SEaRCH

SOUTH EASTERN SYDNEY RESEARCH COLLABORATION HUB

Equity-focused health impact assessment of Communities at the Centre (ComaC)

A place-based equity and wellbeing initiative in Maroubra

NSW GOVERNMENT Health
South Eastern Sydney Local Health District

UNSW SYDNEY

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Sponsor

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December 2018

Version	Date	Responsible	Changes made
v1	22 October 2018	Jinhee Kim	First draft
v2	06 November 2018	Jinhee Kim	
v3	09 November 2018	Jinhee Kim	Incorporating working group feedback
v4	09 December 2018	Jinhee Kim	Incorporating working group feedback
v5	10 December 2018	Jinhee Kim	Final version, all comments removed

SUGGESTED CITATION

Kim J, Harris-Roxas B, Powell L, Leves M, D'Astoli M, Hua M. (2018) *Equity-focused health impact assessment of Communities at the Centre(ComaC): a place-based equity and wellbeing initiative in Maroubra*, South Eastern Research Collaboration Hub, part of the Centre for Primary Health Care and Equity, UNSW Sydney: Sydney.

ABOUT SEaRCH

The South Eastern Sydney Research Collaboration Hub (SEaRCH) a partnership between the UNSW Sydney Centre for Primary Health Care and Equity (CPHCE) and the South Eastern Sydney Local Health District.

CPHCE is a research centre within the Faculty of Medicine, UNSW Sydney, that has been undertake primary health care since 1996. South Eastern Sydney Local Health District is a statutory authority responsible for 8 public hospitals and a range of community-based health services covering a culturally and linguistically diverse population of over 850,000 people.

SEaRCH's role is to strengthen the planning and delivery of evidence-based primary health and integrated care. We undertake research, evaluation and capacity building activities to strengthen primary health care and address health inequities, with the aim of contributing to better, fairer health in the community.

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ABBREVIATIONS

CALD	Culturally and linguistically diverse
ComaC	Communities at the Centre: A place-based equity and wellbeing initiative in Maroubra
EFHIA	Equity-focused Health Impact Assessment
FACS	NSW Department of Family and Community Services
LGA	Local Government Area
PHN	Primary Health Network
RCC	Randwick City Council
SESLHD	South Eastern Sydney Local Health District

EXECUTIVE SUMMARY

This ***equity focused health impact assessment (EFHIA)*** of the "***Communities at the Centre: A place-based equity and wellbeing initiative in Maroubra (ComaC)***" assesses the potential positive and negative impacts of the proposed initiative and offers recommendations that maximizes the positive impacts and minimises any potential negative impacts.

EFHIAs are recommended in the South Eastern Sydney Local Health District's Equity Strategy as a means to improve health equity. An EFHIA working group was formed with representation from the key partner agencies. The determinants social inclusion and access to services were scoped. Potential impacts were appraised using evidence from the community profile, literature review and public knowledge collected through community engagement.

SUMMARY OF IMPACTS:

It is likely that the proposed plans will positively impact **social inclusion** in the community. The plan can possibly bring unintended social exclusion to the 'hard to reach' population.

The proposed plans are likely to positively impact on individuals' **access to services**. However, the impact will be determined by the type of services, hours of operation, and other operational decisions. Many residents have multiple needs and detailed information on the extent of needs are limited. Structural barriers to access services such as transportation or safety can limit accessibility, which can potentially become barriers in bridging the gap.

RECOMMENDATIONS

The recommendations to improve social inclusion and access to services are the following.

What to retain

- Maintain the co-production approach, public knowledge collection and conversations with the community.
- Maintain the key partner agency partnership and governance structure and renew partnership structures when necessary.

What to enhance

- Identify and seek public knowledge with priority populations that were not heard (e.g. youth, Aboriginal people, CALD families).
- Develop strategies to engage with 'hard-to-reach' populations in the local area and communities.
- Develop a strategic communication plan to raise awareness of the *ComaC Initiative.*
- Support community members to participate in *ComaC* governance and activities, e.g. being on reference group, being involved, becoming a Connector – build supportive systems that allow people to be engaged.

What to monitor

- Monitor the unintended exclusion that may result from the *ComaC Initiative* by conducting regular reviews to compare the service users versus the community profile.
- Use Table 2 on effective place-based initiatives as a reference to revisit and assess fidelity of the approach.
- Monitor and strengthen activities to improve the demand-side of access to services. Use Table 3 as a reference to monitor activities and progress to improve access to services.
- Investigate ways of monitoring and describing mental health, isolation, disability (incl. psychosocial) into the initiative (lean data ideas – meaningful data and snapshots).
- Monitor annually the alignment between public knowledge and activities. Engagement of new partners and themes and knowledge might grow.

INTRODUCTION

COMMUNITIES AT THE CENTRE: A PLACE-BASED EQUITY AND WELLBEING INITIATIVE IN MAROUBRA (COMAC)

The "***Communities at the Centre: A place-based equity and wellbeing initiative in Maroubra (ComaC)***" is a multi-agency partnership, place-based initiative that aims to improve health equity in South Maroubra/Maroubra and surrounding areas that have large social housing estates. The community is placed at the centre of this initiative through an asset and co-production approach. South Eastern Sydney Local Health District (SESLHD), Randwick City Council (RCC), Family and Community Services (FACS), The Deli Women & Children's Centre (The Deli) have partnered to co-design the initiative. Through coordinated service delivery among the participating agencies, the initiative focuses on four core elements – a multi-purpose community hub, mobile outreach, community connectors, and community-driven activities. The concept framework of the initiative is depicted in Figure 1.

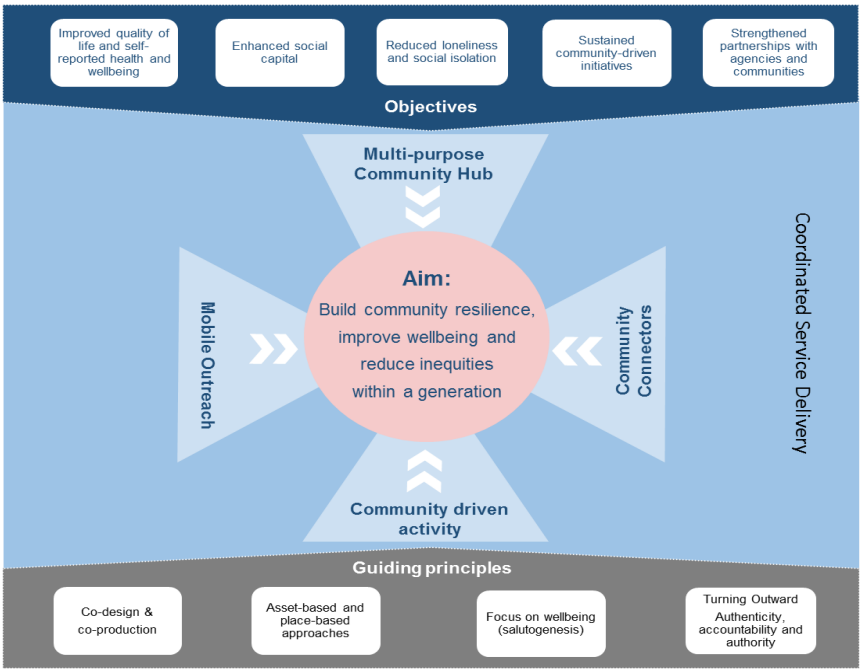

Figure 1. Communities at the Centre: A place-based equity and wellbeing initiative in Maroubra

EQUITY FOCUSED HEALTH IMPACT ASSESSMENT (EFHIA)

An ***equity focused health impact assessment (EFHIA)*** is a form of HIA that focuses on how initiatives can affect population groups differently, and develops recommendations focused on minimising harms and ensuring that benefits are fairly shared (Harris-Roxas, Haigh, Travaglia, & Kemp, 2014). An EFHIA on the ComaC initiative would identify the positive and negative impacts and their distribution of the proposed initiative and offer recommendations that maximizes the positive impacts and minimizes the negative impacts. By engaging key stakeholders and decision-makers in the EFHIA process, we expect that they will consider health impacts, the determinants of health, and the distribution of impacts in their deliberations. EFHIA is called for in the SESLHD Equity Strategy as a means to enhance health equity in guiding decisions and actions in development of its policies, programs, and services (SESLHD, 2015). Details of the EFHIA process can be found in **Annex 1** of this document.

COMMUNITY PROFILE

Relative advantage and disadvantage of Randwick Local Government Area

Figure 2 shows the SEIFA Relative Advantage and Disadvantage Percentile of Randwick Local Government Area (LGA). While the SA1 areas that have large social housing estates are some of the most disadvantaged areas in the country, the neighbouring areas are some of the most advantaged areas in the country.

