



# Community Engagement Evaluation

**Strategies for Building Community-Based Partnerships**

A publication of the Center for Health Equity, Maxine Goodman Levin College of Urban Affairs, Cleveland State University



Advancing Central's Health Together

## Community-Based Participatory Research Process and Intervention Evaluation

May 2009

Mittie Davis Jones, PhD, evaluator

### PARTNERS



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# contents

## Table of Contents

Executive Summary .....	ii
Introduction .....	2
<b>Aim 1:</b> Develop a partnership between the Central neighborhood’s Building Healthy Communities initiative and CSU wherein both citizens and scientists understand CBPR .....	3
<b>Aim 2:</b> Identify an intervention research project to test CBPR methodology and partnership success .....	6
<b>Aim 3:</b> Implement one or two pilot health intervention projects within the Central neighborhood using CBPR principles .....	7
Analysis.....	10
Conclusion.....	13
Project Partners .....	15
<b>Appendix A</b> – Logic Model of CBPR Process.....	16
<b>Appendix B</b> – Logic Model of CBPR Intervention.....	17
<b>Appendix C</b> – ACTTimeline .....	18

# Executive Summary

Mittie Davis Jones, PhD, evaluator

## Introduction

*In 2005, Cleveland State University was awarded funds for a grant entitled Engaging the African-American Community in Reducing Obesity and Its Consequences: Testing CBPR Methodologies in Cleveland, Ohio. The Advancing Central's Health Together (ACT) project was a four-year venture funded by the National Institutes of Health/National Center on Minority Health and Health Disparities (NIH/NCMHD) through a planning grant and conducted in an urban neighborhood in Cleveland, Ohio in the Central Statistical Planning Area. The project was composed of two aspects: 1) involving community members in the process of Community-Based Participatory Research (CBPR) to develop an activity to address obesity and 2) implementing the pilot intervention activity of nutrition and fitness.*

## Major Aims

This initiative was designed to test the hypothesis that implementing CBPR methodologies, over the long term (10 years or more) would yield greater success in health interventions compared to other existing community health interventions that were initiated using traditional methodologies. The project team projected to achieve three specific aims during the four-year planning period:

- Develop a partnership between the Central neighborhood's Building Healthy Communities Initiative and Cleveland State University wherein both citizens and scientists understand CBPR.
- Identify an intervention research project through which to test the CBPR methodology and partnership processes.
- Implement one or two pilot intervention projects within the Central neighborhood using CBPR principles.

The first aim was achieved through the establishment of a collaborative effort among the following partners: Cleveland State University (Center for Health Equity, College of Science, Urban Child Research Center, Department of Health, Physical Education, Recreation and Dance), St. Vincent Charity Hospital, Center for Reducing Health Disparities/MetroHealth Hospital/Case Western Reserve University, Building Healthy Communities Initiative, community organizations (Central Recreation Center, King-Kennedy Boys and Girls Club, Friendly Inn Settlement House, Arbor Park Village), Center for Community Solutions and the Central Community Healthy Group. Based on CBPR principles, collaborative communication and

decision-making processes were established among the participants.

ACT identified an intervention research project using CBPR methods and partnership processes. The planning team conducted a community-wide process of gathering data and suggestions, which settled upon the target population for the intervention as well as the methods of intervention. During the discussion phase, project staff provided information on best practices from similar projects around the country to the residents and other community members. Community consensus was reached to direct the intervention toward children, with a focus on exercise and nutrition.

ACT implemented a four-part intervention project in the Central community over a one-year period in the attainment of the third aim. Four sites in Central hosted a cohort of youth participants for a 12-week program of assessment, nutrition and physical activity conducted by CSU's Department of Health, Physical Education, Recreation and Dance (HPERD). ACT contacted HPERD about providing the four major elements of the intervention: nutrition, physical activity, rhythmic movement, and assessment. Drawing upon the expertise of the HPERD faculty, the project staff and community members decided to target youth between 8 and 12 years of age for the project. A total of 73 youth participated from across the four locations.

## Effects of the intervention on health and nutrition

Pre-test and post-test data were gathered on youth participating in the intervention for 28 physiological and behavioral variables. Non-significant results between pre-tests and

post-tests were reported on the following variables: diastolic blood pressure, cholesterol, HDL, LDL, glucose, BMI, left flexibility, fat, vegetable nutrition, meat nutrition and fat nutrition. However, though not scientifically significant, several of the variables did demonstrate a trend of improvement. Besides weight, significant change was observed in seven physiological and behavioral characteristics including systolic arterial pressure, triglyceride level and measures of strength and endurance. Self-reports of dessert and overall nutrition indicated improvements in nutrition behavior. The differences noted indicate changes that positively impact physiological and behavioral health.

## Analysis

### Attainment of Major Aims

As initially conceived, the project was to test the hypothesis that implementing CBPR methodologies over a period of 10 years or more would lead to greater success in health interventions than those using traditional methodologies. The four-year ACT project laid the groundwork for a longer-term CBPR project; however, its potential impact has not been realized.

Developing the partnership with the community was an ongoing process. While the community residents were not equally involved at the earliest stages in the process, the team took deliberate steps to fully engage community members in all phases of the project. This focus on engagement is due to the natural evolution of the project – especially the obvious need for resident representation to truly validate CBPR principles. Moreover, there was an initial period during which the participants from the various partnering entities became familiar with each other and expectations began to meld.

The success of the intervention hinged largely upon building partnerships with organizations and agencies where the programming could be conducted. The staff was successful in building an organizational infrastructure that brought prospective partners to the table at an early stage to engage in the planning process and pilot implementation. Evidence of improved nutritional and fitness outcomes demonstrates the potential for this type of intervention, particularly if the time frame could be extended.



*Major strides were achieved toward full resident empowerment.*

### Relationship between the CBPR implementation and the Building Healthy Communities initiative

The Building Healthy Communities (BHC) initiative was a precursor to the CBPR project. BHC is a grassroots effort established through community envisioning and goal-setting events through the work of St. Vincent Charity Hospital. It was instrumental in providing community members for the first Appreciative Inquiry (AI) groups that eventually led to the intervention project. Partnership with the BHC initiative provided a base upon which to build and incorporate CBPR into the community. Throughout the project, the BHC met once a quarter and the ACT project team (initially the academic members, then transitioned to community members) reported regularly to BHC on the activities and outcomes of the project. In addition, ACT provided financial support for BHC projects and recruited participants from amongst their members. The relationship between the two entities was sustained throughout all phases of the planning and intervention.

## Executive Summary

### Issues that arose as the result of the process

It is evident that significant time and attention were needed to develop the foundation for the CBPR process in this neighborhood. This step was a necessary precursor to identifying and implementing an intervention project, which delayed its start-up. The delay in acquiring and reporting outcomes for the intervention probably had a negative affect on initial efforts to seek implementation funding.

### New strategies or approaches identified

Three strategies were identified during the project that contributed to the sustainability of the CBPR approach: leadership training, social marketing, and PhotoVoice project. Twelve residents requested and received leadership training, which was provided over an eight-week period. At the conclusion of the training, most of those trained felt better prepared to serve as community leaders.

Social marketing surfaced as a strategy to inform more community members about healthy living and nutrition. Residents created slogans to use in various ways. An initial activity was distributing recipes to community members outside Dave's Supermarket, at Marian-Sterling Elementary School and other locations in the neighborhood.

A subsequent activity was the PhotoVoice project. PhotoVoice is a process through which people can identify, represent and enhance their community through a specific photographic technique. In this case, CCHG members are documenting the strengths and weaknesses of the Central neighborhood with respect to the message "Eat Healthy, Feel Good, Live Longer." A photo display will be presented at the third Town Hall Meeting in June 2009. The goal of the PhotoVoice project is for participants to remain advocates for their community after the project ends.

### Difference in community participation compared to existing, traditionally implemented interventions

One key difference between the community participation associated with CBPR and that of existing, traditionally implemented interventions is that CBPR included involvement across sectors of the community. All sectors were provided with an equal voice in decision making. Residents, in particular, seemed to appreciate this egalitarian approach.

