Addressing Social Determinants of Health Through Community-Based Participatory Research: The East Side Village Health Worker Partnership

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The authors describe the use of a stress process model by the East Side Village Health Worker Partnership (ESVHWP), a project of the Detroit Community-Academic Urban Research Center, as a framework for understanding social determinants of health. Specifically, the authors describe the development by the ESVHWP Steering Committee of a context-specific stress process model for east side Detroit residents. The authors examine data from in-depth interviews to illuminate actions taken by community members to reduce stressors or minimize their impact on health. Finally, the authors describe the use of this context-specific stress process model and data gathered regarding actions to address community stressors to inform the development of interventions by the ESVHWP to reduce stressors or strengthen the conditioning factors that reduce the impact of stress on health. On the basis of these results, the authors discuss opportunities and challenges for partnership approaches to addressing social determinants of health in urban communities.

Differentials in morbidity and mortality on the basis of socioeconomic status have been firmly established by several decades of research carried out across countries, regions, and political economies. These socioeconomic disparities account for much of...
the disparities in health between identified racial or ethnic groups, although some differences remain even after controlling for socioeconomic status.8-10 Stress process models have been used to examine relationships between social status, exposure to acute or systematic stressors, access to resources, and health outcomes.11-13 Much of this research has focused on stressors experienced at the individual level, and population-based aggregates of individual-level data indicate that exposure to stressors is systematically related to social status, with groups of lower socioeconomic status both more likely to experience stressful life conditions and to be more negatively affected by these stressors than groups of higher status.2,13-16 These results suggest that social status may influence health through its effect on exposure to stressors and access to resources with which to respond to those stressors.

In this article, we intend to extend this body of research in two ways. First, we describe the use of a stress process model as a framework to understand social determinants of health on Detroit’s east side, linking stressors to the context within which they are experienced and describing strategies enacted by community residents to modify the impact of those stressors on health. Second, we describe the use of this context-specific stress process model to design interventions to address social determinants of health within this neighborhood. Throughout, we emphasize the use of a community-based participatory intervention research framework designed to bring together multiple perspectives and a range of resources to address public health concerns. Finally, we discuss opportunities and challenges for partnership approaches to addressing social determinants of health in urban communities.

BACKGROUND

The East Side Village Health Worker Partnership (ESVHWP) is a community-based participatory intervention research initiative that seeks to increase our understanding of the etiology of the social determinants of health and improve the health of women, children, and families on Detroit’s east side. The ESVHWP uses a lay health adviser intervention approach (see Eng and Parker17 for a review of the literature on lay health adviser models) to improve health status by reducing stressors and strengthening conditioning variables, such as social support.18,19 In the first funding period (1995-1999), the focus of the ESVHWP was on these social factors as they influence maternal health and infant mortality. In the second funding period (1999-2003), the focus shifted somewhat to a conceptualization of social determinants of health more broadly. Project participants include more than 40 Village Health Workers (VHWs) who live in or near the intervention area and a steering committee made up of representatives from community-based organizations (Butzel Family Center, East Side Parish Nurse Network, Friends of Parkside, Islandview Development Corporation, Kettering/Butzel Health Initiative, and the Warren/Conner Development Coalition), health service providers (Detroit Health Department, Henry Ford Health System), and academic institutions (the University of Michigan School of Public Health).

The structure and the process of ESVHWP are designed to identify stressors and to build on the areas’ resources to address social factors that influence health. Representatives from each of the partner organizations meet monthly as the ESVHWP Steering Committee, extending and strengthening networks between participating organizations and between the participating organizations and the VHWs. The partnership is guided by a set of “Community-Based Public Health Research Principles,” initially developed by
representatives from community-based organizations, academic institutions, and health care institutions to ensure that research conducted by ESVHWP addresses community concerns.19,20 These principles draw heavily on participatory action research efforts that are committed to the active participation and influence of community members in all major phases of the research and intervention, including identification of the research questions, research design, data collection, analysis and interpretation of the results, and design of interventions.21-29 The application of these principles in each stage of the process is intended to ensure that the research questions are relevant to the ESVHWP’s goals and that the results are appropriately integrated into partnership activities. The term Village Health Worker was selected and agreed on by community members participating in this lay health adviser intervention, making explicit links to the African diaspora and the African roots of many community residents.

