A Community Approach to Address Health Disparities

T*H*R*I*V*E

Toolkit for Health & Resilience In Vulnerable Environments

Final Project Report
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A Community Approach to Address Health Disparities

T*H*R*I*V*E

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EXECUTIVE SUMMARY

Under contract with the U.S. Office of Minority Health (OMH), Prevention Institute developed a community resilience assessment toolkit, T*H*R*I*V*E, to help communities bolster factors that will improve health outcomes and reduce disparities experienced by racial and ethnic minorities. T*H*R*I*V*E provides a framework for community members, coalitions, public health practitioners, and local decision-makers to identify factors associated with poor health outcomes in communities of color, engage relevant stakeholders, and take action to remedy the disparities. The tool is grounded in research and was developed with input from a national expert panel. It has demonstrated utility in urban, rural, and suburban settings. Within months of piloting there was already evidence of community change and some initial results of that change were the initiation of farmers' markets and youth programs, among other outcomes. Now that the toolkit has been developed and demonstrated utility, the next steps are to disseminate it and to provide the necessary training and technical assistance.

This report provides an overview of the project, including conceptual background information, a review of existing resilience efforts, research that informed the tool, a description of the project's methodology, a description of the pilot events and outcomes, and recommendations for next steps. At its year two meeting, the members asserted that T*H*R*I*V*E has demonstrated utility and that it should be made available to the public as soon as possible. Further, the panel highlighted the value of training and technical assistance to ensure that the toolkit is put to maximum use.

The Health Disparities Challenge

Poor health and safety outcomes, including chronic disease, traffic-related injuries, mental illness, substance abuse, teen pregnancy, and violence are disproportionately high among low-income people and people of color in the United States.[1] The impact of racism and oppression increases numerous risk factors for illness and injury, including reduced access to fresh nutritious foods, fewer opportunities for physical activity, greater exposure to environmental toxins, and substandard housing and neighborhood conditions.

Some of these environmental conditions directly cause ill health. For example, toxins in the environment can cause cancer, and chemicals and other pollutants in the air can trigger asthma. In other cases, the environment influences behaviors that can lead to ill health or injury. For example, poor choices about diet and physical activity, which account for approximately a third of premature deaths in the U.S., are not just based on personal preference or information about health risks. An individual will have a harder time changing his behavior if he lacks sufficient income to purchase food, is targeted for the marketing of unhealthy products, and does not have access to healthy foods. Similarly, it is much harder for people to be physically active when streets are unsafe and there are few gyms or parks. Targeting even one of these environmental conditions could contribute to decreasing rates of disease and disparities in health. However, even more than focusing on individual and community risks, T*H*R*I*V*E emphasizes the assets that communities have and need to bring forward. T*H*R*I*V*E highlights resilience factors that support health and safety outcomes in communities and at the same time builds resilience and reduces risks.

Methodology

Prevention Institute utilized a five-part methodology in the development and testing of T*H*R*I*V*E. This methodology included an environmental scan to determine the relationship between health and environmental factors, the formation of a national Expert Panel, the development of the T*H*R*I*V*E assessment tool, the pilot testing of this tool in three communities around the country, and the development of a set of preliminary guidelines.

T*H*R*I*V*E Clusters and Factors

T.H.R.I.V.E. features community conditions that influence the *Healthy People 2010 Leading Health Indicators.* These indicators (tobacco use, physical inactivity, overweight and obesity, substance abuse, responsible sexual behavior, mental health, immunizations, violence and injury prevention, environmental quality, access to care) have been linked to eliminating health disparities.[2]

Current prevention strategies have focused largely on reducing risk factors. This is an essential aspect of prevention, but an equally important element is building upon and enhancing positive factors in communities. Building community resilience goes beyond secondary and tertiary interventions and approaches to address the issues out of which health disparities arise. Enhancing community resilience factors can have long-term, positive impacts on individual and community health and such factors can also serve as interim benchmarks in meeting Healthy People 2010 goals.

The factors delineated here are based on findings of the environmental scan and were clustered by the authors into the following four categories: built environment, social capital, services and institutions, and structural factors.

Built Environment
Activity-Promoting Environment
Nutrition-Promoting Environment
Housing
Transportation
Environmental Quality
Product Availability
Appearance/Ambiance

Social Capital
Social Cohesion and Trust
Collective Efficacy
Civic Participation/Engagement
Positive Behavioral/Social Norms
Positive Gender Norms

Services and Institutions
Public Health, Health, and Human Services
Public Safety
Education and Literacy
Community-Based Organizations
Cultural/Artistic Opportunities

Structural Factors
Ethnic/Racial Relations
Economic Capital
Media/Marketing

T*H*R*I*V*E Pilot Process
The T*H*R*I*V*E pilot events took place in Lordsburg, New Mexico with Hidalgo Medical Services (rural site), Del Paso Heights, Sacramento, California with the Mutual Assistance Network (suburban site), and in East Harlem, New York with the New York City Health Department District Public Health Offices (urban site). The purpose of the T*H*R*I*V*E pilot events was to determine the toolkit's applicability and utility.

Overall, the pilot events demonstrated the value of T*H*R*I*V*E. The toolkit contributes to a broad vision about community health, confirms the value of upstream approaches, challenges traditional thinking about health promotion, organizes difficult concepts and enables systematic planning, has rural and urban applicability, has utility for practitioners and community members, and is a good tool for strategic planning at community and organizational levels.

Preliminary Guidelines
The guidelines are for people who recognize the value of a community resilience approach and want to advance the capacity of their communities to strengthen the four clusters and twenty factors delineated in T*H*R*I*V*E. Therefore, the guidelines describe sample actions, resources, tools, and community examples for each cluster and factor. In recognition that the use of the T*H*R*I*V*E toolkit takes place within a community process, the guidelines also provide *general* information designed to strengthen community resilience efforts including considerations about using the T*H*R*I*V*E toolkit, a description of a planning process and associated tools, issues to consider about every factor, and general tools and resources.

Next Steps
T*H*R*I*V*E offers communities an alternative way of viewing the environmental factors that influence health and well-being. The toolkit can be utilized as a learning tool, as a strategic planning tool, and as a needs assessment tool. Expert panel members consider the community resilience assessment tool to be complete and feel that it has immense value and utility in diverse communities. Panel members expressed the importance of bringing T*H*R*I*V*E to various governmental agencies and community-based organizations. They asserted that the pilot events provide a strong case regarding T*H*R*I*V*E's applicability and utility in fostering and promoting healthy individuals and communities. Having concluded that the tool has utility and value, expert panel members emphasized the need to distribute the tool widely (outreach and dissemination), and to get it widely used effectively (bringing it to scale). An important element that emerged is the long-term need for tracking the use of T*H*R*I*V*E and understanding how it is being used and to what effect. Each of these is described in the chart at the end of the executive summary. Expert panel members think it is important to identify other opportunities and resources within OMH and in other places such as with the Centers for Disease Control and Prevention (CDC) and foundations to accomplish the next steps that they recommended.

