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# Building Power to Advance Health Equity:

Findings from a Survey  
of Health Departments  
about their  
Collaborations with  
Community Power  
Building Organizations

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## **About Human Impact Partners**

[Human Impact Partners \(HIP\)](#) brings the power of public health to campaigns and movements for a just society through research, advocacy, capacity building, and field building. Our mission is to transform the policies and places people need to live healthy lives by increasing the consideration of health and equity in decision making.

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# Executive Summary

The inequitable distribution of power is a key root cause of health inequities across the globe today. [Community power building organizations](#) (CPBOs) work to redistribute power and decision making by building power in communities most impacted by economic, political, social, health, and other inequities. They use a diverse range of tactics and strategies to engage communities, bring them together to make connections across their lived experiences and conditions, and take collective action together. The process of building power at a small scale within historically marginalized communities has the potential to **transform how decisions are made, by whom, for whom, and with whom — all of which lead to improved health equity outcomes.**

Government can play a critical role in advancing or hindering equity across systems and within institutions. As part of local and state government, health departments can aid in shifting government policies and practices. **CPBOs can be valuable and effective partners** for local and state health departments to engage those most impacted by inequities and to advance social change. Health departments alone cannot transform policies, systems, and environments to advance equity. CPBOs can facilitate relationship building with community members and other organizations, apply political pressure to pass policies, and provide a clear vision around leadership development and building power to make lasting change.

*“Community organizers are a critical component to impacting policy change. Government may have power over resources, but community partners have the power of voice — and they can bring to light the issues and the real stories of impacted communities in a way that the health department may not be able to do.”*

*- Health Department Staff Person*

## About This Report

Power imbalances clearly impact health and well-being, yet there has been limited exploration of how health departments can support community power building to date. In 2019, Human Impact Partners (HIP) surveyed state and local health departments about their experiences working with CPBOs as part of the Robert Wood Johnson Foundation-funded project, [Lead Local](#). This report shares key findings and observations from staff at 29 health departments. The responses from participants offer valuable insights into *why* health departments should collaborate with CPBOs, and some concrete ways of *how* to partner together.

## Key Findings

Almost all health departments noted that through their collaborations with CPBOs, they were **working to build and share power** by:

- Working together to actively include communities impacted by inequities in decision-making tables and processes
- Intentionally building individual and organizational relationships (e.g., through conducting one-on-ones and regular meetings)
- Strategizing how to advance health-promoting work and policies, and/or leverage the health department's institutional power around an issue or more generally

*"The partnership allows us to be involved in issues without overstepping our bounds as a government agency. The activities that we would be prohibited from doing can be taken on by the organizers, and we can leverage their work by offering supporting data and information related to their priorities."*

- Health Department Staff Person

The partnerships helped health departments **reflect on and leverage their own power** in governmental decision making and public opinion, while also helping **amplify and achieve policy changes** sought by communities impacted by inequities.

The collaborations illustrated the importance of an **inside/outside approach**. This means that health agency leadership and staff are internally building their collective understanding of the root causes of inequity and a commitment to act and take risks. Externally, they are building relationships with those who can demand change and accountability from the health department and other government agencies to address the needs of groups facing inequities. Those groups with whom they are building relationships can, in turn, apply pressure on the health department and its leadership to respond to their priorities. This inside/outside approach allows health departments to leverage their power within their local political context, and to also create cover for riskier work by having community-organizing allies demand change from the outside.

*"[Collaboration with community organizers] has helped to create urgency around our work. It has created a healthy tension for us to take positions on issues that matter to our constituents. It has also pushed us to engage more with policies that affect our constituents. It has helped us to understand how we can be relevant to communities that are oppressed."*

- Health Department Staff Person

## Types of Collaborations

In general, the collaborations between health departments and CPBOs fell into three categories:

- Health departments invited CPBOs into existing health department processes
- Health departments helped CPBOs achieve their goals and transformed the health department's internal and/or external practices
- Health departments and CPBOs worked together to build and share power

### Spectrum of Health Department-Community Power Building Organization Collaborations



The most common type of collaboration (practiced by 26 of the 29 participating health departments) was inviting CPBOs to participate in multi-sector dialogues or convenings organized by the health department. Other common collaboration activities included:

- Inviting CPBOs into multi-sector dialogues and forums, community health needs assessments, and equity work groups
- Transforming health department work by providing research, data, or public testimony on a key topic; introducing community to other government staff; and creating more inclusive decision-making processes
- Sharing power by intentionally building relationships, strategizing about how to advance health-promoting work or policies, and leveraging the health department's institutional power around an issue more generally.

## Impacts of Collaboration

The most common impact (reported by 27 out of 29 health departments) was that collaborations resulted in **increased staff understanding about opportunities and strategies** to address health inequities.

*"We've had to unlearn many health department practices, such as that we are the experts, and move to a 50/50 partnership with community leaders. They are the experts about their neighborhood and community, and when we join forces, we can do better than either usually does alone when tackling complex issues."*

- Health Department Staff Person

Respondents also noted that the collaborations resulted in deeper health department staff knowledge about:

- Barriers facing communities that health departments serve, and the root causes of health inequities
- How health departments can support community-led campaigns and activities to improve health conditions
- The individual and institutional privilege, power, and responsibility government employees carry

One participant noted that health departments have “greater equity impacts when we collaborate between community and staff. Having this priority has also brought much-needed diversity to our department as we begin to hire more staff that have deep ties to the community. We begin to shift the institutional culture within the government.”

Numerous individuals noted that their collaborations **changed the focus of the health department’s work** to move more “upstream” to address inequities. This was reflected by how health departments were prioritizing social determinants of health policy work, including social determinants, health equity, and/or racial equity in their strategic plan, mission/vision, or values; setting DPH goals and objectives in partnership with community; and building staff capacity to understand organizing, narrative change, and policy change.

*“By working with community organizers, our department learned to engage in power analysis together with our partners. While this is by no means a widely adopted understanding or practice, it is an important shift and evolution of our department’s work on social determinants of health (SDOH) — moving beyond only establishing linkages between social determinants and health, to co-developing and implementing power-building strategies to create systems changes.”*

*- Health Department Staff Person*

On a related note, collaborations with CPBOs helped enhance health departments’ capacity to **do meaningful community engagement** by building new relationships and deepening existing ones with residents and communities impacted by health inequities. One participant noted that this helps them “keep a pulse on what’s important to impacted communities and engage residents in a meaningful way in our work.”

Collectively, all of these impacts are critical to changing health departments so they can better advance equity and build power.



## Recommendations

As learned through this survey and the [Lead Local project](#) generally, community power helps catalyze, create and sustain conditions for healthy communities. Collaborations between health departments and CPBOs help support community power building and are an opening to transform public health and government more broadly. As always, but particularly in this moment, transformation of our systems is needed to address the deep and painful inequities in our society.

The following recommendations draw on lessons learned from this survey, the Lead Local Project, and HIP's extensive experience providing capacity-building support to health departments and supporting health department/community organizer collaborations.

### For Health Departments + CPBOs Starting Collaborations

- Identify who you want to connect with
- Do your homework and learn about the other organization and ecosystem of HDs and CPBOs in your region
- Be flexible and persistent in communication
- Start with small, concrete collaborations and goals
- Mobilize public health resources, such as data and evidence, to advance CPBO goals
- Do power analysis together and understand [structural reforms](#) that CPBOs are prioritizing
- Intentionally do activities together that build and deepen trust over time
- Leverage your inside/outside relationships to advance community-organizing goals

### For Funders

- Support health department/CPBO collaborations to advance the goals of CPBOs in your state/region
- Work to [build, share and yield](#) philanthropic power with CPBOs
- Allow flexibility in spending and timelines
- Utilize increased trust, communication, awareness/understanding, and power as metrics for success

### For Researchers

- Document impacts and challenges of health department/CPBO collaborations
- Document process and impacts of community power building
- Document political and social context of collaborations

# Background and Context

*“What we practice at the small scale sets the patterns for the whole system.”*

*- adrienne maree brown*

## Health Department Attention to Health Equity Is Growing

Prior to COVID-19, many state and local health departments across the United States were exploring how to incorporate health equity into their work. Examples of this growing movement include:

- 85% of public health employees across the US believe their agency should be somewhat or very involved in affecting health equity ([PHWINS 2017](#))
- 85% of state and territorial health departments address health equity issues in a strategic plan ([OMH 2016](#))
- Almost two-thirds of local health departments (including 9 out of every 10 large health departments) are supporting community efforts to change the causes of health disparities ([NACCHO 2016](#))
- More than two-thirds of the standards for public health accreditation (in the current Version 1.5) reference or address health equity ([HIP 2018](#))

During COVID, outbreaks in prisons, factories, overcrowded housing, and assisted-care facilities, and among essential workers, have magnified how unsafe living and working conditions put some populations at greater risk of being exposed to the virus, becoming ill, and dying. Particularly hard hit are incarcerated individuals, Black, Indigenous, and People of Color (BIPOC) communities, immigrants, people with disabilities, and others experiencing [structural oppression](#). Many health departments are being confronted with how to address health-related structural inequities in their COVID response and recovery efforts.

## Health Departments Must Address Structural Racism and Power Imbalances

To date, most health department work around advancing health equity has focused on addressing the social determinants of health — for example, working on policies related to housing, living wages, or education. Some health departments are trying to embed equity into their COVID emergency response efforts or long-term recovery planning. This work is important, but often falls short of naming and addressing structural racism and power imbalances as root causes of the inequitable living and working conditions that lead to inequitable health outcomes.

Throughout the history of the United States, beginning with violence against indigenous people and the enslavement of Africans, racism has been used to systematically advantage certain populations over others, concentrating decision-making and resource allocation that impacts all into the hands of a few. Although there have been community-led efforts to redistribute and broaden power over decision making and resource allocation, racial inequities persist in public health. These inequities are visible in education, workforce development, and across all systems, because as stated by the [Racial Equity Institute](#), “we live in a racially structured society, and that is what causes racial inequity.”

Many health departments collect extensive data illustrating that racial inequities exist, but very few conduct data collection, investigation, or discussion about *why* those inequities exist. In order to identify and address the root causes of health inequities, health department and other government staff should understand:

- How power has been and is currently distributed among populations
- Who has made decisions and who is impacted by those decisions
- Why decisions are made (e.g., for profit, consolidation of power, or community well-being)
- How historical contexts impacting current decision making

## What is a CBPO?

### Community Power Building Organizations Work to Redistribute Power

[Community power building organizations \(CPBOs\)](#) and [grassroots organizers](#) work to redistribute power and decision making by building power in communities that are oppressed and marginalized by the decision-making processes that affect their lives. Organizers in the CPBOs use a [diverse range of tactics and strategies](#) to engage communities, bring them together to make connections across their lived experiences and conditions, and take collective action together. The process of building power has the potential to **transform how decisions are made, by whom, for whom, and with whom.**

Working to address community conditions is not new in the field of public health: since its foundations, public health physicians, nurses, epidemiologists, and others partnered with those advocating for sanitation system reforms to protect the public from cholera and other disease outbreaks. Over the past decade, there has been increased attention in the field of public health to the importance of collaboration with community organizers as described in recent work and reports by such organizations as [the Praxis Project](#) and [Prevention Institute](#).

