

AACORN 2ND INVITED WORKSHOP
AUGUST 14-15, 2006
PHILADELPHIA, PA

Participatory Research on African American Community Weight Issues: Defining the State of the Art



Compendium of Speaker Presentation Summaries

CONTENTS

Session I. Community-Based Participatory Research (CBPR): Definitions, Guiding Principles and Challenges / Opportunities to Researchers and Communities

<i>The history, conceptual framework and guiding principles of CBPR</i> Amy Schulz, PhD, MPH and Alex Allen.....	1
<i>Partnerships in Actions (Part 1): Healthy Environments Partnerships</i> Amy Schulz, PhD, MPH and Sonya Grant Pierson.....	2
<i>Partnerships in Actions (Part 2): Chicago Food Systems Collaborative</i> Daniel Block, PhD and LaDonna Redmond.....	3
<i>Partnerships in Actions (Part 3): Philadelphia Area Research Community Coalition (PARCC)</i> Jerry Johnson, MD and Thomas Henry.....	4
Funding CBPR	
Geraldine Perry-Allen, DrPH, RD	5
Wendy Johnson-Taylor, PhD, MPH, RD.....	6
Laura C. Leviton, PhD.....	7

Session II. Other Community Priorities: Are They “In the Way” or “On the Way” to Achieving Healthy Weight Goals?

<i>The Toll of Housing Policies on African American Health</i> Lesley L. Green-Rennis, MPH, Ed.D.....	8
<i>Violence Prevention as a Community Priority</i> Tio Hardiman.....	9
<i>The Impact of Incarceration on African American Communities</i> Khalilah Brown-Dean, PhD.....	10

Session III. Studies That Address Community Priorities

<i>Publishing CBPR Works – A Journal Editor’s View</i>	
Lesli Mitchell.....	11
Kim Dobson Sydnor, PhD.....	12
<i>Sample Programs That Address Life Contexts of African Americans</i> Wendell C. Taylor, PhD, MPH.....	13

CONTENTS

Angela Odoms-Young, PhD and Shannon Zenk, PhD.....	13
Toni Yancey, MD, MPH.....	15

African American Collaborative Obesity Research Network

2nd Invited Workshop

August 14-15, 2006

Compendium of Speaker Presentation Summaries

On August 14 & 15, 2006, AACORN hosted its 4th Annual Meeting and 2nd Invited Workshop entitled: *Participatory Research on African American Community Weight Issues: Defining the State of the Art*. The workshop engaged a diverse group of scholars, scholars-in-training, and community partners from across the United States. The overall goal of this workshop was to explore how Community-based Participatory Research (CBPR) can inform obesity research in African American communities. Sub-objectives included: a) Reviewing concepts, principles, issues in participatory research and clarifying how CBPR approaches apply to obesity prevention and treatment; b) Exchanging ideas with representative community members in order for researchers to understand what constitutes a successful research project to community residents and for the communities to understand what is involved in conducting research; c) Reviewing and reflecting on community priorities and related issues (e.g., housing, violence and incarceration) that may be more immediate than those related to obesity and on how these interface with efforts to address obesity, in conjunction with scholars in other areas of public health research; and d) Considering studies in African American communities that have strong participatory components, including but not limited to research to improve nutrition, physical activity levels, or weight levels. Following are summaries of our workshop presentations.

HISTORY, CONCEPTUAL FRAMEWORK, & PRINCIPLES OF COMMUNITY-BASED PARTICIPATORY RESEARCH (CBPR)

Amy Schulz, PhD
University of Michigan

Alex Allen
Isles, Inc.

Historically, research has rarely benefited and sometimes harmed the communities in which it has been involved. Using models that stress objectivity and impartiality, researchers often eliminate any community influence upon research. As a result, intervention efforts that are developed from this type of research are not as effective as they could be because they have been developed without any community input and were developed without engaging community members in defining the problems or designing the solutions. CBPR is a form of research that seeks to engage the skills, resources, and strengths that exist within communities that face particular challenges to their health and well-being.

Principles of CBPR

- Recognize the community as a unit of identity
- Build on strength and resources within a community
- Promotes collaboration, equity, empowerment and power sharing
- Promote co-learning and capacity building
- Establish a balance of knowledge gained and action steps taken
- Maintain relevance to the local community
- Builds and strengthens the partnership and the community
- Disseminate the findings to communities, involves communities in disseminating findings about their communities
- Maintain relevance to the local community
- Make a long-term commitment to communities



Five stages of the CBPR process:

1. Formation and maintenance of the partnership
2. Assessment of the community
3. Identification of local concerns
4. Taking action to address local concerns
5. Evaluation of the partnership & its effectiveness

Benefits of CBPR

- Community involvement throughout a project enhances the quality and the effectiveness of a project.
- CBPR approach provides opportunities to bring resources into communities.
- CBPR brings together partners with diverse expertise to address complex health problems.
- CBPR increases trust and bridges cultural gaps between partners.
- CBPR provides the potential to translate research findings into the development of further interventions and policy changes.

Lessons Learned & Recommendations:

- Jointly developed CBPR principles are key: mutual understanding of partner expectations
- Follow agreed upon principles in practice and evaluate partnership process
- Balance process and task
- Select mutually defined priorities
- Focus on community strengths as well as challenges
- Establish mutually agreed upon procedures for dissemination
- Establish and maintain infrastructure to support the partnership
- Start small with organizations that represent the community and are credible
- Reach a balance in the distribution of resources and benefits across partners.

Acknowledgements: Detroit Community Academic Urban Research Center: Community Health and Social Services, Detroit Department of Health and Wellness, Detroit Hispanic Development Corporation; Friends of Parkside, Henry Ford Health System; Latino Family Services, University of Michigan Schools of Public Health, Social Work, Nursing; Warren Conner Development Coalition; and Israel B.A., et al. Critical Issues in developing and following community-based participatory research principles. In *Community Based Participatory Research for Health*, Minkler & Wallerstein (eds) 2003. Jossey Bass Pub, San Francisco.

PARTNERSHIPS IN ACTION I: HEALTHY ENVIRONMENTS PARTNERSHIP

Amy Schulz, PhD
University of Michigan

Sonya Grant Pierson, MSW
Rebuilding Communities, Inc.

