide movements for Healthy Cities and for Sustainable (or Green) Cities have stimulated a great deal of innovation and learning. The global Commission on Social Determinants of Health highlights the

necessity of tackling the structural drivers and daily living conditions that affect health inequities and re-states the important role of cities in that.

Urban Planning for Health Equity
- **Reconnecting Urban Planning and Public Health**
  Key Health Objectives for Urban Planners
  Urban planning policies and proposals should encourage and promote the following:
    1. Healthy exercise
    2. Social cohesion
    3. Housing quality
    4. Access to employment opportunities
    5. Accessibility to social and market facilities
    6. Local low-impact food production and distribution
    7. Community and road safety
    8. Equity and the reduction of poverty
    9. Good air quality and protection from excessive noise
    10. Good water and sanitation quality
    11. Conservation and decontamination of land
    12. Climate stability
- **Integrated City-Wide Planning**
    o Urban planning and design can potentially assist in simultaneously reducing poverty, encouraging physical activity and social cohesion, and reducing health inequity.
    o It can achieve this by creating **more compact and integrated cities in which all residents have more equitable access to the benefits of urban life** – such as livelihood opportunities, physical infrastructure and education – **through walking/cycling or through affordable and effective public transportation.**
    o There is a notion of **"spatial justice"** as pioneered by cities such as Curitiba in Brazil and Bogota in Colombia.
    o A key issue in achieving spatial justice is to **focus on improving the quality of life for all.**
    o There is a need to "Promote opportunities for disadvantaged residents, and seek to reduce economic disparities by incorporating socially just solutions to regional problems…planning strategically for strong economic growth, a diversifying employment base, efficient and accessible intra-regional transportation, and a healthy environment for generations to come."

Improving Social Conditions to Improve Urban Health Inequity
- **Improved working conditions and community empowerment**
    o Together with other actions to improve access to resources (e.g. education, healthcare, technology, and credit), the development of women's entrepreneurship through micro, small and medium enterprises has the potential to empower women, transform society, and hence contribute to the reduction in health inequities.
    o Strengthening social capital among and across groups for the positive social transformation of societies and promotion of health can take place in several different ways and settings.
    o Community gardens are known to promote well-being and social capital. The community garden movement has grown in recent decades primarily established as local solutions to food security issues.

- ▪ The Garden Mosaic Initiative (USA) highlights how community initiatives can provide work opportunities, be educational, increase civic engagement, and help build intergenerational trust – each of which is vitally important for health.
- ▪ **Making Cities Safer through Urban Planning and Design**
    - o Creating a safe urban environment is vital for health and health equity, and has three broad aspects:
        - ▪ Creating an environment where unintentional injuries in public spaces and homes are prevented;
        - ▪ Creating an environment where harmonious social conditions result in low levels of crime and violence, and where the planning and design of the built environment makes it easier to avoid crime and violence; and
        - ▪ Creating urban environments that are able to better cope with natural hazards.

Promoting Urban Health Equity Though Action on Climate Change
- • **Urban planning, transport systems, physical activity and climate change mitigation.**
    - o Urban planning that prioritizes humans over vehicles will not only help to reduce GHG [greenhouse gases] emissions through a reduction in fossil fuel use, but will promote better and more equitable health outcomes.
    - o Designing cities to be easily walkable and safe, and with adequate provision of cycle lanes and public transport corridors and hubs, in all parts of the city, will help improve health equity and reduce GHG emissions.
- • **Improving the Built Environment to Improve Health Equity and Help Cities Adapt to and Mitigate Future Climate Change**
    - o Urban health environments amplify climate change related health risks due to the urban heat island (UHI) effect.
    - o The UHI effect represents higher average temperatures arising due to the lack of shade and vegetation as well as dark road and building surfaces in urban settings.
    - o Urban slum dwellers, people of lower socioeconomic status, and minority ethnic and racial groups are more likely to live in warmer neighborhoods and in buildings that are poorly ventilated and absorb heat. Such social groups are the ones least likely to have sufficient resources to cope appropriately with the temperature extremes and are therefore at increased health risk.
    - o **Improved design of housing can reduce dependence on electricity through appropriate ventilation.**
    - o Air conditioning as a means of cooling living spaces creates a major energy demand with associated GHG emissions. Retrofitting of existing homes, if well done, can improve health and respiratory illness, lower the number of extreme temperature related deaths, and help reduce GHG emissions.

