



# HEALTH EQUITY AND COMMUNITY ENGAGEMENT REPORT

## CITY OF BERKELEY



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## Project Description

The Bay Area Regional Health Inequities Initiative (BARHII) is a collaboration of public health directors, health officers, senior managers and staff from eleven of the San Francisco Bay Area local health departments (LHDs), including the City of Berkeley. The BARHII LHD membership formed to collectively address the factors that contribute to egregious differences in life expectancy and health outcomes between different socio-economic groups in the region. The mission of BARHII is to: *Transform public health practice for the purpose of eliminating health inequities using a broad spectrum of approaches that create healthy communities.* As Margaret Whitehead of the World Health Organization defines it, “*Health inequities are differences in health status and mortality rates across population groups that are systemic, avoidable, unfair, and unjust.*” BARHII focuses its work on how

public health departments can address upstream, structural and social factors that perpetuate health inequities. The BARHII Framework<sup>1</sup> describes the problem areas addressed by a continuum of public health practice ranging from cataloguing causes of mortality and disease management on the right side to addressing more upstream social inequalities such as racism and class inequality on the left side.

BARHII’s goal of transforming public health practice is carried out by a LHD staff, in-kind committee structure, one of which is the Community Committee (CC). The CC supports member health departments as they attempt to forge new strategies for community engagement and capacity building to address the broad range of conditions that contribute to poor health, and to establish relationships that can be sustained over time. From 2009-2011, BARHII staff and LHD members of the

<sup>1</sup> BARHII Framework in Action: [http://www.barhii.org/programs/download/conceptual\\_framework.pdf](http://www.barhii.org/programs/download/conceptual_framework.pdf)

CC conducted qualitative assessments in seven local health jurisdictions (LHJs), including focus groups with public health department staff and leadership as well as site visits and focus groups with a few LHD-selected community agencies that have experience working with the LHD. This report includes a summary of analyzed results from qualitative data collected in the City of Berkeley in September 2009 at six focus groups with the following agencies:

- Berkeley Alliance: <http://berkeleyalliance.org/>
- Berkeley Organizing Congregations for Action: <http://www.berkeleyboca.org/>
- Berkeley Youth Alternatives: <http://www.byonline.org/>
- Life Long Medical Care: <http://lifelongmedical.org/>
- City of Berkeley Public Health Department – Leadership: <http://www.ci.berkeley.ca.us/publichealth/>
- City of Berkeley Public Health Department – Program Staff: <http://www.ci.berkeley.ca.us/publichealth/>

This report describes perspectives of both LHD and community agency staff on key themes that emerged in discussions from the focus groups and site visits conducted. The data results presented show local priorities in health inequities and social conditions as well as highlight best practices and lessons learned related to (1) public health and community agency collaborations and (2) how health inequity concerns are being addressed in the City of Berkeley.

## **Social Determinants of Health Inequities in the City of Berkeley**

A clear picture of some of the persistent environmental and social conditions that impact

health inequities in the City of Berkeley emerged from focus groups held with City Local Health Department (LHD) staff and Leadership, as well as site visits and lengthy discussions with selected community-based organizations (CBOs). The description of these health inequities put forth by LHD employees was more health issue-focused, while the CBOs described more of the social, environmental and policy inequities faced by specific groups and communities. However, strong agreement was found in the geographic distribution of inequities, with South and West Berkeley being named as the areas of greatest concern.

Berkeley LHD staff believed that key inequities that need to be addressed in the City include drugs, violence, HIV/AIDS, Chronic diseases (Heart Disease, Diabetes, high blood pressure, high cholesterol), low birth weight, and lack of health care and health insurance. Staff within community-based organizations that were visited listed key inequities in Berkeley to be addressed as access to affordable food (specifically grocery stores), gentrification of neighborhoods displacing long-time residents, racial tensions and racism, having one of the largest racial academic achievement gaps, brain and talent drain within affected communities, and stress and lack of sleep in children and youth.

## **Best Practices in Health Equity and Community Engagement of the City of Berkeley Public Health Department**

Data collected from both the community site visit discussions and LHD focus groups suggested agreement on the success of several of the following community engagement and health equity-focused

strategies being implemented by the LHD, in some cases along with CBO partners. It is important to note upfront that some of these themes that are considered successes are also listed in the challenges – or areas for improvement – as there are examples of both in the LHD-CBO relationships and perspectives.