## Why Health Departments Should Partner with CPBOs

Government can play a critical role in advancing or hindering equity across systems and within institutions. Health departments, as part of local and state government, can aid in the shifting of government policies and practices. Although state and local health departments might have limited experience with community-organizing groups, **CPBOs can be valuable and effective partners** in engaging those most impacted by inequities to advance social change. Health departments alone cannot transform policies, systems, and environments to advance equity. CPBOs can connect departments to community members and other organizations, apply political pressure to pass (evidence-based) policies, and provide a clear vision and skills around leadership development and building power for lasting change.

There are numerous examples of health departments partnering with CPBOs to advance social change. For example:

- [Kansas City \(MO\)](#) collaborated with [Communities Creating Opportunity](#) and other community partners to help:
  - Increase healthcare funding for the uninsured
  - Remove mandatory disclosure of criminal history on job applications
  - Provide paid parental leave
  - Increase the number of banks providing reasonable small loans
  - Include life expectancy as a measure of success in the city's business plan
- [Cook County \(IL\)](#) partnered with the [Collaborative for Health Equity, Restaurant Opportunities Center](#), and other CPBOs to:
  - Support the passage of a city living-wage ordinance
  - Adopt a welcoming village ordinance
  - Limit collection of information about immigration status
  - Work to address wage theft
- [Alameda County \(CA\)](#) collaborated with [Causa Justa::Just Cause](#) and other CPBOs to help pass:
  - An ordinance to cap rent increases
  - Just-cause eviction protection and other renters' rights
  - An affordable-housing bond
  - A policy requiring banks to abate blight in foreclosed properties or pay a fine
  - Proactive code enforcement inspections to address health-related housing complaints

In each of these partnerships, the health department used their power as a government agency to provide data and information, respond to community requests, testify when requested, and lift up the health impacts of policy decisions. CPBOs took on more explicit advocacy roles to push for policy change. Partnerships like these have resulted in concrete improvements in the living and working conditions of communities disproportionately impacted by inequities.

### About This Report

In 2019, HIP surveyed state and local health departments about their experiences working with CPBO, as part of the Robert Wood Johnson Foundation–funded project, [Lead Local](#). This report shares key findings and observations from staff at 29 health departments. The responses from participants offer valuable insights into *why* health departments should collaborate with CPBOs and some concrete suggestions for *how* to partner together. For a glossary of terms about community power building, please visit [Appendix A](#). For detailed explanation of methods, caveats, limitations, and inclusion criteria, please see [Appendix B](#) and [Appendix C](#).

# Findings

The following pages summarize and discuss key survey findings. Raw data and tallies for questions are available in [Appendix E](#).

## Who Is Collaborating with CPBOs?

Of the 29 health departments that were included in our survey analysis:

- *Location:*
  - One-third were located in California
  - One-third in the Midwest
  - The others in New England, the Northwest, and Florida
- *Jurisdiction:*
  - More than three-quarters of the health departments served local jurisdictions, including cities and/or counties — the others worked in central or regional offices of state health departments
  - Two-thirds served populations of 500,000 people or more
- *Political landscape:*
  - One-third of respondents characterized their jurisdiction as liberal
  - One-fifth as conservative
  - Two-fifths as moderate or mixed/combination
- *Position:*
  - One-third of respondents worked in agency leadership positions
  - One-third in program planner, manager, or director positions
  - One-third as health educators or policy/evaluation staff or other positions
- *Where survey respondents work:*
  - The majority of respondents (four-fifths) worked in a division of health equity
  - Roughly half worked in policy and planning
  - One quarter worked in chronic disease or administration
- *Which division/section/team collaborated with CPBOs:*
  - Staff from health equity divisions were the most likely to have collaborated with CPBOs, either currently or in the past, followed by staff from Policy and Planning and then Chronic Disease divisions
  - Roughly one-third of respondents reported that their Maternal/Child Health, Environmental Health, or Administration divisions had or were collaborating with CPBOs
  - Infectious Disease, Injury Prevention, and Accreditation/Quality Improvement were the divisions least likely to have collaborated with CPBOs

## Collaboration more likely with local or shared governance

Working with CPBOs directly and indirectly implies that a health department is willing and able to engage in local or state policy decision making. Although developing policies and enforcing laws and regulations to protect community health and safety are considered [essential public health services](#), not all health departments have or use their capacity to impact public policy.

In their recent [profile of local health departments](#) (LHDs), the National Association of County and City Health Officials (NACCHO) found that “LHDs governed by state authorities are less likely to be involved in policy areas than LHDs governed by local authorities or LHDs with shared governance.” The majority of local health departments governed by state authorities or with shared governance are located in the southern section of the United States (see [map](#) on page 24), suggesting that local health departments in the South may be less likely to engage in policy, and by extension, less likely to engage with CPBOs who are trying to impact policy.

Respondents from our survey reflect this potential division — with 27 responses coming from states where all local health departments are governed by their local government, and 2 responses (Florida and Louisville) coming from states with shared governance between state and local authorities. Health departments from the South are underrepresented in this survey. Collaborations may be happening with CPBOs in the states with state control over local health governance — however, additional barriers to engaging in policy likely exist.

## Collaboration more common, but not exclusively, in large jurisdictions

While two-thirds of the survey respondents work in health departments that serve 500,000 or more people in their jurisdiction, the majority of health departments in the United States (60%) serve small populations of less than 50,000 people and have very small staff sizes, with an average of 20 full-time equivalents (FTEs) per department. Only 150 local health departments serve large populations of 500,000 or more. These departments have much larger staffs: for example, departments serving over 1 million people have an average of 769 FTEs. And although they account for only 6% of all health departments, the 150 large health departments serve more than 50% of the US population, whereas the 1,489 small health departments serve less than 10% of the US population. Grassroots and community organizing may be stronger and more prevalent in places with larger populations, and some smaller jurisdictions may not have any organizing at all. CPBO work often occurs in an [ecosystem of community power building](#), as illustrated in the Lead Local Project’s assessment of 16 geographically distinct areas across the United States.

Our survey suggests that although the majority of health-department collaborations may occur in larger health departments with more staff, small and medium health departments are also able to advance collaborations in their jurisdiction. Similarly, although more collaborations may occur in areas that are considered politically liberal or moderate, some collaborations occur in politically conservative areas.

### Collaboration more common in departments with health equity focus

Importantly, the majority of survey respondents (four-fifths) worked in or with a division of health equity, and half worked in policy and planning. Although having a division of health equity is not a prerequisite to collaborating with CPBOs, health departments with organizational structures that explicitly support advancing equity likely provide a more supportive context for collaboration and power building.

### What Topic Areas Do Collaborations Focus On?

Table 1 describes the topic area that health departments worked on with CPBOs. Respondents were allowed to check all that apply.

Table 1: Topic Areas of Collaboration			
Topic Area	N = 29	Topic Area	N = 29
Housing	21	Health insurance/Medicare/caid	7
Criminal justice/incarceration	15	Education	7
Food justice/access/security	14	Public safety/violence	7
Healthcare access/utilization	12	Asthma	6
Diabetes/obesity	11	Immunizations/screenings	6
Immigration	11	Parks/recreation centers	6
Transportation	10	WIC/food stamps	5
Urban planning	10	Cardiovascular diseases	4
Jobs/Labor conditions/Wages	9	Disability access	3
Physical activity	8	Infectious diseases	2
Tobacco/substance use	8	Injury prevention	2
Environ. justice/climate change	8	Child care	2
HIV/STD prevention	7	Cancer	1
Other (please specify)	<ul style="list-style-type: none"> <li>● Economic dev/asset building/fair lending/reinvestment</li> <li>● Language access</li> <li>● Civic engagement</li> <li>● Lead and mercury poisoning prevention</li> </ul>		



- Participatory budgeting, health equity reporting, LGBTQ health, racial equity
- Health education
- Language and cultural justice for indigenous peoples
- Reproductive health
- Developing shared policy agenda re: SDOH
- Poverty, mental health
- Racial equity

### Majority of collaborations focus on conditions/social determinants of health

Collaborations were most commonly related to work on the social determinants of health, including housing, criminal justice/incarceration, food justice, health care access and utilization, immigration, and transportation. Given that CPBOs work to improve conditions impacting their members' lives, it makes sense that many collaborations focus on "upstream" living and working conditions.

Fewer collaborations focused on topics that are often considered within mainstream public health, like infectious and cardiovascular diseases, injury prevention, and immunizations. Roughly 1 in every 3 health departments collaborated on topics of obesity/diabetes, physical activity, and tobacco use.

Many collaborations focused on multiple related topics:

- Of 21 departments with collaborations focused on housing:
  - 14 also worked on criminal legal system issues
  - 8 also worked on immigration
- Of 14 departments with collaborations focused on food justice:
  - 8 also worked on diabetes/obesity
  - 4 also worked on WIC/food stamps
- Of 6 departments with collaborations focused on parks and recreation:
  - 4 also worked on physical activity

This clustering suggests that some health departments were connecting health outcomes and social determinants of health in their collaborations with CPBOs.

### Housing is most common area of collaboration

Roughly three-quarters of survey respondents worked on housing issues with their local CPBOs, which mirrors the [NACCHO Local Health Department Profile](#) finding that housing is the most common policy area related to social determinants of health. NACCHO found that 25% of all health departments (19% of small, 31% of medium, and 54% of large departments) had worked on housing policy in the previous two years.

## How Did Relationships Start and Where Are They Now?

We asked respondents to list one specific CPBO that their health department collaborated with, and describe their relationship with the group, which constituency the group organized, and how they began working together. Health departments were also invited to share information about collaborations with other CPBOs, but were only asked to describe one collaboration in detail.

### Majority of collaborations with issue- or neighborhood-based CPBOs

Roughly two-thirds of health departments participating in the survey collaborated with CPBOs who focus on particular issues to build power, such as community development or housing, roughly half worked with neighborhood-based CPBOs, and one-third worked with congregation-based CPBOs. Collaborations with worker-based and institution-based CPBOs were the least common. In our survey, almost all of the collaborations with faith-based CPBOs occurred in Midwestern states, whereas the majority of neighborhood-based CPBO collaborations occurred in California.

### Majority of collaborations described as committed and ongoing

To understand health departments' relationships, we asked them to rank their collaboration along a spectrum of commitment. The majority of health departments described their relationship with the CPBOs as "going steady," with the health department and CPBOs collaborating in concrete ways and various people from the health department involved. Four health departments described their relationship as "married," with the organizations formally committed to working together. Very few described their relationship as "dating casually" and still getting to know each other.

