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Health

South Western Sydney
Local Health District

Place-based Interventions:

A Realist Informed Literature Review

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Contacts

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Executive summary

Background

Locational disadvantage refers to environments that are characterised by geographical concentrations of disadvantage. Locationally disadvantaged communities typically have limited access to services and facilities, poor employment, training and educational opportunities and poor physical and social infrastructures. The Centre for Health Equity Training, Research and Evaluation (CHETRE) works as a part of South Western Sydney Local Health District (SWSLHD) to address health and health equity in places of locational disadvantage through working with partners and communities to create knowledge and solutions.

Place-based interventions are one approach that SWSLHD currently participates in to develop health in areas of locational disadvantage. Place-based interventions are **“a collaborative means to address complex socioeconomic issues through interventions defined at a specific geographic scale”** (Cantin, 2010). A review in 2007 by CHETRE found that while many place-based interventions had been implemented to address health issues in areas of disadvantage, a knowledge gap existed as to the effectiveness of these interventions due to difficulties with evaluation (Larsen, 2007). The results that were available showed a range of outcomes that indicated links between the intervention and health outcome changes (Larsen, 2007).

This report aims to update the previous work in line with CHETRE’s recently developed program logic for the locational disadvantage program. This report discusses place-based interventions that utilise mechanisms for building capacity of the community and individuals, supporting services, and fostering coalitions and networks. It aims to describe the place-based interventions currently being implemented to improve health or the social determinants of health (equity) and explain what benefits or outcomes can be observed from place-based interventions and for which populations. The report also describes how variations in program context and mechanisms influence the process and outcomes of place-based interventions.

Methods

The literature review was informed by realist approaches, and conducted as an iterative process. The initial search commenced with peer-reviewed literature and consultation with some key advisors and then expanded to grey literature. The broad and contextual nature of what defines a place-based intervention created difficulties in identifying relevant literature. While conducting the review process the research questions were refined as the researchers’ understanding of place-based interventions developed. It was found that searching

specifically for programs that developed individual skills and health literacy provided resources that failed to integrate the community and/or geographic perspective, and these interventions were excluded.

A broad initial search strategy was used to find peer reviewed literature across multiple databases. Grey literature was found through a review of websites of different governmental and non-profit organisations around Australia, the United Kingdom, Canada, and the United States of America.

A total of 21 peer reviewed documents and 34 grey literature reports were included in the review. Data was extracted from the documents into a table provided in Excel to SWSLHD. This was refined into a table demonstrating outcomes (See Appendix A and B). The papers were reviewed by two researchers, and broad were extracted from the findings. Learnings from the literature were then applied to the SWSLHD context.

Results

The literature review revealed a significant number of place-based interventions being conducted both nationally and internationally. Most interventions were developed uniquely to their location. Most place-based interventions discussed were complicated programs that created complex partnership or coalition networks to implement multiple actions aimed at changing the physical, social or economic environment within the targeted intervention area.

Due to the context-specific approach of place-based interventions the reviewed interventions varied greatly. Variations found in the programs were described in this review under the headings of **structural factors**, **intervention design factors**, **implementation factors** and **outcome factors** (see Table 1). Factors under these categories could exist across multiple categories (i.e. communities can exist under structural, and implementation factors) however are only described in the single category.

Table 1. Variable factors in place-based interventions

Structural Factors	Intervention Design Factors	Implementation Factors	Outcome Factors
Funding Governance Political	Intervention Target -Health -Social Determinants of Health Partnership Processes Geographic Area Program actions Communities Program Duration	Professional Organisations Implementation Completeness	Evaluation types Outcomes -Health -Social Determinants of Health

Major variations that have been identified in the literature or by the researchers as influencing the impact of place-based interventions were found to be:

- Funding,
- Program duration,
- Governance,
- Partnerships frameworks and processes,
- Program Actions, and
- Community involvement.

Programs targeted a wide range of social determinants of health, broadly categorised as:

- Social and Community Context - Social Cohesion,
- Education - Early Childhood Education and Development,
- Neighbourhood and Built Environment - Access to Foods that Support Healthy Eating Patterns,
- Neighbourhood and Built Environment - Environmental Conditions,
- Economic Stability - Employment.

Some interventions targeted health explicitly such as obesity, diabetes, child development and mental health outcomes.

Findings indicated that place-based interventions can be effective in changing some health and health related behaviour outcomes. Depending on the intervention, some programs reduced inequalities between targeted neighbourhoods and less disadvantaged neighbourhoods. Place-based interventions more commonly aimed to create change in social determinants associated with health outcomes, and can be successful in changing built environment, social cohesion and economic environments of intervention areas.

Evaluations of place-based interventions are often limited by funding, program duration and the complexity of evaluating place-based interventions. This is seen to be a limitation of the literature and processes of place-based interventions rather than an indication of a lack of efficacy (O'Dwyer et al., 2007).

Building Successful Place-based Interventions in SWSLHD

This review suggests that place-based interventions may be a useful model for SWSLHD for a number of reasons. The theories of change used in place-based interventions align with SWSLHD's current strategic goals; place-based interventions address underlying social determinants of health that contribute to pathways influencing multiple health outcomes; and utilise wide stakeholder engagement across both their governance and intervention structures to build capacity and create change with both formal partners and communities. In particular, place-based interventions are suited to help SWSLHD achieve the Strategic Directions of "Collaborative Partnerships" and "A Healthy Community" (South West Sydney Local Health District, 2018).

There are a number of considerations when creating or participating in place-based interventions. Some of these include understanding the causal pathways that influence health within the communities, understanding the partnership processes that influence the development and implementation of programs, and the requirement to invest resources. Equity is in some ways implicit in the development of place-based interventions, but there are opportunities to strengthen the equity focus of these programs through the application of equity frameworks to place-based intervention development. SWSLHD may benefit from using one of the evidence-based frameworks (CEF, MAP-IT, MAPP, and THRIVE) identified and described in this review to create coalitions and partnerships that are able to secure funding and implement effective place-based interventions.

Recommendations

Based on the findings and discussion in this report, along with an equity frame, next steps in building strong place-based interventions include:

1. Develop an understanding of the social determinants of health that are relevant to specific targeted communities in SWSLHD,
2. Identify what types of interventions/programs best target these social determinants of health,
3. Commit to long-term investment of time and resources for community-level changes,
4. Ensure early and consistent community participation,
5. Build strong collaborative partnership processes and engagement,
6. Integrate multi-level process and impact evaluations.

Resources and concrete actions under these recommendations are provided in the report.

Conclusions

This review has shown how place-based interventions can add value to changing health in locationally disadvantaged communities through intervening in the underlying drivers of poor health. They are complex interventions that have many features that may influence successful outcomes including their governance and design processes. Community buy-in and involvement are essential components of both the theory and operational aspects of place-based interventions.

Successful place-based interventions that target the social determinants of health can require large and long-term commitment in resources, time and funding. The use of partnerships within the process can assist with leveraging funding and resources, but may pose some barriers to successful processes and outcomes. While place-based interventions are resource intensive interventions, they have the potential to be useful to address health and health equity in south west Sydney.

Background

Locational Disadvantage in South West Sydney

The Centre for Health Equity Training, Research, and Evaluation (CHETRE) aims to ‘co-create intelligence for better health’ in and beyond South West Sydney. CHETRE is a joint unit of South Western Sydney Local Health District (SWSLHD) and the University of New South Wales (UNSW), as well as a member of the philanthropic organisation the Ingham Institute. CHETRE seeks to provide leadership and expertise in training, research and evaluation for health and health equity through enabling communities to develop opportunities to achieve good health.

CHETRE’s programme of work aims to:

- Build and disseminate understanding of the (health) needs of vulnerable populations,
- Create, trial and disseminate – based on firm evidence – approaches to improve health and reduce inequity,
- Influence relevant policy and practice for better health,
- Enhance understanding of the needs of vulnerable families and communities,
- Develop and trial interventions to improve health and address health inequities, and
- Develop and trial ways to widely and sustainably implement effective interventions and innovations to improve health and health equity in whole populations.

CHETRE has a specific program of work in locational disadvantage aimed at improving the health and wellbeing of people living in locationally disadvantaged areas, and the capacity of communities in these areas to take actions that will enhance their health and wellbeing. The recently developed locational disadvantage program logic details the goals and ongoing work to be conducted in this program (Zapart et al., 2017).

The goal of the locational disadvantage program is to create supportive environments for equity and health in the most disadvantaged locations in SWSLHD through working adaptively and responsively with people and organisations to enable trust, empowerment, the ability of people and communities to take control of their lives and health literacy, for health, wellbeing and equity (Zapart et al., 2017). The program works across three streams of work (Figure 1). Activities within these streams include: research and dissemination; learning and training; resource development; collaboration with and or support for local groups, service providers and community workers; networking; and community engagement.

Figure 1. Program Streams in the Locational Disadvantage Program



(Zapart et al., 2017)

The Locational Disadvantaged Communities Program Logic describes three streams of work in which these mechanisms can influence determinants of health and health outcomes (Zapart et al. 2017).

The **Linking and generating research evidence** stream of the Locational Disadvantaged Communities Program ensures a two-way conduit between researchers and the community. This two-way conduit is achieved through learning activities, communication, identifying and responding to need, information and knowledge exchange, and through the development, and conduct of CHETRE generated research and the dissemination of findings from this research.

The **Building capacity of individuals, organisations and communities** stream aims to provide the skills, tools, resources and practices that will increase the capacity of communities in locationally disadvantaged areas to take actions that will enhance their health and wellbeing, including increasing their capacity and capability to appropriately access services. This is done through activities that involve learning, support, collaboration, resource development, and community engagement.

The **Developing and strengthening networks** stream focuses on strengthening existing multi-disciplinary and inter-sectorial networks and or partnerships and developing new ones. This is done through: learning activities, formal and informal networking with organisations, service providers, communities and individuals; support; and working together with, and or in partnership with other organizations, services, and or individuals.

Locational Disadvantage

Locational disadvantage refers to environments that are characterised by geographical concentrations of disadvantage. Locationally disadvantaged communities typically have limited access to services and facilities, poor employment, training and educational opportunities, and poor physical and social infrastructures. In New South Wales, areas that fall under SWSLHD's remit experience some features of disadvantage, which is demonstrated in poorer health outcomes across a number of measures including obesity, smoking, and health outcomes related to these (Zapart et al., 2017). Specific challenges for south west Sydney include socioeconomic disadvantage, a highly diverse population including culturally and linguistically diverse population and covering large geographic areas (SWSLHD, 2014).

The people living in disadvantaged areas of south west Sydney do not experience their disadvantage in the same way. The intersections between social identities such as race, class, religion and gender can contribute to social and health related impacts when combined with features of disadvantage including material deprivation (including physical infrastructure and housing), social and economic exclusion (including civic participation and employment), stigma and lack of respect (including discrimination) (Zapart et al., 2017). Frequently, these issues become entrenched and cyclical within neighbourhoods, communities and families.

Due to the interdependent and pervasive features of locational disadvantage, it is considered a wicked policy problem. That is, it is a problem that is resistant to resolution, which has causes that are highly complex and interdependent (Head and Alford, 2015). Effective interventions are required to be integrated horizontally across multiple stakeholders (Australian Public Service Commission, 2007).

Place-based Interventions

One approach to addressing locational disadvantage is through a place-based approach. As described in Bradford (2005), an urban perspective on interventions is preoccupied with physical infrastructure, facilities and resources, whereas a community perspective focuses on social infrastructure, networking and social inclusion. The place-based perspective understands the perspective of both and calls for their integration (Bradford, 2005).

