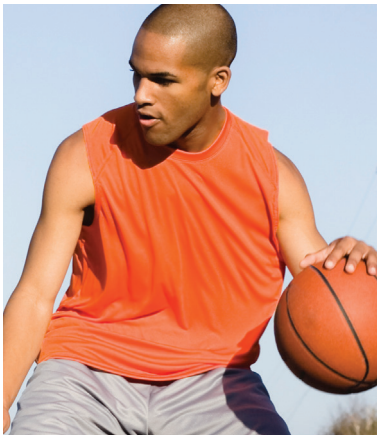
A PRACTITIONER'S GUIDE FOR

ADVANCING HEALTH EQUITY

Community Strategies for Preventing Chronic Disease



National Center for Chronic Disease Prevention and Health Promotion
Division of Community Health

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WWW.CDC.GOV/HEALTHEQUITYGUIDE

Centers for Disease Control and Prevention
Division of Community Health

4770 Buford Highway, NE, Mailstop F-81
Atlanta, Georgia 30341

Phone: 770-488-1170
Fax: 770-488-5964
Email: cdcinfo@cdc.gov

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Additionally, *A Practitioner's Guide for Advancing Health Equity* is not intended to serve as step-by-step instructions, as there is no one-size-fits all approach to advancing health equity. Although this document discusses a variety of evidence- and practice-based strategies, it is not exhaustive. Strategies included may not be appropriate for every organization's situation. Communities must decide what is appropriate for their local context. Therefore, strategies and examples in this guide should be considered in accordance with an organization's and, where applicable, its funder's established protocols and regulations.

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LETTER FROM THE DIVISION OF COMMUNITY HEALTH

PUBLIC HEALTH PRACTITIONER,

There is a growing body of literature exploring how environments in this nation shape our health. To address this issue, public health practitioners are implementing chronic disease policy, systems, and environmental improvements where people live, learn, work, and play. Practitioners are also considering how to ensure such improvements are designed to reverse the negative trends of chronic health conditions among vulnerable population groups. In response to the mounting needs of practitioners seeking reliable tools to advance health equity, the Centers for Disease Control and Prevention (CDC) developed *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease (Health Equity Guide)*.

The purpose of the *Health Equity Guide* is to assist practitioners with addressing the well-documented disparities in chronic disease health outcomes. This resource offers lessons learned from practitioners on the front lines of local, state, and tribal organizations that are working to promote health and prevent chronic disease health disparities. It provides a collection of health equity considerations for several policy, systems, and environmental improvement strategies focused on tobacco-free living, healthy food and beverages, and active living. Additionally, the *Health Equity Guide* will assist practitioners with integrating the concept of health equity into local practices such as building organizational capacity, engaging the community, developing partnerships, identifying health inequities, and conducting evaluations. The *Health Equity Guide* is designed for the novice interested in the concept of health equity, as well as the skillful practitioner tackling health inequities.

We encourage you to visit **WWW.CDC.GOV/HEALTHEQUITYGUIDE** for additional tools and resources that promote health and the integration of health equity into everyday practice. We hope you find the information and examples provided to be useful and an impetus in your efforts to reduce health disparities and advance health equity.

Sincerely,

Leonard Jack, Jr, PhD, MSc
Director, Division of Community Health (DCH)
National Center for Chronic Disease
Prevention and Health Promotion
(NCCDPHP)

Pattie Tucker, DrPH, RN
Acting Associate Director for Health Equity, DCH
National Center for Chronic Disease
Prevention and Health Promotion
(NCCDPHP)

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Core Project Team

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Carolyn Brooks
Centers for Disease Control and Prevention

Rebecca Bunnell
Centers for Disease Control and Prevention

Rebecca Payne
Centers for Disease Control and Prevention

Manal Aboelata
Prevention Institute

Dalila Butler
Prevention Institute

Virginia Lee
Prevention Institute

Shayla Spilker
Prevention Institute

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Contributing Writers and Researchers

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Centers for Disease Control and Prevention

Carolyn Brooks
Belsie Gonzalez
Joi Hudson
Jennifer Kohr
Terry Njoroge
Natalie Stahl

Consultants

Kim Hodgson,
Cultivating Healthy Places

Elva Yañez,
Colibri Strategies Inc.

Emory University Rollins School of Public Health

Jessica Pittman

Prevention Institute

Manal Aboelata
Dalila Butler
Jeremy Cantor
Sana Chehimi
Tony Dang
Rachel Davis
Phebe Gibson
Carolina Guzman
Virginia Lee
Leslie Mikkelsen
Menaka Mohan
Janet Pan
Nicole Schneider
Linda Shak
Ben Simons
Juliet Sims
Shayla Spilker
Sandra Viera
Ann Whidden

SciMetrika

Lesley Guyot

Advisors and Reviewers

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Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion—

Division of Community Health

Anna Berkowitz
Joyce Buckner-Brown
Rebecca Bunnell
Shannon Griffin-Blake
John Francis
Shalon Irving
Leonard Jack, Jr.
Jennifer Kohr
Rashid Njai
Rebecca Payne
Mark Rivera
Angela Ryan
Robin Soler
Pattie Tucker

Division of Diabetes Translation

Larry Alonso
Keri Norris

Division of Nutrition, Physical Activity, and Obesity

Latetia Moore Freeman
Laurence Grummer-Strawn
Sonia Kim
Joel Kimmons
Beverly Kingsley
Carol MacGowan
Stephen Onufrak
Terry O'Toole
Tom Schmid
Katherine Shealy
Demia Wright

Division of Population Health

Lynda Anderson
Sherry Everett-Jones
Holly Hunt
Sarah Lee
Susie McCarthy

Office on Smoking and Health

Steven Babb
Bridgette Garrett
Brian King
Michael Tynan

National Center on Birth Defects and Developmental Disabilities—Division of Human Development and Disabilities

Jacqui Butler

National Center for Environmental Health

Daneen Farrow-Collier
Chris Kochtitzky
Dee Merriam
Margie Walling
Arthur Wendel

National Center for Injury Prevention and Control—Division of Violence Prevention

Sarah Bacon
Linda Dahlberg
Marci Hertz
Greta Massetti
Neil Rainford

Oak Ridge Institute for Science and Education Research Participation Program at CDC

W. Brad Jones

SciMetrika

Tarisha Cockrell
Lesley Guyot
Martha Rider
John Wingfield

Representatives from National and Community Organizations

Linda Aragon
Los Angeles County Tobacco Control and Prevention Program

Sabrina Baronberg
New York City Department of Health and Mental Hygiene

Adam Becker
Consortium to Lower Obesity in Chicago Children

Jim Bergman
Smoke-Free Environments Law Project and The Center for Social Gerontology, Inc.

Elan Bobay
Monterey County Health Department, Steps to Healthier Salinas

Lorraine Boyd
New York City Department of Health and Mental Hygiene

Marie Bresnahan
New York City Department of Health and Mental Hygiene

Isaiah Brokenleg
Great Lakes Tribal Epidemiology Center

Karen Brawley
Public Health - Seattle and King County

Hannah Burton
ChangeLab Solutions

Vicki Carll
Pinellas County Health Department

Caroline Chappell
North Carolina Division of Public Health

ACKNOWLEDGEMENTS (Continued)

Serena Chen
American Lung Association in California, Bay Area Smoke-Free Housing Project

Kristin Cipriani
National Association for Sports and Physical Education

Ann Cody
BlazeSports America

Keith Cooper
American Lung Association, Southwest

Kerry Cork
Public Health Law Center

Shannon Cosgrove
YMCA of the USA

Dave Cowan
Safe Routes to School National Partnership

Quang Dang
ChangeLab Solutions

Char Day
Americans for Nonsmokers' Rights

Daisy DeLaRosa
Boston Public Health Commission

Dr. Scout
Network for LGBT Health Equity at the Fenway Institute

Delbert Elliott
University of Colorado

Karen Farley
California WIC Association

Mark Fenton
Mark Fenton Associates

Catherine Fields
American Lung Association

Chione Flegal
PolicyLink

Rebecca Flournoy
PolicyLink

Barry Freedman
St. Louis County Department of Health

Roberta Friedman
Rudd Center for Food Policy and Obesity, Yale University

Christine Fry
ChangeLab Solutions

Lark Galloway-Gilliam
Community Health Councils, Inc.

Justin Garrett
American Lung Association in California, Center for Tobacco Policy and Organizing

Tony Gomez
Public Health - Seattle and King County

Priscilla Gonzalez
Berkeley Media Studies Group

Bob Gordon
California LGBT Tobacco Education Partnership (LGBT Partnership)

Christine Green
National Complete Streets Coalition

Erin Hagen
PolicyLink

Cynthia Hallett
Americans for Nonsmokers' Rights

Muriel Harris
University of Louisville School of Public Health and Information Sciences

Alisa Haushalter
Bureau of Population Health Programs

Kenneth Hecht
C & K Hecht Consulting

Seung Hee Lee
Johns Hopkins University

Stacy Ignoffo
Respiratory Health Association of Metropolitan Chicago

Delmonte Jefferson
National African American Tobacco Control Network

Allison Karpyn
The Food Trust

Noelle Kleszynski
Association of American Indian Physicians

Ingrid Krasnow
Berkeley Media Studies Group

Hannah Laurison
ChangeLab Solutions

Kathy Lawrence
School Food Focus

Mary Lee
PolicyLink

Christy Lefall
Urban Habitat

Whitney Maegher
NASBE

Shireen Malekafzali
PolicyLink

Jennifer Moore
Multnomah County Health Department

ACKNOWLEDGEMENTS (Continued)

Tammy Morales
Urban Foodlink

Amanda Navarro
PolicyLink

Vu-Bang Nguyen
Urban Habitat

Jeannette Noltenius
Indiana Latino Institute, Inc.

Faryle Nothwehr
University of Iowa, College of Public Health

Ana Novais
Rhode Island Department of Health

Odessa Ortiz
Boston Public Health Commission

Sara Padilla
Community Food Security Coalition

Megan Patterson
Boston Public Health Commission

Katharine Dupont Phillips
Nemours

Lisa Pivec
Community Health Promotion - Cherokee Nation

Janet Porter
Break Free Alliance

Stephanie Ramirez
National Association of Latino Elected Officials

Kurt Ribisl
University of North Carolina Gillings School of Global Public Health

Cheryl Richardson
National Association for Sports and Physical Education

Cynthia Roberts
Rhode Island Department of Health

Catherine Saucedo
Smoking Cessation Leadership Center at UCSF

Sheila Savannah
Houston Public Health Department

Regina Schaefer
American Academy of Pediatrics

Susan Schoenmarklin
Attorney and former consultant to the Smoke-Free Environmental Law Project of the Tobacco Control Legal Consortium

Kevin Schroth
New York City Department of Mental Health and Hygiene

Dave Shaibley
Tobacco Control Law Consortium

Brian Smedley
Health Policy Institute, Joint Center for Political and Economic Studies

Seth Strongin
City Project

Lynnette Swain
Pinellas County Health Department

Erika Terl
National Recreation and Park Association

Mary Thomas
San Antonio Metropolitan Health District

Abby Thorne-Lyman
Reconnecting America

Laurie True
California WIC Association

Adrienne Udarbe
Arizona Department of Health Services

Amanda Wagner
Philadelphia Department of Public Health

Elizabeth Walker
National Association of State Boards of Education - Center for Safe and Healthy Schools

Y. Claire Wang
Columbia University, Mailman School of Public Health

Billie Weiss
Advisor to Safe States Alliance, SAVIR

Stephanie Weiss
The Food Trust

Alzen Whitten
New York City Department of Health and Mental Hygiene

Missy Wilson
Mobile County Health Department

Heather Wooten
ChangeLab Solutions

Ellen Wu
California Pan-Ethnic Health Network

Marc Zimmerman
University of Michigan

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INTRODUCTION

Heart disease, cancer, diabetes, and stroke are the most common causes of illness, disability, and death affecting a growing number of Americans.[4] Many of these chronic conditions tend to be more common, diagnosed later, and result in worse outcomes for particular individuals,[5-7] such as people of color, people in low-income neighborhoods, and others whose life conditions place them at risk for poor health.

(See Appendix A for list of population groups experiencing chronic disease disparities.)

Despite decades of efforts to reduce and eliminate health disparities, they persist—and in some cases, they are widening among some population groups.[8-11] Such disparities do not have a single cause. They are created and maintained through multiple, interconnected, and complex pathways. Some of the factors influencing health and contributing to health disparities include the following:[12,13]

- **Root causes or social determinants of health** such as poverty, lack of education, racism, discrimination, and stigma.
- **Environment and community conditions** such as how a community looks (e.g., property neglect), what residents are exposed to (e.g., advertising, violence), and what resources are available there (e.g., transportation, grocery stores).
- **Behavioral factors** such as diet, tobacco use, and engagement in physical activity.
- **Medical services** such as the availability and quality of medical services.

INTRODUCTION (Continued)

HEALTH EQUITY MEANS THAT EVERY PERSON HAS AN OPPORTUNITY TO ACHIEVE OPTIMAL HEALTH REGARDLESS OF:

- THE COLOR OF THEIR SKIN
- LEVEL OF EDUCATION
- GENDER IDENTITY
- SEXUAL ORIENTATION
- THE JOB THEY HAVE
- THE NEIGHBORHOOD THEY LIVE IN
- WHETHER OR NOT THEY HAVE A DISABILITY[3]

While health disparities can be addressed at multiple levels, this resource focuses on **policy, systems, and environmental improvement strategies** designed to improve the places where people live, learn, work, and play. Many of the 20th and 21st century's greatest public health achievements (e.g., water fluoridation, motor vehicle safety, food safety) have relied on the use of laws, regulations, and environmental improvement strategies.[14,15] Health practitioners play an important role in these improvements by engaging the community, identifying needs, conducting analyses, developing partnerships, as well as implementing and evaluating evidence-based interventions.

These intervention approaches are briefly described below:

- **Policy improvements** may include "a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions."[16]
  Example: A voluntary school wellness policy that ensures food and beverage offerings meet certain standards.
- **Systems improvements** may include a "change that impacts all elements, including social norms of an organization, institution, or system."[17]
  Example: The integration of tobacco screening and referral protocols into a hospital system.
- **Environmental improvements** may include changes to the physical, social, or economic environment.[17]
  Example: A change to street infrastructure that enhances connectivity and promotes physical activity.

INTRODUCTION (Continued)

Such interventions have great potential to prevent and reduce health inequities, affect a large portion of a population, and can also be leveraged to address root causes, ensuring the greatest possible health impact is achieved over time. **However, without careful design and implementation, such interventions may inadvertently widen health inequities.** To maximize the health effects for all and reduce health inequities, it is important to consider the following:

- Different strategies require varying levels of individual or community effort and resources, which may affect who benefits and at what rate.
- Certain population groups may face barriers to or negative unintended consequences from certain strategies (see Appendix B for a list of common barriers). Such barriers can limit the strategy's effect and worsen the disparity.
- Population groups experiencing health disparities have further to go to attain their full health potential, so even with equitable implementation, health effects may vary.
- Health equity should not only be considered when designing interventions. To help advance the goal, health equity should be considered in other aspects of public health practice (e.g., organizational capacity, partnerships, evaluation).

A Practitioner's Guide to Advancing Health Equity provides lessons learned and practices from the field, as well as from the existing evidence-base. This resource offers ideas on how to maximize the effects of several policy, systems, and environmental improvement strategies with a goal to reduce health inequities and advance health equity. Additionally, the resource will help communities incorporate the concept of health equity into core components of public health practice such as organizational capacity, partnerships, community engagement, identifying health inequities, and evaluation.

This resource has four major sections:

- Incorporating Health Equity into **Foundational Skills** of Public Health
- Maximizing **Tobacco-Free Living** Strategies to Advance Health Equity
- Maximizing **Healthy Food and Beverage** Strategies to Advance Health Equity
- Maximizing **Active Living** Strategies to Advance Health Equity

TERMINOLOGY

A clear understanding of definitions is important. The following definitions are offered as a starting place as you review this resource:

Health equity: Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[12]

Health disparities: Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.[7]

Health inequalities: Health inequalities is a term sometimes used interchangeably with the term health disparities. It is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes (e.g., income, education, or race/ethnicity).[7]

Health inequities: Health inequities are a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair.[7,18,19]

Social determinants of health: Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[20]

SECTION 1

Incorporating Equity into Foundational Skills of Public Health

Every day, decisions are made that have an influence on health equity. These decisions may include who is hired, what activities take place, which populations are served, and how strategies are implemented and evaluated. Considering how every decision will impact your health equity goals is an important step in integrating health equity into everyday practice.

This section includes lessons learned from practitioners across the nation who are working to advance health equity. Additionally, key questions for reflection are proposed to stimulate ideas and help you and your organization think about ways to incorporate the goals of health equity into key foundational skills and practices of public health including:

- Building Organizational Capacity
- Engaging Community Members
- Developing Partnerships and Coalitions
- Identifying and Analyzing Health Inequities
- Selecting, Designing, and Implementing Strategies
- Developing Effective Communication Efforts
- Conducting Evaluations

BUILDING ORGANIZATIONAL CAPACITY TO ADVANCE HEALTH EQUITY

ORGANIZATIONS ENGAGE IN MANY PRACTICES—BOTH WITHIN AND BEYOND THEIR WALLS—THAT CAN INFLUENCE THEIR IMPACT ON HEALTH EQUITY. EACH OF THESE PRACTICES (E.G., HIRING DECISIONS, RESOURCE DISTRIBUTION, STAFF TRAINING) REPRESENTS AN OPPORTUNITY TO IMPROVE HEALTH FOR ALL. CONSIDER THESE IDEAS TO ENHANCE YOUR ORGANIZATION'S CAPACITY TO ADVANCE HEALTH EQUITY.

Establish an Institutional Commitment to Advance Health Equity

Create or clarify your commitment by writing health equity goals into critical documents such as mission statements and strategic plans. Support your written commitment with action by establishing permanent structures, such as workgroups or staff positions, to improve health equity practices. Create other informal systems to empower staff to identify and contribute to health equity-related improvements. Additionally, consider conducting an organizational assessment (e.g., Bay Area Regional Health Inequities Initiative Organizational Self-Assessment Toolkit[22]) or review your organization's policies and practices for potential modifications.

Where Possible, Align Funding Decisions with Your Commitment to Health Equity

Establish or revise processes for seeking, distributing, and using resources. Establish a clear understanding of community needs before seeking resources. This will ensure the most efficient use of time and resources. Before distributing funds, make health equity a clear component of funding expectations and requirements to guide the actions of those receiving the funds (e.g., require hiring and collaborating with representatives from underserved communities, require health equity training, develop criteria for prioritizing interventions based on need). Also, consider distributing funding opportunities among non-traditional partners and conducting trainings to build capacity of potential applicants.

Be Deliberate in Recruiting and Building Staff Skills to Advance Health Equity

Reexamine and expand recruitment efforts through outreach to members of professional affinity groups and specific cultural networks. Bring in new skills and perspectives by making experience working with underserved populations a priority in job qualifications, and widely distributing job announcements with an aim toward engaging staff with skills addressing health equity. Additionally, facilitate ongoing training and dialogue among staff and management to help make cultural competency and health equity a part of standard operating procedures.

Track and Capture Health Equity Efforts in Training and Performance Plans

Establish expectations that staff and management engage in activities designed to advance health equity (e.g., training requirements, workgroup participation). Hold staff accountable for these activities in training or performance plans. These expectations may help shift the culture and clarify everyone's role in advancing health equity.

Integrate Health Equity Into Your Services and Resources

Get feedback from community members to ensure services and resources are culturally and linguistically appropriate. Modify services, as needed, to make them more convenient for community members (e.g., bundle services to reduce number of visits, adjust service hours). Continually find ways to improve efforts by tracking those who are benefiting from your services and resources. Also, identify those who are not participating and the reasons for this lack of participation. Ensure anticipated improvements are shared with community members to reinforce partnerships and relationships.

Establish Multi-Sector Collaborations and Relationships with Diverse Communities

Addressing the complexities of health inequities is beyond the scope of any one organization or entity. To build the trust needed to advance health equity, develop multi-sector partnerships and relationships with communities affected by health inequities.

> "WE ARE ACTIVELY WORKING TO STRENGTHEN OUR STAFF AND ORGANIZATIONAL CAPACITY TO ADDRESS HEALTH INEQUITIES. THIS INCLUDES ENSURING OUR INTERNAL WORK IS ROOTED IN THE PRINCIPLES OF SOCIAL JUSTICE AND THAT OUR ORGANIZATIONAL CULTURE SUPPORTS STAFF IN BEING INNOVATIVE, CREATIVE, PASSIONATE, AND ACCOUNTABLE. BUILDING OUR INTERNAL CAPACITY HELPS US DEVELOP STRONG PARTNERSHIPS, ENGAGE IN POLICY CHANGE, CONDUCT INNOVATIVE DATA COLLECTION AND ANALYSIS, ENSURE OUR PROGRAMS AND SERVICES MEET THE NEEDS OF COMMUNITIES, AND WORK IN TRUE PARTNERSHIP WITH COMMUNITIES IN ALAMEDA COUNTY."[21]
>
> — *Alameda County Department of Public Health Website*

MPHD Staff members participating in a training on community-based focused conversations.

Changing the Way They Work to Advance Equity—Nashville and Davidson County, TN

Metro Public Health Department

To effectively address existing health inequities, Metro Public Health Department (MPHD) leadership started changing the way they worked. The following highlights some of the actions they took to build their capacity to advance health equity:

- MPHD built health equity into its Departmental Strategic Plan in order to institutionalize such work throughout the organization. Additionally, in 2012, MPHD's Director of Health issued a directive to all staff to incorporate equity as a decision filter in all policy, programmatic, and practice activities.
- MPHD established organizational structures, such as a department-wide Equity Work Group to support the department in attaining its goals and to ensure continued competency and capacity building.
- MPHD instituted various professional development and learning experiences to support and advance individual competencies and organizational capacity to promote health equity. These experiences included assessing individual biases; understanding the impact of individual biases on practice; and understanding how societal and structural biases, racism, and diversity impact health status.
- MPHD worked to build a team of diverse staff who were reflective of and understood the community by incorporating a health equity perspective in its hiring practices. Recruitment and interviewing processes were modified to hire staff who demonstrated an understanding of health equity and how it translated to practice.
- MPHD continues to foster long-standing relationships with organizations that serve and work with communities affected by health inequities. These partnerships are mutually beneficial and have helped MPHD more effectively understand and connect to populations of greatest need.

Through these actions and other efforts, MPHD continues to incorporate a health equity focus in everything they do.

QUESTIONS FOR REFLECTION: Organizational Capacity

1. Where are we now?

- How do our current organizational policies and practices facilitate or inhibit us from advancing health equity?
- What is our organization's stated commitment to health equity? Is this commitment documented and widely understood?

2. How can we institutionalize our organizational commitment to advance health equity?

- What process (e.g., organizational assessment) can we implement to review current policies and practices in relation to our health equity commitment?
- How can our current infrastructure be enhanced to create accountability and provide guidance on our health equity commitment?
- What expectations and opportunities exist for staff to make health equity a part of their daily work?

3. How can funding decisions advance our health equity efforts?

- How do the funds we typically seek align with identified health equity needs in the community?
- When distributing funds, what funding guidelines or requirements need to be in place to ensure recipients address health equity?

4. How can we build a skilled and diverse workforce committed to health equity?

- How do our recruitment efforts support or hinder us in building a diverse staff and management team committed to health equity?
- How can we add or enhance our training activities to ensure staff and management share a common understanding of the complexities of health inequities and have the skills to advance health equity in their work?
- How can we better align staff performance to health equity practice?
- How can we build accountability for advancing health equity into the performance plans of staff and management?

5. How can we integrate health equity into our products and service offerings?

- What are the cultural and linguistic preferences of our community members? How can we revise our services and resources to accommodate those preferences?
- What structural and operational modifications are needed for our services to be more accessible and of better quality?
- How are we tracking and evaluating our efforts to determine if populations experiencing health inequities are benefiting from the services or resources we provide?

6. How can our partnerships and community outreach efforts help to advance health equity?

- What existing partnerships do we have with organizations serving populations experiencing health inequities?
- What new partnerships should we consider exploring to fulfill our commitment to health equity?
- How is our organization perceived in the community?
- How can we build better connections to and collaborations with populations experiencing health inequities?

7. What are our next steps?

- What can we do differently to improve or enhance our organization's capacity to advance health equity?
- What is our plan of action to implement those changes?

MEANINGFUL COMMUNITY ENGAGEMENT FOR HEALTH AND EQUITY

COMMUNITY ENGAGEMENT CAN HARNESS THE SKILLS AND TALENTS OF A COMMUNITY'S MOST IMPORTANT RESOURCE: ITS PEOPLE. INVOLVING COMMUNITY MEMBERS IN HEALTH INITIATIVES CAN FOSTER CONNECTEDNESS AND TRUST, IMPROVE ASSESSMENT EFFORTS, AND BUILD THE CAPACITY OF INDIVIDUALS TO POSITIVELY AFFECT THEIR COMMUNITY. ADDITIONALLY, THIS ENGAGEMENT CAN ENHANCE THE EFFECTIVENESS OF PROPOSED STRATEGIES AND INCREASE THE SUSTAINABILITY OF EFFORTS. CONSIDER THESE IDEAS TO ENHANCE COMMUNITY ENGAGEMENT ACTIVITIES.

Understand the Historical Context Before Developing Your Engagement Strategy

Examine the history of the community as well as past engagement efforts, to understand any issues, and to learn what has worked and what has been less successful. For example, years of neglect and conflict may have contributed to distrust and prevented meaningful engagement between a community and local organizations. Try to get an accurate picture of how your organization and its engagement strategies are perceived, and work with community leaders to address any barriers to engagement.

Build Community Relationships Early On

Authentic community engagement takes time and requires an ongoing commitment from all involved. Establish and maintain strong relationships with communities experiencing health inequities before funding opportunities arise or urgent health issues develop.

Assess and Address Organizational Barriers to Community Engagement

Some organizations may be reluctant to begin an engagement process due to the necessary time commitment, the staff skills needed, and the ability to demonstrate effectiveness. There may also be concerns about the effort becoming unmanageable. To address these concerns, develop engagement plans and principles that provide a systematic approach to conducting engagement activities. Additionally, consider enlisting the help of other trusted organizations to build staff skills and support engagement efforts.

