

# GRASSROOTS ACTIVISM AND COMMUNITY HEALTH IMPROVEMENT

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## Abstract

Numerous agencies of the federal government of the US have concluded that community engagement is a critical component of any public health strategy, and health professionals, scholars, funders, and practitioners are looking for effective ways to engage neighborhood residents around improving health at the local level. This paper focuses on efforts being made in a small city in upstate New York to address the social determinants of health using an aggressive community engagement and organizing strategy. Four neighborhoods (three urban and one rural) have completed the second of five years of funding, and are in the process of implementing resident-driven plans to improve the local context for health. This paper presents a case study of the four communities, including relevant health disparities statistics, a program description, the community engagement and organizing strategies underway, and the progress thus far achieved.

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American society has always exhibited disparities in power, social status, and economic status, and the gaps separating the advantaged from the less advantaged continue today and are widening. Health disparities have been examined through a number of lenses, including a focus on access to healthcare and the influences of race and poverty on the differential health outcomes experienced by different groups. Most recently, the research spotlight has been on neighborhoods, and numerous studies have revealed how health status can be impacted by the *places* in which people live. As the importance of place has emerged as a factor in population health, the importance of *community engagement* has also been recognized as a critical component of any successful public health strategy. Such agencies as the US Department of Health and Human Services, the National Institutes for Health, and the Centers for Disease Control have all concluded that the involvement of affected populations is a critical component of any successful public health strategy.<sup>1</sup> In the face of limited success on the majority of specific health objectives identified in the nation's Healthy People 2010 plan, and as the elimination of health disparities remains out of reach (Koh, 2010), scholars, health professionals, and community practitioners are looking for ways to effectively engage neighborhood residents around addressing health at the local level.

This paper presents a case study of a place-based project currently underway that utilizes a community engagement and organizing strategy to address the social determinants of health in four neighborhoods in and around a small city in upstate New York. The neighborhoods (three urban and one rural) have completed the second of five years of funding provided by a local health foundation, and are in the process of implementing resident-driven plans to improve the local context for health. During the first two years, each community-based grantee engaged residents to help conduct a community health review and produce a community asset map, to take action on local health issues, and to develop a local health promotion plan. In presenting the case study, we will discuss health disparities and the social determinants of health in general and in the local context. Additionally, we will provide details of the engagement and organizing strategies underlying the funding program, describe how each of the four communities interpreted the program objectives and the community engagement and organizing strategies underway at each site, highlight the progress achieved thus far, and provide a discussion of the potential for similar approaches in place-based efforts to improve community health.

### Health Disparities in the National Context

It is well known and well accepted that the association between socioeconomic status (SES) and health is strong; higher SES leads to better health, and socioeconomic disadvantage is associated with a shorter life expectancy and greater prevalence of disease (e.g., Wilkinson & Marmot, 2003). Children and adults living near the poverty line are more likely to experience poor health (National Center for Health Statistics, 2006), and the greatest burden of disease is felt by those experiencing the most extreme poverty, with health status improving with ascension up the SES hierarchy (Adler, 1997; Dunn, 2000). This phenomena of a “social gradient in health” (p.342) is seen not only in the U.S., but is persistent and consistent across industrialized nations (Dunn, 2000). Living in poverty leads to poor health through a complex connection of social and environmental factors (National Center for Health Statistics, 2006), and this intersection of SES and disease is dynamic; social and environmental influences “create and shape patterns of

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<sup>1</sup> See for example <http://www.hhs.gov>, <http://www.nih.gov>, <http://www.cdc.gov>.

disease” (Link, Northridge, Phelan, & Ganz, 1998, p. 376). If you are poor, you are likely to have fewer resources that support good health, and are likely to suffer from chronic stress, which can also lead to poor health (Wilkinson & Marmot, 2003).

Poverty alone, however, fails to fully explain the difference in health status between whites and persons of color (Lavizzo-Mourey, Richardson, Ross, & Rowe, 2005), and racial health disparities have been found to persist across all socioeconomic groups (James, Thomas, Lillie-Blaton, & Garfield, 2007). Significant research also points to the fact that some groups in the United States enjoy better health status than others based on racial/ethnic background. African Americans and Latinos experience a greater burden of disease, disability, and mortality and are more likely to self-report their health as fair or poor than Americans of European or Asian descent (National Center for Health Statistics, 2006). For all income levels and for both men and women, life expectancy for Whites is greater than for African Americans (House & Williams, 2000). Ample data confirm the existence of racial health disparities nationally and locally. When asked to rate their overall health status, Whites (8.6%) are less likely than African Americans (14.6%) or Hispanics (13.3%) to rate their overall health as fair or poor (National Center for Health Statistics, 2006). This self-report of health status has been shown to be a good indicator of overall health and a predictor of mortality and physical functioning (Idler & Benyami, 1997). Prevalence rates of specific disease states and health conditions also substantiate the gaps between persons of color and Whites. Generally, minorities experience higher morbidity and mortality rates in such diseases as cancer, overweight and obesity, heart disease, diabetes, asthma, HIV/AIDS, and infant mortality and low birth weight.

Many public health interventions target individual behaviors in an effort to impact health status by, for example, reducing smoking, increasing physical activity, and improving nutrition. Lantz and colleagues (1998), while confirming that lower income and educational status are associated with a greater incidence of behaviors that promote poor health (e.g., smoking, sedentary lifestyle), argue: “despite the presence of significant socioeconomic differentials in health behaviors, these differences account for only a modest proportion of social inequalities in overall mortality” (p. 1706). To explain social inequalities in health, increased attention must be paid to the environmental health hazards to which low-income populations are commonly exposed.

The discourse on neighborhood health status increasingly acknowledges the influence of such conditions as substandard housing on health, especially respiratory illness and lead poisoning in children. Cold, damp dwellings with poor ventilation promote the growth of mold and fungi, and such allergens can cause the coughing and wheezing associated with childhood asthma (Shaw, 2004). A major cause of lead poisoning in children is paint in housing built prior to 1978. Children are exposed to lead in dust from painted surfaces that have been poorly maintained, and the resulting poisoning impairs cognitive development and imparts significant, long-term health effects (Centers for Disease Control and Prevention, 2005). Quality housing—beyond providing for physical protection from the elements—also offers security and privacy, which are important for psychological well-being (Ellen et al., 2001). Furthermore, Dunn and Hayes (2000) showed a connection between pride in place of residence and health: people who were proud of their place of residence (both neighborhood and physical space) were more likely to report overall better health. Environmental hazards, including hazardous waste sites and pollution, have been shown to be found more frequently in low-income and minority neighborhoods (P. Brown, 1995). When concentrations of poor and minority populations reside in isolated areas, it has been suggested

that it is “politically more feasible” (p.219) to locate hazards in such communities, protecting non-minority populations and those in higher socioeconomic classes from exposure (Acevedo-Garcia, Lochner, Osypuk, & Subramanian, 2003).

Other aspects of life commonly associated with being poor are also important factors in the production of health disparities (Lantz et al., 1998). Access to healthy and affordable food is commonly limited in low-income and minority neighborhoods, with the lack of produce and other fresh products the result of a paucity of supermarkets. The lack of healthy choices at the local corner market and limited transportation to reach larger grocers compound matters, especially in poor and predominantly African American neighborhoods (Altschuler, Somkin, & Adler, 2004; Macintyre & Ellaway, 2003; Morland, Wing, Diez Roux, & Poole, 2002). The “choice” poor people allegedly make to eat an unhealthy diet is undoubtedly influenced by the fact that foods high in fat and calories—for example, fast food—are readily available in their communities, while wholesome and nutritious foods are not.

Americans have been inundated with information about the importance of regular physical activity to control weight and improve overall health, and researchers have increasingly investigated both the extent to which low-income persons engage in physical exercise and the potential barriers to such activity. Ellaway and colleagues (2005) found the physical environment of a neighborhood influenced the extent to which residents were physically active. Residents of neighborhoods with greater incidences of graffiti and litter and less open green space were less physically active and more likely to be obese than their counterparts in more inviting communities (Ellaway, Macintyre, & Bonnefoy, 2005). To compound the physical disincentive to outdoor exercise, underserved neighborhoods may also lack access to recreational facilities for keeping fit indoors (Macintyre & Ellaway, 2003).