Conclusion
All members of a community are affected by the poor health status of its least healthy members.[3] The U.S. has a history and continued practice of deeply-rooted personal and institutional biases directed against people of color in key elements of community life, such as employment, housing, the justice and education systems, public health and health care. Therefore, it is not

surprising that there are disparities in health. Indeed, given the history of inequality and the resulting disparity in opportunity, health disparities are currently a predictable and persistent problem.

T*H*R*I*V*E provides a framework for identifying and addressing community conditions that can improve health outcomes and close the health gap. The framework translates research into a conceptual model that people can understand and into a toolkit that enables people to identify specific factors and concrete actions that will make a difference in communities. T*H*R*I*V*E works for a variety of health issues and fosters solutions that simultaneously address multiple health concerns. One of its unique contributions is its emphasis on resilience, building on community strengths and encouraging community leadership to foster positive change and close the health gap.

The T*H*R*I*V*E national expert panel identified ways that T*H*R*I*V*E can help close the health gap. There was clear consensus abound the importance of emphasizing a resilience approach and building on strengths in disenfranchised communities to reduce disparities. Further, the panel emphasized the need to track this approach and associated data over time to build a stronger science and practice base for minority communities. Other ways the tool can be emphasized to help close the health gap included: 1) Changing the way people think about health and safety, 2) Providing an evidence-based framework for change; 3) Building community capacity while building on community strength; and 4) Fostering links to decision makers and other resources

Reactions from the pilot process and the expert panel confirm that this approach has great resonance. It links the ways that poverty, racism, and other forms of oppression play out at a community level to a practical approach to health promotion. Synthesis research by the Institute of Medicine and others has documented the powerful influence of social and environmental influences on health. Now that these factors are recognized, effective public health practice demands that they be addressed to reduce the prevalence of racial and ethnic disparities in health. T*H*R*I*V*E is one tool with demonstrated utility for doing so.

There is a great risk that the prevalence of disparities may increase as the population becomes even more multicultural. As the country becomes increasingly diverse, the reality of a healthy and productive nation will increasingly rely on the ability to keep all Americans healthy and eliminate racial and ethnic disparities by improving the health of communities of color. Health care is among the most expensive commitments of government, businesses, and individuals. Illness and injury also generate tremendous social costs in the form of lost productivity and expenditures for disability, worker's compensation, and public benefit programs. Eliminating racial and ethnic health disparities is imperative both as a matter of fairness and economic common sense. This tremendous challenge can—and must—be met with a focused commitment of will, resources, and cooperation to make change happen.

Recommended THRIVE Next Steps
From Expert Panel Members

	Recommended Activities	Audiences
Publications	• Publish articles in professional journals, such as the *American Journal of Public Health* and the *Journal of Health Behavior and Promotion* • Publish articles in newsletters	• REACH 2010 grantees • Foundations • Foundation and government grantees • Federal, state, and local government agencies and departments • Housing authorities • Public health directors • City and urban planners • Transportation agencies and groups • Transportation Research Board • National Governors Association • Annual Mayors Conference • Conference of Legislators • National Association of Community Health Improvement • National Association of City and County Health Officials (NACCHO) • American Public Health Association (APHA) • American Planning Association • State public health associations • Graduate and professional schools • Medical practitioners • Public health practitioners • Social workers • Community-based organizations • Coalitions
Presentations	• Present at association meetings • Present at conferences	
Training and Technical Assistance	• Create a training of trainers program to ensure quality and effectiveness of the toolkit • Create a training certification program to ensure fidelity and quality of the toolkit • Hold satellite trainings across the country to engage a larger audience on the importance of a community resilience approach and on THRIVE • Provide training on ways to build effective coalitions with sectors that cut across THRIVE. • Facilitate community groups to use THRIVE products, and methodology • Translate the toolkit into different languages and provide appropriate material and consulting	
Electronic Technology	• Share information about the toolkit on various list serves • Create a video that highlights the power and efficacy of the toolkit that might include testimonies from the pilot sites and PEP	

	• Create a web-based application of the toolkit • Create a CD-Rom of the toolkit and its effective usage	
Data and Evaluation	• Highlight examples from communities and other groups that have successfully used a resilience approach to improve health or safety, (e.g. case studies and success stories) • Collect and assess long-term data that helps build the science and practice-base for community resilience approaches including THRIVE • Create a mechanism to collect data on the use of the toolkit to determine how it is being used, who is using it, its most effective uses, and what additional materials, training, and technical assistance might be of value	• Graduate and professional schools • Universities • Foundations • State and local health departments • Research organizations

I. Introduction

> *The concern, first expressed in Healthy People, was to look at all problems with a high morbidity and thus a threat to the public's health, and to develop strategies to lower both the incidence and the prevalence. If, however, we look at illness in a different way, we will see that the context of the illness is often the more important issue. To look at illness and ask… what are all the factors involved, is often tremendously complex. The community issues range from access to participation in the solution, from treatment programs to policy and from education to use of specialists. A need exists for infrastructure to make systems work, comprised of hard infrastructure of roads, communication, water and sewage and soft infrastructure of governance both formal and informal.*[4]
>
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Under contract with the U.S. Office of Minority Health, Prevention Institute developed a community resilience assessment toolkit, T*H*R*I*V*E, to help communities bolster factors that will improve health outcomes and reduce disparities experienced by racial and ethnic minorities. The tool is grounded in research and was developed with input from a national expert panel. It has demonstrated utility in urban, rural, and suburban settings. Within months of piloting, several communities had initiated farmers' markets and youth programs, among other outcomes. T*H*R*I*V*E provides a framework for community members, coalitions, public health practitioners, and local decision-makers to identify factors associated with poor health outcomes in communities of color, engage relevant stakeholders, and take action to remedy the disparities. Now that the toolkit has been developed and demonstrated utility, the next steps are disseminate it and to provide the necessary training and technical assistance.

This report provides an overview of the project, including conceptual background information, a review of existing resilience efforts, research that informed the tool, a description of the project's methodology, a description of the pilot events and outcomes, and recommendations for next steps. At its year two meeting, the Project Expert Panel asserted that T*H*R*I*V*E has demonstrated utility and that it should be made available to the public as soon as possible. Further, the panel highlighted the value of training and technical assistance to ensure that the toolkit is put to maximum use.

The Health Disparities Challenge

Poor health and safety outcomes, including chronic disease, traffic-related injuries, mental illness, substance abuse, teen pregnancy, and violence are disproportionately high among low-income people and people of color in the United States.[5] The impact of racism and oppression increases numerous risk factors for illness and injury, including reduced access to fresh nutritious foods, fewer opportunities for physical activity, greater exposure to environmental toxins, and substandard housing and neighborhood conditions.

The National Institutes of Health defines health disparities as the "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[6] When elements of race, poverty, and environment converge, the confluence of these factors leads to greater overall threats to health. Among those that live in poverty, which affects almost every aspect of health, people of color are disproportionately represented.