### Collaborations start in a myriad of ways

Respondents had a wide range of responses about how their health department first started working together with CPBOs. These include:

- With individual relationship building, where someone in the health department developed a relationship (in or outside of work) with someone from the CPBO, either through intentional one-on-one conversations or through participating in the organizing group's activities
- A funder introduced the health department to the CPBO and/or provided funding to support relationship building
- Health department and CPBO did research together — led by the health department, the CPBO, or an academic partner — and/or organizers from the CPBO were hired to help conduct survey outreach or focus groups
- Health department invited the CPBO to participate in their internal processes

Responses for this section varied significantly because of varied knowledge of the collaboration's origins story. In some cases, the survey respondent was directly involved in the initial and/or ongoing relationship building. In other cases, the respondent was reporting on events that occurred long before he or she started as staff.

### **Relationship building is core to organizing and collaboration**

Responses indicate that all health department/CPBO collaborations began with some awareness raising and relationship building — often, between two individuals. A core strategy of most community organizing is using one-on-one relationships to gradually build a base of people who share experiences, analysis of what's causing their problem, and a commitment to take action. Relationship building is a fundamental building block of collaborative work, as well.

Although not explicitly asked in the survey, most health department respondents mentioned the length of their relationship with the CPBOs. The length and strength of the collaboration may have impacted survey completion — specifically, we may have had more department responses from those with more established collaborations. Although a few collaborations had started in the past few years, the majority of collaborations were five or more years in length. This points to two important insights:

- Trust and relationship building takes time
- Multiple staff from each organization must be involved in the collaboration for the partnership to withstand staff turnover, crises (like COVID-19), and other factors over time

### **External funding helps facilitate and strengthen collaboration**

Funding availability also plays an important role. Roughly one-third of health departments participating in our survey, and the CPBOs they listed, received funding to participate in one of two key initiatives:

- The Kellogg and Kresge Foundations' Healthy Heartlands Initiative, focused on aligning public health and faith-based community organizing in five Midwestern states
- The California Endowment's Building Healthy Communities Initiative, which invested heavily in place-based community engagement to improve health conditions

Although the collaboration may have been initially seeded with some funding from a foundation, many of the health departments hold relationships with multiple organizing groups. Trust and relationship building with one organizer or CPBO often translated into increased trust with other groups in the organizers' network, greater understanding of organizing among health department staff, and increased capacity for engagement among both partners.

For example, 25 of the 29 responses noted that collaboration with one organization increased the health department's credibility with other grassroots organizations. Similarly, one respondent noted, "From my perspective, the most important impact to date that the collaborations with community organizers have had is the expanded knowledge, readiness, capacity, and commitment for our unit to broaden and deepen our engagement with current and new community organizers."

## What Strategies Were Used to Facilitate Collaboration?

Survey respondents noted a wide range of collaboration types, which we grouped into three broad and interconnected categories:

- Health departments invited CPBOs into existing health department processes
- Health departments helped CPBOs achieve their goals and transformed the health department's internal and/or external practices
- Health departments and CPBOs worked together to build and share power

### Spectrum of Health Department/Community Power Building Organization Collaborations



The most common strategy (used by 26 of the 29 health departments) for collaboration was to invite CPBOs into multi-sector convenings or dialogues organized by the health department — such as “health in all policies” convenings, equity work groups, and health impact assessments — that may include CPBOs, community groups and other agencies.

More than three-quarters of participating health departments helped CPBOs achieve their goals, and in doing so, transformed their work internally and externally to better support community demands by:

- Providing research/data on an issue that CPBOs were working on
- Convening or participating in public events related to CPBOs' priority issues
- Meeting with CPBOs to discuss an issue they were working on
- Introducing organizers to staff in other government agencies

Importantly, almost all health departments (25 of the 29) noted that they worked to build and share power by:

- Actively including communities impacted by inequities in decision-making tables and processes
- Intentionally building individual and organizational relationships (e.g., through conducting one-on-ones and regular meetings)
- Strategizing how to advance health-promoting work and policies, and/or leverage the health department's institutional power around an issue or more generally

Table 2 below illustrates the different types, strategies, and examples of collaboration from the survey. See [Appendix E](#) for a full list of collaboration types and the tallies of how many health departments utilized each strategy, and [Appendix F](#) for a full list of examples.

**Table 2: Types of Collaboration and Examples from Health Department Participants**

Type	Examples from Survey
<b>Build relationships with CPBOs by:</b>	<ul style="list-style-type: none"> <li>• Leading regular meetings between coalition members (including CPBOs) and staff from across the health agency</li> <li>• Co-organizing education dinners</li> </ul>
<b>Invite CPBOs to:</b>	<ul style="list-style-type: none"> <li>• Participate in task force for second-hand smoke and tobacco retailer licensing</li> <li>• Support low-wage worker and non-English speaker engagement in CHNA + CHIP</li> <li>• Support CHIP action team to build social connectedness and neighborhood relationships</li> </ul>
<b>Subcontract CPBOs to:</b>	<ul style="list-style-type: none"> <li>• Provide training on engaging young adults</li> <li>• Host conference on immigration and health</li> <li>• Advocate for equitable transit-oriented development and affordable housing in city planning process</li> </ul>
<b>Provide data and research for issues CPBOs are working on, such as:</b>	<ul style="list-style-type: none"> <li>• Collecting sub-county level data to fill gaps needed for gender equity surveillance</li> <li>• Documenting impact of increased immigration enforcement and anti-immigrant rhetoric on access to care and services</li> </ul>
<b>Provide media and/or public support for issues CPBOs are working on by:</b>	<ul style="list-style-type: none"> <li>• Testifying on health benefits of paid sick leave and minimum wage</li> <li>• Submitting comment letters about the health impacts of public charge, tenant/rent protections, and preschool-to-prison pipeline</li> </ul>
<b>Expand community engagement by:</b>	<ul style="list-style-type: none"> <li>• Co-organizing a Resident Leadership Academy and ensuring decisions are made by core team of residents, not on their behalf</li> <li>• Building staff and resident capacity for deep canvassing in low-income neighborhoods during pilot of municipal participatory budgeting project</li> </ul>
<b>Leverage government power and connections by:</b>	<ul style="list-style-type: none"> <li>• Working together to reform code enforcement</li> <li>• Working together to pass sanctuary policy and legal defense fund for immigrants facing deportation</li> </ul>
<b>Co-create new research, projects, resources, policies like:</b>	<ul style="list-style-type: none"> <li>• Co-creating a strategic alliance on transportation</li> <li>• Co-applying for funding to build youth leadership</li> </ul>
<b>Formalize collaborations and power sharing by:</b>	<ul style="list-style-type: none"> <li>• Participating together in county governance group</li> <li>• Serving on HIV and Latinx Community Task Force</li> </ul>

Health departments utilize a wide range of strategies to collaborate with CPBOs. This survey did not ask “which came first” in terms of activities that may have occurred at the beginning of the partnership or after the collaboration evolved and trust deepened. However, health departments shared many more anecdotal examples of how they provided data, research, or media support to CPBOs or worked with CPBOs to support community engagement, compared to examples of how they formalized their collaborations and power sharing — a step that likely comes after extensive collaboration.

### Internal unlearning is important component of collaboration

Health department staff noted that collaborations with external CPBOs led to significant internal learning. Staff deepened their analysis of the root causes of health, as well as their understanding of why collaboration and power sharing are important, and how collaboration with CPBOs increased the impact of their work. For example, one individual noted, “We've had to unlearn many health department practices, such as that we are the experts, and move to a 50/50 partnership with community leaders. They are the experts about their neighborhood and community, and when we join forces, we can do better than either usually does alone when tackling complex issues.”

Others noted how their work evolved as their partnerships deepened. For example, one respondent shared: “By working with community organizers, our department learned to engage in power analysis together with our partners. While this is by no means a widely adopted understanding or practice, it is an important shift and evolution of our department's work on SDOH [social determinants of health] — moving beyond only establishing linkages between social determinants and health, to co-developing and implementing power-building strategies to create systems changes.”

#### Case Study: Alameda County Public Health Department

Alameda County Public Health Department's collaboration with housing justice CPBO Causa Justa: Just Cause is nationally recognized as a great example of a power-building partnership for health. Together, and in partnership with other advocacy organizations and government partners, they changed local policies and practices related to housing access, habitability, and affordability to eliminate housing and health inequities in low-income communities.



Some of the strategies they used included:

- Facilitating an extensive community engagement process involving outreach with organizers and their members
- Conducting research on topics of concern to impacted communities (including foreclosures and gentrification) in full partnership with the CPBO
- Working with the CPBO and sister government agencies to advocate for code enforcement policy and proactive inspections
- Building the leadership of others, particularly those with less formal authority
- Supporting larger campaigns for tenant protections and rent stabilization by providing objective health analysis in public testimony and comment letters (while community partners drove advocacy)
- Leveraging health officer authority to highlight health-harming conditions in housing and to support tenant protections
- Acting as convener and catalyst to bring together multi-sector partners

Photo credit: Causa Justa::Just Cause

### Case Study: Kansas City Health Department



Kansas City (MO) Health Department's collaboration with Communities Creating Opportunity (CCO), a largely faith-based community-organizing group, is a great example of close, synergistic, long-term relationships that have enriched both organizations' capacity to do meaningful community engagement and enact upstream policy change. Together, and in partnership with other community and government partners, they had a number of

policy wins, including eliminating criminal-history disclosure on city job applications, passing a local living wage and paid parental leave ordinances, and having life expectancy be included as a metric in the city's business plan.

Some of the strategies they used included:

- Individual relationship building between the Health Director and Executive Director of CCO
- Convening of community members and organizers to develop a plan for addressing health inequities
- Selecting CCO as their community-engagement partner to mobilize local leaders and members around key issues
- Developing a memorandum of understanding (MOU) between the two



organizations about each organization's role and responsibilities in achieving joint goals and in rental of shared office space

- Offering cross-trainings on community organizing and health equity to all new staff in each organization
- Funding community organizing
- Sponsoring and hosting public meetings with elected officials to discuss specific policy decisions

Photo credit: Communities Creating Opportunity

## What Were the Impacts of the Collaborations?

### Collaborations help increase health department capacity and understanding

Survey respondents noted many positive impacts of collaborating with CPBOs, the most common of which were related to increasing staff understanding and capacity to work upstream and address equity with CPBOs. Specifically, of the 29 participating health departments, the collaboration helped:

- 27 increase staff understanding about opportunities and strategies to address health inequities
- 25 better understand barriers facing communities served and root causes of health inequities
- 25 better understand how the health department can support community-led campaigns and activities that improve conditions for health
- 25 prioritize social determinants of policy work
- 25 deepen existing relationships with residents/communities impacted by health inequities

For the complete tally of collaboration impacts on health department practice, staff understanding, staff readiness and capacity, organizational influence in the community, work upstream, and building new and deepening existing relationships, see [Appendix E](#).