VHWs are Detroit residents; 93% are women, and 97% are African American. Some VHWs were initially identified using the “reputational method” described in the literature.30,31 Community key informants considered these individuals to be lay helpers, community members who are trusted and respected by others, and to whom others turn for advice and assistance. Other VHWs were self-identified: Having heard about the partnership, they contacted staff members to become involved. Many VHWs have been involved in local organizing efforts in the past, and most are firmly embedded in social networks where they provide instrumental and emotional support to others. VHWs complete an 8-week training sequence that includes topics such as community problem solving and identification of resources within the community. Furthermore, VHWs meet as a group on a monthly basis with the project coordinator and members of the steering committee and work in smaller action groups to move forward on selected priorities. The project is based at the Detroit Health Department, with an office at the Butzel Family Center, one of the community-based partner organizations.

Context

The east side has been the gateway to Detroit for successive groups of immigrants, and many African Americans settled on the east side as they migrated to Detroit between the 1940s and the 1960s in search of jobs.32 Immediately following World War II, Detroit businesses began to move to outlying areas, followed by middle-class and White residents. Following heightened racial tensions in the 1960s, the movement of Whites to outlying areas increased: Between 1950 and 2000, the population of the city declined from nearly 2 million to less than 1 million.33,34 Redlining, bank-lending policies, and local mobilization and harassment by Whites35-37 contributed to the increasing segregation of African Americans in areas of the city that were hardest hit by economic divestment and the loss of employment opportunities.38 These processes shaped Detroit’s east side. For example, in 1990, 95% of residents of the ESVHWP intervention area were African American, and 37% of households in the area had incomes below the poverty line.39

Stress Process Models and Social Determinants of Health

The ESVHWP uses a stress process model as a framework with which to articulate social determinants of health on Detroit’s east side. Stress process models postulate that exposure to stressors in the social and physical environments influence health outcomes.1,12,40-42
and a substantial body of literature provides support for this hypothesis.\textsuperscript{13,43,44} Stressors may be acute life events; chronic strains such as economic impoverishment; daily hassles; or catastrophic life events such as floods, tornados, or wars.\textsuperscript{45}

Short-term responses to stressors may be physiological (e.g., elevated blood pressure), psychological (e.g., tenseness), or behavioral (e.g., alcohol use). Furthermore, patterns of responses, such as movement of middle-class residents out of communities in response to loss of employment opportunities, may serve to exacerbate the stressors experienced by those residents who remain. When perceived stress and short-term responses continue over time, they appear to increase the risk of enduring health outcomes, such as cardiovascular disease, diabetes, and anxiety disorders.\textsuperscript{46} A number of intervening factors (conditioning variables) may influence any of these processes directly or their relationship to each other. Intervening factors are categorized as social (e.g., social support, community control), psychological (e.g., coping, personal control), biophysical (e.g., age, health status), behavioral (e.g., exercise, diet), and genetic (e.g., family history of illness).\textsuperscript{11,12} As a result of the interplay between these factors, no objective stressor is likely to have the same effect on everyone exposed to it.

Much of the substantial body of research using stress process models has focused on individual stressors and individual responses. Exposure to stressful life experiences and access to resources with which to respond to those stressors have been linked to social status, that is, those with lower socioeconomic status appear to experience a greater number of stressors and to be more negatively affected by those stressors than are those who are more economically or educationally advantaged.\textsuperscript{2,15} In our work, we are interested in exploring the potential of a stress process model to connect what Link and Phelan\textsuperscript{47} have termed “fundamental” determinants of health to context-specific stressors and ultimately the health of individuals or groups within those contexts, with a particular focus on Detroit.