Urban Health Equity through Integrated Action on Planning and Design, Social Conditions, and Climate Change
- ▪ **Urban design, social connection and climate change**
    - o Ensuring parks, green spaces and road side trees as part of the basic urban infrastructure will help regulate city temperatures thus helping to cope with extreme health as a result of climate change and act as carbon sinks.

- o Ensuring such areas are safe and clean will also encourage people to walk more, thereby helping to reduce the risk of obesity, traffic-related injuries, air pollution, and respiratory diseases**.**
- o Such urban design also encourages people to be more socially connected, thus helping to reduce the risk of poor mental health.
- o Green space may help to reduce health inequities.
- o Adapting cities to extreme temperatures from climate change through the design of pedestrian sidewalks to include roofs and shady trees also encourages walking instead of driving, with health consequences similar to those listed above.
- ▪ **Improved urban working environments, better adaptation to climate change and better health**
  - o A number of actions may be taken to mitigate the effects of heat and to mitigate further climate change:
    - ▪ This includes improving the design of the workplace using engineering techniques to improve ventilated indoor working areas.
    - ▪ Redesigning workplaces using special materials for walls and roofs in order to isolate the outdoor climate effect and reduce the use of air conditioning.
    - ▪ Promoting the use of clean technologies for health reduction and providing shaded areas for outdoor workplaces.
  - o Other activities are recommended, such as:
    - ▪ Increasing workers' tolerance to heat by incorporating them gradually into heated activities.
    - ▪ Modification of working schedules which favors the performance of certain heat producing activities during cooler times of the day.
    - ▪ Modification of shift-work (shortening) of specific physically demanding activities.
    - ▪ Providing adequate recesses with the daily working hours (length and frequency).
    - ▪ Ensuring fluid and electrolytes reposition of workers.
    - ▪ The use of personal protective clothing.
- ▪ **Improving urban health equity through climate proofing the urban food supply system**
  - o Urban food is dependent upon climate security and requires immediate implementation of climate change mitigation policies.
  - o The bulk of emissions from agriculture are due to livestock production – a key climate change mitigation strategy would sensibly focus in this area. Given that much of the demand for meat and dairy products is being driven by the urban middle classes in emerging economies such as China and India, policies are needed to reduce consumption of these foods among those populations.

Urban Governance for Health Equity
- ▪ **Key elements of urban governance for health equity**
  - o Effective urban planning and design processes need to be underpinned by effective and participatory urban governance systems.
  - o Upgrade slums and ensure adequate housing for all residents.
  - o Ensure equitable distribution of social resource, ensuring social justice, and reinventing the city as an inclusive city.
  - o Similarly, good urban government has become central to sustainable human settlement.
  - o The participatory processes described throughout the report are entirely applicable to the pursuit of environmental sustainability and city level climate change mitigation and adaptation.

- **Intersectoral action and sectoral coherence**
  - Pursuit of urban health equity requires a form of joined-up governance that brings together the health sector and actors in other sectors of municipal, regional, and national government, that engages with private for-profit and private non-profit groups, and, vitally, that engages and empowers the citizenry, especially the most disadvantaged and least powerful people and communities.
  - Intersectoral action for health – coordinated policy and action among health and non-health sectors – can be a key strategy to achieve this.
  - An essential element of healthy urban governance is policy and sectoral coherence, where each sector pays attention to the health and health equity implications of its own activities.
  - Coherence across sectors is important in order to avoid contradictory policy and practice, and inefficient attainment of sectoral goals and ultimately urban health equity.
- **Water and sanitation: an analytical lens to examine governance and health equity**
  - Unequal access to water and sanitation has historically been a leading cause of urban health inequalities.
  - Governments should be responsive to the needs of their less well off citizens and overcome many of the barriers to improving their urban water and sanitation.

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77. **Adelaide Statement of Health in All Policies:** *moving towards a shared governance for health and well-being* **– Adelaide, 2010**

Adelaide, World Health Organization (WHO), Government of South Australia

To view this report, please click on the link:
http://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf

About: The Adelaide Statement on Health in All Policies aims to engage leaders and policy-makers at all levels of government - local, regional, national, and international. It emphasizes that government objectives are best achieved when all sectors include health and well-being as a key component of policy development. This is because the causes of health and well-being lie outside the health sector and are socially and economically formed. Although many sectors already contribute to better health, significant gaps exist.