### Collaborations help health departments reflect on and leverage their own power

The partnerships helped health departments reflect on and leverage their own power in governmental decision making and public opinion, while also helping amplify and achieve policy changes sought by communities impacted by inequities. For example, one person noted that their partnership helped the health department “more effectively and rapidly respond to emergent community needs related to public health threats (e.g., people facing large-scale eviction in a low-income apartment community),” while another noted that their partnerships enabled successful implementation of “large-scale publicly funded projects (e.g., grocery stores and public basketball courts) to address racial and economic justice . . .

and public health.” Another individual noted: “We are now much more candid about the realities of power and the importance of narrative.”

### **Collaborations broaden and deepen community engagement and support policy change**

Health departments also noted that collaborations with CPBOs helped enhance their agency’s capacity to do meaningful community engagement and enact policy change on the social determinants of health. Over three-quarters of participating health departments noted that their partnerships with organizers helped build new relationships with residents and communities to which the health department didn’t previously have any connections. They also felt they deepened existing relationships with residents and communities impacted by health inequities. Respondents noted that the partnerships:

- *Brought community residents and organizations to the table that we don't interact with, but should*
- *Built trust in the community we serve*
- *Reduced our blind spots, and reduced the issues where "we don't know what we don't know"*
- *Kept a pulse on what's important to impacted communities and engaged residents in our work in a meaningful way*

Through these partnerships and expanded community engagement, the focus of health department or division-specific work has shifted. Multiple respondents acknowledged what one person stated: “The types of issues/priorities our department/division puts effort into has shifted and been informed by our work with grassroots organizers/partners.”

*“As a health department, it is making us better. Particularly in regards to actually addressing the issues affecting people's lives. . . . It has also created tension — but what I would call a very healthy tension that is needed in a county with disturbingly inequitable health outcomes. I think that at least for some residents who had either no knowledge of our health department or perhaps even a simmering mistrust or resentment . . . some perceptions have changed about the health department's role in the community and also about what's possible through collaboration with a government institution that stands with residents.”*

*- Health Department Staff Person*

## Inside/outside approach helps build internal capacity and impact external partnerships and policies

Key to this work is an inside/outside approach, because health departments will never have enough power to advance equity by themselves. By working in close and inclusive partnership with communities that face inequities, the health department is choosing to *share power with* communities, rather than *use power over* communities to amass more institutional power.

Working in partnership with CPBOs has the potential to shift internal practices, the work being done across government, and the ways government engages community. For example, one individual noted their collaboration “has led to focus on racial equity and systemic racism and more effort across the health department, as well as other county agencies, to work with CPBOs to change how we work and change policy to reduce racial inequities.”

As illustrated by the participants’ experiences, within the health department, a collective understanding of equity must be built across all leadership and staff. This should include the historical context of their communities and the impacts of racism, classism, sexism, and other forms of oppression on health and well-being. It should also encompass a commitment and will to act and take risks.

### Collaboration with CPBOs...

*“ . . . has helped to create urgency around our work. It has created a healthy tension for us to take positions on issues that matter and affect our constituents. It has pushed us to engage more with policies that affect our constituents. It has helped us to understand how we can be relevant to communities that are oppressed.”*

*“ . . . has helped us understand community-organizing techniques such as one-on-ones, tension, etc. These techniques have helped us run more productive meetings and created more authentic relationships.”*

*“ . . . allows the work to have greater equity impacts when we collaborate between community and staff. Having this priority has also brought much-needed diversity to our department as we begin to hire more staff that have deep ties to the community. We begin to shift the institutional culture within the government.”*

- Health Department Staff People

In some cases, collaborations have forced health departments to reckon with how they intentionally or unintentionally perpetuate inequitable power imbalances. For example, one individual noted, “In all honesty, the collaborations with community organizers are forcing our department to internally assess the many ways we replicate harm, as gatekeepers to the community, that is endemic to public health practice and our interpersonal relationships. These relationships have also amplified a need to address a spectrum of misaligned perspectives re: whether health equity work should be community-led versus agency-led.”

Some individuals welcome this internal reckoning and value how collaboration with organizers “has provided some staff with a renewed sense of worth of the work, by bringing them closer to the social justice and human-rights ideals of public health, which is what drew them to the field in the first place.”

And at the same time, health departments need to build external relationships and work closely with community groups that can demand change and hold the health department and others in government accountable to the needs of those facing inequities. In tough political situations, those groups can have the health agency’s back. This means playing different roles depending on the context. As noted by one participant, “[We have] been able to solve many political problems because we can select the best-positioned person within our multi-sector partnership to carry a message to specific audiences.” Another participant noted that the partnerships have “shifted the strategies of [our] work to align with the needs and interests of the community.”

## Challenges

Although the collaborations revealed many positive impacts, health-department respondents also acknowledged there were many challenges and political forces at play. Some of the most commonly mentioned challenges include:

- Limited internal support, awareness, and agreement within the health department to collaborate with CPBOs
- An acknowledgement that change processes and impacts take time
- Lack of political commitment and resources to continue, deepen, or expand collaborations with CPBOs
- Limited staff awareness about historical context and root causes
- Disagreement about how the health department should share power with community or center community voices in all decision making

Decision makers wanting to maintain the status quo may describe collaborations with CPBOs as “political,” which can potentially create repercussions. Examples offered by survey participants included additional monitoring of activities, feeling unsupported, being taken off certain projects, or in rare cases, threatened job loss.

Relatedly, potential budget cuts and very limited staff capacities in the time of COVID-19 force health departments to pare down activities that are not viewed as “essential” health practices. For example, one participant noted that “many supervisors do not see collaborating with organizers as something we should be doing as a health department (i.e., not a mandated service) or as something that is an important part of public health practice (i.e., not part of the essential public health services).” Another individual noted that their current work to center community-led decisions and community voices has not been modeled or evaluated, which limits their capacity to advocate for ongoing investment of limited funds into anecdotally successful but not scientifically proven strategies.

Multiple individuals noted that institutional change takes time and persistence. One individual noted that community-organizing techniques applied internally are valuable for shifting practices and building support for social-justice issues, and although that has been “a challenging and difficult process that has required a lot of learning and growth . . . ultimately it has been rewarding on many levels.”

Another individual noted the nascency of power building between health departments and CPBOs: “I believe health departments (and local government agencies) collaborating with community organizing is critically important. However, it is a fragile practice that needs much intentional, thoughtful nurturing and support in order to be sustainable and meaningful. While the SDOH framework and practice may be thought of as more of a pre-teen or young adult, the practice of building power with communities is an infant and needs to be surrounded from multiple angles with love and care for it to keep growing and eventually thrive.”

# Recommendations

The following recommendations draw on lessons learned from this survey, the Lead Local Project broadly, and HIP's extensive experience providing capacity-building support to health departments and health department/CPBO collaborations.

## For Health Departments + CPBOs Just Beginning Collaborations

- **Identify who you want to connect with**
  - *Health Departments:* Identify local community-organizing groups in your area. [Check out this list of organizations](#) to find CPBOs in your state/area. If you don't find any local community-organizing groups, see if your local food bank or other similar service providers have staff that engage their members and talk with them about supporting local organizing work.
  - *CPBOs:* Check out the health department's organization chart and division names. Look for departments or programs with names that include *community* or *equity*, like Community Health Promotion or Office of Health Equity — or try Policy and Planning, Chronic Disease Prevention, or Maternal and Child Health.
- **Do your homework and learn about the other organization + ecosystem of HDs and CPBOs in your region**
  - *Both:* Before connecting, read up about the work they're doing by looking up their organization online. Check out any recent reports, strategic plans, and/or social media, and notice what topics are prioritized, what commitments the organization has made, and with whom they are engaging or partnering. Where possible, look for an organization chart to understand the internal organization of the HD or CPBO.
  - *CPBOs:* Note where there is potential alignment or discord, and whether any key terms or concepts are not clearly defined. If you know any of the people or organizations listed, get in touch to ask about their experience, the inside scoop on department culture, and potential allies on the staff.
- **Be flexible and persistent in communication**
  - *Both:* Organizers often have very busy and evolving schedules, and health departments are part of government agencies that can sometimes move slower than desired by CPBOs. Try to accommodate each other's priorities as you schedule a time to meet, and know that connecting via text or social media may be better than email.
- **Start with small, concrete collaborations**
  - *Both:* Establishing some short-term goals can help create small wins that build trust and buy-in for a longer-term relationship. This can include inviting the other to your staff or member meeting, sharing health-department data

relevant to the organizers' policy priorities, or inviting the other to provide input on plans or reports from a health or community perspective.

- **Mobilize public health resources, such as data and evidence, to advance CPBO goals**
  - *Both:* Data and evidence are often something that health departments have at their fingertips and in abundance. Identify which types of data (eg demographic, health outcomes, social determinants, etc) might be helpful for advancing CPBO organizing goals and have the CPBO submit a formal request for that data to the health department.
- **Do a power analysis together and understand structural reforms that CPBOs are prioritizing**
  - *Both:* Analyze who holds power over decision making, and strategize how to influence those decisions to build community power and support community-identified needs and solutions. Check out [Lead Local's descriptions of structural changes](#) pursued by CPBOs.
- **Intentionally do activities together that build and deepen trust over time**
  - *Both:* It takes time to build a trusting relationship, especially in communities that have been impacted by inequities and disproportionately harmed by government policies — which may have made them wary of the government. But trust is built by sharing values; being transparent about limitations and capacities; and showing willingness to commit, follow through, and receive feedback about the impacts of one's actions and what could be improved moving forward.
- **Leverage inside/outside relationships to advance community-organizing goals**
  - *Both:* Work within each organization's strengths and capacities to advance the relationship and shared goals of addressing inequities, and to understand each other's limitations. For example, this may mean asking the health department to provide data and testify on the health impacts of a proposed policy, while understanding that the health department may not be able to take a formal stance in favor of or against a policy. In addition, the CPBOs may use certain strategies and tactics to mobilize members and public support that the health department cannot explicitly support (although staff can choose what to do in non-work hours).
- Check out [additional information, examples, and resources](#)

## For Funders

- **Support health department/CPBO collaborations to advance the goals of CPBOs in your state/region**
  - Today, most health departments are [chronically underfunded](#) and have little flexible funding to invest in potentially fruitful and valuable new organizer relationships that build community power. Similarly, many CPBOs operate on shoestring budgets and are struggling to support their members' needs during COVID. External funding support can both help seed new relationships and nurture existing ones to maximize their impact.
- **Allow flexibility in spending and timelines**
  - Particularly during COVID, but also in general, flexibility in timelines and the way funding is spent to support the collaborations allows partners to pivot in response to community's and their own needs. It also lets them adjust for decision-making timelines, which may be delayed for factors outside their control.
- **Work to build, share and yield philanthropic power with CPBOs**
  - The National Committee for Responsive Philanthropy released a [report, assessment tool and related webinars and resources](#) for philanthropy about how to build, share and wield power for maximum impact on the equity and justice issues and communities that foundations care about. These tools can be helpful for foundations, as well as health departments and other organizations that serve as funding agencies, to explore how best to leverage their power.
- **Utilize increased trust, increased communication, increased awareness/understanding, and increased power as one set of metrics for success**
  - One goal for these collaborations should be the development of sustainable long-term relationships, which require increased trust, communication, and understanding of each other's work. Including these as process evaluation metrics can help demonstrate progress toward longer-term goals like policy wins, and also demonstrates the foundation's commitment to relationship building.