### Goals of CBPR

Researchers identified two critical ingredients of a CBPR project in the original proposal: trust and a representative governing structure. The project team was able to achieve both of these results. ACT evidenced the formation of a governing body that participants named the Central Community Healthy Group (CCHG). Trust was built through engagement and decision making. In a follow-up survey of participants conducted at the end of the project, 100 percent of respondents expressed that a major outcome of the project was the development of trust between researchers and community residents.

The process was inclusionary, drawing upon input from professionals, senior citizens, youth, and others. The process was integrative in recognizing diverse issues and concerns among community members. The process naturally promoted cooperation among residents from different areas within Central.

Constant feedback on the CBPR process was provided through formative evaluation with results obtained from focus groups and the town hall meetings. While some residents participated consistently, there was noticeable fluidity in participation, which meant that new people (unfamiliar with the process) were common at any given meeting. Nonetheless, the program achieved the goal of reaching out to and educating the community.

Residents were meaningfully involved in the CBPR process as intended. They were involved in planning meetings as well as research meetings. The leadership training provided by the project team allows for the sustainability of the progress achieved. The project enhanced existing community dedication and leadership.

## Conclusion

### Accomplishments

Fundamentally, the ACT project utilized methods to engage residents in meaningful ways. Major strides were achieved toward full resident empowerment. First, residents assumed key leadership positions in the governing structure. Second, participants provided continual feedback. Their feedback (discussion and collective decision-making) was used to inform the team of how information was being received, which enabled changes to be made as needed. Third, once the inter-

vention began, a community health worker was hired to provide additional outreach into the community and to connect with parents of the participating youth.

The CBPR process itself was successful in maintaining the continuing engagement of some community members. These individuals have become more knowledgeable and have the potential to persevere as assets to the community into the future. The project was also successful in promoting collaboration between the participants, including different units at Cleveland State University, St. Vincent Charity Hospital, MetroHealth and community organizations based in Central.

Representatives of the four community center sites that hosted the intervention project responded positively to the program activities. Based on interview data, all respondents found the process of planning and implementation satisfactory. At each site, future projects would be welcomed.

Toward the goal of sustainability, the HPERD staff developed a manual that can be utilized for future programming at the sites. As a step toward replicating the project effort, ACT funds were used to purchase equipment and games for each site. In addition, at each site, two community assistants were hired to work with the HPERD staff with the expectation that they would maintain some activities after the 10-week program ended.

## Barriers and problems

With respect to the CBPR process, maintaining regular communication with the community, particularly stakeholders, was a problem for the project. The regular meetings and town hall meetings were not as reliable as a newsletter or other written communication might have been for keeping the interested public informed.

Four major issues were associated with the intervention. *First*, the level of participation was less than desired for some of the sites – particularly the first and the fourth. *Second*, the level of parent participation in family nights was less than desired. Nonetheless, parents who responded to surveys found the sessions attended and the information received beneficial. *Third*, some sites chosen for the intervention activities were not optimal for the programming. The first location, Central Recreation Center, where the program was conducted in the summer, was not air-conditioned and was not equipped with an elevator to get to the gymnasium on the second floor for families participating in the family nights. Additionally, the

program interfered with current summer programs and this effected recruitment and participation. The last location, Arbor Park Village, did not have suitable accommodations for fitness or exercise programming. Although the staff attempted to make adjustments to fit the circumstances, there were limitations.

*Fourth*, the long-term sustainability of project efforts is uncertain. The greatest obvious impact of the program has been on adults who have stuck with the program to the end. The project provided materials (a manual and equipment) for continued programming at each site but staff resources are not available to support follow-up on their use.

## Lessons learned

Lessons learned from the implementation of the CBPR process and the intervention will instruct future similar efforts in Central or similar neighborhoods.

## CBPR Process

- Institutional processes among participating partners should be aligned with regard to consistency, participation and expectations. Turnover and change in staff affected this project.
- A balance should be struck between the time spent organizing the community around CBPR and initiating an intervention. Lack of demonstrable outcomes can dampen community enthusiasm and funding prospects.
- Written updates or other existing mechanisms could be used to enhance communication and maintain interest.

## Intervention

- A different approach may be needed to train site staff from the neighborhood and prepare for program sustainability.
- The existence or lack of previous programming may make a difference in program outcomes.
- Reaching overweight/obese youth may be a challenge that requires more outreach or incorporating a focus on obesity prevention.
- Involving families, particularly heads of household, may require more attention to promote change in nutritional behaviors.

## Introduction

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*The project was composed of two aspects: 1) involving community members in the process of **Community-Based Participatory Research (CBPR)** to develop an activity to address obesity and 2) implementing the pilot intervention activity of nutrition and fitness. While the planning project included a pilot intervention, as required by NIH, the ultimate goal was to seek an implementation grant to expand and enhance the efforts begun under the implementation phase.*

Central residents were the primary community members engaged in the project; however, agency officials and other stakeholders were also involved. Using CBPR methodology, the project team sought to engage the community in the processes that shaped research and intervention strategies, as well as in the conduct of research itself. Community residents and other stakeholders were involved from the start of the initiative and remained engaged throughout. ACT was a new program, but it used the foundation developed by the Building Healthy Communities (BHC) initiative to launch the resident-driven elements.

The project design allowed the community to contribute to the research design, participate in all aspects of the project and help disseminate the findings. Each phase of the project encompassed several months. The processes of developing partnerships, identifying a community focus, developing a health intervention, implementing the intervention and sustaining those efforts are summarized in Appendix C. At this point, the planning phase of the project is winding down and long-term implementation funding or funds to sustain the achievements are being sought.

This initiative was designed to test the hypothesis that implementing Community-Based Participatory Research (CBPR) methodologies, over the long term (10 years or more) would yield greater success in health interventions compared to existing community health interventions that use traditional

methodologies. Three specific aims were projected to be achieved during the four-year planning period:

- Develop a partnership between the Central neighborhood's Building Healthy Communities initiative and Cleveland State University wherein both citizens and scientists understand CBPR.
- Identify an intervention research project through which to test the CBPR methodology and partnership processes.
- Implement one or two pilot intervention projects within the Central neighborhood using CBPR principles.

Evaluation has been a component of this project from the start. The evaluation team utilized process and summative evaluation methodologies as it participated in the development of the project through data gathering and reporting findings continually to the program personnel. The logic models developed to guide and monitor the project are included in Appendices A and B. This final evaluation report addresses the three critical aims of this obesity initiative. We describe the tools and techniques employed to gather data and the results of those processes. The evaluation also addresses questions posed in the original application for NIH funds:

# Participatory Research Process and Intervention **Evaluation**

- Was there a difference in CBPR implementation because of the existence of the Building Healthy Communities initiative?
- What issues arose as a result of this process?
- Were strategies or approaches identified that might not have been otherwise?
- Was there a difference in community participation in the selected intervention(s) compared to existing, traditionally implemented interventions?
- What challenges surfaced in the implementation of CBPR?
- Did the view of researchers by the community improve?
- Was there any improvement in the health of the residents based on the intervention?

## **Aim 1:**

### **Develop a partnership between the Central neighborhood's Building Healthy Communities initiative and CSU wherein both citizens and scientists understand CBPR**

One of the primary tenets of Community-Based Participatory Research is collaboration among the partners. The major partners on this project were:

- **Cleveland State University (CSU)**
  - *Center for Health Equity, Maxine Goodman Levin College of Urban Affairs*
  - *College of Science*
  - *Urban Child Research Center, Maxine Goodman Levin College of Urban Affairs*
  - *Department of Health, Physical Education, Recreation and Dance*
- St. Vincent Charity Hospital (SVCH)
- Center for Reducing Health Disparities/MetroHealth Hospital/Case Western Reserve University (CRHD)
- Building Healthy Communities Initiative

- Community organizations
  - *Central Recreation Center, City of Cleveland*
  - *King-Kennedy Boys and Girls Club*
  - *Friendly Inn Settlement, Inc.*
  - *Arbor Park Village*
- Center for Community Solutions (CCS)
- Central Community Healthy Group (CCHG)

The Central Community Healthy Group is the name adopted by residents for the advisory group they constituted.