Racial and ethnic disparities in health are evidenced by comparing outcomes for different groups on almost any indicator of health, such as life expectancy, disease and injury rates, or health care usage. For example, age adjusted death rates for all causes in 2000 for Caucasians was 852.1 (per 100,000 individuals) while for African-Americans it was 1,129.9, 696.8 for Alaska Natives, 507.4 for Asian/Pacific Islanders, and 585.6 for Hispanics.[7]Measuring the 'years lost' before age 75 also reveals similar disparities. For every 100,000 people in a given population, the number of years lost for Whites were 7028.9 years, 13,177.3 years for Blacks, 9,471.9 years for Native Americans, 3,928.5 years for Asians/Pacific Islanders, and 6284.4 years for Hispanics.[8]

Health disparities are not the result of specific populations experiencing a *different* set of illnesses than those affecting the general population. Rather, the overall susceptibility to disease is greater and illness rates are higher due to a broad range of environmental conditions. The chief underlying cause of health disparities is increasingly understood to be social and economic inequality; i.e., social bias and institutional racism, limited education, poverty, and related environmental conditions that either directly produce ill health or promote unhealthy behaviors that lead to poor health.[9,10,11]

Far more than air and water (the 'natural' environment), the environment is "anything external to individuals shared by members of the community," including community behavioral norms.[12] In an analysis of the forces influencing health outcomes, environmental conditions were determined to be "by far the most potent and omnipresent set of forces."[13]

Some of these environmental conditions directly cause ill health. For example, toxins in the environment can cause cancer and chemicals and other pollutants in the air can trigger asthma. In other cases, the environment influences behaviors that can lead to ill health or injury. For example, poor choices about diet and physical activity, which account for approximately a third of premature deaths in the U.S., are not just based on personal preference or information about health risks. An individual will have a harder time changing his behavior if he lacks sufficient income to purchase food, is targeted for the marketing of unhealthy products, and does not have access to healthy foods. Similarly, it is much harder for people to be physically active when streets are unsafe and there are few gyms or parks. Targeting even one of these environmental conditions could contribute to decreasing rates of disease and disparities in health. T*H*R*I*V*E delineates a series of environmental factors at the community level.

II. METHODOLOGY

Prevention Institute utilized a five-part methodology in the development and testing of the Toolkit for Health in Resilience in Vulnerable Environments (T*H*R*I*V*E). This methodology included an environmental scan, the formation of a national Expert Panel, the development of the T*H*R*I*V*E assessment tool, the pilot testing of this tool in three communities around the country, and the development of a set of preliminary guidelines.

Environmental scan: Prevention Institute first conducted an environmental scan, which included a review of existing literature, a review of available resources for assisting communities in the development of resiliency-based approaches, as well as a series of informant interviews. Particular attention was paid during this process to *Healthy People 2010* leading health indicators and to the relevance of resilience factors to ethnic minority populations and communities of color. The environmental scan and accompanying interviews also focused on health disparities, on those community resilience factors that influence illness, disease and injury, and on practical strategies for promoting these factors.

The community factors delineated in the environmental scan are based on an iterative process conducted by Prevention Institute from July 2002 - March 2003. The process consisted of a scan of peer-reviewed literature and relevant reports and interviews with practitioners and academics as well as an internal analysis that included brainstorming, clustering of concepts and information, and a search for supporting evidence as the analysis progressed. The literature scan began with medical condition, *Healthy People 2010 Leading Health Indicators,* and the 'actual causes' of death and searched for subsequent information that linked the medical issues with social, behavioral, and environmental elements.

Based on the findings of this scan and analysis, the authors identified a set of twenty community factors that could be linked to California's priority medical issues through research. Further, the authors clustered the factors into the following four interrelated clusters: built environment, social capital, services and institutions, and structural factors. Though developed independently, the four clusters reflect those delineated by PolicyLink in a November 2002 report entitled *Reducing Health Disparities Through a Focus on Communities* following a literature review and interviews with forty community based practitioners.[14]

While people may use different words to describe each of the factors represented and may cluster key concerns in different ways, the factors and clusters reflect the available literature about the underlying factors contributing to health outcomes. There is some overlap between the clusters, and some of the specific factors could arguably be placed in more than one cluster. For simplicity, each factor is only listed once and factors are generally placed in the cluster that is most supported by research.

The results of this process were summarized in Prevention Institute's environmental scan, which was then reviewed and approved, following an initial revision, by the project's Expert Panel.

The formation of a national Expert Panel: Prevention Institute convened a national Expert Panel whose role was to strengthen T*H*R*I*V*E and its collateral products, to track the project's

overall progress, to provide input on the process of tool development, and to make recommendations about tool dissemination and next steps. Prevention Institute recommended individual Expert Panel members and The Office of Minority Health made final selections. Expert Panel members were selected based on the following criteria: a depth of knowledge and experience related to issues relevant to the project (e.g. health disparities, resiliency, and/or community changes); an interest in and willingness to partake in work and openness to spreading the word about the tool and project findings, a strong understanding of advocacy/community needs, and strong conceptual thinking skills with the ability to think beyond own area of expertise. The selection of individuals for the Expert Panel also sought to create balance between genders, between academic/government/community perspectives, among expertise in content areas, in geographic representation, and between individuals who approach health issues from a broad perspective versus a medical model. Individuals were also selected because they brought credibility to the project through leadership, visibility to project, as well as viewpoints or perspectives that complemented those of the rest of the panelists.

Panel members included representatives from relevant local, state and federal government sectors, including planning, transportation, housing, and social capital. They also included donor representatives, and professionals with experience in community development, community assets and resiliency, health disparities, participatory evaluation, ecological analysis, and community prevention interventions. Each of the pilot communities had representatives on the panel. The panel met twice in the two-year project and reviewed and provided feedback on materials in between meetings. Some members participated in a subcommittee to plan the three pilot events.

*Development of the T*H*R*I*V*E assessment tool:* The Expert Panel ratified the factors and clusters in the environmental scan, and they were included in the assessment tool. Members also provided input about the tool. Based on this input, a review of existing tools, and building on existing Prevention Institute tools that had shown utility in community planning efforts, the Institute drafted a community resilience assessment tool. The tool was shared with the Office of Minority Health and a subcommittee of the Expert Panel, including representatives from the three pilot sites. Feedback from the Office of Minority Health and the subcommittee was incorporated into a revised tool, which was shared with the subcommittee for final approval and approved by the Office of Minority Health. After the tool was piloted, minor modifications were made on the tool, and these were shared with the entire Expert Panel. Based on the evaluations from the pilot sites and reports from the pilot site representatives, the Expert Panel ratified the tool.

The pilot testing of this tool in three communities: Based on input from the Expert Panel, OMH expanded the number of pilot sites from two to three in order to include one rural site in New Mexico. These three sites were selected in order to create a balance between urban, suburban and rural locations. This expansion meant that the three final pilot sites were located in New York City, Sacramento and Hidalgo County, New Mexico. Prevention Institute recommended and the Office of Minority Health selected each of these sites based on the following criteria: at least two minority groups were represented in the pilot communities, they were low-income or low-wealth communities, their residents were willing to participate in the project, they possessed the willingness and capacity to make change based on the outcome of the pilot event, they had the capacity to form partnerships between residents, coalitions, and/or government, their ongoing

work complemented the tool, community leaders and other key representatives expressed a willingness to participate in the project and to employ the tool, and they represented different stages of asset building (e.g. one community has a high level of assets and one has a low level of assets).

