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What is This?
Improving policy and practice to promote equity and social justice – a qualitative comparative analysis building on key learnings from a twinning exchange between England and the US

Claire Blanchard1, Ginder Narle2, Martin Gibbs3, Charmaine Ruddock4, Michael Grady5, Chris Brookes6, Trevor Hopkins7 and Jayne Norwood7

Abstract: Community health promotion interventions, targeted at marginalised populations and focusing on addressing the social determinants of health (SDH) to reduce health inequalities and addressing the processes of exclusion, are an important strategy to prevent and control non-communicable diseases (NCDs) and promote the health of underprivileged and under-resourced groups. This article builds on key lessons learnt from a learning exchange between Communities for Health in England and the Racial and Ethnic Approaches to Community Health across the US (REACH US) communities that are tackling health inequities. It presents a qualitative analysis further capturing information about specific community interventions involved in the exchange and identifying lessons learnt. This exchange was led by a partnership between the US Centers for Disease Control and Prevention, the International Union for Health Promotion and Education, the Department of Health of England, Health Action Partnership International, and Learning for Public Health West Midlands. These efforts provide interesting insights for further research, priority areas of action for policy and practice to address the SDH and to promote and sustain equity and social justice globally. The article highlights some key lessons about the use of data, assets-based community interventions and the importance of good leadership in times of crisis and adversity. Whilst complex and time-consuming to arrange, such programmes have the potential to offer other countries including the global south new insights and perspectives that will in turn contribute to the SDH field and provide concrete strategies and actions that effectively reduce inequities and promote the health of our societies. The key learnings have the potential to contribute to the global community and growing documentation on evidence of effective efforts in the reduction of health inequities. (Global Health Promotion, 2013; 20 Supp. 4: 45–56).

Keywords: inequalities, non-communicable diseases, communities, health promotion

Achieving health equity is a major challenge facing the United States, and racial and ethnic communities will continue to play a vital role by creating, implementing and evaluating stronger policy, systems and environmental change strategies. ... The causes of health

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disparities are multifactorial, and the interventions designed to eliminate them will require multisectoral collaborations that employ these diverse strategies. REACH communities have been committed to this collaborative approach. (1)

Introduction

Multi-sectoral and multi-disciplinary approaches are the cornerstone for collaborative efforts to address non-communicable diseases (NCDs) (2). Community health promotion interventions, targeted at marginalised populations and focusing on addressing the social determinants of health (SDH) to reduce health inequalities and addressing the processes of exclusion, are an important strategy to prevent and control NCDs and promote the health of the high-need, underserved and under-resourced groups. Since the Ottawa Charter (3), increasing visibility has been afforded to the SDH and health inequalities with influential international reports leading the way in recent years (4–8). While there is extensive documentation on the nature of health inequalities and growing yet limited documentation on 'what works' to reduce them, there is an essential need to share and develop a better understanding of strategies for actions that can effectively address the SDH and social injustice.

Background

It was in this context, that, in 2008, a partnership between the US Centers for Disease Control and Prevention (CDC), the International Union for Health Promotion and Education (IUHPE), the Department of Health of England (DH), Health Action Partnership International (HAPI), and more recently Learning for Public Health West Midlands (LPH WM), agreed to embark on a learning exchange between Communities for Health (C4H) in England and the Racial and Ethnic Approaches to Community Health across the US (REACH US) communities that are tackling health inequities.ii

The learning exchange initiative was developed to:

• provide an opportunity for community practitioners to learn from the experiences of other similar communities;

• explore and share knowledge, skills and tools in addressing the social determinants of health;

• summarise key aspects of what works and doesn’t work in reducing disparities and inequities; and

• disseminate findings that help inform global practice and improve initiatives that promote health, well-being and equity in populations globally.