### **Broad Representation**

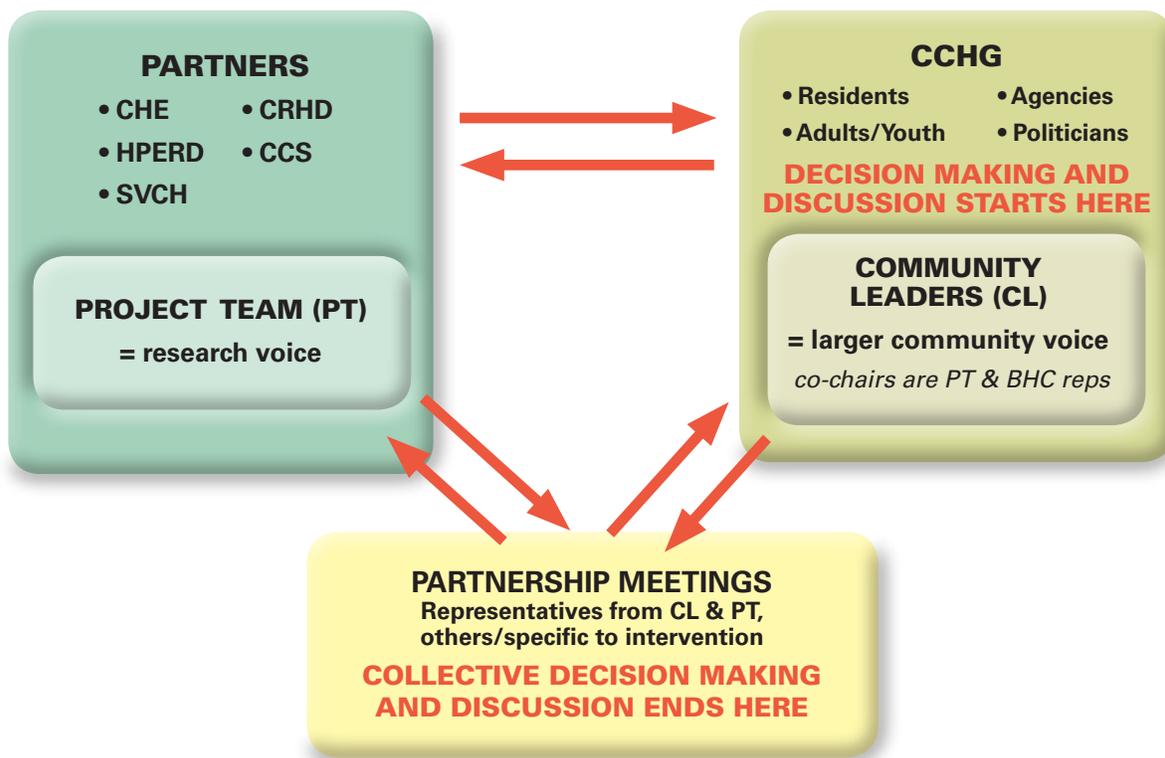
The project team was made up of persons from CSU, SVCH, CRHD, and CCS. They oversaw the project from the beginning to the end. Community members played an equal role in all decision-making.

### **Steps toward Partnership Development**

Prior to launching the project, team members conducted interviews with community organization leaders throughout the Central community. The data collected provided a backdrop for the start-up of the project. Among the issues about which respondents gave their views were:

- The principal obesity-related health problems in the Central community
- The segment of the population that should be targeted
- Programs, institutions, organizations or agencies that have been successful in addressing obesity-related health problems
- Whether emphasis should be placed on diet, exercise or treatment of obesity-related conditions
- The strengths and weaknesses of the Central community related to dealing with obesity and its consequences
- Opportunities and challenges for the Central community related to obesity-related concerns
- Assets that organizations/agencies have to offer to solve the problem of obesity-related concerns

## Evaluation



**Fig. 1. Participant and Communication Diagram for ACT Project**

In the next phase, the team began implementation of the project by employing an Appreciative Inquiry (AI) process involving 84 residents and other community members in focus groups (over 35 were youth). Twelve meetings were held with residents and other community members with two primary objectives: to gather baseline data for the evaluation and to introduce the project and the CBPR approach. Subsequent meetings were held to gain input from residents on the type of intervention to be implemented. The model employed to compile input and guide the decision-making process among residents and community members is shown in Figure 1.

As Figure 1 illustrates, the communication and decision-making processes were collaborative and interrelated. The three key elements were the project team, community members and the partnership team. Project Team members were the researchers responsible for the project – the Center for Health Equity (CHE), MetroHealth (CRHD), CSU’s Department of Health, Physical Education, Recreation and Dance (HPERD), St. Vincent Charity Hospital (SVCH), and The Center for Community Solutions (CSS). The Central Community Healthy Group (CCHG) and other community leaders provided the corresponding community voice to the project.

A community advisory council established at the start of the project evolved into the self-identified Central Community Healthy Group (CCHG). Composed of approximately 30 residents, CCHG is also integrated with the BHC. Each CCHG meeting included discussion about the community’s health concerns and other CBPR programs with the goal of supporting activities and resources throughout the pilot intervention.

The Partnership Team was composed of persons from the community and the researchers as well as others representing the sites where the interventions occurred. As illustrated in the model, decisions were made collectively.

During the AI phase, residents and other community members completed surveys that provided a baseline of their knowledge of CBPR, their viewpoints about obesity-related illness, and their relationships with the participating partners. CBPR, as a process where resident input is given equal weight in making decisions, was a new concept to the residents. Several stakeholders and residents commented that previous projects have often not fulfilled expectations laid out by researchers. Similarly, respondents felt that building trust between researchers and the community was important. While they also thought that producing research results was

important, educating the community and community involvement were more important.

Across the different groups of adults and youth surveyed, residents were aware of obesity-related health problems and their existence in the Central community. Reducing obesity and improving the health of residents were goals that survey respondents thought were important.

Respondents were asked about their prior relationships with the participating institutions – St. Vincent Charity Hospital, MetroHealth Hospital, Case Western Reserve University and Cleveland State University. While the majority of residents reported having some involvement with most of these institutions, some reported no prior contact with them.

Project meetings were held in different locations throughout Central. Through the process of meeting in different settings, the team culled information from a broad swath of the community about the existence of obesity-related illnesses. Residents demonstrated a general awareness of obesity-related illness and how they are manifested in conditions such as diabetes and heart disease. Most importantly, the consensus of the community was that an intervention should entail nutrition and exercise and target youth between the ages of 8 and 12.

As the third major part of the process, community-wide town hall meetings were held. Project resources were used to provide transportation, healthy breakfast and lunch foods, and incentives. At the first town hall meeting, the results of the various AI sessions were shared as well as the proposed target population and program components of the intervention. Those in attendance supported the direction of the intervention. A second town hall meeting was held to report the results of the intervention. A third town hall meeting is scheduled to report the final status of the project (June 2009).

A fourth component of the project developed in an effort to maintain community engagement in the project once the intervention began. This was achieved in two ways – with the participation of residents in the ongoing planning meetings and through additional sessions covering topics they identified such as leadership training and proposal writing.

The regular meetings were used to provide data that would inform the decisions made by the advisory committee. For example, at one meeting the CBPR staff presented options for organizing and structuring the advisory committee. Those in attendance were educated on the differences between

the approaches of a single decider, majority rule, unanimous decisions and consensus decisions. At another meeting, attendees were presented with various choices, derived from research, of how to design the pilot intervention program (discussed below).

Ultimately, much time and energy was devoted to developing the essential collaboration among the partners involved in the project. As one respondent commented:

***CBPR is hard and it takes commitment on all levels. As the project brought in more staff, some of the partners did not understand CBPR and I could see that this affected the project.***

***“The residents’ purpose and meaningful roles made a difference in their community with time.”***

One person who was familiar with CBPR commented that this project did not change any perceptions but the experience confirmed how difficult these projects can be. Another seasoned community organizer observed:

***My perception of resident commitment to community change increased significantly. Providing residents with tools and incentives they needed supporting that change was more important. The residents’ purpose and meaningful roles made a difference in their community with time.***

Some residents were more involved during some stages of the project than others. In a June 2007 journal entry, one resident stated that she was “feel[ing] good about the program . . . and trying [her] best to help promote it.” This individual reported that she was distributing flyers about the program at various locations in the community including businesses and a community center.

