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Lessons Learned and Challenges in Building a Filipino Health Coalition

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Abstract

In recent years, community-based coalitions have become an effective channel to addressing various health problems within specific ethnic communities. The purpose of this article is twofold: (a) to describe the process involved in building the Kalusugan Coalition (KC), a Filipino American health coalition based in New York City, and (b) to highlight the lessons learned and the challenges from this collaborative venture. The challenges described also offer insights on how the coalition development process can be greatly affected by the partnership with an academic institution on a community-based research project. Because each cultural group has unique issues and concerns, the theoretical framework used by KC offers creative alternatives to address some of the challenges regarding coalition infrastructures, leadership development, unexpected change of coalition dynamics, and cultural nuances.

Keywords

coalition development; Filipino American health; community-based participatory research; New York City

In recent years, community-based coalitions have become an accepted vehicle for addressing complex health problems (Wynn et al., 2006). Coalitions serve as catalysts within the community, where members take action to effect change (Fawcett, Paine-Andrews, Francisco,

& Schultz, 1995). Because members share responsibilities, decision-making processes, risks, and resources, the process of creating and developing coalitions may be more effective in addressing health issues compared to conventional methods of implementing community interventions (Minkler, 2004; Wallerstein & Duran, 2003). The Kalusugan Coalition, Inc. (KC), is a multidisciplinary collaboration dedicated to creating a unified voice to improve the health of the Filipino community in the New York metropolitan area through network and resource development, educational activities, research, health service delivery, and advocacy. The purpose of this article is twofold: (a) to describe the process involved in building KC and (b) to highlight the lessons learned and challenges encountered during this collaborative venture. This article provides a case study describing factors affecting the functioning of a Filipino health coalition at its early stages of development. The lessons and challenges enumerated herein offer insight on how the dynamics of a coalition are affected by partnering with an academic institution on a community-based participatory research (CBPR) project. Furthermore, for individuals and organizations interested in developing future collaborations, it offers important areas of consideration before starting such a project and makes suggestions for overcoming challenges that may arise.

Several conceptual frameworks of coalition functioning have been previously described, including collaboration, empowerment, capacity building, and community development (Granner & Sharpe, 2004). The approach used in developing KC closely followed the stages of coalition development that Florin, Mitchell, and Stevenson (1993) described: initial mobilization, establishing an organizational structure, building capacity for action, planning for action, implementation, refinement, and institutionalization.

BACKGROUND

With a population of more than 2.4 million, Filipino Americans are the second largest Asian subgroup and the second largest immigrant population in the nation, behind Mexican Americans (Posadas, 1999; U.S. Census Bureau, 2000). In addition, there are also an estimated 1 million undocumented Filipinos in the United States (Focus Now Organization, 2003). Filipino American communities are concentrated in Hawaii and the western and northeastern coasts of the United States. In the northeast region, the growth of this population has been especially high in recent decades. In New York City alone, the population rose by 44% between 1990 and 2000 (U.S. Census Bureau, 2000). In spite of the growing number of Filipinos in this area, there were very few and limited wide-scale initiatives that specifically address the varying health needs of the Filipino community as a minority group. As of July 2008, records from GuideStar (www.guidestar.org) show that out of 483 registered Filipino nonprofit organizations across the United States, there are only 21 nonprofit organizations in New York and 27 in New Jersey. The majority of them are civic or cultural associations, and only a handful provides social services to the community.

STRATEGIES

Initial Mobilization Stage

It is not uncommon nowadays for civic, social, educational, religious organizations, businesses, and even nations to develop alliances or joint partnerships of any nature to create opportunities of mutual benefit to its partners (Butterfoss & Francisco, 2004). The KC (*Kalusugan* means “health” in Tagalog/Pilipino) started through an initiative of the Center for the Study of Asian American Health (CSAAH) based at the New York University School of Medicine. It was part of CSAAH’s broad-based outreach strategy to foster relationships with various ethnic-specific Asian communities. Founded in 2003, CSAAH is the first Project EXPORT P60 Comprehensive Center funded by the National Institutes of Health solely dedicated to the research and alleviation of health disparities affecting Asian Americans.