Chronic stress has been shown to damage health and may lead to premature death. Anxiety and insecurity, exacerbated by lack of emotional support from friends and family, are more common for those in lower socioeconomic strata (Wilkinson & Marmot, 2003). Neighborhood problems such as crime, violence, poor housing, traffic, and noise have recently been cited as chronic stressors. In a study in the UK, researchers found that residents of neighborhoods that had high levels of stressors were more likely to self-report poorer health and physical functioning (Steptoe & Feldman, 2001). And while having a job is better for health than being unemployed, stress in the workplace also makes people susceptible to illness and disease. Especially vulnerable are those who have little control over their work and those with both high physical demands and little control (Wilkinson & Marmot, 2003). The personal control gained through increased levels of education, and the concomitant achievement of new skills and abilities, has been shown to drive improved health status. Individuals in better-paying jobs are often provided a more creative, independent work environment that fosters good health (Mirowsky & Ross, 2003).

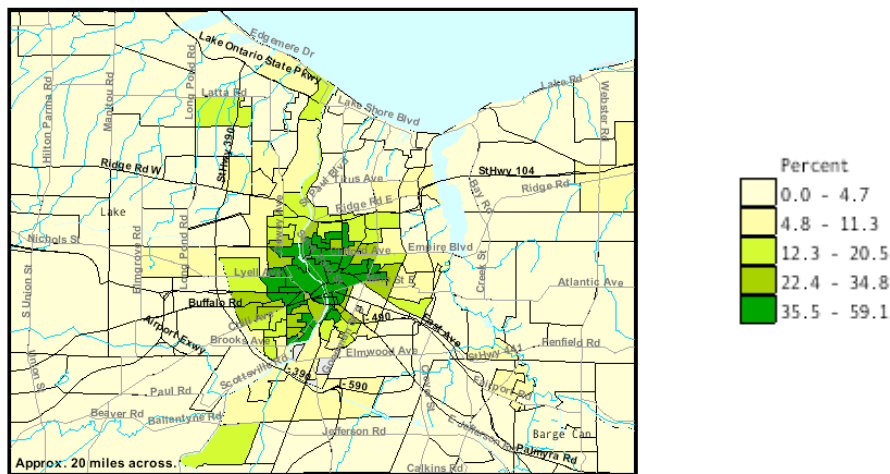
### Health Disparities in the Local Context

Race and socioeconomic status are unambiguously interconnected in the city where this community work is taking place. African Americans (nearly 50%) and Hispanics (13%) account for a large segment of the individuals living in poverty, even though they represent only 38.5 percent and 12.8 percent respectively of the total population (U.S. Census Bureau, 2000). In the metropolitan area, communities are often separated along economic and racial lines. Racial minorities and the economically disadvantaged are more likely to live within the city limits,

while more affluent and White members of the population live in the surrounding suburbs (U.S. Census Bureau, 2000). The U.S. Census provides ample data to support the extent to which the city and surrounding county differ in regards to social and racial demographics. Most of the racial diversity in the county is found within the city limits. African Americans comprise 38.5 percent of the city population, while accounting for only 13.7 percent of the county population. Likewise, Hispanic/Latinos comprise 12.8 percent of total city population, but account for just 5.3 percent of the county population (U.S. Census Bureau, 2000).

The most significant poverty levels are also found in the city, as shown in **Figure 1**. In 2000, the median family income was \$55,900 in the county and \$31,257 in the city; approximately 11 percent of county families lived below the poverty level <sup>2</sup> in 2000, while 23 percent of city families fell below this level (U.S. Census Bureau, 2000).

**Figure 1: Percentage of Families Below the Poverty Level in County 1999: 2000**



Educational disparities also exist between city and county residents, with the city lagging significantly behind the county as a whole. Nearly 85 percent of county residents possess a high school diploma or more advanced education (U.S. Census Bureau, 2000). In the city, almost 27 percent of all residents over the age of 25 lack a high school diploma—in some city neighborhoods, rates of high school non-completion are 50 percent or greater. In 2004-05, more than 13 percent of enrolled students in the city school district dropped out or entered a GED program (University of the State of New York State Education Department, 2005).

In terms of specific diseases and conditions, the health statistics of residents of the county reflect numerous health disparities. One-third of African Americans in the county are obese, compared to one-fifth of Whites (Finger Lakes Health Systems Agency, 2003), a statistic similar to the national data, which demonstrates that 70% of African Americans are overweight compared to 58% of Whites. As obesity is associated with a number of chronic health problems, including diabetes and cardiovascular disease (U.S. Department of Health and Human Services, 2001), the disparity represents a health issue of even greater concern than the growing problem among all Americans. In the county, African Americans are 1.5 times more likely to experience lung cancer

<sup>2</sup> The U.S. Health and Human Services Poverty Guidelines for a family of three in 2000 was \$14,150.

and 1.8 times more likely to have prostate cancer than Whites (Finger Lakes Health Systems Agency, 2003). Nationally, African Americans are significantly (25%) more likely to die from cancer than are Whites; African American men are twice as likely to die from prostate cancer and African American women are 35 percent more likely to die of breast cancer than Whites (U.S. Department of Health and Human Services Office of Minority Health, 2006).

In the region, African Americans are 2.5 times more likely than the general population to die from diabetes (Finger Lakes Health Systems Agency, 2003). While the mortality rate for Hispanics with diabetes is lower on the local level than nationally, it is, nonetheless, on the rise (Finger Lakes Health Systems Agency, 2004). Nationally, African American and Hispanics are 2.2 and 1.5 times as likely to have diabetes as Whites, and African Americans more often suffer significant consequences of the disease, such as amputations and renal failure (U.S. Department of Health and Human Services Office of Minority Health, 2006). Locally, African American children are hospitalized three times more frequently than other children (Finger Lakes Health Systems Agency, 2003). A chronic disease in children across the U.S., asthma affects African American children two to three times more often than children of other races.

### Neighborhoods, Social Capital, and Health Disparities

The concept that where you live might influence your health is not new: sociologists in the early 1940s were beginning to make connections between neighborhoods with significant poverty and distressed housing and considerable health concerns, including low birth-weight babies, violence, and high infant mortality (Sampson & Morenoff, 2000). Presently, when researchers discover health disparities among people living in geographically disparate places, they tend to explain these differences based on either the characteristics of the people who live in those communities (“who you are”) or the effects of the neighborhood itself (“where you are”) (Macintyre & Ellaway, 2003). Scholars who maintain that context matters argue that there are real distinctions between places, such that where you live may influence your health (Macintyre & Ellaway, 2003). A growing body of literature (see reviews in Clark, 2005; Diez Roux, 2001) has attempted to explore neighborhood effects on health while controlling for individual attributes, including race and socio-economic status. In a review of theories, Ellen et al. (2001) summarize four mechanisms by which neighborhoods affect health including those mentioned earlier: (1) neighborhood environmental threats, (2) the presence or lack of neighborhood resources, (3) social conditions that cause stress, and (4) the influence of social networks (Ellen, Mijanovich, & Dillman, 2001).

Despite the economic hardships and racial composition of residents, it appears that it is possible for some neighborhoods and communities to thrive and promote the health and well-being of the families living within. Sampson (2003) suggests, “if ‘neighborhood effects’ of concentrated poverty on health actually exist, they presumably stem from social processes that involve collective aspects of neighborhood life such as social cohesion, spatial diffusion, support networks, and informal social control” (Sampson, 2003, p. 135). Researchers across many fields have learned that educational outcomes, crime, and recently, health status, are associated with the amount of engagement and connectedness that exists among community residents (e.g., Putnam, 1995). Putnam refers to social capital as those “features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit” (p. 67). He suggests that social supports and positive relationships—both between individuals and across a community—are important contributors to health. Social isolation is more

commonly experienced by those living in poverty, and communities with the widest income gaps separating the affluent from the poor exhibit less social cohesion, more violent crime, and higher rates of heart disease (Wilkinson & Marmot, 2003).