Another resident wrote that ACT program activities “made us feel as if we are a real agent for change.”

## Aim 2:

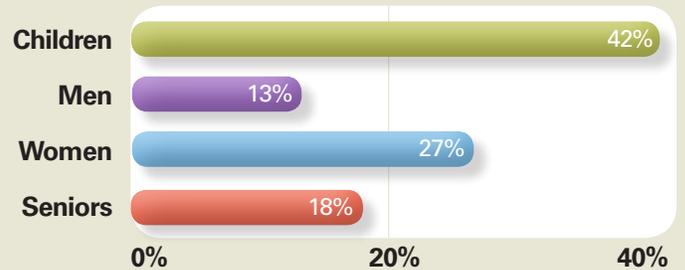
### Identify an intervention research project to test CBPR methodology and partnership success

Before the first community meeting was held, members of the project team conducted a needs assessment by interviewing several community stakeholders. The interviewees were asked a number of questions to gain their perspectives about obesity-related health issues and how to address them. Consensus was expressed on the following:

- The principal obesity-related health problems in the Central neighborhood are that low-income people have poor eating habits and don't have healthful nutrition; in addition, lack of resources and nutritional information are major problems.
- The most vulnerable segments of the population are children, followed by the elderly.
- Children should be targeted for intervention.
- The reasons that obesity-related problems are so prevalent in the Central neighborhood are lack of information and lack of resources, followed by little or no availability of healthful food choices.
- A number of programs, institutions, organizations and agencies have implemented programs that address these programs successfully; some are located in the Central neighborhood.
- Emphasis should be placed on diet and exercise, followed by nutrition education.
- The types of programs that would be most helpful to the community are nutrition education programs, health fairs and ongoing cooking demonstrations.
- Strengths of the Central neighborhood related to dealing with obesity and its consequences are St. Vincent Charity Hospital and neighborhood centers (like Boys and Girls Club).
- Weaknesses of the Central neighborhood related to dealing with obesity and its consequences are the presence of fast food restaurants and lack of resources (affordability of healthful foods) and lack of education.
- The major opportunity related to these concerns is getting residents involved through incentives such as food, games and free transportation.
- The major challenges related to these concerns are getting residents to participate and the absence of a

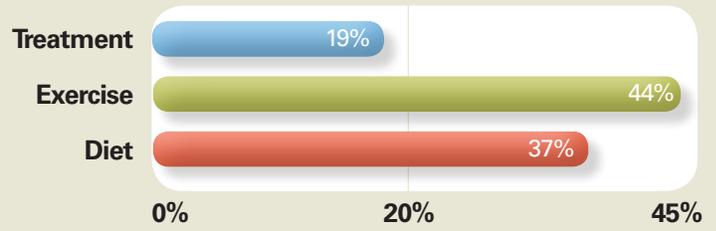
**Fig. 2: Initial Target Group**

Surveyed community on initial target group for pilot intervention.



**Fig. 3: Initial Activities**

Surveyed community on initial activities to be addressed for pilot intervention.



full-service grocery store where healthful foods can be purchased.

- Among the respondents, some of them offer programming to the community to solve the problems related to obesity, e.g., City Mission, Cleveland Metropolitan School District, Cuyahoga Metropolitan Housing Authority and Joslin Diabetes Center.

During the second year of the project, an intervention project was identified based on input from many segments of the Central community. ACT conducted a community-wide process of gathering data and suggestions, which settled upon the target population for the intervention as well as the methods of intervention. During the discussion phase, project staff provided information on best practices from similar projects around the country to the residents and other community members. The ultimate decision to focus on nutrition and exercise programming was consistent across the community and was confirmed at the first town hall meeting. Community members also weighed in on what types of activities they wanted to see, such as African and other types of ethnic dancing.

While most of the regular participants in the planning process were senior citizens, they concurred that children (and

their families, secondly) should be the priority, given the short time frame and limited resources available. A total of 419 persons contributed to the data assembled on the initial target group and the initial focus (through key interviews, focus groups, and walk-around surveys.) (See Figures 2 and 3.) The senior citizens, however, wanted to remain engaged through volunteering and seeking leadership opportunities.

## Aim 3:

### Implement one or two pilot health intervention projects within the Central neighborhood using CBPR principles

As intended, during the planning grant process, much emphasis was placed on building trust among all participants. The trust building occurred during the two major phases of the project: 1) planning and gathering community input and 2) pilot project intervention. Key partners during the intervention phase were youth, families and agencies/organizations where the intervention projects were conducted. As noted above, personnel from the agencies/organizations were involved in planning for the implementation from the earliest possible stages. The advance planning was critical because each site was unique in its facilities, clientele and existing programming. Early and ongoing coordination with the site managers was extremely essential.

The ACT staff used a multifaceted outreach approach to attract participants to the intervention. A full-time community health worker was hired to take the lead in outreach activities — involving families and serving as a liaison between the program and parents. Door-to-door distribution of flyers, attendance at community events and one-on-one contacts were among the strategies to recruit youth and their parents. Before the intervention program began at each site, university researchers scheduled Saturday morning sessions to gather health indicator data for comparison after the intervention. Data were gathered on strength, flexibility, blood glucose and triglycerides. Cooperation was essential since the required procedures entailed getting signed parental consent as well as youth assent before they could be conducted. Care was exercised in explaining the processes to parents and obtaining their agreement. A major responsibility of the community health worker was to insure that parents received the results from the physiological assessments of their children and took appropriate corrective measures where necessary.

Several units of Cleveland State University (CSU) collaborat-

ed in this project. The Center for Health Equity (CHE) was the lead university partner although the College of Science (COS) was involved in the conceptualization of the project through the services of Dr. Bette Bonder. During an early stage of the project, however, Dr. Bonder was promoted to the position of Dean of the COS, which limited her involvement. In addition, the other lead investigator, Dr. George Weiner, retired from CSU during the second year in mid-2007. Peter Whitt was an early project partner from outside the university as Director of Community Outreach at St. Vincent Charity Hospital. After leaving St. Vincent Charity Hospital in 2006, he joined CSU as associate director of the CHE in late 2006. There were some lapses, but progress was made and led to the launching of the first of four cohorts of the pilot program in summer 2007.

CSU's Department of Health, Physical Education, Recreation and Dance (HPERD) was contacted about providing the four major elements of the intervention: nutrition, physical activity, rhythmic movement, and assessment. Drawing upon the expertise of the HPERD faculty and staff, the project staff and CCHG members decided to target youth between 8 and 12 years of age for the project. Factors that influenced the decision were limited resources and the potential for change in that age group. This choice was supported by a quote from David Kaelber, a pediatrician at the Case Western Reserve University School of Medicine, that

***“Better identification of . . . children who have just crossed into the unhealthy weight category is essential for early intervention, which will hopefully prevent not only a childhood of increased health problems, but also what now often becomes an ongoing battle through adulthood with life-long issues.”<sup>1</sup>***

The components of the intervention were organized around the National Association for Sport and Physical Education Standards.

Using the services of the Human Performance Lab, operated by Dr. Ken Sparks, measurement data were gathered at the beginning and end of all four sessions. The FitnessGram®, a validated tool developed by the Cooper Institute for Aerobics Research, was used to evaluate fitness performance by using objective, scientific standards that represent a level of fitness necessary for good health. The tests included cardiovascular fitness, muscular strength and endurance, flexibility, and percent body fat. Body mass index was calculated using height and weight.

<sup>1</sup> Health Watch: Overweight children often not diagnosed, *The Plain Dealer* (December 30, 2008).

## Evaluation

All data were entered into the FitnessGram® software for scoring. Lipid profiles and blood glucose measurements were also obtained for screening of type I diabetes and risks for developing cardiovascular disease. The children were also given the Youth Risk Behavior Surveillance System for Nutrition and Physical Activity and pre-and post-focus group sessions were held to assess health beliefs and practices.

