Community Engagement for Public Health in Cleveland, Ohio, US: Evidence Briefing

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Summary

Community engagement, in public health practice, includes a wide range of activities to work with community members to promote well-being and achieve more equitable health outcomes. This kind of work was critical to pandemic preparedness and response during the COVID-19 pandemic. Cleveland has a vibrant landscape of community organizations, community health workers and activists, academics, and public health practitioners working to improve health equity in the city, but engagement efforts are often siloed or short-term.

Our team recently conducted research in Cleveland, Ohio to revisit community engagement during the pandemic and document lessons learned for future preparedness. This evidence brief includes those lessons learned and ways to consider applying learning to public health strategy.

Considerations for Improving CE for Health Equity and Pandemic Preparedness

Given Cleveland's unique and decentralised CE landscape, several lessons can be drawn for long-term CE to improve health equity outcomes. Similar lessons can be articulated for longer-term pandemic preparedness. We outline these below.

Working with diverse assets in Cleveland. Consider conducting an asset mapping exercise to document the different community organisations serving diverse populations across Cleveland geographies. This could include something more basic (e.g. name of organisation, contact, population served) or it could include interviews with a subset of the organisations to understand their priorities for CE in public health in the city.

Promote existential CE. Community engagement activities are often for the purposes of sharing information with community members. Consider ways to expand more 'existential' activities where listening and learning is prioritised, including ways to 'just show up' and raise the visibility of public health in the city.

Increase the number of listening sessions. Relatedly, the most common feedback we heard during our research was that CE should be about 'listening'. Find ways to increase the number of community listening sessions – this can be in-person or online using social media modalities.

While community health workers and advocates are extremely valuable, they must also be supported for their work. We heard about a wide range of community health workers and advocates who are engaged in public health outreach and CE activities. While this is extremely important for reaching marginalised communities, it can also place a great burden on community health workers who themselves may be facing various forms of financial precarity. Consider ways to formalise their roles or financially support their work in the long term. A city-wide programme could be established to help with formalising this role.

Break through siloes that have been re-established after the pandemic. One common refrain was that the COVID-19 pandemic necessitated collaboration and new ways of working, rather than one-off engagement activities or continued working in siloes. Consider ways to continue collaboration through strategic planning and information sharing more widely.

Focus on the social determinants of health. Staff from community organisations and residents in our focus group discussion highlighted the importance of the social determinants of health. Too often, CE interactions focus on a single health topic, whereas this may not be an individual or community's priority. Consider wrapping public health

priorities into social determinants – acknowledging the urgency of accessing good-quality food, housing, and work in Cleveland. This could include referrals for services and programmes like HEAP or SNAP or assistance with accessing Medicaid.

Acknowledge people's sentiments about our for-profit healthcare system. One driver of mistrust in public health and healthcare is the perception that 'money' is a driving factor in medical recommendations. This surfaced during our discussions with community organisations as well as residents in the focus group discussion. Consider the ways in which partnerships and activities may reinforce (or counter) this narrative – e.g. consider carefully programmes that seek to financially compensate individuals for behaviour change.

CE has the potential to repair relationships of mistrust, but its limitations should be acknowledged. CE is not a panacea for issues of mistrust in public health and medicine. Relationships of mistrust are rooted in a wide range of reasons – from historical neglect to cultural worldviews. CE can repair relationships with some communities, but it should be one part of a wider strategy to build trust in public health.

CE should be rooted in anti-racism and social justice. This could include, for example, CE that seeks to empower rather than inform, or CE that focuses on listening to people's priorities and needs. With the declaration of 'racism as a public health crisis', it is important that CE in Cleveland integrates an anti-racist lens in planning and strategy.

A health worker wears a face mask. © Photo by Ehimetalor Akhere Unuabona on Unsplash.com.

Cleveland skyline © Photo by DJ Johnson on Unsplash.com.