The Healthy Environments Partnership (HEP) illustrates how CBPR can engage all of the partners in all aspects of the research process, including: identifying the research questions to be addressed; planning how the information will be gathered; examining, interpreting, and disseminating the results.

- HEP was the first project of the Academic Urban Research Center (Detroit, MI) that did not have an intervention component. It was designed to examine racial, ethnic, and socioeconomic health disparities as products of inequalities that influence health outcomes. Specifically, HEP examined the ways that race-based segregation and income inequality contribute to racial disparities in health in East, Northwest, and Southwest Detroit.
- HEP utilized a steering committee (responsible for oversight of the project) and multiple subcommittees (all of which comprised academic, health provider, and community partners) to create structures for participation and influence by partners. HEP also utilized other processes which included input from community residents (focus groups and pre-tests of survey instruments); however, these forms of participation were distinct from the Steering Committee in providing less opportunity for influence through decision making.

- Academic and community partners and health service providers all were heavily involved in the analysis and interpretation of the findings, and to plan what future steps would be taken to apply those findings. As a result, several other projects were born out of HEP: **Detroit Academy for Environmental Justice** (*not funded, but components subsequently built into other proposals*); **Lean and Green in Motown Project** (*newly funded*) which looks specifically at aspects of the built environment as they contribute to obesity, and which uses data collected under HEP; **CATCH** (Community Approaches to Cardiovascular Health) which worked with Detroit residents/organizations to plan and test the effectiveness of interventions to reduce the risk of heart disease.
- HEP is a good example of how, by bringing together diverse partners to address a common challenge, unique perspectives and insights can be brought to bear on problem solving to address community health issues. Also, cooperating in the research effort provides opportunities for community organizations, health service providers, and academic partners to pool resources to address complex health concerns.

PARTNERSHIPS IN ACTION II: CHICAGO FOOD SYSTEMS COLLABORATIVE

Daniel Block, PhD

Chicago State University

LaDonna Redmond

Institute for Community Resource Development

LaDonna Redmond began working on sustainable food issues after her seven year old son was diagnosed with asthma induced by food allergies. His diet required organic food products, which Ms. Redmond found were difficult to acquire in her Chicago neighborhood. As a way to broaden consumer choice and address food accessibility concerns, she created the Institute for Community Resource Development and the Chicago Food Systems Collaborative. The CFSC was initially unfunded, and comprised a loosely organized consortium of neighborhood groups (ICRD, churches, several health organizations, and a farming community). CFSC found funding when academic researchers became involved, and the CFSC later became associated with the Policy Research Action Group, a consortium of universities.

The goal of the Chicago Food Systems Collaborative is to improve access to fresh fruits and vegetables and other healthy, high-quality foods in the Austin community in Chicago. The various projects initiated by CFSC emphasized school-based nutrition and market-based research, which showed that the barriers to healthy food Austin residents faced were affordability, quality, and access. The CFSC was formed as a way to:

- Improve the public policy infrastructure around access to food and food production
- Induce market-based change of public policies needed to support healthy food access
- Broaden the range of consumer choices
- Establish a community-owned grocery store in Austin

To find out what food actually was available, CFSC initially conducted a market basket study in Austin (and in the neighboring community of Oak Park) using a Community Food Assessment Tool Kit distributed by the USDA. The USDA document ultimately proved to be inadequate to assess the dietary requirements and preferences of Austin residents. So, the CFSC polled community residents and consulted a nutritionist for additions to the list, which yielded a list with which to gauge availability and prices of 102 foods. Among the findings of the market basket study:

- Fresh produce was available within walking distance (usually in corner stores) but was usually poor quality.
- Where available, the prices of meat and produce were affordable; everything else was inordinately expensive.
- In the 2 independent supermarkets, the prices and quality of fresh produce and meat were fairly good.
- In the discount supermarkets, the prices are considerably cheaper, but the selection of food is markedly smaller.

CFSC conducted focus groups with store owners and consumers, which yielded detailed information about the lengths to which some Austin residents go to satisfy their dietary needs (like bartering the bulk of an allotment of food stamps for a ride to a supermarket). The focus group information, coupled with the market basket study, reinforced the determination of the group to build its own community-owned supermarket.

In order to build a supermarket, the group needed a business plan, and money and expertise to execute the plan. The Kellogg Foundation, one of the funders of the CFSC, financed the work of consultants to work with the CFSC to formulate its business plan; it also provided bridge funding for the plan to be developed. CFSC identified several barriers in its journey to create a community-owned supermarket in Austin: 1) the business model is designed to enrich stockholders, as opposed to meeting the needs of the community; and 2) urban consumers' food-buying habits are largely misunderstood. These two observations on the economics of creating supermarkets in underserved communities are inextricably linked. Misconceptions about what African Americans buy and eat drive the process. But, a single economic model can neither accurately project nor adequately satisfy the diverse needs of the African American community. These were critical issues to be confronted when CFSC attempted to acquire financing for the supermarket project.

The notion of a partnership is essential to overcome the sociological and economic barriers to the capitalization process, and by extension, to counteract the barriers to all other aspects of development of stores in underserved communities. By expanding the scope of their partnerships to include non-profit agencies, philanthropic institutions, financial institutions, federal and local public policy agencies, and by involving their partners at an early stage, CFSC seeks to mimic the successes of the fair housing movement. (*CDCs evolved into non-profit agencies to help create change in communities around the issue of access to affordable housing. Financial and philanthropic institutions became involved in the movement to support the development of housing in undersupported communities.*)

According to Ms. Redmond, one of the biggest challenges in the CBPR process has been the imbalance between the value of the community contribution versus the academic contribution. Eventually, the disparity transforms what initially was an issue borne of race into a class struggle. She suggests changing the way community participation is viewed: "... [that means looking at community participation outside of the rigidity of the community role that is informal and not professional... We have to really look at the communities from an asset-based model," as opposed to viewing the communities through a 'poverty lens.' She added: "We have to add economic development into our projects, and really begin to understand the roots of poverty... hunger is an issue rooted in poverty."