Prevention Institute worked with pilot site representatives from all three pilot communities to plan and implement the T*H*R*I*V*E pilot events. The involvement of the pilot communities in this process was critical in order to learn what changes are necessary for improving T*H*R*I*V*E's applicability at the community level. The methodology behind the pilot events was uniform at all three sites. Each pilot community selected training participants. Prevention Institute also developed a training agenda with the pilot sites and representatives of the Office of Minority Health (OMH) and used the same training curriculum for each of the sites. Following the event, Prevention Institute conducted an evaluation of the pilot process with participants and conducted follow-up interviews with each pilot site. Based on this feedback, Prevention Institute revised the T*H*R*I*V*E tool slightly by changing the order of some of the twenty environmental factors.

Development of the preliminary guidelines: Advice from the Expert Panel members and feedback from the three pilot sites guided Prevention Institute in developing a set of preliminary T*H*R*I*V*E guidelines. The expert panel shaped the format of the guidelines in year one, Prevention Institute conducted a scan of sample actions, tools and resources, and community examples, and the expert panel reviewed the content. In addition to content specific on each factor and cluster, the expert panel provided input on general guidelines that serve as an introduction to the to guidelines. This input was based on outcomes of the pilot events. These guidelines are intended to provide guidance to communities that wish to assess and strengthen the link between resilience and health factors related to the Healthy People 2010 benchmarks. The guidelines are also designed to ensure that T*H*R*I*V*E's potential for reducing health disparities is maximized.

The process used to develop and pilot the T*H*R*I*V*E tool had several potential limitations. The study did not make use of comparison or control communities and although Prevention Institute made efforts, the Office of Minority Health and the expert panel to identify three diverse pilot sites, the small number of pilot events may limit the extent to which the lessons learned from the pilot events can be applied nationwide. In addition, the tool was not translated into any foreign languages and has not been piloted other than in English. Further, although follow-up interviews were conducted with each of the three sites, it is not possible to fully gauge the long-term community impact of the T*H*R*I*V*E tool. Also, because each pilot site selected its own participants, it is possible that the individuals who participated in the pilot events were generally more receptive to incorporating an environmental approach into their community work. Further, not all participants were community members. In New York City in particular, there were only public health officials and community health workers who participated. Though the site found the tool useful, it might also be informative to use the tool with community members in large urban settings to further assess utility in that setting. In the future, it may also be beneficial to pilot the T*H*R*I*V*E tool with other groups such as policy makers, immigrants, and members of the business sector to learn even more about utility in addressing health disparities.

III. BACKGROUND RESEARCH and FRAMING ISSUES

The Role of Primary Prevention in Addressing the Health Disparities Challenge

In their analysis of the most prominent contributors to U.S. mortality, McGinnis and Foege identified a set of factors strongly linked to the major causes of death and referred to these factors as actual causes of death.[15] These actual causes, which are accounted for in *Healthy People 2010*, contribute to approximately half of all premature deaths. Among the leading actual causes are tobacco, diet and activity patterns, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles, and illicit use of drugs. An emerging body of research on the behavioral and environmental determinants of health supports the need to look even further upstream to consider what influences the actual causes. Referred to as 'actual determinants' by Adler and Newman,[16] these influences such as socio-economics, racism, and other environmental factors play a key role in the creation of health disparities. Therefore, reducing health disparities requires strategies that alter these conditions or the ways they play out in communities.

Addressing the underlying causes of disease *before* poor health occurs is called primary prevention. It is distinguished from secondary prevention, which involves taking action when problems such as high blood pressure or elevated blood glucose are identified, and tertiary prevention, which involves intervening to respond to emergencies and prevent recurrences after a traumatic event such as a heart attack or stroke. A primary prevention approach focuses on changing conditions at the community or systems level rather than the individual level. While some individuals are helped through medical services, treating one person at a time will not change the incidence of disease within a specific population or community. Given that health disparities, by definition, affect groups of people, it makes sense to identify and address those conditions that give rise to disparities among different groups of people. Societal structures and policies as well as community factors influence these conditions. This document explores the community factors that can be addressed as a preventive approach to eliminating health disparities.

The Value of a Community Lens in Addressing Health Disparities

People affected by health disparities more frequently live in environments with:

- Toxic contamination and greater exposure to viral or microbial agents in the air, water, soil, homes, schools, and parks
- Inadequate neighborhood access to health-encouraging environments including affordable, nutritious food, places to play and exercise, effective transportation systems, and accurate, relevant health information
- Joblessness, poverty, discrimination, institutional racism, and other stressors
- Targeted marketing and excessive outlets for unhealthy products including cigarettes, alcohol, and fast food.

Therefore, low-income people of color are exposed to the conditions that contribute to injury and illness at disparate rates. Clearly, community conditions such as those described above contribute to poor health outcomes and suggest opportunities for action to improve the health status of

entire communities. Research has now shown that after adjusting for individual risk factors, there are neighborhood differences in health outcomes.[17] According to Dr. Richard Wilkinson, Professor of Social Epidemiology at the University of Nottingham Medical School, "It is now clear that standards of population health are overwhelmingly affected not so much by medical care as by the social and economic circumstances in which people live and work."[18]

T.H.R.I.V.E. features community conditions that influence the *Healthy People 2010 Leading Health Indicators.* These indicators (tobacco use, physical inactivity, overweight and obesity, substance abuse, responsible sexual behavior, mental health, immunizations, violence and injury prevention, environmental quality, access to care) have been linked to eliminating health disparities.[19]

Whether through treatment or education, efforts to improve health have often focused on correcting for or modifying individual behavior. Many of the leading indicators are indications of the influence of behavior on health outcomes like whether to smoke, drink, or use drugs, what to eat, how much physical activity to get, and how careful to be in sexual relations. This is echoed in an analysis by McGinnis, Williams-Russo, and Knickman who, while recognizing that social and environmental factors play a role, assert that 40% of preventable deaths are attributable to behavior choices (tobacco, substance abuse, sexual behavior, and diet and activity.)[20] Behavior surely cannot be ignored, but changing behavior requires understanding what influences behavior in the first place. According to the Institute of Medicine's report on health promotion:

> *To prevent disease, we increasingly ask people to do things that they have not done previously, to stop doing things they have been doing for years, and to do more of some things and less of other things… It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.*[21]

In *Social Perspectives on Risk Reduction,* Henrik Blum reinforces this, noting "getting people to behave…encompasses only a small fraction of the routes to risk reduction and does not stand alone without significant support from major societal mechanisms."[22] While behavior choices are directly associated with a significant share of health outcomes, education focusing on behavior change alone ignores larger environmental factors that can work against the educational message.