**METHOD: DEVELOPING A CONTEXT-SPECIFIC STRESS PROCESS MODEL**

In this section, we describe the multiple methods and the process used to develop a context-specific stress process model. This model was used to (1) address basic research questions regarding relationships between social conditions and health on Detroit’s east side, (2) design specific interventions to address stressors and strengthen conditioning variables, and (3) evaluate the work of the partnership. Methods included focused group discussions, in-depth interviews with community key informants, and in-depth interviews with VHWs.

**Focused Group Discussions**

In 1996, during the first 6 months of the ESVHWP, the steering committee engaged in a series of focused group discussions to identify stressors, responses, and potential moderating or mediating factors experienced by women in the intervention area. The focused group discussions were guided by a set of five statements or questions, beginning with “Women in this community experience stress when ______.” For each stressor participants identified, they were asked, “How do women feel when that (identified stressor) happens?” and “What do women do when they experience (that stressor)?” Next, having
generated stressors and emotional and behavioral responses to those stressors, participants were asked, “What are the long-term effects of experiencing those stressors/feeling that way/responding in that way?” Each of these questions corresponds to components of the stress process model: perceived stressors, responses to stress, and short- and long-term health outcomes.* Using this process, members of the steering committee identified 49 stressors experienced by women raising children on Detroit’s east side (e.g., worries about children’s safety, illegal dumping in neighborhoods, vacant housing).

Next, steering committee members were asked to identify “things that make it not so bad”—that is, when women experienced the stressors that they identified, what were the strategies they used or the resources they drew on to help reduce the impact of the stressors? Once again, steering committee members generated a substantial list of “things that make it not so bad” or protective factors (e.g., social support, the presence of role models). Figure 1 shows the resulting stress process model that captures specific stressors, protective factors, and outcomes experienced by women on Detroit’s east side.

The factors identified through this process were subsequently translated into specific questionnaire items incorporated into a random-sample survey of 700 women living on Detroit’s east side conducted in 1996.19 Data from this survey contributed to a community assessment that informed intervention priorities and provided baseline data for the evaluation of the partnership. Furthermore, data from this survey have been used to test the relationships between components of the stress process model generated by the steering committee.20,48-52

In-Depth Interviews

In 1997, in-depth interviews conducted with VHWs (n = 31) and with community and organizational key informants (n = 17) generated additional information about stressors, as well as the resources and actions taken by community members to promote and maintain health in their communities. The majority of interview participants were African American women, aged mid-20s to mid-80s, but interviews were also conducted with several men who lived, or who were representatives of community-based organizations, in the area. Participants were asked about stressors, behavioral and emotional responses to those stressors, long-term effects of experiencing those stressors, and “the things that make it not so bad”—factors that might intervene in the stress-health relationship.

Data Analysis

In-depth interviews and focus group discussions were analyzed using in vivo coding and a constant comparison method to construct code categories.53-55 Specifically, code categories were developed by clustering in vivo restatements from the focused group discussions and the in-depth interviews and by constantly comparing the restatements within and across categories to ensure that categories were internally consistent and distinct from other categories. Major stressors identified through this process are presented

* The steering committee was made up of representatives from community-based organizations and service providers, both men and women. They were asked to respond to the questions on the basis of their knowledge of the east side and their experience working with east-side residents, hence the wording of the questions (e.g., Women on the east side experience stress when . . . ). Subsequent in-depth interviews and group discussions with female residents framed the question in the first person (e.g., I experience stress when . . . ). The in-depth interviews and group discussions allowed refinement as well as comparison of these initial categories across different participant groups.
RESULTS 1: EXISTING COMMUNITY ACTIONS TO PROTECT AND MAINTAIN HEALTH

Participatory action research efforts and community partnership approaches, such as the one described here, are grounded in the recognition that all partners contribute understanding and resources that influence the effectiveness of the interventions developed and are committed to processes that facilitate those contributions. As the ESVHWP began establishing priorities for interventions, an agreed-upon priority was to understand and, where appropriate, build on or extend community members’ existing strategies to reduce stressors and to strengthen protective factors that might reduce the impact of those stressors on health. Below, we present results from the qualitative analysis of the in-depth interviews that illuminate such existing community strategies.