PARTNERSHIPS IN ACTION III: PHILADELPHIA AREA RESEARCH COMMUNITY COALITION (PARCC)

Jerry Johnson, MD
University of Pennsylvania

Thomas Henry
Southwest Action Coalition

The Philadelphia Area Research Community Coalition (PARCC) is a community-based participatory research partnership which comprises about twenty community and faith-based organizations, non-profit organizations, and academic institutions. PARCC was organized in September 2005 as a result of the expressed interest in developing a CBPR partnership from the attendees of a community symposium held in July 2005 entitled "*Improving the Health of the Community: Becoming Partners in Research.*" The mission of PARCC is to establish, facilitate and coordinate the effective long-term and sustainable health research partnerships between community organizations and institutions that have a shared vision and leadership to change and improve the health of the community in West and Southwest Philadelphia. PARCC's development is supported by a Center of Excellence grant from the National Center for Minority Health and Health Disparities at the National Institutes of Health.

Dr. Johnson is the Chief of Geriatric Medicine and where his work involves a lot of what he calls 'cultural competence' and 'cross-cultural education. Mr. Henry is a longstanding community activist and leader of a coalition of organizations whose aim is to improve the welfare of residents of Southwest Philadelphia. According to Johnson and Henry, there is a palpable level of community distrust of academic institutions arising from the perceived lack of respect for the communities of West and Southwest Philadelphia and the lack of perceived benefit of the research to the community.

Johnson and Henry provided anecdotes about the issues to be faced. Problems may exist on both the university- and the community partner sides of the equation in relation to teamwork and shared leadership and goals. In addition there is a cultural divide between academia and community. In an effort to bridge the gaps in communication between academic and community partners, several key questions must be answered:

- What is research? (*Under what definition of "research" is each partner operating?*)
- What does it mean to be an active participant in research?

- What is the community?
- Who are the real partners?
- Who's going to set policy for the group?
- Who is and who isn't "in the family?"

In the early stages of the formation of PARCC, one of the first orders of business was to establish the mission and principles of the organization. Referencing other CBPR projects across the country, PARCC organizers noticed that they all essentially had the same principles. However, one of the distinct challenges and strengths of this partnership was its invitation to all organizations interested in health care research, not only the organizations with established history of research participation. Governed by a Community Action Board consisting of partner organizations, partners share leadership, responsibility and resources to ensure that each partner has an equal value and an equal voice. The Community Action Board is charged with identifying and designing research, intervention and prevention projects, securing funding for PARCC, and evaluating and disseminating information.

With regard to establishing research priorities, PARCC has successfully accomplished the following:

- Organizational Assessments (*This was a formal process of interviewing heads of member organizations (and/or the person who attends PARCC meetings)*)
- Establishment of healthy lifestyle program
- Developed a formal process to respond to requests to become part of research projects
- Development of a training session to educate member organizations with respect to participation in research
- Training member organizations to write grants

Several salient points emerged during the PARCC Q & A session, including the following:

What kind of exercises...do you do with the community and the researchers to build trust?

For researchers: Be responsive to community requests that may be unrelated to research and devote the time to know the community served. Show respect. Be honest. Be transparent. **For community representatives:** capacity building to allow full participation in research. **For both:** recognize that all organizations have individual agendas, but the goal of the partnership is a shared agenda.

FUNDING COMMUNITY-BASED PARTICIPATORY RESEARCH

Geraldine Perry-Allen, DrPH

Centers for Disease Control & Prevention

The CDC has led the way in community-based participatory research (CBPR), by way of their flagship program, the *Prevention Research Center Program*, which was funded by Congress in 1984. The CDC funds PRCs nationwide, which form partnerships with health departments and other groups that pursue participatory research. Initially, 3 centers were funded by the program in 1986; the program has grown to 33 centers nationwide. The Prevention Research Centers work as an interdependent network of community, academic, and public health partners to conduct prevention research and promote the wide use of practices proven to promote good health. The network partners are all involved in CBPR, and primarily focus their attention upon underserved populations. PRCs are selected through a competitive review process, and managed by CDC as a set of cooperative agreements. Through these cooperative agreements, CDC lends technical assistance to the different centers to develop participatory research.

The Prevention Research Centers Program functions as a consortium of partners. Representatives from the research centers, their communities, and CDC's Prevention Research Centers' Office serve on committees that lead the program in setting standards and policies and in making recommendations for research and other activities. Seven committees now guide the program:

- **Steering Committee** -- Comprises the chairpersons of the standing committees as well as an overall leader elected from one of the Prevention Research Centers. Serves as an executive committee to the CDC program office.
- **Program Committee** -- Coordinates and leads the planning activities of the annual Prevention Research Centers Program meeting.

- **Research Committee** -- Convenes meetings of senior research staff to discuss evolving principles and methods of prevention research and to assess the program's research agenda in light of new developments.
- **Policy Committee** -- Serves as liaison to many of the program's national partners, such as the Association of Schools of Public Health, and helps coordinate efforts to keep policymakers informed about prevention research.
- **Communications and Dissemination Committee** -- Assists the program office in defining communication and dissemination standards and strategies. Creates working groups for the design and development of communication products.
- **CDC National Community Committee** -- Comprises representatives from each Prevention Research Center's Community Committee. Makes recommendations about how the community committees can share information and better serve the individual research centers as well as the national program.
- **Evaluation Committee** -- Brings together PRC staff and partners interested in evaluation to discuss topics such as: identifying technical assistance needs and ideas for addressing them; advising the PRC program office on evaluation and monitoring issues; and suggesting mechanisms for sharing across PRCs.

There is available funding for core community-based projects; there is also funding for special interest projects (SIPs). SIPs are health promotion and disease prevention research projects funded by the Centers for Disease Control and Prevention or other Health and Human Services agencies (such as the National Institutes of Health). A SIP focuses on a topic of interest or a gap in knowledge or research. It can also support the development of effective state and local public health programs and policies. SIPs are typically co-sponsored by one of the PRCs; in other words, SIP applications selected for funding must be from applicants who have received a *Notice of Grant Award* for the PRC grant. The latter is achieved through two levels of peer review: the *External Special Interest Peer Review Panel*, and a panel of senior federal scientists.