The youth's pre-test results were reviewed and used to plan activities that targeted areas in need of improvement while continuing activities in each fitness area: aerobic capacity, body composition, muscular strength, endurance and flexibility. Under the leadership of Mary Motley and Lisa Hunt, various types of physical activity were provided including traditional and nontraditional games, cooperative and problem-solving games, aerobic activities and rhythmic movement (from various dance genres).

A variety of learning modalities were used to generate enthusiasm about nutrition topics and improve nutrition habits. Behavior change was a major objective. Interactive nutritional learning activities and games were utilized in conjunction with cooking demonstrations.

The intervention was known by various titles. One title was "Healthy Movement Healthy Life Intervention" and the second was "Fun-n-Fitness." The format of the intervention called for meeting three days a week, for 10 weeks (two weeks of testing, 10 weeks of activities), with family-focused activities twice a month. *See Table 1 for intervention schedule.*

## Effects of the intervention on health and nutrition

The intervention was premised on a belief that fitness- and nutrition-based intervention would have the most potential for improving the health of residents. Seventy-three youth participated in the program. Pre-test and post-test data were gathered on youth participating at all four sites on 28 physiological and behavioral variables. Non-significant results between pre- and post-test data were reported on the following variables: diastolic blood pressure, cholesterol, HDL, LDL, glucose, BMI, left flexibility, fat, vegetable nutrition, meat nutrition and fat nutrition. However, though not scientifically significant, several of the variables did demonstrate a trend of improvement. *Significant findings are reported in Table 2.*

Besides weight, significant change was observed in seven physiological and behavioral characteristics. The average systolic arterial pressure decreased significantly but remained in the normal range. The average triglyceride level increased but was still in the normal range. Increases in the number of laps run in a designated period of time (PACER), the number of push-ups completed and flexing the right bicep indicate improvements in strength and endurance. Self-reports of dessert and overall nutrition indicate improvements in nutrition behavior. The differences noted indicate changes that positively impact physiological and behavioral health. The long-term impact of these findings could lead to healthier lifestyles, lower incidence of obesity and disease prevention.

**Table 1: Intervention Schedule – The Typical Program Week**

Day One	Day Two	Day Three
<b>Warm-up</b>	<b>Warm-up</b>	<b>Warm-up</b>
<b>Rhythmic Movement</b> African dances, hip-hop	<b>Rhythmic Movement</b> Ethnic dances, modern dances	<b>Rhythmic Movement</b> Praise dances, line dances
<b>Wellness Education</b> Youth topics: healthy lifestyles, hygiene, games/activities	<b>Wellness Education</b> Family topics: healthy lifestyles, easy exercises	<b>Wellness Education</b> Youth topics: healthy lifestyles, leadership skills, hygiene, games/activities
Cool-down & review lessons learned	Cool-down & review lessons learned	Cool-down & review lessons learned
<b>Nutrition Education</b> Youth topics: healthy snacks, food pyramid	<b>Nutrition Education</b> Family topics: healthy recipes	<b>Nutrition Education</b> Youth topics: healthy snacks, food pyramid

**Table 2: Comparison of Healthy Movement Healthy Life Intervention**

Variable	Pre-test n=73 Mean + SD	Post-test n=73 Mean + SD	Change	Sig. (2-tailed) <.05
Age (yrs)	9.75±1.234	10.01±1.275	-0.260	0.000
Height (in)	55.76±3.87	56.19±4.00	-0.4288	0.000
Weight (lbs)	90.52±36.08	93.05±35.92	-2.5274	0.002
Systolic (MmHg)	111.23±10.71	108.12±9.17	3.11	0.023
Triglyceride (mg/dL)	60.60±25.89	68.83±35.14	-8.236	0.029
PACER (laps)	18.46±9.44	22.92±13.56	-4.451	0.001
Push-ups (#)	9.68±7.422	12.20±8.65	-2.521	0.001
Flex Right (in)	10.32±2.38	10.65±2.53	-0.336	0.045
Nutrition Dessert	59.47±39.17	74.62±34.11	-15.152	0.012
Nutrition Overall	48.47±11.85	53.55±10.23	-5.076	0.002

Seventy-three participants completed pre- and post-testing.

Another aspect of the CSU partnership was ongoing monitoring of the results of the program. The lead evaluator, from the university’s Urban Child Research Center in the Maxine Goodman Levin College of Urban Affairs, gathered feedback data from all community sessions and events to gauge process and progress. During the intervention, the evaluation team conducted pre-program and post-program focus groups with youth participants. Parents were also queried through surveys about the effects of the program on their children and families.

At each of the four sites where the Healthy Movement Healthy Life intervention was conducted, the youth participated in a focus group at the beginning of the program. The purpose was to gauge their knowledge about fitness and nutrition before exposure to the information provided in the program. At the end of each session, a follow-up focus group was conducted to assess what the participants had learned during the 10-week period. The results of the pre-intervention focus groups included:

- Youth feel good about the activities, programs, and people in their community.
- Youth are aware of places in the neighborhood where they can exercise.
- Youth enjoy learning new things like games and dancing.
- Youth enjoy exercising at home and school.

The changes noted after the post-intervention focus groups were conducted included:

- Participants understood the purpose of the program more fully.
- Participants were able to discern aspects of a balanced diet, healthful foods and nutritional snacks.
- Participants felt they would be able to use what they learned in the program at home.
- Participants developed a better understanding about the need for exercise.
- Participants acquired extensive knowledge about different fruits, vegetable options and healthy eating.
- Dancing was the favorite activity among the youth.
- Youth learned new physical fitness activities.

The project team engaged community members by sharing program activities and outcomes with them. The necessity for collecting, compiling and reporting data was emphasized to all participants throughout the project. Community-wide town hall meetings were held on two occasions to share the project details and gather additional input from persons involved and not yet engaged with the project. The events were widely publicized throughout the community, transportation was provided, breakfast and lunch were served, and incentives were given to youth and adults. Over 180 persons were in attendance at the two meetings. During the first town hall meeting the wider community was asked their opinions about the proposed intervention – with which they generally concurred. At the second town hall meeting, the results from the intervention were shared.

# analysis

## Analysis

### Attainment of Major Aims

As initially conceived, the project was to test the hypothesis that implementing Community-Based Participatory Research (CBPR) methodologies, over a period of 10 years or more would yield greater success in health interventions than those using traditional methodologies. The four-year ACT project laid the groundwork for a longer-term CBPR project; however, its potential impact has not been realized.

Developing the partnership with the community was an ongoing process. While the community residents were not equally involved at the earliest stages in the process, the team took deliberate steps to fully engage community members in all phases of the project. This focus on engagement is due to the natural evolution of the project – especially the obvious need for resident representation to truly validate CBPR principles. Moreover, there was an initial period wherein the participants from the various partnering entities became familiar with each other and expectations began to meld. One university participant commented that:

***I began to see a community that is a strong community and not only the disadvantaged community I saw on TV. There are individuals who are passionate about their neighborhood and are truly community leaders in that they are always out and about doing things to better the lives of the community. This was really different than what I first thought I would see.***

A similar sentiment was:

***CBPR made me think of the community as partners and not just subjects in a research project. Therefore, it was important for me to make sure that the community was OK with each aspect of the project and really listened to their views and outlook as it related to the project.***

In an effort to allow for continued community involvement, new members were allowed to join the CCHG advisory committee established for the project at any time. This made it difficult to maintain momentum because staff and experienced members had to continually orient new members to CBPR and the project. In addition, turnover among CCHG participants challenged efforts to maintain a steady core of residents.

The challenge of incorporating residents in all phases of the project was difficult to overcome. This problem was due to logistics and lack of transportation. Meetings held at the university were not easily accessible by public transportation and public parking was often not available. Therefore, the team sought to hold most meetings at a location in Central, which seemed to positively impact participation for all except youth and employed persons.