Influencing the Community

Community members used both formal and informal strategies to influence events and conditions within their communities. For example, in response to her concerns about elsewhere and are described only briefly here. Instead, we highlight results focusing on already existing strategies that community members used to address stressors and the application of those results to guide the ESVHWP’s intervention priorities. Names of all the participants have been changed to ensure anonymity.
youths playing in the street, Lora joined the advisory board of her local recreation center “to insist that they try to clean up the recreation center and persuade the parents to start taking the kids there.” Others noted that “you see neighbors influencing other neighbors.” For example, Jamal described the care with which he maintained his home, saying, “If something’s coming loose, coming apart, I make sure its fixed, make sure the exterior is in good order.” He considered these activities an important means of influencing other neighbors to take similar care with the upkeep of their homes: “All summer, I see painting and fixing and, of course, I’m going to want to do it too because I want mine to look just as good as theirs does.” These examples point to community members’ use of both formal (e.g., joining boards of community-based organizations) and informal (e.g., role modeling) mechanisms to address stressors linked to neighborhood conditions. The emphasis on physical maintenance of neighborhoods was considerable and was associated with concerns about the social environment.59-60

**Community Organizing**

Residents participated actively in community-organizing activities to reduce stressors in their communities. For example, in response to concerns about sale of alcohol and cigarettes to minors, Regina participated in a locally organized “Denounce the 40-Ounce” campaign “to see if they could find out if these stores are selling liquor and cigarettes to minors.” Others, like Lora, described a neighborhood store that “had rotten food” and organized “a few of the neighbors and we went to [the store owner]. That didn’t work. So he saw us in a hearing.” Direct contact with local merchants, community mobilization and, when necessary, legal actions were all strategies that community members used to address locally identified stressors. They described the important role of local community-based organizations, which have been termed “mediating organizations” in recognition of their essential contributions of organizing skills, continuity, and resources to support local organizing efforts.61,62

**Working With Police and Municipal Services**

Community members also worked actively with local police to address concerns about safety and lack of responsiveness on the part of the police. For example, Jerutha described the importance of going to “talk to your police commander in your precincts, to show him that you’re concerned about what’s going on in your community.” Others sought to address stressors associated with other municipal services, such as snow removal, streetlight maintenance, and enforcement of local dumping ordinances.51,63 Anita indicated that “I call [city officials] once a month” to get them to clean up dumped material in a vacant house in her neighborhood. Such efforts illustrate the readiness of community members to work with local officials to address local problems, as well as the considerable resourcefulness and skill they use in that process.

**Strengthening and Mobilizing Social Networks**

The social support offered through social networks was unfailingly identified as one of the “things that make it not so bad” as community residents discussed their lives and their health. “Having someone to talk to” and support from neighbors, relatives, friends, or members of their places of worship were consistently described as reducing the negative
impact of stressors. Ravena, for example, described taking meals to an elderly neighbor and “checking in on her if her car hasn’t moved in a few days.” Isis described building intergenerational networks, engaging neighborhood children in community activities, and noting that children now approach her to ask, “‘Do you have any fliers to pass out?’ They get on their bikes, and they will run around and put the fliers in the mailbox or on the cars.” Building, sustaining, and mobilizing local networks to provide social support and engage in community change activities are an important community resource for promoting and maintaining health.43,64