FUNDING COMMUNITY-BASED PARTICIPATORY RESEARCH (Continued)

Wendy Johnson-Taylor, PhD, MPH, RD

National Institutes of Health

Division of Nutrition Research Coordination

NIH is taking dramatic new approaches to making tough funding decisions. Though funding increases have steadily gotten smaller in the last 3 years, and in 2006 there was no increase in funding, there are changes in the NIH funding process that suggest that the current application approval rate of 22% will improve, and that the overall funding environment will change for the better. Among the new initiatives:

- Utilization of a business-model approach (*the new director conceived a 'roadmap' system, which will allow NIH to fund high-risk, potentially high-impact studies.*)
- A new process, the *multiple PI model*, is in the works which will enable funding to be provided to multiple PIs. The hope is that the process will be active for the February 2007 submissions, and will alleviate the need to transfer funds between institutions.
- Development of the Office of Portfolio Analysis & Strategic Initiatives (OPASI), which is expected to expand the way NIH funds projects, and which will allow for funding of initiatives that cross multiple institutes.

OPASI will be comprised of three offices:

1. Division of Resource Development & Analysis – where portfolio analysis will be conducted
 2. Division of Strategic Coordination – the group that coordinates the work of the multiplicity of groups
 3. Division of Evaluation & Systematic Assessments – the group which will develop the tools to perform portfolio analysis and database management
- An example of an OPASI project is the Patient Reported Outcomes Measurement Information System (PROMIS) which involves developing a database of quality of life measures
 - Contemplating research teams of the future, emphasis on transdisciplinary teams
 - Re-engineering the clinical enterprise, e.g., new methodologies
 - Finding ways to improve the ability of NIH to identify public health challenges by examining the public health burden and directing funds to the areas with the greatest needs

With regard to overall funding at NIH, of the \$29 Billion spent, roughly 4% was devoted to nutrition. The budget allocation has remained steady at 4% for about 10 years, but is expected to grow. Obesity has been designated as one of the priorities of the new director.

FUNDING COMMUNITY-BASED PARTICIPATORY RESEARCH (Continued)

Laura Leviton, PhD

Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation was established in 1972 with the personal fortune of its namesake, the founding CEO of the Johnson & Johnson Company. The RWJF Board of Trustees has a collective responsibility to ensure that the Gen. Johnson's fortune was invested for the health and healthcare of all Americans. From inception of the foundation, the bulk of RWJF funds were used to influence public policy. Its impact was so tremendous that models implemented and evaluated at RWJF then became of interest to the federal government. RWJF was influential in a string of important developments in health policy

To achieve the most impact with its funds, RWJF prioritizes its grants into four goal areas:

1. To assure that all Americans have access to quality health care at reasonable cost.
2. To improve the quality of care and support for people with chronic health conditions.
3. To promote healthy communities and lifestyles.
4. To reduce the personal, social and economic harm caused by substance abuse — tobacco, alcohol and illicit drugs.

To accomplish these goals, RWJF uses a variety of strategies; it supports training, education, research (excluding biomedical research), and projects that demonstrate the effective delivery of health care services. Rather than paying for individual care, RWJF concentrates on health care systems and the conditions that promote better health.

Grantees are as varied as the challenges they tackle. They include: hospitals; medical, nursing, and public schools; hospices; professional associations; research organizations; state and local government agencies; and community groups.

RWJF has a special interest in populations of color and low income populations. However, to date RWJF has not invested to any extent in CBPR. However, three examples of RWJF engagement in the CBPR process in the last seven years were offered:

- **Childhood Obesity Prevention** –The work of Susan Scrimshaw was offered as an example of one of the RWJF childhood obesity initiatives. The former Dean of University of Illinois School of Public Health was tasked by RWJF to adapt her rapid anthropological procedure work to evaluate inner-city children's eating and physical activity habits.
- **Border Health Work** – Promotoras were employed to contact and serve new Mexican immigrants in McAllen, TX
- **Allies Against Asthma** – A University of Michigan-led project, AAA involved coalitions working together to better manage children's asthma. In the evaluation of this program, AAA utilized the input of family members and community leaders at every step.

During 2005, the Foundation made 959 grants and contracts, totaling \$369.5 million in support of programs and projects to improve health and health care in the United States, 41% of which (\$150.12 million) was spent on programs that address specific improvements in eight targeted health and health care challenges within a defined time period:

- **Quality Health Care, 20%** (\$29.23 million)
- **Health Insurance Coverage, 17%** (\$25.71 million)
- **Childhood Obesity, 16%** (\$23.98 million)
- **Addiction Prevention & Treatment, 13%** (\$18.81 million)
- **Tobacco Use and Exposure, 11%** (\$16.48 million)
- **Public Health, 9%** (\$13.63 million)
- **Disparities, 7%** (\$11.11 million)
- **Nursing, 7%** (\$11.16 million)

THE TOLL OF HOUSING POLICIES ON AFRICAN-AMERICAN HEALTH

Lesley Green-Rennis

Columbia University

Dr. Green-Rennis works in the Community Research Group (CRG) at Columbia University, which is primarily engaged in qualitative research in the areas of Harlem, South Bronx, and Washington Heights in New York. For the better part of the last 20 years, the group has examined the issue of health promotion and factor communities, multiple causative factors, and structural and environmental factors.

Using Harlem as the primary case study, Dr. Rennis compared Harlem of the 1950s with that of Harlem of the late 1990s. The former Harlem community was interconnected in a multiplicity of ways. Neighborhoods contained extended families of several generations; neighbors cooperated; everyone relied upon a spiritual network of family, friends, neighbors, clergy, and other community residents to work and live in the community on a daily basis. This type of community has been described by Dr. Alexander Layton as an *integrated community*. His definition of integrated community is one that “has the ability to raise healthy children who are prepared to be productive members of society, to regulate the behaviors of its members, to provide for a range of personalities, and to care for the ill and infirm.”

By contrast, 1990s Harlem presented a very different portrait. Block after block of buildings had been abandoned or destroyed. There had been a policy called *planned shrinkage* where many fire departments had been closed in the area, which resulted in uncontrolled fires that burned out a considerable number of buildings and homes. By 1996, Harlem had lost 50% of its housing stock. As a result, Harlem contained hundreds of burned or abandoned structures which were taken over by drug lords. The once proud and thriving community was now comprised of people trapped in crime, poverty, violence, and urban decay. Layton would have described such a place as a *fractured or disintegrated community*, one which has few and weak associations; high levels of hostility and crime; weak communication; few patterns of recreation; riot-spread trauma and violence; and one which is heavily fragmented.