Indeed, the role of environmental factors is increasingly recognized in the literature. Schmid, Pratt and Howze argue that people's behavior and the environments that elicit them are the primary cause of today's medical problems.[23] Neighborhood factors such as concentrations of poverty and poor housing are recognized to contribute to health problems in communities of color.[24] An overemphasis on health behaviors in certain populations, such as low-income communities of color, may be misdirected due to the influence of other factors. Lantz, *et.al*. argue that policies and intervention focused on individual risk behaviors have limited potential for reducing disparities in mortality. Rather, they argue, occupational and environmental hazards may contribute more to mortality rates.[25]

Adler and Newman identify socioeconomic status as a key underlying factor of health;[26] lower income levels are associated with a higher prevalence of health risk behaviors, including tobacco use, physical inactivity, and being overweight.[27] However, individual income has been shown to account for less than one-third of increased health risks among blacks.[28] It was hypothesized that segregation and other neighborhood and community factors make up the additional risk. Race-based segregation has also been linked to poor health outcomes.[29, 30] Consequently, an emphasis should be placed on underlying factors, which cannot be addressed at the individual level.[31]

The idea that there are underlying, persistent, and pervasive factors that impact health and safety in communities of colors is noted by Geronimus. She proposes a weathering framework to explain the widespread prevalence of chronic morbidity and mortality among African American women.[32] She postulates that the cumulative impact of social, economic and political exclusion, including exposure to environmental hazards, social stress, repeated social and economic adversity, and family disruption such as early death, results in a 'weathering' whereby health reflects cumulative experience rather than chronological or developmental age. Maternal health influences child health, which in turn sets the stage for adolescence. Adolescence is a period that includes multiple risk factors as well. Indeed, research is showing that early experiences, such as growing up in a low-income family, may increase the risk of heart disease as an adult.[33]

The Institute of Medicine's study that culminated in *Promoting Health: Intervention Strategies from Social and Behavioral Research* affirms the importance of environmental factors and calls for increased attention to them to achieve better health and safety outcomes. The report asserts, "One-to-one interventions do little to alter the distribution of disease and injury in populations because new people continue to be afflicted even as sick and injured people are cured. It therefore may be more cost-effective to prevent many diseases and injuries at the community and environmental levels than to address them at the individual level."[34] A strategy that focuses on changing these kinds of circumstances, or community conditions, can achieve both short- and long-term results in reducing health disparities.

Since people live, work, and go to school in communities, approaches that impact conditions within the community have a good likelihood of impacting health disparities. Approaches aimed at individuals must take effect one person at a time. Addressing community level factors changes the overall environment where people live and has the capacity to impact everyone in the environment. In implementing this approach, communities can address multiple health concerns simultaneously. For example, designing communities in a way that promotes incidental and recreational physical activity can have a long-term impact on rates of diabetes, cancer, and cardiovascular disease. Specific design strategies include increasing the number of safe playgrounds, developing transportation hubs with local commerce, and designing walking trails or cleaning up parks.

The Relationship between Community Factors and HP2010 Leading Indicators

This section delineates eight of the ten Leading Health Indicators from Healthy People 2010 and identifies community level factors that have the potential to act in preventative measures and positively affect health outcomes related to these indicators. In particular, the relationship between each of the eight indicators and factors that must be considered for primary prevention

efforts to succeed in a community are described. Immunization and access to care are not considered in this section because they are closely associated with healthcare and treatment issues. The following eight factors described are tobacco, physical inactivity, overweight/obesity, substance abuse, responsible sexual behavior, injury and violence, environmental quality, and mental health.

Tobacco: Tobacco use is largely associated with local marketing efforts, the social norms within a community or organization, and the availability of tobacco both to minors and adults. As an example of the impact of availability, tobacco can be easily attained at a very early age in American Indian and Alaska Native lands, which as sovereign nations, are not subject to laws prohibiting the sale of tobacco to minors.[35] This results in a 50% smoking rate among Native American youth, which is considerably higher than other races or ethnicities.[36,37] Further, tobacco is disproportionately marketed and promoted in ethnic communities.[38] Research confirms that the community's attitude, or norms, about tobacco -- which is influenced by marketing, among other factors -- and is predictive of individual attitudes.[39] Other social conditions interrelate with tobacco use; research suggests that low-income women use smoking to help them cope with economic stress and care taking responsibilities.[40]

Physical inactivity: Community and street design, availability of recreational facilities, transportation options, and real and perceived levels of community safety influence physical activity levels.[41] For instance, a CDC analysis of the National Health Styles survey indicated that traffic danger and crime danger accounted for 58% of identified barriers for children walking or biking to school.[42] Further, the greatest association between higher levels of physical activity and perceived levels of safety occurs for racial/ethnic minorities and people over 65.[43]

Overweight/obesity: Overweight/obesity is largely accounted for by physical activity and diet patterns. Availability and affordability of food, transportation, media and marketing, and norms[44] influence diet patterns. Importantly, research links the presence of a supermarket (versus only convenience stores) in African American communities with significant increases in nutrition levels.[45]

Targeted marketing accounts for a proportion of the recent rise in childhood obesity rates.[46] The American Academy of Pediatrics has noted that children who watch a lot of television are more likely to be overweight.[47] This association is attributed both to a lack of physical activity and commercials that depict unhealthy food without any information about healthy food. While use of media entertainment is frequently viewed as an individual decision, it has been shown that the availability of recreational facilities and afterschool programs decrease television viewing. For example, a study conducted in 1996 found that fifty-three percent of children in the Los Angeles 4-H after-school program said they would watch more television if they were not at 4-H.[48]

Substance abuse: Substance use is associated with access to alcohol or illegal substances in the community, the marketing of alcoholic beverages, social cohesion, and norms around substance use,[49] particularly with minors. For example, alcohol access (the presence of distributors in a community) is correlated with per capita consumption.[50] In recognition of the impact of marketing on alcohol consumption, alcohol ads have been banned from television, and alcohol billboards have been banned from certain areas in the cities of Baltimore, Oakland, and San

Diego.[51] However, billboards for alcohol and tobacco are more predominant in minority neighborhoods; a study of one Latino community reported that, "children see as many as 60 alcohol ads on a one-way trip between school and home."[52]

Research indicates that social cohesion and support within the community aid in reducing rates of substance use by youth. Specifically, researchers found that "by creating scales with indicators of norms, role models, opportunities, and social support that were aggregated at the community level... community-level norms and role models accounted for nearly 50% of the variance in eighth grade alcohol use rates."[53]

Responsible sexual behavior: Marketing and media, norms around sexual responsibility and gender within the community, and social cohesion influence sexual behavior. According to the American Academy of Pediatrics, television exposes children to sex but does not show the risks and results.[54] Further, norms related to both male and female roles may promote sexual risk-taking or unwanted sexual behaviors. Alcohol billboards (described above) far too frequently exacerbate irresponsible sexual behavior by associating it with their promotion of alcohol.[55]

Injury and violence: Community design, transportation options, media, and social relationships are all associated with injury and violence. For example, Crime Prevention Through Environmental Design (CPTED) has developed guidelines for designing buildings and streets to reduce crime and violence levels.[56] Street design also impacts transportation injury rates and pedestrian safety. Street width is the most predictive factor of car crashes; as streets get wider and speed increases, the number of crashes per mile increases.[57] As many as 60% of pedestrian deaths appear to happen in places where there is no crosswalk.[58] Further, when there is significant mass transit, car use in a neighborhood will be reduced.