Using state-level data, Kawachi et al explored the connections between levels of social capital and overall mortality rates, and, after controlling for income and poverty, found a strong correlation between social capital and lower rates of mortality (Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997). They also discovered that states with the greatest income disparities had very low levels of social trust and civic engagement. Lochner et al. examined social capital on a smaller scale, focusing on the neighborhood level. Using perceived reciprocity and trust and organizational membership as indicators of social capital, their study found that higher neighborhood social capital was associated with lower death rates (Lochner, Kawachi, Brennan, & Buka, 2003). Comparable research that looked separately at different types of social capital (bonding vs. bridging) found similar protective health mechanisms (Kim, Subramanian, & Kawachi, 2006). Kawachi and colleagues (1999) have suggested a number of ways in which social capital may exert an effect on the health of individuals within a community. They suggest that innovative health ideas—such as preventive health measures—are more likely to be accepted and implemented in unified communities where neighbors know and trust each other. Citing the work of Sampson, Raudenbush, and Earls (1997), Kawachi et al. note that research on criminal behavior has shown that tight-knit communities with high “collective efficacy” are more likely to act in union against crimes in the community; similarly, such collective action against unhealthy activity—for example, intervening when a group of youth are smoking and drinking—may be more likely in these communities (Kawachi et al., 1999). Communities with strong social ties are also more likely to present as a unified force when advocating for their collective well-being. They may be more likely to successfully fight for improved services and amenities, such as street lights, sidewalks, and access to stores selling fresh produce. Building on the work of Wilkinson (1996), researchers suggest that individuals living in tight-knit areas may benefit psychologically with improved self-esteem and more positive outlooks (Kawachi et al., 1999).

While the body of literature on social capital is increasing, no strong empirical evidence to date has shown explicitly that efforts to increase a neighborhood’s social capital will directly result in improved health status for its residents (Lochner et al., 2003). “Investing in social capital alone is unlikely to be sufficient without attending to inequalities in access to other types of capital – financial and human. Thus social capital is an essential but not sufficient ingredient for health improvement” (p. 1804). There is, however, some evidence that in very disadvantaged neighborhoods, a strength or asset-based approach that builds social capital from the ground up may be effective in positioning neighborhood residents to eventually access and utilize other forms of capital (see for example, McKnight and Kretzmann, 1993; Puntteney and Moore, 1998). These authors suggest that in some communities low social capital is associated with an internalized notion of incapacity, or the belief of local residents that they are powerless and incapable of participating in the creation of a healthier community. Measures of social capital in the city in this study reflect this belief. A 2000 telephone survey of residents of the region attempted to quantify the levels of social capital in the area. The survey found that while residents overall were more trusting and somewhat more tolerant than the national comparison, there was little formal involvement in group activities, and gaps in social capital existed based on race, age, educational level, and income (Rochester Area Community Foundation, 2001). African Americans and Hispanics were less trusting than Whites in the region. Trust for all races was

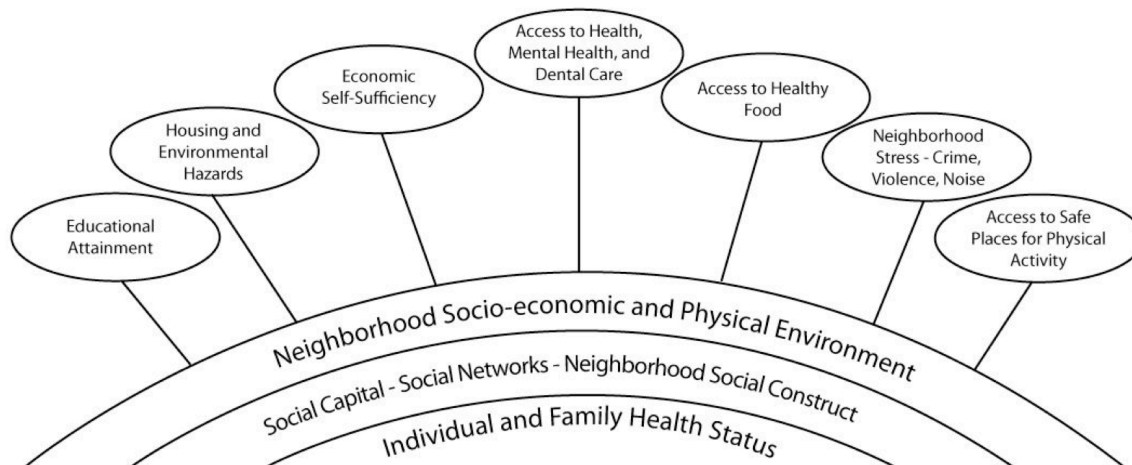
greater in those older than 50 years, and the college-educated were more trusting and more involved in formal groups than those with less education. Similarly, trust and group involvement tended to increase as income levels increased: residents of the city were the least trusting of all surveyed (Rochester Area Community Foundation, 2001).

### Neighborhood Health Status Improvement Grants Program

In 2008, after substantial research and planning, the local health foundation released a Request for Proposals (RFP) inviting local groups to design interventions that attempted to improve the health status of people living in neighborhoods challenged by poverty. The proposals were required to include broad plans to address the health needs of individuals and families by bridging the systems of health, education, housing, and employment and creating a healthier context for life and opportunities for improved health. The RFP was grounded in the idea that place matters, and successful proposals emphasized community residents and organizations working together to improve an array of environmental conditions, create public spaces and places where healthy behaviors were an option, and help ensure that residents' healthcare needs were met.

A general model of the factors contributing to individual and family health status was included in the RFP as a way of guiding applicants in their understanding of what their approach to the grant challenge might be (see **Figure 2** below). Included in the model are seven factors that contribute to neighborhood health, including educational attainment, housing and environmental hazards, economic self-sufficiency, access to health care, access to healthy food, neighborhood stress/crime/violence, and access to safe places for physical activity. These factors together influence the overall neighborhood socio-economic and physical environment as well as the social capital and social networks of a neighborhood, which all impact individual and family health status. The neighborhoods in this project were encouraged to take action on one or more of the social determinants of health by organizing residents around activities that could positively impact the environment in which people live and their own sense of empowerment to create change. Multi-year funding ensured that the grantees would have to support residents as their health improvement strategies increased in sophistication and scope.

**Figure 2: Neighborhood Health Status Improvement—Contributors to Population Health**





Under the grant program, a successful proposal was required to meet the following four specific objectives:

1. Recognize and address the intersection of poverty, place, and individual and family health status in low-income neighborhoods;
2. Make important connections between neighbors and across neighborhoods;
3. Promote asset-based, collaborative, and strategically planned approaches to strengthen neighborhoods and promote neighborhood health; and
4. Promote coordination of services across all relevant venues.

The program defined the general focus of the first three years of funding as: Year 1) assessment, Year 2) planning, and Year 3) implementation. The actual work combined all three simultaneously (assess, plan, do), but each of the first three years' work was generally oriented to these major themes. During Year 1, grantees were expected to develop a community assessment that included the following components:

- Demographic information about the population.
- Asset map of individual skills and capacities; local associations; local institutions; the physical, economic, and social environments; local culture.
- A scan of the health environment and health issues.
- Community-defined priorities for health improvement.

In addition, each grantee was expected to create mechanisms for residents to take a central role in the asset mapping process and defining local health priorities. Performance evaluation after the first year was also based on whether or not the grantee had:

- Effectively engaged a group of residents and helped build their capacity as leaders.
- Completed a comprehensive asset map.
- Started mobilizing the assets identified toward community improvement.
- Created momentum in the local environment around the project and its objectives.
- Developed interest among residents for "health promotion projects," mini-grants that offered groups of two or more residents the opportunity to design and implement an idea—usually small—that would have some kind of positive result.
- Demonstrated some impact or change in the community, primarily in terms of engaging residents.

During Year 2, grantees were expected to develop a comprehensive, multi-year plan for improving the health status of the community. The process was resident-driven, but all project partners were expected to participate in building the plan and supporting the residents in their work. Each plan needed to include two or more major focus areas, explicit strategies and activities within each, a timeline and work plan, and short-, medium-, and long-term health outcomes. The major focus of Year 3—starting for most of the groups in August 2010—will be implementation of the neighborhood plan.<sup>3</sup>

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<sup>3</sup> One grantee, located in a rural community, completed an expedited planning process, and entered Year 3 in the Spring of 2010.

In May 2008, five communities submitted successful grant applications to the foundation and were invited to undertake multi-year, resident-driven projects to address the social determinants of health in their neighborhoods.<sup>4</sup> All of the neighborhoods were similar in terms of the economic status of residents, the health disparities that described the populations, and the variety of conditions that negatively impact health, such as housing, education, etc. In other ways, the neighborhoods were quite different. For example, the rural grantee represented a very large geographic area but a population not that much different than the inner-city grantees. The populations of all the neighborhoods included significant minority members, but the rural community was predominantly White, while the city communities had different percentages of White, Black, and Hispanic members of their populations.