Select Engagement Techniques Appropriate for Your Context

Consider engagement techniques based on the purpose and length of engagement, as well as the resources available to your organization. Examples of engagement activities include interviews with community members, focus groups, community forums, community assessments and mapping, PhotoVoice, community-based participatory research, resident participation on boards or councils, and paid positions for residents within organizations.

Understand and Address Barriers That May Prevent Community Participation

Consider populations that are experiencing health inequities in your community (e.g., people of color, people with disabilities, LGBT populations) and potential barriers they may face with engagement efforts. Community members often have many demands and may be unclear about the value of their involvement. Respect community members' time and efforts by having a clear and agreed-upon purpose for engagement. When necessary, conduct meetings in native languages or provide interpretation or other services needed to address language and cultural barriers to participation. Conduct engagement activities at times and places that are convenient to the community and provide transportation or childcare services, if needed.

Support and Build the Community's Capacity to Act

Community members are vital assets for broader community improvements and may have a long-term interest in the community's well-being. Choose engagement activities that build on the capacity of community members. These activities can increase their awareness of health inequities and provide skills on how to intervene. Such engagement activities may include cultivating residents as leaders or supporting local coalitions or networks. These efforts can serve a community beyond any one project and can also position community members and organizations to apply for additional funding to help sustain efforts.

Value Both Community Expertise and Technical Expertise

Many communities benefit from engaging individuals and organizations with technical expertise in certain health issues. Such expertise can provide lessons learned from initiatives in other settings, as well as guidance to avoid unnecessary barriers in implementation. However, it is critical that the expertise and perspective of community members—those ultimately impacted by any initiative—be respected and valued when engaging such technical expertise.

> "DON'T LEAVE THE COMMUNITY BEHIND, LET THE COMMUNITY LEAD."[23]
>
> *— Lark Galloway Gilliam Executive Director of Community Health Councils*

A community networker standing adjacent to a community store that supports obesity prevention efforts in Chicago, IL.

Provide Individualized Attention Through Community Networkers—Chicago, IL

Consortium to Lower Obesity in Chicago Children (CLOCC)

In its first decade, the Consortium to Lower Obesity in Chicago Children (CLOCC) decided to focus on 10 Chicago neighborhoods with disproportionate rates of childhood obesity. These communities were referred to as Vanguard Communities and are primarily low-income and communities of color. To make sure the consortium developed and implemented effective strategies to reduce such health inequities, CLOCC sought out meaningful ways for organizations and individuals in the Vanguard Communities to be involved in the design, implementation, and evaluation of obesity-focused initiatives.

Five community networkers (employed as full-time staff members) served as a direct link to five of the Vanguard Communities. Other staffing and partnering models were developed for the remaining five neighborhoods. These community networkers served as liaisons between communities and CLOCC, and spent the majority of their time in the field engaged in their assigned communities. They brought the needs and strengths of the communities to the attention of the consortium. Because the community networkers had deep ties to their communities, they understood the context in which activities took place. They were able to provide community partners and members with resources, technical assistance, and other relevant information from the consortium.

This model was highly successful in connecting CLOCC to the community and developing a portfolio of effective community-based strategies for obesity prevention. As a result, CLOCC refined the staffing model and now deploys community program coordinators to serve several regions throughout the city. These individuals coordinate resources and bring intervention approaches to many neighborhoods throughout Chicago.

QUESTIONS FOR REFLECTION: Community Engagement

1. Where are we now?

- What existing relationships do we have with populations experiencing health inequities?
- What is our current process/plan for engaging community members, particularly those experiencing health inequities?
- Are we using language that facilitates or creates barriers to engaging the intended communities?

2. What approaches can we use to effectively engage community members?

- What type of engagement techniques do we typically use? Have they had the effect we intended?
- Are we using techniques that build community capacity and leadership? If not, what techniques could be pursued?

3. What barriers to community engagement should we consider?

- What is our organization's history with the community?
- What organizational barriers exist for meaningful community engagement activities? How can we overcome these barriers?
- How will we identify barriers to community participation? How can we overcome these barriers?

4. How can we engage and balance both community and technical expertise in our efforts?

- How do we show that we value and recognize the expertise of community members?
- Do any strained relationships exist in the community? Why do they exist?
- How can our engagement process best leverage both community and technical expertise?

5. What are our next steps?

- What can we do differently to improve or enhance our community engagement?
- What is our plan of action to implement those changes?

DEVELOPING PARTNERSHIPS AND COALITIONS TO ADVANCE HEALTH EQUITY

PARTNERSHIPS AND COALITIONS CAN HELP ORGANIZATIONS AMPLIFY THE OFTEN UNHEARD VOICES OF POPULATIONS MOST DIRECTLY AFFECTED BY HEALTH INEQUITIES. PARTNERSHIPS AND COALITIONS CAN ALSO WORK TO ACHIEVE EQUITABLE OUTCOMES BY LEVERAGING A DIVERSE SET OF SKILLS AND EXPERTISE. CONSIDER THE FOLLOWING IDEAS TO ENHANCE YOUR PARTNERSHIP AND COALITION EFFORTS AROUND ADVANCING HEALTH EQUITY.

Engage Partners from Multiple Fields and Sectors that Have a Role in Advancing Health Equity

Health inequities do not have a single cause, and public health alone cannot address such inequities. Partner with community, education, housing, media, planning and economic development, transportation, and business partners, and engage these sectors in your coalition. Such multi-sector partnerships can work to improve the underlying community conditions that make healthy living easier, particularly in underserved communities.

Include Partners Working with Population Groups Experiencing Health Inequities

Organizations dedicated to serving these various populations (e.g., people of color, the elderly, people with disabilities, LGBT individuals) may or may not have health-related expertise. However, such organizations often have substantial expertise on the norms, culture, and needs of the populations they serve and can contribute significantly to your efforts.

Establish Mechanisms to Ensure New Voices and Perspectives are Added

Groups that have been collaborating for a long time should be mindful not to exclude potential new partners. Periodically assess membership composition and participation, and evaluate decision-making processes. It may also be necessary to periodically adjust meeting times and locations to accommodate new partners. While important to ensure a diverse partnership, do not assume that individuals from a specific population group can speak for all members of that group. Additionally, be cautious of including community representatives as a symbolic gesture rather than as fully engaged partners.

Develop a Common Language Among Partners from Different Sectors and Backgrounds

Early in the process, establish a shared vision and understanding for the partnership. Plan discussions or trainings to build a common understanding about health equity and the strategies needed to address it. Additionally, establish guidelines for communication, such as spelling out acronyms and avoiding potentially confusing terminology or jargon.

Acknowledge and Manage Turf Issues

Turf struggles may arise over conflicts in ownership, recognition, or resources between organizations. Partners should acknowledge and commit to manage tensions that may arise by anticipating potential turf issues, cultivating trust and respect, and shaping a collective identity. If turf issues arise, a strong, established relationship can create a safe space for partners to address complex issues, competing agendas, and difficult decision making.

Recognize and Address the Power Dynamics in a Partnership

All partners should have an equal opportunity to define issues, create strategies, implement solutions, and make decisions. The different contributions, resources, and expertise each partner brings to the table could be a source of tension or could be leveraged to improve collaborative efforts and outcomes. For instance, without additional resources, some partners may not be able to participate on an ongoing basis due to limited staff and organizational resources. Finding ways to compensate partners (e.g., funding, continuing education credit, travel cost reimbursement, certificates of appreciation) may help provide opportunities for longer-term engagement for some partners. Additionally, partners may be able to cross train each other to build skills in unfamiliar areas, or they may have complementary resources that can be shared.

> "OUR PARTNERSHIPS WILL HAVE TO BE STRONGER IF WE ARE TO HAVE AN IMPACT. WE MUST REACH OUT TO NONTRADITIONAL PARTNERS IN THE PRIVATE SECTOR, INDUSTRY, AND OTHER PARTS OF GOVERNMENT IN THE TRANSPORTATION, EDUCATION, AND JUSTICE SECTORS, FOR EXAMPLE."[24]
>
> — *Dr. David Satcher, Director, Satcher Health Leadership Institute and the Center of Excellence on Health Disparities, Morehouse School of Medicine*

Diverse set of community partners who worked together to increase smoke-free protections for vulnerable populations by implementing a smoke-free campus at Women's Treatment Center in Chicago.

Intentional Recruitment of Partners Working with Underserved Populations—Chicago, IL

Respiratory Health Association of Metropolitan Chicago (RHAMC)

To address tobacco-related health inequities, the Respiratory Health Association of Metropolitan Chicago (RHAMC) and Chicago Department of Public Health have used various strategies to establish diverse partnerships. As part of the partnership process for CDC's *Communities Putting Prevention to Work* program, they took the following actions:

- Established a competitive request for proposals (RFP) process to identify and select appropriate partners. The RFP process was designed to select partners in diverse geographical areas that demonstrated experience in serving populations with disproportionate smoking rates.
- Promoted the RFP beyond traditional channels, including circulating it among current partners and coalitions serving the priority communities.
- Collaborated with city agencies like the Chicago Park District, Chicago Public Schools, and Chicago Housing Authority, as well as community-based social service organizations and community health clinics.
- Established a system to maintain strong partnerships, tracking efforts in underserved communities, and building capacity of community-based organizations through various trainings and technical assistance so they could address tobacco use in the future.

The diverse partnerships developed through this process helped the organization design appropriate strategies to address tobacco-related health inequities.

QUESTIONS FOR REFLECTION: Partnerships and Coalitions

1. Where are we now?

- How do our current partnerships/coalitions reflect the populations experiencing inequities in our community?
- What is the current commitment to advancing health equity among these partners/coalitions? How does this commitment translate into identifiable and measurable activities?

2. How can we build diverse and inclusive partnerships/coalitions?

- What partners are we missing in our network/coalition that should be included?
- What partners do we need to engage in order to address the major social determinants of health impacting our community (e.g., housing, transportation, education, urban planning, business)?
- What are the commonalities in the priorities of potential partners that can serve as levers for collaboration?
- What is each partner's role in addressing health equity?

3. How can we work to engage new partners in a meaningful way?

- What process can we develop to regularly assess our partnerships/coalitions to see who else should be invited to help advance our goals of achieving health equity?
- How can we improve efforts to engage new members in meaningful ways?
- How can we strengthen communication and understanding among partners?

4. How can we anticipate and address group dynamics that may arise?

- What are some of the challenges in collaborating with different partners? Once identified, what steps can be taken to address these challenges?
- What potential issues concern our partners? What issues can be anticipated?
- How can we ensure that all partners meaningfully participate and influence decision making?

5. What are our next steps?

- What can we do differently to improve or enhance our partnerships/coalitions?
- What is our plan of action to implement those changes?

IDENTIFYING AND UNDERSTANDING HEALTH INEQUITIES

WITHOUT A CLEAR UNDERSTANDING OF EXISTING HEALTH INEQUITIES, WELL-INTENTIONED STRATEGIES MAY HAVE NO EFFECT ON OR COULD EVEN WIDEN HEALTH INEQUITIES. IT IS CRITICAL TO HAVE A CLEAR UNDERSTANDING OF WHAT INEQUITIES EXIST, AND THE ROOT CAUSES CONTRIBUTING TO THEM. CLEARLY IDENTIFY AND UNDERSTAND HEALTH INEQUITIES TO ESTABLISH BASELINES AND MONITOR TRENDS OVER TIME, INFORM PARTNERS ABOUT WHERE TO FOCUS RESOURCES AND INTERVENTIONS, AND ENSURE STRATEGIES ACCOUNT FOR THE NEEDS OF POPULATIONS EXPERIENCING HEALTH INEQUITIES. CONSIDER THESE IDEAS TO ENHANCE YOUR ORGANIZATION'S EFFORTS TO IDENTIFY AND UNDERSTAND HEALTH INEQUITIES.

Do Not Rely on Assumptions About What Health Inequities Exist in Your Community

The health inequities in your community may differ from national and state data or other surrounding communities. Utilize the best available data to understand what is happening in your community. As feasible, follow a thorough process to identify existing health inequities, and assess community assets, needs, and challenges.

Gain a Comprehensive Understanding of the Identified Health Inequities

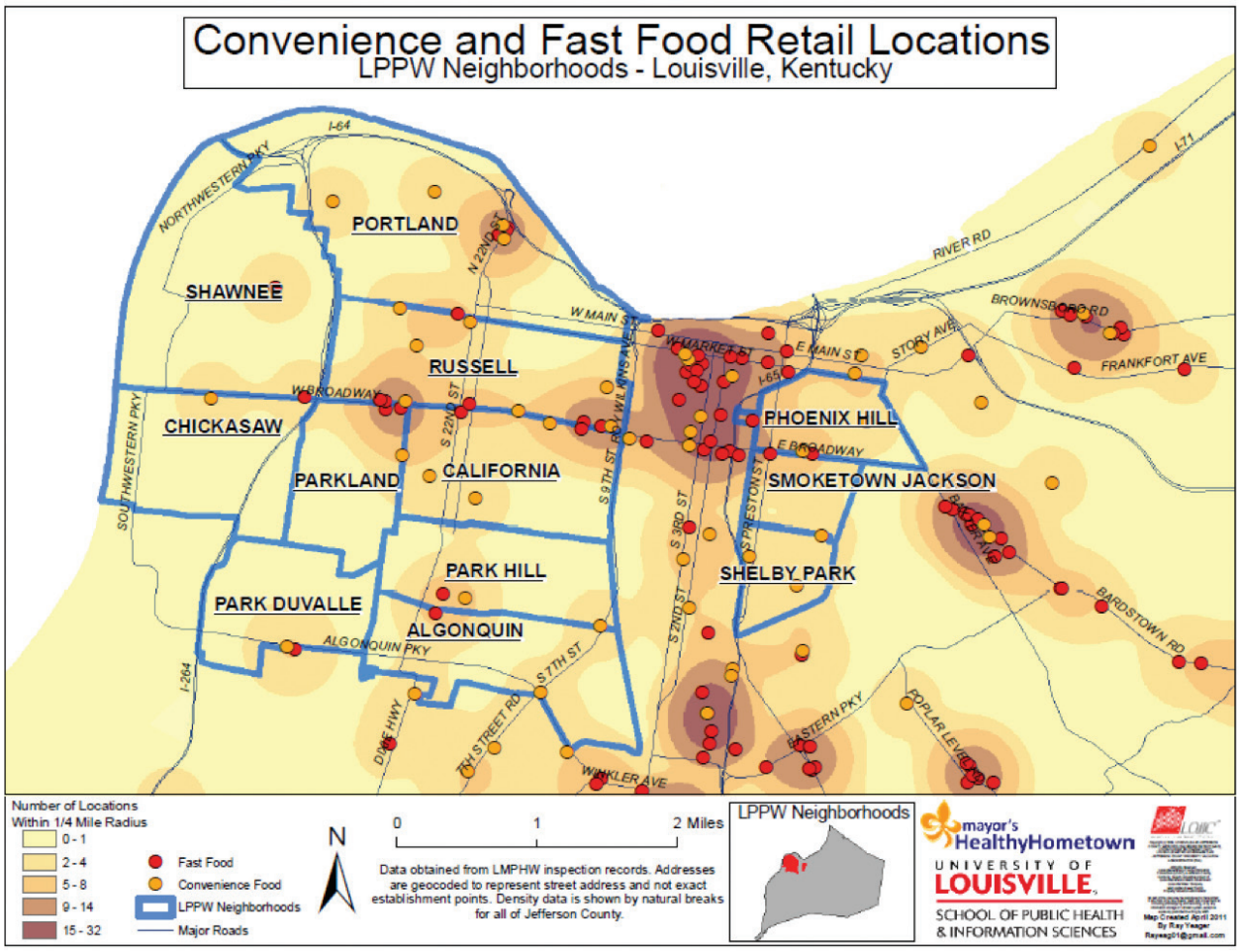
Examine multiple aspects of health in your community to get a clearer picture of health inequities. For example, identify health risk behaviors and disease outcomes according to characteristics such as income, disability status, gender identity, geography, race/ethnicity, and sexual orientation. Additionally, gain insight into the social (e.g., discrimination), economic (e.g., poverty), and physical (e.g., availability of healthy food retail) environments to develop a deeper understanding of health inequities. A community's history and context (e.g., long-standing policies, cultural norms, values) can also be helpful in understanding inequities and identifying effective strategies.

Use Appropriate Tools to Identify Health Inequities

National databases, health departments, and institutions, such as universities and hospitals, are prime sources for finding local data on health outcomes. While these data sets are a good starting place, you may not want to rely solely on this information for understanding health inequities. Partners such as local public works, transportation, and police departments may have access to other data sources (e.g., water quality, street conditions, crime statistics) which may reveal inequities related to social, economic, and physical environments. Where possible, use data sources that allow you to stratify indicators by factors such as age, disability status, race, and sexual orientation. See Appendix C for a list of online resources for identifying and understanding health inequities.

Engage Community Members and Partners in Data Collection and Interpretation

Provide training to community members to enable them to participate in data collection activities (e.g., community asset mapping, PhotoVoice, digital storytelling, walking audits). Once data are collected, community members and partners can also be included in interpreting findings, refining priorities, and developing solutions. The perspectives of community members can bring static data to life by revealing the lived experiences behind the data.



Map of Louisville, KY used as a tool to identify inequities.

Using Multiple Factors to Pinpoint Health Inequities—Louisville, KY

Louisville Metro Public Health and Wellness

The Louisville Metro Public Health and Wellness (LMPHW) Department is committed to reducing obesity-related health inequities. To identify areas with higher rates of obesity, the department analyzed data related to the social determinants of health including income, violence, access to transportation, and access to healthy food (including proximity to fast food restaurants). It also used GIS mapping to identify and locate relevant indicators by ZIP code.

These strategies revealed that obesity rates and environments that did not support healthy eating and physical activity in Louisville were disproportionately higher in 12 low-income neighborhoods—most of which were also predominantly African American. These neighborhoods are characterized as food deserts, where affordable, healthy food is difficult to obtain. These neighborhoods also have higher rates of violence and poverty and low levels of education. Having a clear emphasis on areas experiencing health inequities helped the department to design its initiatives and focus their efforts accordingly.

1. Where are we now?

- [ ] What are our organization's current practices for identifying and understanding health inequities?
- [ ] Can we clearly articulate health inequities related to the health issues we are trying to prevent and/or address? If so, list those health inequities.

2. What types of information can we use to identify health inequities in our community?

- [ ] What process can we set up to get a full understanding of health inequities in our community?
- [ ] What type of information do we need to ensure we have a full understanding of health inequities in our community?
- [ ] Have we looked beyond basic health risk behaviors and standard outcome data to examine social, economic, and physical indicators that may contribute to or maintain health inequities?
- [ ] Have we examined community context and historical factors that may help our understanding of existing health inequities?

3. What tools and resources can we use to identify and understand health inequities?

- [ ] What combination of data sources do we need to better understand experiences of populations affected by health inequities?
- [ ] What sources or partners may already have the data we need for assessing community environments or health behaviors?
- [ ] Where can we go to understand the historical context of health inequities in the community?

4. How can we engage community members in gathering and analyzing data?

- [ ] How do we currently engage community members in our data collection and analysis process?
- [ ] What process can we put in place to routinely engage populations affected by health inequities in collecting and analyzing data?

5. What are our next steps?

- [ ] What can we do differently to improve or enhance our ability to identify and understand health inequities?
- [ ] What is our plan of action to implement those changes?

HEALTH EQUITY-ORIENTED STRATEGY SELECTION, DESIGN, AND IMPLEMENTATION

WITHOUT A DELIBERATE FOCUS ON HEALTH EQUITY IN THE STRATEGY DEVELOPMENT PROCESS, STRATEGIES MAY UNINTENTIONALLY WIDEN HEALTH INEQUITIES. WELL-DESIGNED STRATEGIES CAN INCLUDE SUPPORTIVE ACTIVITIES TO ADDRESS BARRIERS OR UNINTENDED CONSEQUENCES UNDERSERVED POPULATIONS MAY FACE DURING IMPLEMENTATION. SUCH EFFORTS CAN HELP ENSURE MAXIMUM EFFECTS ACROSS COMMUNITIES EXPERIENCING HEALTH INEQUITIES. CONSIDER THESE IDEAS TO ENHANCE STRATEGY DEVELOPMENT EFFORTS.

Balance Community Input and Best Available Evidence

Without community input, there can be challenges with strategy design, implementation and enforcement. Build community ownership in the very beginning of this process to increase the effectiveness and sustainability of strategies. Additionally, examine the best available evidence to ensure that your community is investing resources and time in strategies that are most likely to have the intended impact.

Establish a Process to Ensure Strategies are Linked to Identified Inequities

Given the multiple factors involved in developing and implementing strategies, efforts can sometimes unintentionally shift away from identified population groups. Ensure strategies are aligned with desired outcomes by writing goals that outline identified inequities. Consider developing criteria or questions to be used as a guide for examining all strategies. This ensures the criteria and strategies align with the established health equity goals. (See Appendix D for a sample *Health Equity Checklist*.[25])

Select a Comprehensive Set of Approaches

Consider selecting a comprehensive set of strategies that work together, as one strategy in isolation only goes so far. For instance, while a policy improvement can be impactful, it may need to be supported by educational activities or organizational improvements to have the intended effect on populations experiencing health inequities.

Account for the Diversity Within the Community

Understand the diversity within your community (e.g., age, disability status, geographic area, race/ethnicity, sexual orientation, socioeconomic status). Populations may have different needs that should be considered and accounted for in strategy selection, design, and implementation (e.g., financial incentives, language translation, mobility assistance). Such diversity may also reveal the need for a wide set of partners in the design process.

Recognize that Everyone is Not Starting at the Same Place

Populations experiencing health inequities may have further to go to fully benefit from a given strategy. Identify and account for different levels of existing resources, capacity, and support across population groups when designing strategies to help avoid widening health inequities.

Identify Barriers and Potential Negative Unintended Consequences that Populations Experiencing Inequities May Face

When designing strategies, consider and account for possible barriers to full implementation, enforcement, and benefit for populations experiencing health inequities. Additionally, anticipate negative unintended consequences of any strategy and incorporate solutions early in the design phase. Common barriers may include cost, transportation challenges, safety concerns, lack of capacity or resources, lack of awareness, differing social or cultural norms, and limited health literacy. Potential unintended consequences may include stigma or displacement. Work with partners and community members to identify potential barriers and negative consequences and build in support to address them. (See Appendix B for a description of potential barriers and unintended consequences.)

Use a Tool to Ensure Health Equity is Part of Strategy Selection and Design

Using tools or frameworks can help you think through health equity considerations in each step of strategy selection and design. Such tools can also ensure consistency in planning and help align strategies with health equity goals. You can use an existing tool (e.g., Health Impact Assessment[26] and Health Equity Impact Assessment[27]) or you can work with partners and the community to develop your own tool.

Establish Processes to Identify and Address Implementation Challenges

It can be difficult to fully measure the effect of a strategy until it is completed. However, you can build in opportunities to monitor progress at different stages of implementation to identify issues and assess how well populations experiencing health inequities are being reached. Identify issues early in the process to provide an opportunity to make adjustments that can support equitable outcomes. Be prepared to address potential challenges and provide additional supports throughout a strategy's implementation.

CONSIDER THE FOLLOWING OVERARCHING QUESTIONS WHEN DESIGNING STRATEGIES TO ADVANCE HEALTH EQUITY:

- Are those most affected by the issue actively involved in defining the problem and shaping the solution?
- How does this strategy improve the conditions for those communities most in need?
- Will those most negatively affected by the problem benefit the same, less so, or more so?
- What barriers or unintended consequences should be accounted for to make this strategy effective in underserved communities?
- How can we ensure effective implementation and enforcement of identified strategies across population groups or communities?

Nice Ride bike kiosk located at Farview Park in north Minneapolis, MN—an area with high rates of obesity and physical inactivity.

A Concentrated, Place-Based Approach to Address Health Inequities—Minneapolis, MN

Minneapolis Department of Health and Family Support (MDHFS)

With support from CDC's *Communities Putting Prevention to Work* program, the Minneapolis Health Department (MHD) developed a series of strategies focused in North Minneapolis to address disproportionate rates of obesity and limited access to physical activity and healthy food resources. The Health Department and partners implemented the complementary initiatives listed below:

- Placed bike share kiosks next to parks where MHD outreach workers encouraged families to use neighborhood parks for physical activity.
- Located the kiosks and the new bike walk center near mass transit as well as bike lanes and walking paths to link residents to major community destinations including farmers markets, community gardens, and commercial districts.
- Implemented Safe Routes to School in the same areas to increase opportunities for students to walk and bike to school.
- Used targeted media, advertising, and outreach to increase residents' awareness of biking and walking resources and how the strategies connected to other health initiatives.
- Implemented Electronic Benefit Transfer (EBT) systems and a Market Bucks incentive program at farmers' markets in the area, allowing residents to use EBT cards to purchase fresh fruits and vegetables and providing customers with up to a $5 match in Market Bucks coupons.
- Established a local food resource hub and network in four neighborhoods, including North Minneapolis.

In this place-based approach, each strategy complemented the other, resulting in a focused effort to impact health inequities.

QUESTIONS FOR REFLECTION: Strategy Selection, Design, and Implementation

1. Where are we now?

- What is our current process, if any, for integrating health equity into strategy selection, design, and implementation?

2. How can we address health equity goals when selecting strategies?

- What are the diverse needs we should consider when selecting strategies that will have the greatest impact on populations experiencing health inequities?
- How can we balance community input with evidence-based strategies to select the most effective strategies to reduce health inequities?
- How can we verify that selected strategies align with the needs of populations experiencing health inequities?
- How can we ensure selected strategies build on one another to form a comprehensive approach that advances the achievement of health equity in our community?

3. How can we address our health equity goals when designing strategies?

- What are the diverse needs we should consider when designing strategies that will have the greatest impact on populations experiencing health inequities?
- How can we account for different levels of existing resources, capacity, and supports across population groups when designing strategies?
- What process can we establish to identify and address barriers to, and potential unintended consequences of strategies that populations experiencing health inequities may face?

4. What tools can we use to select and design strategies to advance health equity?

- What existing processes, frameworks, and/or tools can we use to systematically incorporate the goal of health equity into strategy selection and design?
- What processes or tools can we create to systematically incorporate the goal of health equity in all of our strategy selection and design efforts?