The exchange comprised a series of site visits in both countries, debrief meetings to extract lessons learnt from the visits, and a conference to enable broader dissemination of efforts in June 2012. The exchange resulted in the identification of key common themes, along with insight into the fundamentals of the efforts to address health disparities in each country and within the respective communities visited, detailed in Blanchard et al. (9) and in Table 1. Some of the key drivers identified included:

• political context – a driver and determinant;

• community engagement and its impact on sustainability;

• information intelligence (data collection, availability and use);

• collaborative work (working in partnerships);

• time – a factor for change;

• funding and corresponding driving paradigm;

• health – a holistic approach to health and well-being as opposed to disease;

• putting a focus on community assets to build effective interventions; and

• the key role of leadership and the need for building capacity for sustained leadership in communities.

The learning exchange visits and debrief exercises revealed some inspiring lessons and marked the beginning of a broader effort.

Objective

The twinning exchange informed a qualitative comparative analysis, conducted to capture more in-depth information on lessons learnt, drivers, factors for success and strategies that work, and to make recommendations for policy and practice at the local, national and global levels. This article
Table 1. Key themes, lessons learnt and drivers highlighted as a result of the learning exchange site visits and debrief meetings.

<table>
<thead>
<tr>
<th>Key themes, lessons learnt and drivers highlighted as a result of the learning exchange site visits and debrief meetings</th>
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<tbody>
<tr>
<td><strong>Political context – a driver and determinant</strong></td>
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<tr>
<td>• The political context was mentioned as an important driver for community intervention efforts and in many situations, though not all, a determinant of success</td>
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<tr>
<td><strong>Community engagement and its impact on sustainability</strong></td>
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<tr>
<td>• Dedication – an ingredient of community engagement and success factor</td>
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<tr>
<td>• True participation at all levels leading to a sense of and shared ownership – a determinant for sustainability</td>
</tr>
<tr>
<td>• Advocacy and activism – a key part of successful change → it was highlighted this was not very present in the English context and was felt that, though dependent on a number of cultural issues, could be strengthened through capacity building efforts for advocacya</td>
</tr>
<tr>
<td>• Passion / Fun – essential for sustained efforts</td>
</tr>
<tr>
<td>• Building a sense of community – importance of strengthening / having a strong social capital, mental well-being, and feeling of connectedness</td>
</tr>
<tr>
<td><strong>The key role of leadership</strong></td>
</tr>
<tr>
<td>• Leadership &amp; dedication – the key role of leadership, the specific leadership skills and characteristics including empowering skills as demonstrated by the women leaders and the need to build capacity for sustained leadership in communities was also an important point raised</td>
</tr>
<tr>
<td>• Political leadership &amp; an inclusive process – importance of engaging various members of the community (including politicians who themselves are part of the community) – every group, everyone should be considered as a link in the community chain and essential for community cohesion. This is an important factor for successful and sustainable interventions, as decisions made about resource and interventions relating to health care will impact on all individuals living within the community. An inclusive process will create community harmony, buy-in and avoid alienation</td>
</tr>
<tr>
<td><strong>Collaborative work (working in partnerships)</strong></td>
</tr>
<tr>
<td>• Partnerships were deemed essential for sustainability and the current global economic crisis reinforces the importance of such partnerships</td>
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<tr>
<td>• A shared vision of partnership and partnerships that focus on well-being, outcomes and assets are essential</td>
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<tr>
<td>• Innovative partnerships that are creative about making the best of often limited resources and working together towards common outcomes</td>
</tr>
<tr>
<td>• Thinking outside the box – promoting unconventional partnerships (with fire services, football clubs, economic departments, debt management services, housing associations, etc…) and capitalising on co-benefits</td>
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(Continued)
builds on key lessons learnt from the learning exchange and presents the results of the qualitative analysis.