## For Researchers

- **Document impacts and challenges of health department/CPBO collaborations**
  - There should be additional research to connect with the CPBOs involved in each of the collaborations, to learn about their experiences, perceived impacts, and challenges of working with health departments. This would complement the perspective of department staff. Further research and in-depth case studies could also provide valuable insights into how health departments and CPBOs have collaborated during COVID.
- **Document the process and impacts of community power building**
  - Community power building is both a science and an art — requiring significant skill by organizers to develop their members' and their own leadership skills and shared analysis of the issues, support members needs and power building, advance policy goals, influence narrative, and much more. Documenting this work can help broaden public understanding of what organizing is and how it differs from policy advocacy, community engagement, mobilization, and other strategies that are often conflated with organizing. At the same time, documenting the impacts of organizing can help make the behind-the-scenes work organizers do to advance policy more explicit, recognized, and valued.
- **Document political and social context of collaborations**
  - Although about two-thirds of the collaborations included in this report occurred in liberal or moderate larger (500,000+ people) jurisdictions that were governed at the local level, the other third did not. Researchers could investigate how governance structures, staffing, and political context impact whether collaborations with CPBOs occur, and if so, what strategies are used — particularly in terms of advancing inside/outside work and/or behind-the-scenes organizing that helps influence public decisions. Researchers could also assess how COVID response and recovery, and related public health funding, impact collaborations with CPBOs, the focus of health-department policy work, and the degree of cross-sector collaborations. For examples of political context documentation, see the [Lead Local work](#) from University of Southern California and Vanderbilt researchers.

# Closing

*“[We are] recognizing that community organizers are a critical component to impacting policy change. Government may have power over resources, but community partners have the power of voice — and they can bring to light the issues and the real stories of impacted communities in a way that the health department may not be able to do.”*

- Health Department Staff Person

This survey was conducted in 2019, prior to the COVID-19 pandemic and the global uprisings for Black liberation that have called for decarceration of prisons, jails, and detention centers and greater accountability of police departments. The survey was also conducted prior to eviction moratoriums and grassroots demands for rent cancellation; mass unemployment and shelter-in-place orders; and many other social, political, and economic changes that occurred in response to the pandemic and uprisings.

Because of COVID, many health departments have been forced to deal with social determinants of health — such as finding ways to house the unhoused, depopulate prisons, and offer sick leave and protective equipment — as part of local and state COVID response and recovery efforts. These may or may not have been done in collaboration with CPBOs and/or representation from impacted communities.

This report has illustrated how health-department collaborations with CPBOs are needed for advancing health equity and building collective power to address structural and social determinants of health. Our data show that these collaborations are a way for health departments to build and share power with communities experiencing inequities, change policies and improve conditions for health, increase staff understanding, and improve relationships with community partners.

Anecdotally, we have heard that health departments who already had relationships with CPBOs were able to leverage those relationships in their COVID response to more quickly target and support communities impacted by historical and current structural inequities. This included the ability to more quickly receive on-the-ground insights about needs for testing, information, and care options; to more quickly disseminate information in culturally appropriate and language accessible ways; and to have the community weigh in on different COVID response options and allocation of resources. As one health-department staff person noted, collaborations with CPBOs are critical for ensuring efficient and effective allocation of resources and community engagement with populations most impacted by health inequities.

Although partnerships between health departments and CPBOs constitute a relatively new field of practice, there is a good foundation and numerous examples to build from. Importantly, these collaborations have tangible impacts — such as providing rent stabilization and tenant protections, paid sick leave, and higher wages; eliminating employment and benefits barriers to the formerly incarcerated; increasing resources for education, health care, and transportation; and protecting people from racism and xenophobia. As one participant noted: “[The collaboration] has helped the health department begin to be effective at tackling structures of oppression as root causes of health inequities, rather than solely the still predominant focus on behaviors, medical care, and intermediary determinants.”

As learned through this survey and the [Lead Local Project](#) generally, community power helps catalyze, create, and sustain conditions for healthy communities. Collaborations between health departments and CPBOs help support community power building and are an opening to transform public health and government more broadly. As always, but particularly in this moment, we need transformation of our systems in order to address the deep and painful inequities in our society.

As adrienne maree brown states so eloquently, “What we practice at the small scale sets the patterns for the whole system.” Relationship building, trust building, and power building among individuals in health departments and community-organizing groups can transform the way the organizations work together, shift the focus of their work, and lead to practices that set the groundwork for systemic change.

# Appendices

## Appendix A: Glossary of Power Building Terms for the RWJF Lead Local Project

### **Community Power:**

Community power is the ability of communities most impacted by structural inequity to develop, sustain and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions and cultivate ongoing relationships of mutual accountability with decision-makers that change systems and advance health equity. (USC Equity Research Institute)

### **Community Power Building:**

Community power building is the set of strategies used by communities most impacted by structural inequity to develop, sustain and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions and cultivate ongoing relationships of mutual accountability with decision-makers that change systems and advance health equity. Community power building is particularly critical for underserved, underrepresented, and historically marginalized communities who have been excluded from decision-making on the policies and practices that impact their health and the health of their communities. (USC Equity Research Institute)

### **Health Equity:**

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

(<https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>)

### **Social Determinants of Health:**

Commonly referred to as the social determinants of health, these are the “conditions in the environments in which people are born, live, learn, work, play, worship, and age” that influence health. ([https://www.who.int/social\\_determinants/sdh\\_definition/en/](https://www.who.int/social_determinants/sdh_definition/en/)) Such conditions include “economic stability, education, social and community context, health and health care, and neighborhood and built environment” (Definition from [Healthy People 2020](#)). Political and economic factors, power imbalances (for example, racism, sexism, xenophobia, homophobia, and ableism), and systemic injustice also constitute the conditions that determine health inequity.

(<https://www.ncbi.nlm.nih.gov/books/NBK425845/>)

**Base Building:**

A diverse set of strategies and methods to support community members to: be in relationship with one another; invest in each other's leadership; share a common identity shaped by similar experiences and an understanding of the root causes of their conditions; and to use their collective analysis to create solutions and strategize to achieve them. (USC Equity Research Institute)

**Community Power Building Organizations (CPBOs):**

Organizations that may be identified by geography (local, state, regional, national), demography (e.g. youth, workers, multi-racial) or issue(s) (e.g. workers' rights, environmental justice, multi-issue) who conduct a range of activities including base-building. Other terms sometimes used to describe CPBOs include but are not limited to: grassroots organizing groups, social movement groups, movement-building organizations, community-based organizations, community organizing groups, base building groups.

**Community Organizer:**

Community organizers, one type of staff person working at CPBOs, bring the most impacted communities together—through door knocking in neighborhoods and apartment buildings and through institutions like schools and churches—to learn and strategize about how to make, as multiple interviewees described, “material changes in their living conditions.” While organizers across place and issue employ diverse ranges of tactics and strategies—from leadership development trainings to political education curricula to healing circles—it's about bringing people together to help them make connections across their lived experiences and conditions. (USC Equity Research Institute)

## Appendix B: Methods and Limitations

Human Impact Partners sought to document common practices, strategies, and impacts of collaborations between health departments and community organizers working in community power building organizations (CPBOs). Our goals for the survey were to:

- Document the locations, activities, and impacts of these collaborations
- Summarize the ways that health departments can build power to improve conditions for health and advance health and racial equity by working with CPBOs
- Share this information with health departments to support building power with communities impacted by health inequities

### Methods

We collected data from state and local health departments via an electronic survey distributed in summer 2019 and analyzed the results in winter/spring 2020. The survey was developed in consultation with a number of advisors (see Acknowledgements) who work in or closely with health departments and/or with CPBOs. The final survey questions are included in the Appendix.

We piloted the survey with two health departments and distributed it widely via email to national public networks and listservs including:

- National Association of County and City Health Officials (NACCHO)
- Big Cities Health Coalition
- Association of State and Territorial Health Officials (ASTHO)
- Public Health National Center for Innovations (PHNCI)
- Healthy Heartlands listserv of Faith in Action
- County Health Rankings
- Various caucuses and sections of the American Public Health Association

We received 128 responses, of which 72 were eligible for potential inclusion (meaning the survey was completed by a health department and was mostly complete). We reviewed each of the 72 entries to determine whether or not to include them in the final analysis. Responses were excluded if they did not mention one or more specific organizations that they collaborated with, or if the health departments listed community collaborations that did not meet HIP's definition of CPBOs. When multiple staff from the same health department completed surveys on the same collaboration, , the entries were combined into one response. Our final analysis included 29 health departments. Additional details about the process for determining inclusion is in the [Appendix C](#).

## Defining Community Organizer

In the survey (which was administered in summer 2019), we defined community or grassroots organizations as:

*Organizations that work with people who are most impacted by inequities to identify solutions to the problems that they themselves identify and build their leadership, agency, and power to mobilize for social change.*

The survey also included this additional guidance:

*If a community based organization just provides services but does not have an intentional leadership development or power building component to their work, they are not community organizers! If you are not sure, please see our definition of community organizing and consider whether your community partner meets our [definition of a community organizer](#).*

## Caveats/Limitations

This survey was conducted as part of the larger [Lead Local](#) project which sought to investigate “How does community power catalyze, create, and sustain conditions for healthy communities?” The health department-CBPO survey was administered before the Lead Local team developed a glossary of power-building terms (see [Appendix A](#)) and before the project interviews with community organizers and foundations spotlighted the importance of talking about “community power building organizations” (CPBOs) as the organization in which community organizers work.

As seen below, the survey questions were originally asked focusing on collaborations with community organizers, not CPBOs. Although the terms can be used somewhat interchangeably, HIP leaves the original references to ‘community organizers’ in the survey instruments that follow.

Aside from that nuance, these survey results have the following limitations:

- This survey used convenience sampling, and only gathered data from health department staff who elected to participate. It should not be considered representative of all health departments.
- Despite clearly defining community organizers in the survey, a number of health departments were screened out because the partners listed did not meet our definition (for example, the health department only listed social service providers

that they partner with.) Defining criteria for inclusion required nuance. HIP's determinations drew on our direct experience working with grassroots and base building organizations, supporting health departments collaborations with organizers, and summarizing trends in the field of power-building for health. Another organization may have established different criteria for inclusion and exclusion. We share our analysis methods in the [Appendix](#).