As any community transforms from an integrated one to a fractured one, behaviors and activities (drugs, crime, violence, family disintegration) begin to take place that expedite its transformation, and which play a very important part in the health and well-being of its many African-American residents. The CRG examined the factors which contributed to the transition of Harlem from an integrated community to a fractured community, and the impact these factors have had on obesity, asthma rates, stress, and familial relationships. Some of the profound changes were the roles of:

- Adult males – formerly protectors of the community, now were predators, or absent, or struggling to find a place to contribute
- Grandparents and the elderly – formerly revered for their guidance and counsel, now play the roles of surrogate parents for their absent children, or are seen as easy prey
- Schools and churches – once bastions of the community in a host of ways, these institutions have all but completely lost their ability to influence the community for the better

The CRG adapted Layton’s model into what it calls the *Stage State Model of Community Disintegration*. It likens the transformation process to a downward spiral from a model community to a loose collection of individuals with little connection to one another and little solidarity with the community at large. The stages present themselves as:

- **Confusion** – where individuals see changes occurring, but are unable to make sense of what the changes mean. *Harlemites were aware that available housing was deteriorating and decreasing steadily, but didn’t quite know what to do about it.*
- **Disorder** – Stability becomes increasingly difficult to maintain. People are gradually forced out of their apartments and their neighborhoods and moving from place to place, further destabilizing the community.
- **“Nonsense”** – the world seems to have been turned upside down. Children have no supervision or guidance.

For people in the fractured communities in general, and for the 1990s Harlemites in particular, “health” (as it is now understood in the context of eating right and exercising regularly) is not necessarily a priority. In fact, for many African-American fractured community residents, health is a luxury. So, in the context of CBPR, it is important to recognize the big picture. “We’ve got to remember that it’s not easy and people need the kind of support that’s relevant to them in order to make it sustainable. Science is important and research is important, but this is really about people’s lives, and the science should be a by-product of that. The science should inform and help us to really make the differences in people’s lives we are trying to make.”

VIOLENCE PREVENTION AS A COMMUNITY PRIORITY

Tio Hardiman

CeaseFire Chicago

The Chicago Project for Violence Prevention works with community, city, county, state, and federal partners to reduce violence in Chicago and in other communities in Illinois and throughout the nation. In its first 11 years of work, the Chicago Project has built the infrastructure for community-level participation, community-government partnership, and for the development of new roles for all partners, emphasizing community capacity building, community organization roles, clergy roles, and police roles. The project has also designed and tested a new intervention — CeaseFire — that focuses on outreach and the changing of community norms to reduce violence, particularly shootings.

Formed in 1995, the Chicago Project takes a strategic public health approach to violence prevention. This approach has been employed to address and reduce other serious health threats, such as child mortality, heart disease, HIV/AIDS, smallpox, and polio. It includes a full commitment to a specific objective (in this case stopping shootings), the setting of long-term and short-term goals, strategy development based on best practices and adapted to the local situation by local practitioners, and a management structure that works at both the community and city/county levels. The public health approach relies heavily on public education to change attitudes and behaviors toward violence, outreach using individuals recruited from the target population, community involvement to change norms, and evaluation methods to monitor strategy.

The Chicago Project has formed partnerships with community-based organizations to develop comprehensive strategic plans for reducing violence. An Advisory Board and Steering Committee, comprising criminal justice, health, religious, and civic leaders, provide support for strategy development and leverage city and county resources for the project and its partners. The project is supported by private foundation grants and with local, state, and federal funds. The project is housed at the School of Public Health at the University of Illinois at Chicago.

To accomplish its mission of preventing violence, the Chicago Project initially developed a plan and built an organizational structure to provide technical assistance and support for a comprehensive and community-based effort to reduce and prevent violence. CeaseFire is a mix of five core components: community mobilization, youth outreach, public education, faith-based leader involvement, and criminal justice participation. Eventually, through discussions with community partners, crime experts, and representatives from a cross-section of government agencies, the Chicago Project's steering committee developed an 8-Point Plan for reducing violence. CeaseFire, which emerged after five years of development and field testing of various pieces of a violence reduction strategy, brings to life key elements of the 8-Point Plan. Its focus is street violence, particularly shootings and killings.

CeaseFire was adapted from the best violence reduction work of several cities—notably Boston, which had extraordinary successes in the 1990s—and the best research of public health of the last several decades. After reviewing gang violence reduction projects initiated and evaluated by the US Department of Justice and lessons emerging from the Project on Human Development in Chicago Neighborhoods and mindful of the public health approach discussed earlier, the Chicago Project added the community and public education components to its violence reduction initiative.

After a year of needs assessment, planning, and building collaborative relationships at the local level, CeaseFire was formally launched in early 2000 with outreach workers in the West Garfield Park neighborhood of Chicago. Police Beat 1115 was chosen as the first CeaseFire zone in large part because of the high number of shootings. In the first year of CeaseFire, shootings in Beat 1115 dropped by 67%.

By the beginning of 2006 CeaseFire was either established or in the process of being implemented in 15 neighborhoods in the city and at sites in five other cities in Illinois.

THE IMPACT OF INCARCERATION ON AFRICAN-AMERICAN COMMUNITIES

Khalilah Brown-Dean, PhD

Yale University

“It is more than a game of Crime and Punishment; it is a social condition of inequality and degradation that denies us the opportunity to rise and pursue a dignified way of life as guaranteed by the U.S. Constitution. Once convicted, forever doomed has been the practice of this society. We are first to be accused and the last to be recognized. We are branded the lowest of all people; we are the convicted class.” -- excerpted from The Constitution for the United Prisoners’ Union, which argues that prisoners are subjected to a continuous cycle of poverty, racism, and inequality.

The U.S. is a country that fights to establish democracy abroad, but refuses to protect it within its own borders. Across the nation more and more states are devoting larger and larger portions of their state budgets to the criminal justice system. Since the 1970s, the incarcerated population within the U.S. has increased six fold. Altogether, there are over 7 million people under some form of criminal supervision; that means that one in every 132 Americans is either currently incarcerated, or on probation or parole. Black Americans, who comprise approximately 14% of the population, constitute 60% of Americans behind bars. The number of incarcerated Blacks has increased by about 800% in just 50 years.

The Civil Rights Movement was pivotal in reducing the gap between the principle and practice of equality. However, following the Civil Rights Movement, the U.S. experienced a cultural backlash. In the main, Whites considered Blacks ungrateful after the Voting Rights Act, Civil Rights Act, and Brown v. Board. This racial divide gave rise to a sea change in the criminal justice system.