Methodology

The qualitative comparative analysis was conducted in four stages:

1. The planning team devised a questionnaire (10) for organisations / participating projects within REACH US and C4H communities to provide information to highlight some key factors in their projects, including the historical context and their organisational journeys. The questionnaire was constructed around themes (which had emerged from the exchange visits) to

Table 1. (Continued)

**Key themes, lessons learnt and drivers highlighted as a result of the learning exchange site visits and debrief meetings**

| Information intelligence (data collection, availability and use) | • Importance of having ‘hard’ and ‘soft’ data  
| • Importance of building a robust and wide range of evidence  
| • Need to change the culture of what is perceived as reliable data and good evidence and building new measures for sustainable surveillance systems that are able to monitor distribution of SDH and identify inequities  
| • Data-driven decision making vs. practice driven – what are some of the recommendations that can be extracted from the practical experiences to influence policy and decision makers?  
| • Having the right data and using it appropriately  
| • Data to inform work (adapted to context)  
| • Data for accountability and setting priorities  
| • Data collection and data sharing can be an important tool in the community engagement process  
| • Strength and power through data – the importance of having data on the communities you serve available; if this data is not available, the communities and their needs are invisible  
| Time (a factor for change) | • Time was highlighted as an important contributing factor to be taken into account in programmes and expected outcomes (change takes time and cannot be dependent on political cycles)  
| Power distribution | • Addressing the inequitable power distribution needs to start within the health sector with widespread truly participatory approaches  
| Community | • The definition of a community (geographical, ethnic, socio-economic, affinities, identity) facilitates intervention design, outcomes and potential success  
| Economic argument | • It was felt important to integrate cost-benefit and to provide a return on investment (or value for money) into community interventions as the economic argument is powerful in leveraging support  
| A question of paradigm | • All community interventions that took part in the exchange adopted a holistic approach to health and well-being as opposed to focusing on disease, with most having an asset-based perspective  
|  | • Celebrating successes – a vital part of continued engagement. The importance of feeling valued and having a key role and meaning was also highlighted as a driver for engagement and continued efforts  

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2 Advocacy or lobbying or attempts to influence, directly or indirectly, specific pieces of pending or proposed legislation at the federal, state, or local levels is not an allowable activity for projects funded with US federal dollars. CDC does however support community efforts to educate or inform decision makers.

IUHPE – Global Health Promotion Vol. 20, Supp. 4 2013
draw out further information on these key themes, lessons learnt and drivers.

2. After completion of all site visits, questionnaires were sent to the REACH US communities and the Communities for Health projects in England (a list of organisations that took part is available in the complete report (10)) for completion on a voluntary basis. Sixteen completed questionnaires and one short report were received by the deadline. Two US and two English projects also submitted detailed reports and background information that, while providing contextual information, were not used in conducting the qualitative analysis and preparing this report.

3. A qualitative, thematic analysis of the responses received from the 16 projects was conducted to identify key themes, lessons learnt and strategies that worked at both practical and strategic levels.

4. A summary of the analysis and main findings was used to develop conclusions and key learning points to inform policy and practice ‘grounded’ in the data collected in the responses to the questionnaires. Analytical findings and insights were compiled in a draft report, circulated to all participants for comment and review in order to ‘triangulate’ the results and ensure the final report (10) was an accurate reflection and true representation of their inputs.

Results

A summary of the responses to the questionnaire received from 16 organisations / initiatives is provided in Table 2.

Varying approaches to funding systems

There are a number of similarities between the US and England. In both countries the exchange organisations receive some public funding. In England this funding was a mix of NHS/LA (National Health Service/Local Authorities) funds through grants or contracts. In the US funding came through a combination of state grants, private finance and (in some cases) revenue generation via trading activity such as pharmacy sales.

Principles and framework

All the responses conveyed a sense of organisations having strong guiding principles, a clear model/framework for community work, a commitment to understand and be led by the community; and above all valuing the individuals and communities they are supporting. Values of social justice and human rights form the bedrock of their action to address health inequities.

Roles of politics and power structures

The view that community development has a strong political dimension seems to be more openly acknowledged and utilised in the US. However, with a few exceptions, there is little opposition or effective challenge to the medical model or current clinical practice in either country’s responses to the questionnaire. We suggest that this dominant model and practice may be protected by political, professional and structural power. This power imbalance is highlighted in the WHO Commission Report (2008) (5) and the recent WHO European Review (8). Both show the ‘causes of the causes’ of health inequities lie in the conditions in which people are born, live, grow, work and age. Inequalities in access to and balance of power, money and resources give rise to these conditions and deny political voice and influence.