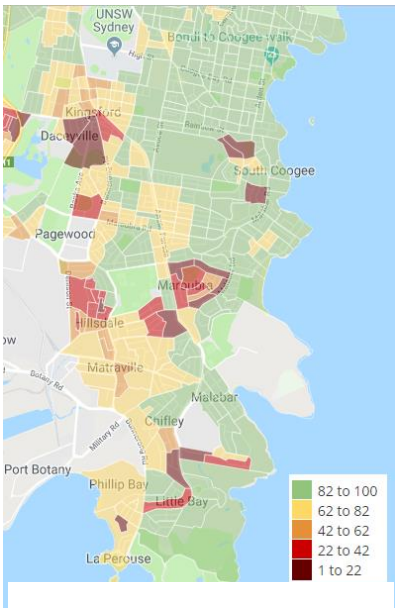

Figure 2. SEIFA Relative Advantage and Disadvantage (IRSAD) Percentile

Demographic profile of the social housing tenants

- There are a total of 5,416 tenants living in the social housing estates located in Randwick LGA. Maroubra houses the highest number of tenants, with a total population of 2,194 tenants, followed by South Coogee (1,019 tenants), Matraville (679 tenants), Malabar (601 tenants), Coogee (497 tenants) and Chifley & Little Bay (426 tenants).
- There are more females (56.0%) than males (44.0%).
- One-third of all tenants are aged 65 and older. Six out of ten tenants are 50 years and older.
- Children between 0-12 years old account for 9.4% of the tenants.
- The social housing tenants come from diverse cultural backgrounds. 1,600 tenants (29.5% of total tenants) come from 104 countries. 458 tenants (8.5%) report their main language to by one other than English.
- One out of ten tenants are Aboriginal.

Disability, Mental health, and social isolation

- In NSW, 35% of all social housing tenants are reported to have disability in 2012/13.
- People living in social housing are 2.4 times more likely to have a severe mental illness than those not living in social housing. It is estimated around 19% of people living in social housing have a severe mental illness, compared to around 8% in the general NSW population (FACS, 2014).
- In the South Maroubra area, 44.2% of all households are lone person households.

EVIDENCE FROM PUBLIC KNOWLEDGE

Staff from key agency partners met with community members during coffee and conversations (community engagement strategy) events and used the ASK Tool developed by the Harwood Institute to listen to and work with communities to identify community assets and aspirations. Four thematic areas were identified as safety, children and youth, housing and a connected community. The details of each theme are shown in Table 1.

Table 1 Themes derived from community conversations using the ASK tool

Theme	Details
Safety	All community members would feel safer and less frightened to leave the house and interact with others in the community. Poor mental health, youth, drug issues, fear of people breaking into houses affect sense of safety in this area. In a safer community, the shops would be open, and people would feel proud they live in this suburb.
Children and youth	Currently there are no programs for children and tweenies. There is only one program in the area hat caters to older teens. Having more programs for the youth would keep them busy and out of getting into trouble. Children and young people contribute to the community and should be valued as individuals.
Housing	Affordable housing would reduce social problems. Well maintained housing would provide more security, sense of safety and ownership. Better planned social housing allocation is needed and houses are needed for bigger families.
A connected community	A trusting community where people know their neighbours and look after each other will reduce isolation, depression and improve mental health.

Community conversations capture more in-depth narratives on each of the four identified themes. To date, a couple of community conversations were conducted on the theme of 'safety'. In the South Maroubra community, residents feel unsafe and threatened to perform everyday activities such as walking to shops and garbage bins, which keeps them from leaving their houses and worsens isolation. The residents' concerns can be grouped into the following categories.

- **Personal factors** : disability(especially elderly), lack of information
- **Structural factors** : lack of transportation options, insufficient lighting, road safety issues, wheelchair accessibility, no pedestrian crossings, busy streets, poor maintenance of housing (infestation, sewerage etc), housing allocations
- **Situational factors** : unsafe at night time, vandalism, too busy to participate in community activities
- **Perceived factors** : scared of neighbours (youth, neighbours with mental issues, neighbours with drug and alcohol issues, drug dealers, anti-social behaviour, screaming and yelling), mistrust of government/change (police, housing, etc.), poor reputation of community, despair ("feel like we're fighting a losing battle")

EVIDENCE FROM THE LITERATURE

'WHAT WORKS' FOR AN EFFECTIVE PLACE-BASED INITIATIVE

In a review of place-based initiatives in the US, UK and EU, a set of common elements were identified to 'work' for an effective place-based initiative (Wilks, Lahausse, & Edwards, 2015). The *ComaC Initiative* plans are reviewed against these elements and presented in Table 2.

Table 2. Place-based initiatives elements and the ComaC Initiative

Place-based initiatives elements		ComaC Initiative	
		Demonstrated?	Comments
Focus on place and person	Spatial targeting	Demonstrated	• The Maroubra place-based initiative has a clear definition and shared understanding of the spatial and social targets.
	Social targeting	Demonstrated	
Design and delivery	Flexible delivery	Partially demonstrated	• There is some flexibility for the services to be tailored to respond to the needs of the community. • The community-driven activities can be a vehicle to develop programs and deliver services according to the community's needs.
	Local autonomy	Partially demonstrated	• Community involvement through coffee and conversations (community engagement strategy) with the residents have been a main activity in the design process.
	Joined-up working	Demonstrated	• Multiple agencies are participating in the design process in the form of the ComaC Initiative Steering Committee. • The four funding partners are SESLHD, RCC, FACS, and Central and Eastern Sydney Primary Health Network(CESPHN). • The initiative has plans to join with other services and programs in the area, including the Kingsford Legal Centre, Junction Neighbourhood Centre, and the social housing providers.
	Governance	Partially demonstrated	• The Steering Committee has developed a Terms of Reference and meets regularly to discuss and make decisions. MOUs were signed. Sub-committees are formed to discuss detailed operations of the initiative. • The funding will be managed by the ComaC Initiative Steering Committee. • However, other than The Deli, the community is not well represented in the Steering Committee. • The extent to how much decision-making delegation to the community will occur is not determined at this stage.
Program implementation	Capacity development	Partially demonstrated	• Staff members have been trained to work with the community through the Harwood approach for public knowledge. • Strategies to overcome community reluctance to engage and include the 'hard to reach' population need to be developed. Some examples include information, transportation, language, low self-esteem, ex-offender status, negative attitude towards participation, etc.
	Lead times	Demonstrated	• The initial design phase is planned to take 6-months. • The lead time is needed to build capacity of the community and the partners and to ensure evaluation capacity is in place.
	Long-term focus	Partially demonstrated	• A three-year financial commitment is confirmed. • The initiative's aim aspires to reduce inequity within a generation.

SOCIAL INCLUSION

In an evaluation of the early phases of a place-based initiative, the Big Local (BL) initiative, in the UK, the following were found on improving the 'breadth' and 'depth' of community participation. A physical space such as The Hub can be a resource to bring people together, however, physical barriers that hinder accessibility will serve to further exclude those who lack access. Some residents are reluctant to participate because they had no prior experience. Others were unable to participate at partnership meetings. Raising awareness of the initiative within the community has been found to have some impact on improving the extent of inclusion. To increase the 'depth' of participation, decision on governance arrangements should be made. Sometimes internal tensions arise resulting in members walking away from the initiative. It is also critical to maintain a positive relationship with the wider community. Although it is not crucial for every member of the community to participate in the decision-making space, it is crucial that everyone is informed. Residents should be allowed to take diverse roles, i.e., residents who volunteer do not always have to be key partner members. The Hub can be a good space where community activities and opportunities can be advertised, questions can be raised and answered, information on what is being done and why can be disseminated. It is also beneficial to have a communication strategy, which explicitly includes targeted sections focusing on specific groups such as younger people, or residents whose first language is not English (Lewis et al., 2018).

ACCESS TO SERVICES

Access to care and services is seen as a function of both supply and demand. It is determined by supply factors such as location, availability, cost, appropriateness of services and demand factors such as the user's knowledge, attitudes, and skills (Levesque, Harris, & Russell, 2013). Table 3 assesses the *ComaC Initiative* plans against the supply and demand side dimensions of improving access to service. Details on the dimensions of access to services can be found in **Annex 4**.

Table 3 ComaC Initiative and access to service

Supply side			*Demand side*		
Dimension	**Addressed?**	**Description**	**Dimension**	**Addressed?**	**Description**
Approachability	Yes	• Co-design and public knowledge generation informs the community of the available services.	**Ability to perceive**	Partially	• Activities to improve health literacy. • Community conversations, co-design features of the initiative
Acceptability	Partially	• The services are designed to be culturally acceptable to diverse backgrounds	**Ability to seek**	Partially	• Tenants express they do not know who to contact to seek services they need.
Availability and accommodation	Partially	• The Hub and Mobile Outreach Van provide a space for service delivery. • Some of the barriers include access to transportation to the Hub, and perceived safety.	**Ability to reach**	Partially	• People with disability (access issues) • (perceived) safety in area • Lack of transportation • Time constraints
Affordability	Yes	• The Hub offers an affordable space for providers to deliver services.	**Ability to pay**	Not applicable at this stage	• The intention is to offer free services, but the co-design process will guide and determine what the costs will be.
Appropriateness	N/A	• The services meet the communities' service needs.	**Ability to engage**	Partially	• Co-production of programs based on public and expert knowledge.