Aware of the considerable growth of the Filipino population between 1990 and 2000, particularly in large cities like New York City and Jersey City, New Jersey, CSAAH, in February 2004, initiated a series of meetings to discuss collaborative opportunities to address Filipino American health challenges. Representatives from various sectors of the Filipino American community in the New York metropolitan area and the Filipino American Health Services, Inc., a Filipino community-based organization in Queens, New York City, were invited to these initial meetings. Priorities included establishing significant community participation to best identify local health problems and then designing program interventions that would address the social determinants of Filipino American health (Chalmers et al., 2003; El Ansari & Phillips, 2001; Lantz, Viruell-Fuentes, Israel, Softley, & Guzman, 2001; Syme, 2004). Integral to this outreach work was the hiring of a Filipino staff member and a graduate research assistant to lay the groundwork for building ties with Filipino organizations in the New York metropolitan area.

This series of meetings resulted in the creation of an ad hoc committee whose first task was to mobilize members of the Filipino American community and to organize the first Filipino American Community Health Forum held in New York City. The health forum was a pivotal event that brought together, for the first time, more than 100 health professionals and community members. It was meant to raise awareness among the community members about health needs, service delivery issues, health disparities, and undocumented workers' concerns. The health forum also served as a venue to start a dialogue about what the participants perceived to be the most pressing concerns of the Filipino community in New York City and New Jersey. The ad hoc committee relied on the strong endorsement and outreach by a well-respected local physician and a community leader. Community initiatives often benefit from the involvement of key community leaders at the initial stages of coalition formation (Cramer, Atwood, & Stoner, 2006). This physician was instrumental in securing community-wide support, resources, and buy-in through his positive relationships with various community-based organizations and Filipino health professional associations. Furthermore, being a prominent entity in the Filipino community, the Philippine Consulate General in New York was chosen by the committee as a venue. Leaders from different sectors were invited to speak about various social and health issues affecting the Filipino community on the East Coast. Table 1 provides examples of some of the topics that were discussed at the forum.

A direct outgrowth of the health forum was the development of a community health needs assessment (CHNA). The CHNA was exploratory in nature, using qualitative and formative research methods. Its main purpose was to create a more systematic examination and appraisal of the type, depth, and scope of needs of the Filipino community for the purpose of setting priorities to be addressed (Rhodes & Benfield, 2001) particularly (a) to identify the health issues of concern for the Filipino community, (b) to determine the resources available, and (c) to assess the best approaches to meet community needs.

The CHNA was administered to Filipino American men and women ages 13 to 80, using the following methods: a self-administered 22-item survey ($n = 135$) administered to a cross-section of Filipino adults (40% men, 60% women), five focus groups ($n = 52$) segmented by age (adolescents, college age, young adults, middle age adults, and seniors), and five key informant interviews that included an immigrant rights advocate, a church leader, a staff member at a social service organization, a retired physician, and a child health advocate. Research instruments were developed by drawing on tools used previously in the Filipino community by the National Heart, Lung, and Blood Institute and the New York City Department of Health and Mental Hygiene.

The strategy of combining data collection with other social activities such as community forums, cultural events, health fairs, and church meetings was used to recruit participants. The

advantage of this technique is that data were collected within the context of an activity for which the participant has already planned time (Berg, 1999). The majority of interviewers and focus group facilitators were of Filipino heritage.

Results from the CHNA reveal that cardiovascular disease and stroke are major concerns for Filipino Americans in the New York metropolitan area, with 71% of survey respondents indicating that these were critical areas to address (see Figure 1). Focus group findings also indicate that Filipino Americans generally do not maintain healthy eating habits, engage in regular physical activity, or routinely access preventive health care. In focus groups with youth and young adults, participants described substance abuse as a major concern. Findings from this study also revealed that as an overwhelmingly immigrant community, Filipino Americans in New York City and Jersey City face challenges associated with separation from family, lack of social support, isolation, loss of social status, cultural alienation, and loss of self-esteem because of discrimination (Abesamis-Mendoza et al., 2007).

The CHNA also revealed gender-related health issues. Respondents noted that women are heavily recruited from abroad to fill in employment gaps such as physical therapy, teaching, and domestic work. Because of increasing economic necessity, there is a high rate of Filipino women in the labor force who are at an increased risk for health and psychological problems, because they are expected to work while still being responsible for domestic tasks and child care (Sanchez & Gaw, 2007). This was confirmed by CHNA respondents discussing stressors, discrimination, and occupational health concerns experienced by domestic workers, most of whom are women. Also mentioned were stigmas around accessing and discussing sexual health and mental health, which prevents Filipino women from seeking preventive care and treatment (Abesamis-Mendoza et al., 2007).