Research shows that television violence affects the thoughts, feelings, and actions of viewers.[59]17 Media violence has been shown to cause aggression, fear and mistrust, callousness and desensitization toward violence, and the "learned desire for further violence involvement of greater frequency and intensity."[60] Levels of social connections have also been shown to impact homicide and suicide rates.[61,62]

Environmental quality: The quality of air, water, and soil is impacted by local transportation options, local industry/commerce, and community members organizing to take on environmental issues. For example, motor vehicles account for the main source of ground-level urban concentrations of air pollutants with hazardous properties.[63] A European study showed that half of all mortality from air pollution came from motorized vehicles and traffic-related air pollution accounted for more deaths than traffic crashes.[64] Further, exposure to environmental toxins is impacted by housing and work conditions. Low-income communities of color have a higher prevalence of being located in polluting sites than other areas[65] and are disproportionately located near industrial and toxic waste sites.[66] While low-income communities of color are disproportionately impacted by poor environmental quality, there are examples of community members coming together to insist on clean-up or ensure that hazardous facilities are not built.

Mental health: Mental health is associated with social connections, housing, appropriate services, and local venues for people's artistic expression. Social support can be a key factor in

reducing the incidence of mental illness, particularly depression. For example, strong levels of social connections within a neighborhood are predictive of lower suicide rates.[67] Other research has demonstrated reductions in reported symptoms of depression following an improvement in housing conditions and/or location.[68]

While the Surgeon General's supplemental report on mental health and disparities attributes disparities to differences in access to treatment, there is growing evidence about the efficacy of a number of programs that prevent the onset or recurrence of mental disorders. These programs may not be as readily available in low-income communities. The Federal Substance Abuse and Mental Health Service Administration's *Building Mentally Healthy Communities* initiative has promoted such evidence-based programs at the community level and early evidence is showing a result not only with children and high-risk populations, but positive results in school environments.[69] Finally, interviews with community-based practitioners have noted the impact of racism on mental health, particularly chronic stress and internalized racism, which contributes to feelings of hopelessness, depression, suicide, and substance abuse.[70]

IV. THE COMMUNITY RESILIENCE LANDSCAPE

Advancing a Resilience Approach

When crafting approaches that seek to improve health outcomes, it is important to focus on both risk and resilience. Risk factors are characteristics or circumstances that increase the likelihood that people within the community will experience poor health and safety outcomes. Resilience is the ability to thrive despite the presence of risk factors.

The effects of risk and resilience factors on health and safety are interactive and cumulative. Not everyone exposed to risk factors will be impacted but those who are exposed to multiple risk factors are at greater risk. The combination, frequency, and severity of risks influence whether or not problems develop. Further, no single risk or resilience factor accounts for much by itself. Rather, poor health and safety outcomes within a community are more generally accounted for by an overwhelming accumulation of risk without a compensatory accumulation of resilience factors. Studies show that resilience factors can counteract the negative impact of risk factors.[71,72] For instance, while a high availability of firearms and alcohol within a community is a risk factor for violence, positive social norms can provide social controls that are protective against the use of weapons. One study demonstrates that the effects of protection on reducing problem behaviors become stronger as levels of risk exposure increase.[73] In effect, resilience factors moderated the negative effects of exposure to risk. Effective approaches need to include attention to both risk and resilience.[74,75] Addressing risk factors results in the absence of factors that threaten health and safety, however, it does not necessarily achieve the presence of conditions that support health. Consider the following examples:

- The proliferation of fast food and junk food is a significant risk factor for poor nutrition and steps to minimize marketing and availability are important aspects of an overall approach. However, it is equally important to ensure that there is availability of safe, healthy, affordable and culturally appropriate food in a community as well.

- It is important to clean up toxic sites that put people at risk for exposure. Further, it is valuable to utilize the cleaned up site as a resource for the community. For instance, it could be developed into a playground for local children or a locally-owned business. These options promote healthy outcomes for the community.

Current prevention strategies have focused largely on reducing risk factors. This is an essential aspect of prevention, but an equally important element is building upon and enhancing positive factors in communities. Given the preponderance of attention to risk factors, *T.H.R.I.V.E.* highlights resilience factors that support health and safety outcomes in communities. Building community resilience goes beyond secondary and tertiary interventions and approaches to address the issues out of which health disparities arise. Enhancing community resilience factors can have long-term, positive impacts on individual and community health and such factors can also serve as interim benchmarks in meeting Healthy People 2010 goals.

Definitions and Concepts

The term resilience brings with it different meanings and connotations. These range from the ability to bounce back from or respond to adversity, to connoting a developmental process in which full potential is realized, to implying a focus on strengths and assets. Although resilience is often associated with individuals, the term has also been applied to communities, families, and institutions.

According to the Atlantic Health Promotion Research Centre at Dalhousie University in Canada, communities are resilient when they respond to a crisis or to significant adversity in a way that strengthens the community, its resources, and its capacity to cope.[76] Communities that possess resilience are better prepared when tragedy occurs and/or when disaster strikes. For example, following the September 11th attacks, numerous projects were created to help individuals and communities cope, such as *The Community Resilience Project of Northern Virginia* and *Project Liberty of New York City*. While the entire community experienced the trauma, the response of these efforts was largely individually focused. These projects provide referrals, education, and counseling services to individuals, groups, and communities most affected by the attacks. *The Community Resilience Project of Northern Virginia* defines resilience as "the ability to recover from misfortune and bounce back."[77] Related to projects created following the September 11th attacks were those created around Y2K. The city of Berkeley, CA created the *Y2K Resilience Network Launch Emergency Preparedness Countdown*, which was a series of community workshops, meetings, and forums that brought together Berkeley residents and community groups to develop an overall strategy in the event of Y2K complications.

Another example of a community coming together was in 1998 when British Columbia experienced enormous plant closures that negatively impacted individual and community livelihood. In response to these plants closings, an economic development organization called *The Center for Community Enterprise* based in British Columbia developed the *Community Resilience Manual: A Resource for Rural Recovery & Renewal*. This manual specifically helps rural communities improve their social and economic outlook by assessing their own state of resilience and creates priorities for strengthening it. The manual addresses the concept of community resilience, which it defines as "a community that takes intentional action to enhance

the personal and collective capacity of its citizens and institutions to respond to and influence the course of social and economic change."[78] They have also identified four dimensions of resilience related to communities, which are: 1) people in the community, 2) organizations in the community, 3) resources in the community, and 4) community process. Each of these dimensions has characteristics that make a community resilient. These characteristics include community leadership that is diverse along age, gender, and cultural background, community pride, optimism, partnerships and collaboration, employment, community economic development, and ongoing action to achieve long-term and short-term community goals. Community resilience is about empowering residents, instilling leadership, and building connections with community members, and community and governmental organizations.

Many recognize community resilience as an approach that builds upon community assets or strengths. For example, *The Connecticut Assets Network (CAN)* in Wethersfield, Connecticut is a grassroots organization of citizens and organizations that work to encourage the successful use of asset-based strategies for community development. CAN believes that, "the assets approach uses the resources and assets of individuals, organizations, and communities as the building blocks of successful health promotion strategies." Their approach does not just look at problems and weaknesses of a community, but rather focuses on building existing community assets and strengths.