In the interest of encouraging neighborhood/foundation partnership, as well as establishing grantee ownership of some aspects of the program, the foundation invited the successful grantees to interview and select the technical support provider with whom they wanted to work for the subsequent three years. This was conceived by the foundation as the first step in honoring the grantees' right to define how they would approach the work they were about to undertake, as well as ensuring the grantees would be comfortable with the assistance they received. The grantees interviewed a short list of TA providers selected by the foundation after reviewing their responses to a Request for Qualifications (RFQ), and decided unanimously on a TA provider with expertise in the asset-based community development (ABCD) approach.

This technical support was provided by an associate of the Asset-Based Community Development Institute (ABCD) at Northwestern University. Research conducted by ABCD offers evidence that when communities organize around their assets rather than their needs, improvements in the local neighborhood can result in numerous areas, including the physical, environmental, social, and economic contexts (e.g., Kretzmann & McKnight, 1993; Kretzmann & Puntenney, 2010; McKnight & Block, 2010; Puntenney & Moore, 1998). Outside practitioners of asset-based community development and other scholars have also documented how mobilizing communities using an asset-oriented approach can lead to more engaged residents with expanded capacity for addressing community issues (e.g., Blejwas, 2010; Green, 2010; Snow, 2001).

In accepting the grantees' selection of the ABCD Institute as the technical support provider, the foundation was aligning itself with other funders around the country that support community-based efforts to address entrenched social problems. There are numerous examples of funders supporting grassroots community building strategies that begin with an asset orientation. A few examples:

- The Denver Foundation's Strengthening Neighborhoods program was launched in 1998 after several years of planning and development. The program offers small grant support and leadership training to grassroots groups in ten target communities. The program began with a strong commitment to an asset-based community development approach, and has been refined over the years to incorporate closer linkages of small grants with larger grants to organizations in the area that provide leadership training and other capacity building supports.

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<sup>4</sup> One of these grantees failed to meet the majority of project objectives and dropped out of the grant program; we will discuss the four grantees that are currently part of the program.

- The Dade Community Foundation's approaches all of its program activities with a focus on building community. It conducts activities and supports efforts that build community assets and relationships among individuals, organizations, and communities that connect people with resources and opportunities to improve their quality of life. The goal of each grant is to strengthen relationships between and among the diverse residents of the Miami-Dade community; all grant proposals are considered in the context of the Foundation's commitment to bringing the area's diverse ethnic and social groups together in constructive relationships. It seeks grantees that have a deep understanding of the needs, interests and resources within the communities they serve, and that clearly understand their unique role and contribution in responding to these needs and interests.

There are more funders that support community development projects that, while they do not identify explicitly as having an asset orientation, nevertheless reflect an underlying belief that building on the good things found in tough neighborhoods can result in positive outcomes. A few examples:

- The W.K. Kellogg Foundation funded the Boston Health Public Housing Project, a four-year project that brought together research universities, public housing residents, and Boston health and housing agencies to address issues of pest control and asthma in Boston public housing. The role of the residents was greater than that of research subjects: residents set the priorities for which environmental issues should be tackled first, and were compensated for their time participating in the project (W.K. Kellogg Foundation, 2005).
- The Health Action Fund in Dayton, Ohio, used a non-traditional model to encourage neighborhoods, community groups, and churches to identify problems and develop strategies to encourage the development of health promotion and prevention programs within the community. Available only to community groups, these funds were intended to help the groups address the needs they had identified. Community members took leadership roles in making their neighborhoods healthier. Since 1993, 41 projects were funded with \$500 or less, with over 5,600 individuals participating in programs. Through this project, communities were empowered to identify and meet their own needs and developed trusting relationships with academics; academics learned that the community is an integral partner in the promotion of health; and natural leaders in the community were identified and offered academics a point of access into the community (Maurana & Clark, 2000).

The principles and practices associated with asset-based community development have also been central to several unique projects associated with neighborhood health prior to their application in this project.

- In Minneapolis, the Allina Foundation brought groups of residents and health care workers together to identify and seek local solutions to issues that had an impact on the community's health status. Over a thousand people were organized over a two-year period and the Healthy Powderhorn project was launched in the mid-1990s as a community-based initiative to improve health and wellness in the neighborhood. Part of the work undertaken in the first year was to identify the assets already existing in the neighborhood that could be mobilized toward the community's health objectives. By the second year, the community had discovered and connected enough local assets to start the

planning process for the Powderhorn/Phillips Cultural Wellness Center, which continues as a community health provider to the present day.

- In Michigan, the W.K. Kellogg Foundation was an early funder of Healthy Community Partners, which used an asset-based approach to create a resident-driven vision for community health in the St. Mary's neighborhood of Saginaw. The neighborhood partnered with two universities involved in health professions training and a local hospital to utilize local residents as “educators.” These residents offered insights to the professionals in training on understanding how the community defines wellness and well being, and how they could—in their future professional careers—collaborate with local associations, organizations, and institutions on local healthy community initiatives.
- Funded by the Chicago Community Trust, the Community Memorial Foundation and other local funders, a community-based project Greater Lyons Township outside Chicago worked to build a community that would be especially friendly to older adults. Using an asset-based approach, older adults living in each of the 20 communities that comprise the township came together in a project that identified local assets that could be mobilized toward creating a community that was friendly to people as they aged. Forming a 100-person strong community council, older (and younger) adults actively engaged in defining and advocating for the kinds of amenities they thought they would require to successfully age in place, including healthy appropriate housing, safe public spaces, easier access to public spaces and activities, and a variety of other things.
- In Chicago, the West Side Health Authority (WHA), a local community-building group, mobilized local citizens, associations and institutions to improve the health and well-being of the residents of the West Garfield and Austin neighborhoods. Working with their partner group, Every Block a Village, WHA promoted (and still promotes) health through four related programs: Healthy Lifestyles; Junior Healthy Lifestyles; Healthy Babies for Healthy Communities; and a research project aimed at better understanding the community’s health challenges. Recent accomplishments include lead testing for about 240 children and 350 homes, and “community medicine” training for more than 400 Cook County physicians.

Asset-based community development is most well known as a method for engaging diverse audiences around the positive elements of community, and its essential principles and practices include:

**Principles:** people-centered, resident-driven, asset-based, locally focused, bottom up or grassroots orientation.

**Practices:** asset mapping (identification of different types of local assets) and asset mobilizing (organizing residents to use their assets to address local issues).

The approach emphasizes six types of assets present in a local context, and suggests that some form of each of these asset types is present in every community, no matter how disadvantaged or disinvested it may appear to be.

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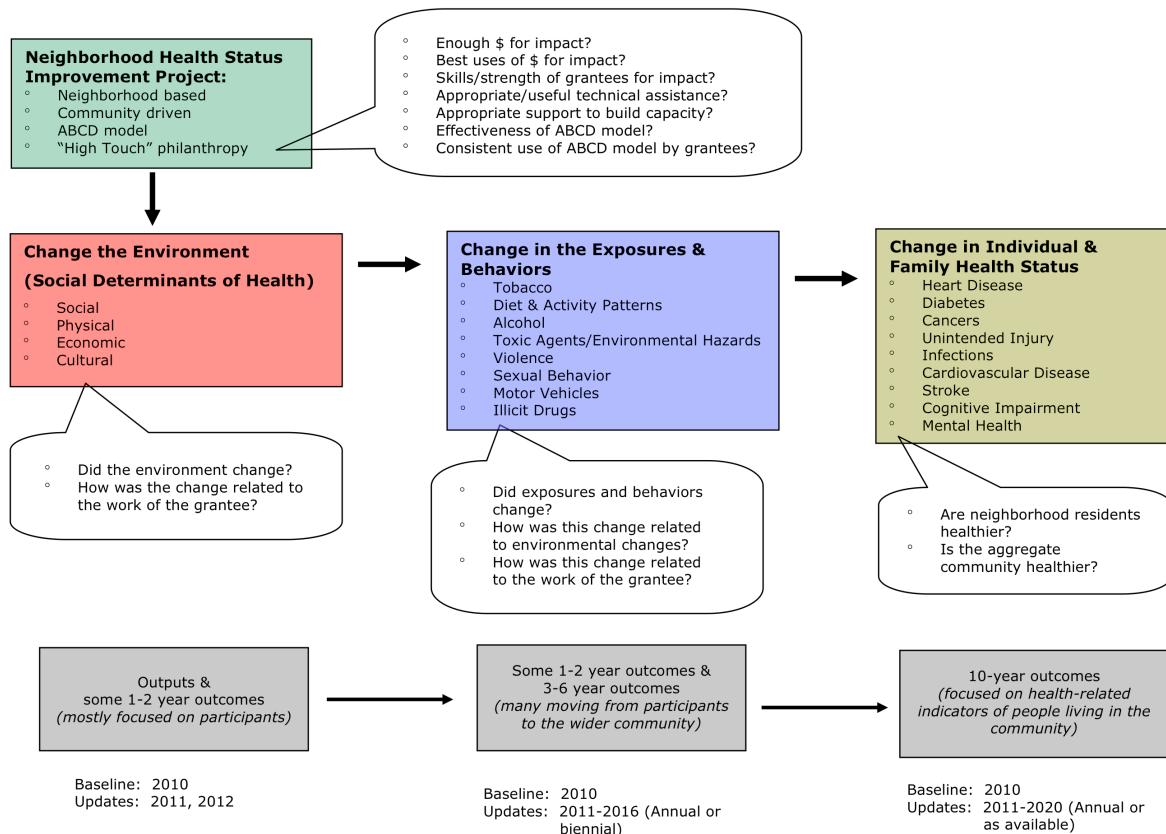
1. Individuals: the talents and skills of local people.
2. Associations: local informal groups and the network of relationships they represent.
3. Institutions: agencies, professional entities and the resources they hold.