5. How can we address our health equity goals when implementing strategies?

- How can we work with partners to anticipate needs among populations experiencing inequities and provide necessary supports to advance equitable outcomes?
- What methods have we put in place to monitor progress in implementation, identify issues early in the process, and assess how well populations experiencing health inequities are being reached?
- What agreements have we reached with our partners on the long term plans and results?

6. What are our next steps?

- What can we do differently to improve or enhance our strategy development process to advance health equity?
- What is our plan of action to implement those changes?

MAKING THE CASE FOR HEALTH EQUITY

THERE ARE VARYING IDEAS ABOUT WHAT IT MEANS TO "ADVANCE HEALTH EQUITY." EFFECTIVELY MAKING THE CASE FOR HEALTH EQUITY REQUIRES AN UNDERSTANDING OF THE COMMUNITY CONTEXT AND INTENDED AUDIENCES, AN APPROPRIATELY FRAMED MESSAGE THAT APPEALS TO CORE VALUES, AND INCREASED AWARENESS OF EXISTING HEALTH INEQUITIES AMONG STAKEHOLDERS. CONSIDER THESE IDEAS TO ENHANCE EFFORTS IN MAKING THE CASE FOR HEALTH EQUITY:

Assess the Community Context Before Developing Messaging Around Health Equity

Without a proper understanding of the community context, messages around health equity can go unnoticed or may lead to unfavorable actions. It is important to consider the needs, assets, and priority issues of both community members and key stakeholders. Also, consider their receptiveness to the concept of health equity before developing any messaging. Understanding these issues may provide insight into common values, competing demands, fiscal priorities, and related efforts, which may help in refining messages.

Leverage Opportunities to Advance Health Equity Efforts

Become aware of health equity-related work in your area and around the country. If health equity-oriented efforts are underway, connect with those efforts to heighten the visibility of your efforts and to reinforce your message. Additionally, identify partners or coalitions with complementary goals (e.g., community- and faith-based organizations) as they may be able to support your message.

Support the Case for Health Equity with Relevant Data

Use data on health inequities to complement your overall message and raise the awareness of key stakeholders. For example, visual and experiential data (e.g., mapping, digital storytelling) can provide vivid examples of the real experiences of communities affected by health equities. Cost data can also be used to reveal the significant financial implications of existing inequities (e.g., unnecessary health care costs, costs associated with premature death among populations experiencing inequities).

Highlight Solutions When Framing Your Messages Around Health Equity

Lengthy descriptions of the existence of health inequities may detract from actionable solutions. The description of the problem should not overshadow potential solutions. Establish which inequities exist in your community; however, ensure the message focuses on actions to address health inequities.

Ensure Health Equity Messages are Appropriately Disseminated

It is important that everyone from staff and community members to partners and stakeholders have a shared understanding of your health equity goals. Provide trainings to equip staff members with a clear understanding of health equity as they are the voices for advancing your organization's efforts. Create opportunities for dialogue among community members and stakeholders to share concerns and develop skills to advance health equity in their communities. Identify ways to connect your partners' broader networks to ensure diverse perspectives are contributing to solutions for health equity. Use a variety of communication methods (e.g., earned media, radio spots) to both broadly disseminate and appropriately tailor your messages.

Mapping Our Voices for Equality—Seattle and King County, WA

Public Health Seattle & King County (PHSKC) and Partners

Mapping our Voices for Equality (MOVE)[28] uses media to promote health equity in Seattle and King County. MOVE combines over 100 community-developed multilingual digital stories and features a local map showing both the impact of place on health and some place-based changes that will improve health in King County. To implement MOVE, Public Health Seattle & King County (PHSKC) with support of CDC's *Communities Putting Prevention to Work* program, did the following:

- Engaged community members in dialogue about health equity issues and provided workshops on digital storytelling to gather stories, empower community members, and promote positive health changes in King County.
- Invited local stakeholders to community meetings and forums where community members could showcase their videos and have a discussion.
- Posted over 100 multilingual digital stories to a website with widespread reach, encouraging other community members to get involved.
- Created templates and worksheets to foster dialogue among key stakeholders and community groups when holding meetings and health equity discussions.
- Successfully contributed to multiple policy, systems, and environmental improvements including enhanced school nutrition policies, increased hours to a local community center, and increased access to healthy food in a local "food desert."

The MOVE media initiative is empowering community members to identify and raise awareness of the health inequities impacting them.

QUESTIONS FOR REFLECTION: Making the Case for Health Equity

1. Where are we now?

- How do we currently frame our efforts regarding health equity; what are our messages?

2. How can we assess the community context to develop our health equity messages?

- How receptive are our key stakeholders toward adopting a health equity approach?
- What are the views and perceptions of our key stakeholders as they relate to health inequities? How should we consider those views in our messaging?
- Are other activities and ongoing efforts occurring in our community that could support or inhibit a health equity-based approach? How can we build on these supportive activities and overcome challenges to implementing a health equity-based approach?
- How can we identify and connect with potential partners/coalitions currently engaged in health equity-focused work?

3. What type of data can we use to support the case for health equity?

- What are some creative ways to capture and highlight the lived experience of health inequities in our community?
- What combinations of data can we use to help make the case for health equity?

4. How can we share our message about health equity?

- How can we ensure our staff and partners have a common understanding of our work to advance health equity?
- What are the key messages needed to tell the health equity story in our community?
- How can we create a dialogue around health equity among community members and other key stakeholders?
- Which communication methods will be most effective to reach our intended audiences?
- How can we identify and communicate our health equity success stories?

5. What are our next steps?

- What can we do differently to improve or enhance our ability to make the case for health equity?
- What is our plan of action for implementing those changes?

ADDRESSING HEALTH EQUITY IN EVALUATION EFFORTS

WITHOUT A FOCUS ON HEALTH EQUITY IN EVALUATION EFFORTS, THE EFFECTS OF AN INTERVENTION ON ADDRESSING HEALTH DISPARITIES AND INEQUITIES CAN GO UNNOTICED. FOR EXAMPLE, AN EVALUATION MAY REVEAL OVERALL IMPROVEMENTS IN HEALTH, BUT OVERLOOK THE FACT THAT HEALTH DISPARITIES OR INEQUITIES ARE WIDENING. HEALTH EQUITY-ORIENTED EVALUATIONS CAN BE DESIGNED TO UNDERSTAND WHAT WORKS, FOR WHOM, UNDER WHAT CONDITIONS, AND REVEAL WHETHER HEALTH INEQUITIES HAVE DECREASED, INCREASED, OR REMAINED THE SAME. INTEGRATE HEALTH EQUITY CONSIDERATIONS THROUGHOUT EACH STEP OF AN EVALUATION TO MORE ACCURATELY INTERPRET FINDINGS AND EFFECTIVELY FOCUS INTERVENTIONS. CONSIDER THESE IDEAS TO INTEGRATE HEALTH EQUITY GOALS INTO YOUR EVALUATION EFFORTS.

Develop a Logic Model That Includes Health Equity Activities and Goals

Guide implementation and evaluation efforts by documenting your health equity-related process activities and outcome goals in your logic model. Include these goals and activities to provide clarity on your intended effects on health equity. Secure buy-in and participation by engaging diverse stakeholders, including community members experiencing health inequities, in the development of the logic model. Also include them in every other step of the evaluation process.

Incorporate Health Equity into Evaluation Questions and Design

Since evaluation questions guide the evaluation process, it is critical that your health equity goals are reflected in them. Such questions may help you determine what has worked for whom and under what conditions. Additionally, consider indicators of success at all stages of the logic model to assess whether an intervention reached the intended population, was implemented correctly, and had the intended outcome(s).

Identify Appropriate Variables to Track Populations Experiencing Inequities

Appropriate variables and strategic sampling plans are needed to assess differential effects of interventions across population groups or settings. Choose relevant variables (e.g., income, race, zip code) early in the process to ensure sufficient data on populations experiencing inequities will be gathered, tracked, and analyzed. In addition, carefully select sites/settings or participants that are to be included in the sampling frame.

Use Culturally Appropriate Tools and Methodologies

Evaluations may be planned and carried out by individuals with different educational backgrounds, primary languages, and cultural identities than the populations experiencing health inequities. Therefore, gather the best possible data by using culturally appropriate tools and methodologies that consider factors such as the population's language needs, literacy levels, and facilitator preferences.

Use Multiple Approaches to Understand an Intervention's Effect on Health Inequities

One approach may not sufficiently account for the complexities of health inequities or reflect issues and successes identified as important by the community. Consider multiple approaches (e.g., GIS analysis, focus groups, assessment of environmental improvements) to understanding an intervention's effect to broaden the range of credible evidence, create new measurement models, and integrate new voices into the understanding of a strategy's effects. Additionally, consider a long-term plan for data collection, as it takes time to change the underlying factors that contribute to health inequities.

Include Health Equity Indicators Into Performance Monitoring Systems

Performance monitoring systems may be revised or developed to track whether changes occur in places where they are most needed, as well as other efforts to advance equity. Such tracking provides an opportunity to monitor progress, identify necessary mid-course corrections in underserved communities, and answer questions that may emerge as the evaluation proceeds.

Use Process and Outcome Evaluations to Understand the Effect on Health Inequities

Use process evaluation to gather information about the planning, engagement, and implementation of a strategy. These data may later help explain successful (or unsuccessful) outcomes as they relate to health inequities. Outcome evaluations can be used to understand the effect of an initiative across different populations and indicate whether health inequities have decreased, increased, or remained the same. Incorporating health equity implications in both process and outcome components of an evaluation can help explain an intervention's effect on health inequities.

Widely Disseminate the Results of Equity-Oriented Evaluations

Knowing what works, what does not work, and what may have promise is essential to expand the type of interventions being used to advance health equity. Contribute to the evidence-base by sharing findings, particularly if results identified disparate effects, such as an increase in health inequities. Additionally, build capacity and increase awareness among community members and stakeholders by sharing findings and providing the data they need to decide on next steps.

> "UNLESS THERE IS A DELIBERATE INTENTION TO ADDRESS HEALTH INEQUALITIES AND TO BUILD UP EVALUATIONS THAT PURPOSEFULLY USE EQUITY AS A VALUE CRITERION, THE FIELD OF HEALTH PROMOTION MAY GO ASTRAY REGARDING ITS UNDERLYING COMMITMENTS TO EQUITY IN HEALTH."[29]
>
> *— Louise Potvin, Université de Montréal*

Setting Up Systems to Understand Who Was Affected—Boston, MA

Boston Public Health Commission (BPHC)

The Boston Public Health Commission (BPHC) worked to ensure their *Communities Putting Prevention to Work* (CPPW) efforts were effective in reaching the populations experiencing obesity and tobacco-related health inequities. BPHC implemented the following steps in developing their evaluation plan:

- Developed evaluation questions to gauge their impact on health inequities.
- Required partners to routinely collect data on race/ethnicity, age, gender, and zip code for all of their initiatives. The data documented how activities benefitted the community in general, as well as population groups/areas experiencing health inequities.
- Increased sample size for the *CPPW* Behavioral Risk Factor Surveillance System in order to ensure sufficient power to assess neighborhood-level changes over time.
- Designed an analysis plan to assess the overall effect of the selected strategies, as well as the effect(s) across population groups.
- Set up their performance monitoring to identify areas where additional efforts may be needed to enhance intervention effects in underserved communities.

This strategic evaluation design enabled BPHC to make mid-course adjustments and enhanced their ability to contribute to the evidence-base regarding the influence of their initiative on advancing health equity.

QUESTIONS FOR REFLECTION: Addressing Health Equity in Evaluation Efforts

1. Where are we now?

- [ ] How are we currently assessing the effect(s) of our efforts to address health equity?

2. How do we start the evaluation process with health equity in mind?

- [ ] Do we have the expertise to develop, implement, and assess an equity-oriented evaluation plan?
- [ ] What process can we establish to routinely engage community stakeholders, including those experiencing health inequities, in all aspects of our evaluation efforts?
- [ ] What are our current health equity strategies, activities and goals?
- [ ] How can our logic model be modified to reflect our health equity activities and goals?

3. How can we consider health equity in evaluation questions and design?

- [ ] How can we reframe or create new evaluation questions to better understand our effect on health inequities?
- [ ] What are the key variables we should use to track the influence of our efforts on populations experiencing health inequities?
- [ ] How can our sampling plan be designed or modified to answer our health equity-oriented evaluation question(s)?

4. How can we integrate health equity principles in the data gathering process?

- [ ] What processes do we have in place to determine when culturally appropriate tools or methodologies are needed?
- [ ] If modifications are needed, how can we ensure our evaluation tools meet the needs of populations experiencing health inequities (e.g., language and literacy needs)?
- [ ] Are the data we are collecting reflective of the real experience of the populations experiencing inequities? Are other approaches needed?
- [ ] Does our performance monitoring system allow us to track and identify needs that may arise when implementing efforts in underserved communities?
- [ ] How can we structure our evaluation processes to understand the long-term effects of our efforts on health inequities?

5. How can we understand our effect on health equity through our analysis plan?

- [ ] Does our analysis plan allow us to answer the following:
  - What worked?
  - For whom?
  - Under what conditions?
  - Is there any differential impact?
  - Have inequities decreased, increased, or remained the same?
- [ ] If not, how can we modify the analysis plan to answer these questions?
- [ ] Does our outcome evaluation allow us to determine differential effects across population groups?
- [ ] Does our process evaluation allow us to understand the key factors that influenced the outcomes of our efforts in underserved communities?
- [ ] What actions do we need to take to improve or enhance our evaluation plan to understand our effects on health equity (e.g., have inequities decreased, increased, or remained the same)?

6. How can we share our evaluation efforts with diverse stakeholders?

- [ ] How and where do we typically disseminate our evaluation findings?
- [ ] What commitment can we develop to ensure we share findings, even if negative?
- [ ] How can we ensure we share our findings in plain and clear language that can be understood by stakeholders, partners, and community members?
- [ ] How can our findings be used to support more action in communities of greatest need?
- [ ] How can we revise the ways in which we share lessons learned to help others concerned with addressing health inequities?

7. What are our next steps?

- [ ] What can we do differently to improve or enhance our ability to conduct health equity-oriented evaluations?
- [ ] What is our plan of action to implement improvements in our evaluation efforts?

SECTION 2 Maximizing Tobacco-Free Living Strategies to Advance Health Equity

USE THE CONTENT TO:

- FOSTER DIALOGUE ON HEALTH EQUITY CONCERNS WITHIN A COMMUNITY.
- TRAIN STAFF AND PARTNERS ON EQUITY ISSUES SURROUNDING TOBACCO-FREE LIVING STRATEGIES.
- IDENTIFY WAYS TO ADDRESS HEALTH EQUITY IN THE DESIGN AND IMPLEMENTATION OF STRATEGIES.
- DEVELOP YOUR OWN APPROACH FOR ENSURING EFFORTS ARE ADDRESSING HEALTH INEQUITIES.

Despite overall declines in cigarette smoking, some population groups have disproportionately higher rates of smoking. These groups include certain racial/ethnic minority groups, particularly American Indians/Alaska Natives; those with low socioeconomic status; those with mental health and substance abuse conditions; those in the lesbian, gay, bisexual, and transgender communities;[30] and those with disabilities.[31] Identifying and eliminating tobacco-related health inequities among population groups is an important component of tobacco control efforts.[32]

The Tobacco-Free Living section of *A Practitioner s Guide for Advancing Health Equity* provides equity-oriented considerations, key partners, and community examples related to the design and implementation of the following strategies:

- Comprehensive Smoke-Free Policies
- Smoke-Free Multi-Unit Housing Policies
- Tobacco Cessation Services
- Point-of-Sale Strategies to Address Access and Exposure to Tobacco Products

The content presented is not exhaustive and is not intended to act as a "how-to" guide. Rather, this section is devised to stimulate ideas for ensuring tobacco-free living strategies are designed to address the needs of populations experiencing health inequities. Please refer to the disclaimer on page ii when using this Section.

COMPREHENSIVE SMOKE-FREE POLICIES

COMPREHENSIVE SMOKE-FREE POLICIES MAY INCLUDE STATE OR LOCAL LAWS OR REGULATIONS THAT PROHIBIT SMOKING IN ALL INDOOR AREAS OF WORKSITES AND PUBLIC PLACES, INCLUDING RESTAURANTS AND BARS.[33,34]

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for comprehensive smoke-free policies that advance health equity:

- **Differential Policy Coverage in Workplaces Employing Vulnerable Populations:** Comprehensive smoke-free policies are the most effective means to fully protect all workers from secondhand smoke exposure in workplaces.[33] In contrast, policies that exempt venues, such as restaurants, bars, hotels, casinos, and factories, may exclude many blue-collar and service sector workers from smoke-free protections and create disparities in secondhand smoke exposure.[35,36] These workers—many of whom are racial or ethnic minorities, immigrants, and individuals with limited education and low incomes—may have disproportionate exposure to secondhand smoke in the workplace.[37,38]

- **Lack of Enforcement and Compliance with Existing Smoke-Free Policies in Some Communities:** Even when a comprehensive smoke-free policy exists, some groups may not fully benefit from the policy due to inconsistent education and enforcement regarding the policy.[35,39,40] Lack of community engagement or culturally appropriate efforts to inform these groups about policies and failure to provide these populations with cessation services may also influence who benefits from the policy.

- **Challenges with Adopting Comprehensive Smoke-free Policies in Rural Areas and Tribes:** Some rural areas or tribes may be resistant to smoke-free policies as indicated by higher smoking rates in these areas.[30,41] Others may be resistant because the economy may rely on tobacco production or use.[42-44] Additionally, in many American Indian and Alaska Native tribes, barriers to such policies may arise if cultural and historical norms regarding ceremonial or traditional tobacco practices are not considered when adopting and implementing smoke-free policies.[44] Considering the cultural and social norms in communities is critical for the development of successful, smoke-free strategies.

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating comprehensive smoke-free policies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
COMMUNITY AWARENESS & INVOLVEMENT Engage communities to understand and shift social norms around smoking and secondhand smoke	Some communities, particularly those with high rates of smoking, may be reluctant to implement comprehensive smoke-free policies. In other communities, tobacco control interventions may not be a priority.	• Understand the social norms around smoking and secondhand smoke in underserved communities. • Work with organizations that serve population groups experiencing inequities to engage the community. • Use culturally appropriate media and education efforts to build awareness of the health effects of smoking and secondhand smoke exposure in the underserved communities.
CAPACITY & INFRASTRUCTURE Build community capacity and infrastructure to support implementation of comprehensive smoke-free policies	Limited capacity and infrastructure among agencies serving populations experiencing inequities may be a challenge to implementing comprehensive smoke-free policies.[44] Additionally, some of these organizations may receive financial and other supports from the tobacco industry.[45-47]	• Prioritize inclusion of organizations serving or working with populations experiencing inequities in tobacco control coalitions. • Identify community leaders and train them to educate stakeholders about the disparities that result when policies are not prioritized in underserved communities. • Use partnerships to leverage resources. Explore funding opportunities to support organizations that want to join smoke-free implementation efforts.
ACCESS TO CESSATION SERVICES Integrate cessation support as part of a comprehensive approach	Given existing inequities in access to and quality of health care,[48] access to cessation supports and services may vary.[49,50]	• Incorporate free or low-cost cessation services before and during policy implementation to help motivated individuals quit. • See strategy on Tobacco Cessation Services for more information.
LACK OF SUPPORTIVE DATA Identify and track health inequities	Lack of timely and comprehensive data that fully explore health inequities may be a barrier to tobacco control efforts[49] (e.g., data examining inequities in secondhand smoke exposure among different groups).	• Improve collection and use of standardized data across population groups (e.g., geography, occupation, sexual orientation) to assess inequities in secondhand smoke exposure and policy coverage. • Use findings to identify where interventions are needed, monitor effects of an intervention, and track progress in addressing health inequities.
VARIABILITY IN IMPLEMENTATION & ENFORCEMENT Expand smoke-free policies and institutional practices	State and local smoking restrictions may not cover all settings, including certain worksites (e.g., bars and casinos), outdoor public spaces (e.g., dining areas, construction sites), and institutions (e.g., mental health and substance abuse treatment facilities).	• Eliminate exemptions in existing smoking restrictions. • Prioritize efforts in institutions with high rates of secondhand smoke exposure when local or state policies do not cover these settings. • Use media to address the health benefits of smoke-free policies and any misperceptions about these policies. • Develop appropriate enforcement mechanisms to support policy implementation.

Build the Team: Partnership for Success

Successful efforts to implement comprehensive smoke-free policies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Area Agencies on Aging
- Cessation support services
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Employee rights groups
- Health care systems, hospitals, community clinics, and health care providers
- Leaders and community champions from multiple sectors
- Local businesses
- Mental health and substance abuse treatment facilities
- Organizations serving populations experiencing health inequities
- Parks and recreation department
- Public health agencies
- School districts, universities, and community colleges
- State tobacco control programs
- Tobacco control groups
- Youth, the elderly, and people with disabilities

HEALTH EQUITY IN ACTION

Native American Tribes Adopt Tobacco Protections for Tribal Members and Future Generations

Montana

In Montana, 43% of Native American adults self-report cigarette smoking.[51] These high rates of commercial tobacco products use contributes to high rates of disease and premature death among Montana's Native Americans.[52] To address the commercial use of tobacco in their communities, the Blackfeet and Fort Peck tribes worked together to implement comprehensive smoke-free indoor protections. These protections also safeguard casino visitors and employees from secondhand smoke.

Respect for cultural traditions of tobacco use was instrumental in the development and implementation of strategies to create smoke-free environments. Several years earlier, the Native American Tobacco Coalition of Montana approached tribal elders to ask if they would support the creation of smoke-free environments. Initially, the elders were not supportive, because they believed this could potentially hinder traditional uses of tobacco, which are rooted in spiritual beliefs and medicinal practices. The elders engaged in a four-year process of teaching the historical and ceremonial practices of traditional tobacco use, including spiritual offerings. In turn, the coalition educated elders about the impact of commercial tobacco use and secondhand smoke exposure on tribal youth and future generations.

With support from the elders, the coalition educated the tribal members about the distinction between the sacred use of tobacco and the use of commercial tobacco. Community engagement activities included commercial tobacco-free celebrations, health fairs, youth-focused events, and trainings. By conducting extensive educational initiatives for tribal members and elders, the Blackfeet and Fort Peck Tribal Nations were able to create smoke-free indoor environments that included casinos. As a result, other tribes have created smoke-free environments in most tribal facilities. The coalition learned a valuable lesson: to be successful, smoke-free strategies need to be true to the people and rooted in cultural tradition.

Smokefree table tent at Birmingham, AL restaurant. Photo courtesy of the JCDH and the HAP.

Partnerships and Educational Initiatives Lead to Smoke-Free Air Protections

Birmingham, AL

Jefferson County Department of Health (JCDH) and the Health Action Partnership (HAP) are helping to implement smoke-free protections in Birmingham—impacting approximately 356,000 Jefferson County residents and commuters. With support from CDC's *Communities Putting Prevention to Work* program, the health department conducted community needs assessments and used geographic information systems (GIS) mapping to track rates of smoking, heart attack, and cancer to identify communities with the highest need for smoke-free protections. Then they overlaid those maps with maps of low-income areas.

After identifying high-need communities, JCDH and HAP conducted evaluation interviews in these areas to assess the key organizations and community champions that could become a conduit for educating residents on secondhand smoke issues. Working with a variety of local organizations, faith-based leaders, and the media, the community was able to successfully educate and increase community awareness about the benefits of smoke-free environments. The Friends of West End, a local organization with strong ties to the targeted communities, educated nearly 100 neighborhood association presidents. The presidents then educated their respective communities while local pastors did the same among their congregations. JCDH's understanding of culturally appropriate educational media led to a well-received radio soap opera, *Live Well Camberwell*. The educational radio program and health expert interviews were aired on stations with largely African American audiences.

All of these educational initiatives contributed to increasing awareness around the health effects of secondhand smoke exposure in indoor places of employment including restaurants, bars, and hotels. When smoke-free protections were put in place, the HAP provided technical assistance to ensure proper implementation of and compliance with the smoke-free protections.

SMOKE-FREE MULTI-UNIT HOUSING POLICIES

SMOKE-FREE MULTI-UNIT HOUSING POLICIES AIM TO PROTECT NONSMOKERS WHO LIVE IN, WORK, AND VISIT MULTI-UNIT RESIDENCES SUCH AS APARTMENTS, CONDOMINIUMS, TOWNHOUSES, DUPLEXES, AND AFFORDABLE HOUSING COMPLEXES FROM SECONDHAND SMOKE.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for smoke-free multi-unit housing policies that advance health equity:

- **Increased Secondhand Smoke Risks among Vulnerable Populations:** Low-income individuals generally have higher smoking rates,[30] which may result in increased exposure to secondhand smoke in affordable and public housing. Given that many residents living in these settings are vulnerable population groups (e.g., children, older adults, racial/ethnic minorities, and those with a disability),[53] secondhand smoke exposure is critical to address. For instance, many racial/ethnic minorities and low-income populations suffer higher rates of asthma and other tobacco-related health issues,[54] making them particularly vulnerable to the effects of secondhand smoke exposure. Children are also vulnerable to developing health effects from secondhand smoke exposure.[55]

- **Residents Who are Being Exposed to Secondhand Smoke May Have Limited Alternative Housing Options:** Even when residents of multi-unit housing do not allow smoking in their unit, secondhand smoke can enter their unit from other units or common areas through shared ventilation systems, air spaces, windows, and hallways, putting residents at risk.[54,56,57] Low-income residents in affordable or public housing complexes who are being involuntarily exposed to secondhand smoke in their homes in this manner may have limited alternative housing options or be unable to move.