The need and importance of gathering data for evaluative purposes was explained to residents throughout the process. As a result, they are willing to participate in evaluation processes including completing questionnaires and maintaining journals (for up to 16 months). The survey provided useful data about program activities and the journals were insightful. The data revealed that some residents in the Central community are highly engaged in many aspects of community life. One resident was very volunteer and activism oriented, being involved in community events like parades and fairs, Girl Scouts, and seeking an RTA circulator bus for Central.

The success of the intervention hinged largely upon building partnerships with organizations and agencies where the programming could be conducted. The staff was successful in building an organizational infrastructure that brought prospective partners to the table at an early stage to engage in the planning process and pilot implementation. As a result, the intervention project, Healthy Movement Healthy Life, was conducted for four 10-week sessions at four locations in Central. Evidence of improved nutritional and fitness outcomes demonstrates the potential for this type of intervention, particularly if the time frame could be extended.

## **Relationship between the CBPR implementation and the Building Healthy Communities Initiative**

The Building Healthy Communities (BHC) initiative was a precursor to the CBPR project. BHC is a grassroots effort established through community envisioning and goal-setting events through the work of St. Vincent Charity Hospital. BHC strives to support and empower community residents in identifying key issues and implementing action plans that will result in a healthier community. It was instrumental in providing community members for the first Appreciative Inquiry groups that eventually led to the intervention project. Some of the more active members of the CBPR advisory group were initially BHC participants and continue to be involved. These members seem to have acquired another set of skills with which to pursue community health issues through the CBPR activities.

start-up. The delay in acquiring and reporting outcomes for the intervention probably had a negative affect on initial efforts to seek implementation funding.

## **New strategies or approaches identified**

Three strategies were identified during the project that contributed to the sustainability of the CBPR approach: leadership training, social marketing, and PhotoVoice project. Twelve residents requested and received leadership training, which was provided over an eight-week period. The participants were satisfied with the training (4.2 on a 5-point Likert scale). They reported learning skills in the areas of public speaking, presentation, listening, confidence, leadership, networking and speaking up. At the conclusion of the training, most also felt better prepared to serve as a community leader.

Social marketing surfaced as a strategy to inform more community members about healthy living and nutrition. Resi-

***One key difference in the community participation associated with CBPR and existing, traditionally implemented interventions is that CBPR included involvement across all sectors of the community.***

Partnership with the BHC initiative provided a base upon which to build and incorporate CBPR into the community. Throughout the project, the BHC met once a quarter and the ACT project team (initially the academic members and later transitioned to community members) reported regularly to BHC on the activities and outcomes of the project. In addition, the ACT provided financial support for BHC projects and recruited participants from their members. The relationship between the two entities was sustained throughout all phases of the planning and intervention.

## **Issues that arose as the result of the process**

It is evident that significant time and attention were needed to develop the foundation for the CBPR process in this neighborhood. This step was a necessary precursor to identifying and implementing an intervention project, which delayed its

students created slogans to use in various ways. An initial activity was to distribute recipes to community members outside Dave's Supermarket, at Marian-Sterling Elementary School and other locations in the neighborhood.

A subsequent activity was the PhotoVoice project. PhotoVoice is a process through which people can identify, represent and enhance their community through a specific photographic technique. In this case, CCHG members are documenting the strengths and weaknesses of the Central neighborhood with respect to the message "Eat Healthy, Feel Good, Live Longer."

Twelve CCHG members agreed to participate by taking photos and sharing the meanings of each photo during group discussions. A display of about 35 photos will be placed on a public exhibit. A photo display will be presented at the third town hall meeting in June 2009. The goal of the PhotoVoice

## Analysis

project is for participants to remain advocates for their community after the project ends.

### **Difference in community participation compared to existing, traditionally implemented interventions**

One key difference in the community participation associated with CBPR and existing, traditionally implemented interventions is that CBPR included involvement across sectors of the community. All sectors were provided with an equal voice in decision making. Residents, in particular, seemed to appreciate this egalitarian approach.

Some of the active community members perceive the area more in terms of being part of Ward 5 than as Central, it seems. This could be a unifying approach from the standpoint of working cooperatively with the ward councilperson, Phyllis Cleveland, or her successors in the future.

### **Goals of CBPR**

Two critical ingredients of a CBPR project were identified in the original proposal: trust and a representative governing structure. The project team was able to achieve both of these results. As described above, community participants were engaged from the beginning and settled upon the name of Advancing Central's Health Together (ACT). ACT evidenced the formation of a governing body that participants named the Central Community Healthy Group (CCHG). Trust was built through the processes of engagement and decision making. In a follow-up survey of participants conducted at the end of

the project, 100 percent of respondents expressed that a major outcome of the project was the development of trust between researchers and the community residents.

The goals of the CBPR process were achieved in this project through inclusion of the broad community from the start. All participants had an equal opportunity to be involved and the process was organic, i.e., it was responsive to the developing and emerging needs and interests of the community – as evidenced by the leadership training and social marketing.

The process was inclusionary, drawing upon input from professionals, senior citizens, youth and others. The process was integrative in recognizing diverse issues and concerns among community members. The process naturally promoted cooperation among residents from different areas within Central.

Once the intervention was under way, efforts were made to obtain community involvement and provide feedback primarily through CCHG and town hall meetings. Constant feedback on the CBPR process was provided through formative evaluation with results obtained from focus groups and the town hall meetings. While some residents participated consistently, there was noticeable fluidity in participation, which meant that new people (unfamiliar with the process) were common at any given meeting. Nonetheless, the program achieved the goal of reaching out to and educating the community.

Residents were meaningfully involved in the CBPR process as intended. They were involved in planning meetings as well as research meetings. The leadership training provided by the project team allows for the sustainability of the progress achieved. The project enhanced existing community advocacy and leadership.

*Two critical ingredients that were identified in the original proposal: trust and a representative governing structure.*

# Conclusion

## Conclusion

### Accomplishments

Fundamentally, the ACT project utilized methods to engage residents in meaningful ways. The team gathered information from community stakeholders to help fine-tune the approach of reaching the community. Utilizing existing program structures and participants, such as Building Healthy Communities and the local Red-Hat Women Society, community members were a part of the exploration process of deciding upon an intervention and the target group. When the meetings failed to provide input from middle-aged males in the community, the team began a process of walk-around surveys and gathering information from several barbershops. Throughout the project, the project team adapted its approaches to maximize resident involvement.

Major strides were achieved toward full resident empowerment. First, residents assumed key leadership positions in the governing structure. Second, participants provided continual feedback after each session. Their feedback was used to inform the team of how information was being received; this enabled changes to be made as needed. Third, once the intervention was started, a community health worker was hired to provide additional outreach into the community and to connect with parents of the participating youth.

The CBPR process itself was successful in maintaining the continuing engagement of some community members. These individuals have become more knowledgeable and have the potential to persevere as assets to the community into the future. The results of the CBPR process and outcomes have been shared in partnership with community members in various forums including a brown bag luncheon presentation, a national conference (American Public Health Association) and a speaker series (Works-in-Progress with Case Western Reserve University). The project was also successful in promoting collaboration between the participants, including different units at Cleveland State University, St. Vincent Charity Hospital, MetroHealth and community organizations based in Central.

Representatives of the four sites that hosted the intervention project responded positively to the program activities.

All found the process of planning and implementation satisfactory. At each site, future projects would be welcomed.

Toward the goal of sustainability, the HPERD staff developed a manual that can be utilized for future programming at the sites. As a step toward replicating the project effort, ACT funds were used to purchase equipment and games for each site. In addition, at each site, two community assistants were hired to work with the HPERD staff with the expectation that they would maintain some activities after the 10-week program ended.

### Barriers/Problems

Maintaining regular communication with the community, particularly stakeholders, was a problem for the project. The regular meetings and town hall meetings were not as reliable as a newsletter might have been for keeping the interested public informed.

**Four major issues were associated with the intervention:**

**First**, the level of participation was less than desired for some of the sites — particularly the first and the fourth. The first session was held during the summer when youth were distracted by other activities. The fourth session was held in a facility that was not amenable to the fitness activities.

**Second**, the level of parent participation in family nights was less than desired. The project staff attempted to modify the format of the family nights, including trying a party setting, but the attendance was still less than desired.