SUMMARY OF POTENTIAL IMPACTS

Impact on social inclusion

It is likely that the proposed plans will positively impact social inclusion in the community. The initiative can possibly bring unintended social exclusion to the 'hard to reach' population.

Impact on access to services

The proposed plans are likely to positively impact on individuals' **access to services**. However, the impact will be determined by the type of services, hours of operation, and other operational decisions. Many residents have multiple needs and detailed information on the extent of needs are limited. Structural barriers to access services such as transportation or safety can limit accessibility, which can potentially become barriers in bridging the gap. It is also possible that these services may not be utilized by the community.

RECOMMENDATIONS

WHAT TO RETAIN

These recommendations include those approaches in place that should be maintained.

Table 4. Recommendations - what to retain

Priority	Recommendations	Source of evidence
Must	Maintain the co-production approach, public knowledge collection and conversations with the community. Maintain the key partner agency partnership and governance structure and renew partnership structures when necessary.	Lit review, public knowledge Lit review
Encourage	Engage community and diversify activities to build rapport with the community.	Lit review, public knowledge

WHAT TO ENHANCE

These recommendations include those approaches that should be added or strengthened to enhance the impact of the *ComaC Initiative*.

Table 5. Recommendations - what to enhance

Priority	Recommendations	Source of evidence
Must	Identify and seek public knowledge with priority populations that were not heard (e.g. youth, Aboriginal, CALD families, etc).	Community profile, Lit review
	Develop strategies to engage with 'hard-to-reach' populations in the community. Identify the barriers these populations face in engaging in the activities.	Lit review
	Develop a strategic communication plan to raise awareness of the *ComaC Initiative.*	Lit review, public knowledge
	Support community members to participate in governance and activities, e.g. being on reference group, being involved, becoming a Community Connector – build supportive systems that allow people to be engaged.	Lit review
Encouraged	Include community members in the governance mechanisms as a key component of the co-design processes.	Lit review
	Embed formal check-ins with the community to validate if the initiative is meeting the community's needs and ensure accountability, authority, authenticity of community engagement.	Lit review, public knowledge
	Develop a monitoring/data collection mechanism to investigate for monitoring isolation, disadvantage, mental health, disability.	Community profile

WHAT TO MONITOR AND REVIEW

These recommendations include those approaches that should be monitored to enhance impact on equity of the *ComaC Initiative*.

Table 6. Recommendations - what to monitor

Priority	Recommendations	Source of evidence
Must	Monitor the unintended exclusion that may result from the *ComaC Initiative* by conducting regular reviews to compare the service users versus the community profile.	Lit review, Community profile
	Use Table 2 on effective place-based initiatives as a reference to revisit and assess fidelity of the approach.	Lit review
	Monitor and strengthen activities to improve the demand-side of access to services. Use Table 3 as a reference to monitor activities and progress to improve access to services.	Lit review, Community profile
	Investigate ways of monitoring and describing mental health, isolation, disability (incl. psychosocial) to into the initiative (lean data ideas – meaningful data and snapshots)	Lit review
	Monitor annually the alignment between public knowledge and activities. With the engagement of new partners, themes and knowledge might evolve.	Public knowledge
Encouraged	Monitor and reflect on the community rhythm and discuss the 'breadth' and 'depth' of community engagement with the participating partners and the community.	Lit review

CONCLUSION

The ComaC Initiative seeks to improve health equity through an assets-based approach to wellbeing which recognises that communities are experts in their own lives, and seek to mobilise the strengths (e.g. leadership, informal networks, knowledge and skills) within local communities so they have more control over the conditions that affect their health and wellbeing. The Initiative also recognises that solutions to health problems are not solely about the provision of services in the community.

Evidence from the community profile, public knowledge and literature support that this multi-agency, place-placed initiative will positively impact social inclusion and access to services. To ensure the benefits of the initiative are equally shared, measures to minimize unintended social exclusion and enhancing the demand-side dimension to improving access to services should be considered.

It is highly recommended that strategies to engage the 'hard-to-reach' populations, annual reviews to ensure the activities are aligned with the community profile and public knowledge, and a data collection mechanism to investigate information around social isolation, mental health and disability, etc. should be developed.

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ANNEX 1 – THE EFHIA PROCESS

RATIONALE FOR AN EQUITY FOCUSED HEALTH IMPACT ASSESSMENT (EFHIA)

A ***health impact assessment (HIA)*** is a structured process for considering potential positive and negative health impacts before implementing changes and incorporating research evidence into the design planning process in a transparent way (Harris, Harris-Roxas, Harris, & Kemp, 2007).

An ***equity focused health impact assessment (EFHIA)*** is a form of HIA that focuses on how initiatives can affect population groups differently, and develops recommendations focused on minimising harms and ensuring that benefits are fairly shared (Harris-Roxas et al., 2014). EFHIAs typically consider impacts on different groups in terms of location, socioeconomic status, existing levels of disability and health, age, culture and ethnicity, gender, and sexuality during their scoping.

An EFHIA would:

- enable a "health check" on plans as the initiative evolves
- ensure the initiative aligns with available evidence, broadly defined, and reflects good practice
- identify enhancements and "tweaks" that can improve the equity of changes due to the initiative, including that it reaches and benefits the people with greatest need.

An EFHIA on the "***Communities at the Centre: A place-based equity and wellbeing initiative in Maroubra***" or "**ComaC**" would identify the positive and negative impacts and their distribution of the proposed initiative and offer recommendations that maximizes the positive impacts and minimizes the negative impacts. By engaging key stakeholders and decision-makers in the EFHIA process, we expect that they will consider health impacts, the determinants of health, and the distribution of impacts in their deliberations.

EFHIA is called for in the SESLHD Equity Strategy as a means to enhance health equity in guiding decisions and actions in development of its policies, programs, and services(SESLHD, 2015).

THE EFHIA PROCESS

The Steering Committee decided to take a rapid EFHIA of the initiative. A rapid EFHIA follows the same process as a typical HIA but draw on a more limited range of evidence in order to ensure timely input. This EFHIA process includes a scoping review of the literature, analysis of the existing community profile data, and public knowledge derived from the Harwood approach and previous initiatives in the area.

The EFHIA working group was composed of representatives from key agencies of the Steering Committee and guided and informed the practical aspect of the EFHIA process.

Table 7 The ComaC Initiative EFHIA process

Steps of EFHIA	Purpose	ComaC EFHIA process
Screening	Determine whether an EFHIA is appropriate and required	The use of EFHIA is called for in the SESLHD Equity Strategy. An EFHIA for the ComaC

		Initiative was called for by the Steering Committee as a tool to ensure equity in designing and delivering this place-based initiative.
Scoping	Set out the parameters of the EFHIA	The EFHIA working group held two meetings to discuss the scope of the EFHIA. The working group was comprised of representatives from SESLHD, RCC and FACS. The main impact areas and sub-groups at risk of disadvantage were identified. A scoping report was produced and submitted to the Steering Committee.
Identification	Develop a community/population profile and collect information to identify potential health impacts	The EFHIA working group compiled information on the demographic profile of the area, conducted a literature review, and collected public knowledge using the Harwood process. This is in Annex 3 of this report.
Assessment	Synthesise and critically assess the information in order to prioritise health impacts	The evidence from the community profile, literature and public knowledge was appraised for potential impacts.
Decision making & Recommendations	Make decisions to reach a set of final recommendations for acting on the EFHIA's findings	A set of recommendations was drafted and shared with the EFHIA working group to finalise according to the priority of the impacts. The final recommendations were submitted to the Steering Committee for discussion.
Evaluation & Follow-up	Evaluate the processes involved in the EFHIA and its impact, and follow up the EFHIA through monitoring and a health impacts management plan	A debrief of the EFHIA process(*process evaluation*) will be conducted after the report is submitted. A second EFHIA is planned to be conducted after the implementation of the ComaC Initiative.

SCOPING

Scoping sets out the parameters of the EFHIA. The working group discussed the level and depth of the EFHIA, decided on the scope of the potential impacts of the initiatives, and which evidence to review. A scoping report was documented and shared with the Steering Committee. A summary of the scope of the EFHIA is outlined the next section.

IDENTIFICATION AND ASSESSMENT

Identification of impacts will take place through (i) profiling and (ii) the collection of evidence using a variety of methods.

Profiling

Profiling provides contextually-specific information on which to base health impact predictions. In this EFHIA profiling will include:

- A demographic profile, including information on distribution according to age, gender, socioeconomic status, ethnicity and culture and health status where available.
- A demographic profile based on FACS housing management data.