According to the National Charrette Institute, resilient communities that promote health and safety often work towards improving the social, economic, and physical well being of their people, places, and natural environments. [79] They are communities that work to enhance existing resilience factors such as daily physical activity, social cohesion and trust, safe streets that include walking paths and trails for residents, and transportation options that reduce automobile congestion and encourage economic, social, environmental and cultural sustainability.[80]

The Community Resilience Working Group was formed to delineate a set of asset-based community factors that could be fostered as part of a comprehensive youth violence prevention plan.[81] The group members recognized the prevalence of a focus on community risk factors, such as firearm and alcohol availability, without a complementary focus on strengths. Further, the group recognized that some efforts to promote resilience focused on process outcomes, leaving community practitioners unsure about how to foster assets. As a result, the draft framework delineated best and promising practices to promote community resilience to reduce youth violence, such as promoting service learning opportunities and job training apprenticeships. The framework also included attention to ensuring that community factors fostered individual resilience factors including supportive relationships, high expectations, and opportunities for meaningful involvement.

The combination of these concepts and definitions contributes to the definition of resilience for this project. Fundamentally, T*H*R*I*V*E acknowledges that communities have strengths and assets that, when fostered, can provide powerful opportunities to promote health and well being. Further, by focusing on health disparities, this project acknowledges that certain groups of people live in vulnerable environments in which there may be greater health risks. Therefore, it is critical to define the positive elements that will enable people to bounce back from these risks or to thrive in spite of them. For the purpose of this project, 'community resilience' is defined as:

the ability of a community to recover from and/or thrive despite the prevalence of risk factors. (Please see Appendix F for a synthesis of why a community resilience approach can help eliminate disparities.) Such resilient communities also take the necessary steps to create positive and lasting economic, social, and environmental change. Just as youth development approaches address the quality of settings (environments) for young people, a community resilience approach addresses the quality of the overall environment in which people live and work. Community resilience factors are those elements within a community that foster safety and well-being and negate the detrimental impact of risk factors. In fostering these factors, there is an implicit understanding that strengthening the environments in which people live will improve health and safety, while also fostering individual resilience factors.

Review of Existing Resilience Efforts

In recent years, there has been increasing attention to the subject of resilience. In addition to those described above, several individuals and institutions are recognized as the leaders in these efforts. The Search Institute has identified a groundbreaking list of key community assets; John McKnight has promoted methods for mobilizing assets in communities; and Karen Pittman, Bonnie Benard, and Annie Sullivan have developed resilience-focused approaches to youth development within schools and communities. This project will build on the work of these pioneers and the efforts described in the following pages.

Centers for Disease Control, Prevention Research Centers
The Centers for Disease Control has funded a set of four Prevention Research Centers across the U.S. to develop a survey instrument to assist communities in promoting health and justice outcomes. Funded sites include Tulane University, University of Illinois, Chicago (UIC), St. Louis University (SLU), and University of New Mexico (UNM). The fundamental purposes of this survey instrument are to 1) develop a measure of community assets with scientific properties and 2) develop a dialectic instrument that can be used with communities. This project is focused specifically on developing measures that can be used by community-based initiatives in advancing their mission and goals. The survey instrument focuses on measures of leadership, organizational capacity, and ability to translate capacity into action. The results from this survey then can be used in strategic planning for community groups. Phase one of the project was recently completed (as of February '03), which consisted of developing and testing the instrument. The next phase of the project is to analyze the survey for validity and reliability. The final phase of the project includes working with community partner organizations to field test and implement the survey.

Different project sites have worked with different communities and organizations during the development and testing of this tool, including rural African American coalitions in Missouri (SLU), pueblo communities in New Mexico (UNM), community-based initiatives and neighborhood groups in Louisiana (Tulane), and urban community-based organizations with institutional connections in Chicago (UIC). St. Louis University (SLU), in St. Louis, MO, has been working with African American coalitions in both rural Missouri and in St. Louis city. SLU's work in rural Boothill, MO, has focused on helping local coalitions become more effective in their work. Findings from this work indicate that the effectiveness of coalitions is influenced by broader influences, such as racism and economic development, which affect their

ability to garner resources and set priorities. In response to the needs identified by these coalitions, SLU has assisted them with increasing community leadership and leveraging resources, such as setting up mini-grants to community groups in order to assist them in setting and acting on self-determined priorities. For example, in response to the institutional racism within schools, one coalition set up mentoring programs through community churches and community-based organizations. SLU has also implemented this tool with the Interfaith Partnerships, a health ministry group in St. Louis. This group has focused on creating an infrastructure to reduce obesity rates in the city. In response to the finding that grocery stores in St. Louis have decreased by 50% in the last 10-15 years, the group is setting up grocery-like training facilities to help local residents establish and run grocery stores in the area. This project also trains community members on nutrition issues and provides cooking demonstrations to promote improved nutrition.

Illinois Violence Prevention Authority

The Illinois Violence Prevention Authority (IVPA) is a nonpartisan, supervisory branch of the Illinois Department of Public Health that coordinates violence prevention and other related activities within Illinois State government. IVPA is currently launching a three-year grant called *Safe to Live* for or in community organizations in several communities in Illinois. The purpose of this project is to assist local communities in developing strategies to create healthier and safer environments by taking into account both the risk and resiliency factors in communities. The communities have been chosen according to a set of criteria that include attention to rural/urban considerations, existence of strong partnerships between local organizations, and capacity to make change.

This project is currently in the first of three years. Year one is focused on orientation for grantees, conducting a community needs assessment of risk and resilience factors, and preparing for the strategy process. The orientation sessions will include information on risk and resilience factors, health promotion and disease prevention, and the importance of adopting a comprehensive approach. Year two will focus on strategy development and year three will continue with strategy implementation and evaluation of the project. The project also includes an interdisciplinary state-level technical assistance coalition. Representatives from various state coalitions, including public health, human services, justice, and education, will assist communities in strategy development and implementation.

Health Realization Institute/Visitacion Valley Project

Health Realization Institute, Inc. (HRI) is an educational institute in California that provides training and consulting services to government and nonprofit and corporate organizations on the issues of personal resiliency and community capacity building. *The Health Realization Institute* (HRI) is dedicated to advancing the principles underlying and shaping human experiences. According to Dr. Roger Mills, the Director of HRI, the Principles of Mind, Consciousness and Thought work together before the form of our thinking, feelings, and behavior to construct our resulting outlook and motivate our actions. As people recognize how reality is created through the moment by moment weaving together of these Principles, they also realize their own resilience, their wisdom and beauty, and their genuine potential for a healthier life.

Health Realization Institute, Inc. has worked with residents in a number of economically and otherwise disadvantaged communities in cities that include Miami, Chicago, San Francisco, Oakland, and New York City. HRI focuses on building community capacity by increasing collective efficacy through counseling and motivation techniques for individual community residents, service providers, and community organizations. HRI then assists communities in channeling this increase in collective efficacy into a community organizing plan based on the community's self-determined needs.

