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Cite this article as:
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Health Affairs, 33, no.11 (2014):1905-1913

doi: 10.1377/hlthaff.2014.0652

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A Health-In-All-Policies Approach Addresses Many Of Richmond, California's Place-Based Hazards, Stressors

DOI: 10.1377/hlthaff.2014.0652
HEALTH AFFAIRS 33,
NO. 11 (2014): 1905–1913
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ABSTRACT Poor and minority residents of Richmond, California, have faced a host of place-based hazards and stressors such as pollution, gun violence, and a dearth of economic opportunities, all of which have likely contributed to their poor health outcomes. In this article we describe the city's efforts to reverse its fortunes by embracing a health-in-all-policies strategy for community development. Starting in 2007, the city organized a series of participatory planning projects with residents, community activists, school officials, and other stakeholders to ensure that the city took health equity into account when devising each phase of its new community development strategy. The result was an approach designed to address the social determinants of health by directing development resources toward vulnerable communities and by adopting a health-in-all-policies ordinance. Specific projects focused on improving the built environment and community safety and redirecting government funds to areas of social need. The process has contributed to rising levels of resident satisfaction about personal health, the direction the city is taking, and the quality of neighborhood development. Richmond's experience suggests that adopting a health-in-all-policies strategy is one way to promote health equity in distressed cities.

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Where people live and how their place of residence is governed can determine their frequency of illness, whether they receive medical treatment, and even their odds of premature death.[1] Many urban neighborhoods can be beneficial for human health since they can offer different population groups a range of economic and educational opportunities, affordable housing, opportunities for cultural and political expression, and other positive social determinants of health.

Yet not everyone in cities can take advantage of these socially produced resources. The poor and socially marginalized, in particular, often experience avoidable health inequities as well as limited access to health-promoting resources.[2] For example, in California's San Francisco Bay Area (the geographic focus of this article), an African American child born in West Oakland will die, on average, fifteen years earlier than a white child born just a few miles away in Walnut Creek.[3] (Exhibit 1).

Community development is a process of engaging residents and local institutions, from nonprofits to local governments, to coproduce assets that improve the quality of life for low-income and socially marginalized communities. Community development for health promotion includes building capacity both outside local government—for example, in community-based organizations and social movements—and inside it so that entrenched bureaucracies are more responsive to community needs and can deliver

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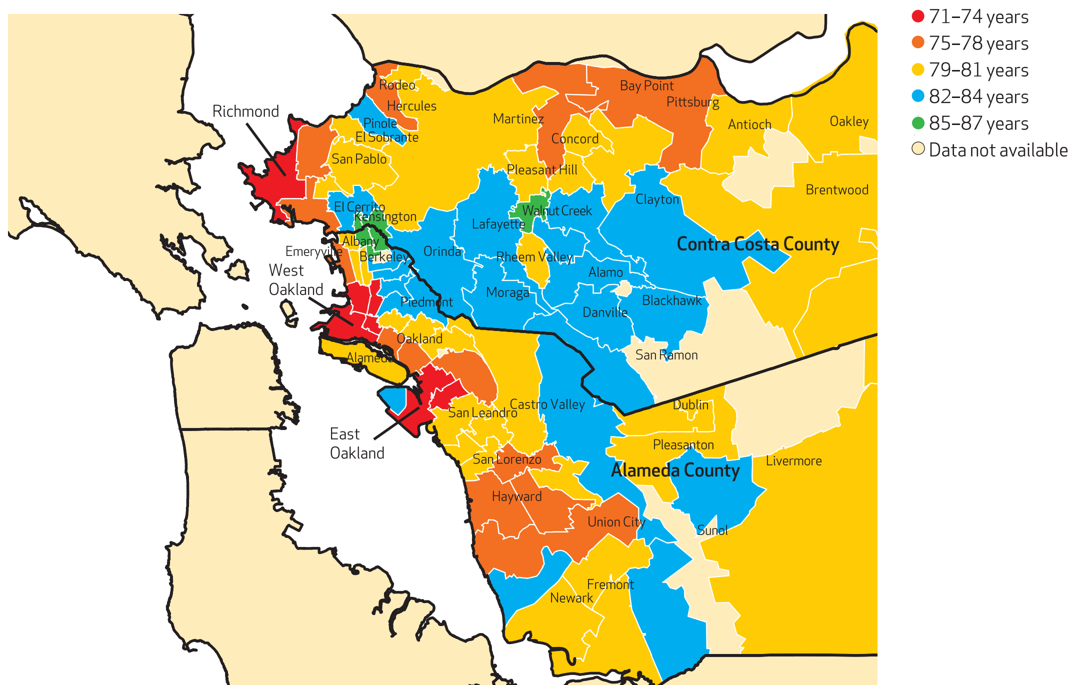
EXHIBIT 1