- Health profile/user data from SESLHD.

Collection of evidence

Evidence will be collected to identify potential impacts of the *ComaC*. This will be collected through:

- a review of the literature;
- public knowledge (Harwood process public knowledge generation);
- a working group workshop to identify and predict potential impacts and to provide a contextual "check" on potential identified through the literature review.

DECISION-MAKING AND RECOMMENDATIONS

A concise and action-oriented set of considerations and recommendations will be developed and refined in consultation with the EFHIA working group.

SCOPING REPORT SUMMARY

In consultation with the EFHIA Working Group, the two major areas to be scoped were identified as follows:

- Social inclusion
- Access to services

Differential impacts will be defined as the distribution of impacts affecting groups or sub-groups at risk of disadvantage, specifically:

- Families and households with young children
- Age - especially the old and (unattended) youth
- People experiencing drug and alcohol related issues
- Aboriginal people
- Isolated people who have been released from incarceration without social support
- Families with people involved with custodial justice
- Disability (including serious mental illness)
- Poverty

ANNEX 2 – DETAILED COMMUNITY PROFILE

DESCRIPTION OF THE COMMUNITIES AT THE CENTRE AREA

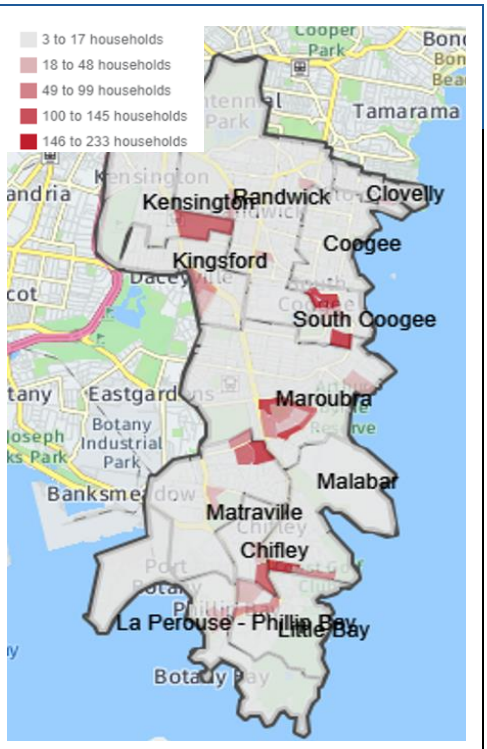
SOCIAL HOUSING ESTATES IN RANDWICK COUNCIL AREA

In Randwick City, a total of 3,467 households rent social housing[1]. Close to one third of these households (1,001 households) live in Maroubra, mostly in the social housing estate located around Coral Sea Park. The community hub is located within this area and the mobile outreach service will reach the surrounding social housing estates.

The ComaC primarily focuses on the social housing estate located in South Maroubra but will serve the broader population in other social housing estates in Randwick City Council.

Table 8. Households renting social housing in Randwick City

Suburb	Number of social housing households	Percentage of all households in suburb (%)
Maroubra	1,001	8.3%
South Coogee	676	30.9%
Matraville	431	12.2%
Malabar	320	23.3%
Kensington	204	4.1%
Randwick	192	1.6%
Chifley	177	16.0%
Kingsford	143	2.5%
Little Bay	106	6.0%
La Perouse - Phillip Bay	65	18.2%
Coogee	42	0.6%
Clovelly	18	1.0%
Randwick City (Total)	**3,467**	**6.4%**



Source : Australian Bureau of Statistics, Census of Population and Housing 2016. Compiled and presented in atlas.id by .id , the population experts. Note: Due to changes in the ABS rules regarding perturbation of small numbers to protect the confidentiality of individuals in 2016, the totals of all SA1s in an area may not equal the total derived from the area as a whole.

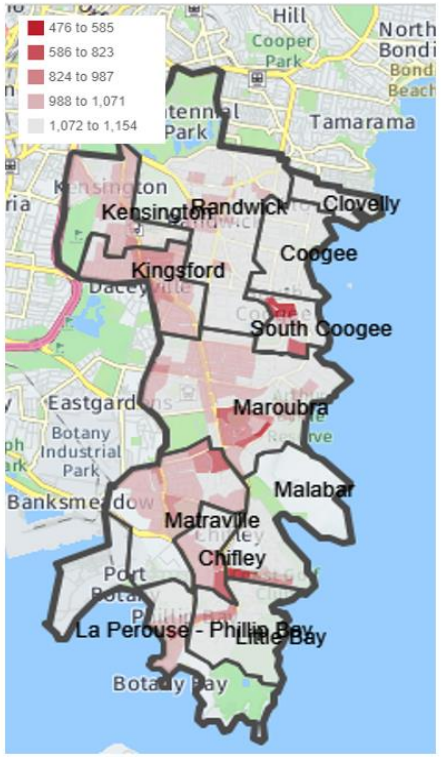
[1] *Forms of subsidised housing, usually rental, for designated households. In Australia includes: Public housing: Social housing owned and operated by public agencies. Community housing: Social housing managed (and sometime owned) by a not for profit community based organisation. Indigenous community housing: Social housing owned and (usually) managed by indigenous community organisations. (FACS NSW Glossary).*

SOCIO-ECONOMIC DISADVANTAGE OF THE AREA

Table 9 shows the SEIFA Index of Socio-economic Disadvantage for the suburbs in Randwick City Council. The map shows the SEIFA index by SA1 level. The highly disadvantaged areas reflect the areas where the social housing estates are densely located.

Table 9. SEIFA Index of Socio-economic Disadvantage

Area (Suburb)	2016 index	Percentile
South Coogee	982.5	35
Malabar	993.9	41
Kingsford	1001.4	46
La Perouse - Phillip Bay	1005.3	49
Matraville	1014.1	54
Chifley	1024.0	60
Maroubra	1039.6	70
Kensington	1052.9	78
Little Bay	1075.2	89
Randwick	1086.7	93
Coogee	1107.6	98
Clovelly	1113.8	99

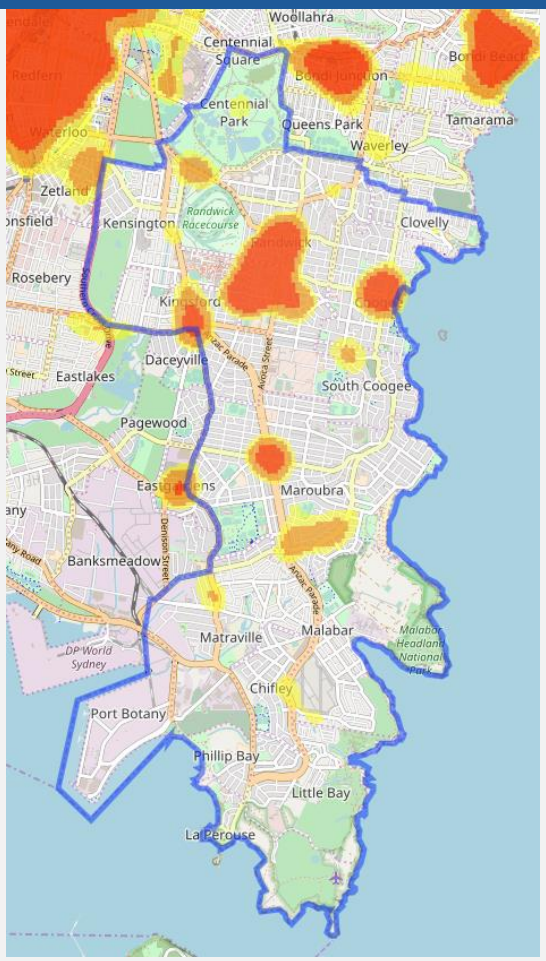
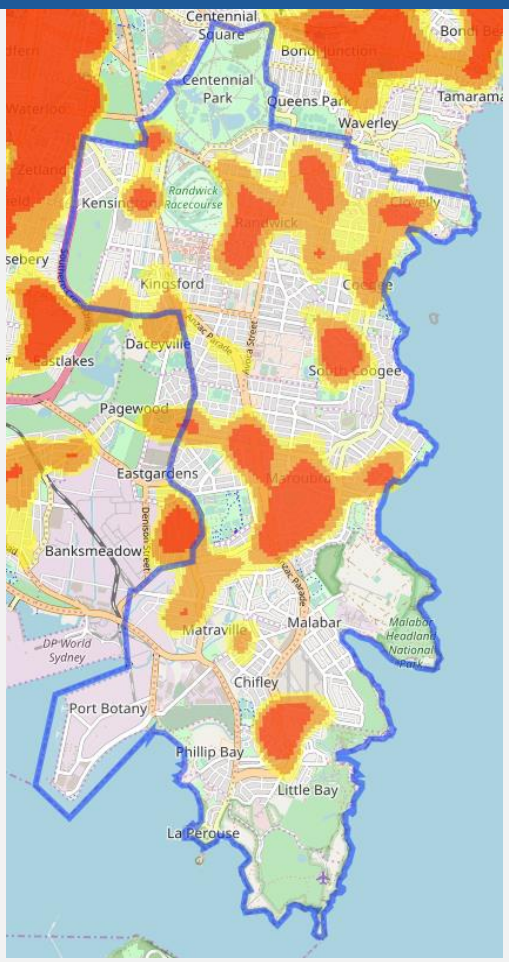


Source : Australian Bureau of Statistics, Census of Population and Housing 2016. Compiled and presented in atlas.id by .id , the population experts.