This review adopts a contemporary definition of place-based interventions **“as collaborative means to address complex socioeconomic issues through interventions defined at a specific geographic scale”** (DHHS, 2012). A

review of place-based approaches by the University of Tasmania (2012) found place-based approaches have certain characteristics in that they:

1. Are designed to meet the unique needs of locations,
2. Engage stakeholders across all sectors in collaborative decision-making,
3. Seize opportunities, particularly local skills and resources,
4. Evolve and adapt to new learning and stakeholder interests,
5. Encourage collaborative action by crossing organisational borders and interests,
6. Pull together assets and knowledge through shared ownership, and
7. Attempt to change behaviour and norms in a location.

Place-based interventions overlap with other classifications of community interventions such as Collective Impact interventions, which encourage wide partnership processes to create social change but in theory are not developed around geographic boundary (Moore et al., 2014). Are there any other classifications?

A review of place-based initiatives conducted by CHETRE in 2007 found that while many interventions had been implemented to address health issues in areas of disadvantage, a knowledge gap existed as to the effectiveness of these interventions due to difficulties with evaluation (Larsen, 2007). The results that were available indicated links between the intervention and health outcome changes. This review noted a shift from infrastructure-focused interventions to include community capacity development and wider social and economic changes (Larsen, 2007).

SWSLHD already engages in at least one place-based intervention within its local area, the Community 2168 Project. This project commenced in 1999 and focuses on suburbs within the 2168 postcode. This community renewal and capacity building partnership has a wide partnership governance structure including NSW Health, Family and Community Services (FACS), Liverpool City Council and other government agencies, non-government organisations (NGOs) and community bodies. The priorities listed for the Community 2168 2015-2018 strategic plan are:

- Community Building, Engagement, Participation and Communication,
- Community Pride and Harmony,
- Urban Renewal,
- Employment and Skill Development,
- Education and Training,
- Community Safety,
- Health and Wellbeing (Liverpool City Council, n.d.).

Actions undertaken in these projects encompass a wide range of activities, including cultural and community pride programs, reduction of graffiti and vandalism, environmental sustainability programs, programs to increase employment opportunities, and police and community partnerships (Liverpool City Council, n.d.). The project also provides support and guidance for other Liverpool city council projects such as the Children’s Parliament project.

CHETRE conducted an evaluation of the Community 2168 project and found that the partnership process was a strength, and was seen as effective for developing communication, connection and trust and relationships between residents, service providers and organisations (Jaques, Silk and Kemp, 2014). The evaluation also found cost effectiveness was positively associated with improvements in outcomes in education and crime and safety indicators (Jaques, Silk and Kemp., 2014).

Mechanisms

In order to understand what makes effective place-based interventions it is important to understand not just their outcomes but also how they work and why. Mechanisms are a way of conceptualising how interventions work to create change. They create the link between the intervention activities (e.g. running a training program) and outcomes (e.g. increased employment rates). Mechanisms themselves are often not directly observable but can be understood as creating a change through providing resources (e.g. knowledge) that results in changes to peoples’ reasoning and reactions in a given context. The locational disadvantage program delivered by CHETRE operates across a number of mechanisms including building individual skills and community capacity, health literacy, fostering coalitions and networks, and supporting services (Table 2).

Table 2. Locational Disadvantage Program Mechanisms

Building community capacity - of or relating to the skills, instincts, abilities, processes and resources of a group in a geographical setting.
Fostering coalitions and networks - to convene groups of individuals to identify and work toward broader goals and have a greater impact than what can be addressed by individuals or a single organization. This includes formalizing partnerships.
Supporting services – providing assistance to services through supplying or supplementing resources, education or expertise.
Individual skill building - focus on increasing skills at the individual level.
Health literacy - the capacity of individuals to access, process and understand health services and information to make appropriate health decisions (Department of Health, 2011).

Approach

The aim of this project was to provide an evidence review of the impact and effectiveness of place-based interventions, and to provide recommendations for interventions that could be implemented with locationally disadvantaged communities in SWSLHD. A realist-informed approach was used. Realist approaches are based on an understanding that interventions occur within complex systems where context influences what and how mechanisms operate to lead to certain outcomes. Realist approaches assume that the same interventions do not work everywhere for everyone. The implication for this literature review is that there was a focus on identifying how and why place-based interventions work or not work, for whom, to what extent, in what ways, in what circumstances, and over what duration.

Early literature searches for this review showed that in many programs, the mechanisms were closely aligned to the intended project outcomes (for examples, projects that worked through build community capacity also explicitly aimed to build community capacity). Research questions were developed to identify how place-based interventions can assist SWSLHD with addressing locational disadvantage.

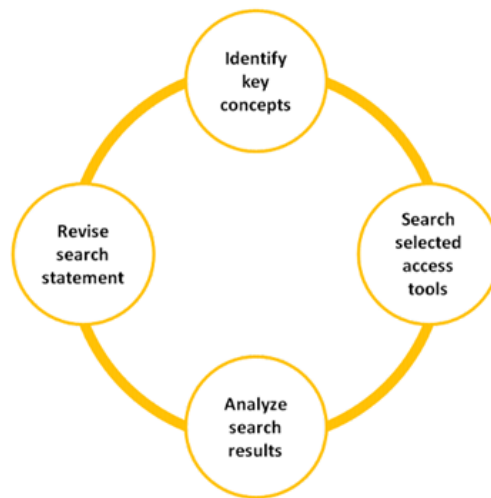
- 1. What place-based interventions are currently being implemented globally to improve health or the social determinants of health using the mechanisms of building individual skills and health literacy, community capacity, supporting services, and fostering coalitions and networks?**
- 2. What benefits and outcomes can be observed from place-based interventions and for whom?**
- 3. How do variations in program context and mechanisms influence the process and outcomes of place-based interventions?**

Methods

Search strategy

The literature review was conducted as an iterative process. The initial search was started in the peer reviewed literature and through consultation with some key advisors, then the search was expanded to the grey literature.

Figure 2. Iterative Search Strategy



(Virginia Polytechnic Institute and State University, 2017)

Identification of literature for inclusion

Inclusion criteria for the search were articles that were of:

- English language,
- Date range (2003-2017),
- Discussing place-based interventions,
- Relative to human health or determinants of human health, and
- Relative to disadvantaged areas by some categorisation.

The broad and contextual nature of what defines a place-based intervention created difficulties in identifying relevant literature. As such, the peer review literature search used a broad initial search strategy and then refined the search through MeSH headings used to code relevant papers in each database. Databases searched were *MEDLINE*, *Embase*, *CINAHL* and *Informit*. Search terms were developed through the use of primary search terms of *place-based*. Examples of primary MeSH terms used in combination include *program development*,

program evaluation, community based. Examples of secondary MeSH terms used in combination include *Public Health, Socioeconomic Factors* and *Health Status Disparities*.

Early reviews of the peer reviewed literature found that interventions focusing solely on individual skill building or health literacy failed to integrate a community and/or geographic focus characteristic of place-based interventions, and as such these papers were excluded.

Grey literature was found through a variety of sources. Different government and not for profit organisations around Australia have developed grey literature and/or reports documenting place-based interventions. Additionally, search engines such as the Guide to Community Preventive Services (U.S. government catalogue of evidence-based interventions), the Canadian Best Practices Portal, Substance Abuse and Mental Health Services Association's National Registry of Evidence-based Programs and Practices, Healthy People 2020 Stories from the Field and Google were used to identify place-based interventions. The grey literature was reviewed and catalogued using the guidelines outlined in the research proposal, including the setting of the program; the four mechanisms (community capacity, fostering coalitions and networks, supporting services, individual skill building and health literacy); which social determinants were addressed; whether and how it was evaluated; funding; partners; and relevance to Locational Disadvantage Program Logic.

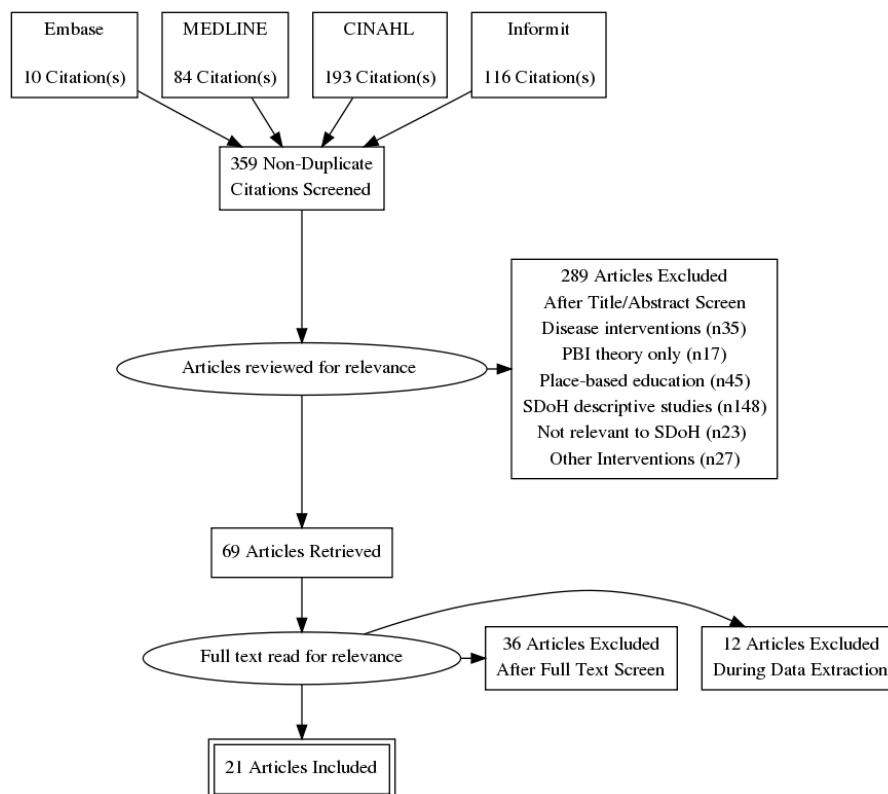
A systematic assessment of quality of the papers and methodologies used was not carried out.

Results

There was a significant body of peer reviewed literature and a large number of place-based intervention reports available describing place-based interventions being conducted in Australia and overseas. The peer reviewed literature ranged from theoretical discussions of place-based intervention to process and impact evaluations of place-based interventions. The peer reviewed literature search found 359 papers initially, of which 69 papers underwent a full review and 21 selected for inclusion in the final review (Figure 3). The grey literature was restricted to 30 reports and frameworks that were identified as describing place-based interventions that might be applicable to SWSLHD.

The 21 included peer reviewed papers addressed various topics including descriptions of place-based interventions, and included process and outcome evaluations of 15 different place-based intervention programs. One systematic review was included in the review. The peer reviewed papers were of varying quality in terms of the rigour and appropriateness of the studies and design. Papers were chosen based on how they added to the understanding of place-based interventions. Within the grey literature, there were frequently gaps in the information described in the reports including funding, partners, evaluations and context-specific measures.

Figure 3. Flow chart of the peer reviewed literature selection



Abbreviations: Place-based interventions (PBI), Social Determinants of Health (SDoH)

Appendix A contains a table showing the process and impact outcomes of programs described in the peer reviewed literature, and Appendix B contains a table showing the process and impact outcomes of the grey literature identified. Full data extraction tables will be made available to SWSLHD Population Health.

Of the reviewed literature, a majority were from programs run in the United States of America (n=17) and Australia (n=14). Seven papers described programs run in the United Kingdom. A few papers discussed programs run in Canada (n=2), the Netherlands (n=2) and Sweden (n=1). One report described a program that was run across the United States of America, Canada and Australia (Communities that Care, n.d.).