Following the urban riots in Detroit, Los Angeles, and Chicago and other major American cities, Richard Nixon instituted a law and order campaign, with which he intended to send a very clear message that every citizen had to respect and obey the laws of the land. This campaign catapulted Nixon into office and set in motion a number of policies aimed at giving the system a stronger presence within the African American community. In the same vein, Ronald Reagan later launched the *War on Drugs*, which precipitated many of the disparities we see today. During the Reagan era, many states abolished parole, adopted mandatory minimum sentence structures, and created discrepancies for drug offenses.

While the overwhelming majority of African Americans in prison are male, African American women represent the fastest growing prison population. More and more women are going to prison; unfortunately, the system is ill-equipped to handle the increase. Fewer women’s correctional facilities exist, so female inmates are sometimes transferred to other states. As the numbers of women incarcerated has increased, so have the numbers of African American children entering the foster care system.

These trends have had a devastating effect on the Black community. Young people with incarcerated parents are more likely to suffer from depression, anxiety, poor anger management, and are likely to remain in the foster care system until they reach the age of majority.

Other effects of incarceration are the barriers to re-entry into society. President Bill Clinton signed into law the *Welfare Reform Act*, which included a provision that banned for life people convicted of drug offenses from living in public housing or receiving any form of public assistance. Also, in most states, felons are barred from professions which require bonding or licensure (including jobs like barber and plumber), and they are prohibited from receiving federal student loans (for themselves or for their children). So clearly, the challenges to becoming a good citizen after incarceration abound.

Why should the average, law-abiding citizen care that so many African Americans are incarcerated?

The expansion of the criminal justice system is eroding many of the gains of the civil rights movement.

- In 32 states, probationers and parolees are barred from voting.
- In 13 states, convicted felons are barred for life from voting in any election.
- Blacks represent about 40% of the 5 million Americans who are permanently barred from voting because of felony convictions. Taken together, Blacks and Latinos represent about 60%.

The 2000 Presidential election provides a very practical example of the importance of the issue of felony disenfranchisement. Black voters overwhelmingly support the Democratic party. In the pivotal state of Florida alone, there were at least 300,000 ex-felons (30% of black males of voting age) who were barred from voting in that election. If one focuses solely on the Black ex-felons, it follows that if they were allowed to vote, Sen. Al Gore would have scored a decisive and uncontestable victory.

Why does it matter? Would these people vote anyway? Why should anyone care?

Despite being unable to cast ballots, inmates still profoundly affect the political process. Inmates are counted as residents of the town in which they are incarcerated, not the town in which they previously resided. As a result, prison towns are able to inflate their census counts and acquire a greater share of resources. Because each prisoner is worth about \$25,000 in annual income to a town, there is a direct economic incentive for towns to build prisons to accommodate larger and larger numbers of inmates.

Because urban areas are more heavily populated, crime is usually concentrated in urban areas. For example, the majority of Connecticut's inmates come from highly urbanized areas like Hartford, Bridgeport and New Haven. New Haven is about 40% African American and 20% Latino. Very few dollars flow into New Haven to address the issues like poverty which give rise to crime and violence. Instead, the money for services, education, and improving the infrastructure goes to those rural areas that don't have large numbers of citizens in need of those services because a significant portion of their population resides behind bars.

These factors wreak a disproportionate amount of havoc on poor, undereducated, urban populations. The growth of mass incarceration in the U.S. poses direct and indirect challenges to the fate of African American communities. We now have more men and women going into the criminal justice system. We now have more children who are left to fend for themselves in the foster care system. We need to promote a change in the way that we think about the purpose of incarceration, to provide incentives to discourage recidivism, and to provide structures to aid people in their transition back into society.

PUBLISHING CBPR WORKS: A JOURNAL EDITOR'S VIEW

Lesli Mitchell

*Managing Editor, Preventing Chronic Disease Journal
Centers for Disease Control*

Preventing Chronic Disease (PCD) is a peer-reviewed electronic journal established to provide a forum for public health researchers and practitioners to share study results and practical experience. The journal is published by the National Center for Chronic Disease Prevention and Health Promotion of the Centers for Disease Control.

The mission of the journal is to address the interface between applied prevention research and public health practice in chronic disease prevention. *PCD* focuses on preventing diseases such as cancer, heart disease, diabetes, and stroke, which are among the leading causes of death and disability in the United States.

PCD's primary audience of 15,000 subscribers comprises:

- Researchers of chronic disease prevention
- Researchers of health promotion
- Public health practitioners
- Advocacy groups
- Schools of public health
- Community-based organizations

PCD's primary goals:

- To promote dialogue between researchers and practitioners on research findings and practical experience.
- To encourage interdisciplinary approaches that examine more than one dimension of a public health intervention.

- To advance the fields of chronic disease prevention and health promotion by exploring new theories and concepts. PCD has both peer reviewed and non-peer reviewed sections; the latter help to provide a venue for field work performed by individuals who are not trained in traditional academic publication methods. In the CBPR context, *PCD* features:
- **Community Case Studies** -- articles that describe disease prevention activities such as community programs, community-based interventions and evaluations, and field observations. They emphasize the context (community) in which the activity occurs and should offer special insight and commentary. Community case studies are subject to peer review.
- **Step By Step: Making Your Communities Healthier** -- these articles are intended to provide lay community leaders with practical information on promoting health in their communities. These articles are not subject to peer review.

In its inaugural issue, *PCD* featured articles relevant to CBPR:

Yancey AK, Kumanyika SK, Ponce NA, McCarthy WJ, Fielding JE, Leslie JP, Akbar J. Population-based interventions engaging communities of color in healthy eating and active living: a review. *Prev Chronic Dis* [serial online] 2004 Jan [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2004/jan/03_0012.htm

Katz DL. Representing your community in community-based participatory research: differences made and measured. *Prev Chronic Dis* [serial online] 2004 Jan [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2004/jan/03_0024.htm

Syme SL. Social determinants of health: the community as an empowered partner. *Prev Chronic Dis* [serial online] 2004

PUBLISHING CBPR WORKS: A JOURNAL EDITOR'S VIEW (Continued)

Kim Dobson Sydnor, PhD

*Associate Editor, Progress in Community Health Partnerships: Research, Education, and Action
Morgan State University*

An international peer-reviewed journal dedicated to community-based participatory research (CBPR) for health, *Progress in Community Health Partnerships: Research, Education, and Action* features peer-reviewed articles of original CBPR findings, scholarly reviews on the broad range of topics relevant to CBPR, and works that address current issues such as the definition of community and the distinction between community-placed and community-based research. The Journal addresses topics that focus on the growing field of CBPR while promoting further collaboration and elevating the visibility and stature of CBPR as a means toward eliminating health disparities and improving health outcomes. *Progress in Community Health Partnerships: Research, Education, and Action* encourages discussion about how CBPR should be applied methodologically; about the relationships between research processes and outcomes; about how research can be translated into information communities can use; and about other emerging issues as they arise.