Health in All Policies approach:
- A clear mandate makes joined-up government an imperative.
- Systematic processes take account of interactions across sectors.
- Mediation occurs across interests.
- Accountability, transparency and participatory processes are present.
- Engagement occurs with stakeholders outside the government.
- Practical cross-sector initiatives build partnerships and trust.

Tools and Instruments that have shown to be useful at different stages of the policy cycle include:
- Inter-ministerial and inter-departmental committees.
- Cross-sector action teams.
- Integrated budgets and accounting.

- Cross-cutting information and evaluation systems.
- Joined-up workforce development.
- Community consultations and citizens' juries.
- Partnership platforms.
- Health Lens Analysis.
- Impact assessments.
- Legislative framework.

Drivers for achieving Health in All Policies:
- Creating strong alliances and partnerships that recognize mutual interests, and share targets.
- Building a whole of government commitment by engaging the head of government, cabinet and/or parliament, as well as the administrative leadership.
- Developing strong high-level policy processes.
- Embedding responsibilities into governments' overall strategies, goals, and targets;
- Ensuring joint decision-making and accountability for outcomes.
- Enabling openness and full consultative approaches to encourage stakeholder endorsement and advocacy.
- Encouraging experimentation and innovation to find new models that integrate social, economic, and environmental goals.
- Pooling intellectual resources, integrating research, and sharing wisdom in the field.
- Providing feedback mechanisms so that progress is evaluated and monitored at the highest field.

New Role for the Health Sector:
New responsibilities of health departments in support of a Health in All Policies Approach will need to include:
- Understanding the political agendas and administrative imperatives of other sectors.
- Building the knowledge and evidence base of policy options and strategies.
- Assessing comparative health consequences of options within the policy development process;
- Creating regular platforms for dialogue and problem solving with other sectors.
- Evaluating the effectiveness of intersectoral work and integrated policy-making.
- Building capacity through better mechanisms, resources, agency support and skilled and dedicated staff.
- Working with other arms of government to achieve their goals and in so doing advance health and well-being.

78. Health Systems Financing: The Path to Universal Coverage – the World Health Organization (WHO), 2010

To view this report, please click on the link:
http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf

About: In this report, the World Health Organization maps out what countries can do to modify their financing systems so they can move more quickly towards this goal - universal coverage - and sustain the gains that have been achieved. The report builds on new research and lessons learnt from country

experience. It provides an action agenda for countries at all stages of development and proposes ways that the international community can better support efforts in low-income countries to achieve universal coverage and improve health outcomes.

An Agenda for Action

- Pay for Health in ways that do not deter access to services
    - There is too much reliance on direct payments as a source of domestic revenue for health.
        - Ensure the bulk of domestic funding for health is derived from a form of prepayment that is then pooled to spread financial risks across the population.
    - There is strong evidence that raising funds though compulsory prepayment provides the most efficient and equitable path towards universal coverage.
        - Countries that rely heavily on employer and/or employee contributions from payroll taxes for prepaid revenue will need to consider diversifying their sources of funding as populations age.
    - Almost every country has the capacity to raise additional funding for health, either by giving health a higher priority in government spending or by raising additional revenues from underexploited levies (e.g. on harmful products like tobacco or alcohol).
    - Contributions to the health system must be perceived as affordable and fair if the system is to be sustainable.
        - One contributory scheme is a progressive tax system overall.
    - Universality can be achieved only when governments cover the health costs of people who cannot afford to contribute.
    - Eliminating direct payments will not necessarily guarantee financial access to health services.
        - Conditional cash transfers have been used by the health sector in some countries to extend coverage, especially for prevention measures, while unconditional cash transfers are used to reduce income inequalities and allow people to buy goods and services.
    - Difficult choices cannot be avoided on the road to universal coverage.
    - Ultimately, however, universal coverage requires a commitment to cover 100% of the population.
- Consolidate funding pools and adopt compulsory prepayment
    - It is impossible to achieve universal coverage through insurance schemes when enrollment is voluntary.
    - Small pools are not financially viable in the long run.
        - Small pools can be useful where it is difficult to raise funds, to encourage a sense of solidarity, and for offering a degree of financial-risk protection.
    - Multiple pools serving different population groups are inefficient because they duplicate efforts and increase administrative and information system costs. They also make it more difficult to attain equity and risk protection. Financial risk protection is enhanced when all persons pool risks and costs. To attain equity and financial protection through multiple pools requires considerable administrative capacity, and pooling across pools.
- Use resources more efficiently and equitably.
    - All countries can improve efficiency, sometimes by a great deal, thereby freeing resources to ensure more rapid progress towards universal coverage.
        - An example of this is focusing on medicines, e.g. improving prescribing guidance or ensuring transparency in buying and tendering.