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating smoke-free multi-unit housing policies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
MISPERCEPTIONS Clarify intent and address misperceptions about smoke-free multi-unit housing strategies	Organizations that work on behalf of low-income residents (e.g., residents' rights organizations, affordable housing groups) may have misconceptions about the intent or effects of smoke-free multi-unit housing strategies.	• Ensure residents and owners understand that the smoke-free policy is designed to promote a healthy home environment and reduce secondhand smoke exposure—not to remove smokers or prevent new smokers from moving in, as long as they comply with the policy. • Consider working across different types of multi-unit housing (e.g., public, affordable, and market-rate) to show everyone deserves clean air and prevent concerns about discrimination.
STAKEHOLDER SUPPORT Address concerns and build support among housing providers	If landlords are unaware of resident support for smoke-free policies, they may have concerns that such a policy will lead to reduced occupancy or will be difficult to enforce.	• Alleviate concerns of stakeholders (e.g., landlords, apartment owners) by educating them on the business, health, and safety benefits of smoke-free policies. • Provide tools and training on how to gather resident feedback, navigate the implementation process, develop monitoring mechanisms, and address noncompliance.
COMMUNITY INVOLVEMENT & AWARENESS Engage residents in strategy development and implementation	Strategies developed without resident input may negatively affect strategy implementation and enforcement.	• Identify residents to serve as champions and involve them throughout the development and implementation process. • Gather input through resident surveys and forums, and collaborate with resident associations to develop the strategy. • Establish mechanisms to ensure that residents are aware of the policy and its benefits (e.g., culturally appropriate education initiatives, resident forums).
ACCESS Increase access to free or low-cost cessation services	Residents without access to cessation supports may not comply with smoke-free policies, placing other residents at risk for secondhand smoke exposure.	• Provide smokers with free access to evidence-based cessation treatments to ease the transition to a smoke-free environment, increase compliance, prevent smokers from feeling stigmatized, and help them quit smoking, thus maximizing the policy's health benefits. • Offer and promote cessation services in or near the complex at convenient times before and during policy implementation.
EQUITABLE IMPLEMENTATION Anticipate additional challenges to policy implementation	After policy implementation, smokers may tend to congregate in outdoor areas near buildings, exposing residents in outdoor or adjacent indoor areas to secondhand smoke, which may enter the building through doors, windows, or vents.	• Make the entire property smoke-free or restrict smoking to a few designated outdoor areas located far enough away from entrances and exits to prevent secondhand smoke from infiltrating indoor areas. • Improve compliance by conducting tailored resident engagement, education, and cessation efforts. • In supportive housing settings, (e.g., homeless shelters, mental health and substance abuse treatment facilities), work with staff to find tailored, context-specific approaches.

Build the Team: Partnership for Success

Successful efforts to implement smoke-free multi-unit housing policies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Area Agencies on Aging
- Cessation support services
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Condominium owners
- Faith-based organizations
- Housing industry organizations, local housing authorities, and nonprofit housing associations
- Immigrants and refugees
- Low-income residents
- Organizations serving populations experiencing health inequities
- Real estate developers
- Residential property owners, management companies
- State tobacco control programs
- Residents' rights/fair housing organizations
- Youth, the elderly, and people with disabilities

HEALTH EQUITY IN ACTION

Creating Healthy Environments through Smoke-Free Multi-Unit Housing Policies

San Antonio, TX

Everyone has the right to breathe clean air, especially in their own home. Yet in many San Antonio multi-unit housing complexes, residents were being exposed to secondhand smoke infiltrating their units from neighboring units. To address this issue, the San Antonio Metropolitan Health District (SAMHD) worked with the San Antonio Housing Authority (SAHA) to implement a smoke-free multi-unit housing policy for all 70 of its housing sites. These efforts were made possible with support from a combination of state and local funds.

SAMHD focused on making multi-unit housing smoke-free with a strategy that covered all indoor areas, since a comprehensive policy would have a greater impact on health equity for all SAHA residents and staff. Both organizations recognized the importance of community engagement to ensure policy success. They worked closely with residents and staff in mini-community centers associated with each housing campus. Engaging the residents through the community centers—a resource that residents were already turning to for information—was key to the success of this approach.

SAMHD bolstered its outreach and education efforts through a partnership with the American Cancer Society (ACS). ACS educated community center staff on how to answer questions about the new policy, to refer residents to the state quitline, and to discuss options for obtaining nicotine replacement therapy (e.g. nicotine patches). All materials were printed in both English and Spanish, and staff in many centers were able to communicate the benefit of smoke-free air protections to residents in their own language.

ACS and SAHA also helped organize town hall meetings to educate residents and discuss the benefits of smoke-free protections in an open forum. As a result of the policy, nearly 16,000 residents (many of them low-income immigrants and racial/ethnic minorities) now have access to cleaner air in their homes.

Housing Authority and Public Health Commission Partner on Smoke-Free Housing

Boston, MA

Building relationships with the Boston Housing Authority, other city agencies, and community-based organizations, the Boston Public Health Commission (BPHC), with support from the CDC's *Communities Putting Prevention to Work* program, educated housing providers about the voluntary adoption of smoke-free multi-unit housing policies. The Commission has also successfully leveraged support for smoke-free housing among residents in all market sectors (e.g., market rate, public housing), as well as used data to identify disparities in health outcomes across residents of different types of housing. The goal is to ensure that residents, particularly those most vulnerable to secondhand smoke exposure, have clean air to breathe in their homes. Smoke-free protections in public housing, affordable housing, and market-rate housing have the potential to provide protection for populations with high exposure to secondhand smoke, including low-income families, children with asthma, immigrants, elderly residents, and persons with chronic diseases or disabilities.

The BPHC has taken a series of steps to increase smoke-free protections in and around multi-unit housing complexes. One key to the success of the BPHC's policy was its approach of working closely with stakeholders such as the Boston Housing Authority and landlords, property management companies, and community development corporations. Input from residents in policy development was critical, and mini-grants to community development corporations supported community engagement. The BPHC also worked strategically with a variety of community partners to make the case to landlords and housing agencies that a majority of residents wanted smoke-free housing, and that going smoke-free would benefit all stakeholders. The BPHC provided technical assistance in developing and implementing a smoke-free multi-unit housing policy. Because Massachusetts has relatively good coverage of smoking cessation treatments, many smokers in the state can access affordable cessation services.

The BPHC approach led to some notable early successes. The Boston Housing Authority portfolio became 100% smoke-free in September 2012, assuring a healthier environment for the 23,000 residents living in their 12,000 units. Community development corporations have transitioned over 600 units to smoke-free status, and continue to bring additional units on line as smoke-free. There are now 6,600 non-public smoke-free units and the BPHC sees this as just the beginning. As Margaret Reid, Director of the Division of Healthy Homes and Community Supports at the BPHC, says, "We are supporting smoke-free policies and awareness so that smoke-free becomes the norm in Boston multi-unit housing, whether it is public, subsidized, or market-rate."

TOBACCO CESSATION SERVICES

TOBACCO CESSATION STRATEGIES HELP PEOPLE QUIT SMOKING OR USING OTHER FORMS OF TOBACCO. THESE STRATEGIES MAY INCLUDE CLINICAL SCREENING AND REFERRAL SYSTEMS, QUIT LINES, BEHAVIORAL COUNSELING, AND CESSATION MEDICATIONS.[58]

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for tobacco cessation strategies that advance health equity:

- **Varying Rates of Smoking and Cessation among Different Communities:** In the United States, certain population groups stand out as having higher-than-average smoking rates, lower-than-average cessation rates, or higher-than-average rates of tobacco-related diseases.[49,59,60] For example, population groups with disproportionately high rates of smoking include American Indian and Alaska Natives,[7,60] the lesbian, gay, bisexual, and transgender (LGBT) communities,[61-63] people with mental illness[64] and substance abuse conditions,[7] and people with disabilities.[65] African American adults have been found to be more likely to express interest in quitting and more likely to have tried to quit in the past year than white adults, but are less likely to use proven treatments (e.g., counseling and/or medications) and are less likely to succeed in quitting.[59] Adults aged 65 or older have also been found to be less likely to attempt smoking cessation compared to younger adults.[59,66] Additionally, low-income populations are more likely to smoke, less likely to quit, and often lack access to affordable cessation support.[49,60,67]

- **Barriers to Accessing Cessation Resources:** Differential access and quality of health care may present barriers to quitting.[50] For example, uninsured smokers may be less likely to receive quitting advice or other forms of cessation treatment from health care providers.[50] Additionally, certain population groups, including African Americans and Hispanics, are less likely to be screened for tobacco use or receive smoking cessation interventions.[59,68-70]

- **Challenges to the Widespread Use of Evidence-Based Cessation Interventions:** There is limited research on effective approaches for promoting and increasing utilization of cessation interventions among population groups experiencing health disparities.[71,72] A lack of sensitivity to social norms and cultural traditions in developing cessation interventions may influence intervention use and ultimate effectiveness.

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating tobacco cessation strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
ACCESS Increase access to cessation services by integrating them into health systems and making them convenient	Certain population groups are less likely to be screened for tobacco use or receive tobacco cessation counseling.[69,70] Additionally, cessation services may be underused because of limited knowledge, awareness, and cultural beliefs.[73,74]	• Prioritize integration of tobacco screening and provision of/referral for evidence-based cessation treatments into institutions that are already serving vulnerable populations (e.g., community health centers, Federally Qualified Health Centers, rural health clinics, mental health and substance abuse treatment facilities). • Prioritize the promotion of existing cessation services including tobacco quitlines and Web sites to populations experiencing health disparities. • Integrate cessation programs and support into community institutions located in places where people already go (e.g., public housing, faith-based settings, social service agencies). • Train community health outreach workers to provide cessation services during home visits.
COST Remove/reduce cost and insurance barriers	Costs associated with cessation services, which may result from lack of/inadequate health insurance coverage pose particularly significant barriers for low-income populations.[75-77]	• Develop relationships with private and public health insurers and health care systems, including state Medicaid programs, to expand insurance coverage of cessation services. • Consider ways to eliminate or minimize cost and other barriers (e.g., co-pays, prior authorization requirements) to accessing cessation treatments.
DIVERSE NORMS AND CUSTOMS Ensure that cessation services are culturally relevant and appropriate	Limited research on effective approaches to promote cessation services interventions across different groups may hinder the utilization of such interventions.[49,71,78] For example, tobacco quitlines may be accessed less by groups with cultural norms that avoid seeking counseling from strangers.	• Evaluate the effectiveness of cessation interventions across different population groups. • Ensure that underserved populations have access to and are aware of cessation services (e.g., promote services through culturally appropriate communication channels). • If such populations are still not using, or are unsatisfied with, existing cessation services, partner with relevant organizations to increase culturally relevant training of providers or to tailor these services to meet the populations' needs.

Build the Team: Partnership for Success

Successful efforts to implement tobacco cessation strategies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Academic institutions
- Cessation support services
- Community-based organizations
- Community health centers, including Federally Qualified Health Centers and rural health clinics
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Employers
- Health care systems
- Health insurers
- Lay health providers/promotoras
- Leaders and community champions from multiple sectors
- Media
- Mental health and substance abuse treatment facilities
- National culturally specific cessation guidance organizations
- Public health agencies
- State quitline providers
- State tobacco control programs
- Tobacco control groups
- Workplace wellness organizations

HEALTH EQUITY IN ACTION

Expanding Cessation Services in Marginalized Communities

St. Louis, MO

With the goal of reducing tobacco-related health disparities, the St. Louis County Department of Health (DOH), with support from CDC's *Communities Putting Prevention to Work* program, set out to increase access to cessation services among populations with high smoking rates. "Being in their neighborhood and speaking their language" was a critical strategy for helping people most in need of cessation resources, noted Barry Freedman, Project Manager for the *Communities Putting Prevention to Work* program at the DOH. DOH partnered with three trusted organizations that had strong ties in the community to provide free and low-cost services and culturally competent care. Each partnership is briefly described below.

Casa de Salud, a local health clinic, provides cessation services to low-income and limited-English-speaking Hispanic populations, including onsite one-on-one cessation counseling and nicotine replacement therapy (NRT), such as nicotine patches. All of this is done using culturally appropriate materials in an environment where clients can feel safe.

SAGE Metro St. Louis works with the lesbian, gay, bisexual, and transgender (LGBT) communities and offers cessation counseling services and NRT free of charge. SAGE also provides education on the techniques the tobacco industry has used to target LGBT communities. Having a presence at the city's three major gay pride events proved an effective outreach and education approach.

The St. Louis Christian Chinese Community Service Center worked to provide cessation services, including individual counseling, support, and other resources, to Asian-American restaurant employees with high rates of smoking. Because of limited health literacy in the communities they serve, the Center conducted traditional Chinese puppet shows to encourage cessation and provided health information to over 500 Chinese Americans. The shows are especially powerful because they respect Chinese cultural norms while conveying important health messages to multiple generations.

In addition to these partnerships, the DOH is helping support low-income and uninsured community clinic clients. DOH is training providers in those clinics to facilitate a free cessation program, and is offering a free three-month supply of NRT products to smokers who want to quit.

Using Partnerships to Increase Access to Cessation Services

Santa Clara County, CA

"A one-stop shop [is] more likely to work than having people go to different places for [tobacco cessation] services," noted Kris Vantornhout, Program Manager for the *Communities Putting Prevention to Work* program at the Santa Clara County Public Health Department (SCCPHD). With this in mind, Santa Clara County's Tobacco Prevention Program strategically partnered with established community-based organizations (CBOs) throughout the county. These CBOs were poised to implement cessation services in neighborhoods with high numbers of smokers. At times, securing diverse community leadership involvement was challenging, but focused efforts were successful in finding champions to lead the way.

SCCPHD awarded twenty-seven mini-grants to CBOs to expand cessation counseling, referrals, and access to nicotine replacement therapy (NRT). These grants supported organizations working with the Vietnamese, African American, Latino, and Lesbian, Gay, Bisexual, and Transgender (LGBT) communities, and engaged diverse partners. Efforts also focused on improving cessation services and referral systems in mental health facilities, health care clinics, and college campuses.

CBOs integrated cessation services into organizational practice by implementing the "ask, advise, refer" model during intake processes and, as appropriate, referring patients or students to trained staff for cessation assistance. Providing culturally and linguistically relevant messaging around secondhand smoke exposure was also important for increasing the uptake of cessation services. Tobacco-free messaging and cessation information were shared onsite, as well as at outreach events such as the San Jose LGBT Pride Celebration, the annual Martin Luther King Luncheon, and the Holiday Fair.

As a result of the Tobacco Prevention Program's partnership efforts, cessation services are now available to some of the most vulnerable populations

Smoke-free sign on medical center campus in Santa Clara County, CA. Photo courtesy of Breathe California.

in the county. Thirty health facilities, 8 colleges, and 11 CBOs now have staff or clinicians using the "ask, advise, refer" model to reach over 544,000 residents. Approximately 8,000 units of NRT were distributed through these networks within less than two years, and post-intervention surveys have shown an overall 39% quit success rate, with an amazing 50% quit rate within the Vietnamese community.

POINT-OF-SALE STRATEGIES TO ADDRESS ACCESS AND EXPOSURE TO TOBACCO PRODUCTS

POINT-OF-SALE (POS) STRATEGIES TO REDUCE THE AVAILABILITY AND APPEAL OF TOBACCO PRODUCTS MAY INCLUDE ADDRESSING THE MARKETING AND AFFORDABILITY OF THESE PRODUCTS THROUGH RESTRICTIONS ON THE POINT-OF-SALE TOBACCO ADVERTISING, PROMOTION (INCLUDING PRICE PROMOTIONS), DISPLAYS, AND PLACEMENT; THE SALES OF SPECIFIC TYPES OF TOBACCO PRODUCTS (E.G., FLAVORED PRODUCTS); AND TOBACCO RETAILER LOCATION AND DENSITY.[79-81,*]

MAKE THE CASE:

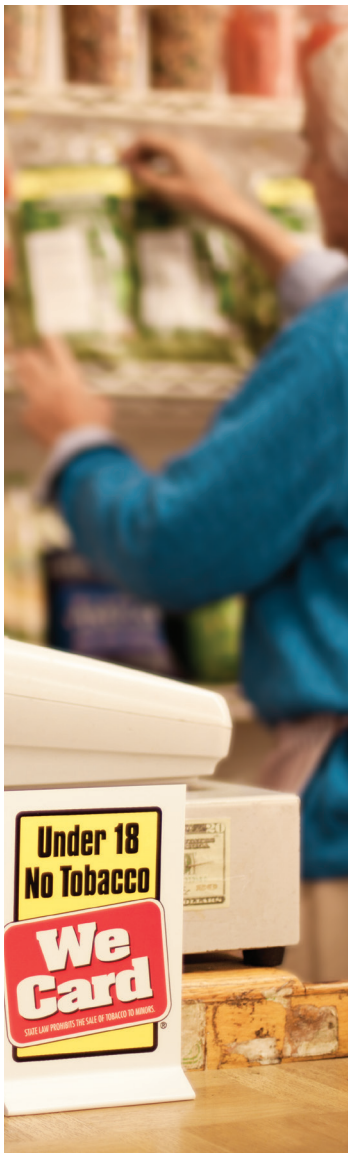
Why Is This A Health Equity Issue?

The issues below highlight the need for POS strategies that advance health equity:

- **Different Exposure to POS Advertising and Targeted Marketing:** Studies have consistently shown that low-income communities[82] and communities of color are more heavily exposed to POS tobacco advertising than other communities.[83,84] Additionally, such advertising may be targeted to or disproportionately impact certain population groups. For instance, the messaging used in marketing menthol cigarettes has been culturally tailored and targeted toward communities of color, especially Africans Americans.[85]

- **Placement of and Price Discounts on Tobacco Products:** Tobacco companies have used a variety of point-of-sale strategies to place tobacco products prominently in the retail environment and keep these products affordable.[86] For example, in 2011, the tobacco industry spent an estimated $8 billion, or nearly $23 million per day, on cigarette advertising and promotional expenses in the United States alone. Approximately 84% (or nearly $7 billion) of this expenditure was spent on price discounts to cigarette retailers or wholesalers to reduce the price of cigarettes to consumers.[87] A placement strategy may include placing tobacco products (e.g., cigarillos, cigars) next to candy or within the view of children and youth.[88] Additionally, tobacco companies may deeply discount their products in stores in lower-income communities and require targeted placement of signs advertising lower prices in these stores.[89] Youth and low-income individuals may be particularly sensitive to prominently placed, inexpensive tobacco products.[79,90]

- **Greater Density of Tobacco Retailers in Underserved Communities:** Research has shown that tobacco retail outlets are more heavily concentrated in low-income communities and communities of color than in higher income communities.[91-94] This makes tobacco products more readily accessible, potentially increasing consumption.[94]



*Note: The Tobacco Control Act preserves the authority of state, local, and tribal governments to regulate tobacco products in certain specific respects. It also prohibits, with certain exceptions, state and local requirements that are different from, or in addition to, requirements under the provisions of the FDCA relating to specified areas.

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating POS strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
RESOURCE & FUNDING LIMITATIONS Prioritize and prepare resources for communities in greatest need	Underserved communities may have fewer resources to implement POS strategies. Additionally, such communities may have other priorities that make it difficult to implement tobacco control initiatives.	• Conduct assessments to examine tobacco retail density, the amount of POS advertising, and tobacco-related health disparities. • Prioritize intervention efforts to address areas with greatest need. • Engage partners who can provide technical assistance to identify viable POS strategies and overcome barriers. • Participate in community coalitions and events in order to understand community priorities, align POS efforts with those priorities, and educate and mobilize the community around these efforts.
ECONOMIC STABILITY Support retailers when implementing POS strategies	Underserved communities, which can have disproportionately high concentrations of tobacco retailers, may oppose POS strategies due to concerns about the potential financial effects on local businesses.	• Find creative mechanisms to support retailers that are implementing POS strategies. • Establish programs that may help retailers transition from relying on sales of tobacco product to selling healthier products (e.g., Healthy Food Financing,[95] healthy corner store initiatives[96]).
COMMUNITY AWARENESS Build community awareness and skills to counter tobacco advertising	Tobacco product displays and POS advertising may distort perceptions of the pervasiveness of tobacco use among adolescents,[97] increase the likelihood of youth smoking initiation,[97,98] and may prompt impulse buys (e.g., among smokers who are trying to quit).[99]	• Increase community awareness of industry marketing tactics to help people critically assess the advertising they see around them. • Work with media outlets serving specific population groups to reinforce positive messaging and to counter any negative effects of tobacco marketing.
VARIABLE IMPLEMENTATION & ENFORCEMENT Support Implementation and Enforcement of POS Strategies, particularly in communities with tobacco-related inequities.	Disparities may increase if POS strategies are not fully implemented or enforced in communities with high smoking rates or social norms that support tobacco use.	• Consider developing implementation plans to support consistent and equitable policy compliance. • Consider establishing processes for accountability and gathering feedback from all communities affected by the policy.

Build the Team: Partnership for Success

Successful efforts to implement POS strategies in communities with tobacco-related disparities depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Healthy food retail groups
- Leaders and community champions from multiple sectors
- Local governments
- Local store owners
- Public health agencies
- Public Works Department
- School districts, universities, and community colleges
- Senior centers
- State tobacco control programs
- Tobacco control groups (including groups representing populations experiencing health disparities)
- Youth volunteers/coalitions
- Zoning and planning organizations

HEALTH EQUITY IN ACTION

Citywide Restrictions Tackle Flavored Tobacco Products

New York, NY

"The price point for entry into the world of tobacco is one dollar." Kevin Schroth, Senior Legal Counsel for Policy, at New York City's (NYC) Department of Health and Mental Hygiene was describing sales of single, flavored cigarillos and little cigars. These inexpensive alternatives to cigarettes are heavily marketed in stores in low-income and minority urban neighborhoods. These products are often flavored, come in brightly colored packages, and are prominently placed in stores next to gum and candy—all features that make them appealing to children and youth.

"Kids spend twice as much time in convenience stores as adults," said Schroth. "It's not a coincidence that these flavored tobacco products look similar to other products marketed to kids." The point-of-sale marketing of these products contribute to perceptions among youth that these products are easily accessible and that their use is acceptable and cool.

The health department partnered with the New York City Coalition for a Smoke-Free City and community-based organizations such as Korean Community Services, which serves an Asian population with high smoking rates. Together, with support from state and city funds, they educated community stakeholders about the health risks associated with flavored non-cigarette tobacco products. In 2009, the NYC City Council passed a law that restricted the sale of flavored non-cigarette tobacco products, with the exception of menthol, mint, wintergreen, and tobacco-flavored products, in stores throughout the city, with the exception of tobacco bars. The strategy is part of a comprehensive approach to protect all residents, especially impressionable youth, in all New York City communities from tobacco industry marketing. The example has motivated other local jurisdictions, such as nearby Providence, Rhode Island, to implement similar measures.

Tobacco-Free Pharmacies Promote Health for All

San Francisco, CA

Many people go to pharmacies to purchase medications and other items to improve their health. Why then do many major pharmacy chains and independent pharmacies sell tobacco products which contribute to severe health effects? The California LGBT Tobacco Education Partnership (the Partnership) saw this discrepancy as an opportunity to decrease the widespread availability of tobacco products.

With the high rates of smoking within the LGBT population, the Castro District (historically considered the center of San Francisco's LGBT communities) was the Partnership's priority location in its attempt to eliminate tobacco sales in pharmacies. The Partnership strategically engaged independent pharmacies that were already tobacco-free, acknowledging them with certificates. These pharmacies also educated community stakeholders on the benefits of tobacco-free pharmacies. In addition, a public opinion survey of smokers and nonsmokers assessed the need for tobacco-free pharmacies.

To ensure that every San Francisco resident, not only those living in the Castro District, has access to tobacco-free pharmacies, the Partnership, with support from the California Department of Public Health, Tobacco Control Program and others, implemented a citywide strategy. Working with diverse partners, including the San Francisco Tobacco-Free Coalition, the University of California at San Francisco School of Pharmacy, and the Board of Supervisors, the Partnership made a compelling research-supported argument that pharmacies should be hubs for health, and that this role was inconsistent with selling tobacco products. Even in the face of opposition from some local media outlets and national retailers, the Partnership remained focused on the message that health for all should be the priority.

On October 1, 2008, San Francisco became the first city in the United States to eliminate the sale of tobacco products in its pharmacies (through changes to the Health Code), affecting an estimated 100 pharmacies and all 805,000 city residents. The policy's success has inspired similar efforts in cities from nearby Richmond, CA to Boston, MA. As Bob Gordon of the Partnership stated, the policy has "changed a social norm around the availability and accessibility of tobacco products in San Francisco. That alone is an amazing outcome."

SECTION 3 Maximizing Healthy Food and Beverage Strategies to Advance Health Equity

USE THE CONTENT TO:

- FOSTER DIALOGUE ON HEALTH EQUITY CONCERNS WITHIN A COMMUNITY.
- TRAIN STAFF AND PARTNERS ON EQUITY ISSUES SURROUNDING TOBACCO-FREE LIVING STRATEGIES.
- IDENTIFY WAYS TO ADDRESS HEALTH EQUITY IN THE DESIGN AND IMPLEMENTATION OF STRATEGIES.
- DEVELOP YOUR OWN APPROACH FOR ENSURING EFFORTS ARE ADDRESSING HEALTH INEQUITIES.

Rural areas, low-income communities, and communities of color are most affected by limited access to healthful food and beverages. Limited access to healthful foods makes it particularly difficult to make healthy choices in these environments.[100] Addressing inequities in healthy food and beverage environments may help address many chronic disease health disparities.

The Healthy Food and Beverage section of *A Practitioner s Guide for Advancing Health Equity* provides equity-oriented considerations, key partners, and community examples related to the design and implementation of the following strategies:

- Community Food Retail Environment
- Healthy Restaurants and Catering Trucks
- Healthy Food in School, Afterschool, and Early Care and Education Environments
- Food Access through Land Use Planning and Policies
- Breastfeeding Practices and Policies

The content presented is not exhaustive and is not intended to act as a “how-to” guide. Rather, this section is meant to stimulate ideas for ensuring healthy food and beverage strategies are designed to address the needs of populations experiencing health inequities. Refer to the disclaimer on page ii when using this Section.