**Context:**

4. Infrastructure and physical assets: land, property, buildings, equipment.
5. Economic assets: the productive work of individuals, consumer spending power, the local economy, local business assets.
6. Cultural assets: the traditions and ways of knowing and doing of the groups living in the community.

Because asset-based community development is a place-based and resident-driven, there is no single method or model for practicing this approach. Instead, every community designs and implements its work based on the vision it develops for a healthier future and the assets it identifies as available for mobilizing to action. As the projects associated with this study worked through the repeating cycle of *assess, plan, and do*, the *doing*—or action—was critical. Although assessment and planning are also necessary steps in the community development process, grassroots resident engagement usually works best when people can take regular action that produces small but noticeable changes in the community. The primary purpose of all of the local activities was to engage residents and mobilize them around local health concerns, broadly defined. Renewable on an annual basis, the grants provided funding for each community to conduct small-scale local research—including an environmental scan and asset mapping—most relevant to their own concerns, and develop and implement strategies through which they could engage, organize, and empower residents around health issues and outcomes, both in terms of direct action and advocacy.

**Figure 3: Neighborhood Health Status Improvement–Change Model**



The foundation's model for change for this project is illustrated in **Figure 3** on the previous page. Prepared by the funding program's evaluators to reflect the understanding of the foundation, the ABCD technical support provider, and the evaluators, the model illustrates assumptions about the social determinants of health, the asset-based community development orientation, and the kinds of long-term improvements in the health status that might be achieved through such an asset-based resident engagement process.

For the entire grants program, the asset orientation was central, with the initial community-based research balancing asset mapping with more traditional needs assessments. This orientation allowed the grantees to begin building on the positive elements of their communities and to understand that while they could not solve every problem on their own, their own voices and energies were critical to the process. With the underlying assumption being that the communities would initially consider the social determinants of health rather than trying to directly impact individual health outcomes, the funder acknowledged that changing health among community residents would require far more than simply changing individual choices that impact health, but rather, would demand that the context in which residents make choices change for the better. The funder recognized that for residents to have any hope of changing either the social determinants of health or individual health status, they would require long-term financial support as well as partners at the local agency and institutional levels. But the foundation also recognized that the impetus to launch community building activities needed to come from the residents living in each place, and that as residents organized around relatively small activities and plans, they would gradually increase their capacity to effect larger scale change. Therefore, the foundation both offered a great deal of autonomy and flexibility to each grantee in terms of designing and implementing their own community plan to improve neighborhood health, and committed to multi-year funding to support ongoing plans. Starting at \$65K in the first grant year, the funding program was designed to gradually increase the financial support provided each year to a total of \$185K during the third year (and subsequent years) as the neighborhood plans were fully geared up in the process of implementation. The foundation also anticipated that its own support would eventually be leveraged to bring in funding from additional sources as the local projects gained in size and sophistication.

### Grantees and Their Accomplishments

Beginning in June, 2008, and continuing to the present, the four community groups currently receiving funding from the Neighborhood Health Status Improvement grants engaged in direct action in their neighborhoods. The TA provider offered support via face-to-face meetings and community events, as well as ongoing telephone and email support. Initial support was comprised of a day-long training in asset-based community development, help with establishing strategies for approaching the work, and offering regular advice to support and encourage the work. As the projects established themselves and began organizing in earnest, the TA provider also delivered specific training to individual groups, in areas such as leadership development, engaging hard-to reach residents, and launching small community improvement efforts through the use of neighborhood mini-grants. Grantees also came together and began to build cohesiveness among themselves, and to talk together about ideas that had worked, and issues and challenges they were all facing.

The following paragraphs describe the grantee in each of the four neighborhoods, and then briefly review the work accomplished to date by each one. Each project was uniquely configured, including different types of local partners and different staffing arrangements. Each project had at least one part-time staff person dedicated to overall project coordination, and at least one person dedicated part-time to resident coordination/organizing. On some projects these tasks were assigned to the same individual during Year 1, but in Year 2, all projects increased the staff dedicated to resident coordination/organizing, most to at least one full-time equivalent.

### **Community One:**

This project is anchored at a 90-year-old settlement house located in the neighborhood. The project was launched with partners that include a university-based community health program and local health care provider, as well as two neighborhood associations. The project area includes a population of about 2,100.

Community One's project had numerous successes during Year 1 that increased residents' confidence in their ability to have an impact (e.g., letter writing campaigns, advocacy with the Mayor, involvement in gaining fund for environmental clean up site in the community). The project engaged a group of residents through two existing—though stagnant—neighborhood associations, which actually merged in forming the core group for this project. More than 80 individual residents and other community stakeholders attended neighborhood meetings, and about 18 became regular participants who took on more and more responsibility for project activities over time. The co-chairs of the group are neighborhood residents and the number of executive committee members who are neighborhood residents increased from three out of eight in Year 1, to five and then six out of eight by the end of Year 2.

Residents worked together to address community-defined issues, including mediating a problem with street lighting, and changing the food options served at neighborhood meetings to healthier fare, and actively supporting block club development and capacity building for block club captains. The neighborhood group pushed for some new health-focused activities in the community and took on an advisory role for a larger city community redevelopment effort starting in their area (larger than the grant project area), with a view to ensuring resident involvement in the planning for that effort. The project administrator, with the support of the foundation, successfully advocated for the city planning process to move more slowly to ensure resident participation in establishing the vision for the future of the neighborhood. The neighborhood group also worked with grant staff and university partners to develop its community survey, which was conducted in Year 2 rather than Year 1. The door-to-door survey method conducted by students did not generate much data, and the group ended up generating what information it did gather from meetings in the community. At the end of Year 1, Community One had accomplished a great deal in the way of community engagement and solidifying their resident team, and, although they had completed only a modest map of local assets and a community needs scan, the group learned about what the community cared about through less formal means than a community assessment. The project learned that residents had a number of issues that concerned them, including beautification, lead abatement/containment, education, access to fresh fruits and vegetables, job readiness, healthy youth activities, and crime and drugs. But they also learned that residents were willing to get involved in a variety of ways, including creating a public park, working to decrease guns and violence, planning and implementing block parties and other celebrations, cleaning streets and planting flowers, and

advocating for a youth center. Fully 78% of those surveyed offered at least one way they would be interested in getting involved.

By the end of the first year the neighborhood group was strong and ready to undertake both small-scale community action and the planning process scheduled for Year 2. The resident concerns and interests discovered in Year 1 were used to drive discussions about actions that could and should be taken to create a healthy neighborhood. For much of Year 2, the neighborhood meetings were broken into three working groups focused on 1) public safety/block clubs; 2) health; 3) housing/jobs. The groups identified goals, strategies and activities that were both short-term and long-term. As part of the *assess, plan, do* approach, groups created a strategic plan that addressed immediate needs and more long-term strategies (e.g. create employment pathways for neighborhood residents). At the same time the residents of Community One were engaged in planning, they were also engaged in numerous local improvement activities and generated a number of intermediate outcomes.