Study respondents also noted how Filipino men particularly delay seeking health care more than women, which was partly attributed to prescribed gender roles in Filipino culture in which men are taught to be strong, macho figures (Nadal, 2000). The CHNA also found in the literature that Filipino American males have a high prevalence of alcoholism and the highest rate of smoking among all Asian subgroups (Chi, Lubben, & Kitano, 1988), which focus group respondents confirmed, recognizing tobacco and alcohol use as a socially acceptable behavior among Filipino men.

Another important finding of the CHNA as expressed by many respondents was the need to coalesce as a unified and coordinated community. Many participants described deep divisions among Filipino Americans in the region and reported low community solidarity. Some respondents described divisions based on socioeconomic status, power struggles among community members, the inability to organize or mobilize community members, or discrimination from other Filipino Americans and non-Filipinos. The community's call and commitment to create more concerted efforts illustrated their readiness to develop an organization to address Filipino health. What grew out of the CHNA was the formation of a community-wide advisory committee to tackle many of the concerns raised by the study.

Several community leaders and organizations were approached and invited to be part of a Filipino Community Advisory Committee in the summer of 2004. Participants were drawn from the social service, cultural, educational, professional, and entertainment sectors. Among the initial committee members were representatives from the Damayan Migrant Workers Center, Filipino American Human Services Inc., Kinding Sindaw, LFP International Productions Inc., Philippine-American Friendship Committee–Community Development Center, Philippine Nurses Association of America, Sumisibol, New York University CSAAH, New York University Asian/Pacific/American Studies Program & Institute, and community

physicians and students. Collectively, these organizations had decades of experience with the Filipino community in the region.

Establishing an Organizational Structure Stage

Coalitions often use strategic planning retreats to solidify their initiative (Bryson, 1994). After several months, the Filipino Community Advisory Committee felt that having a strategic planning retreat was the next step to produce fundamental decisions and actions that would shape and guide the coalition (Bryson, 1994). An external facilitator used large-group brainstorming, small-group discussions, and consensus-building activities to explore the purpose of the committee's existence and a Strengths, Weaknesses, Opportunities, and Threats analysis to examine internal strengths and weaknesses as well as external opportunities and threats. Several important tasks were accomplished during the retreat. The members of the advisory committee decided that they wanted the committee to take a role within the community beyond advising. Many insisted that it would be more appropriate and timely that the committee be action oriented. The advisory group felt it was necessary to have a name of its own that was easy to remember and that would reflect the purpose of its existence. Thus, the name "Kalusugan Coalition" (KC) was born. According to Butterfoss, Goodman, and Wandersman (1993), coalition formation may be stimulated by positive attitudes toward coordination and recognition of mutual need. Such positive attitudes of the advisory group led to the formation of the much-needed coalition. Cauley (2000) described this period as the identification stage in which participants are discovering information about each other and determining the scope of work of the potential partnership. The retreat also resulted in the creation of the coalition's mission and vision, guiding principles, and statement of core purpose, as well as the coalition's initial organizational infrastructure.

Building Capacity and Planning for Action Stages

In the summer of 2005, KC partnered with CSAAH for what was going to be its first major project. The partnership applied for and successfully obtained a CBPR grant from the National Institutes of Health, National Center for Minority Health and Health Disparities. Based on the literature and the CHNA, which demonstrated a high burden of cardiovascular disease in the community and provided significant evidence of health access barriers, KC and CSAAH agreed that the study should address cardiovascular disease among the Filipino community in New York City and Jersey City, New Jersey, using a community health worker intervention. The project is currently in its initial stage of intervention implementation.

In 2007, KC adopted its bylaws and became incorporated under the State of New York. It later secured a fiscal agent and is now in the process of applying for tax exemption under the IRS Code 501(c)3. These steps have enabled KC to become autonomous and to determine the future of the coalition beyond its historical affiliation with an academic institution.