Health care systems as defining factors driving inequities in health

All the projects in this study are facing challenges arising from race and health inequalities but the implications and responses differ by country. In England the issue appears to be that services exist but some individuals and communities are excluded and marginalised, and as a consequence find it hard to access them.

In the US, there is inadequate provision for those who experience socio-economic disparities, despite Medicaid (a publicly financed health insurance for individuals who are below a certain federal poverty level) and not-for-profit health centres that receive special federal government funding to provide health care to those not qualified for Medicaid and without employer-sponsored health insurance or private health insurance. This is a key driver of health inequity, with evidence of a correlation...
Table 2. Summary of the qualitative comparative analysis of the responses to the questionnaire received from 16 organisations / initiatives.\textsuperscript{vi}

<table>
<thead>
<tr>
<th>Questions (extract from questionnaire)</th>
<th>Summary of responses received</th>
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| 1. What is the role and function of your organisation including funding? | • Organisational types were very varied, from English respondents, ranging from grassroots community organisations to statutory services although in many cases the project activities were supported by either the NHS or a local authority (LA). Funding was also a mix of NHS/LA finance through grants or contracts.  
  • Responses from US projects reported the organisations were all community or social enterprises. Some were supported by academic institutions. Many were larger in size and scope than in England. Funding came through a combination of state grants, private finance and (in some cases) revenue generation via trading activity. |
| 2. When was the organisation established and why? | • The organisations in both countries ranged in age from over 100 years to just 1 year old.  
  • The reasons for being established were more varied in England than in the US, but all were addressing health inequalities and social determinants of health.  
  • In the US the organisations were in the mainstream delivering primary health/social care services to poor minority communities that were not adequately served by the private health insurance or social services systems. |
| 3. What has changed over the years? | • Across both countries all organisations reported similar changes.  
  • Some projects reported successful performance and outcomes.  
  • Others noted that their work remained stable although activities varied as the community and external environment changed.  
  • A clear outcome for many was that they had developed a better understanding of the community they served, and this often led to improved practices.  
  • The organisations universally stated that health inequalities had become worse over time. |
| 4. What would you consider was most helpful to your organisation? | • There was consensus across the organisations that successful partnerships and collaborations were the most helpful factor in achieving outcomes.  
  • This included good community relationships, ranging from good engagement processes to co-production of community services.  
  • Other important factors noted were; leadership, organisational and staff commitment and secure funding. |
| 5. What was considered to be unhelpful? | • The lack of funding or sustainable funding was most frequently cited as being most unhelpful.  
  • A linked issue was that the benefits of community engagement and development work were not well understood and were not valued (in policy making).  
  • Community approaches were marginalised by the dominance of the medical model, academic research and clinical practice. |
Questions (extract from questionnaire)  Summary of responses received

6. What have been the key drivers for success?  • The majority of the projects stated that strong, effective relationships with communities were a key factor.

   • Successful engagement relied on the ability to provide culturally appropriate support and to acknowledge that communities were not just deficit ridden but also had many assets.

   • In addition in many of the responses success is described as the organisation’s ability to stay true to community engagement or development principles and practice (often in the context of difficult power relationships).

7. Identify one major challenge and how was this overcome?  • Understandably, responses to this question were varied, although the lack of sustainable funding was universally cited as an enduring challenge.

   • While in England the new commissioning arrangements were seen as a potential opportunity, in contrast a number of US responses were anxious about further outsourcing of services to larger organisations.

   • Some interesting solutions were suggested, which included a variety of enterprise models and methods for generating capital resources.

        e.g. ‘We need to increase private funding and establish an endowment’ – US community.

   • In addition there was a significant appetite to challenge the dominant models of service delivery and champion the community-led approach.

8. Can you share your vision, potential challenges and opportunities?  • Future visions included influencing policy at strategic level and making better use of resources through collaboration and partnership working.

   • In England there were specific references to using more community assets in the future and local commissioning.