Engaging Religion and Spirituality

Community members also identified religion and spirituality as important strategies or resources used to reduce the impact of stressors on health. Examples ranged from prayer to specific examples of times and places that they had received instrumental or emotional support from church members. To illustrate the power of prayer, one community member said laughingly, but making a serious point, “My mother is the only one I ever knew who prayed herself out of having surgery,” whereas others described the support that they felt when members of their church prayed for them during times of illness or crisis. This finding is consistent with literature that describes the important role of the church and spirituality in health.65

RESULTS 2: BUILDING AND ACTING ON A SHARED VISION OF CHANGE

Understanding the ongoing actions that community residents take to address local stressors allowed the ESVHWP to build on those existing activities in designing specific interventions. The ESVHWP undertook several specific strategies and actions to develop priorities for their interventions, including dialogue and discussion by steering committee members and VHWs, to discuss results from the survey, in-depth interviews, and VHWs’ own experiences within their communities (see Schulz et al.66 for a more detailed description of this process). Action groups made up of VHWs and steering committee members were established for each of five selected priority areas—policing and safety, economic development, providing support for parents, health services, and cardiovascular disease and diabetes—to develop and implement intervention strategies. Below, we describe the ways that these efforts build on the existing strategies presented in the preceding section.

Addressing Safety by Working With Local Police Precincts

Concerns about safety were identified as important stressors in this community, in focus groups, in-depth interviews, and survey responses. Regression analyses testing the relationships between safety stressors and health outcomes indicate that these relationships are statistically significant.51 VHWs and steering committee members agreed that addressing concerns about safety and their connection to residents’ trust (or lack thereof) in the police would be one of the partnerships’ priorities.

The results described in the preceding section indicated that some community members were already working actively with local police, although they also noted that, based
on prior experience, their expectations regarding the effectiveness of such strategies were limited. The interviews also identified one potential strategy for addressing police and safety stressors—the community relations officers and community boards established within each of the police precincts to facilitate communication between community members and that police precinct. In some precincts, these boards have proactively engaged community members in working with local police to, for example, reduce vandalism and arson.67

The ESVHWP decided to invite the community relations officers from the three precincts that cover the partnership’s intervention area to join the ESVHWP steering committee. Although officers in two of the three precincts greeted those invitations with enthusiasm, only one followed up with attendance at steering committee meetings, and despite the efforts of ESVHWP staff members, that attendance was sporadic. VHWs and ESVHWP staff workers then attempted another strategy. VHWs and staff members participated actively in annual “Police Week” activities at the local precincts, offering blood pressure screenings to officers and community members and getting to know their local officers. VHWs also attend monthly community relations meetings, organized by the community relations officers, to improve communications between the officers and community residents. One VHW has been elected as a member of the Community Relations Board, a citizens’ board that works with the community relations officer at each precinct. ESVHWP staff members have also established connections with other citizen mobilization efforts working to address issues of safety and to strengthen relationships with local police. These efforts, which have enjoyed a range of successes and failures, suggest the importance of developing multiple strategies toward specified objectives, as well as perseverance and flexibility in working toward meeting those objectives.

Enhancing Economic Security

The dearth of employment opportunities available for east side residents contributes to economic vulnerability, a chronic stressor experienced by many residents. The importance of socioeconomic resources to health has been demonstrated in numerous studies in the United States and globally, as well as on Detroit’s east side.3,7,50,68 Recognizing the limited opportunities available for employment in the area, particularly for women with responsibility for young children, the Economic Development Action Group of the ESVHWP has focused to date on developing strategies to support micro enterprises to reduce financial stress. Specifically, members of this group have developed and conducted workshops for women to provide support for the development of micro enterprise activities, such as hair-braiding businesses, to reduce economic vulnerability.

Strengthening Social Support Networks

In addition to actions taken to directly address stressors in their communities, the ESVHWP is engaged in efforts to strengthen the conditioning variables in the stress process model, for example, to strengthen social support networks and to increase residents’ access to information or resources to protect and maintain their health. The Sister’s Roundtable Action Group has sponsored a number of “Pamper Me Nights” for women in the community. These evenings offer massages, manicures, pedicures, and information about breast cancer and other health issues in a supportive environment that encourages women to come together to talk and support each other. VHWs also use their churches as
forums for developing and strengthening social support networks, for example, organizing overnight sessions for women designed to strengthen social networks and to encourage reciprocal exchange of social support through those networks.