SAFETY

The hotspot map of Randwick City Council is shown in Table 10. The hotspot maps indicate higher incidents in areas where the social housing estates are located.

Table 10. Hotspot maps of incidents of assaults from July 2017 to June 2018

Non-domestic assault	Domestic assault
	

Source : NSW Bureau of Crime Statistics and Research

DESCRIPTION OF RESIDENTS OF THE AREA

TENANT DEMOGRAPHIC PROFILE

There are a total of 5,416 tenants living in the social housing estates located in the suburbs of Randwick City Council. Maroubra houses the highest number of tenants, with a total population of 2,194 tenants, followed by South Coogee (1,019 tenants), Matraville (679 tenants), Malabar (601 tenants), Coogee (497 tenants) and Chifley & Little Bay (426 tenants).

Gender

There are more women than men in the social housing estates in Randwick City Council (Table 11).

Table 11. Number of social housing tenants by gender (2018)

Suburb	Female	Male	Unknown/Unborn	Total
Maroubra	1,219 (55.6%)	893 (40.7%)	82 (3.7%)	**2,194 (100.0%)**
South Coogee	538 (52.8%)	427 (41.9%)	54 (5.3%)	**1,019 (100.0%)**
Matraville	387 (57.0%)	247 (36.4%)	45 (6.6%)	**679 (100.0%)**
Malabar	267 (44.4%)	296 (49.3%)	38 (6.3%)	**601 (100.0%)**
Coogee	260 (52.3%)	209 (42.1%)	28 (5.6%)	**497 (100.0%)**
Chifley & Little Bay	213 (50.0%)	192 (45.1%)	21 (4.9%)	**426 (100.0%)**
Total	**2,884 (53.2%)**	**2,264 (41.8%)**	**268 (4.9%)**	**5,416 (100.0%)**

Source : NSW Department of Family and Community Services

Age group

Table 12 shows the number of social housing tenants by age group in each suburb. In general, the age profile presents a higher proportion of older residents. One-third of all tenants are aged 65 and older, which is the age group with the greatest number of people. Six out of ten tenants are 50 years and older.

Table 12. Number of social housing tenants by age group (2018)

Suburb	0-12 yrs	13-18 yrs	19-24 yrs	25-49 yrs	50-64 yrs	65 yrs +	Total
Maroubra	227 (10.3%)	135 (6.2%)	113 (5.2%)	472 (21.5%)	530 (24.2%)	717 (32.7%)	**2,194 (100.0%)**
Malabar	58 (9.7%)	30 (5.0%)	25 (4/2%)	135 (22.5%)	154 (25.6%)	199 (33.1%)	**601 (100.0%)**
Chifley & Little Bay	32 (7.5%)	28 (6.6%)	18 (4.2%)	75 (17.6%)	104 (24.4%)	169 (38.7%)	**426 (100.0%)**
South Coogee	80 (7.9%)	62 (6.1%)	47 (4.6%)	231 (22.7%)	268 (26.3%)	331 (32.5%)	**1,019 (100.0%)**
Matraville	79 (11.6%)	61 (9.0%)	31 (4.6%)	113 (16.6%)	147 (21.6%)	248 (36.5%)	**679 (100.0%)**
Coogee	34 (6.8%)	35 (7.0%)	33 (6.6%)	89 (17.9%)	115 (23.1%)	191 (38.4%)	**497 (100.0%)**
Total	**510 (9.4)**	**351 (6.5%)**	**267 (4.9%)**	**1,115 (20.6%)**	**1,318 (24.3%)**	**1,855 (34.3%)**	**5,416 (100.0%)**

Source : NSW Department of Family and Community Services

FAMILIES AND HOUSEHOLDS WITH YOUNG CHILDREN

There are a total of 1,510 households in the SA1 regions Maroubra social housing estate area[2], of which 280 households (18.5%) have dependent children(Table 13). There are 85 single family households with dependent children, and 195 couple families.

Table 13. Families and households with dependent children in project area (2016)

Total number of households	Households with dependent children		
	Couple families	Single families	Total
1,510 households (100.0%)	195 households (12.9%)	85 households (5.6%)	280 households (18.5%)

Source : Australian Bureau of Statistics, Census of Population and Housing 2016. Compiled and presented in atlas.id by .id , the population experts.

ABORIGINAL PEOPLE

Table 14 shows the Aboriginal tenants in social housing estates located in Randwick City Council. In total, there are 571 Aboriginal tenants, which account for 10.5% of all tenants. In Maroubra, there are 205 Aboriginal tenants.

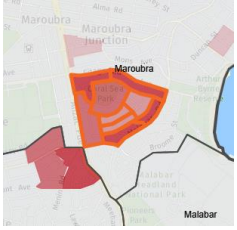
Table 14. Aboriginal people

Suburb	Aboriginal tenants	Percentage of all tenants in suburb	Tenants (total)
Malabar	89	14.8%	601
Chifley & Little Bay	54	12.7%	426
South Coogee	64	6.3%	1,019
Maroubra	205	9.3%	2,194
Matraville	99	14.6%	679
Coogee	17	23.3%	73
Total	571	10.5%	5,416

Source : NSW Department of Family and Community Services

[2] *Based on community profile data of SA1 regions 1156723, 1156719, 1156709, 1156714, 1156722, 1156713, 1156725, 1156724, 1156702, where the social housing estates are located.*

Map of the nine SA1 regions



CULTURALLY AND LINGUISTICALLY DIVERSE (CALD)

The social housing tenants come from diverse cultural backgrounds. Among the 5,416 social housing tenants in Randwick City Council, 1,600 tenants(29.5%) come from 104 countries.

The top ten countries are as follows:

Table 15. Number of tenants by country of birth (Top 10)

No	Country of birth	Number of tenants	(%)
1	Russian Federation	193	12%
2	UK of Great Britain and Northern Ireland	112	7%
3	New Zealand	102	6%
4	China	92	6%
5	Iraq	82	5%
6	Poland	70	4%
7	Ukraine	61	4%
8	Philippines	52	3%
9	Greece	41	3%
10	Chile	38	2%

Source : NSW Department of Family and Community Services

In the broader South Maroubra community, 45.5% of the residents speak language other than English at home and 8.5% are reported to be not fluent in English. Among the 5,416 social housing tenants in Randwick City Council, 458 tenants(8.5%) report their main language to be one other than English.

The top ten languages other than English are as follows:

Table 16. Number of tenants by main language for non-English speakers(Top 10)

No	Main language	Number of tenants	(%)
1	Russian	89	19%
2	Australian Languages	46	10%
3	Arabic	35	8%
4	Spanish; Castillian	33	7%
5	Assyrian	32	7%
6	Cantonese	21	5%
7	Turkish	15	3%
8	Mandarin	14	3%
9	Serbian	13	3%
10	Indonesian	12	3%

Source : NSW Department of Family and Community Services

PEOPLE WITH DISABILITY

According to the 2016 census data, there are 133 people in need of assistance due to disability in the South Maroubra area. In NSW, 35% of all social housing tenants are reported to have disability in 2012/13. While FACS does not collect data on the prevalence of mental health in social housing, internal modelling estimates people living in social housing are 2.4 times more likely to have a severe mental illness than those not living in social housing. It is estimated around 19% of people living in social housing have a severe mental illness, compared to around 8% in the general NSW population (FACS, 2014).

SOCIAL ISOLATION (LONE PERSON HOUSEHOLDS)

In the South Maroubra area, there are a total of 667 households(44.2%) which are lone person households. This is almost half of all households in the area. Moreover, two out of ten households in this area are lone person households who are aged 65 years and over (Table 17).

Table 17 Lone person households in South Maroubdra (2016)

Total number of households	Lone person households		
	Older (65+ years)	Young (15-44 years)	Total
1,510 households (100.0%)	329 households (21.8%)	96 households (6.4%)	667 households (44.2%)

Source : Australian Bureau of Statistics, Census of Population and Housing 2016. Compiled and presented in atlas.id by .id , the population experts.