COMMUNITY FOOD RETAIL ENVIRONMENT

COMMUNITY FOOD RETAIL STRATEGIES CAN INCREASE ACCESS TO HEALTHY FOOD OR DECREASE ACCESS TO UNHEALTHY FOODS IN LOCAL STORES, SUPERMARKETS, FARMERS' MARKETS, AND OTHER FOOD RETAIL OUTLETS. SUCH STRATEGIES MAY INCLUDE DEVELOPING FULL-SERVICE GROCERY STORES, IMPROVING OFFERINGS IN SMALL STORES, AND STARTING OR EXPANDING FARMERS' MARKETS.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for community food retail strategies that advance health equity:

- **Limited Access to Healthy Food in Underserved Communities:** Differences in geographic food access have been documented in several national studies.[100,101] For example, low-income communities, communities of color, and rural areas have been found to have fewer supermarkets than wealthier communities, predominantly white neighborhoods, and urban areas.[102,103]
- **Additional Barriers Exist for Many Underserved Communities in Accessing Healthy Food:** Barriers to accessing healthy foods may include dependence on public transit, difficulty transporting groceries due to lack of reliable transportation,[100] and lack of access to healthy options that reflect cultural food preferences. Additionally, higher costs of healthy foods,[100,104-106] and low-quality food selection in some communities,[107,108] may serve as barriers.
- **Improving Access to Healthful Food Can Provide Opportunities for Economic Development in Underserved Communities:** Strategies that increase access to healthy food in underserved communities can have positive effects beyond improved nutrition. Such strategies may create jobs, revitalize commercial areas, and provide tax revenues. For example, grocery stores may act as anchors for retail developments, spurring local economic development.[100]

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating community food retail strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
COMMUNITY AWARENESS & INVOLVEMENT Ensure community engagement in and awareness of healthy food retail projects	Decisions about food availability may not reflect the needs and desires of community residents including perceptions of what is culturally appropriate.	• Engage populations experiencing health inequities in community food assessments, GIS mapping, and other efforts to assess food access. • Ensure those selected for food policy councils and other food initiatives designed to improve the food environment have an understanding and the capacity to address health disparities affecting certain population groups. • Increase residents' awareness of new healthy food retailers, incentives for purchasing healthy foods (e.g. Double Up Food Bucks program[109]), and healthy food preparation.
AFFORDABILITY Ensure affordable pricing for healthy food options and increase low-income residents' purchasing power	Low-income communities and communities of color may have higher food prices for healthy food than high-income and white communities.[105,108,110,111] Additionally, healthy food retailers may not accept SNAP and WIC as forms of payment.	• Promote the use of food assistance programs (e.g., Supplemental Nutrition Assistance Program (SNAP) and the Women, Infant, and Children's Program (WIC)) at healthy food retailers.[112] • Lower retail costs by supporting efforts that encourage lower prices (e.g., streamlining distribution, facilitating bulk purchasing by multiple stores).[112,113] • Provide support to increase demand of healthy options (e.g., assist with marketing and displaying food) and reduce food waste due to spoilage (e.g., offer ways to store and refrigerate foods).[112,113] • Increase SNAP participant purchasing power by providing incentives for the purchase of healthy food (e.g., Double Up Food Bucks program[109]).
NEGATIVE PERCEPTIONS & LIMITED CAPACITY Provide support for bringing food options to underserved communities	A barrier to attracting healthy food retailers to underserved communities may include perceptions that businesses may suffer financially due to poor customer base, theft, or safety issues. Additionally, small stores may lack space, equipment, or staff expertise to carry fresh produce or to handle perishable foods.	• Find mechanisms to support healthy food retailers who locate in underserved communities (e.g., simplify applications and permit procedures, bundle land to encourage supermarkets to locate in both affluent and low-income areas). • Provide support to help stores sell healthier options (e.g., staff training in handling perishable items, free local advertising).

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
ECONOMIC DEVELOPMENT Support local economic development through healthy food retail	Retailers in underserved communities may not understand how they can support and enhance local economic development.	• Connect local agriculture and food production directly to local markets to help keep food dollars in the community. • Establish workforce development programs to train local residents for high-quality jobs in a variety of food retail settings.[114,115] • When making decisions about food retail, consider developing criteria to support businesses that contribute to local economic development (e.g., commitment to hire local residents).
TRANSPORTATION NEEDS Address transportation challenges to increase access to healthy food retail	Individuals who live in communities with poor access to healthy food retail and depend on public transit may have more difficulty transporting groceries—especially perishables and bulk packages. Even if affordable healthy food outlets are nearby, lack of transportation may prevent residents from accessing them.	• Increase connectivity between transit and healthy food retail by assessing and improving existing routes. • Develop safe pedestrian connectors that provide a direct link between food outlets and nearby transit. • In rural areas, and for populations with limited mobility (e.g., the elderly, people with disabilities), consider offering vanpools or shuttles to healthy food options. • Provide online ordering and home delivery of healthy options for customers with transportation limitations.
SAFETY & CONCERNS OF VIOLENCE Address concerns of violence which may serve as a barrier to healthy retail use	Community violence, real or perceived, may be a barrier to shopping at healthy food retail in low-income communities.	• Consider violence prevention strategies to create safe routes and/or reduce concerns of safety on the way to healthy food destinations. • See *Preventing Violence Strategy* in Active Living Section of this guide.

Build the Team: Partnership for Success

Successful efforts to implement community food retail strategies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Area Agencies on Aging
- Community development, revitalization, and redevelopment agencies and organizations
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Developers
- Food banks
- Health care systems, hospitals, community clinics, and health care providers
- Housing agencies
- Industry leaders
- Leaders and community champions from multiple sectors
- Local farmers and regional food distributors
- Organizations serving populations experiencing health inequities
- Public health agencies
- Public Works Department
- Retailers and vendors
- Social service agencies
- Zoning and planning organizations

Corner Store Initiative Supports Community Health and Local Store Owners

Philadelphia, PA

The driving force for a citywide healthy corner store effort came about when school leadership expressed concerns that healthy food policies in schools might drive students to purchase less healthy snacks at nearby corner stores. What started out as a small-scale initiative by The Food Trust to increase the availability of healthy foods, has grown from 10 corner stores near schools to over 600 corner stores in low-income neighborhoods. Results from the Healthy Corner Store Initiative have brought health benefits not only to students, but also community residents who depend primarily on corner stores for food. These efforts have been supported by CDC's *Communities Putting Prevention to Work* and *Community Transformation Grant* programs, as well as other non-federal funding.

Health equity is a central tenet of the corner store efforts. Using existing relationships with local grocers associations (including mom-and-pop store owners), community groups, and school advocates, The Food Trust succeeded in establishing credibility with local corner store owners, making it easier to cultivate new relationships and get buy-in and support. By having a constant presence in the community and working closely with store owners to figure out good solutions, The Food Trust staff created a program that was viable and profitable for the owners. For example, the menu approach taken includes whole foods (e.g., whole-grain tortillas, beans, tofu) and low-fat dairy products, in addition to fresh produce. This allows store owners to select options that fit the store's capacity, while being culturally appropriate for customers. Additionally, the program gave more stores a modest incentive to participate and allowed them to see the potential for increasing their profits. The process helped store owners see themselves as part of the community. The Food Trust is also focused on identifying sustainable solutions and offering additional supports for the most dedicated stores, such as cost-free training and technical assistance and larger infrastructure renovations (e.g., shelving, refrigeration) to accommodate more healthy food options.

Through this initiative, The Food Trust was able to build a meaningful program that continues to benefit store owners and increases availability of healthy food for many low-income neighborhoods throughout Philadelphia.

Improving Food Access and the Local Economy through Farmers' Markets

Southwest Georgia

The residents of Baker County in southwest Georgia (80% of whom are African American) live in a rural food desert. Over time, grocery store retailers abandoned the area, making it difficult for low-income residents with limited transportation to access healthy foods. The lack of grocery stores also impacted economic vitality in the community, leaving local farmers struggling to maintain their livelihood. To simultaneously address the resulting food access and economic issues, the East Baker Historic Society (EBHS) and the Southwest Georgia Project for Community Education began partnering with the Georgia StrikeForce Initiative and The Federation of Southern Cooperatives—organizations that assist African American and disadvantaged rural farmers—to repurpose unused public land for farmers' markets in all 22 counties of the southwest region in Georgia. These efforts were supported by the United States Department of Agriculture and CDC's *Communities Putting Prevention to Work: State and Territorial Initiative*.

The farmers' market development process began with identifying potential land. Next, community members, community-based organizations, local business owners, and government officials including commissioners and community development councils, participated in several strategic planning meetings, lending their input and getting approval to use public land. Disadvantaged farmers were identified and their needs were determined and addressed with training. When the market was ready to open, community activities, such as local high school band performances, were held to attract patrons. Residents with limited transportation now had access to nearby healthy food retail, African American and disadvantaged rural farmers gained customers to purchase their products, and town centers were revitalized with additional foot traffic from farmers' market customers.

By May 2012, four markets had opened. Southwest Georgia's food desert is being revived with fresh foods—one farmers' market at a time.

HEALTHY RESTAURANTS AND CATERING TRUCKS

HEALTHIER RESTAURANTS AND CATERING TRUCKS ARE EXAMPLES OF FOOD AWAY FROM HOME THAT MAY SERVE AS A MAJOR SOURCE OF FOOD IN SOME COMMUNITIES.[116,117] STRATEGIES TO IMPROVE FOOD SELECTIONS IN THESE SETTINGS MAY INCLUDE PROMOTIONS AT THE POINT-OF-PURCHASE, INCREASING THE RANGE OF HEALTHY FOOD OFFERINGS, AND PROMOTING THESE BUSINESSES THROUGH MEDIA AND EDUCATIONAL INITIATIVES.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for healthy restaurant and catering truck strategies that advance health equity:

- **Higher Concentration of Full-Service and Fast Food Restaurants in Low- and Middle-Income Communities and Communities of Color:** Low-income and middle-income communities and communities of color have been found to have more full-service and fast food or quick-service establishments compared to high-income communities.[118-120] Eating away from home in food retail venues such as these has been linked to a variety of poor nutritional and health outcomes.[121]

- **Time and Economic Pressures May Contribute to Reliance on Prepared Food Sources:** While time and economic pressures apply to most households, households with limited income may have a tighter budget for purchasing food. Members of these households may also have limited time because of working multiple jobs or having long commute times. Long distances to access resources may be even more common in rural areas.[100,122] These time and economic pressures may contribute to individuals relying on quickly prepared food sources found at restaurants and catering trucks.

- **Targeted Marketing to Youth of Color Influences Food Choices:** African American and Latino youth are often the target of ethnically-specific marketing initiatives by various food companies.[123] Targeted marketing may increase the likelihood that youth will prefer and consume food options that may be calorie-dense and nutrient-poor, which may negatively affect their diet, weight, and health.[123]

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating healthy restaurant and catering truck strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
TRUST & ENGAGEMENT Build relationships with retailers and overcome cultural barriers	Retailers, particularly those in underserved communities, may be overlooked for health-promoting initiatives due to cultural barriers and misperceptions about their willingness to participate.	• Identify residents or partners with cultural and community ties to engage and recruit retailers in health-related initiatives. • Build trust by helping retailers with various aspects of their business (e.g., training staff, incorporating healthy foods).
COST Prioritize cost-effective strategies for food preparation and food offerings	Many smaller full-service and quick-service restaurants and catering trucks operate on thin margins of profit and may be reluctant to modify menus for fear of losing customers and revenue.	• Suggest changes to food preparation and selection that are not only healthy, but also cost-effective (e.g., offer whole beans in addition to refried beans, switch from lard and margarine to oils).
PROMOTION Provide cost-free promotion for restaurants with healthy items	Some small local businesses may not have marketing budgets to promote healthy food options.	• Encourage business owners to adopt healthy practices by helping them with promotional efforts (e.g., point-of-purchase signs) and advertising (e.g., radio spots, newspaper ads).
VARIABLE IMPLEMENTATION & ENFORCEMENT Ensure a comprehensive approach to nutrient labeling for non-chain, locally owned restaurants and catering trucks	Nutrient labeling may be burdensome for non-chain restaurants and catering trucks. These establishments may lack standardized recipes and may not have the resources to conduct nutrient analyses.[124] Furthermore, some community members may not be responsive to nutrient labeling.[125]	• Assess whether nutrient labeling is a viable strategy for your community. • Find partners to help save on the cost of nutrient analysis. • Build customers' awareness and understanding of nutrient labeling and healthy food options (e.g., use symbols to simplify understanding of nutrient content, offer educational sessions).

Build the Team: Partnership for Success

Successful efforts to implement healthy restaurant and catering truck strategies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Community-based organizations working on food systems, health, and/or agriculture
- Community development, revitalization, and redevelopment agencies and organizations
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Faith-based organizations
- Leaders and community champions from multiple sectors
- Local farmers and regional food distributors
- Public health agencies
- Public Works Department
- Regional or local restaurant associations/ ethnic restaurants
- Restaurant and catering truck owners and managers
- Zoning and planning organizations

HEALTH EQUITY IN ACTION

Carryout Project Brings Healthful Foods to Low-Income Neighborhoods

Baltimore, MD

Low-income African Americans in Baltimore have been found to consume a significant portion of their calories from carryout facilities or restaurants.[127] These findings and others prompted Johns Hopkins researchers to create the Baltimore Healthy Carryout (BHC) project, with the goal of increasing healthy food options. The Baltimore Healthy Carryout intervention was funded by the Diabetes Research and Training Center, University of Maryland and Johns Hopkins University, as well as the Center for a Livable Future at Johns Hopkins University.

Being sensitive to restaurant owners' concerns that significant changes might drive away customers, BHC adopted a phased approach, implementing improvements over time. BHC staff maintained close contact with the owners, visiting each restaurant at least once a week. Through a series of discussions with community members, BHC staff members were able to gauge which healthy foods customers would want. These discussions guided the restaurant owners toward culturally and seasonally acceptable side options such as collard greens, watermelon, broth-based soup with vegetables, yogurt, and fruit cups. Carryout restaurants eventually began offering healthy combo meals (e.g., a healthy entrée with a healthy side instead of fries, bottled water in place of soda) that matched the price of original combo meals, making them accessible to price-sensitive groups.

BHC also addressed concerns about potential profit loss by helping owners with promotion. Paper menus were replaced by more durable laminated signs. Literacy was considered during menu and poster creation, and images were used on the menus to help customers identify healthy choices. The modified menu boards and posters provided an aesthetic improvement, a co-benefit that business owners appreciated. BHC brought healthful foods to Baltimore residents in a way that supported existing local carryout businesses.

Healthy Hometown Restaurant Initiative

Louisville, KY

Many people generally consume a large portion of their calories outside of the home in Louisville, KY.[126] In an effort to promote healthy eating, Louisville Metro Public Health and Wellness (LMPHW), with support from CDC's *Communities Putting Prevention to Work* program, implemented the Healthy Hometown Restaurant Initiative to encourage restaurants to provide healthier options for their patrons. A voluntary menu-labeling resolution was implemented that included a nutrition analysis of meals with printed calorie information and recommendations for healthier menu choices.

LMPHW learned that the community's strong social connectedness provided a benefit when trying to get buy-in from restaurant owners. Restaurateurs were most motivated to join if they were approached by individuals they trusted, and if those individuals thought their customers wanted the change.

Initially, LMPHW conducted community surveys through the University of Louisville and local youth, hosted professional cooking demonstrations, and attended business association meetings. These activities helped spread the word about the restaurant initiative to residents and restaurant owners. However, only restaurants located in affluent neighborhoods were responding. To engage restaurant owners in Louisville's low-income neighborhoods, outreach coordinators conducted in-person visits to restaurants. LMPHW overcame owner hesitation by engaging champions including a neighborhood association and the owner of a local restaurant who had previously signed on to the initiative. The champions spread the word about the Healthy Hometown Initiative and encouraged other restaurateurs to join. Their local outreach led five additional restaurants to join the initiative.

HEALTHY FOOD IN SCHOOL, AFTERSCHOOL, AND EARLY CARE AND EDUCATION ENVIRONMENTS

HEALTHY FOOD AND BEVERAGES STRATEGIES TO IMPROVE THE HEALTH OF CHILDREN MAY INCLUDE THE DEVELOPMENT AND IMPLEMENTATION OF POLICIES AND PRACTICES (E.G., WELLNESS POLICIES, NUTRITION STANDARDS FOR COMPETITIVE FOODS, WATER AVAILABILITY), IN SCHOOL, AFTERSCHOOL, AND EARLY CARE AND EDUCATION ENVIRONMENTS.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for healthy food and beverage strategies that advance health equity:

- **Low-Income Children May Be More Dependent on Foods Provided in School, Afterschool, and Childcare Settings:** Many children benefit from and rely on meals served in school, afterschool, and childcare settings for much of the food they consume per day.[128-132] Specifically, many children from low-income households qualify for free or reduced-price meals and participate in food programs such as the National School Lunch Program, the School Breakfast Program, and the Child and Adult Care Food Program.[132-135] However, some barriers may keep children who qualify for free and reduced-price meal programs from enrolling and benefiting from these services.[136-138] For instance, lack of information about the application process, language and literacy challenges, lack of cultural sensitivity and appropriateness of the food served, and stigma associated with participating in these programs[138,139] may serve as barriers to enrollment and participation.

- **Settings May Differ in Their Capacity to Provide Healthy Food Environments:** The quality of food may vary substantially between and within different settings (e.g., school districts, public and private settings). Some settings may be more constrained by limited budgets, and others may have limited facilities in which to prepare and serve food. Additionally, some schools may rely on the revenues generated from competitive foods, including vending sales, to support various school functions and activities.[140,141] These constraints may contribute to less healthy food environments for children in these settings.

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating healthy food and beverage strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
VARIABILITY IN IMPLEMENTATION Provide additional supports to under-resourced school, afterschool, and childcare settings	The resources available to institutions may affect their ability to improve their food environment.	• Provide additional staff training or technical assistance in settings with fewer resources. This assistance may help maximize enrollment in meal programs and preparation of healthy foods. • Explore alternatives for institutions with limited facilities for the preparation and storage of foods/snacks (e.g., develop agreements with nearby institutions to use their facilities, use mobile vending carts).
PARTICIPATION Reduce barriers to enrollment and increase overall participation in meal programs	Barriers may keep many eligible children from benefiting from these programs.[136,137] Additionally, time constraints and lack of sensitivity to cultural and religious food preferences may limit participation in meal programs.	• Make it easier for parents to enroll children by making them aware of eligibility and providing assistance with paperwork in multiple languages. • Take advantage of automatic or school-wide enrollment options, especially in low-income settings. • Adjust the time and length of meals to ensure children have time to get and eat lunch. • Train staff to be aware of the cultural backgrounds of students in preparation of a culturally appropriate food menu.
STIGMA Take steps to reduce stigma associated with meal programs	Stigma may act as a barrier to participation in meal programs.[138,139]	• Work with stakeholders to identify efforts to prevent obvious identification of eligible students. • Consider avoiding separate lines for competitive foods and food programs. Provide the same food options to all students. • Explore a cashless point-of-sale system where all students have an account in a database.
LACK OF EXPOSURE Increase exposure to healthy foods	Many children may have limited access to and familiarity with healthy foods, particularly children from underserved communities.	• Find opportunities to increase students' exposure to healthy foods (e.g., farm-to-school partnerships, gardening programs). • Work with schools to serve as sites for farmers' markets on the weekends or during child pick-up hours to increase healthy food access. • Consider strategies to make healthy options more commonplace (e.g., discourage use of less healthy food as a reward, encourage fundraising activities that include healthy options, offer healthy competitive foods and vending).

Build the Team: Partnership for Success

Successful efforts to implement healthy food and beverages strategies in school, after-school, and childcare environments depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Board of Education members
- Childcare licensing agencies
- Childcare staff
- Community-based organizations such as YMCA, Boys and Girls Club, sports associations, Boy Scouts, Girl Scouts
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Food service managers and staff
- Local chefs
- Leaders and community champions from multiple sectors
- Local food organizations
- Parents and students
- Parks and recreation agencies (for afterschool and summer programs)
- Principals
- Public health agencies
- School district administrators
- School Health Councils
- Teachers
- Vendors

HEALTH EQUITY IN ACTION

Tailored Institutional Practices to Increase Access to Healthy Foods in Childcare Centers

Southern Nevada

Many Southern Nevada children lack access to healthful food and opportunities for physical activity.[142] This fact, as well as the childhood obesity rates,[143] prompted the Southern Nevada Health District (SNHD) to support childcare centers in implementing institutional health-promoting practices and policies. Budgetary constraints spurred the district to explore no- to low-cost sustainable solutions.

With support from CDC's *Communities Putting Prevention to Work* program, the SNHD Community Health Division worked with the district's Division of Nursing to provide training to childcare center staff and one-on-one guidance in developing healthy food and physical activity practices and institutional policies. To ensure these efforts reached the children most in need, the district targeted high-need childcare centers, including casinos and other places with high rates of unemployment and participation in need-based programs.

By March 2012, more than 65 centers had implemented institutional nutrition and physical activity policies informed by a best practice policy drafted by the Health District. Each center was able to craft an institutional policy that was most appropriate for it and most feasible for implementation. This flexibility gave each center ownership over its institutional practices instead of requiring a standardized approach that might not have accounted for each center's unique level of resources and needs.

Each participating center received a curriculum designed specifically for childcare centers and used it to help establish staff development opportunities. Worth at least four continuing education units (CEUs), the curriculum and related training provided an incentive to each center's support staff to learn how to promote healthy behaviors. Staff can work toward fulfilling a state law that requires licensed childcare professionals to attain 15 CEUs per year, with at least two of those hours in the areas of childhood obesity, physical activity, nutrition, or wellness. Childcare center staff now have the training, resources, and the incentive to have an impact on childhood obesity in Southern Nevada.

Centralized Kitchen Facilitates Healthy Meals for All Schools

Bibb County, GA

Helping students learn is part of the mission of the Bibb County School Nutrition program.[144] The program helps keep students focused and alert by ensuring every student has access to nutritious food. Through collaborative efforts with school nutrition, school administrators, and Title I Home-School Facilitators providing in-kind and other support, Bibb County, GA wanted to remove barriers to healthy food access in schools by encouraging all families to apply for free and reduced-price meals. They also implemented a meal accounting system for *all* students. The system is intended to reduce stigma and prevent obvious identification of students enrolled in the meal program.

Bibb County also built a centralized kitchen for basic prep work and cooking to ensure that each of the county's 41 schools could serve healthy meals. The kitchen provides meals made from basic healthy ingredients, using little sugar, salt, and fat and no preservatives. The centralized kitchen has allowed each school to implement healthier food options without investing in significant kitchen equipment or staffing changes. For example, schools can phase out fryers without purchasing new equipment.

Bibb County already had finishing kitchens in each school, and efforts focused on ensuring that equipment to prepare healthy meals was equitably available across the district. The district intentionally created a standardized menu to ensure that all schools serve healthy options without sacrificing taste, diversity, or appeal. Menu options have included "harvest of the month" items such as fresh beets, sweet potatoes, brussels sprouts, and locally grown strawberries.

Daily vegetarian options feature choices such as black bean empanadas or veggie burgers. For districts that cannot afford a centralized kitchen, Dr. Cleta Long, Director of the Bibb County School Nutrition Program, suggests: "Centralize specific preparation within different schools… one school handles entrees, one school is a bakery, one makes sauce." By creating a parallel distribution system, districts can still serve fresh, healthy food in every school even when kitchen equipment and staff are limited.

FOOD ACCESS THROUGH LAND USE PLANNING AND POLICIES

LAND USE PLANNING AND POLICIES TO IMPROVE FOOD ACCESS MAY INCLUDE ATTRACTING HEALTHY FOOD RETAIL (E.G., SMALL BUSINESSES, MOBILE VENDING), LIMITING THE DENSITY OF LESS HEALTHY FOOD RETAIL, AND PERMITTING URBAN AGRICULTURE AND COMMUNITY GARDENS.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for land use planning strategies that advance health equity:

- **Historical Land Use Policies and Practices Have Shaped Community Resources:** Historically, land use strategies, such as zoning regulations, were used to separate residential areas from industrial areas. However, some of these strategies were used to segregate groups of people based on race, ethnicity, or income status.[145-147] Such land use decisions and other issues have left many low-income and communities of color with limited access to essential services, facilities, and infrastructure,[145,148-151] including food resources.

- **Barriers to Healthy Food Options May Exist in Underserved Communities:** The density of fast food outlets has been found to be higher, and the availability of supermarkets is lower, in low-income communities and communities of color.[108,110,120] Additionally, low-income communities and communities of color may have higher food prices for healthy food than high-income and white communities.[105,108,110,111] The quality of healthy food may also be lower in these underserved communities.[108,110,111] Land use planning and policies can be used to improve the food options in a community.

Note: As many land use and zoning strategies fall in the purview of other sectors, public health agencies should work with appropriate partners when considering such strategies.

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating land use planning strategies to improve access to healthy food:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
COMMUNITY AWARENESS & INVOLVEMENT Engage residents who lack access to healthy food in planning and policy development	Historically, low-income populations and communities of color have been excluded from, or not actively recruited into, land use planning and policy development.[145]	• Partner with organizations that have credibility and ties to residents to foster meaningful engagement. • Provide training to build residents' leadership skills and increase their understanding of the planning process. • Establish systematic processes to ensure that resident concerns are gathered and reflected in land use plans when they are updated.
DISPLACEMENT Make improvements to food retail in underserved communities with current residents in mind	Economic development including new food retail may result in increases in property values and rent. If such changes occur, existing residents may be displaced if they are unable to afford living there.	• Ensure comprehensive plans outline how improvements in food access will affect other priorities such as housing and jobs (e.g., incentivize local hiring for new food retailers). • Align transportation decisions (e.g., transit hub locations, bus routes), with food access needs, particularly for those who may depend on transit (e.g., people with disabilities, the elderly).
DISPROPORTIONATE NEGATIVE EFFECTS Be aware that the same methods used to attract healthy options may also be used to bring in less healthy options	Efforts to attract healthy food retail may inadvertently allow or incentivize less healthy options. For example, retailers in underserved communities may be accustomed to selling low-cost and less healthy food options, and may use any incentives to continue selling these items, instead of healthier options.	• Consider linking specific requirements for healthy food to any incentives to attract or enhance food retail, particularly in underserved communities. • Provide support to food retail outlets operating in food deserts that meet some established healthy food requirements (e.g., additional vending permits, training, Electronic Benefit Transfer (EBT) equipment).

Build the Team: Partnership for Success

Successful efforts to implement land use planning strategies to increase access to healthy food depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Community development, revitalization, and redevelopment agencies and organizations
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Developers
- Food system coalitions and organizations
- Leaders and community champions from multiple sectors
- Local economic development agency
- Local farmers and regional food distributors
- Public health agencies
- Organizations serving populations experiencing health inequities
- Public Works Department
- Retailers and vendors
- Social service agencies
- Zoning and planning organizations

Massachusetts Ave Project (MAP) Growing Green Youth listen as city officials introduce Buffalo's Green Code (form-based rezoning effort) during participation in a public meeting in Buffalo,NY. (2011). Photo courtesy of MAP.

Using Planning and Zoning to Create Access to Healthy and Affordable Foods

Buffalo, NY

An unstable economy has left the once-thriving city of Buffalo with a declining population, unemployment,[152] high rates of poverty, and chronic disease.[153] It has also left a large number of vacant lots. While some may view vacant lots as blight, residents saw an opportunity to turn them into community gardens. However, the current comprehensive plan and zoning code was difficult for residents to navigate.