Life Expectancy In Years, By Census Tract, In Contra Costa And Alameda Counties, San Francisco Bay Area, 2008



SOURCE Authors' analysis of data from Beyers M, et al., Life and death from unnatural causes: health and social inequality in Alameda County (see Note 3 in text); and Bohan S, Kleffman S. Day 1: three East Bay ZIP codes, life-and-death disparities (see Note 17 in text). **NOTES** The statewide average life expectancy in 2008 was eighty years. County boundaries are denoted by heavy black lines.

neighborhood improvements in a sustained way.[4]

Community assets for promoting health equity include the physical or built environment (high-quality parks, affordable housing, libraries, and so on), intellectual or human capital (including skills, knowledge, and an understanding of community history), social capital (such as trust and shared understandings that enable productive partnerships and relationships), financial capital (income, employment, and intergenerational wealth building), and political capital (power, representation, and leadership in public policy making).[5–7]

Health equity in this context is not equality (sameness) for all. Instead, it implies societal efforts to ensure that historically marginalized groups have enhanced opportunities to access health-promoting resources and that existing access barriers are removed.[8] In short, health equity means promoting distributive and procedural justice—that is, directing resources to reduce social inequalities and ensuring openness and fairness in the political processes involved in decisions about allocating public resources.

Community development for health promotion depends on the joint participation of community-based organizations and a newly responsive local government, so that basic services are targeted to the people most in need and institutional structures are created to ensure greater accountability and processes for ongoing negotiation of community benefits.[9–11] Existing studies of community development and health are limited, tending to ignore the ways in which government institutions can facilitate or hinder the participation of community groups in the planning and implementation of neighborhood-based development activities.

In this article we explore how local governments can facilitate and formally adopt community development practices that aim to address the social determinants of health and reduce health inequities. We describe community development practice in Richmond, California, from 2007 to 2014, noting how community-based organizations and the city government worked together to address the social determinants of health and reduce health inequities.

We conducted over twenty-five interviews with leaders of local government agencies and community-based organizations in Richmond. We reconstructed events using minutes of tens of

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public meetings, internal staff e-mail, confidential project grant reports, and publicly available documents such as meeting reports and presentations found on the City of Richmond's website.[12] Finally, we used four waves of the Richmond Community Survey (2007, 2009, 2011, and 2013) to report on residents' perceptions, disaggregated by race or ethnicity, of health and community well-being.

The Richmond Community Survey is administered to a random sample of over 3,000 households. Conducted by the National Research Center's National Citizen Survey program, the survey asks residents about local government responsiveness, the qualities of city neighborhoods, and priorities for government action. The survey is overseen by the International City/County Management Association and used by this group to compare issues and priorities for local development across US cities of similar size. To better understand how community development actions might be influencing the social determinants of health in places targeted for interventions in Richmond, we analyzed the two waves of this survey—from 2011 and 2013—that included questions about self-rated health in specific Richmond neighborhoods.