ANNEX 3 –PUBLIC KNOWLEDGE

PUBLIC KNOWLEDGE FROM LEXINGTON PLACE

Public knowledge, in contrast with expert knowledge, is knowledge generated through and ongoing asking and listening to the voices of the community, which is a complex mix of individuals in interrelated micro-communities. The ComaC Initiative applies the Harwood Institute model to gather public knowledge in the South Maroubra social housing community.

The Harwood model calls for two main processes for gathering public knowledge. First, the ASK tool, comprised for four questions, generates the beginning of public knowledge. After the initial voices of the community are heard, community conversations provide an in-depth discovery of priority shared aspirations, issues, specific concerns, community assets and energy to begin.

Staff from key agency partners met with the community members during coffee and conversations events and used the ASK Tool developed by the Harwood Institute to listen to and work with communities to identify needs and solutions.

The ASK Tool is composed of the following four questions :

- What kind of community do you want to live in?
- Why is that important to you?
- How is that different from how you see things now?
- What are some of the things that need to happen to create that kind of change?

Community conversations are scheduled to collect more in-depth narratives on each of the four identified themes. To date, a couple of community conversations were conducted on the theme of 'safety'. Staff from SESLHD, RCC and JNC convened, scribed and observed the sessions.

Each session consisted of the following ten open-ended questions.

1. What kind of community do you want?
2. What are the two or three most important issues or concerns when it comes to the community?
3. What concerns do you have about this issue? Why?
4. How do the issues we're talking about affect you personally?
5. What do you think about these things? How do you feel about what's going on?
6. What do you think is keeping us from making progress we want?
7. When you think about what we've talked about, what are the kinds of things that could be done that would make a difference?
8. Thinking back over the conversation, what groups or individuals would you trust to take action on these things?
9. If we came back together in six months or a year, what might you see that would be an indication that the things we talked about tonight were starting to happen?
10. Now that we have talked about it a bit, what questions do you have about it?

Engaging the community is an integral part of the ComaC Initiative. The ComaC Steering Committee plans to hold more systematic conversations with the community. These will include conversations on the remaining three themes and conversations with residents in surrounding estates. However, at the current initial stage of the initiative, members who are ready for engagement are showing up for these sessions. The preliminary summaries of the public knowledge do not represent the views from the diverse members of the community.

PUBLIC KNOWLEDGE FROM PREVIOUS SOURCES

The public knowledge from the coffee and conversations are consistent with the public knowledge derived from previous conversations with the community as shown below.

Table Public knowledge from communities in and surrounding Maroubra (2005, 2010)

	2005	2010
Title of initiative	Families First	Working from the Ground Up
Communities of interest	Families with young children (up to 8 years of age) in Maroubra, Matraville, Malabar Aboriginal families Culturally and Linguistically Diverse(CALD) families	Social housing estates in South Maroubra and Matraville (Coral Sea Estate, Soldiers' Settlement Estate) Aboriginal tenants Mental health Over 55s residents Children and young people
Public knowledge collection methods	Conversations with families with young children (up to 8 years of age), interviews with service providers	Survey, interviews, focus groups with residents, youth, service providers, local businesses
Themes from public knowledge	Fragmented communities Physical isolation and poor transport Local services and support Alcohol and substance misuse Poverty and polarization Domestic and family violence Mental health Family breakdown Lack of access to information Local and external service providers Lack of available childcare Waiting lists for respite care and speech therapy Play equipment	**Adult residents** More support for residents, family and individuals More activities for young people and children Better maintenance and relationships with Housing Less crime and vandalism Improved parks and social spaces **Youth** Improving the environment More activities for young people and community events More work opportunities Free transport for all students

ANNEX 4 – LITERATURE REVIEW

PLACE-BASED APPROACH

KEY ELEMENTS OF PLACE-BASED INITIATIVES

Definition

Simply put, place-based approaches can be defined as "stakeholders engaging in a collaborative process to address issues as they are experience within a geographic space, be it a neighbourhood, a region, or an ecosystem" (Bellefontaine & Wisener, 2011). "A collaborative means to address complex socioeconomic issues through interventions defined at a specific geographic scale" (DHHS, 2012). Addressing the broader social determinants of health rather than specific health issues is another key feature of the place-based approach.

Common Characteristics of Place-based Approaches (Bellefontaine & Wisener, 2011)

- Are designed (or adapted) locally to meet unique conditions
- Engage participants from a diverse range of sectors and jurisdictions in collaborative decision-making processes
- Are opportunity-driven, dependent on local talent, resources, and constraints
- Have an evolving process due to adaptive learning and stakeholder interests
- Attempt to achieve synergies by integrating across silos, jurisdictions, and dimensions of sustainability
- Leverage assets and knowledge through shared ownership of the initiative
- Frequently attempt to achieve behaviour change

In practice, partnerships or coalitions are reported to be the foundational factor in place-based initiatives. Building community capacity is another important factor, which is through a variety of activities, including inclusion in the governance process (Crimeen, Bernstein, Zapart, & Haigh, 2017).

TYPOLOGY OF PLACE-BASED INITIATIVES

There are many different models, methods and practices that represent the key elements of place-based approaches as mentioned above. Public Health England (2015) groups the family of approaches around four strands:

- **Strengthening communities** – This group of approaches focus on strengthening community capacity to take collective action that lead to changes in health or social determinants of health.
- **Volunteer/peer roles** – This group of approaches focus on enhancing individuals' capabilities to provide advice, information and support or organize activities around health and wellbeing.
- **Collaborations and partnerships** – This group of approaches involve working in partnership with communities to design and/or deliver service and programmes.
- **Access to community resources** – This group of approaches focus on connecting people to community resources, information and social activities.

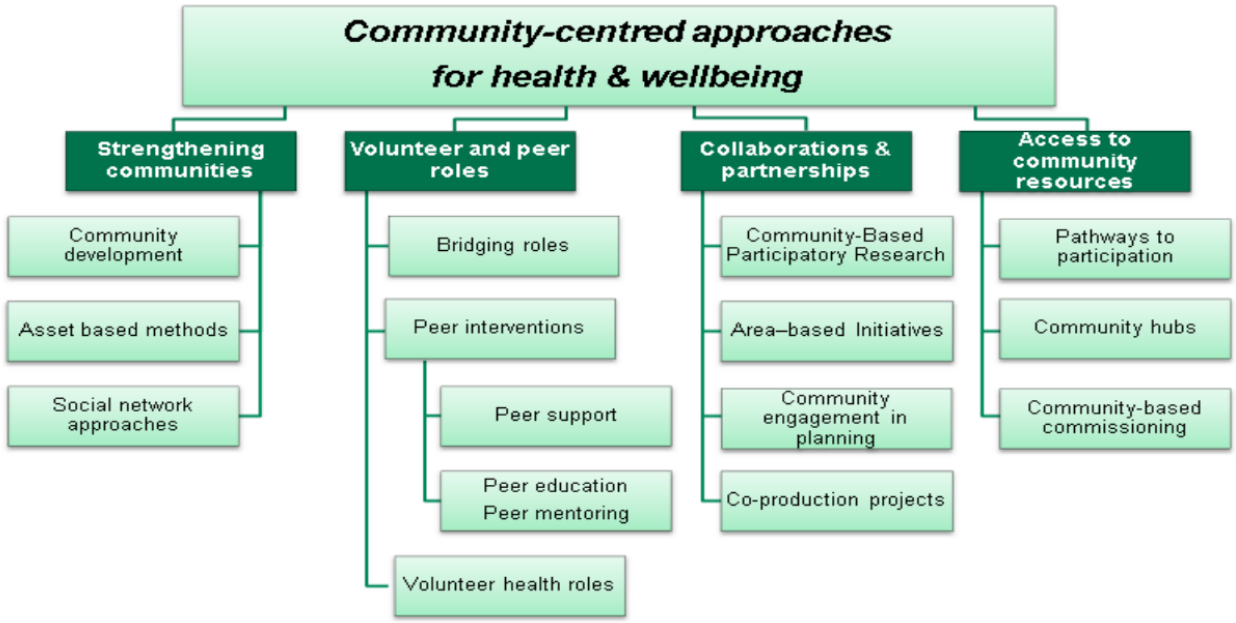


Figure 3 The family of community-centred approaches for health and wellbeing (PHS, 2015)

The program components of the ComaC Initiative share features with all four approaches of this model.

The installation and operation of the Community Hub relate to the "community hubs" approach which provide a physical space to provide multiple activities and services that address health or wider determinants of health. By establishing a network or a community anchor, this approach links referral routes, reduces barriers to accessing services and social participation, and coordinate group activities.

The coordinated services provided by multiple partner agencies through the Hub and the Mobile Outreach Van improve "pathways to participation". Pathway approaches aim to connect individuals with non-clinical or social needs.

The community connectors component is relevant with the "volunteer and peer roles" approach, which focus on community members to reach out and connect with groups experiencing deprivation or social exclusion. Some members from the community typically receive training and support to provide advice, information and support and to organize activities around health and wellbeing in their own or other communities.