DISCUSSION

There are a number of pragmatic lessons that can be taken from the process of developing KC. Lesson 1 is as follows: Creating and nurturing trust is a basic element to a successful and mutually beneficial community-academic relationship. There were some specific attributes that contributed to the successful process of forming the health coalition. First, several CSAAH staff members were of Filipino heritage and lived in neighborhoods of New York City with a high concentration of Filipinos. Hence, the insider's perspective of these Filipino academic partners was a significant facilitator of trust building between the university and the community. Second, CSAAH staff also attended numerous community partners' events as a way of fostering greater levels of trust in the community, cultivating relationships, and demonstrating support of their work. Third, many community-based organization

representatives were open to joining the new initiative, as CSAAH was the lead initiator and seen as a neutral entity compared to other community-based organizations with potential competing interests. Also, the Filipino community's experience with research and partnerships with academic centers was relatively new. Therefore, at the time, there were minimal opportunities for distrust to develop, unlike in other racial and ethnic minorities who have a historical legacy of distrust and skepticism of academic partners (Israel, Schulz, Parker, & Becker, 1998; Minkler, 2004; Ugalde, 1985; Wallerstein, 1999).

Last, for some organizations, it seemed attractive for them to be affiliated with an academic research center because they felt it lent credibility to their endeavors and could be used as leverage for the work they were pursuing. This perspective may be attributed to the high value Filipinos place on education. Filipinos view education as a passport to good jobs, economic security, social acceptance, and as a way out of a cycle of poverty and lower class status not only for their children but also for the whole family (Santos, 1983). Oftentimes, community groups are inclined to partner with academic universities because it opens the door to various resources (Berg, 1999). This was the case here, where community groups acknowledged that partnering with New York University may increase their access to resources such as funding opportunities.

Lesson 2 is as follows: Using an intergenerational approach can be an effective tool to building the coalition's organizational structure. One unique characteristic of leadership within the initial infrastructure of KC was the presence of two co-chairs: The first was an emerging leader and young professional and the other a more established leader in the community. Similarly, the composition of KC's Board of Directors was also intergenerational. This follows the principle of an intergenerational approach (International Center for Research on Women, 2003), which calls for a positive interaction between people from a younger generation and those from an older generation to deal with issues that are important to both generations and to the wider community. This unique structural configuration has allowed for mentoring and opportunities for future leadership development within the group so as to promote participatory governance and sustainability (Vroom & Jago, 1978; Weiner & Alexander, 1998). Moreover, both younger and older board members have unique connections and ties to different segments of the Filipino community and bring varying perspectives based on their experience and background.

Lesson 3 is as follows: Addressing diversity within the community can foster inclusiveness and active participation of members. Butterfoss et al. (1993) described community coalitions as representative of a given community and that membership should reflect all segments of that community's population. From the initial stages, KC reached out to various sectors within the Filipino community to understand the scope of strategies and approaches, to deal with the health disparity issues, and to address the need to coalesce as a unified community. The recruitment of new members of KC following its creation has been informal, expanding through personal outreach and word of mouth. The implementation of the CBPR project also provided an excellent opportunity to recruit new members, including clinicians, community leaders, and members of community-based and faith-based organizations involved in the project. It is the hope that study participants will also become future members of the coalition to expand its community representativeness. The main reason for this comprehensive community approach was best described by Sanchez and Gaw (2007), who noted that interdependence and social cohesiveness are central to Filipino identity. It was important then to reach out to organizations and individuals from various areas of expertise to mirror the various subgroups existing in the Filipino community and to provide a voice for subgroups that historically have been "invisible."

Another aspect of KC's membership that differs from traditional coalitions is that it allows individual members without affiliations as well as organizational representatives to participate.

According to Butterfoss & Francisco (2004), membership is considered to be the primary asset of coalitions given that each stakeholder brings a unique set of skills and resources. Therefore, involving organizational members provided an opportunity for subgroups to learn about each other and allowed for the sharing of resources. Individual members, on the other hand, are deemed crucial to the success of KC because they provide an abundance of resources, time, and expertise in different fields without having limitations that might come from their affiliate organization. By involving a diverse group of individuals and organizations in the process, KC also enhances its membership core and expands its community reach, which is significant to providing the grounds for sustainability.

Furthermore, the gender makeup of KC at present helps ensure that the coalition appropriately addresses health issues affecting men and women alike. KC membership gender breakdown closely mirrors the general Filipino population in New York City wherein 56% are women and 44% men (U.S. Census Bureau, 2005). Currently, 60% of individual coalition members and organizational representatives are female, and 40% are male. The composition of the Board of Directors of KC is also relatively evenly distributed by gender, as it comprises four women and five men.