   • Interestingly, insecure funding was the dominant feature in responses on challenges from both English and US organisations. However, all organisations stated they would find ways to survive.

9. Is there anything else you want to tell us?  This question yielded some of the most powerful comments in the questionnaire responses as, without exception, they conveyed the values and principles of the organisations’ commitment to their approach to working with communities in the most appropriate and beneficial ways.

10. General observations  • We observed that all of the projects state either explicitly or by implication that their work is intertwined with power structures.

    • Power imbalances influence both the need for their services in the communities they serve as well as their status, value and position as organisations in the public health and social care system.

    • Despite the differences between English and US organisations in terms of their size, type and role, all attribute some of the challenges they and their communities face to the unequal distribution of power and influence over decisions in relation to public health policies and distribution of resources.
between levels of spending on social and health care and levels of all-cause mortality (11).

**Different perspectives (race and ethnicity vs. socio-economic status) — a common goal**

There is a further difference in that US projects were much more explicit in identifying race as a key factor. While the C4H Programme was not targeted at black and minority ethnic populations, the majority of the English projects were working with minority ethnic communities and other excluded groups. Despite this they placed less emphasis on race as a primary factor in health inequalities. In the US race is discussed as one of many issues including disadvantage of gender, sexual orientation, disability, age, religion and belief which are interwoven and overlaid on social status and also linked to gaps in service provision or perceptions about and appropriateness of services.

In addition, the policy recommendations of the English Review of Health Inequalities (7) has influenced the context. The six key policy objectives of that review to address health inequalities in England were:

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure healthy standards of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill-health prevention.

The report highlighted the social gradient in health, identifying that the lower a person’s social position the worse his or her health is. This provides a broad context for action and has been broadly adopted by the Government in England. These key drivers are implicit in many of the projects as a holistic response to addressing the SDH rather than focusing on illness.

**Funding — a major barrier to project implementation and achieving project objectives**

The majority of responses reported a lack of funding as the greatest barrier impacting the community interventions. This fell into several areas: funding cuts, short-term funding, funding criteria, inflexible funding and bureaucratic funding regimes. The major lesson learnt from community experiences is that continuity of funding is a prerequisite for sustainable change in community work but that it is frequently not addressed (12).

**Marginalisation of community interventions focused at addressing the SDH in marginalised / deprived pockets of the population**

If we consider the funding issues alongside other insights gained from the analysis we conclude that community development, its associated methods and the organisations/services that adopt this way of working, remain marginalised within mainstream health and social care systems in both countries.

Despite awareness that health inequity is driven by unequal access to power, opportunities, resources, political influence and voice (all of which deny the basic human right to a healthy life), these issues are not being addressed in high-level policy or commissioning structures. Addressing the processes of exclusion is a critical element in addressing health inequity (7).

**Understanding complexity — a must for addressing SDH and reducing social injustice**

Frequently projects reported understanding more about the complexity of communities they worked with and how this links to environmental/social conditions and their relationship with health inequalities. The knowledge produced was in some cases used to change the practice of health professionals.

**Discussion**

The learning exchange visits highlighted some major differences in defining the way the community interventions were shaped, developed, implemented and sustained. These included funding mechanisms (commissioning in England vs. meeting a community need/filling a gap in the service and raising funds to provide a service in the US) and varying health care systems (the English NHS as a safety net vs. the
private payer health insurance system in the US). However, experiences clearly showed that neither system was perfect and that there was a need to inform improved practice through exchanging experiences and strategies that work whilst adapting them to the specific contexts in which they are to be implemented for successful transfer/translation.

These efforts also identified commonalities between community interventions from both countries, such as the embracing of a holistic paradigm addressing health and well-being beyond physical health and disease; the clear need to have interventions adapted to the context, whether political, cultural, social or environmental; and the importance of creativity in partnerships, often unconventional, to capitalise on existing and limited resources (human, financial or other types).