The community-driven activity component can be related to the "peer-based interventions or the "social network approaches". "Peer-based interventions" aim to recruit and train people on the basis of sharing common characteristics to improve support mechanisms and social connections. "Social network approaches" focus on strengthening social support between people through collective or community organizing activities (as opposed to individual-based peer support). It is difficult to determine at this stage as the details of this component is not yet discussed.

EFFECTIVENESS OF PLACE-BASED INITIATIVES

In general, there is reasonably solid evidence on the positive impact of community participation and community engagement on better physical and emotional health, increased wellbeing, self-efficacy, self-confidence, social connectedness and perceived social support for disadvantaged groups(PHE, 2015). The evidence present variations in the observed effectiveness, emphasizing that place-based initiatives require a 'fit for purpose' rather than 'one size fits all' approach(O'Mara-Eves et al., 2015).

By connecting health and human service providers with disadvantaged groups community coalition-driven approaches have the potential to benefit individual health outcomes and behaviours(Anderson et al., 2015). Successful outcomes of place-based initiatives influenced *social determinants of health*, such as social cohesion, education and early childhood development, access to healthy foods, environmental conditions and employment than health outcomes such as changes in self-rated health, life satisfaction levels, mental health, and health behaviour. Elements that influence the effectiveness of the initiative were identified as: funding duration and cycles, program duration, governance, partnership processes, program actions and community involvement (Crimeen et al., 2018). Fostering coalitions and networks and building community are the foundation factors in conducting place-based initiatives. Trust-building and commitment to power-sharing are critical components to achieve the desired benefits(Jagosh et al., 2015).

Community engagement, especially with those who are hard-to-reach and the most disadvantaged groups, is integral. In a review of 161 studies on the benefits of involving immigrants in the collaborative process, engaging immigrants generated more reliable data, increased relevance, raised awareness, created positive changes in the community, enriched interpretation, and increased sustainability(Vaughn et al., 2017).

The outcomes of place-based initiatives are not linear and are often connected. Table 18 summarises the range of potential outcomes from working together with communities to improve equity in health and wellbeing.

Table 18. Range of outcomes from community-centred approaches (PHE, 2015)

Individual	Community level	Community process	Organisational
Health literacy Behaviour change Self-efficacy, self-esteem, confidence Self-management Social relationships (social support, reduction of social isolation) Wellbeing Health status Personal development	Social capital (social networks, community cohesion, sense of belonging, trust) Community resilience Changes in physical, social and economic development Increased community resources (including funding)	Community leadership (collaborative working, community mobilization/coalitions) Representation and advocacy Civic engagement – volunteering, voting, civic associations, participation of groups at risk of exclusion	Public health intelligence Changes in policy Re-designed services Service use – reach, uptake of screening and preventive services Improved access to health and care services, appropriate use of services, culturally relevant services

Source : Public Health England (2015). A guide to community-centred approaches for health and wellbeing.

A note on the unintended negative effects of place-based initiatives

Evidence show potential unintended risk to wellbeing that could arise from community-centred initiatives. Community members experience exhaustion and stress from participation, as it drains energy, time and financial resources. For people with disabilities, physical demands of engagement, such as attending meetings, were particularly onerous. Moreover, meetings tend to be held for the convenience of service organisations and failed to take the community's needs into consideration. In communities where multiple initiatives are taking/have taken place, the community expressed consultation fatigue. In cases where the initiatives failed to continue or when the community's suggestions for service improvement were not acted upon, the community experience disappointment. For some this can be as a disincentive for future engagement. (Attree et al., 2011).

Community-led programs to improve health equity are likely to be effective when adequate time is allowed for engagement (Harris J, 2015). It takes time to :

- engage with community members and develop enough rapport to get them involved in social networks
- facilitate social networks to enable community members to create new and further enhance existing relationships that incorporate dialogue, critical reflection, and development of critical consciousness related to the social determinants of health
- allow participants to be in control of identifying what they would like to do to address health and other issues, as well as taking action to develop capabilities.

Harris (Harris J, 2015) emphasize these principles are not being used enough in community-led initiatives that focus on working with disadvantaged and vulnerable groups to address social determinants of health. The program agencies continue to design and implement programs based on professionally determined information instead of socially generated public knowledge.

'WHAT WORKS' FOR PLACE-BASED INITIATIVES?

In international literature, evaluations of place-based initiatives suggest elements that 'work'. In analysing evaluation reports of place-based initiatives in international and Commonwealth contexts, several common elements are found as in Table 19 (Wilks et al., 2015).

Table 19. Common elements of place-based initiatives

Place-based initiatives elements		Definition
Focus on place and person	Spatial targeting	Spatial targeting means that the initiative has an appropriate focus on geographical areas. Spatial targeting is based on the prevalence of a specific type or theme of disadvantage in a location.
	Social targeting	Social targeting means that the initiative has an appropriate focus on populations, such as low-income families, residents of deprived areas, disadvantaged children and families, Indigenous communities, etc.
Design and delivery	Flexible delivery	Flexible delivery refers to the how the rules of service delivery and expenditure of funding can be adjusted to the need of the community. These include administrative freedom, managerial freedom, and/or flexibility in funding mechanisms.
	Local autonomy	Local autonomy calls for the involvement of the community in decision-making and the extent of community ownership
	Joined-up working	Joined-up working refers to the partnership and coordination of multiple agencies and sectors.

	Governance	Governance mechanisms that emphasize on joined-up working and delegate decision-making
Program implementation	Capacity development	Capacity development refers to resources and training required for the operation and evaluation of the place-based initiative at both local and government levels, including staff qualities and skills in communication and management; skills to design, implement and maintain place-based initiatives; capacity to undertake outreach work, etc.
	Lead times	Lead times are periods required for set-up prior to program implementation, which are required to develop relationships within communities, build capacity among the partners and develop strategies and delivery plans.
	Long-term focus	Long-term focus reflects the complex nature of place-based initiatives, and how it takes time and sustained investment for visible change to appear.
Evaluation	Causality	Establishing that PBIs are working by using international best practice such as matched comparison areas, longitudinal data (survey and/or administrative) and sophisticated statistical analyses to rule out other confounding factors in establishing the effectiveness of PBIs (using randomised trials is difficult).
	Attribution	Considering the presence of other initiatives when trying to establish whether a particular PBI "works", as it is possible to have several PBIs operating in the one area.
	A theory of change	Having a well-articulated "program logic" or mechanism by which the PBI effects on the key outcomes of interest can be measured, especially in the short term, to enable policies to be refined, applied to other contexts, "scaled up", and adjusted to address elements of the PBIs that are not working.
	Residential mobility	Accounting for population flows into and out of the area in the context of assessing whether a PBI is effective.
	Cost-effectiveness	Routinely analysing the costs associated with the delivery of a program and being clear about the long-term benefits in order to establish its cost-effectiveness.

SOCIAL INCLUSION

The Social Exclusion Knowledge Network (SEKN) defines social exclusion as "dynamic, multi-dimensional processes driven by unequal power relationships". The four dimensions of the power relationships that constitute the continuum from inclusion to exclusion are ***cultural*** (extent to which diverse values, norms and ways of living are accepted and respected), ***economic*** (access to and distribution of material resources necessary to sustain life), ***political*** (power dynamics in relationships which generate unequal patterns of both formal rights embedded in legislation, constitutions, policies and practices and the conditions in which rights are exercised) and ***social*** (proximal relationships of support and solidarity that generate a sense of belonging within social systems) (Popay et al., 2008).

Having the right and freedom to participate in economic, social, political and cultural relationships has intrinsic value. Restricted participation has negative impacts on health and wellbeing, it results in other deprivations to resources key to promoting health. For example, being excluded from the labour market will lead to low income, which can in turn lead to poor nutrition, housing problems etc., which, ultimately, widens health inequity.

Social inclusion means changing the system, that was systematically designed to 'exclude' them in the first place, to meet the needs of the excluded. It is NOT including or integrating them into the existing system. It is about accommodating individuals and groups with relative powerlessness to challenge the hierarchies that create the exclusion. For practitioners, it can mean continuously checking if the access to support and resource avoid any other exclusion of others in the community (Labonte, 2004).

In general, community engagement interventions have a positive impact on a range of health and psychosocial outcomes(O'Mara-Eves et al., 2015). Even after a brief 6-month operation of community activities such as interactive games, learning programmes, healthy eating and exercise classes, etc., in a public housing estate in Hong Kong, residents reported a modest, but significant increase in closeness and trust in neighbours, as they were able to build friendlier relationships in their community (Chen et al., 2017). The moderating effect of social cohesion on the association between financial deprivation or employment and mental health is especially stronger for low socioeconomic communities(Erdem, Van Lenthe, Prins, Voorham, & Burdorf, 2016). Initiatives that focus on community engagement do not bring direct health outcome or on the quality of services, but demonstrate positive impacts on housing management, perceptions of crime, information flow between community and service providers, social capital and community empowerment(Milton et al., 2012).