- People in leadership positions or in a health equity role were more likely to reply than other positions within a health department to the survey. This may reflect who is partnering with CPBOs and/or who was more likely to receive the initial request to complete the survey.
- Individual answers do not necessarily reflect responses from the entire organization, particularly in very large or geographically diverse health departments.
- We only surveyed health department staff, not community organizing partners. Time and resources permitting, it would be valuable to interview the organizers involved in these processes.
- Although we included a section about challenges of collaboration in our survey, due to a glitch in the survey format, none of the respondents saw nor answered the questions about challenges. We were therefore unable to capture information about challenges beyond what was shared in the open comments sections of the survey.
- Both survey data collection and the majority of report writing were conducted prior to the COVID-19 pandemic. Health department infrastructure, capacity, and priorities have shifted dramatically in response to COVID-19, and further shifts are likely during recovery. Given this context, collaborations with CPBOs can become even more critical to maximizing outreach and impact in communities disproportionately impacted by COVID.



## Appendix C: Criteria for Inclusion

In order to be included in our analysis, a survey response had to meet the following criteria:

1. The respondent works at a health department
2. Most of the questions are completed
3. The respondent listed one or more specific organizations that they worked with
4. The partner organization listed met HIP's definition of community organizers.

Deciding whether an organization met our definition of “community organizers” was a complex task. We went through each response that met criteria 1-3 and conducted an internet search for information about the partner organization listed. We sought to confirm whether the organization:

- had an explicit focus on organizing or power building
- had a membership base that they organized and were accountable to
- used a decision-making process guided by their members

We identified some patterns based on the type of partner organization, which are summarized in Table C.1. We share this information to be explicit and transparent about our decision-making process. We recognize others may use different definitions of organizing. Our process allowed us to ensure to the greatest extent possible that we compared “like” organizations and met the goals of this research.

If a response mentioned multiple community partners, and at least one met our criteria for community organizers, then we included the response in our analysis.

Table C.1: Case-by-Case Basis for Inclusion or Exclusion			
Type of Organization	Included	Excluded	Rationale
Community Development Corporations (CDCs)	Community organizers are on staff and have an explicit orientation towards organizing and power building	Staff are working on asset building and community development without an explicit organizing focus	Although many CDCs promote resident engagement, the engagement is often to inform a specific, pre-existing process or structure, rather than to build power for ongoing social change on issues prioritized by members. CDCs in which residents only share their opinions in an advisory capacity and on limited topics (e.g. through a resident council) do not meet our definition.

Youth Organizing or Youth Leadership	Leadership development includes peer outreach and engagement to influence decision-makers on a specific topic or project	The focus is on building individual youth's policy and advocacy skills to directly influence a decision-maker and not involve engagement of peers.	Youth organizing can look different from community/adult organizing because organizers use different terms and different strategies to engage youth. We distinguish between youth organizing and youth leadership development.
Mobilization Groups - eg Get Out the Vote or Parents Groups	Members determine the agenda, and there is a clear ladder for leadership growth/ opportunities, or membership structure.	The focus is solely on turning people out to vote or to support policy priorities that are determined by staff, without member input or involvement in decision-making.	We make a distinction between organizing and mobilizing. We included groups that engage in mobilizing when the organizations clearly engaged in leadership development, building their base (e.g. through house meetings or door knocking) and included members in making the decisions about priorities

**Table C.2. Organization Excluded from Analysis unless they described an explicit activity focused on organizing + building power**

Health organizations focused on policy, systems and environmental (PSE) change	<p>Rationale</p> <ul style="list-style-type: none"> <li>- PSE policy and advocacy work is an important strategy for changing conditions that influence health, but it is often done without organizing. An organization can do advocacy and organizing simultaneously, for example expanding their base through a policy campaign, but paid staff must be accountable to a member base that is involved in decision making in order to meet HIP's definition. Health organizations using a PSE approach often understand <i>why</i> it is important to engage impacted communities, and may consult with communities about problems or solutions, or invite community representatives to be spokespeople or to join decision-making bodies. However, we did not consider this organizing unless the organizations explicitly conducted work to build the power of marginalized communities.</li> </ul> <p>Example:</p> <ul style="list-style-type: none"> <li>- Regional coalition that uses PSE approach to their work, values increased and authentic community engagement and strengthening organizational capacity. Work is focused on coalition-building and capacity building, ensuring more diverse representation at coalition decision-making table. Thus focus is on broadening and deepening engagement, not organizing or power/base building. To better</li> </ul>
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	<p>understand the difference between broadening engagement and base building, please see the Glossary of Terms in <a href="#">Appendix A</a>.</p>
<p>Education and Service Organizations</p>	<p>Rationale</p> <ul style="list-style-type: none"> <li>- Capacity building (eg. raising awareness, training, skills building, leadership development, etc) without power building is not organizing.</li> <li>- Providing training, public awareness and technical assistance, or developing networks for sharing of information and resources are important aspects of capacity building and can be a strategy used by organizers, but community organizing must also include power building.</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>- Groups using an “individual empowerment” framework to help individuals and families access government services, jobs, advocacy, support or other opportunities, which help individuals navigate systems but do not build their power to change those systems.</li> <li>- Providing capacity building or technical assistance to meet community needs (e.g. TA for disability access, support staying in school)</li> <li>- Community organization that organizes educational activities to educate the public about specific topics (e.g. suicide, drug prevention), with the goal of influencing behavior or connecting people to existing resources</li> </ul>
<p>Coalitions, Councils and Partnerships</p>	<p>Rationale</p> <p>The main focus of these organizations is bringing together different stakeholders to address identified community needs or a specific health issue (eg diabetes, suicide, tobacco, harm reduction, HIV/AIDS, ACES). This may be a strategy used by organizers, but if it does not include power or base building, it is not organizing.</p> <p>Examples</p> <ul style="list-style-type: none"> <li>- Organizations who do policy and conduct capacity building or trainings for service providers (eg around Harm Reduction, LGBTQ awareness, or disability access)</li> <li>- Organizations who do build coalitions with other organizations but not with individuals</li> <li>- Community-driven initiatives focused on creating new programs without explicitly building a base of members working to change systems, eg a coalition of parents, farmers, and teachers supporting healthy eating and local food through urban gardening, summer camp, and farm-to-school projects</li> </ul>
<p>Policy or Advocacy Organizations without a membership base</p>	<p>Rationale</p> <p>Advocating for changes in public policy is an important strategy used by organizers, but if the policy priorities are determined by staff who are not accountable to a membership base, this does not meet HIP’s definition of community organizers. Examples</p>

	<ul style="list-style-type: none"> <li>- Organizations that advocate for policies to benefit a particular group of people — eg individuals with breast cancer, HIV, or the LGBTQ community — where policy priorities are determined by staff.</li> <li>- Community health education or outreach to promote awareness in specific communities or the general population, including service providers that do policy advocacy for their patients. A community advisory group may provide recommendations to the organization about what to focus on, but decisions ultimately made by staff and/or board of directors</li> </ul>
Resident Councils	<p><b>Rationale</b> Resident councils are created to represent the residents of specific housing communities and may be trained in leadership, conflict management, consensus building, administration, and other skills that are helpful for building power, however they are not trained on organizing. They are not given latitude to mobilize, organize or build power with their residents - and may be stripped of their power if they do so. This is different from We distinguish between resident councils and tenant councils organized by housing justice organizations, in which members determine what issues to address and which strategies will be used.</p> <p><b>Example</b></p> <ul style="list-style-type: none"> <li>- A resident council with elected or appointed members established by a public housing authority or property owner in order to liaise between residents and landlords about issues related to their housing community.</li> </ul>
Cultural and ethnic organizations doing service provision and advocacy	<p><b>Rationale</b> Some organizations work with a specific cultural or ethnic group, such as African Americans or Cambodian immigrants and refugees, in order to promote cultural traditions, help people navigate services, support personal leadership development and transformation, and advocate for communities. Some of the strategies used by these organizations may also be used by community organizers. However, if work is solely focused on service provision and policy advocacy but does not include organizing or base building of their members/clients, it was not included. See <a href="#">Appendix A</a> for additional definition and concept clarification.</p>

## Appendix D: Health Departments Included in Analysis

The following 29 state, county and city health departments were included in the analyses outlined in the report. One or more staff from each of these organizations completed HIP's survey and their organization clearly met HIP's criteria for inclusion, described above. As described in the limitations, the one survey response may but does not necessarily reflect the experiences of all staff in their health department staff, there are numerous other health departments that have also worked with CPBOs that did not complete the survey, and others that did not sufficiently complete the survey to be included in the analysis.

- Alameda County Public Health Department, CA
- Boston Public Health Commission, MA
- California Dept of Public Health, Environmental Health Investigations Branch, CA
- City of Long Beach Dept. of Health & Human Services, CA
- Cook County Department of Public Health, IL
- Cuyahoga County Board of Health, OH
- Douglas County Health Department, NE
- Eau Claire City-County Health Department, WI
- Florida Department of Health in Orange County, FL
- Ingham County Health Department, MI
- Kent County Health Department, MI
- Los Angeles County Department of Public Health, CA
- Louisville Metro Department of Public Health and Wellness, KY
- Merced County Department of Public Health, CA
- Monterey County Health Department, CA
- New Hampshire Dept of Health and Human Services, NH
- NYC Department of Health and Mental Hygiene, NY
- Oregon Health Authority - Public Health Division, OR
- Public Health - Seattle & King County, WA
- Ramsey County Health Department, MN
- Rhode Island Department of Health, RI
- Riverside County University Health System - Public Health, CA
- San Francisco Dept of Public Health, CA
- San Mateo County Health, CA
- Santa Barbara Public Health Department, CA
- Spokane Regional Health District, WA
- Ventura County Public Health, CA
- Washtenaw County Health Department, MI
- Winnebago County Health Department, WI

## Appendix E: Survey Tallies

The following tables provide tallies for the majority of survey questions. Tallies are not included for the questions asking about individual collaborations or that included identifying information.

### Collaboration on What Topic Areas?

The following table describes the topic area that the health department worked on with CPBOs. Respondents were allowed to check all that apply. As one can see, the most common topic areas were related to work on the social determinants of health.

Topic Area	N = 29	Topic Area	N = 29
Housing	21	Health insurance/ Medicare/caid	7
Criminal Justice/Incarceration	15	Education	7
Food Justice/Access/Security	14	Public safety/violence	7
Health care access/utilization	12	Asthma	6
Diabetes/Obesity	11	Immunizations + Screenings	6
Immigration	11	Parks/recreation centers	6
Transportation	10	WIC/Food Stamps	5
Urban Planning	10	Cardiovascular diseases	4
Jobs/Labor conditions/Wages	9	Disability access	3
Physical activity	8	Infectious diseases	2
Tobacco + Substance Use	8	Injury Prevention	2
Envir'l justice/climate change	8	Child care	2
HIV/STD prevention	7	Cancer	1
Other (please specify)	1) Economic dev/asset building/fair lending/reinvestment 2) Language Access 3) Civic Engagement 4) Lead and mercury poisoning prevention 5) participatory budgeting, health equity reporting, LGBTQ health, racial equity 6) Health Education 7) language & cultural justice for Indigenous Peoples 8) Reproductive health 9) Developing shared policy agenda re: SDOH 10) Poverty, Mental Health 11) Racial Equity		

## What do HD-CPBO Collaborations Look Like?

To better understand how health departments and CPBOs were collaborating, we identified three general dimensions to potential collaborations:

- Health departments including organizers in HD internal processes
- Health departments helping organizers achieve their goals
- Health departments and CPBOs working to build power.