Overview of Place-based Interventions

The literature review revealed a significant number of place-based interventions being conducted both nationally and internationally. Programs are very diverse in their development and implementation, and target a wide range of health determinants. As a whole, most interventions were developed uniquely for their location, using a wide range of stakeholders and partnership approaches to design and/or implementation. Most place-based interventions were sophisticated programs that created complex partnership or coalition networks to implement multiple-component interventions aimed at changing the physical, social and/ or economic environment within the targeted intervention area. Comparing interventions was difficult given the variation within their processes and designs, as well as the reporting and indicators of success or effectiveness chosen by evaluators. There is significant discussion in the literature on how to properly evaluate place-based interventions and difficulties faced, and commentary on the varying quality of evaluations. Despite this, when evaluated for process or impact, a number of place-based interventions report positive outcomes. These results are expanded on in later sections.

Many programs targeted social determinants of health over specific health conditions, although some programs were explicitly focused on health or health related behaviours such as programs around healthy eating, exercise or tobacco use. The social determinants of health addressed most frequently in the grey literature were around the social and community context, neighbourhood and built environment development, education and economic stability.

There were several key factors that were described or extrapolated from the literature across a range of place-based interventions. These variations in program context were listed as occurring under broader headings of **Structural factors**, **Intervention design factors**, **Implementation factors** and **Outcome factors** (Table 3).

Table 3. Factors in place-based interventions

Structural Factors	Intervention Design Factors	Implementation Factors	Outcome Factors
Funding Governance Political	Intervention Target -Health -Social Determinants of Health Partnership Processes Geographic Area Program actions Communities Program Duration	Professional Organisations Implementation Completeness	Evaluation types Outcomes -Health -Social Determinants of Health

Some factors or features were explicitly noted in the literature as impacting on the effectiveness of place-based interventions. Patterns were also identified that appeared to influence the effectiveness of the programs. These factors have been highlighted in the below text, and are:

- Funding duration and cycles,
- Program duration,
- Governance,
- Partnership processes,
- Program actions, and
- Community involvement.

Mechanisms

The literature demonstrated that there were a variety of intervention designs that generate the mechanisms identified by CHETRE (Table 2). Interventions targeting different social determinants and health problems used the five mechanisms in a variety of ways. Most programs used multiple mechanisms. All peer reviewed literature referred to partnerships between organisations and community groups (*fostering coalitions and networks*) as a foundational factor in creating and conducting place-based interventions. Communities are a key consideration in place-based interventions, and *building community capacity* was found in most of the interventions reviewed. This underscores the importance of community input and activation in influencing the processes and outcomes of place-based interventions. Different programs developed community capacity through a variety of activities, including inclusion in the governance processes, involvement in the design of programs or specific program

actions aimed to develop capacity. *Supporting services* was more difficult to identify, however many programs involved the sharing of resources, funding local actors to implement programs and providing resources for implementers. Some programs had training (*individual skill building*) built in for the individual representatives of groups or businesses to enable those individuals to design and deliver the program and become its champions among their peers. In some cases, the *individual skill building* was related to increasing *health literacy* among community members.

One paper that looked at mechanisms of a place-based intervention was a case study of the New Deal for Communities (NDC) initiative. The NDC initiative is a bottom up strategy that involves key residents in neighbourhoods to create partnerships that implement a series of projects around a theme area to improve goals related to wide ranging areas such as crime, worklessness, education, health and housing quality. The paper suggested that health impacts from this program may result from three mechanisms; addressing socio-spatial stigma, community participation and the commissioning of projects designed to change the distribution of determinants of health, including access to services and healthy lifestyles (Parry et al., 2004).

In the following sections, the findings from the literature review are described in more detail.

Structural Factors

Funding

Funding for place-based interventions in the literature varied widely, but primarily came from government and/or grant processes. Most programmes were funded by government funds, although some were supported financially through philanthropic or private companies. Some interventions had mixed funding from government and non-government organisations, including organisations involved in the intervention partnerships. Occasionally these program partners provided other resources such as staffing or advice. In the Swedish program *Partnerships for Sustainable Welfare Development*, Froding et al. (2013) describe a model where partner organisations pay membership fees to be part of the place-based intervention but ultimately this partnership process was not sustainable for the partner organisations.

Funding

Funding is necessary for creating successful place-based interventions, supporting the partnerships, interventions and evaluation. However, a systematic review found that some interventions were successful despite inadequate funding support, indicating that other factors can support successful place-based interventions (O'Dwyer et al., 2007).

The amounts ranged from 20,000 Australian dollars for one year (VicHealth, 2013) to upwards of 5 billion euro over five years (Droomers et al., 2014). Frequently, large scale programs had an allocated funding amount that was distributed between smaller intervention areas. Many reports did not include the funding amount. Overall, it was found that programs that were supported by robust, multi-year funding were able to better capture evaluation metrics. These programs demonstrated more successful evaluation outcomes (O'Dwyer et al., 2007). Examples of this include the Australia-based *Communities that Care* program ("Communities that Care," n.d.) and the Canadian *Aboriginal Head Start in Urban and Northern Communities* Initiative ("Evaluation of the Aboriginal Head Start," 2012).

Some literature demonstrates how short duration, low-cost place-based interventions can be successful such as the *Localities Embracing and Accepting Diversity (LEAD)* program (VicHealth, 2013). This program created positive changes to self-rated measures associated with discrimination within the workplace, however its longer-term impacts are unknown (VicHealth, 2013). Participants in the *Townsville Health Action Zone (HAZ)* in the UK described that funding was a barrier to sustainable community participation, and leads to disillusionment with the process (Crawshaw, Bunton and Gillen, 2003). O'Dwyer et al. (2007) also noted in a systematic review of the effectiveness of place-based interventions that some interventions were considered successful despite

inadequate funding, indicating that other influencing factors can be important for ensuring good outcomes from place-based interventions.

Governance

Governance structures of place-based interventions often involve multiple levels of partnerships and governance, however details provided in the reports on these processes were often brief. Among the programs reviewed there were often an Advisory Committee and/or a Steering Committee, as well as working groups to address the different goals of the intervention. For instance, in the U.S.-based *Delta Bridge Project*, engaged parties created “Goal Teams” such as Economic Development, Housing, and Leadership Development (“Comprehensive Community Strategic Planning to Revitalize the Rural South,” n.d.).

A review of the governance systems by Plochg et al. (2013) found that a process of governance by collaboration used three stages: (i) formulating policy objectives, (ii) translating policy objectives into interventions, and (iii) executing health interventions. This collaborative governance process resulted in interventions being designed pragmatically rather than based on the original objectives selected. This undermined the effectiveness of the programme in reducing health inequalities (Plochg et al., 2013). This paper concluded that the local authority needs to pay attention to constructing effective governance processes, including the building and governing of networks, a competent public health workforce and supportive infrastructures (Plochg et al., 2013).

Political

O’Dwyer et al. (2007) noted in their systematic review that political contexts were a significant feature within the literature. While the grey literature did not identify political contexts as impediments or facilitators, peer reviewed literature evaluating process outcomes often noted that the policy making was influenced by political factors. Over half of the included program evaluations in the systematic review identified the political environment as influencing the outcome of the program; these included factors such as sudden changes in policy and insecure funding. Some place-based interventions were successful in spite of being conducted in insecure political environments (O’Dwyer et al., 2007). This study also concluded that political decisions often moved interventions away from strategies that could seriously tackle health inequalities (O’Dwyer et al., 2007).

Intervention Design Factors

Target of the intervention

By definition, place-based interventions aim to address social determinants of health (see Appendix A). Most of these social determinants targeted have well-established causal links to health outcomes. Within the grey literature, over a third (n=11) of the programs reviewed did not have any explicit health outcome targets and were instead designed to address at least one social determinant of health. Many programs targeted change in multiple areas.

Place-based interventions reviewed in the grey literature included a variety of partners, often rallied around one particular problem (not necessarily a health problem, but health-related i.e. determinants) to which each type of partner could contribute to program actions that aligned with their core company expertise (see additional example *Choice Neighbourhood*). Taking advantage of existing community assets to contribute to the program, partnership, or coalition can contribute to success and sustainability (“Cambridge Mass in Motion 2013 community report,” n.d.).

Health Targets

Place-based interventions have been used to address a diverse range of health problems and to change health related behaviours, from diabetes prevention (Maribyrnong City Council, n.d.) to obesity (REACH US). The partnership process allowed organisation to contribute different sets of expertise and a service delivery that might address the health target or related social determinants. For example, partners in Hoonah, Alaska, worked together to help address high rates of obesity. Led by the tribal communities, schools, residents, and other community groups organized a number of initiatives around this shared goal (“Fun and Fit,” 2012). Collaborating organisations like the Big Brothers Big Sisters offered expertise and access to the youth of the township, an important demographic group. Local government was also involved, allowing parks and recreational spaces to stay open for increasing physical activity and delivering social support interventions in community settings.

Below is a list that demonstrates the wide range of health or expressly health-related targets that programs aimed to change (note these are not mutually exclusive, numbers provided for grey literature only as provision of health targets were inconsistent in the peer reviewed literature):

- Increase physical activity (n=7),
- Increase consumption of fruit and vegetables (n=5),
- Improved mental health (n=3),

- Smoking cessation (n=3),
- Decrease substance abuse, delinquency, violence, teen pregnancy, school dropout, and mental health difficulties among young people,
- Increase access to fruit and vegetables,
- Increase access to opportunities for personal and community development through the arts for people from marginalised or otherwise disadvantaged communities to provide,
- Increase successful air quality monitoring,
- Decrease exposure to second hand smoke, and
- Prevent diabetes.

Social Determinants of Health Targets

The social determinants of health addressed by the place-based interventions reviewed were grouped into five broad classifications of: Economic Stability; Education; Social and Community Context; Health and Health Care; Neighbourhood and Built Environment (Office of Disease Prevention and Health Promotion [ODPHP], 2016). This classification system is used in the Healthy People 2020 report and provides an easy grouping system for multiple social determinants of health (Table 4).

Table 4. Classifications of Social Determinants of Health

Overarching social determinant of health	Sub-categories
Economic Stability	<ul style="list-style-type: none"> ● Employment ● Food Insecurity ● Housing Instability ● Poverty
Education	<ul style="list-style-type: none"> ● Early Childhood Education and Development ● Enrolment in Higher Education ● High School Graduation ● Language and Literacy
Social and Community Context	<ul style="list-style-type: none"> ● Civic Participation ● Discrimination ● Incarceration ● Social Cohesion
Health and Health Care	<ul style="list-style-type: none"> ● Access to Health Care (including primary care) ● Health Literacy
Neighbourhood and Built Environment	<ul style="list-style-type: none"> ● Access to Foods that Support Healthy Eating Patterns ● Crime and Violence ● Environmental Conditions ● Quality of Housing

(ODPHP, 2016)

The social determinants of health and sub-categories addressed most frequently in the literature were:

- Social and Community Context - Social Cohesion,
- Education - Early Childhood Education and Development,
- Neighbourhood and Built Environment - Access to Foods that Support Healthy Eating Patterns ,
- Neighbourhood and Built Environment - Environmental Conditions, and
- Economic Stability – Employment.

There were no place-based interventions reviewed that focused solely on Health and Health Care or its sub-categories.