Social inclusion and participation are necessary conditions for communities to enhanced collective control over processes that impact their health and wellbeing. However, they are not sufficient in themselves. Previous place-based initiatives have continued to fail to extend the benefits beyond those who actively participated in the initiative. The initiative needs to systematically reach into the community to increase the 'breadth' of the participation, and also provide a range of opportunities to increase the 'depth' of the participation, so that residents can exercise collective control over decisions that impact their community(Lewis et al., 2018).

In an evaluation of the early phases of a place-based initiative, the Big Local(BL) initiative, in the UK, the following were found on improving the 'breadth' and 'depth' of community participation. A physical space (e.g. The Hub) can be a resource to bring people together, however, physical barriers that hinder accessibility will serve to further exclude those who lack access. Some residents are reluctant to participate because they had no prior experience. Others were unable to participate at partnership meetings. Raising awareness of the initiative within the community have been found to have some impact on improving the extent of inclusion. To increase the 'depth' of participation, decision on governance arrangements should be made. Sometimes internal tensions arise resulting in members walking away from the initiative. It is also critical to maintain a positive relationship with the wider community. Although it is not crucial for every member of the community to participate in the decision-making space, it is crucial that everyone is informed. Residents should be allowed to take diverse roles, i.e., residents who volunteer do not always have to be key partner members. The Hub can be a good space where community activities and opportunities can be advertised, questions can be raised and answered, information on what is being done and why can be disseminated. It is also beneficial to have a communication strategy, which explicitly include targeted sections focusing on specific groups such as younger people, or residents whose first language is not English(Lewis et al., 2018).

ACCESS TO SERVICES

Access to care and services is seen as a function of both supply and demand. It is determined by supply factors such as location, availability, cost, appropriateness of services and demand factors such as the user's knowledge, attitudes, and skills(Levesque et al., 2013). Levesque (2013) conceptualizes five dimensions of access capturing the supply-side as 1) Approachability; 2) Acceptability; 3) Availability and accommodation; 4) Affordability; and 5) Appropriateness. The five dimensions of access related with the demand-side, or the abilities of persons include 1) Ability to perceive; 2) Ability to seek; 3) Ability to reach; 4) Ability to pay; and 5) Ability to engage. These dimensions are depicted in Figure 4.

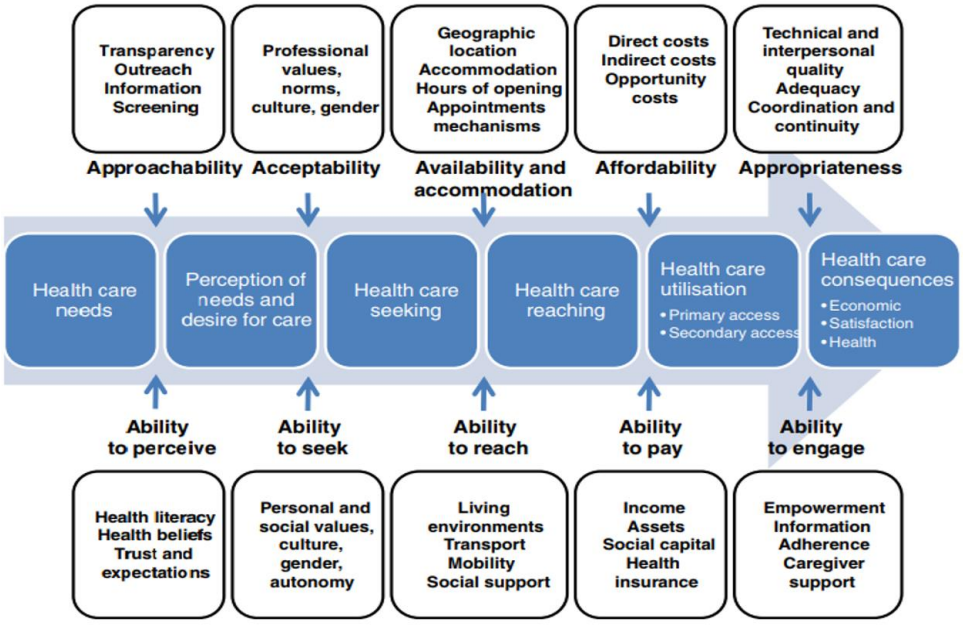


Figure 4 A conceptual framework of access to health care (Levesque, et al., 2013)

Dimension (supply side)	Definition
Approachability	Approachability of services relates to the fact that people facing social and healthcare needs can identify that some form of services exists, can be reached, and have an impact on their health.
Acceptability	Acceptability of services relates to the cultural and social factors determining the possibility for people to accept the aspects of the service.
Availability and accommodation	Availability and accommodation refer to the services(either the physical space or those working in social and healthcare roles) can be reached both physically and in a timely manner.
Affordability	Affordability reflects the economic capacity for people to spend resources and time to use appropriate services.
Appropriateness	Appropriateness denotes the fit between services and clients need, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment and the technical and interpersonal quality of the services provided.

Dimension (demand side)	Definition
Ability to perceive	Ability to perceive translates into the ability of people to identify their needs for social and healthcare services.
Ability to seek	Ability to seek relates to factors that would determine expressing the intention to obtain social healthcare services.
Ability to reach	Ability to reach relates to factors that would enable one person to physically reach service providers.
Ability to pay	Ability to pay is described as the capacity to generate economic resources to pay for social and healthcare services without catastrophic expenditure of resources required for basic necessities.
Ability to engage	Ability to engage relates to the participation and involvement of the client in decision-making and treatment decisions, which is in turn strongly determined by capacity and motivation to participate in care and commit to its completion.

ANNEX 5 - APPRAISAL OF POTENTIAL IMPACTS

This rapid EFHIA was scoped to focus on four activities (1.Community Hub, 2. Mobile Outreach, 3. Community Connectors, 4. Community-driven Activities) and its equity impact on two determinants(1. Social inclusion, 2. Access to service). Sources of evidence included a community profile, literature review, and information collected from public knowledge. The appraisal of potential impacts use considerations that are commonly used in HIA, that are based on the likelihood, direction, and level of the impact. (Harris et al., 2007; Hirono et al., 2017).

Likelihood – This describes whether or not the potential impact is likely to eventuate.

- Likely – very likely to happen. Direct strong evidence from a range of data sources.
- Possible – more likely to happen than not. Direct evidence but from limited sources.
- Speculative – may or may not happen. Plausible but with limited evidence to support.

Direction – This describes the nature of the effect.

- Positive – impacts that improve or maintain health or wellbeing.
- Negative – impacts that diminish health or wellbeing.
- Missed opportunity – impacts that have the potential to benefit wellbeing that are not realised.

Level – The core protective factors of mental wellbeing can have significant impacts on the wellbeing of both individuals and whole communities. This describes whether the impact will predominantly affect individuals or the community.

- Individual – impacts that affect the wellbeing of individuals.
- Community – impacts that affect the wellbeing of communities.

SOCIAL INCLUSION

Based on the evidence from the community profile, literature review and public knowledge, evidence on the impact on social inclusion can be appraised as in Table 20.

Table 20. Appraisal of evidence - social inclusion

Impact	Community profile	Literature review	Public knowledge
Social inclusion	The majority of the population in the project area are over 50 years of age. The number of lone person households is high. The community is ethnically	Social inclusion generally benefits positively to health and wellbeing. Older adults and lower socioeconomic groups benefit more from social cohesion.	The community strongly agrees that social exclusion and isolation is a main barrier in their community. The community express fear of their neighbours (e.g. youth, people with mental

	diverse. Language may be an issue to some residents. Information of 'excluded' subgroups is limited.	Social inclusion initiatives should aim to change the system that created the exclusion, and not try to include people into the existing system. Sometimes initiatives with a focus on improving social inclusion can unintentionally worsen exclusion. Community engagement in all stages of the process is effective in fostering social cohesion. Community experience frustration, exhaustion, mistrust, takes time to build rapport.	health and drug and alcohol issues, etc). The residents want to be more connected with the community. Many have offered to volunteer in activities.

ACCESS TO SERVICES

Based on the evidence from the community profile, literature review and public knowledge, evidence on the impact on access to services can be appraised as in Table 21.

Table 21. Appraisal of evidence - access to services

Impact	Community profile	Literature review	Public knowledge
Access to services	Many residents have multiple needs. Detailed information on the extent of service need is limited.	Dimensions in the supply side of access to services include: approachability; acceptability; availability and accommodation; affordability; and appropriateness. Dimensions in the demand side of access to services include the ability to : perceive; seek; reach; pay; engage.	Activities for youth and children are not available. Lack of services is a general issue and residents have expressed unmet health and social care needs. Structural barriers to access services such as transportation, safety is a crucial issue.