**Interventions to Reduce Diabetes**

At an annual weekend VHW retreat, VHWs identified diabetes as a priority health concern. Working together, the ESVHWP obtained a small grant that supported training for VHWs to expand their knowledge of diabetes, area resources, and strategies to reduce the risk of diabetes. The Healthy Eating and Exercising to reduce Diabetes (HEED) Project has incorporated social support and community change activities, for example, walking clubs for senior citizens (the “Wisdom Strut”) and minimarkets that offer fresh produce at reasonable prices (there are no major supermarkets in the intervention area). Space for this effort is provided by the Butzel Family Center, one of the partner organizations involved with the steering committee, and produce is provided at wholesale prices by LaGrasso Brothers Produce, a locally owned produce distributor.

**DISCUSSION AND IMPLICATIONS FOR PRACTICE**

Stress process models offer a framework for understanding relationships between social stressors, protective factors, and health. We have described an application of a general stress process framework to understand the complex and dynamic processes that link social factors to health outcomes on Detroit’s east side and to design interventions that build on that knowledge. Many aspects of the process described here are not dissimilar from other widely used public health strategic-planning methods, for example, Precede/Proceed. What is particular about this effort is the use of a community-based participatory intervention approach with its strong emphasis on active engagement of community members in defining the problem, in conjunction with the use of a stress process framework. This framework enables partners from a range of perspectives—in this case, academic researchers, health service providers, community residents, and community-based organizations—to examine proximate stressors experienced by members of the intervention community and their relationship to health. It also provides a framework for examining and highlighting the rich array of strategies, resources, skills, and determination used to maintain and sustain health within any given community. Those strategies became a starting point for interventions to address social conditions that produce health and disease. Finally, this stress process framework helps to link locally experienced (proximate) stressors to more fundamental social processes that produce those conditions.

The experience of the ESVHWP highlights a number of challenges associated with community-based participatory interventions to address social determinants of health. The broad scope of the problem and the multiple manifestations of social determinants at the local level, for example, inadequate police response, poor schools, gang activity, illegal dumping, and vacant and burned-out housing, require the selection of priority issues to address and, inevitably, negotiation and compromise. These are essential skills that are components of community capacity to create change, and the process of selecting priorities is both a challenge for partnerships and an opportunity to build those skills. Health
educators can play an important role in facilitating these processes and the development of skills that are part of community capacity.

A second challenge for community-based partnerships seeking to address social determinants of health is determination of points of intervention. The changes that are most meaningful for community members who experience the daily assaults of stressful life conditions (e.g., burned-out street lights, illegal dumping) may be those proximate determinants of stress and health. These community-identified priorities offer an opportunity for public health practitioners to work with communities to intervene in practical, immediate, and palpable ways. Other community members, as well as public health professionals from outside the community, may place higher priority on addressing more fundamental social or economic policies that underlie these local conditions. Although these different perspectives may potentially be a source of conflict or division within a partnership, they also offer an opportunity to recognize points of connection and synergy. For example, the literature on local mobilization and/or community organizing emphasizes the importance of local relevance and short-term success in building movements for change. As community members work together, they develop ties with other community members and skills that provide a foundation for effective collective action. In addition, by working and developing ties with, for example, local police precincts, residents begin to build political connections within the city, as well as knowledge of the systems that shape police responsiveness. These networks are essential components of community building and social action as strategies for community organizing and community change. Thus, local interventions may have tangible and immediate implications for the lives of residents at the same time that they build a foundation for addressing more fundamental factors.