**Third**, some sites chosen for the intervention activities were not optimal for the programming. The first location, Central Recreation Center, where the program was conducted in the summer, was not air-conditioned and was not equipped with an elevator to get to the gymnasium on the second floor for families participating in the family nights. Additionally, the program interfered with current summer programs and this effected recruitment and participation. The center is a primary gathering place for youth in the neighborhood, and upgrading facilities and equipment would not only benefit this program but services available to the community generally.

## Conclusion

The last location, Arbor Park Village, did not have suitable accommodations for fitness or exercise programming. Although the staff attempted to make adjustments to fit the circumstances, there were limitations. Participants suggested using the nearby facilities of Cleveland State University, Cuyahoga Community College and the YMCA during the course of the program but transportation was a major impediment to moving it outside the immediate area.

**Fourth**, the long-term sustainability of project efforts is uncertain. The greatest obvious impact of the program has been on adults who have stuck with the program to the end. Materials (a program manual and equipment) for continued programming at each site were provided but resources are not available to support follow-up on their use.

### Lessons Learned

Lessons learned from the implementation of the CBPR process and the intervention will instruct future similar efforts in Central or similar neighborhoods.

#### CBPR Process

- Institutional processes among participating partners should be aligned with regard to consistency, participation and expectations. Turnover and change in staff affected this project.
- A balance should be struck between the time spent organizing the community around CBPR and initiating an intervention. Lack of demonstrable outcomes can dampen community enthusiasm and funding prospects.
- Written updates or other existing mechanisms could be used to enhance communication and maintain interest.

#### Intervention

- A different approach may be needed to train site staff from the neighborhood and prepare for program sustainability. Problems were encountered with the youth selected as community assistants.
- A balance of community input versus practical measures for sustainability would have assisted in project initiatives.
- The existence or lack of existence of previous programming may make a difference in program outcomes. For example, the Boys and Girls Club site had the capacity to help with recruitment, which not all sites were able to do.
- Reaching overweight/obese youth may be a challenge that requires more outreach or incorporating a focus on obesity prevention.

*The greatest obvious impact of the program has been on adults who have stuck with the program to the end.*

# Project Teams and Community Representatives

*Advancing Central's Health Together (ACT)* was initiated under the direction of George Weiner, PhD (principal investigator 2005-2007) and continued under Peter Whitt, MSW, LSW (2007-2009 principal investigator), Center for Health Equity, Maxine Goodman Levin College of Urban Affairs, Cleveland State University. Funding for this project is fully supported from a National Institutes of Health/National Center on Minority Health and Health Disparities – Community-Based Participatory Research (CBPR) Initiative in Reducing and Eliminating Health Disparities: Planning Phase grant (NIH/NCMHD R24 MD001794).

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**Christi Johnson**, Community Health Worker, St. Vincent Charity Hospital

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*Retired: Principal Investigator '05-'07*

## Intervention Team

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### NUTRITION EDUCATION COMPONENT

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Diabetes Association of Greater Cleveland

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## Community Representatives

### **City of Cleveland:**

#### **Central Recreation Center**

**Bill Myers**, Director

**Princess Agee**, Community Assistant

**Robin Walton**, Community Assistant

### **Boys and Girls Club: King Kennedy**

**Ron Harris**, Director

**Erica Cook**, Community Assistant

**Tomaraa Green**, Community Assistant

### **Friendly Inn Settlement, Inc.**

**Paula Lewis**, Youth Coordinator

**Brittany Jackson**, Community Assistant

**Anthony Lang**, Community Assistant

### **Arbor Park Village**

**Stephanie Davis**, Manager

**Tiletta Jones**, Community Assistant

**Champale Russell**, Community Assistant

### CENTRAL COMMUNITY HEALTHY GROUP MEMBERS

**Sharon Anderson**      **Deloris Abdul Malik**

**Bennie Benjamin**      **Lila Mills**

**DeEtta Brown**      **Queen Moss**

**Akbar Eel**      **Minnie Perry**

**Anne Franklin**      **Dorothy Roberts**

**Darrell George**      **Benjamin Rutledge**

**Jean Howard**      **Audrey Smith**

**Sadie Jackson**      **Priscilla Walton**

**Shelia Jackson**      **Diane White**

**Nikki Ali Jarreux**      **Lavallia Williams**

**Valerie Johnson**      **Loretta Williams**

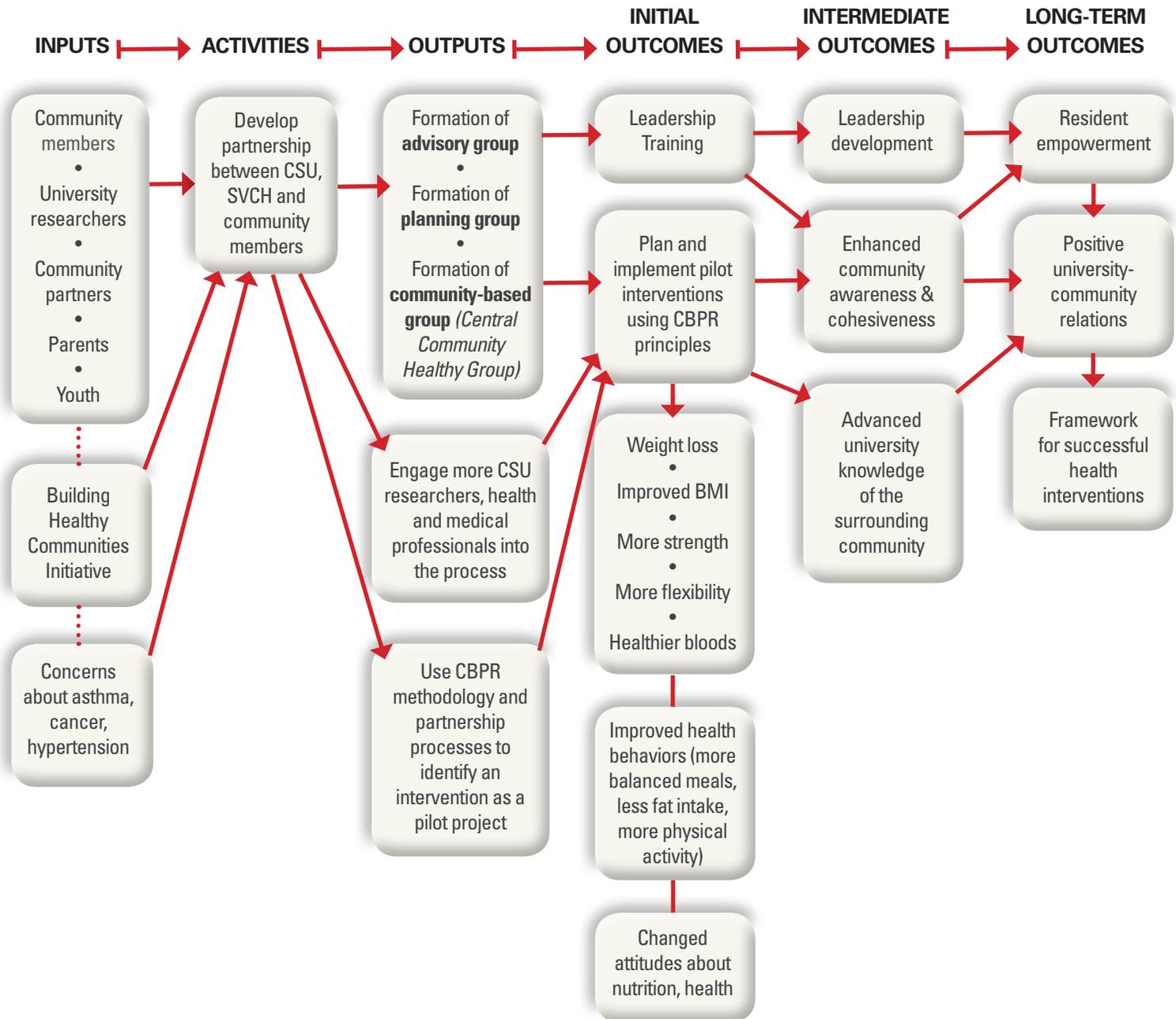
**Mildred Lowe**      **Laqueta Worley**