Health Inequities

Located in Contra Costa County, in the San Francisco Bay Area, Richmond had a population of over 103,000 residents in 2010.[13] It is one of the most ethnically diverse cities in the Bay Area: Its population is 40 percent Latino, 26 percent African American, 21 percent white, and 13 percent Asian or Pacific Islanders. In Richmond in 2010 nearly 20 percent of residents were unemployed, 38 percent of children were living in poverty, and 57 percent of households spent more than 30 percent of their income on housing.[13] Also in 2010 nearly half of the homes in one Richmond ZIP code, 94804, were in foreclosure or at risk for foreclosure,[14] and the city was ranked among the most violent cities in America.[15]

In 2010, according to the Contra Costa County health service agency, 22 percent of African American children in Richmond were hospitalized for asthma, compared with fewer than 9 percent of white children in the city; 32 percent of people ages 20–44 in Richmond were obese, compared with 21 percent of Californians in the same age group; and over 28 percent of Richmond residents reported their health as fair or poor, compared with only 16 percent of Californians.[16]

Health outcomes in Richmond reflect these social inequalities. The *Contra Costa Times* reported in 2010 that residents in the central Richmond ZIP code of 94804 had a life expectancy of 71.2 years (the California state average was 80.0 years). In contrast, in another city ZIP code (94803) only a few miles away, in Richmond Hills, life expectancy was over 87.0 years.[17]

A Community Development Approach To Health Equity

In part as a response to persistent health inequities, Richmond residents over the years have organized for environmental and social justice. Beginning in the 1980s African American, Latino, and Laotian residents organized environmental justice groups such as the West County Toxics Coalition, Communities for a Better Environment, and the Asian Pacific Environmental Network with the aims of reducing pollution from Richmond's Chevron oil refinery, improving community health, and fostering greater economic development for people of color.

In 2006 the City of Richmond launched a planning process to update its General Plan, a legally required document that presents a blueprint for community development thirty years into the future. Activist groups pressured the city to include environmental health and justice as part of the update, something that had never been done in California. In response, the city sought and received a grant from the California Endowment to draft a "Community Health and Wellness" element (or chapter) as part of the updated General Plan.

A working group of community and government stakeholders stated that the element would "address health disparities and promote healthy living, and use the General Plan as a vehicle for promoting sound public health and land use policy." The working group also stated that the element would "outline a framework and methodology for evaluating and understanding existing community health and wellness conditions, develop goals, policies and implementing actions to address key community issues and opportunities, and create a tool for tracking progress over time. The Element will involve key stakeholders and the Richmond community in the process, and focus on key community needs and opportunities."[18]

In 2008, after numerous public forums and workshops, the first draft of the "Community Health and Wellness" element was released by the city. It articulated eleven aspects of healthy community development: improved access to parks, recreation, and open space; expanded access to healthy food and nutrition choices; improved access to medical services; safe and convenient public transit and active transportation options—that is, walking and cycling; high-

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quality and affordable housing; expanded economic opportunity; neighborhoods that offered a number of health-promoting services; improved safety in neighborhoods and public spaces; improved environmental quality; green and sustainable development practices; and government leadership in building healthy communities. Each aspect of healthy community development included both evidence from the published literature that linked the issue to human health and specific policies and actions that were designed to make the aspect a reality.

The draft acted as the framework and evidence base for neighborhood-specific healthy development pilot projects. The Iron Triangle and Belding Woods—two Richmond neighborhoods with poor health, social, and economic conditions—were selected by the city and a coalition of community groups for short-term interventions. By 2011, healthy development projects in these neighborhoods included street and sidewalk paving and safety improvements, new street lighting, plans for safe routes to schools, tree planting, the conversion of tennis courts into fields for *futsal* (a variant of soccer), and the redesign and reconstruction of a playground called Pogo Park.

The pilot projects helped the city and community partners learn by doing on a small scale. The place-based development projects also helped build trust between neighborhood residents, on the one hand, and city and public health officials, on the other hand. The three groups had not previously collaborated with each other.

Two missing elements came to light during the pilot project phase: The school district was not involved, and there was no strategy for integrating health into all city management decisions. To address these omissions, a new effort—called the Richmond Health Equity Partnership, which included the school district and governmental and nongovernmental organizations—was launched. Building on draft guidance by the California Department of Public Health, the Richmond Health Equity Partnership decided to focus its efforts on drafting and adopting a health-in-all-policies ordinance and implementing strategy for Richmond.[19]

The Health-In-All-Policies Approach

Health in all policies is an approach to decision making that recognizes that most public policies have the potential to influence health and health equity, either positively or negatively. It also recognizes that policy makers outside of the health sector may not routinely consider the health consequences of their choices and may thereby miss opportunities to advance health and prevention.[20] The State of California adopted a health-in-all-policies strategy in May 2012 and revised the state's Health and Safety Code in 2013 to make health in all policies the core strategy of the state's new Office of Health Equity.[21]

The health-in-all-policies strategy focused on how the city's policies and actions could reduce toxic stressors.