- Youth designed community welcome kits.
- Resident participation in workshops and conferences, e.g., in community gardening.
- Community garden with raised gardening beds developed on a corner lot.
- Annual community clean sweep and block party events
- Growing list of block captains.
- Growing representation of neighborhood in broader community, e.g., on boards of directors, sector planning committees.
- Guest speakers deliver talks on resident-defined topics at community meetings, e.g., 2010 Census, access to the nearby soccer stadium, resident health promotion projects.
- Neighborhood group members key to chartering a local Rotary Club.
- Healthy living and home repair classes made available to residents.
- Community information shared broadly.
- Governmental officials engaged, e.g., the police and neighborhood services departments attend community meetings to provide information.
- Local businesses engaged in the planning process.
- Neighborhood active in the larger city planning process.
- Neighbors increasingly attend government meetings to provide input and advocacy for issues of importance to the neighborhood.

The final health improvement plan for Community One includes three major focus areas and numerous activities under the following categories:

#### Work/Life Opportunities:

- *Prepare youth and young adults for the future* through expansion of teen club programming, connecting youth with targeted employment resources, and exploring programs for the reintegration of delinquent teens.
- *Create employment pathways for neighborhood residents* through linking residents to training and skill development opportunities, and exploring job opportunities from local employment sources.



### Healthy Living:

- *Support resident participation in healthy lifestyle choices* through supporting resident-implemented health strategies through mini-grants, and classes on healthy living; promoting peer learning and support networks that encourage healthy choices; and increasing access to nearby recreational facilities.
- *Decrease barriers to obtaining health services* through exploring transportation alternatives, and promoting neighborhood resources such as telemedicine.

### Safe and Healthy Environment:

- *Promote healthy housing and physical environment* through beautifying and detoxifying neighborhood areas, exploring partnerships to implement Healthy Homes, advocate for the demolition or rehabilitation of derelict housing and for homeownership opportunities, and advocate for the rehabilitation of a local brownfield site.
- *Create a safe neighborhood* through facilitating changes in environmental design that promote crime prevention, collaborate with police on resident safety initiatives, and clean up empty lots and plant community gardens.
- *Cultivate an environment of community empowerment for strategic engagement* through organizing and supporting block clubs, providing regular community-wide communications about news and opportunities, linking residents with other community assets, and supporting resident participation and collaboration in all development processes affecting their lives.

### Community Two:

This project is anchored at a community development corporation with a 35-year history in the neighborhood. The project was launched with partners that included two health centers, a housing investment group, a business association, a youth center, and two resident associations. The project area includes a population of about 3,181.

Community Two began their project by convening a small neighborhood council with a solid membership of 4-5 individuals, and invested energy—with limited initial success—in increasing the size this council. The group helped guide the project's work and initially reviewed the community survey before it was completed. Community Two worked hard during Year 1 to balance the community organizing component of the project with information gathering for the community assessment, so that they would have both products at the end of the grant period. During Year 1, the organizers consciously worked to bring residents to the table from the parts of the catchment area not strongly represented. The project's aggressive pursuit of participants from specific streets paid off at their spring community meeting, at which they had several new, active participants representing these areas. The neighborhood council members helped with the community inventory and asset map, starting out by conducting it among their neighbors and other people they know, as well as helping to create plans for doing it in the community at places where people come together, e.g., churches, senior housing, etc. Because the area included a high percentage of Hispanic residents, and because many of them were connected with a local Catholic Church, this became a central organizing area for Community Two. But after the resident group started to solidify, the organizers also engaged in outreach to African Americans

in the community. That effort was slow to produce results, but the use of natural partners to more effectively engage these residents paid off, and neighborhood meetings increasingly included people from different racial groups in the community. In its efforts to engage broad representation, Community Two also developed bilingual training materials and invited caterers representing different food styles to provide meals for their meetings.

Community Two was particularly successful in integrating an asset-oriented approach to building community health with its own organizational approach to organizing the community. Almost 40% of respondents in its neighborhood survey indicated they had lived in the area for more than 20 years, and 60% said they belonged to some kind of community group. Tapping into this potential became a strategy of this community. The project used the Resident Health Promotion Projects as an opportunity for engagement around health, and facilitated a working session for residents on completing project proposals. Residents requested funds for, and completed, four Health Promotion Projects in Year 1, including a clean up effort, two community gardens, a youth beautification effort, and an effort focused on greening a vacant lot.

By the end of the first year the Community Two neighborhood group was poised to undertake the planning process scheduled for Year 2. During the first community visioning meeting, the resident group became galvanized around the drug issue in the neighborhood. Two resident factions launched a potentially volatile argument about how to approach the problem of trafficking on street corners. One group argued that residents couldn't do anything until the police got rid of the dealers; the other group argued that the time had come for residents to take action themselves. One elderly life-long neighborhood resident and a local priest challenged the residents at the meeting to make a commitment to doing something positive, and doing it immediately. Within the space of an hour, preliminary plans were made for a resident march, and strategies for both spreading the word and engaging local police officers were complete. The factions agreed that their agendas were the same, and the incident served to solidify the neighborhood group, who agreed that the number one focus area on their community-building plan would be related to the neighborhood drug problem. Community Two proceeded through the planning year with two primary foci: continuing and expanding their neighborhood anti-drug marches, and developing their health improvement plan. Each resident meeting provided time for committees to work on specific areas in the plan, and for the entire group to discuss the marches. Many of the activities undertaken during the year focused on the drug issue, and the project continued to generate outcomes related to this, and other, issues during year two.

- Established a strong partnership with the city police.
- Engaged more than 50 residents in the planning process.
- Engaged as many as 150 residents in community events.
- Developed and supported the growth of four block clubs.
- Engaged government officials and representatives of local institutions.
- Developed a successful communications strategy for announcing local opportunities.
- Nurtured growing resident relationships.
- Worked with police to install camera at a drug hot spot in the community.
- Worked with police to monitor drug activities and design a process for residents to safely call in incidents without fear of retaliation.
- Built strong relationships between police and residents.
- Prompted police undercover work that resulted in 17 arrests and half a million dollars in assets seized.

The final health improvement plan for Community Two includes four major focus areas and numerous activities under the following categories:

#### Drugs and Alcohol:

- *Increase youth engagement* through opening a youth drop-in center, and exploring and offering new teen activities locally.
- *Promote neighborhood self-improvement* through supporting block clubs and neighborhood events, organizing anti-drug and opportunity promotion marches, and continuing the Take Back Public Space campaign.
- *Campaign Against Drugs* through informational brochures, seeking media attention for local efforts and local advertisements, explore anti-buyer initiatives, and support drug free neighborhoods.

#### Personal Lifestyle Changes and Healthy Opportunities:

- *Decrease the social isolation of seniors* through health improvement initiatives.
- *Promote use of neighborhood green space* through vacant lot beautification and community gardens, and building a local playground.
- *Leverage existing assets to increase access to health resources* through assisting the perinatal network with a healthy neighborhoods assessment, link block club input to organizations looking for funding, and explore partnerships with agencies that promote neighborhood health status improvement.

#### Youth Development:

- *Offer safe places for youth to gather* through opening a youth drop-in center, and identifying other assets to be used as safe spaces.
- *Promote youth/adult relationships and positive role models* through connecting youth to college students, and encouraging youth resident health promotion projects.
- *Engage and educate youth for future success* through conducting a youth voice survey, supporting drug free neighborhood petitions, developing asset and referral listings, teaching life skills, and promoting community pride.

#### Public Safety:

- *Support neighborhood self-improvement* through promoting community pride, and continuing the Take Back Public Space campaign.
- *Improve neighborhood and police relation through community responsibility and teamwork* through facilitating officer support at resident meetings and events, ensuring interaction between city decision makers and neighborhood council, support block club meetings and events, and promote and support anonymous illegal activity reporting sheets.
- *Advocate to improve city infrastructure as it pertains to safety* through city property fencing, creating a neighborhood task force on vacant houses, tearing down hazardous vacant houses, and improving street lighting.

### **Community Three:**

This project is anchored at a rural health network with a 10-year history in the community. The project was launched with partners that included the eight agencies participating on the county health planning council, the public library, local school district, the housing council, the office for aging, a local youth center, and an emerging resident association. The project area includes a population of about 5,041, scattered across three small towns and a large rural area.

For Community Three, the asset-based community development approach resonated from day one in the sense that the grassroots orientation appeared to come naturally for them. This may have been because it is a rural group and residents tend to be more accustomed to doing things for themselves. Unlike the city grantees, the relative independence of the project from an established institution also seemed to give this group of residents the sense that the project was owned entirely by the community. In this rural area, the issues associated with poverty and race are not as visible as they are in the city, though concentrations in specific residential areas do exist. Poverty, in particular, is sometimes difficult to discern without traveling extensively on back roads. The isolation of minority groups and extreme poverty is actually more intense because of the distances between people, and makes it even more difficult to mobilize all parts of the community. During Year 1, the project convened a group of about 18 residents who called themselves *Champions*, and who met regularly to discuss the future of the community and the activities in which they wanted to engage. The group included residents and individuals employed by local organizations and agencies (e.g., the youth center, the county, etc.). The Champions group gradually reached out to other local development efforts, for example, by rotating attendance at the community revitalization meetings, and eventually the members of some of these initiatives merged with the larger project group.