The mission of the PCHP Journal is to facilitate dissemination of programs that use community partnerships to improve public health, to promote progress in the methods of research and education involving community health partnerships, and to stimulate action that will improve the health of people in communities. The Journal is dedicated to supporting the work of community health partnerships that involve ongoing collaboration between community representatives and academic or governmental partners.

The Journal's primary audience is public health, nursing, and medical professionals engaged in community-based work. A secondary readership is drawn from the broader community, including community-based organizations and other community members and practitioners.

SAMPLE PROGRAMS THAT ADDRESS LIFE CONTEXTS OF AFRICAN AMERICANS

Wendell C. Taylor, PhD, MPH

*The University of Texas Health Science Center at Houston
School of Public Health*

One of the first published studies related to the environmental justice movement was by Dr. Robert Bullard from Texas Southern University in Houston, Texas. He reported that 6 of 8 incinerators and 15 of 17 landfills in Houston were located in African American communities. More than three quarters of the city's garbage was deposited in a section comprising one quarter of the population. Another study, conducted in EPA Region IV and covering eight Southeastern states, revealed that 3 of the 4 large commercial hazardous waste landfills were located in African American communities. A third study, covering the entire United States, concluded that 3 of every 5 Black and Hispanic Americans lived in communities with uncontrollable toxic waste sites. These studies precipitated a grassroots movement which pressured the federal government to address this disparity. The government, in turn, established an agency to address the issue, and established several principles based on environmental justice:

- **Fair treatment** – no particular population should bear a disproportionate burden related to the environment
- **Procedural justice** – when there are decisions to be made about the placement of toxic landfills, everyone potentially affected should be a part of the decision-making process.

Do environmental justice principles have any relevance to physical activity patterns?

The evidence suggests that these principles can be instrumental in developing effective physical activity interventions and understanding current physical activity patterns. People with lower incomes and people of some racial / ethnic groups have lower rates of physical activity. The environment plays a part in understanding these lower rates as well as developing interventions to increase physical activity levels.

A study published in The Journal of Urban Health advocated a “second wave” of environmental justice, which would focus upon “walkability” and neighborhood quality. (The “first wave” addresses placement of landfills, lead poisoning, pollution, etc.) Another study concluded that environmental facilitators and barriers should be considered when one thinks about promoting physical activity and reducing weight. **Deprivation amplification** occurs when people with limited resources also live in communities where they are unable to buffer themselves from further deprivation and are faced with greater barriers to lead healthy lives.

When urban planners evaluate the environment for its affect on physical activity, they look for three D's:

1. **Density** – *The more people located within a certain geographic area, the more likely people will be physically active.*
2. **Diversity** – *Is the environment characterized as ‘mixed-use’? Are there destinations (banks, post offices, cafes) within walking distance?*
3. **Design** – *Have activity areas (jogging trails, bike paths, etc.) been created in the environment?*

By conducting an ‘environmental audit,’ all of these features can be evaluated. And if, in fact, conducting an environmental audit is important for the community, community members can be trained to conduct them. The environment and the neighborhoods in which we live have a profound impact upon our behavior.

SAMPLE PROGRAMS THAT ADDRESS LIFE CONTEXTS OF AFRICAN AMERICANS (Continued)

Angela Odoms, PhD

Northern Illinois University

Shannon Zenk, PhD

University of Illinois at Chicago

Although the causes of obesity are clearly multi-factorial, a growing body of evidence has focused on the link between the built environment and weight-related behaviors, including dietary intake. Whereas studies historically focused on understanding the relationship between dietary intake and overweight at the individual level, there is increasing recognition of the role of the food environment in shaping individual and family level dietary behaviors. Accordingly, the retail food environment faced by African-Americans in Detroit, Michigan became the focus of two community-based partici-

patory research (CBPR) projects: the East Side Village Health Worker Partnership (ESVHWP) and the Healthy Environments Partnership (HEP). Both the ESVHWP and HEP are affiliated with the Detroit Community-Academic Urban Research Center (URC). Detroit is a predominantly African American city which experiences high morbidity and mortality due to chronic diseases for which obesity is a significant risk factor.

Concern about the retail food environment emerged initially in the context of the ESVHWP. Initiated in 1996, the goal of the ESVHWP was to identify and address social determinants of women's health on the eastside Detroit using a lay health advisor approach. In conversations among those involved in the ESVHWP, residents described the scarcity of fresh fruits and vegetables at Detroit stores and difficulties accessing the transportation needed to reach suburban supermarkets in order to obtain fresh produce. They also described how the dearth of supermarkets and high-quality healthy foods made it difficult for residents to maintain a healthful diet. In response, the ESVHWP initiated monthly fruit and vegetable "mini-markets" to increase the availability of high-quality fresh produce at low prices in eastside Detroit and healthy soul food cooking demonstrations to provide skills in healthy food preparation. In addition, members began new data collection efforts to understand the retail food environment and its implications for the health of Detroit residents.