**Carolyn Wyley**

# Appendix A – Logic Model of CBPR Process

## PROGRAM OBJECTIVE:

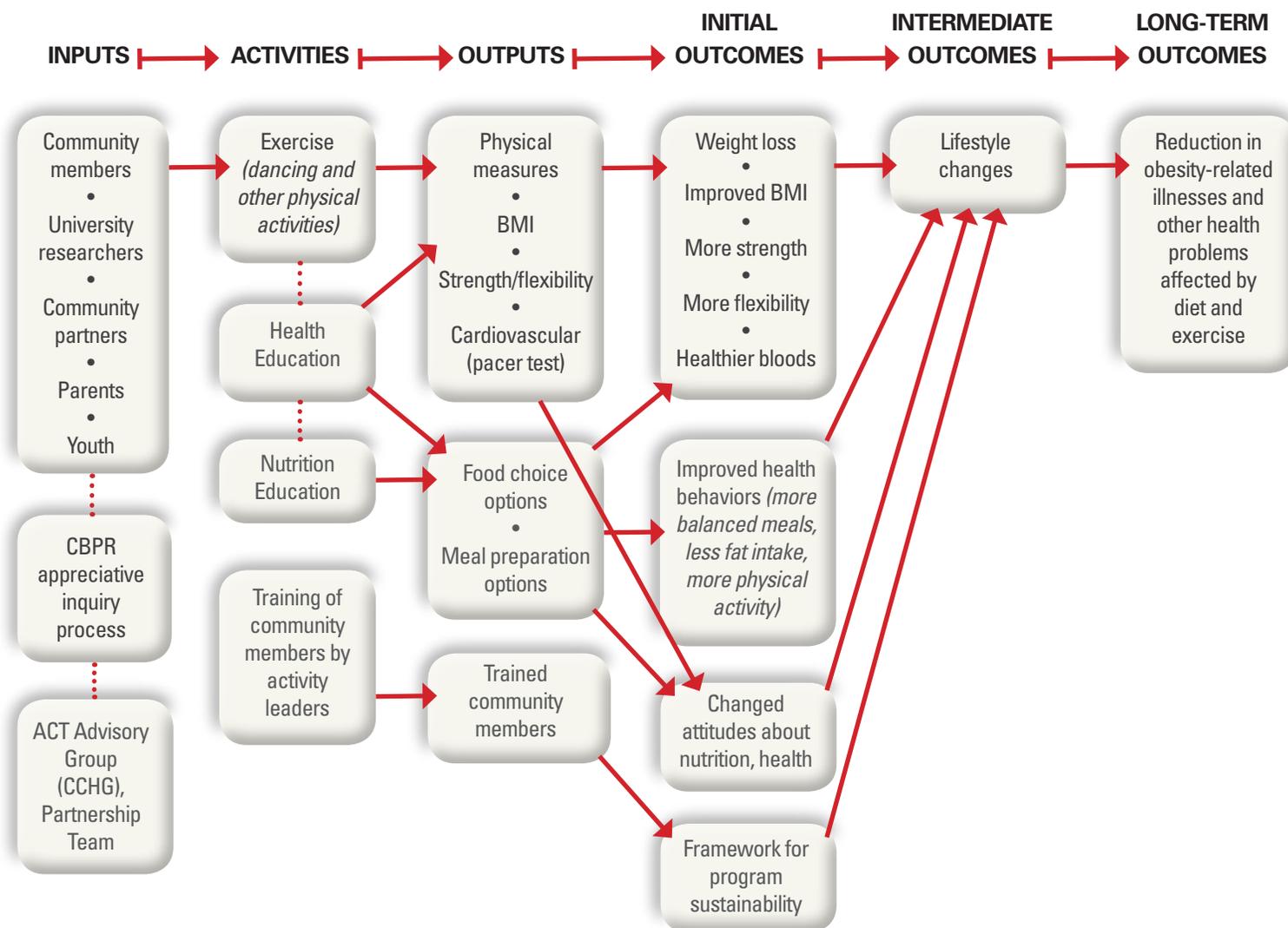
CBPR will yield greater success in health interventions compared to interventions initiated using traditional methodologies



# Appendix B – Logic Model of CBPR Intervention

## PROGRAM OBJECTIVE:

Residents of this community have high rates of obesity-related illnesses. This program will focus on youth (between the ages of 8 and 12) by providing them with a 10-week regimen of exercise, nutrition and health education and involving their families in order to improve their potential for long-term healthy life-style choices and better health outcomes.



# Appendix C – ACT Timeline

2005			2006												2007																							
10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12												
<b>A.</b> Developed Central neighborhood partnerships (October 2005 – October 2006)			<b>B.</b> Found a community focus within the context of obesity and its consequences (October 2006 – February 2007)												<b>C.</b> Developed an obesity-related health intervention (February – June 2007)												<b>D.</b> Implemented pilot project (June 2007 – June 2008)											

During the initial steps of the planning phase, several key activities were conducted concurrently — developing partnerships and assessing community needs — as detailed at right. These activities were instrumental in making the community aware of CBPR and obtaining community input in order to refine the pilot intervention project.

**A. DEVELOP CENTRAL NEIGHBORHOOD PARTNERSHIPS (October 2005 – October 2006)**

*The project team conducted several meetings with community residents and organizations.*

- Introduced the purpose, project activities and CBPR methodologies.
- Built a foundation of trust and participation.
- Developed a partnership with St. Vincent Charity Hospital and its Building Healthy Communities resident-driven initiative.
- Established a core community advisory council, later self-identified as the **Central Community Healthy Group (CCHG)** with 20 to 30 consistent residents.
- Completed community reconnaissance and contacted 419 individuals through key interviews, focus groups and walk-around surveys.

**B. FIND A COMMUNITY FOCUS WITHIN THE CONTEXT OF OBESITY AND ITS CONSEQUENCES (October 2006 – February 2007)**

*The project team informed interested residents about the prevalence of obesity and the seriousness of its consequences.*

- Analyzed data from community reconnaissance.
- Developed partnership with local organizations serving youth.
- Presented best practices of national programs focused on nutrition and exercise for youth.
- Determined community concerns as it related to obesity.
- Refined areas of concern and commitment through an **Appreciative Inquiry** process at the first town hall meeting.

2008

1 2 3 4 5 6 7 8 9 10 11 12

2009

1 2 3 4 5 6

**E.**  
**Created sustaining activities**  
*(June 2008 – June 2009)*

**C. DEVELOP OBESITY-RELATED HEALTH INTERVENTION**

**(February 2007 – June 2007)**

*The project team collected and analyzed information from a town hall meeting and determined the specific obesity-related health intervention that was introduced.*

- Developed partnership with academic departments supporting youth intervention.
- Developed 10-week **Healthy Movement Healthy Life** program consisting of rhythmic movement, wellness education and nutrition education components targeting 8-12 year olds and their families [2 weeks of testing, 10 weeks of activities].
- Implemented a strategy to incorporate intervention in the community.

**D. IMPLEMENT PILOT PROJECT**  
**(June 2007 – June 2008)**

*The project team worked with the community to implement a 10-week intervention targeting 8-12 year olds.*

- Educated the community on the CBPR research process.
- Conducted the 10-week intervention at four neighborhood sites.
- Communicated the results to the community in the second town hall meeting.
- Sustained and **empowered CCHG members** through a series of training areas as requested on nutrition, leadership and advocacy.

**E. DEVELOP SUSTAINING ACTIVITIES**

**(June 2008 – June 2009)**

*The project team developed sustaining mechanisms within the community.*

- Analyzed pre- and post-test outcome intervention physiological measures.
- Developed a manual and purchased equipment for local sites to continue intervention activities.
- Developed a **toolkit** on engaging communities and building partnerships for community-based projects.
- Implemented a **Summer Health Promotion** campaign.
- Implemented a **PhotoVoice** project.
- Communicated the results to the community at the third town hall meeting.





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