### **Community Engagement**

According to LHD staff and leadership focus groups, the LHD focuses its community efforts where community relationships are the strongest, such as regular gatherings for residents of South and West Berkeley where the LHD had existing relationships. Another approach of the LHD’s community work is to focus resources where they could have the most impact and break generational cycles with at-risk groups. For example, focusing resources on pregnant and parenting teens can have impact on their own lives as well as those of their children (age 0-5) and their future health outcomes. In addition, another important strategy to community assessment and engagement implemented by the LHD is to focus on the existing qualities and expertise of the people in the community. This approach recognizes how well-respected community leaders and young people wishing to do something for their community are important local voices to be heard as well as invaluable resources for program success and sustainability.

### **Public Health Presence in the Community**

The LHD builds trust by providing a consistent presence in the community, according to both LHD and CBO data. It is appreciated when public health staff (especially LHD Leadership) go “*beyond the clinic walls, beyond downtown*” and go “*where the people are*” to meet the community members and learn first-hand knowledge of the streets and neighborhoods most in need. In addition, it is

important to have public health staff implement activities regularly in the community, share with CBOs their events and program plans as well as show up as consistent partners at community meetings to provide support for community-led efforts. One CBO pointed out the importance of the LHD communicating with them regarding their work in the community, saying, “*We just want to be included, because we are working with the same families.*” These LHD actions build trust and connection to the community, increase LHD knowledge of what is happening on the ground in neighborhoods, and provide a foundation for building meaningful, working relationships with CBOs.

### **Building Relationships and Cultural Bridges**

Important parts of building trust and relationships were described as “*knowing how to speak the ‘language’ of individuals and groups in the community*” – in other words, having an understanding of the community culture(s), displaying cultural humility and seeing the community as true experts. Several CBO members discussed the importance of recognizing and tapping into the resiliency and skills of community members, including youth and elders. In addition, LHD staff that “*show their heart*” in community interactions (i.e. that they are genuinely concerned about the people in the community and serious about the work) are able to provide real entry points for CBOs and the community to understand health department priorities, operating processes and collaborative access points. One CBO staff member explains, “*The (public health) folks that I have relationships with,... folks that we sat in meetings with and I’ve been able to see their heart, it’s like you’re serious about your work, you’re not like just punching a paycheck or just trying to meet some arbitrary goal, like you’re really serious about the people and about the work. You know, when you can identify those folks then those folks become*

*We just want to be included, because we are working with the same families.*

*your entry point.”*

One effort that was mentioned by both CBOs and LHD staff as a particularly strong and successful community engagement effort is the Heart 2 Heart project. This neighborhood-based outreach and community engagement strategy for cardiovascular disease prevention focuses on neighborhoods most affected by health inequities (West and South Berkeley). LHD leaders and staff spent time walking the neighborhoods, being present in the community and going door to door to assess needs and offer information and resources to residents. One CBO described Heart 2 Heart as an example of a “*true partnership with community-based organizations that provided credibility for the City Health Department within the community.*”

According to LHD staff, the Health Department provides support to CBOs and continually thinks about how to extend the work they do into new partnerships with community, such as being a partner in community-driven environmental and policy change efforts. In addition, Community Advisory Boards (such as that used with the program Heart 2 Heart) serve as a good venue for public health-community dialogue and training people in the community to continue the flow of the community work when the LHD steps aside. The LHD can share their expertise in helping community members to prioritize strategies to address community health issues.

### ***Community Capacity-Building***

Both CBO and LHD staff mentioned the capacity-building strengths of the Community Health Worker Training Program that trains individuals from the community to take staff positions as Community Health Workers as well as creates policies to hire Health Promoters (Promotoras) that receive stipends for their work to reach neighbors with information and resources. These individuals provide a hands-on familiarity with the neighborhoods and the cultural communities within the areas most affected by inequities and can be an important bridge between

the health department and the community, serving as translators for the different literal and cultural languages spoken, as well as finding and framing the common ground between varying agendas and priorities.

Investing in community capacity-building and leadership development such as the Community Health Worker Training program directly increases the capacity of community members to succeed in educational and professional endeavors thereby decreasing the inequities we see in education and employment. However, the positive outcomes of community capacity-building go beyond the specific knowledge and skills that are increased in the individuals who participate. By investing in the community in these ways, health departments also continue to build trusting relationships, increase the translation and transference of information between communities and public health and both entities mutually engage as more effective, organizing forces for local, sustainable change.