The place-based interventions that did address any sub-category of Health and Health Care did so in conjunction with other determinants. In the review of the grey literature, the most commonly addressed social determinant of health was Neighbourhood and Built Environment. A number of peer reviewed papers also discussed social determinant of health targets of housing and built environment, along with changes to the physical environment. Many of these interventions were related to promoting and/or encouraging physical activity and healthy eating. However, there were some place-based interventions targeting Neighbourhood and Built Environment that sought to encourage tobacco cessation (“Community-Wide Effort to Make Florida Tobacco Free,” 2012), improve educational outcomes (Blank, Jacobson, and Minerve, n.d.; DSS, 2012; “Building child-centered communities,” n.d.; “Comprehensive Community Strategic Planning to Revitalize the Rural South,” n.d.; “Evaluation of the Aboriginal Head Start,” 2012; “National Partnership Agreement on Remote Service Delivery [NPARSD] Evaluation 2013,” 2014; “Promise Neighborhoods Institute,” 2015; United Way, n.d.), and even provide housing for high-priority frequent presenters to the local Emergency Department (The Alex, n.d.). Most (n=18) of the interventions reviewed addressed multiple social determinants of health, which reflects their interconnected nature. Economic stability to support early childhood development programs also featured, such as in the *Best Babies Zone* in Oakland, California, where a community market served as one program to reduce infant health inequalities (Vechakukl, Shrimali and Sandhu, 2015).

Partnership Processes

All place-based interventions reviewed enlisted multiple partners or partnering organizations. Common partners included:

- Public health organizations (government and community-based) (DSS, 2012; VicHealth, 2013),
- Academic institutions (from primary school through post-secondary) (Blank, Jacobson, and Minerve, n.d.; VicHealth, 2011b),
- Community-based organizations with a social determinant focus (The Alex, n.d.),
- Public services (“Improving Air Quality Through Community Partnerships,” 2012),
- International service organizations (e.g. Rotary Club) (“Communities that Care,” n.d.), and
- Philanthropic organisations (“Building Child-centered Communities,” n.d.).

Partnership Processes

Partnerships are a foundational aspect of place-based interventions, both theoretically and practically.

These partnership processes are key in increasing the reach, buy-in, and implementation, and ultimate success of place-based interventions.

A few place-based interventions with specific programmatic targets (e.g. arts for community and personal development) engaged organizations that would not traditionally be associated with a health-driven mission such as arts or workplaces (VicHealth, 2009, Ferdinand et al., 2017). Programs attempting to address a variety of social determinants benefitted from a variety of partners from different industries. Froding et al. (2013) found that alliances have the best chance of forming sustainable structures when they are formed at both the strategic and operational levels.

The complexity of partnership processes within place-based interventions was discussed in the peer reviewed literature. For example, a qualitative evaluation of the partnerships processes of the VicHealth LEAD program found that the complex partnerships model implemented was supported by the diverse participating organisations, but was time intensive, requiring effort to craft messages and allow partners to adopt new ways of thinking (Ferdinand et al., 2017). The evaluation of collaborative governance by Plochg et al. (2013) found that partnership processes could be considered an enabler or a barrier. A realist evaluation of the *Meeting for Care and Nuisance (MCN)* place-based intervention in the Netherlands found that the partnership process impacted outcomes at three levels- the organisational, the district and the neighbourhood. The biggest successes for the partnership processes were found at the organisation level, where the coordinated partnership strategy enabled role alignment, communication, and leadership. At the neighbourhood level, MCN’s joint assistance and enforcement strategy removed many of the underlying reasons for disturbances in

the neighbourhood, resulting in less nuisance. At the district level the impacts were less clear, with only one district noting improved perceptions of social control and area safety (Plochg et al., 2013).

In the review of grey literature, four frameworks for developing programs through partnerships were identified: some are focused on engaging the community for a needs assessment that is appropriate to the community context and represents the needs of all its groups, while others instead emphasised enlisting community support for action. A common theme among the four frameworks reviewed was guidance on mobilizing communities and local organizations. Some frameworks, such as *Mobilize, Assess, Plan, Implement, Track* (MAP-IT) and *Mobilizing for Action through Planning and Partnerships* (MAPP), focus on mobilizing the community to assess needs and priorities (Office of Disease Prevention and Health Promotion [ODPHP], n.d.; National Association of County and City Health Officials [NACCHO], n.d.). While these frameworks do include guidance for planning and implementation, their emphasis is on appropriate assessment. In contrast the *Community Engagement Framework* and *Tool for Health and Resilience In Vulnerable Environments* (THRIVE) concentrates on designing interventions in tandem with community representatives, and provide detailed, step-by-step instructions to create impactful programs (Smith, 2017; Prevention Institute, n.d.).

Geographic Area

The scale of place-based interventions ranged from one local community area (e.g. *Braybrook on Board*) to multiple communities around a state or nation (e.g. *Raising Places*). When the programs were implemented in multiple areas simultaneously, the evaluation methods were adapted to the local considerations and circumstances, but generally the overall program goals were captured across localities, with local results of different metrics of interest reported by each community (“Evaluation of the Aboriginal Head Start,” 2012; “NPARSD Evaluation 2013,” 2014; “Promise Neighborhoods Institute,” 2015).

The systematic review of place-based interventions effectiveness described geographic scale as an important factor (O’Dwyer et al, 2007). However, the authors felt that despite geographic location being a reference point of context for the intervention, addressing the area specific problems was rarely a central concern for place-based interventions that were evaluated (O’Dwyer et al., 2007). This was seen as a flaw of the evaluated programs, as the specific characteristics of an area provide important context to the theoretical approach of a place-based intervention.

Program actions

Program actions were diverse and often poorly described in the sources found. In large scale interventions such as *Health Action Zones (HAZ)* and the *New Deal for Communities (NDC)*, the overall funding and agendas for the program were set at high levels of the project governance, however the local program governance groups determined the specific actions to be implemented within each area. As such, less information is available about the program actions that occurred at the local level as part of these large programs.

The various program actions described across the place-based interventions can be considered under the following headings:

- Economic and employment,
- Health promotion,
- Housing and built environment development,
- Racism and discrimination,
- Education/opportunity, and
- Food system development.

There were a number of interventions that created health promoting changes to the housing and neighbourhood function. For example, making a community more conducive to physical activity or healthy eating through reopening a local pool or environmental changes and upgrades such as creating community gardens, in addition to designing interventions in community spaces (“Fun and Fit,” 2012, Healthy Eating Active Living, n.d.; Insurgency against Food Insecurity, n.d.; VicHealth, 2014). Twelve of the thirty interventions from the grey literature focused on two or more program actions.

Health promotion activities fall under the program actions, however most of the peer reviewed and grey literature did not provide insight into specifics of these programs, or the overarching best practices for health promotion activities in place-based interventions. The Neighbourhood Renewal program in Victoria, Australia, however found from a qualitative evaluation that there were two different approaches to the health promotion conducted under this program, namely cooperative and procedural (Warr, Mann and Kelaher, 2013). Cooperative approaches were efforts to understand and engage with the circumstances of the residents’ lives, and the procedural approaches tended to use generic off the shelf health promotion programmes with a focus

Program Actions

Program actions varied significantly and were not well reported in the literature. The systematic review by O’Dwyer et al. (2007) noted that ways of empowering people, and the use of various health promotion activities appeared to be linked to the success of place-based interventions.

more on organisational partnerships, and less reflection on the local contexts on health-related issues and (Warr et al., 2013). O'Dwyer et al (2007) noted that successful interventions all included ways of empowering people and various health promotion activities aimed at specific health issues such as smoking, heart disease and mental health.

Communities

Communities are a vital element through every stage of the place-based intervention process, as the ultimate aim is to improve the health of people within the geographic areas they reside. The literature suggests that buy-in and involvement of both communities and partnering organisations is crucial to the success of place-based interventions. Even the same program that targeted a particular health determinant delivered in multiple communities (often simultaneously) needed adaptation because of the variability of the feedback and priorities from distinct geographic communities (“Community-Wide Effort to Make Florida Tobacco Free,” 2012; “Promise Neighborhoods Institute,” 2015). There was a tendency of the literature to focus on descriptions of the challenges faced by communities whereas the strengths within the community were not described.

Community involvement

Multiple place-based intervention reports reviewed indicated that success hinged upon community participation and buy in, either at the governance, planning or implementation stages of the programs.

One demonstration of the value and use of community involvement is the *REACH US* program by the CDC, which utilised a community participatory approach from the earliest parts of design planning. This program used a community-based participatory approach to design community coalitions to act across three major interventions: building strong community-based coalitions; focusing on policy, systems and environmental improvements; and culturally tailored interventions (Youlian et al., 2016). A project called *My Health Matters* carried out in Stoke on Trent in the UK also used community participatory research as an approach to build effective community partnerships, and then the partnership consensus was used to identify, prioritise and design intervention(s) related to specific health disparities. The community was further involved through the recruitment of local residents to help with the delivery and sustainability of target interventions (Davey et al., 2011). The *Cape York Welfare Reform* delivered in a number of localities, noted that the success of the program varied in direct proportion to community buy-in (DSS, 2012).

Some of the larger-scale place-based intervention programs required communities to apply for funding within the process, which Parry et al. (2004) identified as possibly having negative impacts on the communities to be judged as “deserving” through the increasing social spatial stigma.

Specific Population groups

Communities targeted through place-based interventions were geographically based, and tended to be described and reported on as a homogenous group. However, some place-based interventions prioritised certain sub-groups by characteristics such as age (VicHealth, 2011b), housing status (The Alex, n.d.), or cultural/national/ethnic background (“PACE”, n.d.). The most common among these were families and children or culturally and linguistically diverse (CALD) groups (VicHealth, 2013; VicHealth, 2014).

Many place-based interventions found in the grey literature focused on young people as the target audience; these interventions were aimed at early childhood education and development (Blank, Jacobson, and Minerve, n.d.; Australian Government Department of Social Services [DSS], 2012; “Building Child-centered Communities,” n.d.; “Comprehensive Community Strategic Planning to Revitalize the Rural South,” n.d.; “Evaluation of the Aboriginal Head Start,” 2012; “National Partnership Agreement on Remote Service Delivery [NPARSD] Evaluation 2013,” 2014; “Promise Neighborhoods Institute,” 2015; United Way, n.d.), as well as issues related to youth problems (e.g. substance abuse, teen pregnancy, mental health, etc.) (“Communities that Care,” n.d.).

Within Australia there are a number of place-based interventions targeting specific population groups including:

- Aboriginal and Torres Strait Islander people,
 - *COAG Indigenous Trials* (2002-2007),
 - *Meeting Challenges, Making Choices* (2002-2005),
 - *Communities in Crisis* (2003-2007) (in Gilbert, 2012).
- CALD groups,
 - *Localities Embracing and Accepting Diversity* (LEAD) (Ferdinand et al., 2017),
 - *Building Bridges* (VicHealth, 2013).
- Families and Children,
 - *Ready to Read* (United Way, n.d.),
 - *Communities that Care* (n.d.).

Program Duration

Program durations differed significantly, ranging from one year to a decade or longer, and often varied in proportion to funding. A number of the large scale, well-funded programs ran for significant timeframes. In general, the longer-term interventions were seen as more able to be effective in creating change in their communities.

However, some smaller scale programs also reported achieving their proposed outcomes. As mentioned in the Funding section, the short term, low-resource *Building Bridges* from VicHealth was able to successfully create opportunities for local organisations to bring community members together with the goal of reducing prejudice and improving mental health among new arrivals to Australia, including refugees (VicHealth, 2013).

Program Duration

While the peer reviewed literature suggests that longer duration, better funded programs were likely to be more successful, some shorter term, smaller scale programs were found to produce successful change within the social determinant environments. However the longer term impact of these programs is unknown.