A third challenge for community-based participatory partnerships working to address social determinants of health lies in evaluation of their efforts. Determining the appropriate level and foci of evaluation efforts can be a considerable undertaking. Evaluations must be tied appropriately to the intervention itself and consider questions of process and impact, as well as outcome. Process evaluations that capture the extent to which a partnership adheres to principles of participation and mutual influence and seeks and attains consensus are important indicators of the participatory nature of the partnership’s efforts and the extent to which the partnership successfully navigates the multiple interests and perspectives of the partners involved. Impact evaluations sensitive to intermediate indicators of change are key, particularly for interventions seeking to address social determinants of health where the outcomes may take some time to emerge. For example, indicators of aspects of collective empowerment, such as group process, critical analysis, and the ability to influence political and social processes, may be important indicators of the potential for policy change. In keeping with the participatory nature of interventions, both process and impact evaluation results can be fed back to participants on a regular basis and used to strengthen the work of the partnership. Outcome evaluations are essential to examine the extent to which the activities undertaken by the partnership are actually effective in achieving their ultimate goals, whether those are to achieve change in underlying economic conditions or to improve health.

Although not the focus of this article, and therefore not described in detail, the ESVHWAP uses multiple methods to evaluate our process as well as the impact and outcomes related to the efforts described in the preceding pages. Annual questionnaires completed by VHWs and members of the steering committee assess key indicators of process and their impact on relationships, for example, the extent to which adherence to community-based participatory principles is related to the development of trust among members.
of the partnership. Feedback forms completed by community members who attend community events are an important aspect of the evaluation and are used to assess and improve future activities. Pre- and posttest assessments of knowledge levels have enabled the partnership to assess the impact of the HEED training. In-depth interviews conducted with VHWs and with members of the steering committee at 3-year intervals are a component of the process and the impact evaluation. All of these—process questionnaires, feedback forms, pre- and posttraining knowledge assessments, and in-depth interviews—are used in the formative evaluation of the partnership. In other words, results are presented to the steering committee and the VHWs and are used to discuss strengths and challenges, as well as to determine appropriate actions to strengthen the work of the partnership.

Finally, a random-sample community survey conducted in the 1st and 6th year of the partnership’s efforts is an essential aspect of the evaluation. This survey, conducted in the 1st year, provided data that were used to determine the partnership’s priorities. That same information will serve as baseline data and will be compared with data from the second wave of the survey to assess changes in key indicators during the life of the partnership. Evaluations of community-based participatory efforts to address social determinants of health should examine carefully the scale of the intervention and tailor the evaluation to the scope of change that might reasonably be expected, given resources and the timeline in which the project is carried out. The multiple aspects of evaluation (process, impact, outcome), combined with the emergent nature of the development of priorities and interventions described in the preceding pages, contribute to the challenges as well as the opportunities for evaluators working with such partnerships.

CONCLUDING COMMENTS

Community-based participatory public health partnerships that attempt to address social determinants of health must make explicit the connections between community or neighborhood stressors and broad political and economic processes that have drawn capital out of urban areas and at the same time recognize and honor the priorities of community residents engaged in the partnership. Community residents may choose to focus their energies on the specific stressors that they confront in their neighborhoods, which have immediate implications for their lives and health. In doing so, they build network ties, skills, and resources that are essential components of mobilization for change.

The social conditions that shape health within local contexts do not arise within those communities in isolation from broader social processes, and those broader processes may be difficult for local communities alone to affect—indeed, if the considerable capacities and resources within communities were sufficient to address those broad social processes, it is likely that they would have done so long ago. Thus, the strength, as well as the challenge of participatory community-based partnership approaches to improve health, lies in efforts to bring together those with resources that extend beyond the community with those whose resources are deeply embedded within the community to identify common priorities and to develop effective strategies for change. As described here, the application of a context-specific stress process model using multiple sources and data collection methods is a viable strategy for identifying such priorities and interventions. Effective partnerships recognize and value the different lived experiences, perspectives, skills, and priorities that partners bring to the table and are committed to the identification of common goals around which to mobilize those diverse resources.
References