### ***Data Collection and Sharing***

Both CBO and LHD staff noted the important role that the LHD plays as the organization with the greatest capacity for data collection, analysis and reporting. The LHD may use these data to demonstrate the overall direction of public health programs and initiatives and movement towards goals. These data are an important resource to guide and support the LHD and community in making decisions together to prioritize and drive the work. CBOs can draw on their knowledge and relationships in the community to “fill out” the data picture. In addition, CBOs stressed the importance of the LHD reporting data that would help both CBOs and the LHD to apply for additional resources through grant funding and other sources.

### ***Administrative Structures that Support Health Equity Efforts***

The organizational structure of the LHD and its partnering agencies allows for the integration of

efforts across programs, divisions, departments, and sectors. Recently there has been an increase in collaboration between the schools and the LHD to address educational inequities in the Vision 2020 program. The LHD also triages issues brought forth by community and then forwards them on to the appropriate sectors so they can be solved in a timely manner, as not everything can be solved by Public Health. According to LHD leadership, the LHD management has a strong understanding of the nature of community engagement work in order to maximally support staff they are supervising. LHD staff also use the structure of Community Action Teams as an important community engagement effort. In 1999, City General Funds were provided for health disparities programs. In addition, despite some limitations due to categorical programming, the LHD tries to leverage public health categorical funding to do more community-wide, health equity work, such as in the example of Heart 2 Heart described above.

## Best Practices in Health Equity and Community Engagement of Local Community Agencies

CBO staff members were interested in sharing some of the work they were doing to engage the community and move towards health equity in which the LHD was not necessarily a partner. These strategies are outlined below.

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### Community Engagement and Leadership Development

The organizations interviewed for this project said they place an emphasis on “home-grown leadership” by using the strengths of long-time residents and key individuals in the community, as well as recognizing the potential and passion of young people.

One CBO member explains that “people who grew up in Berkeley, who experienced this inequity, who are now also in positions of leadership... coming to the table have been extremely valuable in being able to bridge gaps.” Another CBO staff member describes how they support the unique quality of youth leadership: “That’s where we’re going to have some serious leadership in the community, because (youth) don’t have a lot of political skills in the game. They’re very clear about what they want, and so we’re trying to make sure that they have the tools and the skills in order to do that well.”

One organization described the strengths of their leadership work in faith-based communities: “We believe that the best advocates and the best educators for any issue are the people themselves. So there is a real strong commitment to finding people, helping them identify their pain and the source of that pain, and give them language and some training and some empowerment so they themselves can be organized and begin to produce some gains for their own families and their own communities.” This organization intentionally works to “grow” leadership within congregations, holding “listening campaigns” to truly understand community needs, building leadership and providing a forum for community residents and City policymakers to meet in a safe, political space to work on problems together.

CBOs can be instrumental in providing safe forums for dialogue and civic engagement. Another agency

explains the importance of making this effort in policymaker-community engagement in a safe space “in which people with a lot of authority, sometimes elected officials...can have conversations with community groups and not be in jeopardy of alienating their own constituencies or departments. This requires framing conversations in a safe way.”

CBOs discussed the importance of having Community Advisory Boards to provide input into the programming their organizations were doing and recommended that City programs should have the same. The Community Advisory Board for the Heart 2 Heart program was a vital part of the success of the program.

### *Developing Cross-Sector Partnerships and Collaborations*

Both LHD and CBO participants describe the importance of a cross-sector approach for efficiency and sustainability. A youth development organization described how working across sectors (i.e. with teachers, parents, police department, probation officers, etc.) to address youth needs helped in their success to build sustainable, effective youth primary prevention programming. Another CBO staff member described this approach almost as a national movement towards progress: “*The good news is a lot of communities are figuring this out, and what it’s taking is a cross-jurisdictional, cooperative, creative, measurable venture that is really making strides...Harlem Children’s Zone in New York...community school models around the country...Memphis is doing a really good job...the whole community really got together and said ‘enough is enough’. And that’s what we’re trying to do here in Berkeley. And there is will. There’s a lot of will.*”

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sector effort, Vision 2020, to reduce the academic achievement gap between students in the Berkeley Unified School District began the work by calling an “All-City Equity Task Force.” Cross-sector work, in which all partners agree on indicators for evaluation of the effort and where each organization provides skills, resources and expertise to the problem, is crucial to having an impact on structural equity issues such as educational attainment.

### *Place-based Land Use Policies and Projects*

CBOs have worked on place-based land use projects in neighborhoods with low access to parks and quality physical activity opportunities such as converting an unused park tennis court to a soccer court for neighborhood children who did not have access to a soccer field.