Implementation Factors

Professional Organisations

Professional organisations such as public health governmental bodies, organisations, and professionals most commonly initiate and govern place-based interventions. They are also frequently the accountable bodies for the processes and outcomes of the programmes. A qualitative-based process evaluation of the *Target Wellbeing* program in England found that the interdependency of area-based initiative providers with other actors in their organisations constrained the ways in which they worked with providers outside of their own organisations (Powell, Thurston and Bloyce 2014). Earning a ‘Local’ status, enabled some providers to have greater control over the way in which provider relationships developed during the course of the initiative (Powell et al., 2014).

While reports indicate that professional organisations were often responsible for spearheading the design, delivery, and evaluation of the place-based interventions reviewed, there were exceptions. The *Talking About Mental Illness* program (n.d.), which sought to increase awareness of mental health and related stigma, was developed to be delivered by people without specialised training. The *Aboriginal Head Start in Urban and Northern Communities* (2012), a community-based early intervention children’s program, funded Canadian Aboriginal community organizations to design and deliver the intervention.

Implementation Completeness

The systematic review by O’Dwyer et al. (2007) noted that place-based interventions were often inadequately implemented. Reporting on implementation was infrequent within the peer reviewed and grey literature, and it is difficult to know how the planned program actions were eventually implemented. This is a potential for significant deviation of programs from their goals and has the potential to impact outcomes.

Outcome Factors

Evaluation

Depending on the program, evaluations ranged from surveys administered to participants directly after all or part of an intervention, to policy and population-level health outcomes. Programs that were coordinated within multiple localities simultaneously often employed different methods and metrics for evaluation. Many programs reviewed were rolled out in many different localities, coordinated by one national (or international) body, with each locality adapting the place-based intervention to local needs and determining their own partners. For example, localities around the U.S. adopted the federal Department of Education *Cradle to Career* Program, a collective impact-focused program with communities of practice, targeting education outcomes (“Promise Neighborhoods Institute,” 2015). Each participating community chose its unique programmatic focus as well as appropriate partners. As a result, evaluation metrics and methods varied by setting. Examples include: kindergarten readiness score; percent of children in early learning environment; participation in expanded learning programs; parenting knowledge and behaviours; and absenteeism. This can also be seen in examples across the United Kingdom of the HAZ and Whole Place Community Budgets programs which were coordinated centrally but implemented regionally in a variety of ways (“Altogether Better West Cheshire,” n.d.).

An Australia-based place-based intervention, *Communities that Care* (n.d.), aimed at preventing youth problems of delinquency, teen pregnancy, substance abuse, violence, school dropout, and mental health difficulties employed a randomised control trial (RCT) design in the evaluation, showing that those who participated in the program were less likely than the controls to initiate the problems targeted, or directly-related behaviours. This RCT design, while commonly accepted as the gold standard, could be hard to accomplish for ethics and funding-related issues. This is compounded by the issue of finding a suitable control group, a particularly difficult task when an intervention is to be delivered in one particular geographic setting. The *Well London* program is one example of a larger scale program that was designed as an RCT (Wall et al. 2009).

Outcomes

Many successful outcomes have been shown in both process and outcome or impact evaluations. Some studies showed a slowed or reduced widening of measures of inequality when compared to non-intervention areas, indicating the slowing of the widening gap between communities living in disadvantaged and non-disadvantaged communities (Kelaher, Warr and Tacticos, 2010, Youlain et al., 2016). A systematic review found that while only five of the 24 evaluations included were considered to be generally successful by the evaluators, this did not imply that place-based interventions are not useful or effective interventions (O’Dwyer et al., 2007). O’Dwyer and colleagues noted that judging success of place-based interventions is difficult due to external influencing

factors, the diversity of the interventions and evaluation quality (2007). Overall, the paper concluded there is evidence that value is demonstrated in well-designed and well-funded programs to change the places they are conducted in.

Social Determinants of Health Outcomes

The literature indicates that place-based interventions have successfully influenced social determinants of health outcomes, using a variety of methods and metrics to measure the changes. An evaluation of the New Deal for Communities (NDC) intervention found it may have contributed to narrowing, or at least preventing the widening of, the gap between the most and least disadvantaged parts of England across a number of social determinants including education (Stafford et al., 2014). A quasi experimental study of the “Go Well” Neighbourhood renewal strategy in the UK found that proportionate universalism (resourcing and delivering of services at a scale and intensity proportionate to the degree of need) was in practice regarding the investment patterns of the program and that the more disadvantaged areas were allocated more financial investment (Egan et al., 2016). This study also reported that these areas of higher investment had a modest reduction in area-based disadvantage compared to areas that received less investment.

Below are a number of examples of how social determinants of health feature in the evaluation of select place-based interventions.

Social and Community Context - Social Cohesion

To capture improvements in social cohesion, *Community Arts Development Scheme* evaluators indicate that responding participants reported improvement in social support and mental health and wellbeing along with increased awareness of mental health and wellbeing (VicHealth, 2009). Similarly, new arrival participants in the *Building Bridges* program reported improvements in mental health (VicHealth, 2013).

Education - Early Childhood Education and Development

The *Cape York Welfare Reform* captured community-level outcomes such as increase in educational attainment among Indigenous Australians and increased school attendance overall as metrics of early childhood education and development (DSS, 2012). United Way (n.d.), instead surveyed participating parents and children and noted increased confidence and emotional resilience for starting school to measure the same social determinant. A controlled intervention study of the NDC areas found that the intervention may have contributed to a reduction in the widening of inequalities in educational attainment and self-reported health scores when compared to non-intervention (Stafford et al., 2014).

Neighbourhood and Built Environment - Access to Foods that Support Healthy Eating Patterns

VicHealth's *Food for All* (2011a) cited increased provision of fresh food, inclusive community garden programs and increased community transport as indicators of improving access to foods that support healthy eating patterns, while *Insurgency Against Food Insecurity* (n.d.) accomplished this through reducing the number of food deserts.

Neighbourhood and Built Environment - Environmental Conditions

In evaluating the effect of the *Partnership for an Active Community Environment (PACE)* (n.d.), evaluators noted that the social determinant related environmental conditions were addressed and evaluated these through observation (state and physical activity taking place). In the final assessment report for the NDC program, it was reported that neighbourhoods saw improvements across a broad range of indicators in comparison to similarly deprived areas with no intervention. The biggest change reported was among the indicators associated with how residents felt about their neighbourhoods (Batty et al., 2010).

Economic Stability - Employment

The social determinant of employment was captured by increased numbers of job placements (NPARSD Evaluation, 2014) as well as community attitudes that indicated individuals believed their own lives were improving with respect to employment (DSS, 2012). The *Best Babies Zone* in Oakland, California, found early changes that indicated positive economic outcomes through the creation of a local community market (Vechakul et al., 2015).

Health outcomes

Health outcomes were less frequently noted as outcome changes in place-based interventions. This is attributed to the difficulty in evaluating health changes in the participating populations, and also the known challenges of measuring health changes in complex systems. Two interventions aimed at housing and built environment changes found positive impacts of their interventions. A before-after study of a neighbourhood renewal program in Victoria, Australia found the self-rated health and life satisfaction levels of people living in the intervention areas improved compared to those in the surrounding local government area (Kelaher et al., 2010). A longitudinal cohort study of a city-wide housing-led place-based intervention found that mean self-reported mental health scores improved, and physical health scores decreased less, in areas that received higher levels of investment than those that received lower levels of investment (Egan et al., 2016). The REACH program, a place-

based intervention program created using a community-based participatory approach found a reduced prevalence in Black communities participating in the program to non-participating communities (Youlian et al., 2016).

In the grey literature, many interventions included self-reported health outcomes, or health behaviour outcomes. For example, intention to be more physically active (Vic Health, 2016), increased perceived social support (VicHealth, 2009), and increased confidence and emotional resilience in starting school (United Way, n.d.). One youth smoking prevention/cessation program also reported on billions of dollars saved (“Community-Wide Effort to Make Florida Tobacco Free,” 2012), which may be an especially persuasive metric when advocating for resources or policy changes. The program *Insurgency Against Food Insecurity* (n.d.) documented community-level reductions in diabetes and obesity, and *Health Eating and Active Living* (n.d.) measured weight loss as a health outcome.

Discussion

Building Successful Place-based Interventions in South West Sydney

The health challenges faced by communities in South West Sydney are underscored by complex and multifaceted social, economic, environmental and political factors. Addressing these challenges requires working outside of the health system to partner with communities and non-health organisations. Place-based interventions provide a way of working within these complex systems.

Population Health at SWSLHD and CHETRE currently engage with the complexities of the determinants of health equity through their strategic plans and practice. Place-based interventions provide a structured process to address the determinants of health that fall outside of the sole remit, expertise or resources of health organisations. This review has identified a number of features and recommendations for creating successful place-based interventions that SWSLHD could consider during development or participation in place-based interventions.

Influencing health through determinants

Place-based interventions are more frequently and successfully used to target social determinant of health outcomes, rather than health outcomes. Influencing health through a place-based intervention approach requires careful consideration of the ways in which determinants influence health and the complex systems in which they occur. The effectiveness of place-based interventions can also depend on choosing determinant targets that are within the reach and power of the involved local actors to influence. For example, O'Dwyer et al (2007) note that employment policies may be enacted at a federal level, making local interventions for employment restricted in their potential success unless actions attempt to work around this structural disadvantage.

Recommendation

Develop an understanding of the social determinants of health (equity) of community of interest (including causal pathways to ill-health).

Before commencing place-based interventions it is important to develop a thorough understanding of the mechanisms and contextual influences that lead to potential health outcomes. It is also important to understand which activities are amenable to change at a local level. Activities that can build this knowledge include; use of social determinant of health and equity frameworks when exploring social determinants, mapping exercises of stakeholder's' roles and influence, and engaging in techniques such as community based participatory research when researching communities.

Equity within programs

Equity is a key concern of SWSLHD and CHETRE, due to the nature of the disadvantage experienced by the local communities in the area. Health inequity is best addressed through changing social circumstances and processes that produce unfair differences in health in certain communities, indicating that improving health equity is implicit to the place-based intervention approach (VicHealth, 2015). However, the terminology around health equity is infrequently explicitly used within the literature. Results from some of the evaluations show that areas that are the focus of place-based interventions have slower widening of social inequities or disease rates (e.g. obesity in the *REACH US* program) or self-reported health (*Neighbourhood renewal strategy*). The early inclusion of communities and the use of a community based participatory research or co-design can assist to understand the specific intersections of social determinants of health and the priorities for populations. Use of an equity framework should underscore any place-based intervention approach taken by SWSLHD to identify and understand how the potential interventions may address the avoidable health differences found within the local community.

Place-based interventions can support SWSLHD in promoting equity in areas such as early childhood development and education as well as for programming to promote the health of culturally and linguistically diverse communities. For example, interventions such as *Building Bridges* and *Localities Embracing and Accepting Diversity* developed by VicHealth would be achievable with relatively small amounts of funding to address race-, nationality-, and ethnicity-based discrimination (VicHealth, 2013; VicHealth, 2014).

Recommendation

Understand what types of program actions effectively target those social determinants of health equity at the community level.

This includes considering the evidence base as well as the feasibility of program actions thoroughly before they are implemented. If using health promotion interventions from other programs or locations, use the previously established knowledge of the community specific causal pathways and context to adapt programs for a local fit. Carry out an analysis of potential equity impacts during intervention selection and planning. Further investigation of the applicability of research translation for scaling up programs would be useful to understand the components of effective scaling up.