The project launched conversations with the local schools, the three town boards serving the area, business groups, farming groups, etc. An early success for this group came when the Champions connected the local Rotary with a migrant health center around the opening of a one-day-a-week dental clinic. The Mennonites, a group originally identified as somewhat marginalized in the community, took the lead on starting a farmer's market using a resident health promotion mini-grant to help launch this effort. Once the Champions group was solidified, the project stepped up its outreach to the marginalized poor (especially the homebound and very isolated) through all of their connections in the three communities. Five resident health promotion projects were funded in the first year, including the farmer's market, a program to spay and neuter feral cats, training on the inclusion of kids with disabilities, a baby exercise program, and a community fitness program. Additional resident projects during Year 2 included a community mural, transportation for a local food distribution program, and preliminary work on a Scottish festival and a business plan for a local craft shop.

By the end of Year 1, the project completed and delivered a comprehensive community assessment, including the results of their asset-mapping effort, and a broader community scan. The assessment was designed to function as a roadmap for the group through Year 2 and beyond, because it included a rich array of local assets, and because it reflected the extent to which the project had already started to make connections and spin off independent local activities. The asset-mapping process revealed several areas of community concern, including beautifying the project area, increasing economic opportunity, expanding opportunities for physical exercise and social activities, changing personal health behaviors, and increasing services. The Champions

and the larger community used these areas as the initial categories for work groups during the planning undertaken in Year 2. Starting that planning effort with a community-wide meeting attended by 40 residents, the project launched a series of meetings regularly attended by 30-40 residents who contributed ideas and labor to both planning future activities and implementing current ideas. Some of the intermediate outcomes achieved by Community Three include:

- Established a monthly award for a resident who gave back to the community in an important way (the first award went to a cat who spent his days in the window of a store on Main Street).
- Numerous mentions of the project in the local media.
- Outreach efforts to hard-to reach members of the population regularly undertaken at the food pantry, Head Start, and other venues, in addition to door-to-door efforts.
- Strong relationship developed with the mayor and other government officials.
- Leadership training for members of the Champions group.
- Weekly farmer's market established.
- Youth run coffee shop and entrepreneurship training launched.
- Youth center renovated and new activities added.
- Planters installed and maintained on Main Street.
- New safety devices in the form of handrails and painted curbs installed on Main Street.
- County social service providers bringing regular services to the youth center as a central community gathering point.
- Relationships developed with all the town boards, the local school district, and local churches.

The final health improvement plan for Community Three includes three major focus areas and numerous activities under the following categories:

#### Physical Health of the Neighborhood:

- *Promote healthy behaviors* through increasing opportunities for physical activity; increasing availability and consumption of fruits and vegetables; preventing/decreasing tobacco, drug, and alcohol use, especially among youth; and increasing opportunities for stress management.
- *Increase access to social services* through increasing awareness and utilization of existing services, and increasing the services that are available and accessible.
- *Fund two-three resident health promotion projects* that will improve personal health behaviors and/or increase access to social and human services.

#### Social Health of the Neighborhood:

- *Promote expansion of existing community events* and incorporate healthy activities and foods at these events.
- *Develop new healthy community events that promote social connections* through developing evening and weekend activities, especially for youth; developing more group activities for all ages, including intergenerational activities; and developing new annual community events.

- *Fund two-three resident health promotion projects* that will increase the number of community activities that promote healthy social interactions and other healthy activities.

#### Economic Health of the Neighborhood:

- *Promote the development and growth of small business* through creating a micro-enterprise program to support the start-up of locally-owned small business.
- *Create attractions that will draw tourists/consumers to the area* through creating a store to sell locally produced goods, exploring the creation of other attractions such as Mennonite tours and talk, a tour of historic homes, and the creation of a wine museum.
- *Improve the appearance and amenities of the area* through improving the condition of the storefronts and sidewalks, and providing a public restroom and picnic tables.
- *Fund two-three resident health promotion projects* that will improve the economic health of the neighborhood.

#### **Community Four:**

This project is anchored at a local health center with a 35-year history in the community. The project was launched with partners that included a local school, a city recreation center, an urban garden group, a local university, and local community associations and the alliances. The project area includes a population of about 1,300.

Community Four got off to a rocky start due to health issues among key project staff and the unexpected and abrupt departure of the project coordinator midway through the first year. This setback was overcome in the final months of Year 1 and the project began making strides in its neighborhood engagement strategies and activities. With encouragement from the technical support provider, the project began to move forward by simply listening to residents and focusing on bringing people together, rather than on building a rigid structure for their involvement. After the loss of the project coordinator—who departed before completing the community scan and asset mapping—another staff member stepped in to complete the requirements for Year 1 of the grant, and position the project for the planning in Year 2.

During the final months of Year 1, the project conducted a series of 10 youth and 10 adult focus groups, during which relationships were built, project enthusiasm developed, and community surveys completed. The project provided training for youth and adult leadership for these events, and these individuals helped facilitate the focus groups that followed. Through the focus groups, 87 youth and 120 adults completed the community survey, and the information generated through the survey was delivered back to the residents through a series of eight community tie-back meetings that occurred early in Year 2. At this point, opportunities were created for residents to collectively explore the assets identified and their own capacity for doing something positive with them.

The project also supported youth from the local community center to work with students from a local technical institute for 10 weeks to conduct community research and develop a publication that told a positive story about the neighborhood. Using writing, photography, and community-based research, the youth gained skills as well as local knowledge through the process. These youth were also part of the community tie-back meetings, and participated in the identification of

local health priorities and community plans. At these meetings, a total of 52 residents signed up for community projects, and resident health promotion project opportunities (mini-grants) were introduced to these individuals. Of these, 25 indicated a willingness to serve on the resident council, and eight volunteered to serve as co-chairs. In the summer of 2009, the TA helped facilitate a large community meeting, delivering a basic introduction to asset-based community development, and supporting project staff in helping the active residents design their council, which was comprised of adult and youth residents. The meeting also functioned as a visioning session, and the community began to define community health priorities and think about the planning phase of their work.

With a special emphasis on youth, the project incorporated their youth residents in a number of ways, and hired a youth coordinator to maintain their interest. Young people undertook an assessment of the physical and economic assets in the neighborhood, with training ahead of time to approach the things they found with a positive mind set, seeing them as potential community building blocks rather than community problems (e.g., empty lots were viewed as potential green space rather than eyesores). As the project progressed through its planning year, young people also accepted roles in helping to move the project forward, including working again with the technical institute on materials that support the project, and planning community art projects to help create a stronger sense of community. The project learned during Years 1 and 2 that the community wanted to build a more positive identity, so many of its activities have this as community image as a major or minor objective. Some of the intermediate outcomes achieved by Community Four include:

- Increased physical activity on empty lots, e.g., kickball.
- Family Movie Night launched in response to resident interest, and set to expand to a more visible city venue.
- Community clean-ups undertaken each year, followed by neighborhoods cookouts.
- Community resource guide developed.
- Relationships forged with local pastors.
- High quality healthy foods offered at a local "grocery fair."
- Improved access to prescription medicines through partnership with a national organization.
- Relationships developed with local for-profits, e.g., the funeral home.
- Creation of a parent group that coordinate transportation for their children to the local recreation center.
- Series of learning community events planned.
- Community gardens prepped for the summer and flower giveaway completed.
- Most Improved Streetscape contest held with 13 entries.
- Block club development effort underway.
- Ongoing and expanding partnership with the local school

The final health improvement plan for Community Four includes four major focus areas and numerous activities under the following categories:

#### Public and Personal Safety:

- *Improve the physical condition of the streets and lawns* through organizing regular neighborhood clean ups, and training residents to collaborate with city officials to maintain street conditions.

- *Create social connectedness by promoting collective safety* through establishing and supporting community groups in the four community quadrants, and establishing effective communications in the neighborhood.
- *Partner with the city and other organizations that support safety* through establishing and strengthening partnerships with city officials to mobilize safety initiatives, and building on existing relationships to mobilize resources for public events.