## **Challenges in Health Equity and Community Engagement Practice**

Focus groups with the LHD and CBO staff described the following programmatic limitations and practices that are challenging to successful community engagement and health equity work that have been or still are the norm, in spite of the successes described earlier.

### *Short-term Programming*

One of the key themes that emerged from the CBO participants regarding what is not working as well with LHD programs is the sense that programs come and go as short-term efforts, or they may stop and

start and stop again due to funding changes or other administrative decisions. In this scenario, the ability for these programs to have a lasting impact is limited and this “in and out” process in the community also does not help in the building of trust and true, sustainable, community partnerships. As a CBO staff member put it, *“(One of the) worst things (is to) have a project we say we are doing and get people all fired up and they come in and then it gets shut down, every time that happens, it’s a little withdrawal in the trust account.”*

### ***Presence of a University***

Although there are many benefits to having a major University in Berkeley, including economic and social influences, a few frustrations and barriers were mentioned by some of the focus group participants with regards to this strong, academic presence. One comment from LHD leadership was that, with a *“University being so close, the population is ‘over-studied’*”. This oversampling of the population, especially in disenfranchised communities, can lead to more mistrust and a questioning of where the information goes and what changes are being made to better the community as a result of gathering these data. Similarly, one CBO staff member mentioned how some academic and political leaders who are supported by the University and who are national and global experts in their fields can be disconnected with local efforts: *“Because of our culture of derivative activism, I’ll call it, a lot of those thought leaders have disengaged completely from what’s going on locally.”*

### ***Lack of Trust and Meaningful Community Engagement***

Both CBO and LHD staff mention the historical, community perception of local government having lots of resources but *“wasting them”* and *“missing opportunities for work to have a significant impact.”* LHD leadership suggests moving beyond just having *“good intentions”* and instead working on community relationship-building to earn back trust, acknowledge past wrongs and increase transparency of programmatic decision-making.

CBO and LHD participants expressed how some of the gaps in both community-public health communication and collaborative entry points can lead to fewer successful programs, less community participation and more mistrust. For example, one CBO staff describes a scenario where *“when the (LHD) comes in with another program and they haven’t talked (with the CBO), the likelihood that (the program) is going to succeed is pretty low, because people are going to come and say, ‘Hey, does (CBO) know about this? Do you guys know that the (LHD) is coming here on Thursday night to do an outreach? No’, and we just start laughing, and go, well that’s a waste of money.”*

One LHD staff member explains that the LHD is not really *“hearing”* what community is saying and instead they are *“making assumptions about what the community needs.”* A CBO partner explains the importance of on-going, informal assessment in the community, as *“a community isn’t a static thing, so you can’t go out, last Friday (and meet with community) and say, okay, now*

***(One of the) worst things (is to) have a project we say we are doing and get people all fired up and they come in and it gets shut down, every time that happens, it’s a little withdrawal in the trust account.***

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*I know everything about the community. It's a process and you have to continually be out there, so it's not so much what you know or what you should know. You should know that you never know enough."*

Although some LHD staff are well embedded in community efforts and relationship-building, according to one LHD staff member, *"It is usually not the norm for CBOs to feel they have an entry point with LHD staff...to have someone they feel comfortable going to, to ask questions and get support."*

Another CBO staff member expressed how sometimes the rigidity in organizational structures may discourage community member engagement and challenges staff to see *"how can we make our institutions more humane in that way?...and I think it only happens by all of us as the institution, becoming more organic or rooted in people's experience."*

### **Funding Limitations**

LHD staff and leadership voiced concern over the limitations put on the LHD by the current public health funding structures and bureaucracy. Even though a lot of LHD staff work with the same individuals and families, LHD staff commented on how there is not as much collaboration as there could be, mostly due to the siloed funding and separate programming. Another result of having definitive job roles via categorical programming is a lack of time for collaborative processes and wider community efforts. LHD staff explained how in community planning efforts there is a lack of LHD program planners and implementers at the table. Therefore, the *"people who are designing the actual programs and going out and implementing them, (such as) public health nurses... are not being represented well."*

### **Staff Burnout and the Role of Public Health**

There is a limit to what a local public health department can do in terms of resources, and at the same time, there is an understanding of the links and a commitment to addressing what the community may see as priorities – things that usually relate to larger social issues that affect health outcomes. One LHD leader describes this reality as *"needing to keep boundaries to the work you do in the community that makes it complicated, sometimes you can't throw in parameters,"* and feeling the need to do things that fall outside technical program parameters.