To draft the health-in-all-policies ordinance and strategy for Richmond, fourteen community workshops were held between March 2012 and November 2013. The participants were residents; members of community-based organizations; and representatives of the city, county, and school district. They worked together to define *health* and *health equity* and identify the specific factors that might be contributing to differences in health across neighborhoods and population groups (for example, youth, the elderly, Latinos, and African Americans).

Community residents described how they typically navigated the city and what impacts their travels and interactions might have on their health. For instance, residents noted that in a single day they might experience or fear violence, eviction, environmental pollution, discrimination at work or in school, challenges accessing public services, intimidation by immigration and customs officers, and an inability to pay health care bills. These reflections helped focus the health-in-all-policies strategy on multiple and cumulative toxic neighborhood stressors instead of on one disease, risk factor, or behavior.

The idea of cumulative toxic neighborhood stressors was grounded in medical and public health evidence suggesting that chronic social and environmental stressors throughout one's lifetime influence the body by damaging the immune system in multiple ways.[22] Thus, the health-in-all-policies strategy focused on how the city's policies and actions could reduce the multiple toxic stressors that likely influenced health disparities in Richmond.

The health-in-all-policies ordinance and strategy included six community development inter-

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City and community stakeholders worked collaboratively to publicize the new attention to health equity in the city.

vention areas: governance and leadership, economic development and education, full-service and safe communities, neighborhood built environments, environmental health and justice, and high-quality and accessible health homes and social services.[12] Indicators or measures of implementation and impact on population health were developed by a subgroup of the Richmond Health Equity Partnership for each intervention area. The Richmond City Council approved the health-in-all-policies ordinance in April 2014.

Challenges

The drafting and adoption of the health-in-all-policies ordinance and strategy faced a number of challenges in Richmond. First, the effort was led by the city manager's office. Other city departments were initially reluctant to participate because they viewed the effort as adding a layer of review, cost, and potential delay to their work. Eventually, community stakeholders and staff members at city agencies agreed to link goals within the health-in-all-policies ordinance to the city's budget. A citywide interdepartmental health-in-all-policies leadership group was established to develop health-in-all-policies performance incentives for all city departments.

Second, the county health department did not collect population health data on the neighborhood scale in Richmond, and this presented a challenge for drafting indicators of healthy community development. Data on health outcomes and determinants were needed in the health-in-all-policies effort to explain complex health concepts and jargon, but such explanations were difficult without neighborhood information. This remains an outstanding issue.

As a temporary measure, leaders of the Richmond health-in-all-policies effort were forced to use health data collected on the county and ZIP code scale, sometimes for specific population groups, and estimate health outcomes for the city's neighborhoods. Neighborhood-based land use data and US census and Richmond Community Survey data were used to better understand place-based health determinants and residents' perceptions of such things as safety, social ties, and government responsiveness.

Third, the health-in-all-policies effort faced opposition from those inside and outside government who were opposed to equity-based development and environmental health interventions that directed city resources to the poor and communities of color. To build support and highlight how all residents of Richmond could benefit by reducing health inequities, the Richmond Health Equity Partnership subgroup conducted a series of community workshops, listening sessions, trainings, and informational presentations to the City Council.

Impacts Of Community Development On Health Determinants

We suggest that the ongoing healthy community development work in Richmond is responsible for a value shift: In contrast to the past, the city government now places a premium on health equity and the needs of the poor and people of color. This shift and the forging of a new government-community coalition that focuses sustained attention on health equity issues are likely the most significant impacts of the health-in-all-policies work to date. But there have been other impacts.