And asked health departments to check off all the activities that applied for each of those dimensions. Below are the responses from the 29 health departments.

Collaboration Type: HDs include COs in HD internal processes	N = 29
Organizers participate in multi-sector dialogues or convenings organized by our department (e.g., HiAP convenings, HIAs, film screenings, equity workgroups, etc that may include community groups and other govt agencies)	26
Organizers participate in processes for health assessments and plans (e.g. CHA/CHIP)	23
Our department subcontracts with organizers as their community engagement partner (e.g., to support community outreach; to promote “know your rights” campaigns; to educate on health department services)	18
Our department subcontracts with organizers for policy/systems/environmental (PSE) work to change policies and practices (e.g., support community engagement in city and regional planning processes, technical assistance to advance local solutions, promotion of systems change work)	11
Organizers participate in our departmental strategic planning	4
Our department subcontracts with organizers to provide translation/interpretation support at health department meetings and processes	4
Other <ul style="list-style-type: none"> <li>• Provide feedback on how we share/showcase our equity info/data/framing</li> <li>• COs serve on a 15-member Governing Board that makes budget and strategy decisions for a multisector partnership</li> <li>• Contract with orgs to implement assessment of environmental toxins (not part of CHA/CHIP)</li> <li>• Policy development, research and advocacy support through our HE Policy and Planning unit</li> </ul>	

Collaboration Type: HDs help COs achieve their goals	N = 29
Provides research/data on an issue that organizers are working on	25
Convenes or participates in public forums or events relate to an issue that the organizers are working on	25
Meets with CPBOs to discuss an issue they are mobilizing around	24
Introduces organizers to staff in other government agencies to support their work	23
Serves as technical advisor in coalitions convened by organizers to bring a health perspective	19
Provides organizers with training or TA on health, data, framing, or other topics	18
Provides public letter/testimony in support of an issue that organizers are working on	15
Provides organizers with guidance on how to do community-led research	12
Provides press/media support (e.g. write op-eds, do a press interview, participate in press conference, share press quotes, etc) in support of an issue that organizers are working on	6
<p>Other</p> <ul style="list-style-type: none"> <li>● Promote organizers' priorities/goals to other organizations (e.g., program promoting good food purchasing, an assessment/referral process for injured workers to large healthcare system; integration of a program into the County President's Roadmap)</li> <li>● Participate in a racial equity committee that is led by CPBOs.</li> <li>● Work with organizers to obtain County support positions on key legislation</li> <li>● Apply for funding on their behalf to support collective work across organizing groups</li> <li>● Provide flexible funding to organizers through contracts</li> <li>● Sponsors and promotes speaking events / pays honoraria for organizers to speak at events</li> <li>● Support community-based, community-led, community-defined research through identifying, interpreting data, providing resources, connecting researchers with other experts, etc while following CO guidance and lead.</li> </ul>	



<b>Collaboration Type: HDs + COs working together to build + share power</b>	<b>N = 29</b>
Work together to actively include communities impacted by inequities in decision-making tables and processes	25
Intentionally build individual and organizational relationships (e.g., through conducting 1-on-1's, regular meetings)	25
Strategize about how to advance health promoting work, policies, and/or leverage the health department's institutional power around an issue or more generally	24
Work together to change the narrative around what creates health and equity	22
Co-convene multi-sector dialogues, convenings, or processes (e.g., health-in-all-policies convenings, film screenings, equity workgroups)	20
Co-design and implement projects to advance health equity and support community engagement on issues of concern to organizers	20
Co-facilitate trainings to HD staff, organizers' staff and members, and/or the public	17
Support development of new groups/coalitions/networks to advance equity	17
Co-submit grant applications to advance joint work	13
Participate as Advisor/Board Member/Commissioner or other formal governing role to the other's organization	7
Develop a Memorandum of Understanding or other formal agreement to establish how and why the two groups will collaborate	7

**What were the impacts of HD-CO collaborations?**

<b>IMPACTS: Changed our health department practice by:</b>	<b>N=29</b>
Developing more formal relationships with community organizing groups	19
Advocating on social determinants policy reform with other government agencies and elected officials	19
Weighing in on decision making by other government agencies	18
Allocating funding to support organizer engagement of community residents	12

Leveraging public health authority to promote policy and systems change (e.g., by fining landlords for not maintaining properties, suspending restaurant permits of owners who are committing wage theft)	12
Allocating funding to support organizer training and capacity building	10
Other <ul style="list-style-type: none"> <li>● Beginning health equity work at the department level</li> <li>● Formally including organizers priorities as our priorities and allocating our staff time to those priorities</li> </ul>	

<b>IMPACTS: Increased Staff Understanding About:</b>	<b>N=29</b>
Opportunities and strategies to address health inequities	27
Barriers facing communities that we serve and the root causes of health inequities	25
How the health department can support community-led campaigns and activities that improve the conditions for health	25
Our individual and institutional privilege, power and responsibility that we carry as government employees	23
Other: Historical awareness and understanding of how to be supportive of CO work.	1

<b>IMPACTS: Expanded our readiness and capacity to:</b>	<b>N=29</b>
Reflect internally about racism and other structural inequities impacting health	24
Outreach to communities impacted by health inequities	22
Partner with and acknowledge community grassroots leadership to identify and address health equity issues in setting DPH goals and objectives.	22
Work on community-defined priorities	22
Prioritize deep and meaningful engagement of communities impacted by health inequities	21
Communicate in other languages with the communities we serve	12
Other: (1) Better understand and reflect on the political barriers and opposition to tackling power imbalances originating within the local County government hierarchy of appointed and elected officials that prevents the public health department from taking more effective action on the structural determinants and related policies. (2) Work towards changing narratives	2

<b>IMPACTS: Increased our organizational influence in the community by:</b>	<b>N=29</b>
Increasing our credibility with other grassroots organizations	25
Increasing our reputation as a “neutral” convener/facilitator across sectors	17
Increasing the recognition of the health department by elected officials	11
Increasing the number of invitations to key decision-making spaces like formal committees	11
Increasing the recognition of the health department in the media	7
Increasing our credibility with other grassroots organizations	25

<b>IMPACTS: Started working more upstream by:</b>	<b>N=29</b>
Prioritizing social determinants of health policy work	25
Including work on social determinants of health, health equity and/or racial equity in our strategic plan, mission/vision, or values	24
Focusing CHA/CHIP processes on equity and/or social determinants of health	21
Documenting the connection between issues communities care about and health	18
Meeting regularly with other government agencies, community groups and others to advance health in all policies	16

<b>IMPACTS: Built new relationships with:</b>	<b>N=29</b>
Residents/communities that we previously didn’t have any connections to	23
Other government agencies	12
Elected officials and other decision-makers	12
Other <ul style="list-style-type: none"> <li>● Other organizers or key stakeholders supporting organizers</li> <li>● Community leaders engaged in ambitious policy change agendas and community leaders in other parts of the country.</li> </ul>	2

IMPACTS: Deepened existing relationships with:	N=29
Residents/communities impacted by health inequities	25
Other government agencies	12
Elected officials and other decision-makers	15

IMPACTS: Other....
<ul style="list-style-type: none"> <li>● <i>Building on resident empowerment</i></li> <li>● <i>Enhanced relationships</i></li> <li>● <i>Expanded our understanding of the power of partnership with community organizers. Moving towards inclusion of these efforts in our departmental strategic plan. Being more strategic about partnerships that can impact policy.</i></li> <li>● <i>Transformed our organization culture to value partnerships with community organizers.</i></li> <li>● <i>Generated a discussion among leadership staff about what power building means, and what the work is like for community organizers.</i></li> <li>● <i>Health department has relationships with the community gatekeepers</i></li> <li>● <i>More effectively and rapidly responded to emergent community needs related to public health threats (e.g. people facing large-scale eviction in a low-income apartment community)</i></li> <li>● <i>Built trust in the community we serve</i></li> <li>● <i>Realized how unprepared we are to tackle social injustices at the root</i></li> <li>● <i>Done place-based organizing in low-income neighborhoods</i></li> <li>● <i>Successfully implemented large scale publicly funded projects (grocery stores and public basketball courts) to address racial and economic justice... and public health.</i></li> <li>● <i>Strengthened cross sector efforts at systems alignment and support for mutually reinforcing activities focused on SDoH and with more authentic resident engagement</i></li> <li>● <i>Reached residents that we don't typically get to our meetings and involve in our projects</i></li> <li>● <i>Expanded government access for organizers</i></li> <li>● <i>Been able to solve many political problems because we can select the best positioned person within our multisector partnership to carry a message to specific audiences</i></li> <li>● <i>Shifted the strategies of work to align with the needs and interests of community</i></li> </ul>

**IMPACTS: Top/most important impact that the collaboration(s) with community organizers had on health department**

*[Note- indented bullets indicate an answer from another staff member from the same health department]*

- *Build new relationship with communities/residents that we didn't previously have*
- *Allowed on the ground work*
- *Collaborating with community organizers has allowed for the Division to have the opportunity to build meaningful relationships with residents which has given residents power to engage with government staff and share their stories to make change.*
- *White residents inserting themselves as the messengers*
- *Recognizing that community organizers are a critical component to impacting policy change. Government may have power over resources, but community partners have the power of voice - and they can bring to light the issues and the real stories of impacted communities in a way that the health department may not be able to do.*
- *Brought community residents and organizations to the table that we don't interact with, but should.*
- *They can advocate more explicitly than we can internally.*
- *The partnership allows us to be involved in issues without overstepping our bounds as a government agency. The activities that we would be prohibited from doing can be taken on by the organizers, and we can leverage their work by supporting with data and information related to their priorities.*
- *We are more grounded and aware of priorities and realities in the communities that we serve.*
- *From my perspective, the most important impact to date that the collaborations with community organizers have had is the expanded knowledge, readiness, capacity and commitment for our Unit to broaden and deepen our engagement with current and new community organizers.*
  - *It has helped the health department begin to be effective at tackling structures of oppression as root causes of health inequities, rather than solely the still predominant focus on behaviors, medical care, and intermediary determinants.*
- *By deepening the relationships with community organizers we have increased our effort to build capacity and provide resources such as data, subject matter experts and convene partners to address community health concerns.*
  - *A different perspective, outreach with a different lens.*
- *Building relationships (1 on 1's) to work more authentically with external organizations*
  - *I believe it gives public health departments the nudge they need to be more intentional about working on health equity and what it takes to do so.*
- *Been held more accountable to action items regarding eliminating health inequities and injustices*
- *Right now, I feel the most important impact has been on developing stronger relationships with community organizers and residents most impacted by inequities. We still have lots of work to do translating this to support for specific campaigns and policy change that organizers are and have been pushing for*
  - *Community collaboration*
  - *It has brought more attention to health equity issues*
- *In all honesty, the collaborations with community organizers are forcing our department to internally assess the many ways we replicate harm as gatekeepers to the community that are endemic to public health practice and in our interpersonal relationships. These relationships have also amplified a need to address a spectrum of mis-aligned perspectives re: whether health equity work should be community-led versus agency-led. With recent budget cuts, decisions will have to be made re: the scope of the health department's responsibility toward & capacity to invest in the community. We have several*