Lesson 4 is as follows: Recognizing each voice within the coalition will enhance consensus-building strategy. Although nearly all KC members share a common heritage, their differences based on immigration status, U.S. born vs. non-U.S. born, education, income, gender, and age can be causes of conflict. It is common in the Filipino culture to assign deference to individuals who are older, more educated, and wealthier. As such, providing a space for all individuals within KC to voice their opinions has been challenging but crucial. SenGupta (2000) noted that clear and open communication based on mutual respect, understanding, and information sharing are essential building blocks of a successful community-campus partnership. To ensure this, KC has used a consensus-building strategy as a way to create a climate in which every concern from the general membership is heard so that an equitable agreement can be reached (Poirier Elliot, 1999). For example, making group decisions regarding project selection and grant applications has been highlighted as an internal challenge for KC members. As a general rule, efforts are made to reach consensus on decisions, but when there are instances that consensus cannot be reached, the coalition uses a majority rule. During these meetings, the floor is opened to members to discuss and debate the pros and cons of such issues.

The chair frames a proposal after listening carefully to everyone's concern until a convergent agreement is reached (Poirier Elliot, 1999). The chair will then present the proposal to the coalition's board for its final approval. Issues in the general membership meetings are discussed by order of its importance as determined by the Board of Directors. The same principle of consensus building applies for the Board of Directors of KC when it deals with other major issues related to its role and responsibilities.

KC also uses a quorum; that is, a majority of the entire membership of the body must be present to conduct the coalition-related business. For instance, there must be at least 51% of members present for general meetings, board meetings, and taskforce meetings to vote on an issue. Otherwise, these issues are tabled until the next time the group convenes a meeting. These decision-making processes illustrate a group process that supports the coalition development stages of implementation, refinement, and institutionalization and enable members to work together to accomplish goals, impacts, and outcomes (Granner & Sharpe, 2004).

Lesson 5 is as follows: A CBPR project can increase the coalition's capacity and visibility. The involvement of KC as a community partner of CSAAH on a CBPR project opened a wide door of opportunities. KC members benefited from the learning environment in which members received ongoing training and technical assistance for performing competent community

assessment, planning, data analysis, implementation, and evaluation (Armbruster, Gale, Brady, & Thompson, 1999; Spitz & Ritter, 2002). By promoting the CBPR project to the Filipino community, KC has gained wider media exposure; developed new relationships with community groups, faith-based organizations, businesses, and health care agencies; and enabled its members to do advocacy on behalf of the Filipino community.

Lesson 6 is as follows: Continuous assessment of coalition structure and action plans is integral to coalition maintenance. In addition to the benefits mentioned, KC also experienced several challenges that altered its dynamics as a result of the CBPR project. (a) KC needed to expand the scope of its activities. Upon receipt of the CBPR grant, the efforts of the coalition were directed solely toward initiating the CBPR project. For nearly 1 year, KC general membership meetings ceased and became replaced with the CBPR project meetings. As a consequence, planning for new health initiatives and becoming incorporated as a distinct entity were not pursued until a later time. (b) The hiring of coalition members as consultants also raised the issue of conflict of interest. Although this was used as a way to compensate members for their contributions, it presented the challenge of maintaining their involvement once funding expired. (c) Because much of the efforts of KC were redirected toward the initiation and implementation of the CBPR project, this circumstance directly affected the coalition's ability to expand its membership for a period of time. (d) Some coalition members also felt that the identity of KC was shrouded and lost within the CBPR project. For instance, there was more name recognition of the CBPR project within the community than the coalition itself. (e) Since the incorporation of KC, many coalition members were also concerned with issues of autonomy and being recognized as an independent entity not solely affiliated with or part of the partnering academic institution. (f) Concerns about equitable distribution of resources from the CBPR project and decision-making processes were also challenges. According to Connolly (2000), it is the process of sharing power among partners, especially in an academic-community partnership, that must be held as a priority, not only to share available resources but also, even more importantly, to increase the resource infrastructure or capacity building of the partnership.