Place and scale

The issue of local context is important to the creation of place-based interventions in the South West Sydney area. While the literature does not describe the key contexts of the place in which place-based interventions are carried out, the programs described are dependent on the areas in which they are based. Place-based interventions can be enacted on multiple scales as seen throughout the review. It is important to understand the individual contexts of each region involved, the unique factors influencing determinants of health and the diverse populations in that area and the multiple scales that interventions may operate, influence and be influenced by. No studies described the process of adapting or transferring interventions to fit new areas, or factors related with scaling up programs. O'Dwyer et al. (2007) noted that scaling programs up is possible but it is important not to override the power of local actors in the area, or to reduce the potential interactions between stakeholders.

Investment and returns

Place-based interventions are long-term investments that often take time to demonstrate population-level health outcomes. As place-based interventions seek to change structural and social determinants of health, systems change is involved. Changing high-level systems requires cooperation and action by many groups, and often local leadership and government are essential. As systems change takes place, health indicators that result from this change may not appear for years. To successfully account for these changes, consistent investment in evaluation of the overall impact and effectiveness should be built into planning from the onset. This should include resources to support a better understanding of how PBI's work through multi-level evaluation and the requisite staff time.

Recommendation

Commit to long-term investment of time and resources.

Stakeholders in place-based interventions should commit where possible to formalising partnership structures and funding for longer term programs. Sustainability of the partnerships and programs should be considered from the earliest planning stages to ensure longevity, and accountability procedures are in place to follow this up.

Partnership structures and relationships

Partnership structures are a core foundation of place-based interventions in theory and practice. The review has highlighted that place-based interventions are frequently developed and implemented through large and complex partnerships with other organisations and communities. The evidence suggests that while these processes can be challenging, they are also rewarding in that investments in complex partnership processes can lead to positive changes for all stakeholders involved (Moore et al., 2014). The relationships between partners, as well as their arrangement and governance structure, can influence place-based intervention conception, design, implementation and evaluation. The literature noted that some of these processes could be positive, enabling communication, leadership and role alignment. However, these partnerships can have negative effects on a program's effectiveness through altering the focus of a program or politically influencing processes and outcomes. The implications of this should be considered in the development of the governance structures.

Of the frameworks reviewed, *Community Engagement Framework* (Smith, 2017) and *THRIVE* (Prevention Institute, n.d.) might be suitable for use in SWSLHD, as they focus on applying findings from previously-conducted community health needs and assets assessments. Two other frameworks focus on engagement with community partners in assessing community health and needs (MAP-IT, MAPP). Considering community and organisational buy-in have been identified as important factors for place-based intervention effectiveness in the

review, SWSLHD might consider a combination of different roles to take on. SWSLHD could assume a facilitating role in convening place-based intervention partnerships or help define a common goal for the participating community and organizations in a high-priority suburb or neighbourhood. This could be providing evidence around a particular health problem and its social determinants to galvanize support and action towards addressing these.

The literature offers little evidence for what might be protective factors to the sustainability of partnership structures in relation to place-based interventions. This might indicate that it varies from context to context as well as by the mix of partners involved.

Recommendation

Build strong partnership processes and engagement.

SWSLHD might consider a combination of different roles to take on within the partnership processes. The use of *Community Engagement Framework* (Smith, 2017) and *THRIVE* (Prevention Institute, n.d) may be useful resources for SWSLHD, due to their use on previously-conducted community health needs and assets assessments. Partnership and stakeholder mapping can assist with identifying strengths and resources that organisations already possess. Building formal partnerships is an important process that can assist with sustainability and longevity.

Change and compromise

Multiple factors within the place-based intervention process indicate that change and compromise are features to consider when undertaking place-based interventions. Plochg et al. (2013) found that the process of co-producing programs with multiple local actors can result in program actions not reflecting the original program goals. These changes can occur throughout the intervention process, and it is useful to remain aware that negotiation and change of direction are part of managing multiple expectations and stakeholders. These changes may not be detrimental to the success of place-based interventions, but they should be acknowledged as the project progresses to ensure that program interventions and outcomes still align with the intended aims of the program, or the readjustment of goals.

Recommendation

Integrate multi-level process and impact evaluations.

Monitoring and evaluation of place-based interventions should involve both process and impact evaluations and commence early in the planning stages of the program. These evaluations should be included in the original funding proposals, and accountability structures built in to ensure they are implemented.

Community control and empowerment

Best practices for community interventions recommend shifting control to communities, allowing (empowering) them to build and enact their own programs. While place-based interventions frequently focus on the partnerships and processes between formal implementers, multiple interventions also include community members in setting the direction and actions of the program (VicHealth, 2011b). Communities hold a stake in the success of place-based interventions; individual members can be empowered to contribute to the health of their communities, as was the case in *Let's Go Smart*, which aimed to improve access to healthy physical environments to residents of Springfield, Missouri. Residents in Springfield were educated on the benefits of and then engaged in improving the built environment for health (CDC, n.d.). Further, depending on the scope of the program and structures or determinants targeted, buy-in from the community, government at the local to federal level, and community institutions such as schools can be the key to the success and impact of place-based interventions (“Altogether Better West Cheshire,” n.d.; DSS, 2012; VicHealth, 2011b).

Recommendation

Ensure early and consistent community participation.

Incorporating approaches for co-production and co-design from the earliest planning stages assists in fulfilling the important contextual approach of place-based interventions. Using guidelines for best practice community participation provides the formal program developers and implementers a system to ensure programs are being built in a way that achieves the supporting opportunities for communities to build capacity.

Limitations

The conclusions made within this report are limited by methodological choices made to limit the scope of the project due to the time and resources available to conduct this review as well as the large amount of information available regarding place-based interventions. While the search across literature databases was methodical, the differences in labelling and terms used to identify place-based interventions meant that potential resources were missed during this process. Earlier iterations of the search strategy proposed contacting lead researchers with knowledge in place-based intervention however due to time constraints this was not completed. The grey literature search was conducted through searching major databases. The review could have been extended through snowball sampling and pursuing referenced works in other texts, which may have allowed for more in-depth searching for specific design elements in the literature such as place-based interventions that had been scaled up.

As discussed earlier in the report, the quality of documentation surrounding place-based interventions varied greatly. Sources across both the peer reviewed and grey literature reported inconsistently on the features of their programs. The completed evaluations were of inconsistent approach and rigour, even in the peer reviewed literature. This made comparing and analysing features difficult, and has been noted in previous literature. In future reviews of the literature, attempting to understand the specific outcomes of the program actions within the place-based intervention umbrella would be useful for examples of more specific workings of place-based interventions.

Conclusion

This review has shown how place-based interventions can add value to changing health in a region through taking a social determinants of health approach. By addressing the underlying determinants of health, place-based interventions provide an opportunity for health service providers to be involved in collaborative initiatives to address the underlying causes of ill health in areas of locational disadvantage that are characterised by material and social deprivation. They also work through mechanisms that build capacity and allow communities to take control of their own health outcomes. Community buy-in and involvement are essential components of place-based interventions.

Successful place-based interventions that target the social determinants of health can require large and long-term commitment in resources, time and funding. This review suggests that the best way to leverage funding and maximise benefits is through partnerships. Four evidence-based frameworks (CEF, MAP-IT, MAPP, and THRIVE) have been developed to assist public health practice organizations in forging the type of coalitions and partnerships that secure funding for, and implementation of, effective place-based interventions.

Place-based interventions are an appropriate approach to assist and influence the underlying causes of health in places of locational disadvantage like those found in areas of South West Sydney. Place-based interventions are currently carried out in the region and SWSLHD are already involved in PBIs such as Community 2168. This review has identified and integrated programmatic and theoretical knowledge of effective of place-based interventions and provides recommendations that can guide current and future PBIs in South West Sydney .

Key recommendations for building place-based interventions coming out of this review are:

1. Understand the contextual social determinants of health (equity) in the community of interest (including causal pathways to health)
 - a. Use of equity and social determinants of health frameworks to understand the local context
 - b. Early inclusions of community to understand their perspective and experience
2. Understand what types of interventions/programs target those social determinants of health
 - a. Consider the evidence base for programs as well as the feasibility
 - b. Adapt program actions for local context
3. Commit to long-term investment of time and resources
 - a. Formalised structures and funding committed by all stakeholders for longer term programs
 - b. Consider sustainability
4. Ensure early and consistent community participation
 - a. Use of approaches for co-production and co-design
 - b. Use of best practice community participation
5. Build strong collaborative partnership processes and engagement
 - a. Use of the frameworks CEF, MAP-IT, MAPP, and THRIVE
 - b. Build formal, accountable and long-term partnership commitments
 - c. Actor mapping
6. Integrate multi-level process and impact evaluations
 - a. Build in cost provisions and accountability structures early in design

Resources

Resources for building place-based interventions:

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Appendices

Appendix A) Outcomes Table - Peer Reviewed literature

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Townsville Health Action Zone (United Kingdom) Crawshaw et al., (2003)		
Social and community Context (It is suggested that multiple other determinants are addressed)	Not listed, reported multiple health outcomes sought	PROCESS: The community involvement process was seen to be a strength but involved challenges for professionals. There was debate around the definition, access and involvement of communities. The frequency of initiatives in targeted areas as well as initiative fatigue was noticed. A key process noted was the ability for communities to set the agenda in terms of needs, and the pressure to meet national priority agendas. Questions were raised around the process of participation and which community members were engaged. OUTCOME: Not reported in this study, outcomes available from other literature
My Health Matters (United Kingdom) Davey, et al., (2011)		
To be determined by community	Physical Activity and Healthy eating	PROCESS: The protocol study describes the process of using community-based research to design and develop the place-based intervention. OUTCOME: Not described in this study
Dutch District Approach (The Netherlands) Droomers et al., (2014)		

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Economic Stability Education Social and Community Context Neighbourhood and built environment	Not specified	<p>PROCESS: Standardised questionnaires, face to face interviews and a content analysis of the area-based interventions were conducted. It was determined that most districts address all the social determinants included in the review. It was seen that investments in primary schools, housing stock, green space and social safety had potential to create change at a district level. However, the scale of activity aimed at employment, income, education attainment and the social environment seemed too small to see impacts at the district level.</p> <p>OUTCOME: Not included in this paper</p>
Healthy Places North Carolina (USA) Dupre et al., (2016)		
Not identified in this study	Not identified in this study	<p>PROCESS: This study aims to explain the attributes of local actors involved in the process. Respondents' leadership attributes were similar across Healthy Places North Carolina counties. Local actors reported high levels of awareness and collaboration around community health improvement, the study found lower levels of capacity for connecting diversity, identifying barriers, and using resources in new ways to improve community health. Actors outside the health sector had generally lower levels of capacity than actors in the health sector. Those in the health sector exhibited the majority of network ties in their community; however, they were also the most segregated from actors in other sectors.</p> <p>OUTCOME: Not reported in this study</p>
Go Well (United Kingdom) Egan et al, (2016)		
Neighbourhood and Built Environment	Health inequalities by SF-12	<p>PROCESS: not reported in this study</p> <p>OUTCOME: This study suggested that an allocation to housing led renewal of areas was allocated according to population need (proportionate universalism was in practice). This had led to a modest reduction in area-based inequality over a five-year period.</p>
Partnerships for Sustainable Welfare Development (Sweden) Froding et al., (2013)		