#### Personal Development:

- *Improve the physical health of the neighborhood* through creating opportunities for youth and adult recreational activities within the target area, partnering to provide nutritional education and healthy cooking alternatives, and educating adults and youth about medical, dental, and personal hygiene.
- *Develop life management skills* through providing opportunities and programs for residents to learn problem solving, proper parenting, and financial literacy; and providing continuing education and workforce development opportunities for youth and adults.
- *Develop youth adult mentoring programs* through developing learning communities in partnerships with local schools, and partnering with churches and other organizations that offer mentoring.

#### Community Pride and Identity:

- *Increase the beauty and functional use of the physical environment* through enhancing existing green spaces and public gardens; improving streets and sidewalks by incorporating benches, bike paths, art work, and bus shelters; enhancing play spaces and developing new ones.
- *Create a neighborhood identity* through incorporating community art projects through the area, and exploring innovative project to draw positive attention to the area.

#### Mobility and Transportation:

- *Partner with institutions in the target area to create a transportation alternative for residents* through creating a transportation model in a collaborative manner.

### Challenges Overcome

The grantees faced numerous challenges during Phases 1 and 2, including those related to adopting and implementing a relatively unfamiliar model of community development, those related to actually engaging their community in productive ways, and those related to producing and delivering products that would both satisfy the foundation's expectations and their own community development needs. One challenge—unsurprising to the TA provider, but new to the grantees—was the fact that asset-based community development, while based on simple principles, can be difficult to do and requires sustained effort as well as creativity to implement. Any form of grassroots organizing, or "bottom-up" development requires long-term investment for success, but ABCD can be particularly slow at first as residents reorient their thinking from the needs to the strengths focus. In addition, the resident groups associated with these grants had to think about the pathway from their small, local community building efforts, to a generally healthier community years down the road. As this effort progressed, residents could more clearly



see the importance of, for example, their beautification activities, on the overall health of their community, but this took regular reminders that the ultimate goal needed to be articulated as a healthier community. The grantees are still working on this issue, and gradually building a sort of local logic model for getting to actual health outcomes. This effort has been facilitated by each grantee's work with the program evaluators, who helped them identify short, medium, and long term health outcomes for each of their project activities.

All of the grantees demonstrated strengths and weaknesses in their community organizing and planning over the two-year period, and while some of these were consistent across all the groups, how these strengths and weaknesses manifested themselves was generally different for each group. So, for example, while all of the groups encountered some difficulties with resident engagement, Community One resolved the issue by tapping into the energies of an already existing resident group, while Community Two worked with a smaller group of residents until a major local issue sparked involvement, and Community Four offered small temporary stipends to residents for participating in some community engagement activities. The difficulties Community Three encountered in organizing were initially overcome by "following the flow," that is, taking advantage of those residents who would come out and participate. However, in spite of their success in developing a strong resident group, they remain aware that there is more to accomplish in terms of engaging the most marginalized residents in their community. Planning, too, presented some challenges for the grantee groups. Community Three was able to retain interest and build four very strong work groups who worked independently on their component of the planning process. The other communities had active resident groups, but these groups preferred more active involvement of the project staff in terms of developing their plan.

Community One encountered some initial challenges related to its history in the neighborhood and the array of community work its sponsoring organization is engaged in. While most of that work can be construed as addressing the overall health of the neighborhood, the challenge was for the organization to be clear with the resident group that *they* would need to direct the health improvement work and not assume the organization would be in charge. Community One also needed to overcome its tendency to rely on professionals associated with its key institutional partners (e.g., the universities) to define community health objectives, and instead rely on the active resident group for leadership. The professionals associated with the project also actually slowed progress in year one by merging students training (e.g., reliability and validity) with the community's objective of better understanding their local assets.

Community Four experienced the challenge of losing key staff at an important point. This is a relatively common occurrence in any community-building project, and this group successfully rallied to overcome the setback. But the underlying reality represents a learning opportunity for all of the grantees, who need to consider what kind of succession planning they may need to undertake in order to be able to withstand such losses.

A challenge faced by all the grantees, and the foundation as well, was the deterioration of the economy as the grants program began. For the grantee communities and residents, problematic conditions became ever more immediate as the job market tightened and state and federal funds diminished. For the foundation, the prospect of investing significant dollars during a period in which the endowment was shrinking was also a challenge. Both the grantees and the foundation overcame this challenge with renewed commitment to carry forward. In the communities, the

projects represent one bright spot in what could be even greater neighborhood disinvestment; for the foundation, the early accomplishments of each group represent sufficient impetus to carry on.

### Implications of Grassroots Organizing for Community Health Improvement

We started this paper with a brief review of health disparities research and the social determinants of health, and presented both national and local data on how they impact poor and minority neighborhoods in particular. We reviewed some of the literature on social capital and described some funders' efforts at the community level to address inequities, including those that have an impact on resident health. Finally, we presented a case study of an effort in New York state directly supporting neighborhood residents to take action on improving the social conditions that contribute to poor health. We also pointed out the array of federal agencies that increasingly consider the involvement of affected populations to be a necessary component of any effective future public health strategy. In fact, as the topic of the American Public Health Association's 2010 annual meeting suggests, a critical public health necessity is increased social justice across our communities.<sup>5</sup>

Health is produced through a complex combination of individual behaviors, the social/economic/environmental factors associated with the contexts in which people live, genetics and family history, access to care, and personal experiences. Health can also be undermined by these same factors, and for many minority and low-income individuals, those associated with the contexts in which they live can be especially salient. As their efforts to increase efficiency in service delivery have failed to reduce health disparities, federal, state, and local agencies charged with community welfare have increasingly recognized that institutions cannot deliver health and well being without the participation of the individuals impacted. Specialization of services has resulted in fractured and inefficient systems for addressing the combination of issues faced by poor communities. Institutions face the varying degrees of mistrust and lack of confidence typical of people living in neighborhoods characterized by institutional abandonment, and they end up frustrated by what can appear to be a lack of cooperation among individuals served. Residents in poor neighborhoods, on the other hand, see the ways that institutions have failed to deliver the basics of a healthy life—quality schools, safe streets, reliable transportation, opportunities for reasonable employment—and can respond with behaviors that may seem counter-productive but which may be the best choice among less-than-good options.

There are, of course, disagreements about whether neighborhoods cause their own problems or institutions need to take more responsibility for community well being, but we know that systems of racism and economic injustice contribute to the problems poor communities face. Yet the long history of organizing poor and minority communities around the array of inequities that impact their well-being may provide a model for a starting place in the case of health disparities and the social determinants of health. If neighborhood residents have reduced their hopes and expectations in the face of the conditions they face, and if they see themselves as incapable of altering the course of their lives, they are unlikely to fully participate in either healthy individual behaviors or professionally recommended health strategies. On the other hand, if they understand the nature of health disparities, and that their neighborhood may have been disinvested of

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The title of the American Public Health Association's annual meeting in 2010 is *Social Justice: A Public Health Imperative*.

opportunities for health in addition to all the other opportunities that have disappeared, they may begin to see possibilities for altering some of the conditions that combine to create a place that makes good health impossible. Organizing around such an array of issues is a tall order, but improved health will only happen in these neighborhoods if residents participate by changing their own health behaviors, invest their time in small local actions that can actually impact conditions, *and* demanding changes in the systems responsible for serving them (e.g., police, health systems, schools, etc.). This requires a balance. Poor people are not responsible for the current situation, but the fact is they must engage if it is to change.

Organizing with an asset-based community development orientation allows for small efforts focused on possibilities and positive elements in the community to demonstrate to residents that any individual or small group can take action that produces an improvement in the place, even with very few financial resources. Incrementally more complex and focused activities help people understand themselves as capable actors, in this case as the producers of improved opportunities for health and well being. And as small steps, like planting a community garden, produce visible outcomes, the responsibility for the creation of health is viewed more and more as a collective responsibility. In addition, as small results lead to larger and larger results, residents gain the confidence they need to engage the institutions that bear co-responsibility for community well being on the issues most relevant to them. In our case study, for example, Community Two was characterized by isolated residents afraid to use public space due to the drug sales and use going on in many parts of their community. The very small step of inviting residents to consider their neighborhood from a positive perspective, as well as supporting resident defined and implemented neighborhood improvement projects led to a large and increasingly sophisticated coalition of neighbors who overcame their ambivalence about the police and now engage regularly with them on issues of community concern. The fact that these activities were entirely resident driven made the difference. Nobody told them what to do; nobody told them they had to do it, the organizing project simply pointed out opportunities for regular people to get involved.

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