One of them is policy diffusion, which means that decisions made outside the health-in-all-policies process were nonetheless influenced by the discourse and evidence generated by the healthy development process. One example of this policy diffusion is that the mayor and City Council, citing community health benefits, proposed to use the power of eminent domain to support families under threat of losing their homes to foreclosure and to redevelop abandoned neighborhoods.[23]

Another impact relates to community-police relationships in the city, which has historically had a high murder rate. During the health-in-all-policies drafting process, the police department, city neighborhood safety officers, and community groups worked together. When the county proposed expanding a jail in Richmond, the Richmond police chief challenged the project and suggested that the money would be better spent on improving community services and supporting parolees. According to one leader of a community group participating in the health-in-all-policies drafting process, the decision by the city was "a great example of elected officials really,

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truly listening to the voice of the community and responding."[24]

The final impact to be discussed here was changing the perception that Richmond was an unhealthy place that was too risky for new development. City and community stakeholders worked collaboratively to publicize the new attention to health equity in the city. The city successfully lobbied the Lawrence Berkeley National Laboratory and the University of California, Berkeley, to locate their second campus in Richmond, selecting the city over twenty other possible locations. In the press conference announcing the new development project, university leaders emphasized that Richmond was a city on the rise and that the university and the laboratory wanted to be a part of this renaissance.[25]

The Richmond Bay Campus project will likely be the largest development project in the San Francisco Bay Area for the foreseeable future. It is projected to add at least 10,000 new jobs and to provide a host of other economic, environmental, and infrastructure benefits to the community. Reflecting the priorities of the health-in-all-policies ordinance and strategy, the university and the laboratory agreed to support a community advisory committee coordinated by the Richmond city manager's office that will oversee a community improvement grant fund.

The development project also provides specific community benefits for Richmond that were outlined in a statement from the Lawrence Berkeley National Laboratory and the University of California, Berkeley. These benefits include hiring local residents, new workforce training programs, transportation improvements, pollution reduction, and services that "address income, health and education equity."[26]

Finally, a San Francisco Bay Area newspaper described the changes in Richmond as a "renaissance": "A new spirit in city government has helped transform industry, the quality of life in the city, and Richmond's grim reputation. The city has undergone a facelift, citizens are attending community meetings and events in unprecedented numbers, and new businesses—many of them green—are bringing economic opportunities back to town.

"While other cities are desperately contending with debilitating budget deficits and struggling to maintain public safety and other basic services, Richmond has produced balanced budgets and enjoys a full complement of police officers. The combined efforts of city departments and community members have resulted in meaningful reductions in violent crime. And the city has completed numerous civic and neighborhood revitalization projects that have given Richmond a new air of vitality and community health."[27]

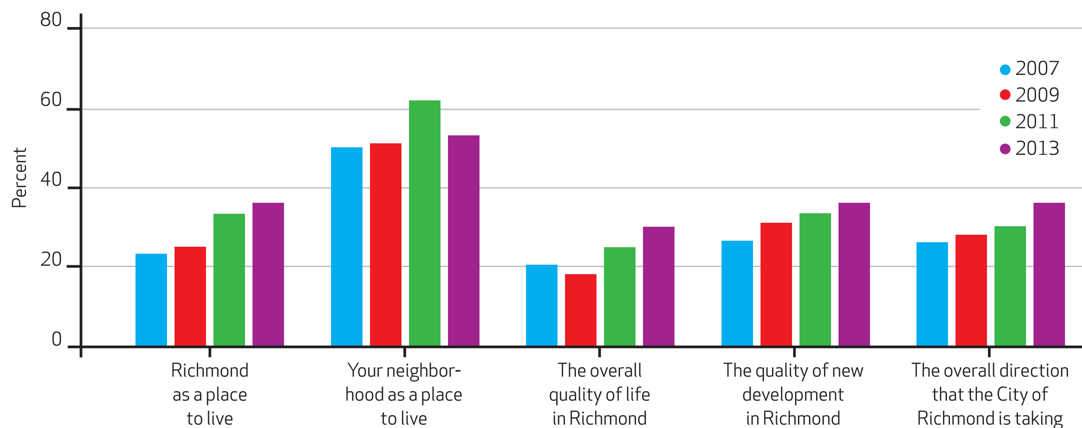
Community Survey

We used data from the Richmond Community Survey to assess how residents felt about the changes that were under way. As noted above, a random sample of over 3,000 Richmond households has been surveyed every two years, starting in 2007.