A team led by Dr. Samina Raja, Associate Professor at the University of Buffalo, works with the Massachusetts Avenue Project (MAP), a community-based organization, to tackle one of Buffalo's biggest challenges—food insecurity. In 2008, the University team mapped grocery stores and found there were fewer grocery stores in communities of color than predominately white communities. MAP took on this challenge by bringing a mobile market to neighborhoods without a grocery store to increase residents' access to healthy and affordable foods; but an existing zoning ordinance restricted where the vehicle could park.

Through a partnership with the Buffalo Niagara Medical Campus, several organizations including the University of Buffalo, MAP, and others formed Healthy Kids, Healthy Communities (with support from the Robert Wood Johnson Foundation)—at a time when Buffalo was focusing its efforts on policy improvement strategies. Buffalo was undergoing an update of its land use plan and zoning code, and the partnership saw an opportunity to highlight the links between zoning and food access. Youth from MAP's programs and other groups in Buffalo were invited to help educate community stakeholders on the benefits of improving access to healthy food sources. They also discussed the impact of zoning codes on growing healthy and culturally appropriate food in the community.

As a result of these educational efforts, the mayor announced his support of strategies that promote access to healthy foods at the first Buffalo Food Policy Summit. The city of Buffalo will likely implement a zoning code that supports an equitable food environment by including strategies such as making market gardens a permissible land use. In addition, the Food Policy Council of Buffalo and Erie County was created by the Erie County Board of Health, and will provide support and act as a resource on food systems and its impact on the health of the community.

How a Model for Social Change Led to Grocery Stores and a Fast Food Moratorium

Los Angeles, CA

South Los Angeles residents suffer from disproportionate rates of chronic disease[154] and low life expectancy.[155] In 1992, the nonprofit organization Community Health Councils (CHC) formed to address the health care safety net crisis in Los Angeles. Seven years later, health disparities loomed large in South LA, and CHC explored the root causes of these inequities. Using a model for social change grounded in community engagement and coalition building, CHC focused on inequities surrounding food and the built environment. The group took the time to build key relationships, an important step for addressing unintended consequences as they arose.

Community members, churches, and community-based organizations, in collaboration with CHC, led an intensive assessment that documented disparities in food access with support from CDC's *Racial and Ethnic Approaches to Community Health* program. Over 100 residents participated, many traveling to West LA (an area with some of the best health outcomes in the county) to note differences in the types of food available. Compared with West LA, South LA lacked sufficient grocery stores that carried healthful foods and faced an overabundance of fast food restaurants. The inequity in access to healthy foods became apparent, and community forums spurred dialogue about environmental impacts on health.

Residents envisioned what a healthy South LA would look like and determined that healthy food options were critical. With this groundwork and support from the community, CHC explored strategies to address the density of fast food restaurants and attract grocery stores. The City Council approved a Grocery Store and Sit-Down Restaurant Incentive package that created economic incentives for attracting healthy food retailers to South LA. Building upon relationships with the local planning department, CHC also worked to support the implementation of other strategies to create a healthier food environment. In 2008, the Los Angeles City Council established an interim control policy that placed a moratorium on permits for new stand-alone fast food restaurants in the targeted neighborhoods for a maximum two-year period. The moratorium later became a permanent policy in the form of a general plan amendment preventing the development of new stand-alone fast food restaurants within a half-mile of an existing establishment.

Examples of food options predominant in South Los Angeles,CA. Photo courtesy of Community Health Councils.

By focusing on the needs identified by community members, CHC made meaningful strides toward improving the food environment. Community members were involved in every step of the process. Lark Galloway Gilliam, Executive Director of CHC stated the key to a successful initiative: "Don't leave the community behind. Let the community lead."

BREASTFEEDING PRACTICES AND POLICIES

SUPPORTIVE BREASTFEEDING STRATEGIES TO IMPROVE THE INITIATION, EXCLUSIVITY, AND DURATION OF BREASTFEEDING MAY INCLUDE ADDRESSING HOSPITAL PRACTICES (E.G., BABY-FRIENDLY HOSPITAL INITIATIVE[156]), SUPPORTING WORKPLACE ACCOMMODATIONS, AND BUILDING SUPPORTIVE COMMUNITY ENVIRONMENTS.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for breastfeeding strategies that advance health equity:

- **Inadequate Access to Services and Support for Some Populations Experiencing Inequities:** Breastfeeding rates are lowest among African American mothers[157,158] and mothers living in rural areas.[157,159,160] Several factors may account for lower rates of breastfeeding among African American mothers, including how they are treated by health care providers with respect to breastfeeding encouragement and information.[161] For mothers in rural areas, factors such as poverty and inadequate access to needed maternity and health services may serve as barriers to breastfeeding.[159,162]

- **Limited Access to Breastfeeding Support in the Workplace:** Mothers returning to the workplace may face several barriers to breastfeeding due to workplace conditions (e.g., break time for pumping, onsite storage) and the level of benefits provided (e.g., maternity leave).[157] For instance, many mothers do not have paid maternity leave. Additionally, those with lower incomes and those in the service and manufacturing fields have been found to have even lower rates of paid maternity/family leave.[157] Breastfeeding may also be particularly challenging for hourly, low-wage mothers as they may have less flexibility and break options.[157,163]

- **Social Norms May Serve as a Barrier for Underserved Communities:** Social norms such as lack of support from family and friends[161] and not having examples of breastfeeding[157,164] may be barriers for some population groups. Additional barriers may include norms around the sexual role of breasts as opposed to their nurturing function of breastfeeding, and perceptions of breastfeeding as an unusual feeding option.[157,164]

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating breastfeeding strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
LIMITED RESOURCES & CAPACITY Address challenges to implementing hospital practices that increase breastfeeding initiation	The process required for achieving official Baby-Friendly Hospital designation may seem too rigorous for some facilities or present barriers within overburdened hospitals.	• Provide additional support to hospitals serving populations with disparities in breastfeeding to help them work toward Baby-Friendly Hospital designation. • Understand challenges to implementing Baby-Friendly hospital practices and work with hospitals to identify and implement incremental steps toward encouraging breastfeeding.
VARIABILITY IN CARE PROVIDED Ensure sufficient breastfeeding support from health care providers and staff	Varying cultural and socioeconomic factors, as well as a lack of information on breastfeeding, may result in some women not receiving the support they need to initiate and continue breastfeeding.[165]	• Train providers on breastfeeding disparities and approaches to address cultural and economic barriers to ensure they provide appropriate breastfeeding education to all. • Encourage hospitals to partner with the Women, Infants, and Children Program (WIC)[166] to ensure continuity of breastfeeding support for low-income mothers following discharge.
TRAINING NEEDS Provide adequate and culturally competent training for peer counselors who provide breastfeeding advice	Mothers may get discouraged from breastfeeding when they face challenges and do not have support from properly trained individuals.	• Encourage use of properly trained peer counselors, along with professional support, to provide culturally tailored support for breastfeeding.[157,167] • Partner with WIC and other organizations to identify residents who reflect the cultural values of breastfeeding mothers and can be trained as peer counselors.
VARIABILITY IN ADOPTION & IMPLEMENTATION OF BREASTFEEDING STRATEGIES Collaborate with community resources to enhance worksite breastfeeding support	Some employers, including those that employ low-wage staff, may not understand how to properly accommodate breastfeeding workers. They may also lack the resources and infrastructure (e.g., space, refrigeration) to comply with breastfeeding regulations.	• Reach out to employers, including those that employ low-wage staff, to address workplace barriers and provide support for breastfeeding accommodation. • For smaller businesses, consider addressing barriers by building partnerships among employers located close to one another to combine resources (e.g., establish one common space that can be used by all their employees). • Find creative solutions to provide information and accessible spaces for breastfeeding mothers (e.g., leverage existing community infrastructure such as faith-based institutions, libraries, childcare centers).

Build the Team: Partnership for Success

Successful efforts to implement supportive breastfeeding strategies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Chambers of commerce
- Childcare centers and provider organizations (e.g., Head Start)
- Community-based organizations
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Cultural institutions and networks
- Faith-based organizations
- Family members
- Health care systems, hospitals, community clinics, and health care providers
- Local businesses
- Local/regional employers (particularly employers of low-income, hourly workers)
- Public health agencies
- Regional and local breastfeeding coalitions (e.g. La Leche League, lactation consultants)
- Social service agencies
- State and local WIC programs

HEALTH EQUITY IN ACTION

Promoting Baby-Friendly Hospitals to Increase Equity

Los Angeles, CA

Of the 50 California counties where births occur, Los Angeles County ranked 43rd out of 50 for exclusive breastfeeding rates. Furthermore, Los Angeles County housed 9 of the 15 lowest scoring hospitals in the state.[168] In response, Breastfeed LA: Breastfeeding Task Force of Greater Los Angeles collaborated with the Regional Perinatal Programs of California to provide training and technical assistance to improve the quality of maternal care and guide hospitals toward the Baby-Friendly Hospital designation.

In 2008 and 2009, Breastfeed LA reached out to hospital decision makers, emphasizing breastfeeding as a quality improvement indicator and promoting baby-friendly practices. Focusing on three counties with the lowest rates of exclusive breastfeeding, the group provided bedside nurse and train-the-trainer workshops using the Birth and Beyond California[169] curriculum. Priority was given to hospitals with high birth rates, high rates of Medi-Cal (state Medicaid) use, and low breastfeeding rates. The funding for this project was from the California Department of Public Health Federal Title V Maternal and Child Health Block Grant.

Hospital participation in some areas was sluggish at first. To overcome lack of interest, Breastfeed LA, with funding from First 5 LA, encouraged local public health officials to become champions by making the case to hospitals that breastfeeding is a public health issue. Grants were given to targeted hospitals from the First 5 LA Baby-Friendly Hospital Project, which helped these hospitals overcome the cost barrier for staff training and systems improvements. These hospitals primarily serve women of color and low-income women.

Collaborative learning has been a key strategy. Breastfeed LA and the Los Angeles County Department of Public Health are convening three Regional Hospital Breastfeeding Consortia where lower performing hospitals can learn from higher performing ones. Since the Consortia kickoff in April 2010, 11 LA hospitals have achieved Baby-Friendly Hospital designation. Many more are in the process.

Note: Breastfeed LA is a partner with the County of Los Angeles, Department of Public Health to continue the vital work of encouraging and guiding hospitals to improve maternity care practices and ultimately achieve Baby-Friendly designation. With support from CDC's *Communities Putting Prevention to Work* program, the three County Hospitals achieved the Baby-Friendly Designation, and technical assistance is being provided to 16 additional hospitals with support from CDC's *Community Transformation Grants* program.

Family participating in the Healthy Start Brooklyn program. Photo Courtesy of Healthy Start Brooklyn.

Building Community Capacity to Support Breastfeeding

New York, NY

Breastfeeding initiation rates in central Brooklyn hospitals were high,[170] but women may have found breastfeeding challenging to maintain and integrate into their daily routines.[171] With funding from the Health Resources and Services Administration, Healthy Start Brooklyn (HSB) found innovative ways to support these women. Coordinated efforts that focused on five low-income, predominantly African American and Latino neighborhoods created empowerment zones to shift breastfeeding practices and norms.

The By My Side program was developed to deliver low-cost services to low-income and immigrant women. It also opened up job opportunities for women living in the targeted neighborhoods. Women were trained as doulas, providing emotional, physical, and informational support to mothers during delivery and conducting home visits before and after birth. Doula services that are typically available to higher-wealth communities are now accessible by low-income families through By My Side. The doulas also serve as lactation consultants, offering guidance on how to breastfeed and linking mothers to resources such as HSB's Breastfeeding 911! Hotline.

Program results show that mothers who have used a doula have higher rates of exclusive breastfeeding. In addition to integrating doula services into hospital practices, HSB has reached out to organizations with strong community ties to initiate culturally appropriate breastfeeding support, expanding the training program so organizations can offer their own doula services. By March 2012, the program had successfully trained more than 30 women in the community. These doulas, along with those already working for By My Side, have participated in more than 100 births.

HSB supports the continuation of breastfeeding behaviors beyond hospital doors by shifting community norms, creating new long-term economic opportunities, and improving the lives of women and their families overall. Some 125 faith-based institutions now have breastfeeding spaces and signs on their premises. Working with pharmacies to provide a space for breastfeeding in their stores is a next step.

SECTION 4 Maximizing Active Living Strategies to Advance Health Equity

USE THE CONTENT TO:

- FOSTER DIALOGUE ON HEALTH EQUITY CONCERNS WITHIN A COMMUNITY.
- TRAIN STAFF AND PARTNERS ON EQUITY ISSUES REGARDING ACTIVE LIVING STRATEGIES.
- IDENTIFY WAYS TO ADDRESS HEALTH EQUITY IN THE DESIGN AND IMPLEMENTATION OF STRATEGIES.
- DEVELOP YOUR OWN APPROACH FOR ENSURING EFFORTS ARE ADDRESSING HEALTH INEQUITIES.

Not all communities have equal access to physical activity resources or environments that support an active lifestyle. Low-income communities and communities of color have been found to have limited facilities and spaces for physical activity, poor sidewalk and street infrastructure, and disproportionate exposure to violence.[172-176] These hindrances may deter or limit opportunities for those populations to engage in physical activity. Additionally, the physical activity infrastructure that does exist in many communities, low-income or not, may not be developed with all potential users in mind. As a result, populations with special needs such as the elderly and people with disabilities may not be properly accommodated.[177 180]

The Active Living section of A Practitioner's Guide for Advancing Health Equity provides equity-oriented considerations, key partners, and community examples related to the design and implementation of the following strategies:

- Joint Use Agreements
- Safe and Accessible Streets for All Users
- Trails and Pathways to Enhance Recreation and Active Transportation
- Physical Activity in School, Afterschool, and Early Care and Education Settings
- Neighborhood Development that Connects Community Resources to Transit
- Preventing Violence

The content presented is not exhaustive and is not intended to act as a "how to" guide. Rather, this section aims to stimulate ideas for ensuring active living strategies are designed to address the needs of populations experiencing health inequities. Refer to disclaimer on page ii when using this Section.

JOINT USE AGREEMENTS

JOINT USE (OR SHARED USE) AGREEMENTS CAN INCREASE RESIDENTS' ACCESS TO SAFE PHYSICAL ACTIVITY RESOURCES BY ALLOWING RESIDENTS TO USE EXISTING COMMUNITY FACILITIES (E.G., PLAYGROUNDS, GYMS, POOLS).

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for joint use agreements that advance health equity:

- **Differential Access to Physical Activity Resources**: Access to physical activity resources (e.g., parks, bike paths, playgrounds) may differ by community, socioeconomic status, and race.[176,181,182] For example, lower-income neighborhoods and communities of color generally have fewer such facilities.[176]
- **Additional Challenges to Using Physical Activity Resources:** Even when physical activity resources are geographically close and appear accessible, some residents may encounter barriers which may limit the use of these resources. Barriers may include neighborhood safety concerns, lack of transportation, lack of time, or expenses related to the facility.[183] Additionally, existing social and community norms or a lack of universally accessible facilities for older adults and those with mobility issues can be barriers.
- **Fewer Joint Use Agreements in Underserved Communities:** After-hours access to facilities such as schools may differ depending on communities' socioeconomic and racial/ethnic composition. For example, certain communities may experience or perceive more barriers to implementation of joint use agreements. These barriers may include concerns about crime and vandalism, as well as costs related to liability, maintenance, or operations.[181,184-186]

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating joint use agreements:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
SAFETY Promote safety to ensure implementation and use of joint use agreements	Concerns about neighborhood safety and vandalism can keep physical activity resources locked or underutilized after-hours, particularly in areas where physical activity resources are needed most.	• Engage violence prevention partners during planning to address safety concerns. • If possible, implement joint use agreements near or in facilities where residents already feel safe. • Use environmental design strategies (e.g., improving lighting, limiting or maintaining shrubbery) to enhance safety.
LIABILITY CONCERNS Address liability concerns related to joint-use agreements, particularly in high-crime areas	Under-resourced communities may have heightened liability concerns due to factors such as older facilities and higher crime rates. Such concerns may hinder facilities from implementing joint use agreements.	• Identify and address barriers and concerns of community partners who may be resistant to joint use agreements. • Assess existing coverage status of joint use partners, as many schools and recreation partners may already be sufficiently covered.
FUNDING LIMITATIONS Establish partnerships to secure funding and sustain joint use agreements	Under-resourced communities may have concerns regarding funding, personnel, and maintenance to keep facilities open outside of normal business hours.	• Combine resources from multiple partners to create stable funding for initial implementation, as well as ongoing operations, maintenance, and programming. • Consider multiple funding sources to support joint use agreements (e.g., grants, state/local bonds, developer fees, tax increment financing). • When funds become available, direct funds to low-resource communities where physical activity opportunities are needed most.
COMMUNITY AWARENESS & INVOLVEMENT Engage residents and create awareness of physical activity resources	Joint use agreements may not be enough to encourage the use of facilities (e.g., school gym) by communities that have gone years without access to such resources beyond normal business hours.	• Use educational initiatives, social media, and partners to increase awareness of existing facilities that are now available to the community. • Encourage use by involving residents in developing programs (e.g., dance classes, walking clubs) that are culturally and age appropriate. • Assess user activity regularly to ensure residents' needs are met and multiple users (e.g., the elderly, people with disabilities, young girls) benefit from the resource.
EQUITABLE ACCESS Support equitable access to parks and open spaces	The physical activity opportunities created by joint use agreements may mask the need for more permanent physical activity resources (e.g., parks), particularly in underserved communities.	• Identify inequities in physical activity resources by conducting an assessment of the distribution, hours, and pricing of such resources. • Understand decision-making processes for physical activity resource allocation. • Work with partners to examine additional strategies to increase options for physical activity in communities with the greatest need and ensure options accommodate differing levels of mobility (e.g., older adults, people in wheelchairs).

Build the Team: Partnership for Success

Successful efforts to implement joint use agreements depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Area Agencies on Aging
- Community-based organizations such as Boys and Girls Club, sports associations, YMCA, Boy Scouts, Girl Scouts
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Custodians
- Faith-based organizations
- Health care systems, hospitals, community clinics, and health care providers
- Law enforcement
- Land trusts or conservancies
- Organizations serving populations experiencing health inequities
- Public agencies, including public health, parks and recreation, housing authority, libraries
- School districts, universities, and community colleges
- Union leaders

HEALTH EQUITY IN ACTION

Beyond Conventional Joint Use: Farmers' Market and Trails in Public Housing Communities

San Antonio, TX

The San Antonio Metropolitan Health District (SAMHD) was not afraid to "be bold, and try new things." It teamed up with the San Antonio Housing Authority (SAHA)—the landlord for 70 different public housing communities—to think creatively about using existing resources to create opportunities for low-income children, adults, elderly residents, and those with disabilities to be healthy. The results of a community health assessment revealed that SAHA residents were already well aware that a healthier diet and more physical activity would improve their health, but they did not have access to fresh produce or a safe place to be active.

Moving beyond the conventional idea of a joint use agreement, SAHA took advantage of its unique position to provide the space and infrastructure that could nurture ideas for improving health. In response to residents' identified needs, the partnership initiated an effort to develop walking trails on five SAHA sites. This project benefits not only residents living in public housing, but the neighboring community as well. To address concerns about the availability of healthy foods, the partnership collaborated with the San Antonio Food Bank to successfully establish a farmers' market in one of the public housing communities. SAHA residents felt strongly that it should be easily accessible and located where they live. This much-needed farmers' market now provides access to affordable, healthy fruits and vegetables in a neighborhood that lacks a grocery store.

Through this joint use partnership with the housing authority, SAMHD was able to directly reach residents who were most in need. These efforts were supported by CDC's *Communities Putting Prevention to Work* program.

Using a School Playground as a Community Resource

Santa Ana, CA

Santa Ana is a community with a predominantly Latino, low-income population that faces high rates of chronic disease, including diabetes.[187,188] The city has only one acre of parks per 1,000 Santa Ana residents, leaving little open space for much-needed recreation.[187,188] Many of the few existing parks are small, not within walking distance of residential neighborhoods, and perceived as places that attract crime.

Working with residents and with support from the California Endowment, Latino Health Access (LHA) pursued a community access agreement at the neighborhood Roosevelt Elementary School, which was accessible and familiar to residents. Joint use agreements allowed community residents to use school grounds outside of school hours. However, existing agreements did not provide free access to recreational spaces to the community at large. They primarily accommodated sports leagues, most of which required a fee. For most residents living below the poverty line, these programs were not a viable option. LHA and residents were able to establish a community access agreement at Roosevelt in partnership with the Santa Ana Unified School District so that everyone in the community, not just those who could pay, gained free access to recreational space. As LHA staff member Nancy Mejia put it, "We are creating a more equitable environment by providing physical activity access for the *whole* community."

Community engagement was central to this success. LHA led parent focus groups to identify programming needs, resulting in ideas such as martial arts classes and art workshops. Parent feedback underscored the importance of opening the school on weekends to ensure a majority of residents could use the space. A community resident board led the project, bringing awareness to the new space and actively engaging other community members in activities, such as a walking audit around the school, skill building, and a driver safety

Children playing in an open schoolyard in central Santa Ana, CA. Photo Courtesy of Latino Health Access.

educational initiative. The success of the project motivated the city and the school district to jointly apply for state funding that could provide a community center at Roosevelt Elementary. The City was awarded $5 million from California Prop 84 funds for the construction of a 10,000 square-foot community center at Roosevelt Elementary. The site serves as a best-practice model that could open other schoolyards in Santa Ana—providing even more physical activity opportunities for everyone in the community.

SAFE AND ACCESSIBLE STREETS FOR ALL USERS

STREET INFRASTRUCTURE AND TRANSPORTATION STRATEGIES MAY INCLUDE COMPLETE STREETS POLICIES, SAFE ROUTES TO SCHOOL POLICIES AND PROGRAMS, AND COMMUNITY DESIGN STANDARDS. THESE STRATEGIES CAN HELP ENSURE THAT STREETS ARE ROUTINELY DESIGNED, MODIFIED, AND UPDATED TO SUPPORT ALL FORMS OF TRANSPORT, INCLUDING ACTIVE TRANSPORT. ACTIVE TRANSPORTATION INCLUDES MODES OF HUMAN POWERED TRANSPORTATION SUCH AS WALKING, BIKING, AND USING A WHEELCHAIR.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for street infrastructure and transportation strategies that advance health equity:

- **Inadequate Infrastructure for Active Transportation Exists in Many Low-Income Communities and Communities of Color:** Low-income communities and communities of color have been found to have poorly maintained sidewalk and street infrastructure, higher rates of crime, and increased dangers from traffic.[174,175] These barriers may discourage some residents from engaging in active transportation or make it difficult and unsafe for those that depend on such infrastructure.
- **Challenges for Active Transportation Exists in Many Rural Communities:** Rural communities, including rural tribal lands, may experience unique infrastructure inequities. These communities may have less pedestrian and bicycling plans and infrastructure than urban communities,[189] and rural roads are some of the most dangerous for pedestrians.[190] Additionally, the long distances between key institutions/settings may present challenges to active transportation.
- **Street Design May Neglect Users with Special Needs:** There are a variety of potential users to consider in street infrastructure and transportation strategies (e.g., the elderly, those with a disability, children). For example, older adults often have difficulty navigating busy, traffic-heavy roads, areas with obstructed or difficult to read signage, and inadequate sidewalks.[177,179,191] Significant barriers may also exist for people with strollers and people with disabilities (e.g., those with hearing and vision impairments, those using wheelchairs).

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating street infrastructure and transportation strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
COMMUNITY AWARENESS & INVOLVEMENT Encourage community participation and leadership	Community members may face barriers (e.g., language, time constraints, lack of transportation) that prevent them from being engaged in infrastructure and transportation planning processes.	• Organize events (e.g., walk and roll audits) to increase awareness of and participation in planning processes among underserved communities. • Work with partners to address barriers to participation (e.g., provide venues for input at convenient times and locations, hold forums in prevalent languages or with interpreters, provide childcare if needed). • Engage representatives from organizations who are trusted by underserved populations to commit to long-term participation in planning processes.
INCLUSIVE DECISION MAKING & DESIGN Ensure decision processes accommodate people with special needs	People with special needs, such as the elderly and people with disabilities, may be overlooked in the design and implementation of street infrastructure and transportation strategies.	• Work with transportation planners to engage people with special needs in planning and implementation processes. • Encourage transportation planners to include guidelines and strategies developed specifically for people with special needs. • Use inclusive language when discussing such strategies (e.g., "walk, bike, and roll" has been used to include those in wheelchairs).
RESOURCE LIMITATIONS Find ways to address funding limitations for street improvements in underserved communities	Funding may not be available for street improvements, particularly in underserved communities. Additionally, residents of these communities may lack the time and resources to apply for funding that addresses infrastructure.	• Leverage existing funds to make necessary improvements and enhancements (e.g., incorporate street improvements into routine road maintenance procedures). • Provide technical support and training to underserved communities to enhance their capacity to apply for infrastructure funding. • When evaluating proposals for funding, use criteria that prioritize communities in greatest need.
DISPLACEMENT Account for the potential displacement effects of street improvement strategies	When a community becomes a popular place to walk, bike, or use other modes of active transportation safely, local businesses may benefit. A possible result is that property values may increase and current residents may be displaced if they are no longer able to afford living there.	• Conduct an assessment (e.g., health impact assessment) to examine the possibility of displacement with all street improvement policies. • Utilize supportive mechanisms and community benefits agreements (e.g., affordable housing protections, local hiring ordinances) to ensure current residents are not displaced and can benefit from infrastructure improvements.

(Also see Neighborhood Development that Connects Community Resources to Transit on page 91)

Build the Team: Partnership for Success

Successful efforts to implement street infrastructure and active transportation strategies depend on strong partnerships that bring a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Area Agencies on Aging
- Community development, revitalization, and redevelopment agencies and organizations
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Environmental and climate change groups
- Leaders and community champions from multiple sectors
- Local transportation planning department
- Organizations serving populations experiencing health inequities
- Program evaluators
- Public health agencies
- Public Works Department
- School districts, universities, and community colleges
- Transit agencies
- Transportation organizations
- Zoning and planning organizations

HEALTH EQUITY IN ACTION

Creating Safe Routes in a Rural Community

Sault Ste. Marie, MI

The service area of the Sault Ste. Marie Tribe of Chippewa Indians covers seven rural counties in Michigan's Eastern Upper Peninsula. These counties have higher percentages of low-income populations than other places in the state. Limited infrastructure options often force residents who live in tribal housing to drive to local stores, schools, childcare, and employment, even though these resources are within walking or biking distance. Rising gas prices coupled with limited household incomes prompted the Sault Tribe Community Health Program, with support from the CDC's *Strategic Alliance for Health* program, to explore infrastructure improvements that would support active transportation.