Context

Cleveland is a major city in Ohio, located on the southern shore of Lake Erie. It constitutes part of the Greater Cleveland area, as a large part of the population lives outside of the central city limits. Located in Cuyahoga County, Cleveland (central city) has a population of 372,624, while Greater Cleveland has over two million residents. In the 1930s, housing discrimination and redlining practices led to the institutionalisation of systems of racism and inequality that negatively shaped minoritised communities' experiences in Cleveland as well as other northern cities in the US. These practices included the denial of credit, insurance, healthcare, housing loans, and the emergence of food deserts in racialised communities, where those communities lack access to grocery stores or supermarkets. While redlining was officially banned over 50 years ago, the effects of redlining continue today. Persisting patterns of structural inequalities underpin how the COVID-19 pandemic disproportionately affected black communities in Cleveland, in particular, compared to other minoritised groups. Black communities face higher rates of chronic disease, including those known to be co-morbid with COVID-19. For example, hypertension affects 40 per cent of black residents in Ohio, compared to 34.9 per cent of whites, 28.1 per cent of Hispanics, and 13.8 per cent of Asian residents. In the first year of the COVID-19 pandemic, 19.6 per cent of COVID-19 cases, 28.4 per cent of deaths, and 17.9 per cent of hospitalisations have been among Black residents, while they make up just 15 per cent of Ohio's population. Black residents were also overrepresented among essential workers in the state, increasing their risk of COVID-19 exposure.

Cleveland: Community Engagement in Practice

People and Institutions:

Cleveland's public health community engagement landscape is largely decentralised, with engagements taking place at various levels and processes – from one-off community events such as a vaccination clinic or tabling with public health information to more sustained engagements through support for community health workers. Community engagement and outreach for public health programmes and activities fall under the purview of Cleveland and Cuyahoga County public health departments, but also a patchwork of healthcare providers. These include (e.g. large hospitals – MetroHealth, University Hospitals, and the Cleveland Clinic and federally qualified health centres), non-profit organisations, community development corporations, philanthropies and funding agencies, and academic institutions. A range of individual actors also play a vital role in community engagement, including community health workers, patient navigators, activists, and volunteers. They are often inconsistently engaged and there is often one 'go to' person for a geographic area or community.

Purpose:

Community engagement within the Cleveland context primarily serves the **purpose of informing community members** about health issues and, in the COVID-19 pandemic case, on what is known about the virus as well as preventative efforts. A secondary, but less commonly reported, purpose of community engagement is to **empower community members** and facilitate collaboration between community members and multiple agencies and coalitions who are in one way or the other involved in community work. In the context of community engagement, empowerment was perceived to mean addressing the imbalanced power dynamics between the community members and service-providing institutions or government agencies, with regard to who gets to define what issues (health included) should be prioritised and targeted for intervention within the communities.

Empowerment also means that amid multiple campaigns about the need for various behavioural adjustments or modifications (such as smoking cessation), there is often the recognition that community members may lack the means to engage in such modifications. Community engagement in this instance becomes enacted to empower or provide resources community members may need to engage in such behavioural modifications that are of value to the individual and public health.

"A type of engagement process that took shape during the pandemic, in addition to other processes earlier mentioned, was the dollar-doses programme."

In addition, community engagement is sometimes seen as a **tool to promote justice**, especially in the aspect of addressing structural disadvantages and other social determinants of health. When this purpose is in mind, community engagement efforts target marginalised communities to address or remedy these disparities. Further, the purpose of community engagement could also be to **reduce organisational pressure**. Often, as a condition for receiving funding, recipient organisations involved in community work or research are required to carry out some community engagement efforts. In a similar vein, some community members expressed that community engagement can be **tokenistic** in some ways. Tokenism in this sense includes bringing on influential community members to be a part of projects or intervention efforts after major decisions of what to address and how to address it have been made. It also includes having people who 'look' like members of the community where interventions are supposed to be situated, to be the face of implementation. All of these can serve to create a symbolic front of community engagement and encourage a wider buy into interventions or projects by community members without any actual practical community engagement taking place.