Exhibit 2 presents the percentages of respondents responding favorably to a variety of questions in the first four waves of the survey. Exhibit 3 uses the same questions and survey

EXHIBIT 2

Percentage Of Richmond Residents Responding "Excellent" Or "Good" To Community Survey Questions, 2007–13



SOURCE Authors' analysis of data from City of Richmond. Community survey [Internet]. Richmond (CA): The City; 2007–13 [cited 2014 Oct 2]. Available from: http://www.ci.richmond.ca.us/index.aspx?NID=1871. **NOTE** Each question began, "How do you rate [X]."

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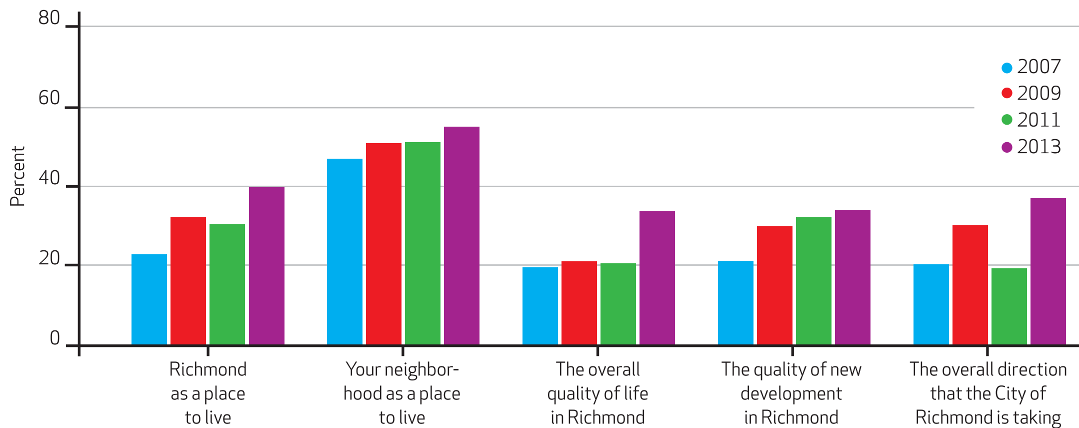
EXHIBIT 3

Percentage Of Richmond Residents Of Color Responding "Excellent" Or "Good" To Community Survey Questions, 2007–13



SOURCE Authors' analysis of data from City of Richmond. Community survey [Internet]. Richmond (CA): The City; 2007–13 [cited 2014 Oct 2]. Available from: http://www.ci.richmond.ca.us/index.aspx?NID=1871. **NOTES** Each question began, "How do you rate [X]." Residents of color identified themselves as nonwhite Hispanic or Latino, black or African American, Asian or Pacific Islander, or American Indian or Alaskan native.

years as Exhibit 2 but presents the percentages of people of color who responded favorably. Exhibit 4 presents percentages of survey respondents who reported that their health was excellent or good for the two years of the survey for which these data were available by neighborhood.

We found that in general, Richmond residents perceived their community as getting better, although a majority of respondents still did not rate the city highly. Importantly, residents were increasingly satisfied with the quality of development in Richmond. For instance, with a few exceptions occurring from 2009 to 2011, larger percentages of people of color gave favorable answers to all five questions than they did previously, although at a lower percentage than everyone in Richmond.

In addition, a greater percentage of the population in the neighborhoods targeted by healthy community development efforts and surrounding areas rated their health as excellent or good in 2013, compared with 2011. For example, in the Iron Triangle and adjacent neighborhoods of North Richmond and Atchison Village, the percentage of residents rating their own health as good or excellent in 2011 was 23.7 percent, but in 2013 it was 28.2 percent. These data are incomplete, but together they suggest that the healthy community development initiatives in Richmond may be having a positive influence on residents' perceptions of both their health and where they live.

Contributors To Healthy Community Development

As we have tried to outline here, healthy community development in Richmond is not about addressing one unhealthy behavior, improving health care access, or altering one aspect of the built environment. Instead, it has taken an integrated approach to planning, community asset building, and responsive government at multiple scales. At least three factors seem to contribute to healthy community development in Richmond and might act as guiding frameworks for other places.