The Sault Tribe's Strategic Alliance for Health Project staff and coalition members conducted walking audits in tribal housing, as well as the broader community. Pictures taken by community members illustrated the need for bicycle and pedestrian improvements. The presentations were effective in educating community stakeholders about the need for pedestrian and bicycle facilities, resulting in construction of a sidewalk connecting tribal housing in one community to a major employment center. In another neighborhood, a need was identified for a midblock crossing near a childcare center to allow caregivers to take young children on walks during the day. The Strategic Alliance for Health Project also facilitated a partnership between tribal transportation planners and the City of St. Ignace to invest in sidewalk improvements that will connect housing to a nearby high school athletic field.

Key partnerships among tribal transportation planners, tribal housing authority, local government, and school systems fostered success. These partnerships were instrumental in implementing strategies that will support the creation of complete streets in five communities and in the seven-county region, focus on safe bicycle and pedestrian projects in the regional transportation plans, and address health and safety needs of all residents.

Transportation Framework Supports Health Equity and Sustainability

Multnomah County, OR

When Multnomah County Health Department staff realized the tremendous impact of transportation decisions on the health of Oregon's residents, they wanted to get involved. They wanted to ensure transportation projects would contribute to—not detract from—their health and equity goals. With funding from CDC's *Communities Putting Prevention to Work* program, the health department leveraged their relationships with local transportation leaders and other community-based organizations and began working with Upstream Public Health (a Portland-based public health policy organization), the City of Portland Bureau of Transportation, and the North American Sustainable Transportation Council. One goal of the cross-sector partnership was to create a system to ensure health, multimodal safety, and equity outcomes are improved in the planning, analysis, and operation of transportation plans and projects.

In 2010, the North American Sustainable Transportation Council developed the Sustainable Transportation Analysis and Rating System (STARS) pilot project application manual. STARS is a framework for developing and rating transportation projects, plans, and programs. It is a performance-based system with a multimodal focus that allows planners to compare and improve performance across all modal strategies. The STARS project manual currently consists of 12 core credits that encompass the "triple bottom line," also known as the "three Ps" of access (people), climate and energy (planet), and cost effectiveness (prosperity). Projects that achieve at least nine of the 12 core credits are qualified for STARS certification. Through Multnomah County's collaborative effort, three new STARS credits have been developed to increase the likelihood that transportation projects improve key health, safety, and equity criteria.

With health equity as a driving principle, STARS gives credit for meaningful engagement of the communities most affected by the transportation project. Focusing on meaningful engagement ensures residents have a say in how transportation projects are planned and implemented. Credits are also awarded to projects that are planned so that transportation-disadvantaged communities gain improved access to meet daily needs and are not burdened disproportionately. Plans and projects that earn safety, health, and equity credits take one step closer to becoming STARS certified, providing an incentive for transportation planners and project managers to integrate health, safety, and equity into their work. Certified projects may be prioritized for government funding. Communities across the country can use STARS to ensure that their own transportation projects and plans include health and multimodal safety, while maximizing efforts to achieve equitable outcomes.

Infrastructure improvements on the Hawthorne Bridge in Multnomah County make safe, sustainable, and equitable transportation options available to all users. Photo Courtesy of Greg Raisman.

TRAILS AND PATHWAYS TO ENHANCE RECREATION AND ACTIVE TRANSPORTATION

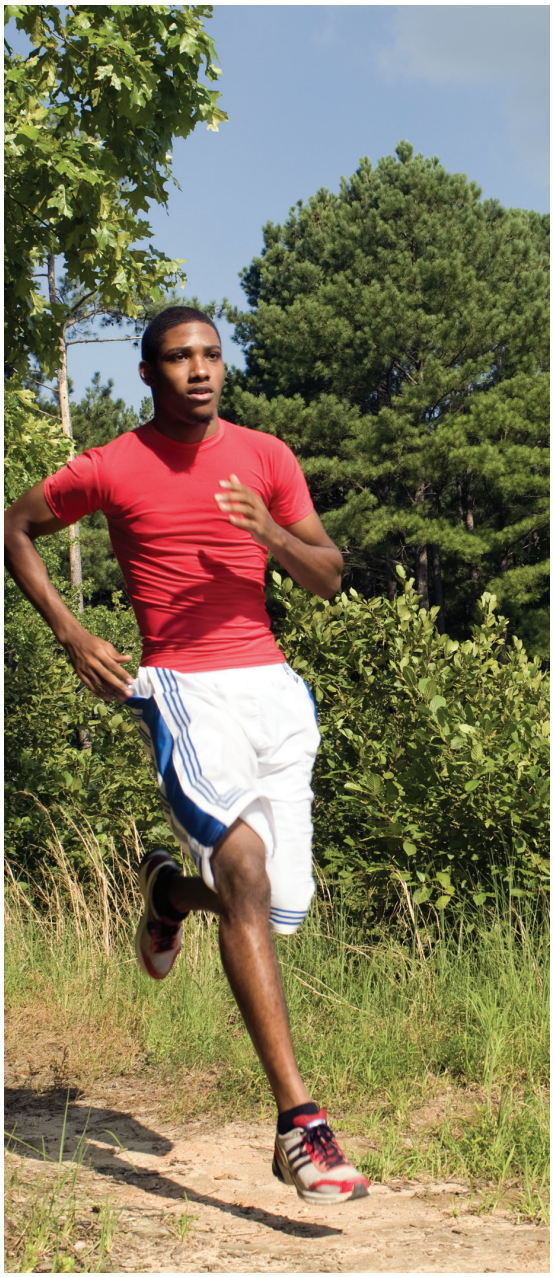
TRAILS AND PATHWAYS CAN PROVIDE A VENUE FOR RECREATIONAL PHYSICAL ACTIVITY, AS WELL AS ACTIVE TRANSPORTATION (E.G., WALKING, BIKING, USING WHEELCHAIRS) TO WORK, SCHOOL, AND COMMUNITY RESOURCES.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for trail and pathway strategies that advance health equity:

- **Limited Access to Physical Activity Resources in Many Underserved Communities:** Communities with higher poverty rates and higher proportions of people of color have been found to have few physical activity resources.[176,192] Additionally, rural communities may have less access to resources such as recreational facilities and sidewalks.[193]
- **Barriers to the Use of Trails and Pathways May Exist for Some Population Groups:** Trail use may be deterred by litter issues, excessive noise from the street, the presence of tunnels, safety concerns, and vegetation density.[194] Additionally, trail use may be challenging for older adults and people with disabilities if trails are not designed to consider their needs. For example, barriers to physical activity among these populations may include physical obstacles (e.g., narrow paths, low lighting, uneven or soft surfaces that make wheelchair use more difficult), logistical challenges (e.g., lack of transportation to facilities),[195] and poor visibility (e.g., unmarked entry points to trails).



Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating trail and pathway strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
RESOURCE LIMITATIONS Pursue creative financing strategies and enhance existing trails and pathways in underserved communities	Developing a new trail or pathway may be unrealistic in certain communities given the complexity of the project, financial resources required, and geographic constraints.[196,197]	• Leverage land trusts to navigate the financing and real estate aspects of securing land for public good. • Pursue public-private partnerships and creative financing strategies, (e.g., railbanking, local finance measures, block grants) to support trail development. • Expand or improve existing trails, sidewalks, or paths when resources and/or physical space are limited.
COMMUNITY AWARENESS & INVOLVEMENT Engage residents in planning and monitoring decisions relevant to trails and pathways	Participation in local and regional planning processes can be a challenge due to time, logistical barriers, and the technical knowledge required for full participation.	• Partner with trusted organizations to identify residents to serve as community liaisons in planning processes. • Train community liaisons to serve as spokespeople, monitor the processes, inform others about input opportunities, and collect data as needed.
SAFETY Improve or maintain safety to maximize trail usage in underserved communities	Real or perceived concerns about safety may deter people from using trails and paths.	• Conduct ongoing maintenance (e.g., clear vegetation and trash, remove graffiti) to promote safety of paths. • Engage community groups and residents to provide long-term trail maintenance. • Use approaches such as Crime Prevention through Environmental Design (CPTED)[198] to create safer environments.
SOCIAL AND OTHER SUPPORTS Provide supports that enhance trail use	Residents who have historically lacked access may not be aware of trails or may need additional support to make trail use a part of their routine.	• Develop initiatives to encourage trail use (e.g., health education initiatives, physician referrals, walking clubs). • Partner with local agencies to host events and activities that use paths and trails. • Partner with local law enforcement to promote safety. • Enhance existing trails to facilitate access between community resources (e.g., housing, transit stations, parks, schools, retail centers).

Build the Team: Partnership for Success

Successful efforts to implement trail and pathway strategies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partnerships may include the following:

- Area Agencies on Aging
- Chambers of commerce
- Community-based organizations
- Community development, revitalization, and redevelopment agencies and organizations
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Faith-based organizations
- Health care systems, hospitals, community clinics, and health care providers
- Land trusts or conservancies
- Leaders and community champions from multiple sectors
- Local businesses
- Local governments
- Local department of transportation
- Local organizations of those with differing abilities
- Parks and recreation department
- Public health agencies
- Public Works Department
- Real estate developers
- Social services agencies
- State department of conservation
- State department of natural resources
- State department of transportation
- Zoning and planning organizations

HEALTH EQUITY IN ACTION

Trails Upgraded to Better Connect People and Destinations

Mid-Ohio Valley, WV

"If you build it, they will come" did not ring true for the miles of underutilized trails in rural Mid-Ohio Valley, partly because low-income residents lacked access to these pathways. This lack of access presented a real barrier to active transportation. To understand how to promote more trail usage, the Mid-Ohio Valley Regional Health Department, with support from CDC's *Communities Putting Prevention to Work* program, conducted mapping and community assessments. Results highlighted the need for better connectivity between trails and desirable destinations, mile markers, and informative signage such as kiosks in parks with maps of trails denoting wheelchair accessibility and level of trail difficulty.

Capitalizing on the diversity of partner expertise, the health department worked with the West Virginia Parks and Recreation Department, the Regional Council, county commissioners, and others to develop a master plan with a strong emphasis on improving existing trails. Community coalitions, faith-based organizations, and youth organizations were also engaged to ensure low-income residents were engaged throughout the planning process. Community members had a vote in which trail improvements were the highest priorities. By May 2012, the master plan was adopted by five of the six counties in Mid-Ohio Valley.

Strong collaboration and leveraging funds were keys to success for implementation and sustainability. Local churches granted access to their property where portions of the trails crossed. In Pleasants County, the health department partnered with the Department of Education to connect the county's elementary school track to a nearby community and nursing home for public use. Smaller communities dealing with budgetary restraints were able to leverage Complete Streets policy and transportation enhancement efforts for trail improvements.

Community residents in Jefferson County, AL engage in development of the Red Rock Ridge and Valley Trail System Master Plan.
Photo courtesy of Freshwater Land Trust.

Trails and Pathways Increase Connectivity for All in Alabama

Jefferson County, AL

A mapping assessment showed that many people lacked access to places for physical activity in Jefferson County—a jurisdiction in Alabama with many African American and low-income populations. Residents experiencing the highest rates of chronic disease and the lowest levels of activity live in neighborhoods where connectivity to trails and greenways was limited.

To address this lack of access, Freshwater Land Trust (FWLT), a local greenway conservation organization teamed up with the Health Action Partnership and the Jefferson County Department of Health to lead development of the Red Rock Ridge and Valley Trail System Master Plan. These efforts were supported by CDC's *Communities Putting Prevention to Work* program. Collaborating with established community organizations helped to drive the project's success. Churches spread the word to congregations about opportunities to be involved in planning, and a consulting firm with deep community connections facilitated stakeholder meetings in the smallest towns in the county. Over 40 meetings were held at convenient and neutral locations including churches, local museums, city halls, and the Civil Rights Institute in Birmingham—the largest city in the county. An online interactive map provided opportunities to participate and add suggestions virtually.

Over 3,000 residents contributed suggestions in the development of the Master Plan, which connects more than 200 miles of greenways and trails to nearby homes, schools, churches, and businesses. Wendy Jackson, Executive Director of FWLT underscored the impact of the community-driven planning process: "If you want to know where people want to walk but there is no trail, you have to ask them. There were many connections that would not have been made if it were not for [community participation]." The coalition's "Our One Mile" planning process inspired residents, businesses, and local organizations to embrace the Master Plan.

PHYSICAL ACTIVITY OPPORTUNITIES IN SCHOOL, AFTERSCHOOL, AND EARLY CARE AND EDUCATION SETTINGS

PHYSICAL ACTIVITY STRATEGIES FOR CHILDREN AND YOUTH INCLUDE A RANGE OF POLICY AND ENVIRONMENTAL IMPROVEMENTS SUCH AS PHYSICAL EDUCATION (PE) REQUIREMENTS, PHYSICAL ACTIVITY BREAKS, AND ACTIVE COMMUTING OPTIONS IN SCHOOL, AFTERSCHOOL, AND EARLY CARE AND EDUCATION SETTINGS.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for physical activity strategies that advance health equity:

- **Opportunities for Physical Activity Outside of School Are Limited in Many Underserved Communities:** Access to affordable, culturally appropriate physical activity opportunities outside of school time such as gyms, clubs, and recreation facilities is limited in under-resourced communities.[176,199] Factors such as unsafe recreation areas, lack of open space, violence, perceptions of violence, inadequate walking and biking paths, and dangers from traffic may also play a role in discouraging children from physical activity.
- **Many Institutions Have Limited Resources to Implement Physical Activity Programming:** Even when supportive institutional policies are in place, differential access to resources can make implementing physical activity opportunities a challenge for institutions in low-income communities. Insufficient funding, inadequate or inaccessible recreation facilities and equipment, and lack of qualified staff can decrease the ability of institutions to offer quality programming.[181,200]
- **Needs Differ Among Children of All Abilities:** Children with disabilities may have some restrictions that limit participation in certain activities. Understanding their ability to access equipment, space, and infrastructure is essential for promoting physical activity.[201] Additionally, gender and cultural norms and preferences should be considered to ensure the appropriateness of physical activity opportunities.

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating physical activity strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
EQUITABLE IMPLEMENTATION & ENFORCEMENT Promote equitable implementation and enforcement of physical activity programs and policies	Even if a policy is in place, under-resourced settings may have difficulty implementing quality physical activity improvements and policies, resulting in children in these settings receiving fewer benefits from the programs and policies.	• Put accountability measures in place to monitor and enforce implementation efforts across settings. Address the needs of under-resourced institutions. • Prioritize professional development, continuing education, and training opportunities for staff working in underserved communities. • Consider allocating technical and financial resources to under-resourced settings to implement physical activity improvements.
LIMITED RESOURCES (STAFF & INFRASTRUCTURE) Find low-cost and creative ways to incorporate physical activity for all children	Limited staff, space, and facilities may be obstacles to implementing physical activity, particularly in under-resourced settings.[202]	• Partner with nearby schools, public health agencies, faith-based organizations, and local businesses to locate funding for activities or leverage alternative sites for physical activity near the school. • Combine resources to hire physical education (PE) specialists that rotate to different schools and afterschool programs to provide quality instruction and help train staff. • Explore play activities that require minimal equipment or consider integrating physical activity into classroom instruction.
LIMITED CAPACITY Develop creative solutions for small and home-based childcare facilities to prevent undue burden	Home-based childcare facilities are relied on heavily by low-income and single-parent families. These facilities, along with other small childcare facilities, may have limited capacity to adequately implement or may not be included in physical activity program or policy requirements.	• Identify small and home-based childcare providers and engage them to help develop feasible physical activity practices in these settings. • Understand challenges and provide technical assistance and continuing education programs to build capacity among providers. • Promote cost-neutral physical activity strategies and find creative ways to leverage existing resources in these settings.
COMMUNITY AWARENESS & INVOLVEMENT Create meaningful opportunities for parents/guardians to engage in decision making	Lack of parent/guardian engagement may make it difficult for settings to prioritize physical activity or have the voluntary supports to make improvements. Competing responsibilities and language needs may also make it difficult for some parents/guardians to participate in school meetings.	• Engage parents/guardians and provide leadership and decision-making opportunities about wellness policies, PE, recess, intramural sports, afterschool programs, and other physical activity-related issues. • Schedule school forums at convenient times and provide additional support, such as language interpretation and childcare services to maximize participation. • Develop feedback tools such as surveys, so families can provide input outside of formal meetings.

Build the Team: Partnership for Success

Successful efforts to implement physical activity strategies in school, afterschool, and early care and education settings depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Afterschool providers (e.g., Boys and Girls Club, YMCA)
- Childcare centers and provider organizations (e.g., Head Start)
- Childcare licensing agencies
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Faith-based organizations
- Leaders and community champions from multiple sectors
- Organizations serving populations experiencing health inequities
- Parent-teacher associations and organizations
- Parks and recreation department
- Public health agencies
- School districts, universities, and community colleges
- School district administrators, teachers, and PE specialists
- Social service agencies
- State departments of education, particularly agencies focused on early childhood development
- Youth development organizations

HEALTH EQUITY IN ACTION

Volunteer Services Increase Physical Activity in Afterschool Programs

California

With the goal of improving health, educational, and social outcomes, Coaching Corps partners with low-resourced schools, community organizations, and institutions of higher learning across California to increase students' access to high-quality sports activities. Coaching Corps works directly with these organizations to improve afterschool programming and coordination among physical education teachers, recess supervisors, and afterschool providers to ensure that each student engages in quality physical activity for at least 60 minutes a day.

A trained and supportive coach can significantly increase the number of students who participate in sports activities. Coaching Corps' previous model provided funds to hire sports coaches for low-resourced afterschool programs. However, once that funding ended, programs were often unable to afford coaches and could no longer provide these opportunities.

Recognizing that this model was unsustainable, Coaching Corps began partnering with local colleges and universities to recruit and train college students as volunteers. Partnerships with these academic institutions enable Coaching Corps to continue providing ongoing free support to low-resourced schools and afterschool programs. At the same time, the student volunteers build leadership and technical skills, establish meaningful relationships with young people, and give back to the community.

Even with limited staffing and fiscal resources, these efforts have been successful in increasing physical activity among underserved children and youth. Working with the Evelyn and Walter Haas Jr. Fund and generous individual donors, Coaching Corps has placed nearly 2,500 coaches in afterschool programs, reaching nearly 20,000 students since 2005.

Playworks providing opportunities for physical activity and safe meaningful play in the community. Photo courtesy of Playworks Detroit.

Playworks: Using Recess as a Place to Play and Be Active

Detroit, MI

The long winters in Detroit, coupled with the lack of safe places to play, make physical activity during the school day challenging. But Playworks Detroit has turned these challenges into opportunities. A national nonprofit, Playworks partners with low-resource schools in local communities to provide organized recess using games that are highly adaptable, require few resources, and promote positive behavior. In 2010, Playworks Detroit was launched to address the activity needs of local students, and has since served 18,000 students. With support from the Robert Wood Johnson Foundation and other local foundations, corporations and individuals, Playworks is able to implement strategies using physical activity and safe meaningful play to improve the well-being of children in the community.

Playworks has found ways to use spaces, from hallways and parking lots to auditoriums and gyms, as places for play. Games that require very few pieces of equipment have come in handy for smaller spaces. For example, Playworks can make games fun and action-packed with as little as a ball, a few hula hoops, and a couple of safety cones.

During recess, Playworks coaches organize stations with games such as tag, four square, and kickball, which can be modified to include students of all abilities. Playworks coaches model positive behavior, and this creates a shared understanding among students. This shared understanding leads to fewer conflicts on the playground and more productive classroom time.

In addition to working in schools, Playworks Detroit plays with the community once a month by partnering with local organizations, the police department, and the mayor's office to host events such as Recess Days. During one Recess Day, Detroit's mayor joined hundreds of students in downtown Detroit as they learned how to play safely while having fun. "Getting kids to be physically active is a good place to start. Then you can begin a conversation on how do we as a community create more safe places to play," says Jeannine Gant, Executive Director of Playworks Detroit. By providing trained coaches, working with a wide variety of partners, and demonstrating that children can play anywhere if they are supported, Playworks Detroit is getting students and the larger Detroit community to play again.

NEIGHBORHOOD DEVELOPMENT THAT CONNECTS COMMUNITY RESOURCES TO TRANSIT

TRANSIT-ORIENTED DEVELOPMENT (TOD) AND MIXED-USE ZONING ARE TWO INTERRELATED STRATEGIES THAT CAN FACILITATE AVAILABILITY OF AFFORDABLE HOUSING CLOSE TO PUBLIC TRANSPORTATION, PHYSICAL ACTIVITY INFRASTRUCTURE, HEALTHY FOOD RETAIL, AND OTHER HEALTH-PROMOTING SERVICES AND COMMUNITY INSTITUTIONS. THESE STRATEGIES CAN ALSO HELP FACILITATE OPPORTUNITIES FOR ACTIVE TRANSPORT SUCH AS WALKING, BIKING, AND USING A WHEELCHAIR.

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for TOD and mixed-use zoning strategies that advance health equity:

- **Accessible and Affordable Public Transit Is a Need for Many Underserved Populations:** Public transit may be a necessity for individuals who cannot afford the cost of an automobile and the associated owning, operating, and maintenance expenses. Additionally, individuals with a low-income, older adults, and people with disabilities may also need to rely heavily on public transportation[203,204] for reaching services, employment, and recreation.

- **Negative Consequences of Zoning Strategies May Exist in Underserved Communities:** Over time, zoning and other factors have contributed to the differential distribution of community resources (e.g., healthy food and physical activity opportunities), and ultimately health inequities.[151,205] Zoning strategies such as transit-oriented development may also lead to changes in neighborhood demographics and housing values. Such changes may lead to the displacement of some populations, possibly placing them further away from quality employment opportunities, schools,[203] and health-promoting resources such as healthy food retail and parks.

- **Rural Communities Face Unique Issues Related to Transportation and Access to Goods and Services:** Many residents in rural areas frequently lack or have limited access to public transportation options.[206] Further, long commute times, infrequent service, cost, and lack of infrastructure to facilitate transit use may present additional barriers to reliable transportation for rural public transit users.

Note: As many land use and zoning strategies fall in the purview of other sectors, public health agencies should work with appropriate partners when considering such strategies.

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating transit-oriented development and mixed-use zoning strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
INCLUSIVE ANALYSIS Establish an inclusive process designed to assess health effects and define local solutions	Zoning and transit projects may move ahead without a clear understanding of potential outcomes for health and health inequities.	• Use health and equity impact assessments to identify potential unintended negative consequences of all community improvement efforts. • Engage residents in the assessment process and raise awareness of potential health effects of proposed plans and any alternatives. • Use assessment process to increase transparency in decision-making and improve communication between partners.
COMMUNITY AWARENESS & INVOLVEMENT Build capacity and promote engagement of people who are typically absent from planning processes	Underserved residents may be left out of planning processes,[207] which may result in development decisions that fail to encompass diverse perspectives. Planning processes can also be time consuming and technical,[208] which may present a barrier to resident participation.	• Diversify leadership on boards and commissions to ensure multiple perspectives in decision-making processes. • Cultivate resident understanding, leadership, and decision-making through training programs, guided reviews of plans, neighborhood scans, and mapping activities. • Ensure public input is inclusive, timely, and representative of community experiences.
DISPLACEMENT Account for potential displacement effects of TOD and mixed-use zoning strategies	Transit investments may drive up median area income, housing values, and rents. A possible result of such changes is that existing residents and small business owners may no longer be able to afford living or doing business there.	• Conduct an assessment (e.g., health impact assessment) to examine the possibility of displacement with TOD and mixed-use zoning strategies. • Utilize supportive mechanisms and community benefits agreements (e.g., affordable housing protection, local hiring ordinances, tax credits) to ensure current residents are not displaced and can benefit from improvements.[209]
TRANSPORTATION NEEDS Consider TOD and mixed-use zoning strategies in transportation networks that serve all transit users	Many TOD efforts are centered on rail with little focus on bus transit or bus rapid transit. Rail projects can be resource-intensive, may often serve more affluent populations, and could divert funds from bus transit upgrades.[210,211]	• Consider TOD and mixed-use zoning strategies near transit hubs, transit connections, and intersections that are served by multiple bus routes in communities where rail is limited. • Where possible, align development and transit with the places people need to travel (e.g., housing, employment, services).
EXISTING OPPORTUNITIES Expand TOD and mixed-use zoning efforts to address social determinants of health	Transit-oriented development and mixed-use zoning may not explicitly address community conditions like access to healthy food and physical activity opportunities, or other social determinants such as safety, jobs, and housing.	• Use TOD and mixed-use strategies to provide incentives to businesses that could provide healthy food options, and to create environments that support physical activity. • Consider limiting aspects of nuisance businesses (e.g., density, location) which may affect quality of life, increase safety concerns, and be more common in low-income neighborhoods. • Consider ways to create access to living wage employment through compact zoning and development that connects residents to employment opportunities. • Employ techniques such as Crime Prevention through Environmental Design[198] to address safety.

Build the Team: Partnership for Success

Successful efforts to implement transit-oriented development and mixed-use zoning strategies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Area Agencies on Aging
- Community-based organizations
- Community development corporations
- Community finance institutions
- Community members and residents affected by transit investments (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Developers
- Funders
- Local businesses
- Local, state, and regional governments
- Metropolitan planning organizations
- Public health agencies
- Public Works Department
- Regional transit agencies
- Zoning and planning organizations

HEALTH EQUITY IN ACTION

Addressing Equitable Development through a Health Impact Assessment of a Zoning Code

Baltimore, MD

Many Baltimore neighborhoods have higher rates of homicide and chronic disease than the rest of Maryland.[212] The investigators of the *Zoning for a Healthy Baltimore* Health Impact Assessment (HIA) argued that truly tackling health disparities in Baltimore required addressing factors in the zoning code related to crime and violence, with the goal of enabling walkable, mixed-use neighborhoods. They made the case that environmental changes to address safety concerns could increase walking and activity for neighborhood residents.