Key characteristics/ingredients for successful community interventions were identified and brought to light, such as action-oriented efforts driven by the communities themselves, acknowledging the history, through negotiated collaborations and engagement of multiple stakeholders (community, political, and policy decision makers); essential carrying out and reporting on evaluation of efforts to inform improved practice; and capitalising on very important learning exchange opportunities locally, regionally, nationally and globally.

The analysis also highlighted that evaluation of community development programmes needs to factor in the impact of the context and how this interacts with the programme’s methodology to generate outcomes. There is a need to use participatory methods and approach evaluation as ‘reflective practice’ (13).

Further thinking is needed on one of the key challenges identified in nearly all of the responses – the question of how to fund organisations using the approaches developed by all the projects in the exchange. To develop a basis for commissioning that supports community development and community building, it is important to not only look at how activities are commissioned but also that activities are funded (14) with the aim of empowering individuals and communities to take control over their own health and lives, thereby creating opportunities for them to flourish. This requires greater levels of social well-being and social cohesion within communities so as to create the conditions within which individual citizens can thrive (7).

As public health transfers into top-tier local authorities in England we have an ideal opportunity to encourage a debate amongst elected decision makers on the politics of health inequalities, and of promoting a human rights approach across the social gradient and across the life course. The expected end result is one in which strategies and policies based on the assets and strengths of empowered individuals and local communities are deployed (7). Similar opportunities could be sought in the US as President Obama’s health care reforms are put in place.

It would be useful to examine relationships of power that are implicit within and between organisations, citizens, communities and political leaders. Understanding these power dynamics may enable the development of interventions addressing power imbalance – a major social determinant of health and contributor to health inequity. Expanding the examination of power dynamics in both countries to also include that between countries will, undoubtedly, not only add insights into some of the efforts described in this report, but may influence policies and practices globally for greater equity between high, middle and low-income countries.

Further investigation into the organisational culture of entities that carry out this kind of work would also be pertinent. Is there an empowerment culture in the organisation that matches the community empowerment that they seek to deliver? In this context, an organisational culture that fosters empowerment is defined as one with dispersed leadership and good working conditions which foster control and reduce stress. Is the organisation’s driving paradigm a success factor or barrier to sustainability? Is a paradigm shift centred on community assets as opposed to being driven by funding necessary for successful and sustainable efforts?

Finally, a point that was touched upon but needs further exploration is the impact of gender as well as leadership characteristics and traits. One of the observations reported by English visitors to the USA was that most community interventions were led by women. This raises some questions. Does community development work attract a certain kind of person who has already developed empowering skills? Does a gender difference exist with women demonstrating greater transformational focus than men (15), and
are women more nurturing as a consequence of different patterns of socialisation and thus more likely to choose these more nurturing career paths than men (16)? The teams concluded further research is required to confirm some of the reasons why this may be the case.

Insights from the learning exchange to inform future policy and practice

Based on these findings and learnings from the US/English exchange, the following recommendations for priority actions in policy and practice that effectively promote health and equity and reduced inequities are suggested:

1. **Develop a well-equipped workforce as a priority**
   a. An integrated approach to the wider public health workforce development is required, to promote networking and sharing of information, develop partnerships, collaboration and better use of resources.
   b. Raise awareness about the advantages of sharing data, analysing and interpreting to enhance and target interventions and enable cost-effective and efficient delivery, avoiding duplication.

2. **Build leadership capacity across the multidisciplinary sector, to support and empower communities and influence local and national leaders, promoting the work being delivered at the frontline and building on success through sustainability of programmes and interventions**

3. **Develop improved and broader surveillance systems**
   a. Surveillance systems that capture measures of SDH and health inequities and generate sound data widely accessible to all.
   b. A broadened surveillance to cover economic, trade, education, housing, and other social and environmental factors.

4. **Promote ‘creative’/‘flexible’ partnerships for ‘win–win’/co-benefit approach and best investment from limited resources – going beyond the health sector and encouraging multi-sectoral and multi-disciplinary practice**

5. **Increase investments in asset-based approaches**

These recommendations need to be considered within the cultural, political, social and environmental context from which they arose and may therefore not be relevant to all settings, though some parts could be considered for adaptation in other countries and globally.