BOTTOM-UP INITIATIVE First, healthy community development was defined and advocated by residents and community-based organizations. This was not a top-down initiative, but a bottom-

EXHIBIT 4

Percentage Of Richmond Residents Responding "Excellent" Or "Good" On Self-Rated Health Question, By Neighborhood, 2011 And 2013

Neighborhood	2011	2013
Point Richmond and Marina Bay	53.6%	55.2%
Santa Fe, Coronado, and Cortez[a]	30.3	38.7
Laurel Park, Eastshore, and Parkview	33.7	38.2
North Richmond, Iron Triangle, and Atchison Village[a]	23.7	28.2
Richmond Heights	45.8	52.1
Hilltop Village	38.3	44.4
May Valley and El Sobrante	52.5	56.3
Parchester Village	25.1	27.8

SOURCE Authors' analysis of data from City of Richmond. 2013 community survey [Internet]. Richmond (CA): The City; [cited 2014 Sep 29]. Available from: http://www.ci.richmond.ca.us/index.aspx?NID=1871. [a]Neighborhoods targeted by Richmond's healthy development pilot projects.

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up one. However, the local government was engaged and was responsive to community demands, and local officials recruited professionals to help draft the health element in the city's updated General Plan and implement the place-based projects. The local government also took a lead in institutionalizing community desires through the Richmond Health Equity Partnership. Thus, healthy community development required both outside (activist) and inside (local government) strategies.[28]

SMALL PLACE-BASED ACTIONS Second, small place-based actions—namely, the pilot implementation of the healthy community development plan in the Iron Triangle and Belding Woods neighborhoods—helped engage residents and deliver tangible community development improvements. The pilot implementation phase of the "Community Health and Wellness" element in the updated General Plan also allowed stakeholders to learn together how to implement healthy community development, and it eventually expanded the number and types of city agencies that participated. In addition, the interventions encouraged new partnerships between the health department, school district, and city government, as well as integrating new community-based organizations into the development projects.

LEARNING BY DOING Third, the learning-by-doing approach mentioned above built new partnerships that prompted each governmental body involved in the planning and implementation activities to continue to justify the work internally and to the public. It also fostered coalitions that applied for and secured financial resources in the form of grants to continue the work. For example, the county, city, and school district secured a major grant from the California Endowment to help fund the Richmond Health Equity Partnership.

Each agency was able to apply for state grants to finance built-environment projects. For example, the California State Parks Office of Grants and Local Services awarded the City of Richmond a $5 million Proposition 84 Statewide Park Program grant to develop a new public space called Unity Park along the Richmond Greenway. Under tight fiscal constraints, healthy community development was possible when community-based organizations and governments secured financial resources, often external to their annual budgets in the case of local governments, to support their ongoing participation.

Conclusion

It is too early to measure population health outcomes from the healthy community development work in Richmond. However, residents, community organizations, and the city government are now working collaboratively to support policies and projects that promote health. Collaborations between the city and community-based organizations are contributing to measurable neighborhood changes, such as improved public spaces. When these are combined with the new governmental commitment to the health-in-all-polices approach and a more open and participatory decision-making process, they seem to be contributing to improvements in self-rated health.

The city has made health equity a priority by committing all city departments to the work of the Richmond Health Equity Partnership and the implementation of the health-in-all-policies ordinance. Just as important, the culture of community development has shifted to make health equity a central and explicit focus. We hope the experiences of healthy community development in Richmond can act as an example for other cities facing the challenge of promoting population health. ■

Funding for the drafting of the Health Element and the work of the Richmond Health Equity Partnership (RHEP) was provided by the California Endowment. The authors thank Jonathan Malagon and Meredith Lee and the entire RHEP staff for assistance with the health-in-all-policies strategy. Jason Corburn conducted an evaluation of the Community Health and Wellness element drafting process and acted as an adviser to the RHEP. In the latter capacity, he conducted research on documenting health inequities, examples and case studies of health-in-all-policies or similar practices from other cities around the world, and suggestions on data gathering and measurement of health equity for Richmond. He also conducted trainings and workshops for city staff members and others. Both Shasa Curl and Gabino Arredondo contributed to this article in their personal capacities. The views expressed are their own and do not necessarily represent the views of the City of Richmond, California.

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