The Public Health Working Group at Johns Hopkins University and the Baltimore City Health Department conducted a HIA funded by Robert Wood Johnson Foundation, in order to address the intersection of urban planning and public health by emphasizing that zoning can influence health. The HIA was used to identify which elements of the Baltimore zoning code (in its first rewrite since 1971) might promote or inhibit health—both generally and related to childhood obesity in particular.

The HIA began with a detailed literature review. One of the several findings was that the density of alcohol outlets in an area is linked to increased rates of violence. Several steps were already being taken to improve walkability and food access, however, the HIA helped draw attention to the role alcohol outlets might play in affecting neighborhood health. An evaluation of how the zoning regulations might change, reviews of the scientific literature, and interviews with stakeholders and urban health experts made it clear: addressing the number and location of alcohol outlets in certain neighborhoods could begin to shift perceptions of safety and impact physical activity rates to reduce the wide health disparities in Baltimore.

By using neighborhood health profiles, violent crime statistics, and alcohol outlet location data, the HIA team was able to demonstrate the need for additional consideration of alcohol outlet locations in the city's rewrite of the zoning code. Working with a variety of stakeholders including the departments of Law, Planning, and Health, the HIA team developed recommendations to address the density of alcohol outlets. Since the development of the recommendations, Baltimore City has revised its zoning code to incorporate dispersal standards and other strategies for new and existing alcohol outlets.

Fruitvale Arch Monument at the Fruitvale Transit Village which now connects community residents to housing, services, and other resources. Photo Courtesy of Brandon Moore.

Job Opportunities and Services Come to a Neighborhood via Transit-Oriented Development

Oakland, CA

In the early 1990s, Bay Area Rapid Transit (BART) announced a plan to build a massive parking garage near the Fruitvale transit station in Oakland. The proposed garage would have increased single-occupant automobile traffic and isolated the Fruitvale neighborhood, a largely immigrant community of households living below the federal poverty level. In response, residents worked closely with The Unity Council, a community development corporation that helps families and individuals build wealth and assets, to develop an alternative plan for the Fruitvale Transit Village. This village was one of the first transit-oriented developments in the United States.

The new transit village development provides housing, services, and jobs to low-income residents in a central location. The Unity Council leveraged funding from several federal, state, local and private sources. The Council also partnered with BART and the City of Oakland to address concerns regarding public safety, walkability, affordable housing, and economic development.

Businesses and organizations in the Fruitvale Transit Village now cater to residents, commuters, and visitors. The Village has a daycare center, clinic, high school, senior center, library, and sit-down restaurants. It also hosts a weekly farmers' market and one of the largest Day of the Dead festivals in the nation. Five hundred jobs are provided onsite and several thousand people receive services in the Village each day.

The Fruitvale Transit Village has become a safe haven, bringing generations—preschoolers, teenagers, and older adults—together and fostering a collective sense of respect for the community space. The Unity Council has begun the next phase of the project: more housing and a large community center that will be open seven days a week, with culturally appropriate youth-focused programming at low or no cost. Careful planning has helped protect against displacement of residents, encouraging a flourishing mixed-income neighborhood through job opportunities, services, and affordable housing.

PREVENTING VIOLENCE

PREVENTING COMMUNITY VIOLENCE IS CRITICAL TO CHRONIC DISEASE PREVENTION AS VIOLENCE (REAL OR PERCEIVED) MAY BE A BARRIER TO HEALTHY BEHAVIORS SUCH AS WALKING AND BICYCLING, USING PARKS AND RECREATIONAL SPACES, AND ACCESSING HEALTHY FOOD OUTLETS. PREVENTING COMMUNITY VIOLENCE REQUIRES BRINGING TOGETHER MULTI-SECTOR PARTNERS AND THE COMMUNITY TO SELECT AND IMPLEMENT POLICY, ENVIRONMENTAL, AND STRUCTURAL INTERVENTIONS BASED ON THE BEST AVAILABLE EVIDENCE AND THE COMMUNITY CONTEXT. SUCH INTERVENTIONS MAY INCLUDE COMMUNITY ECONOMIC DEVELOPMENT STRATEGIES (E.G., BUSINESS IMPROVEMENT DISTRICTS[213]), BUILT ENVIRONMENT STRATEGIES (E.G., CRIME PREVENTION THROUGH ENVIRONMENTAL DESIGN[214-216]), AND STREET OUTREACH AND COMMUNITY MOBILIZATION (E.G., CURE VIOLENCE—FORMERLY KNOWN AS CEASEFIRE CHICAGO[217]).

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues listed highlight the need for violence prevention strategies that advance health equity:

- **Some Communities Have A Disproportionate Burden of Violence:** Inequities in violence-related outcomes (e.g., homicides, injuries, incarceration) are related to a variety of systemic issues.[218,219] While violence is a reality in all communities, some communities and groups are far more exposed to diminished neighborhood conditions (e.g. neighborhood poverty, high alcohol outlet density, social isolation) that give rise to violence, and violence can thus become the norm."[220,221]

- **A Disproportionate Burden of Violence Exists for Some Youth of Color:** The risk of experiencing violence varies significantly by race and ethnicity. For example, in 2010, among 10-to-24 year-olds, homicide was the leading cause of death for African Americans, second leading cause of death for Hispanics, third leading cause of death for American Indians/Alaska Natives, and the fourth leading cause of death among Asian/Pacific Islanders and non-Hispanic Whites.[222] The disparity in ranges of violence extend beyond homicide, as a higher percentage of African American/Black high school students (40%) and Hispanic (37%) youth report that they have been in at least one physical fight in the previous year than non-Hispanic White students (29%).[223]

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating strategies to prevent violence:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
DIVERSE PARTNERSHIPS Work with systems that have been part of the Pipeline* to get to different outcomes	Racism, discrimination, and stigma may exist in many institutional practices, and may perpetuate prejudicial treatment. For example, practices related to school discipline, media portrayal, and the criminal justice system might foster differential outcomes for youth of color.	• Build multi-sector partnerships to change institutional practices that have a disproportionate effect on certain population groups. • Ensure school discipline practices are consistent for all students. • Encourage positive media coverage of young people in communities affected by violence. • Address policies and practices in the criminal justice system that result in higher rates of involvement in the criminal justice system for young men of color.
ECONOMIC OPPORTUNITY Promote economic opportunities and growth to build viable and stable communities	Limited economic and occupation opportunities may drive residents away, creating instability and a higher concentration of low-income residents. These factors may increase the risk for youth to resort to violence.[224]	• Learn about and partner with agencies with experience in community economic development strategies. • Create opportunities to support business investments and community development to create an economically viable community.
SAFE SPACES Create a safe physical environment and provide spaces to strengthen social relationships	Visible signs of disorder and neglect in a community make it more appealing as a venue for crime and violence.	• Consider changing the physical characteristics of housing, schools, and community areas to improve perceived and actual safety, and to reduce opportunities for crime and violence. • Consider Crime Prevention through Environmental Design (CPTED)[198] strategies (e.g., improved lighting, unobstructed sights lines, improved landscaping, graffiti removal, increased video and natural surveillance) to address crime and safety concerns. • Partner with law enforcement to improve safety and increase spaces for social interaction.
SOCIAL COHESION Facilitate the social cohesion of the community	The risk of violence is higher in communities where individuals, groups, and organizations do not interact with each other in positive ways.[225,226]	• Provide opportunities for residents to form positive relationships and contribute to the well-being of the community. • Engage youth in activities, since they are particularly vulnerable to experiencing negative health and safety outcomes associated with a disorganized community. • Consider street outreach and community mobilization strategies to promote positive interactions.

* The Children's Defense Fund has named the trajectory that results in disproportionate incarceration rates for African American and Latino males 'The Cradle to Prison Pipeline'. http://www.childrensdefense.org/programs-campaigns/cradle-to-prison-pipeline/

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
COMMUNITY AWARENESS & INVOLVEMENT Engage community members and local organizations in a meaningful way	Individuals most affected by violence may not be included in violence prevention efforts in meaningful ways. Additionally, resources directed to the violence prevention efforts may not reach local organizations serving communities in need.	• Provide support and build capacity for local groups to be involved in violence prevention efforts. • Train residents in identifying risk and protective factors for violence, and implementing strategies to prevent violence. • Find ways to engage youth and survivors of violence who offer a unique perspective.
RESOURCE LIMITATIONS Integrate efforts to prevent violence within multiple community initiatives	Communities in greatest need may not have sufficient resources to address issues of violence.	• Integrate violence prevention efforts into other strategies addressing chronic illness, economic and community development, and educational attainment. • Explore creative solutions for leveraging related initiatives and resources.

Build the Team: Partnership for Success

Successful efforts to implement community violence prevention strategies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Community-based organizations
- Community members, including former gang members, survivors of violence, and youth
- Faith-based organizations
- Family members, including caregivers
- Health care systems, hospitals, community clinics, and health care providers
- Local businesses
- Media
- Police, criminal, and juvenile justice agencies
- Public health agencies
- School districts, universities, and community colleges
- Social service agencies
- Youth development organizations

HEALTH EQUITY IN ACTION

Building Community Capacity to Foster Healthy and Safe Communities

Louisville, KY

Residents of the Shawnee neighborhood of Louisville experience more negative health outcomes and higher rates of violence compared to some other local communities.[230] Many of the neighborhood's violent assaults have been linked to poor community conditions, including an overabundance of alcohol and community blight. When the Louisville Center for Health Equity, the Shawnee Neighborhood Association, and local youth joined together to reduce violence, they promoted a sense of safety by working with local businesses to decrease the presence of alcohol promotions, increase street lighting, and eliminate graffiti and blight. These improvements, which were supported by the

Convergence Partnership, were aimed at creating an environment where residents could walk around safely, increasing access to their local grocery store and recreational spaces.

The project cultivated leadership by working with youth as well as adult residents, encouraging them to become active in their own community. Shawnee youth engaged in conversations confronting equity issues—exploring how oppression and institutional racism make communities unsafe and unhealthy. The youth took this analysis to heart, shifting their focus from individual issues toward broader community solutions.

Using Crime Prevention Through Environmental Design and digital storytelling, youth and adults identified environmental determinants that influenced safety and physical activity. Poignant photos and videos captured neighborhood assets and concerns and informed recommendations to decision makers. Over 18 months, the Shawnee neighborhood saw many improvements: neighborhood blight decreased, retailers removed tobacco and alcohol advertisements from storefronts, and the city facilitated major street repair.

HEALTH EQUITY IN ACTION

Building a Culture of Peace through Resident Engagement

Boston, MA

Some communities in Boston experience disproportionate rates of violence.[227] Such violence may create concerns for businesses, such as grocery stores, to locate in these communities and for residents who may want to walk and be active in their neighborhood.[228,229] To address this issue, the Boston Public Health Commission (BPHC) uses a public health approach to prevent violence in these communities with support from a variety of federal and local funds. BPHC focuses on engaging community members, building autonomy in neighborhoods, and fostering connectedness between residents.

In November 2007, the mayor, health commissioner, and police commissioner decided to make violence prevention a Boston priority. This commitment was key to ensuring that resources and support were allocated to the issue. With the help of more than 100 city staff across all agencies plus a large number of volunteers, BPHC led a neighborhood assessment and educational initiative, visiting every single house in neighborhoods heavily impacted by violence. BPHC provided more than 1,100 backpacks filled with information about BPHC and preventing violence. Residents also completed more than 700 surveys. The results identified community policing, communities working together, and youth programs as possible ways to prevent violence in their neighborhoods.

Using results from the assessment, BPHC developed the Violence Intervention and Prevention Initiative (VIP), which supports community-based organizations bringing together neighborhood coalitions including youth, long-time residents, and local businesses. Through community education, VIP coalitions work to ensure residents have the knowledge and resources to drive sustained improvements that decrease violence where they live. Each local coalition developed neighborhood violence prevention plans tailored to the community's needs and priorities. Dr. Barbara Ferrer, BPHC Executive Director noted, "Resident engagement was so important for us [because preventing violence is] about a culture of building peace."

BPHC provides funding and technical assistance for a community organizer and block captains in each neighborhood. BPHC also supports a network of coalitions across all the neighborhoods. The network enables residents to share lessons learned and continue to build their capacity to address violence.

APPENDICES

APPENDIX A
Health Disparities in Chronic Disease Risk Factors by Population Group

APPENDIX B
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APPENDIX A

HEALTH DISPARITIES IN CHRONIC DISEASE RISK FACTORS BY POPULATION GROUP

Despite decades of effort to reduce and eliminate health disparities, they have largely persisted—and in some cases are widening.[9-11] Specifically related to chronic diseases, there is a concentrated, disproportionate burden of chronic disease in many underserved populations and communities. The table below describes disparities in chronic disease risk factors by various population groups.

PEOPLE OF COLOR (RACIAL/ETHNIC MINORITIES)	According to the 2010 Census, approximately 16% of Americans identified themselves as Hispanic or Latino, 13% as Black, 5% as Asian, 1% as American Indian and Alaska Native, and 0.2% as Native Hawaiian and other Pacific Islander.[231] On a variety of health indicators, significant disparities among these racial and ethnic minorities continue to exist.[7,232] For example, adult obesity rates in the U.S. are higher among non-Hispanic African Americans (50%) and Mexican Americans (40%) than among non-Hispanic Whites (35%), and they are highest among African American women, at 59%.[233] In 2011, cigarette smoking among adults was highest among American Indian/Alaska Native populations (32%), compared to other racial/ethnic groups.[234]
PEOPLE WITH MENTAL OR SUBSTANCE USE DISORDERS	In the United States, adults with mental or substance use disorders comprise approximately 25% of the population. However, this population accounts for an estimated 40% of all cigarettes smoked resulting in a disproportionate burden from the health consequences of smoking.[235]
PEOPLE LIVING IN RURAL COMMUNITIES	Approximately 19%, or 60 million Americans, live in rural areas.[236] Rural residents are more likely to be elderly, in poverty, in fair or poor health, and to have chronic health conditions.[48] For example, the prevalence of obesity is higher in rural adults (40%) than urban adults (33%).[237] Adults living in non-metropolitan counties also have a higher average annual percentage of smoking (27%) than adults living in large metropolitan counties (18%).[238]
PEOPLE WITH DISABILITIES	Approximately 20% of U.S. adults have a disability.[239] Approximately 28% of adults with disabilities smoke, compared to 16% of those without a disability.[31] Adults with disabilities are more likely to be physically inactive (22%) than are adults without disabilities (10%).[240] Obesity is also higher among adults with a disability (38%) compared to those without a disability (24%), according to self-reported data.[241]

PEOPLE WITH LOW-INCOME AND THOSE EXPERIENCING POVERTY

In 2011, an estimated 15% of the U.S. population lived below the federal poverty level.[152] Poverty is correlated with perceived and actual poor health outcomes. People living in poverty are five times more likely to report their health as "poor" compared to high-income individuals.[242] People with a household income below the poverty line (29%) have a much higher prevalence of smoking compared to people with household incomes at or above the poverty line (18%).[234] Healthy eating (specifically fruit and vegetable consumption) is also lower among low-income populations compared to higher income populations.[243]

PEOPLE WITH LESS THAN A HIGH SCHOOL EDUCATION

Approximately 15 % of Americans 25 years old and older have not earned a high school diploma.[244] Those with undergraduate degrees have a lower prevalence of smoking (9%), compared to those with less than a high school education (25%) or only a high school diploma (24%).[234] Additionally, those with a GED have the highest prevalence of smoking (45%). Regarding obesity, college graduates or above had the lowest rate of obesity (28%) in 2009-2010, compared to those with less than a high school education (38%).[245]

OLDER ADULTS

The proportion of our nation's population aged 65 years and older is expected to increase from approximately 13% of the population in 2010 to an estimated 19% in 2030.[246] In 2009–2010, 45% of adults aged 65 and over were diagnosed with two or more chronic conditions.[247] Regarding inequities, older adults living in poverty and isolation may be particularly vulnerable.[248]

PEOPLE WHO IDENTIFY AS LESBIAN, GAY, BISEXUAL, OR TRANSGENDER (LGBT)

The lesbian, gay, or bisexual population is estimated at 3.5% in the United States, with an additional 0.3% identifying as transgender.[249] Regarding sexual orientation, use of any tobacco products have been found to be higher among lesbian, gay, bisexual, and transgender populations (38.5%) compared to the heterosexual/straight population (25.3%).[61] Obesity prevalence has also been noted among the LGBT community, particularly among lesbians who have been shown to have a higher prevalence of being overweight and obese than heterosexual women who are overweight and obese.[250]

NOTE: This list is not exhaustive and the groups are not mutually exclusive; individuals may belong to more than one population group.

APPENDIX B

CONSIDERATIONS FOR HEALTH EQUITY-ORIENTED STRATEGY SELECTION, DESIGN, AND IMPLEMENTATION

Policy, systems, and environmental improvement strategies have great potential to prevent and reduce health inequities, affect a large portion of a population, and can also be leveraged to address the underlying social determinants of health. **However, without careful design and implementation, such interventions may inadvertently widen health inequities.** Collaborate with partners and community members, including those experiencing health inequities, to identify possible barriers or negative unintended consequences that may limit a strategy's effectiveness. Then, account for identified challenges in strategy development to maximize the health effects for all and reduce health inequities. Consider the following barriers, unintended consequences, and questions when selecting, designing, and implementing equity-oriented strategies:

1 LIMITED COMMUNITY CAPACITY AND RESOURCES

Variability in community capacity and resources can influence decisions about which communities and community organizations to partner with, especially if resources are limited. While there are benefits to funding and collaborating with partners that can "hit the ground running," it is also important to build the capacity of other groups through training and additional support.

- Has lack of capacity or resources kept critical partners away?
- What training opportunities can build the capacity of residents or organizations to make community improvements?
- Are the same organizations repeatedly benefiting from funds distributed in the community? What steps can you take to engage other organizations?

2 VARIABILITY IN HEALTH LITERACY

Addressing health literacy means ensuring that all members of the community have the capacity to access and understand the information they need to engage in health improvement strategies or reap their health benefits.

- Will the improvements be understood by all community members?
- Is training needed to support and sustain the improvements?
- How will language, culture, and other differences be accommodated?

3 LACK OF COMMUNITY ENGAGEMENT, AWARENESS, AND PARTICIPATION

A well-designed effort may fail to reach its full potential if residents are unaware of the improvements or were not invited to participate in the planning and implementation process. Community residents and stakeholders should be consulted and engaged from the very start, and this engagement should be sustained throughout the process.

- How will stakeholders representative of the community's diversity be engaged?
- What steps will be taken to engage community members in planning, implementation, and evaluation?

4 **COST, RESOURCES, AND OTHER FISCAL CONSIDERATIONS**	There may be costs related to strategy implementation, either for the institutions making the improvements, or for the people who are the intended beneficiaries of these improvements. Examine how budget constraints may hinder implementation or uptake in underserved communities.	• Will costs prevent underserved populations from fully benefitting from the strategy? How can affordability be ensured for all? • Which partners might be able to help provide required resources (e.g., funding, materials, staff, other assets) to implement the strategy?
5 **TRANSPORTATION CHALLENGES**	Lack of personal transportation, unaffordable or unreliable public transportation, or inadequate infrastructure may reduce access to goods, services, or environmental improvements, including tobacco cessation services and other health care services. Explore whether transportation issues such as access, cost, and proximity exist.	• Is lack of transportation a problem for the intended beneficiaries of the strategy? • Are the locations where services are provided too distant, inconvenient, inaccessible, or unsafe?
6 **POTENTIAL DISPLACEMENT EFFECTS**	Changing community conditions may contribute to cycles of displacement. It is important to ensure that improvements will benefit residents rather than create conditions that displace them. Identify factors that may drive displacement and protections that can prevent it.	• How might community improvement strategies lead to displacement in the future? • What protections can be put in place to preserve affordable housing and prevent displacement? • How might concerns about displacement prevent residents from engaging in community improvements?
7 **VARIABILITY IN IMPLEMENTATION**	Uneven implementation of a policy or systems improvement may worsen inequities. Explore the factors (including those listed in this table) that might prevent consistent implementation of a strategy and develop solutions early in the planning process.	• Once your strategy is adopted or implemented, what steps will ensure proper implementation? • How will you ensure implementation occurs where it's needed most? • Which institutions need additional support to implement the improvements?
8 **CRIME/SAFETY INFLUENCES (BOTH REAL AND PERCEIVED)**	Even if effective strategies are put in place, fear of crime at locations where the intervention or service is being delivered may keep residents from using the new resources. Assess safety conditions and residents' perceptions of these conditions, and, if necessary, take steps to ensure participants' safety.	• How might concerns about safety prevent the community from benefitting from the strategy? • Are there visible signs of crime and violence?
9 **LACK OF AWARENESS OF DIVERSE NORMS AND CUSTOMS**	Understanding the diversity in culture, norms, and customs among population groups can ensure that strategies are designed to be inclusive. Institutions also have their own customs and norms, and these should also be considered, as they might affect decision making.	• How will community members with different norms and customs be engaged in strategy design? • Are differences in culture and norms understood in ways that result in respectful strategy development?

APPENDIX C

EXAMPLE RESOURCES FOR IDENTIFYING AND UNDERSTANDING HEALTH INEQUITIES

This table describes several online resources that you may be able to use to identify and understand health inequities in your area. This list is not exhaustive and you should determine what best fits your local needs.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)[251]	A state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.
CENSUS DATA[252]	A database that provides demographic information on income, education, race/ethnicity, housing, and other factors that are viewable at multiple levels: national, state, county, and smaller geographic areas. Interactive features also allow cross tabulation of indicators and population groups.
COMMUNITY COMMONS[253]	An online interactive mapping tool that provides free geographic information systems (GIS) data from the state level to the block group level. The Commons is linked to the National Prevention Strategy and provides a peer learning network and other resources.
COMMUNITY HEALTH ASSESSMENT & GROUP EVALUATION (CHANGE): BUILDING A FOUNDATION OF KNOWLEDGE TO PRIORITIZE COMMUNITY NEEDS[17]	A tool to help community teams develop a community action plan. This tool provides steps for community team members to use in an assessment process. It also helps define and prioritize possible areas of improvement to address the root causes of chronic diseases, as well as related risk factors.
COUNTY HEALTH RANKINGS: MOBILIZING ACTION TOWARD COMMUNITY HEALTH[254]	A ranking of counties in each of the 50 states according to summaries of a variety of health measures. Summary measures include health outcomes (mortality and morbidity) and health factors (health behaviors, clinical care, social and economic aspects, and physical environment).

COMMUNITY HEALTH STATUS INDICATORS (CHSI)[255]	A report that contains over 200 measures for each of the 3,141 U.S. counties. The report presents indicators for deaths due to heart disease and cancer as well as on behavioral factors such as tobacco use, diet, physical activity, alcohol and drug use, sexual behavior, and others that substantially contribute to these deaths.
DATA SET DIRECTORY OF SOCIAL DETERMINANTS OF HEALTH AT THE LOCAL LEVEL[256]	A directory that contains an extensive list of existing data sets that can be used to address social determinants of health. The data sets are organized according to 12 dimensions (broad categories) of the social environment.
HEALTHY COMMUNITIES NETWORK (HCN)[257]	A network that tracks over 200 health and quality-of-life indicators. It also provides guidance on 1,800-plus community-level interventions. Local information is collected and combined with other data.
HEALTH DISPARITIES CALCULATOR[258]	Statistical software from the National Cancer Institute that imports population-based health data and calculates different disparity measurements.
HEALTH EQUITY INDEX[259]	An online tool created by the Connecticut Association of Directors of Health that outlines and measures the social determinants of health with specific health outcomes. The index produces scores as well as GIS maps.
HEALTH INDICATORS WAREHOUSE[260]	A Web site maintained by CDC's National Center for Health Statistics. This resource provides data on communities' health status as well as different determinants. There are over 1,000 indicators that can be categorized by geography, initiative, or topic.
THE TOOL FOR HEALTH AND RESILIENCE IN VULNERABLE ENVIRONMENTS (THRIVE)[261]	A tool intended to help people understand and prioritize the factors within their own communities in order to improve health and safety. The tool identifies key factors around equitable opportunity, people, and place, and allows users to rate how important each factor might be in their community.

APPENDIX D

HEALTH EQUITY CHECKLIST: CONSIDERING HEALTH EQUITY IN THE STRATEGY DEVELOPMENT PROCESS

The Health Equity Checklist provides questions for consideration when designing a strategy to ensure health equity remains central to all aspects of an initiative.

STEP 1: IDENTIFY

Clearly identify health inequities and protective factors in both health outcomes and community conditions across population groups and geographic areas through the use of existing data, community input, and environmental assessments.

STEP 2: ENGAGE

Include and meaningfully engage representatives of population(s)/area(s) defined in Step 1 in your partnerships, coalitions, or on leadership teams.

STEP 3: ANALYZE

Ensure the selection, design, and implementation of strategies are linked to the inequities identified in Step 1, and will work to advance health equity. Consider the following:

Is the strategy TARGETED to a population group(s)/area(s) experiencing health inequities?

- Is the outcome written in a way that allows you to measure the effect of efforts?
- Is it culturally tailored to the unique needs of population group(s)/area(s) experiencing health inequities, and are potential barriers addressed?

Does the strategy rely on SITE SELECTION (e.g., selecting X number of sites for smoke-free cessation services, creating X number of farmers' markets)?

- Do selection criteria for sites reflect populations/areas with the highest burden?
- If not, are selection criteria logical and justified?
- Are there additional supports provided for selected sites that might require them to be successful?

Is the strategy POPULATION-WIDE?

- Have population(s)/area(s) experiencing health inequities been engaged in efforts to identify possible barriers and unintended consequences of the proposed strategy?
- Are identified barriers regarding implementation and enforcement being addressed?
- Have potential unintended consequences been considered and accounted for in proposed activities?

STEP 4: REVIEW

Review evaluation and monitoring plans to ensure health equity-related efforts will be measured. Additionally, ensure appropriate data will be collected to conduct sub-analyses. These data will help in assessing the differential effects of each strategy across population group(s)/area(s), as well as the overall impact of strategies on reducing health inequities.

SUGGESTED CITATION: Centers for Disease Control and Prevention - Division of Community Health. *Health Equity Checklist*: Considering Health Equity in the Strategy Development Process. Atlanta, GA: US Dept of Health and Human Services; 2010.

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