Relationships:

While trust is essential to community engagement, we find that this very feature is often lacking when the relationship between institutions and the communities they set out to engage is considered. This lack of trust stems from historical as well as current issues rooted in segregation, inequality, and redlining - the effect of which is still very evident in Cleveland today. Personal negative encounters (such as preferential treatment for those who can afford it) with the medical systems, also contributed to this lack of trust. This lack of trust became particularly salient during the pandemic and was evident in the significant levels of vaccine hesitancy in the Cleveland area. Institutions and organisations interested in community engagement during this period to drive up vaccine uptake were aware of this level of mistrust. To mitigate it, they often engage community members through local on-the-ground organisations, faith-based organisations (mainly churches), and known community members.

Further, relationships between these various institutions and organisations involved in community engagement within the Cleveland community appear to not be adequately coordinated, at least before COVID-19. Organisations would often enter partnerships with other organisations in attempts to engage and deliver services to community members. But even this type of relationship is often fragile and significantly impacted by high staff turnover, which resulted in the breakdowns of such partnerships.

Processes:

What counts as community engagement activities for the various organisations and departments that engage in it include outreaches, town hall meetings, listening sessions in places such as the Cuyahoga Metropolitan Housing Authority and other

senior housing, sending out educational information through media outlets such as radio spots, advertisements on Facebook, tabling at community events, webinars, word of mouth, and door-to-door visits. Many of these activities were engaged in during the COVID-19 pandemic.

Community Engagement Amidst Covid-19 Pandemic

Most of the people, institutions, and purposes associated with community engagement as described above remained the same during the COVID-19 pandemic. Relationships in some regards were, however, impacted, especially between organisations. It was the consensus among participants that the pandemic facilitated collaborative relationships between various organisations in a way that was not so in the pre-pandemic period. The morbidity and mortality rates of the virus during the pandemic required the rapid pooling of resources together between organisations to prioritise the delivery of preventive efforts, mostly vaccines, to communities.

However, narratives of mistrust between these organisations and the community members they try to reach remain. In addition, priorities on the side of the community members (such as getting a job, getting proper housing, and putting food on the table) were often mismatched with what health personnel considered to be of priority during the pandemic (such as getting vaccinated, staying at home, and maintaining social distancing). These factors continued to affect relationships and contributed to outcomes such as the observed low rates of vaccination in some areas of Cleveland. This reality led to some modifications in community engagement processes.

A type of engagement process that took shape during the pandemic, in addition to other processes earlier mentioned, was the dollar-doses programme. This programme was designed to facilitate vaccine uptake and mitigate vaccine hesitancy specifically for COVID by paying community members in gift cards and cash to take the vaccines. There was legislative backing for the programme and multiple coalitions and organisations used it to increase vaccine uptake.

Since things have relatively become calm, and we are in a period of 'good times' as one participant described it. That is, a period without a public health emergency of similar scale and magnitude to the COVID-19 pandemic. Relationships now seem to be returning to their pre-pandemic nature where community engagement activities were largely uncoordinated and based on the mandates and prioritised targets of individual organisations.

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Group of teenagers outdoors wearing face masks. © Photo by Freepik.com.

Conclusion

This brief presents considerations for CE in Cleveland based on our study that documented lessons learnt from the COVID-19 pandemic in terms of CE in public health. This was a small study, and more research with a wider range of stakeholders is needed to assess CE needs more widely. However, the key considerations we earlier shared remain relevant for planning purposes.

While community engagement and outreach are happening widely throughout the city, more efforts can be made to systematise CE and centre it around key public health goals to reduce health inequities in the city. To do this, it will be important to include elements of 'existential' CE as well as ongoing activities that are more focused, such as tabling or sharing information about health services. The World Health Organization also provides good guidance on CE for public health.

Living Roots

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