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Varied depending on setting	Not listed in this study	<p>PROCESS: Political support, alliances and citizen participation are important building blocks for the place-based work. Political support was attributed as a way to achieve the outcome, and allowed for a consistent approach and allocation of resources. Preconditions to sustainable partnerships were seen to be continued political support after the formalised partnerships end as well as citizen participation. Alliances were found to have better chances of being sustainable if they were involved at multiple levels.</p> <p>OUTCOME: Not provided in this study</p>
Place-based interventions in Indigenous Communities in Australia (Summarized in Gilbert, 2012) Gilbert (2012).		
Multiple described in multiple interventions		A summary paper for the Indigenous Justice Clearinghouse details the processes and outcomes of multiple place-based interventions.
East Oakland Best Babies Zone (USA) Iton and Shrimali, (2016), Vechakul et al., (2015)		
Economic Stability Social and Community Context Neighbourhood and Built Environment	Reducing infant mortality rates, improving general health and wellbeing measures	<p>PROCESS: One program action was developed via a human centred design process. Interviews suggested this process could enhance community engagement; expedite the timeframe for challenge identification, program design, and implementation; and create innovative programs that address complex challenges.</p> <p>OUTCOME: Preliminary program impacts from one program action demonstrate that the Castlemont Community Market received positive responses and made some early positive economic outcomes.</p>
Neighbourhood Renewal (NR) Strategy (Australia) Kelaher et al., (2010)		
Social and Community Context Economic Stability Health and Health Care Neighbourhood and built Environment	Site dependent	<p>PROCESS: The interviews and group described two different styles of health promotion and community engagement-cooperative and procedural. Cooperative approaches were marked by efforts to gain an understanding of and engagement with the circumstances of the resident's lives, and the procedurals limited reflections on the local contexts on health-related issues, languages that emphasised the differences and generic "off the shelf" health promotion programmes focus more on organisational partnerships</p> <p>OUTCOME: Not described in studies reviewed for this report but can be found here http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.679.4076&rep=rep1&type=pdf and here https://www.parliament.vic.gov.au/images/stories/committees/paec/2010-11_Budget_Estimates/Extra_bits/Neighbourhood_Renewal_-_evaluations.pdf</p>
Meeting for Care and Nuisance (The Netherlands)		

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Kramer et al., (2016)		
Social and Community Context	Not Specified	PROCESS: At organisational level, MCN's coordinated partnership strategy enabled role alignment, communication, and leadership.
Neighbourhood and Built Environment		OUTCOME: At the level of nuisance households, MCN's joint assistance and enforcement strategy removed many of the underlying reasons for nuisance. This resulted in less neighbour nuisance. At the district level, perceptions of social control and area safety improved only in one district.
New Deal for Communities Urban Regeneration scheme (UK)		
Parry et al., (2004), Stafford et al., (2014)		
Neighbourhood and Built Environment - environmental conditions	Health outcomes	PROCESS: A review of the potential mechanism for health changes finds health impacts may result from three mechanisms: socio spatial stigma, community participation and the commissioning of projects designed to change the distribution of determinants of health.
Social and community context		OUTCOME: Some evidence that the NDC intervention may have contributed to narrowing, or at least preventing the widening of, the gap between the most and least disadvantaged parts of England.
Crime and Safety		Full evaluation not included in this review but available from Batty, E., Beatty, C., Foden, M., Lawless, P., Pearson, and S., Wilson, I., (2010). <i>The New Deal for Communities Experience: a final assessment</i> . The New Deal for Communities Evaluation: Final Report — Volume 7. Department for Communities and Local Government, London.
Education and Employment		
Target Wellbeing (UK)		
Powell et al., (2014)		
Neighbourhood and Built Environment	Healthy Eating, Physical Activity, Mental Wellbeing Incidence of Coronary Artery Disease	PROCESS: The interdependency of area-based initiative providers with others in their organisation (what is termed here as 'organisational pull') constrained the ways in which they worked with providers outside of their own organisations. 'Local' status, which could be earned over time, enabled some providers to exert greater control over the way in which provider relations developed during the course of the initiative.
Social and Community Context		OUTCOME: Not evaluated in paper reviewed
Well London (UK)		
Wall et al., (2009)		
Neighbourhood and Built Environment	Diet, Physical Activity, Mental Health and Wellbeing	PROCESS: Not evaluated in paper reviewed
Social and Community Context		OUTCOME: Not evaluated in paper reviewed Phase 1 evaluation available in separate literature

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Racial and Ethnic Approaches to Community Health across the United States (REACH US) (USA) Youlian et al., (2016)		
Health and Health Care Neighbourhood and Built Environment Social and Community Context	Health promotion and chronic disease prevention, obesity reduction	PROCESS: Not evaluated in this paper OUTCOME: The prevalence of obesity among Black communities within the REACH US project decreased from 2009 through 2012.

Appendix B) Outcomes Table - Grey Reviewed literature

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Localities Embracing and Accepting Diversity [LEAD] (Australia) https://www.vichealth.vic.gov.au/programs-and-projects/localities-embracing-and-accepting-diversity		
Social and community context-social cohesion, discrimination	Mental Health via anti-racism and anti-discrimination	<p>PROCESS: 974 inter-group contacts were observed; 5-7 Aboriginal and CALD workers recruited to administer surveys in each LGA; 1236 residents completed the Community Attitudes survey; 1139 people from CALD communities completed the Experiences of Racism Survey</p> <p>OUTCOME: The pro-diversity social marketing, pro-diversity or cultural awareness training, work experience for diverse groups' human resources policy development, local awareness-raising and pro-diversity policy change strategies all resulted in a decrease in the belief that people from different racial, ethnic, cultural and religious backgrounds don't get along in the workplace, and in an increase in people preferring to work in a diverse organisation. Increase in reporting vicarious discrimination; increase in believing that discrimination is a problem in Australia; decrease in feeling uncomfortable with having a manager from a different background; decrease in feeling anxiety around people from a different background; decrease in believing that Australia is weakened by people from various backgrounds sticking to their old ways was associated with four of the six strategies</p>
Promoting physical activity through local community programs (Australia) https://www.vichealth.vic.gov.au/media-and-resources/publications/community-activation		
Neighbourhood and built environment-environmental conditions	Increase physical activity	<p>PROCESS: 5 councils/community spaces; 417 hours of physical activity delivered; 430 events delivered; 1,091 days of activation; 23,830 participants; 65 partnerships developed</p> <p>OUTCOME: Of participants surveyed, 59% intended to remain more physically active; 89% felt that the space made it easier to be physically active; 93% felt the space made it easier for them to be more socially connected in their community</p>
Food For All (Australia) https://www.vichealth.vic.gov.au/programs-and-projects/food-for-all		

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Neighbourhood and built environment- Access to Foods that Support Healthy Eating Patterns	Increase consumption of and access to healthy foods	<p>PROCESS: Not reported</p> <p>OUTCOME: By the end of the funding period in 2010, food security was incorporated into many council plans, policies and strategic priorities, including those that address infrastructure barriers; council operations were changing in order to support food security. Hundreds of partnerships between local government and local community organisations formed; increased capacity of local government, community members and organisations to advocate for food security at a state and local level; among community members: raised awareness, understanding and intention to implement new knowledge related to shopping, food preparation, and cooking; increased knowledge, skills and intention to implement among newly arrived people and those from non-English speaking backgrounds; increased provision of cheap meals by local businesses; reduced barriers and increased consumption (emergency food relief); increased provision of fresh food; communal gardens effective in overcoming social and cultural barriers; community transport reduced barriers in older people and probably increased consumption of healthy foods.</p>

Community Arts Development Scheme (Australia)

<https://www.vichealth.vic.gov.au/search/evaluation-of-the-community-arts-development-scheme>

Social and Community Context- social cohesion	people from marginalised or otherwise disadvantaged communities to provide opportunities for personal and community development through the arts	<p>PROCESS: High scores on the Arts Climate Scale from all participating organizations</p> <p>OUTCOME: Among respondents: improvement in social support; improved mental health and wellbeing; increased awareness in communities of mental health and wellbeing; the arts organisations were successful in engaging the community in civic dialogue</p>
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Streets Ahead (Australia)

<https://www.vichealth.vic.gov.au/search/streets-ahead-evaluation-report-2008-2011>

Neighbourhood and built environment- environmental conditions		<p>PROCESS: not reported</p> <p>OUTCOME: different outcomes depending on the locality. Increase in active travel rate; at least fifty Karen, Sudanese and Burundi children and youth were assisted to play winter sport over one year</p>
Also targeted a cultural/attitude shift around actively commuting	Increase physical activity	

Building Bridges (Australia)

<https://www.vichealth.vic.gov.au/search/building-bridges-evaluation>

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Social and community context- social cohesion	supporting contact between culturally diverse groups in order to reduce prejudice and improve the mental health and wellbeing of participants	PROCESS: not reported OUTCOME: Improved mental health of new arrivals to Australia
Rapid Response Notification System (U.S.A.) https://www.healthypeople.gov/2020/healthy-people-in-action/story/improving-air-quality-through-community-partnerships		
Neighbourhood and Built Environment- Environmental Conditions	Air quality monitoring	PROCESS: not reported OUTCOME: LHD and partners had successful response to 12/14 human generated dust incidents; greater ability to keep air quality levels from exceeding health-based air pollution thresholds
Choice Neighbourhood (U.S.A.) https://portal.hud.gov/hudportal/documents/huddoc?id=cssp_hud_seattle.pdf		
Education- Early Childhood Education and Development	No explicit health outcome.	PROCESS: 180 students (out of 400 total enrolled) participated in an after-school tutoring program, which was supported by 80 Seattle University students, five non-profit partners, and 10+ teachers OUTCOME: Major increase in percentage of students passing the 5th grade state science test; creation of endowed scholarship fund for students to attend Seattle University
Cape York Welfare Reform (Australia) https://www.dss.gov.au/sites/default/files/documents/06_2017/cywr_evaluation_report_v1.2_0.pdf		
Economic Stability-employment Education- (absenteeism) Social and community context- social cohesion also sought to encourage home ownership, family responsibilities, business development, parenting skills workshops and college savings	No explicit health outcome. However, under the umbrella of social responsibility are expanded money management services: set up Wellbeing Centres offering counselling for drug, alcohol and emotional issues	PROCESS: Implementation of the CYWR varied across the four streams, the governance arrangements, service delivery and community participation; implementation in the four CYWR communities differed considerably; most of the services were welcomed both by community members and by service providers; 103 created paid jobs; 442 rental agreements in place OUTCOME: (some variation of outcomes among communities) increase in school attendance; increase in educational attainment among Indigenous Australians; (negative outcome) increase in disengaged youth; decreases in crime rates; increased perception that things were getting better and people were taking more responsibility for their lives; decline in hospitalisation rates for assault; decline in serious assaults; increase in percentage of Indigenous people who were volunteers; increased number of job placements; (negative outcome) increased proportion of adults on income support payments; increased school attendance

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
programs for parents		

National Partnership Agreement on Remote Service Delivery (Australia)

<https://www.pmc.gov.au/sites/default/files/publications/npa-remote-service-delivery-evaluation-2013.PDF>