- o Fragmentation leads to problems in pooling resources and inefficiencies in purchasing and service delivery.
- o Active or strategic purchasing of and contracting for health services helps countries move faster towards universal coverage but should not be undertaken lightly.
  - ▪ Allocate resources based on value for money, performance and information on population needs.
- o Incentives to provide efficient, equitable and quality services are essential whether services providers are publicly or privately owned.
- o Fee-for-service payment generally encourages overprovision for people who can pay (or who are covered by insurance) and under provision for those who cannot.
  - ▪ Many countries are experimenting with a mix of payment and administrative procedures to exploit strengths and mitigate weaknesses.
- o Preventive and promotional interventions can be cost effective and reduce the need for subsequent treatment.
  - ▪ It is sometimes necessary, however, for governments to fund population-based prevention and promotion activities separately from the financing system for personal services linked largely to treatment and rehabilitation.
- o Effective governance is key to improving efficiency and equity.
- o Health financing strategy needs to be home-grown – pushing in the direction of universal coverage out of the existing terrain.

Supporting Change
- ▪ Action 1: Establishing a vision
  - o The commitment to universal coverage recognizes the objectives of reducing financial barriers to access and increasing and maintaining financial risk protection. It recognizes, however, that there will be trade-offs along the way in the proportion of the population, services and costs that can be covered for any given level of resources
- ▪ Action 2: Situation analysis – understanding the starting point
  - o The situation analysis should focus on the two components of universal coverage from a financing perspective: access to needed services and financial risk protection. In planning for the future, the situation analysis needs to consider factors inside and outside of the health system that may affect progress on the path to universal coverage.
- ▪ Action 3: Financial assessment
  - o The current and likely future availability of funds for health from government, households, the private sector, nongovernmental organizations and external partners needs to be assessed to create a comprehensive funding framework for the health system.
  - o On a country-by-country basis, involve international financial institutions and external partners in resource assessment discussions.
  - o Policy-makers will also want to establish whether government spending will be restricted and how spending limits might be increased.
  - o Complementary roles for different sources of funds to the health system should be considered.
  - o At a minimum, countries should consider whether health is receiving its rightful share of government spending and look at possibilities for raising taxes on tobacco, alcohol, and other products harmful to health.
  - o Being able to speak the language of economists will also enhance the ability to argue for additional funding. Critical to this effort is a health ministry's capacity to draw on health

policy analysis skills to produce the necessary documentation and engage in dialogue with the finance and planning ministries.

- Action 4: Constraint assessment
  - An assessment of potential constraints allows decision-makers to identify policy areas that require widespread consultation. Such an assessment would culminate in the political decision to move forward.
- Action 5: Develop and formalize strategies and targets for change
  - Based on the situation analysis and an accurate assessment of the likely funding scenarios, detailed technical work on strategy can begin, focusing on the three key health financing phases: raising funds; pooling them; and using them to ensure that services are available.
- Action 6: Implementation, including assessing organizational structures and rules
  - This step will vary on a country-by-country basis, depending upon current institutions and organizations, as well as current health insurances schemes and funding.
  - Legislation can certainly help the development of health financing systems for universal coverage and it can also help protect an individual's right to receive health care.
  - Build technical and organizational capacity by drawing upon the expertise of accountants, actuaries, auditors, economists and lawyers. It may be necessary to reassess educational/training priorities to develop the requisite skills and to develop strategies to attract and train skilled professionals from outside the country.
  - Financing plans must also enhance the quality and quantity of service delivery, and ensure appropriate medicines and technologies are available. Conversely, decision makers need to be mindful of the implications for financing when reforming other areas of the health system.
- Action 7: Monitor and evaluate
  - Financing systems do not necessarily respond to changes as planned. It is important, therefore, to be prepared for the unexpected and be able to make rapid adjustments.
  - Monitoring needs to focus on whether people have access to needed health services and risk financial hardship in paying for them.
  - Identifying who is truly covered by publicly funded services can be difficult, even with reliable data from well-designed household surveys.
  - Obtain regular flows of data, which will depend upon:
    - A functioning health information system that provides information on coverage of those in need, ideally broken down by age, sex, socioeconomic status, and other indicators of vulnerability or deprivation. This requires that those responsible for managing health system administrative data have good links with national statistical agencies.
    - A system for monitoring financial flows. National health accounts provide crucial information, as do intermittent household surveys, for measuring out-of-pocket spending and financial risk protection.
  - Policy-makers should strive to create a unified financial reporting system that is not broken down by program, administrative decentralization, or the insurance status of the population.
  - It is also vital to gather information from all the actors in a health system, private and public.