One new research effort examined spatial access to supermarkets. We found:

- The city of Detroit had only 9 supermarkets for 950,000 residents in late 2002, whereas supermarkets were abundant in the surrounding metropolitan area
- Inequities in the distance to the nearest supermarket by neighborhood racial composition and poverty level, with the longest distances to supermarkets found for the most economically disadvantaged neighborhoods where African-Americans lived

In another research effort, we conducted in-person audits of food stores in four Detroit area communities to explore whether high-quality fresh fruits and vegetables were less available in economically disadvantaged African-American communities than in more advantaged communities. We found:

- Stores in the economically disadvantaged African-American community, on average, had poorer quality fresh produce for sale than stores in the middle-income racially heterogeneous community
- This quality differential was only partially explained by differences in the types of stores present
- No difference in fresh produce selection or price by community

The Eastside Village Health Partnership initiated questions in a second wave survey with African-American women in eastside Detroit to better understand the issue of food access. Of interest was whether the stores to which women had access, as well as their perceptions of fresh fruit and vegetable selection, quality, and price at those stores were associated with their intake of fruits and vegetables. We found:

- Women who shopped at supermarkets and specialty stores consumed fruits and vegetables more often than those who shopped at independent grocery stores
- Women who perceived the selection and quality of produce more positively at the store where they shopped also consumed fruits and vegetables more often
- Women with higher income were more likely to shop at supermarkets than neighborhood stores

The Healthy Environments Partnership (HEP) has expanded efforts to understand the role of the retail food environment in dietary behaviors and health outcomes among Detroit residents. HEP began in 2000 as part of the National Institute of Environmental Health Science's "Health Disparities Initiative" to examine relationships between neighborhood social and physical environments and cardiovascular disease risk among adults in three Detroit communities (eastside, southwest, and northwest) using a CBPR approach. HEP has begun a series of analyses examining relationships between "objective" measures of the retail food environment (e.g., proximity to different types of retail food outlets; neighborhood food availability, quality, and price), perceptions of the neighborhood food environment, food shopping behaviors, dietary behaviors, and related health outcomes (e.g., obesity, cholesterol) among Detroit residents.

Finding from this work suggests that more theoretical models need to be developed to guide research in this area. Thoughts for future research include:

- To incorporate both individual and environmental factors and explore their relationships with weight outcomes
- To explore how the food environment actually impacts health beyond food availability

- To understand the interactions between families and the food environment
- To look at individual/family variations in resources and constraints that impact access
- To examine the relationship between food availability, food access, and some of the traditional factors (culture, social networks, etc.) that are related to food choice
- To develop valid measures
- To identify better ways to address community perceptions because they may differ from what is indicated by the objective assessments
- To examine how people access food in plentiful environments
- To create interventions that target racism as it relates to food access
- To ensure that solutions are relevant to the community. All initiatives have unintended consequences, and without the communities involvement, it is difficult to avoid those consequences.

The combination of constraints and the interaction between availability and individual resources profoundly affect food access.

The Healthy Environments Partnership (HEP) (www.hepdetroit.com) is a project of the Detroit Community-Academic Urban Research Center (www.sph.umich.edu/urc). HEP's partner organizations include Boulevard Harambee, Brightmoor Community Center, Detroit Department of Health, Detroit Hispanic Development Corporation, Friends of Parkside, Henry Ford Health System, Southwest Detroit Environmental Vision, and the University of Michigan Schools of Public Health, Nursing, Social Work and the Survey Research Center. Support for this project has been provided by the National Institute of Environmental Health Sciences, #R01 ES10936, and #R01ES014234-02.

The East Side Village Health Worker Partnership (ESVHWP) included Butzel Family Center, Detroit Department of Health and Wellness Promotion, Friends of Parkside, Henry Ford Health System, Kettering/Butzel Health Initiative, University of Michigan School of Public Health, and Warren Conner Development Coalition. The research was funded by the Centers for Disease Control and Prevention through the Detroit Community-Academic Urban Research Center, #U48/CCU515775.

SAMPLE PROGRAMS THAT ADDRESS LIFE CONTEXTS OF AFRICAN AMERICANS (Continued)

Toni Yancey, MD, MPH

UCLA School of Public Health

Pervasive targeted commercial marketing greatly impacts why people prefer what they prefer, and also significantly impacts physical activity. Dr. Yancey's project endeavored to study the effects of commercial advertising on physical activity that began as an afterthought funded by the California State Department of Health Services with end-of-budget-cycle dollars, has now grown into one that encompasses six cities, and compares high and low income status, predominantly Black, Latino, and white neighborhoods. Included among the findings:

- In the Philadelphia metropolitan area, essentially no outdoor advertising exists promoting goods and services related to physical activity. There do exist, however, large amounts of sedentary entertainment and transportation advertisements in low income communities, particular African American communities.

In 2004, Yancey's group published a Los Angeles County health survey of 8,000 adults (40% White, 40% Latinos, 10% African Americans, 10% Asians). Among its findings:

- More than 40% were classified as sedentary (getting less than 10 minutes of physical activity per week.)
- Self perceived overweight was linked to sedentary behavior, not BMI

There hasn't been much change in the leisure time physical activity levels during the past several decades of the acceleration of the obesity epidemic, but there have been marked increases in sedentary entertainment and transportation. So, physical activity levels within an increasingly sedentary, deconditioned, overweight population are unlikely to increase primarily through individual motivation and volition.

In the context of formulating strategies to control obesity, why might it be strategically important to emphasize physical activity?

There is less controversy and stigma associated with physical activity than exists with regard to food and nutrition. Corporate interests stand to benefit from the success of efforts to emphasize physical activity, as opposed to food industry fears of losing money by producing more whole grain foods and fruits/vegetables, and less fatty and sugary foods.

Also, to avoid exacerbating health disparities, “push” strategies (approaches that make physical activity essentially unavoidable, like workday group dance breaks, childhood physical education classes, walking meetings, and near-parking restrictions) need to have priority over “pull” strategies (incentives like free gym memberships to encourage people to consider physical activities). We must make it easier to be active than inactive.

Cultural barriers and facilitators also exist. The cultural orientation in the AA community has historically centered on the collective mindset, as opposed to the ‘rugged individualism’ of the mainstream culture. Social support and conformity desires can drive participation. In addition, movement to music throughout the life span is central to AA social activity, making African Americans more likely than whites to view the incorporation of workday group exercise as refreshing and enjoyable rather than coercive and taxing! Minimal intensity intervention can be an effective way to approach this issue.



The mission of AACORN is to improve the quality, quantity, and effective translation of research to address weight related issues in African American communities. For additional information on other AACORN resources please visit us on the web at www.aacorn.org or contact:

Shiriki Kumanyika, PhD, MPH, Founder
Vikki C. Lassiter, M.S., Director (vlassite@mail.med.upenn.edu)
African American Collaborative Obesity Research Network
Center for Clinical Epidemiology & Biostatistics
University of Pennsylvania School of Medicine
8th Floor Blockley Hall
Philadelphia, PA 19104
Phone: (215) 746-0360
Fax: (215) 573-5311