Conclusion and perspectives for the future

These efforts provide interesting insights for further research and recommendations of priority areas of action for policy and practice to address the SDH and promote equity globally. It is evident that the two countries differ in the way the health care systems have been set up and how this affects issues relating to accessibility and funding. This therefore impacts on the way communities develop local initiatives to either enhance the care available from the health care sector or fill the gaps where services are not available. Whilst neither system is perfect, there is evidently learning from both sides in terms of strengthening core services, sustaining and expanding what works well, supporting localism and empowering leaders to advocate for services for their communities. Some of the barriers and challenges highlighted by the exchange participants were in accessing funding, lack of data sharing and building capacity and leadership. These are not uncommon in other parts of the world, and are often issues that are high on the agenda of most politicians and leaders, leading to some passionate exchanges as views and opinions vary.

It may be impossible to eradicate the social injustice and inequity in many parts of the world; we recognise that the USA and England have made considerable leaps towards acknowledging the needs of communities and in response have established mechanisms to improve the health and well-being of individuals. The findings of the exchange highlight that there is a need for further work from politicians and leaders to grasp the significance of a healthy population and how investment prevention can be cost effective, improve
quality of life, productivity and save investment into long-term critical-care interventions.

We need to harness and replicate some of the positive interventions and develop programmes to promote the good practice and leadership behaviours displayed by community champions. These assets need to be developed further and sustained, strengthening communities and empowering young citizens of the future. Whilst funding and structures are important in maintaining health and social care, there needs to be an understanding about the important role partnership, social cohesion, environmental factors and cultural beliefs play in the whole-systems approach. There needs to be a different approach to commissioning, whereby commissioning supports community development and community building, empowering individuals and communities to take control over their own health and lives, thereby creating opportunities for them to flourish.

Expanding such learning exchanges to other countries, including the global South, will provide new insights and perspectives that will in turn contribute to the SDH field and provide concrete strategies and actions that effectively reduce inequities and promote the health of our societies. In fact, community experiences in countries such as Argentina, Brazil, or Mexico, where a decrease in inequalities was recently reported (17), could provide invaluable information to strengthen initial findings from the presently described efforts.

We hope these key learnings will contribute to the global community and growing documentation on evidence of effective efforts in the reduction of health inequities.

Acknowledgements
Thanks to all the communities, their dedication and engagement over the years that made this learning exchange such an enriching effort.

Thanks to all the partners (US Centers for Disease Control and Prevention (CDC), the International Union for Health Promotion and Education (IUHPE), the Department of Health of England (DH), Health Action Partnership International (HAPI), Learning for Public Health (LPH), the Health Inequalities Unit at University College London, the US REACH community programme and the C4H programme) that have remained engaged and dedicated throughout the whole process of this learning exchange in sometimes challenging political and economic contexts and understood the importance of change happening over time.

Funding
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Notes
i More information about the Communities for health programme can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107093
ii More information about the US REACH programme can be found at http://www.cdc.gov/reach/communities/index.htm
iii Advocacy or lobbying or attempts to influence, directly or indirectly, specific pieces of pending or proposed legislation at the federal, state, or local levels is not an allowable activity for projects funded with US federal dollars. CDC does however support community efforts to educate or inform decision makers.
iv ‘Thematic analysis’ is the most common form of qualitative research analysis. It emphasises pinpointing, examining, and recording patterns (or ‘themes’) within data.
v The analysis was conducted by a key expert from Asset Based Consulting with extensive experience of working in local government on partnership approaches towards improving health and well-being and challenging health inequalities, an interest in the relationship between connected, cohesive communities and the development of resilience and improved health outcomes from an asset-based perspective.
vi In the social sciences, ‘triangulation’ is often used to indicate that more than two methods are used in a study with a view to double (or triple) checking results. This is also called ‘cross examination’.
viii At the time the article was written the idea of the social network was being explored by IUHPE and LPHWM with the aim of getting buy-in from all partners to support the development, coordination and maintenance of the, at the time of the article, informal network.

References


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