An Agenda for the International Community
- Maintain levels of assistance or increase them to the required level.
- Ensure that aid is more predictable.

- Innovate to supplement health spending for poor populations.
- Support countries in their health plans rather than impose external priorities.
- Channel funds through the institutions and mechanisms crucial to universal coverage.
- Support local attempts to use resources more efficiently.
- Set an example in efficiency by reducing duplication and fragmentation in international aid efforts.

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79. How Doctors Can Close the Gap: Tackling the social determinants of health through culture change, advocacy, and education – Royal College of Physicians, 2010

Royal College of Physicians, Royal College of General Practitioners, Royal College of Psychiatrists, National Heart Forum, NHS Sustainable Development Unit, Faculty of Public Health

To view this report, please click on the link:
http://www.marmotreview.org/AssetLibrary/resources/new%20external%20reports/RCP-report-how-doctors-can-close-the-gap.pdf

About: This statement contains recommendations that cover the need for change in doctors' attitudes towards the social determinants of health, a change in healthcare and social systems, and a change in the education of doctors.

Changing Perspectives
To effectively tackle the social determinants of health, a holistic approach is required, with doctors not only taking a lead in promoting and protecting health, and preventing ill health, but also working collaboratively across all sectors to develop systems to reduce health inequalities.

Recommendations:
- All doctors should consider the impact on health inequalities of their day-to-day practice.
- Senior medical figures and medical educators should legitimize, encourage, and harness the power of student advocacy and action on the social determinants of health.
- Information-sharing on best practices in the NHS and beyond concerning the social determinants of health should be encouraged and centralized.
- Medical professionals should highlight and advocate policies and programs that both have benefits for the physical and mental health of socially disadvantaged groups and result in reductions in greenhouse gas emissions.
- All medical professionals should be educated and informed about the implications of their healthcare decisions on greenhouse gas emissions.
- Clinical doctors and public health specialist teams should work together more closely in shaping services and developing programs to promote and protect people's health, prevent ill health, and tackle health inequalities.

Changing Systems
A key challenge in addressing health inequalities is that the most disadvantaged and marginalized are often the last in society to seek medical help.

Recommendations:

- Doctors need to work innovatively and collaboratively to develop systems to reduce health inequalities and must be given adequate resources, including finances, information, and time, to do this.
- There should be adequate medical input into decisions taken within non-health sectors to ensure that the initiatives do not exacerbate health inequalities and simultaneously maximize potential health gains.
- Healthcare services should be better integrated into the community to reach out to disadvantaged and marginalized groups in society and reduce the many barriers impeding access to advice, prevention, diagnosis and treatment.
- In the course of all doctor-patient consultations there needs to be more scope to discuss the root causes of ill health and signpost patients towards appropriate support and services, inside and outside of the health sector.
- All providers of healthcare should be encouraged and given incentives to implement sustainable care pathways and working environments.

Changing Education

We must give medical students and trainees the encouragement and support to act on social determinants of health and to promote health throughout the population, rather than exclusively concentrate on treating individual patients.

Recommendations:

- Learning about health promotion, health inequalities, disease prevention, and the social determinants of health should be made more engaging. This learning should be embedded as a vertical strand throughout medical education and ought to be considered a key outcome of the process.
- Experimental and research-based student selected components in the social determinants of health should be offered at every medical school.
- Dynamic trainers and teachers should be fostered, encouraged, and trained to devise and implement innovative programs in the social determinants of health.
- The training of all foundation year 2 doctors should contain an element of primary care or public health.
- The structure of postgraduate medical training of all doctors must be examined, to see how opportunities to engage with the social determinants of health can be better incorporated through practice, research and amendments.
- Innovative and flexible options for certification and continuing professional development need to be instigated to give clinical doctors the opportunity to remain involved with public health issues and vice versa.