<p>Neighbourhood and Built Environment- quality of housing</p> <p>Health and Health Care- Access to Health Care</p> <p>Economic Stability- employment</p> <p>Education- Early Childhood Education and Development</p>	<p>No explicit health outcome.</p>	<p>PROCESS: Mixed views on service coordination with some stakeholders and service providers suggesting that, in some instances, additional services had made the coordination task more challenging; the majority of service providers were positive about the effectiveness of Government Business Managers (GBMs) –66% and Regional Operation Centres (ROCs)–59% in helping to coordinate service delivery</p> <p>OUTCOME: Increase in service provision in NPA RSD communities such as new houses, Children and Family Centres, youth services and social services particularly for families; higher proportion of local service providers in RSD communities (43%) reported that services had increased in the previous three years than service providers who worked in non-RSD communities (28%); Indigenous overcrowding rates in RSD communities fell at a considerably faster rate from 2006 to 2011 than for very remote areas in general; half of all community members surveyed considered that their community (50%) and their own lives (52%) were improving (housing, infrastructure, early childhood education, employment); there were statistically significant differences in local service providers’ views of the NPA RSD, with those in Western Australia (78%) and Queensland (70%) more likely than those in the Northern Territory (62%) and New South Wales (53%) to say the RSD was beneficial; The objectives of the NPA RSD against which the least progress has been made are in building community capacity to engage with governments and building community governance and leadership capacity generally</p>
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Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Cradle to Career - Promise Neighbourhoods Institute at Policy Link (U.S.A.) http://promiseneighborhoodsinstitute.org/about-our-movement/site-results		
Education- Early Childhood Education and Development	No explicit health outcome.	<p>PROCESS: Not reported</p> <p>OUTCOME: (varied by individual setting) Among students: Decreased absenteeism; kindergarten readiness; increased number of children in early learning settings; increased Academic Performance Index scores. Among parents: parenting knowledge and behaviours increase; increase in parental engagement.</p>
Insurgency against Food Insecurity (U.S.A.) http://ctb.ku.edu/en/community-stories/insurgency_against_food_insecurity		
Neighbourhood and Built Environment- Access to Foods that Support Healthy Eating Patterns	increase access to fresh fruits and vegetables	<p>PROCESS: 7 gardens and 1 orchard built, 300 children per day fed in summer; 100 children per day fed during school year</p> <p>OUTCOME: Fewer food deserts; increased access to fruits and vegetables; lower community-level rates of diabetes and obesity</p>
Ready to Read (Australia) http://unitedway.com.au/place-based-community-collaborations		
Education- Early Childhood Education and Development, Language and Literacy	No explicit health outcome.	<p>PROCESS: Intervention reached 5570 children in 33 communities</p> <p>OUTCOME: For child and parent: increased confidence and emotional resilience for starting school, development of literary identity; connectedness, bonding and inclusion for parents and children; affinity for reading; language, vocabulary, life lessons, literacy, cultural norms, emotional regulation, life options, home literacy practice</p>
Comprehensive Community Strategic Planning to Revitalize the Rural South "Delta Bridge Project" (U.S.A.) http://ctb.ku.edu/en/southern-bancorp-strategic-planning		
Education- High School Graduation, Enrolment in Higher Education	No explicit health outcome.	<p>PROCESS: Not reported</p> <p>OUTCOME: Not a single club member has become a parent in a county with a high teen pregnancy rate. The launching of a \$2.1 million sweet potato processing facility and a \$25 million, 40-million-gallon per year biodiesel plant expands job opportunities.</p>
Pathways to Housing (Canada) http://housingfirsttoolkit.ca/evaluation-spotlight & http://www.thealex.ca/housing/		
Economic Stability- Housing Instability	No explicit health outcome.	<p>PROCESS: Not reported.</p> <p>OUTCOME: Not reported</p>
Communities that Care (U.S.A., Canada, Australia) http://cbpp-pcpe.phac-aspc.gc.ca/interventions/communities-that-care/		

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Education- High School Graduation Neighbourhood and Built Environment- Crime and Violence Social and Community Context- incarceration	decrease substance abuse, delinquency, violence, teen pregnancy, school dropout, and mental health difficulties among young people	PROCESS: Not reported OUTCOME: Those who were engaged with the program were: 25% less likely to have initiated delinquent behaviour, 32% less likely to have initiated the use of alcohol, 33% less likely to have initiated cigarette use than control community youths
Partnership for an Active Community Environment [PACE] (U.S.A.) http://cbpp-pcpe.phac-aspc.gc.ca/ppractice/partnership-for-an-active-community-environment-pace/		
Neighbourhood and Built Environment- Environmental Conditions	Increase physical activity	PROCESS: Not reported OUTCOME: No significant difference between intervention and comparison neighbourhoods; Observed physical activity - slight increase around the path but not the playground: moderate and vigorous activity, and vigorous activity from 10.5% to 13.7%
Talking About Mental Illness [TAMI] (U.S.A.) https://www.thecommunityguide.org/stories/community-wide-effort-make-florida-tobacco-free		
Social and Community Context- social cohesion, Discrimination Health and Health Care- health literacy	Mental Health awareness and decreasing related stigma	PROCESS: Not reported OUTCOME: Significant improvement in attitudes toward mental illness; significant increases in knowledge about mental illness
Community-Wide Effort to Make Florida Tobacco Free (U.S.A.) https://www.thecommunityguide.org/stories/community-wide-effort-make-florida-tobacco-free		
Social and Community Context- civic participation	Smoking cessation	PROCESS: Not reported OUTCOME: The smoking rate for adults in Florida decreased by 18.6%; 2 counties received additional funding to create a faith-based initiative to engage churches and ministers in promoting smoking cessation programs and resources to their congregations.
Rural Community Works Together to Stay "Fun and Fit" (U.S.A.) https://www.thecommunityguide.org/stories/rural-community-works-together-stay-fun-and-fit		
Neighbourhood and Built Environment- Access to Foods that Support Healthy Eating Patterns, Environmental Conditions	healthy eating and physical activity	PROCESS: Workgroup/coalition represents all segments of the Hoonah community including residents, community leaders, and organizations such as Big Brothers Big Sisters, Parents as Teachers, Hoonah Organizers for Peace and Equality, community youth centres, and local and state government agencies OUTCOME: Not reported

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Mass in Motion (U.S.A.) http://www.mass.gov/eohhs/docs/dph/mass-in-motion/community-reports/2013/cambridge.pdf		
Neighbourhood and Built Environment- Access to Foods that Support Healthy Eating Patterns, Environmental Conditions	healthy eating and physical activity	PROCESS: Not reported OUTCOME: 2 corner stores recruited for healthy market initiative; 3 farmers market began accepting WIC (Women, Infants, and Children)/SNAP (Supplemental Nutrition Assistance Program); increase in SNAP purchases; 1 new winter farmers market created; obesity rate is reported (but with no baseline comparison)
Healthy Eating Active Living (Australia) http://www.health.nsw.gov.au/heal/Publications/healthy-eating-active-living.pdf		
Neighbourhood and Built Environment- Access to Foods that Support Healthy Eating Patterns, Environmental Conditions	healthy eating and physical activity	PROCESS: 25,000 people participated in services OUTCOME: Decrease in overweight and obesity rates for children compared to 2012 (2013 Population Health Survey); 3.8kg in weight loss and 5.1 cm off waist circumference on average achieved by Get Healthy participants; 80 per cent of early childhood services across NSW participate in the Munch and Move program; One tonne combined weight loss achieved by 900 people from 20 Aboriginal communities
Aboriginal Head Start in Urban and Northern Communities (Canada) http://cbpp-pcpe.phac-aspc.gc.ca/aboriginalwtt/aboriginal-head-start-in-urban-and-northern-communities/		

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
<p>Education- Early Childhood Education and Development</p> <p>Health and Health Care- Health Literacy, Access to Health Care</p> <p>Social and Community Context- social cohesion</p>	<p>No explicit health outcome.</p>	<p>PROCESS: 155 AHSUNC early childhood educators attended Early Childhood Education training; 19 sites are delivering AHSUNC in the North; 55% of stakeholders report accessing knowledge products; 72 of AHSUNC sites receive in-kind donations</p> <p>OUTCOME: Measurable, positive effect on participants' language, social, motor and academic skills; length of time in the program correlates to higher school readiness scores; children with prior participation in the program had significantly higher school readiness scores at the beginning of the school year than new registrants of the same age; parents and teachers report children participants' improved confidence as well as social and verbal skills to greater cultural awareness and comfort with routines; language and cultural component led to increased exposure to Aboriginal culture and language skills; increase in AHSUNC participants' feeling that Aboriginal culture is important to them; increase in exposure to cultural activities; increase in participation in cultural activities such as telling stories, singing songs and participation in traditional or seasonal activities; 75% of parents/caregivers report having adopted positive change (nutrition or physical activity practices, healthy parenting practices, consultation with health professionals);63% of families report increase exposure to Aboriginal culture as a result of their child participating in the program Social, emotional & spiritual health: pro- social behaviour, self- regulation child's self- esteem, coping skills and overall emotional well-being; positive effects on children's access to daily physical activity as well as health and dental care; 67% of AHSUNC sites have leveraged funds from other sources and at an average rate of 19 cents per dollar of PHAC funding; improved educational outcomes (high school average, attendance, repeating a grade, tutoring & chronic health outcomes)</p>
<p>Tobacco-free Living (U.S.A.) https://www.cdc.gov/nccdphp/dch/programs/communitytransformation/accomplishments/index.htm</p>		
<p>Social and Community Context- civic participation</p> <p>Neighbourhood and Built Environment- Quality of housing</p>	<p>Decrease second-hand smoke exposure (and theoretically also tobacco cessation)</p>	<p>PROCESS: Not reported</p> <p>OUTCOME: 1 million+ North Carolina residents have increased protections from second-hand smoke exposure in county government buildings, local municipal government buildings, indoor public places, parks, multiunit private and HUD-supported rental housing, and college campuses</p>
<p>Let's Go Smart (U.S.A.) https://www.cdc.gov/nccdphp/dch/programs/communitytransformation/accomplishments/index.htm</p>		
<p>Neighbourhood and Built Environment- Environmental Conditions</p>	<p>increase physical activity</p>	<p>PROCESS: Not reported</p> <p>OUTCOME: Not reported</p>

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Healthy Communities of Clinton County Coalition (U.S.A.) http://www.countyhealthrankings.org/roadmaps/stories/engaging-community-through-health-coalitions		
targeted smoking within the home, sort of early childhood development but not exactly	teenage pregnancy, tobacco use, obesity and infant mortality	PROCESS: Not reported OUTCOME: 93% success rate for women who at least make it to the second session.
Braybrook on Board (Australia) https://www.maribyrnong.vic.gov.au/Community/Community-programs-and-grants/Leadership		
Neighbourhood and Built Environment- Environmental Conditions Economic Stability- employment Social and Community Context- social cohesion	diabetes prevention	PROCESS: 28 community members have graduated from Braybrook on Board, with six participants undertaking further education at university, TAFE or VET. 21 community projects involving 82 volunteers have been delivered, reaching more than 1,500 community members OUTCOME: Not reported
OPAL [Obesity Prevention and Lifestyle] (Australia) http://www.sahealth.sa.gov.au/wps/wcm/connect/4ea30f00446c4dfead87af76d172935c/G337+OPAL+Case+Studies+Copper+Coast+Wallaroo+INTERNAL.pdf?MOD=AJPERES&CACHEID=4ea30f00446c4dfead87af76d172935c		
Neighbourhood and Built Environment- Environmental Conditions, Access to Foods that Support Healthy Eating Patterns	No explicit health outcome.	PROCESS: Water fountains have been installed in the Wallaroo playground in addition to 13 bike racks OUTCOME: Not reported
Raising Places (U.S.A.) https://www.raisingplaces.org/		
Neighbourhood and Built Environment- Environmental Conditions Education- Early Childhood Education and Development	No explicit health outcome.	PROCESS: Not reported (each community still designing and researching their interventions) OUTCOME: Not reported (each community still designing and researching their interventions)
Altogether Better - West Cheshire (U.K.) http://www.altogetherbetterwestcheshire.org.uk/wp-content/uploads/2012/10/Operational-Plan1.pdf		

Social Determinant Addressed	Targeted Health Outcome	Evaluation Findings
Economic Stability - employment Neighbourhood and Built Environment - crime and violence	No explicit health outcome.	PROCESS: Not reported OUTCOME: Not reported