*teams currently developing public health strategies that address social determinants of health, but only a few currently explore how to center community-led decisions and community voice, which we anticipate may change as these strategies become modeled and evaluated.*

- *innovation, creativity, meaning, depth*
- *We are now much more candid about the realities of power and the importance of narrative.*
- *Help us reach community residents Help back up data with compelling stories from residents*
  - *By working with community organizers, our department learned to engage in power analysis together with our partners. While this is by no means a widely adopted understanding or practice, it is an important shift and evolution of our department's work on SDOH -- moving beyond only establishing linkages between social determinants and health, to co-developing and implementing power building strategies to create systems changes.*
- *Identified new state health priorities - like institutional bias.*
- *It has helped to create urgency around our work. It has created a healthy tension for us to take positions on issues that matter and affect our constituents. It has pushed us to engage more with policies that affect our constituents. It has helped us to understand how we can be relevant to communities that are oppressed.*
- *Having a perspective that is grounded in the community.*
- *Connected work more deeply and authentically to community-developed narrative and systems change*
- *Developed relationships that allow us to work over years toward policy change, even though government staff have limits.*
- *Authentic understanding of health equity needs and partnerships to advance critical health equity strategies*
- *Reducing our blindspots, and reducing the issues where ""we don't know what we don't know""*
  - *Bringing community priorities into the institution*
- *Keeps a pulse on what's important to impacted communities and engages residents in a meaningful way in our work.*
- *Prioritizing our focus on health equity as our overarching mission, and how we frame and communicate about health equity*
- *Community driven initiatives, being able to reach more people and serve as a liaison between community and the health department.*
- *In the Environmental Justice Program, the most important impact is recognizing the community as the expert and the lead on setting priorities for the community and recognizing that we are a resource, not the subject matter expert.*

## Appendix F: Collaboration Types, Strategies + Examples

Health Department Collaborations with CPBOs: Types, Strategies and Examples		
Type	General Strategies for Collaboration	Specific Examples from Survey Participants
<b>Build relationships with organizers</b>	<ul style="list-style-type: none"> <li>• Schedule virtual or in-person coffee date + discuss an issue mobilizing around</li> <li>• Invest in intentional individual and organizational relationship building (e.g., 1-on-1's, regular meetings)</li> <li>• Co-facilitate trainings to health department staff, organizers' staff and members, and/or the public</li> </ul>	<ul style="list-style-type: none"> <li>• Regular meetings to shepherd progress on issues in the community</li> <li>• Regular meetings between coalition members and health department staff from across agency</li> <li>• Personal relationship goes back 15 years.</li> <li>• Co-organize education dinners</li> <li>• Do mutual consulting on different issues</li> </ul>
<b>Invite organizers to participate</b>	<ul style="list-style-type: none"> <li>• Invite into multi-sector dialogues or convenings organized by the health department (e.g., HiAP convenings, HIAs, film screenings, equity workgroups, etc that may include community and other govt agencies)</li> <li>• Invite into processes for health assessments and plans (e.g. CHA/CHIP) or Departmental strategic planning</li> </ul>	<ul style="list-style-type: none"> <li>• Invited organizers to participate on taskforce for secondhand smoke and tobacco retailer licensing</li> <li>• Convening an organizers roundtable to bring the executive directors of groups organizing across issues/geographic</li> <li>• Engaged low wage workers and non-English speakers in CHNA and CHIP</li> <li>• Helped ensure equitable community engagement and investment throughout the CHIP</li> <li>• Co-support CHIP action team to build social connectedness and neighborhood relationships</li> <li>• Participate in strategic alliance on health equity</li> </ul>

<p><b>Subcontract organizers</b></p>	<ul style="list-style-type: none"> <li>● Subcontract to provide translation/interpretation support at meetings and processes</li> <li>● Subcontract as a community engagement partner (e.g., support community outreach; promote “know your rights” campaigns and health services)</li> <li>● Subcontract to help advance policy/ systems/ environmental (PSE) work to change policies and practices (e.g., support community engagement in regional planning, TA to advance local solutions, systems change)</li> </ul>	<ul style="list-style-type: none"> <li>● Subcontract to provide training on engaging and including young adults in initiatives</li> <li>● Subcontracts with partner on initiatives related to transportation, nutrition, physical activity and community clinical linkages</li> <li>● Subcontracted to support tobacco policy program</li> <li>● Funded coalition to host conference on supporting immigrants and workshop on immigration and health</li> <li>● Provided short and long term funding to support CPBOs’ work</li> <li>● Helped develop health and wellness element of General Plan</li> <li>● Subcontracted for Community Transformation Grant work</li> <li>● Funded partner to advocate for equitable transit-oriented development and affordable housing in city planning process</li> <li>● Funding and co-designing anti-displacement strategies and skills strengthening</li> </ul>
<p><b>Provide data and research for issues organizers are working on</b></p>	<ul style="list-style-type: none"> <li>● Share research/data with organizers</li> <li>● Publish relevant data briefs or reports</li> <li>● Serve as technical advisor in coalitions convened by organizers to bring a health perspective</li> <li>● Provide guidance on how to do community-led research</li> </ul>	<ul style="list-style-type: none"> <li>● Compiled new data on county ordinance coverage of municipal workforces and template fact sheet</li> <li>● Collected sub-county level data to fill gaps needed for gender equity surveillance</li> <li>● Developed fact sheet summarizing public health arguments for Earned Sick Leave and Minimum Wage increases</li> <li>● Documented impact of increased immigration enforcement and anti-immigrant rhetoric on access to care and services</li> </ul>



<p><b>Provide media and/or public support for issues organizers are working on</b></p>	<ul style="list-style-type: none"> <li>● Provide public letter/testimony</li> <li>● Provide press/media support (e.g. write op-eds, do a press interview, participate in press conference, share press quotes, etc) in support of an issue that organizers are working on</li> <li>● Provide training or TA on health, data, framing, or other topics</li> </ul>	<ul style="list-style-type: none"> <li>● Developed outreach materials and communications for hospitals and health providers about health care access, benefits for undocumented people, and immigrant rights</li> <li>● Produced testimonies on importance of tenant protections, rent stabilization, and eviction and rent protections</li> <li>● Testified on health benefits of Sick Leave and Minimum Wage</li> <li>● Submitted a comment letter about health impacts of public charge</li> <li>● Provided media advocacy supporting tenant protection ordinances</li> <li>● Developed editorial/sign-on letter engaging health community</li> <li>● Supported statewide campaign and network to address preschool to prison pipeline and address crosscutting issues</li> </ul>
<p><b>Leverage government power and connections</b></p>	<ul style="list-style-type: none"> <li>● Introduce organizers to staff in other government agencies to support their work</li> <li>● Convene or participate in public forums or events relate to an issue that the organizers are working on</li> <li>● Strategize about how to advance health promoting work or leverage the health department's institutional power around an issue</li> </ul>	<ul style="list-style-type: none"> <li>● Supported visits with city officials</li> <li>● Participated in multi-sector meetings to support encouragement of community involvement in evaluation of local PH programs</li> <li>● Worked together to reform code enforcement</li> <li>● Worked together to pass sanctuary policy and legal defense fund for immigrants facing deportation</li> <li>● Pressure government and property owner to make tenant protections changes</li> <li>● Coordinated programming to build social connectivity between LGBTQ youth and seniors</li> <li>● Work with transit agencies to make bus shelters</li> <li>● Brought resources (eg food distribution, support group, etc) to neighborhoods in need</li> <li>● Fund structural improvements to basketball courts and youth organizing</li> </ul>

		<ul style="list-style-type: none"> <li>● Support information sharing about community events and know your rights as immigrants</li> <li>● Support housing affordability systems mapping project + passage of landlord registry and proactive inspections ordinance</li> <li>● Helped plan and roll out county insurance plan for uninsured county residents</li> <li>● Support census community outreach efforts</li> </ul>
<p><b>Co-create new activities, research, projects, resources</b></p>	<ul style="list-style-type: none"> <li>● Co-convene multi-sector dialogues, convenings, or processes (e.g., HiaP convenings, films, workgroups)</li> <li>● Co-design and implement projects to advance health equity</li> <li>● Co-conduct community based research</li> <li>● Submit grant applications for joint work</li> <li>● Work together to change the narrative around what creates health and equity</li> </ul>	<ul style="list-style-type: none"> <li>● Co-lead work group on health and housing</li> <li>● Collaboratively developed initiative and provide ongoing oversight</li> <li>● Co-created strategic alliance on transportation</li> <li>● Actively partner on immigrant integration</li> <li>● Co-produced research reports on foreclosure crisis and gentrification</li> <li>● Partnered on grants affecting our African American communities</li> <li>● Helped write grants to the EPA + partnered on health education, screening, workshops, training of trainers</li> <li>● Co-apply for funding to build youth leadership</li> </ul>

<p><b>Expand community engagement</b></p>	<ul style="list-style-type: none"> <li>• Work together to actively include communities impacted by inequities in decision-making processes</li> <li>• Support development of new groups/coalitions/networks to advance equity</li> <li>• Support leadership development and capacity building of impacted communities</li> </ul>	<ul style="list-style-type: none"> <li>• Make sure decisions are made through core team of residents and decisions not made on their behalf</li> <li>• Respect resident leadership and participation</li> <li>• Convene + expand participation in tenant meetings</li> <li>• Partnered to build more community involvement and awareness of LGBTQ health resources</li> <li>• Helped recruit and train over 35 residents through collaborative initiatives</li> <li>• Co-organize Resident Leadership Academy</li> <li>• Support coalition building of environmental justice groups</li> <li>• Co-created and co-participated in leadership program for leaders of color</li> <li>• Established new local chapter of Homes for All when housing emerged as priority from health department + community organizer collaborations</li> <li>• Build staff and resident capacity for deep canvassing in low income neighborhoods during pilot of municipal participatory budgeting project</li> </ul>
<p><b>Formalize collaborations and power-sharing</b></p>	<ul style="list-style-type: none"> <li>• Participate as Advisor/Board Member/Commissioner or other formal governing role to the other's organization</li> <li>• Develop an MOU or other formal agreement to establish how and why the two groups will collaborate</li> </ul>	<ul style="list-style-type: none"> <li>• Participate in County governance group</li> <li>• Participate as member of group's racial equity committee and a trainer of its Why Race Matters curriculum</li> <li>• Serve on HIV and Latinx Community Task Force</li> </ul>