To address these issues, KC relied on its core leaders, the Board of Directors who were consistently involved in the various stages of the coalition development and made it possible to regroup and reassess its mission and goals. Literature has pointed to the importance of core leaders who not only are able for recruitment and obtaining resources but also have the ability to pay attention to individual members' concerns and have strong negotiation, problem-solving, and conflict resolution skills (Feighery & Rogers, 1989).

These core leaders, that is, the Board of Directors of KC, initiated several action planning meetings with its members and restructured its infrastructure to include five task forces to tackle integral areas for coalition maintenance. (a) The coalition development task force is in charge of conducting an internal resource assessment, determining capacity-building needs of members, membership recruitment, coordination of internal communications (i.e., listserv, membership directory), infrastructure building, board development, and human resource systems and processes. (b) The funding development task force deals with identifying grant opportunities, preparing grant applications, cultivating potential donors, and financial management. (c) The partnership development task force focuses on conducting outreach to potential collaborators and volunteers, the development of public relations protocol for KC, and the creation and maintenance of KC's Web site and publicity materials. (d) Strategic development taskforce deals with conducting ongoing needs assessments to determine new areas for program development and coordinating the implementation and evaluation of coalition projects. (e) The advocacy and policy development task force tracks U.S. and international policies affecting Filipino Americans, informs KC about current and future health campaigns and activities, develops position papers for KC on relevant health issues,

coordinates advocacy trainings for members, and participates in advocacy activities on behalf of the coalition.

Action plans were developed by each task force that delineated goals, objectives, and proposed activities for the next 3 years. At bimonthly general membership meetings, each taskforce chair provides a summary of the progress of its activities and solicits feedback from all members on areas for improvement. KC also periodically reviews the task forces' action plans as a group to assess how the coalition is doing in meeting its goals and objectives.

It was important for the coalition members to go through such a process to recommit themselves to the mission and vision of KC, assess areas for growth, and strategize what resources and types of support are needed to build a stronger infrastructure for the coalition. Cross-trainings also occur at these meetings for coalition members to build each other's capacity to address health issues beyond cardiovascular disease so the coalition is better equipped to begin expanding its programmatic and advocacy plans.

CONCLUSION

By taking into account the lessons learned and drawing inspiration from its challenges, KC continues to grow and to mature in its mission of bringing together a diverse group of individuals and organizations who share a mutual interest to address Filipino health. This case demonstrates that the importance of understanding the culture of a population can be an effective tool for institutions and community leaders in forming new initiatives such as a coalition.

This article uses KC's lessons and challenges in coalition development to describe the various principles of coalition functioning, such as member characteristics and perceptions (i.e., member recruitment, commitment, ownership), organizational or group processes (i.e., clear mission, decision making, roles and procedures), organizational or group characteristics and climate (i.e., community context and readiness, group relations/collaboration, strong leadership), and impacts and outcomes (i.e., linkages to other groups/community, empowerment, community capacity) (Butterfoss & Francisco, 2004; Granner & Sharpe, 2004). KC will more systematically evaluate these principles in the future to measure its capacity and the impact it has on improving the health outcomes of the Filipino community. Evaluation results will help KC build more of its credibility and capacity to apply for future funding, solidify its membership base and increase their commitment, nurture current leaders and foster emerging ones, and develop new program areas and activities. As such, KC will therefore address what most coalitions face: the challenge of sustainability. Finally, the development of KC emphasizes how coalitions can serve as a forum to discuss how community health should be addressed in a collaborative manner.

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FIGURE 1.
Community Health Needs Assessment Results

TABLE 1

Sectors, Speakers/Organizations, and Topics Represented at the First Filipino American Health Forum

Sectors	Speakers/Organizations	Topics
Health professionals	Philippine Medical Association, New York Philippine Nurses Association, New York Asian Pacific Islander Coalition on HIV/AIDS	Mobilizing Filipino doctors to address community's health needs both in the Philippines and the United States Service delivery issues and role of Filipino nurses in U.S. health system Impact of HIV/AIDS on the Filipino American community
Social service providers	Philippine American Friendship Committee, Inc. (PAFCOM)	Cardiovascular disease and diabetes health education and outreach efforts for Filipino American community in Jersey City, New Jersey
Grassroots	DAMAYAN Migrant Workers Association	Health issues for undocumented workers
Legal professionals	New York Lawyers for the Public Interest	Legal issues facing immigrants in accessing health services in New York City