Another concern of LHD leadership in this process of community engagement and public health work is the potential for burnout of some staff, *"especially when you come from the community and are working with the community and the heavy issues."*

In addition, LHD staff also noted that at times they feel as though they *"get stuck in a 'middleman' position between community and LHD leadership or county elected officials"* who may have disparate priorities or goals.

Members of the LHD voiced the need for public health to sort through where in the government the work belongs for specific problems and to triage community issues to other City departments even when everything can be connected to health. Along these lines, the LHD has worked with other City colleagues to move some work into other City Departments and Divisions. According to LHD leadership, there is a sense of *"having the responsibility to do something with the information you get from the community, and that can seem challenging at times."*

LHD leadership mentioned that one of the biggest challenges is being able to critically examine and

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change current public health approaches, “especially when data are showing that the same disparities and inequities are persisting in spite of the programs we are providing.” The public health charge suggested here is to “force a radical re-examining of public health – (an) opportunity not to just be discouraged but to conclude that birth outcomes are more than the perinatal period. It is a lifetime and generation of racism, etc... this supports health equity work.”

## Recommendations

In summary, the main themes that emerged as challenges or areas for improvement for the LHD related to increasing health equity and community engagement include:

1. Build meaningful, on-going relationships with community members and CBOs as true partners in public health planning as well as community-led, organizing efforts;
2. Support more flexible staff time and advocate with funders to allow for the development of health equity efforts that focus across and outside categorical programs towards improving community health and development;
3. Work together as a City, across departments, disciplines and agencies and with common goals in order to have a collective positive impact on issues such as the racial divide in educational attainment and the underserved areas of West and South Berkeley; and
4. Define public health practice within the context of upstream, social determinants and health equity, versus being confined alone to health outcome categories.

The results summarized in this BARHII report are based only on the qualitative data from six focus groups in September 2009. In order to more completely assess the strengths and areas for improvement in the efforts of the LHD to

increase health equity and community engagement, BARHII recommends that the implementation of the Organizational Self-Assessment for Addressing Health Inequities Toolkit. This toolkit, available as a free PDF download (<http://www.barhii.org/resources/toolkit.html>), includes information on how to assess and work to improve both the organizational and staff capacity to better address health inequities. Given that the City of Berkeley LHD implemented the BARHII toolkit as a pilot in 2008, in the process of the toolkit development, BARHII recommends the review and usage of these LHD assessment results, as well as a potential re-implementation of all or parts of the toolkit, given the extreme changes in LHD staffing levels, roles and activities since the initial health equity assessment implementation.

# Acknowledgements

This report was produced by the Bay Area Regional Health Inequities Initiative (BARHII) Community Committee.

**Key Contributors:** **Amy V. Smith, MPH**, Program Manager, Bay Area Regional Health Inequities Initiative  
**Cio Hernandez, MS, LMFT, LPCCC**, Mental Health Practitioner, Marin County Health and Human Services  
**Cara Mae Woledge-McGarry, MPH**, Health Education Specialist, Napa County Health and Human Services  
**Dale Murai**, Program Specialist, Alameda County Public Health Department  
**Doris Y. Estremera, MPH**, Senior Community Health Planner, San Mateo County Health System  
**Kristi Skjerdal, MPH**, Public Health Educator, San Mateo County Health System

We would like to recognize the valuable contributions of:

**David Hill, PhD, MPH**, Formerly of Santa Clara County Public Health Department

**Heidi Merchen, MBA**, Public Health Analyst, Napa County Health and Human Services

**Julie Michaels, MPH**, Policy Analyst, Marin County Health and Human Services

**Leslie Goodfriend, MPH**, Health Services Manager, Santa Cruz County Health Services Agency

**Lincoln Casimere**, Community Capacity Building Coordinator, Alameda County Health Public Health Department

**Sandi Galvez, MSW**, Executive Director, Bay Area Regional Health Inequities Initiative

**Bob Prentice, PhD**, Former Executive Director, Bay Area Regional Health Inequities Initiative

**Saleena Gupte, DrPH, MPH**, Former Staff, Bay Area Regional health Inequities Initiative

This report was made possible by funding from The California Endowment, the San Francisco Foundation, and Kaiser Permanente. BARHII receives fiscal sponsorship from the Public Health Institute.