One of HRI's current efforts is a comprehensive community revitalization project in Visitacion Valley, one of San Francisco's poorest and more disadvantaged communities. This neighborhood is the site of one of the largest, most crime-ridden and impoverished public housing developments (close to 800 units) and several other low-income housing complexes. This area had one of the highest rates of unemployment, crime, violence, family dysfunction, delinquency, and school failure in the city. The Visitacion Valley Community Resiliency Project began operation in January 2000 with the hiring and training of residents who themselves had only recently completed welfare-to-work programs, addiction treatment or who had been incarcerated for drug trafficking. HRI staff trained local leadership in its resilience framework and then trained them to conduct outreach to others in their community. An evaluation of the project reveals that, by the end of April 2001, over 500 residents had been reached via outreach activities. Over 150 residents had participated in the "personal empowerment and leadership" classes and 82% of the respondents reported that the classes significantly helped them feel less isolated from others.[82]

Search Institute

Search Institute is an independent, nonprofit organization whose mission is to advance the well being of adolescents and children by generating knowledge on developmental assets and promoting their application to social and health issues. To accomplish this mission, the institute generates, synthesizes, and communicates new knowledge, brings together community leaders, and works with state and national organizations to advance an agenda that includes attention to positive development as well as risks. Search Institute's strategy is based on a framework of developmental assets, which are the positive experiences, relationships, opportunities, and personal qualities that young people need to grow up healthy, caring, and responsible. The Institute's work has focused on five major areas: research, communications, networking, community support, and training.

In 1996, Search Institute launched the *Healthy Communities, Healthy Youth* initiative. The goal of this initiative is to motivate and equip individuals, families, organizations, and communities to work together to build developmental assets for and with children and adolescents. Instead of focusing only on reducing risks and intervening in problems, Search Institute is assisting communities to rebuild a social foundation that supports the healthy development of all young people.

University of Michigan

Dr. Gilbert Gee, at the University of Michigan School of Public Health, worked with a group of students to conduct an assessment of community issues in Flint, MI. Flint is a fairly segregated, primarily African-American community in central-lower Michigan. The project consisted of the

development of an assessment instrument and the collection and analysis of qualitative data from community residents. This assessment consisted of several questions that focused on resident concerns, community strengths and community resources, including transportation, health care, and availability of services, and pressing community health issues. The assessment was conducted in partnership with the local health department and school district and was administered through distribution of surveys to parents of local school children. Although Dr. Gee's project was not administered with strict experimental design, several of the findings from his research support the Community T*H*R*I*V*E project. Respondents listed the following as their top five community strengths: 1) community cooperation, 2) schools, 3) community activities/after school programs, 4) religious organizations, and 5) physical condition of the community.

The Community Toolbox: Bringing Solutions to Light

There is a web-based organization, *The Community Toolbox: Bringing Solutions to Light*, which is maintained by the University of Kansas, Work Group on Health Promotion and Community Development. Their mission is to promote community development and health through connecting people, ideas, and resources. They developed a toolbox called *Identifying Community Assets and Resources*, which outlines the importance and effectiveness of emphasizing what a community has rather than what it is lacking. It focuses on the importance of using an asset and strengths based approach when trying to improve overall community well-being. In the toolbox, community assets are defined as "anything that can be used to improve the quality of community life."[83] These assets can be an individual, a business, a physical structure or place, and/or everyone living in the community.

Analysis of Gaps in Existing Resilience Efforts

Numerous organizations have focused on resilience rather than risk, however, attention is generally given to individual assets, not to community level assets. To the extent that community-oriented assets are addressed, they tend to be defined as assets that build individual resiliency rather than being targeted at environmental conditions within a community. Other efforts, such as those in university settings, have focused on one or several factors, but have not usually broadened their scope to look at the relationship between a multitude of community factors and their relationship to health. This is not surprising given the research nature of their work. Thus, a scan of the community resilience landscape highlights the need for a practical tool that can assist communities in identifying and increasing those resilience factors related to the health of their community.

V. COMMUNITY RESILIENCE FACTORS

This section details community conditions that might be amenable to change to reduce or eliminate the toll of health disparities. As Larry Wallack and Lori Dorfman have asserted, "Real improvements in health status will not come so much from increases in personal health knowledge as from improvements in social conditions."[84] It is critical to focus on improving community conditions that will have an impact. The factors delineated present an opportunity for communities to focus on their strengths and to foster them. Further, as low-income communities of color become healthier, they are more likely to act on their own behalf: creating green space,

improving schools, and building hope—all of which can gradually lead to improved social equality.

The factors delineated here are based on findings of the environmental scan and were clustered by the authors into the following four categories: built environment, social capital, services and institutions, and structural factors. The title of the tool is *T*H*R*I*V*E: Toolkit for Health and Resilience In Vulnerable Environments.*

Many of the factors are indicative of a risk-resilience continuum. That is, the presence or absence of something may represent a community risk and the opposite a resilience factor. For example, a lack of economic opportunity is a risk factor, whereas the presence of economic capital, such as living wage jobs and the availability of loans, represents a resilience factor. Resilience, however, cannot always be represented on a continuum with risk. For example, removing a weapon from a gang member represents the elimination of a risk factor. Fostering resilience means more than the absence of a weapon, and might mean pairing the gang member with a mentor or replacing the weapon with a paintbrush, book, or computer. While the overall emphasis of the following list is on resilience, there are several factors that primarily address risk factors, in particular, environmental quality and product availability. Such factors are included in the list for two reasons. First, these factors pose a particularly high risk to low-income communities of color, and any community effort to address health disparities must consider the relative weight of them within that community. Second, the clusters and community factors delineated here are intended to represent an inclusive list of community conditions that impact health and safety, which is intended to assist communities in their planning process. Rather than needing to rely on two separate planning tools, the range of issues represented here should help communities identify key needs and strengths. A process of community planning can then build upon existing resilience factors and address other factors contributing to health and safety among the population.

Delineation of Resilience Clusters

Built Environment
Activity-Promoting Environment
Nutrition-Promoting Environment
Housing
Transportation
Environmental Quality
Product Availability
Appearance/Ambiance

Social Capital
Social Cohesion and Trust
Collective Efficacy
Civic Participation/Engagement
Positive Behavioral/Social Norms
Positive Gender Norms

Services and Institutions
Public Health, Health, and Human Services
Public Safety
Education and Literacy
Community-Based Organizations
Cultural/Artistic Opportunities

Structural Factors
Ethnic/Racial Relations
Economic Capital
Media/Marketing

In general, the following can be said about these factors:

- **Each of the factors influences health and safety.** Some have a direct influence on health and safety. For example, modifying transportation design can directly impact asthma rates and pedestrian injury. In other cases, factors may have an indirect impact on health. Modifying transportation design also impacts rates of physical activity, and therefore indirectly affects rates of overweight/obesity and cardiovascular disease.
- **Each of the factors is likely to impact more than one of the *Healthy People 2010 Leading Health Indicators.*** For example, improving housing conditions may impact mental health, physical activity, and injury and violence.
- **Strengthening one factor may strengthen other factors.** For example, fostering activity-promoting environments has been shown to impact economic capital.
- **Developmental needs should be taken into account with each of the factors.** For example, different features within a park will foster physical activity among children, teens, and seniors. Younger children benefit from safe and interesting playgrounds, teens may value athletic courts and fields, and seniors may look for safe walking paths. The relative importance of some factors may vary across the life span.
- **Factors have a cumulative effect.** Multiple factors build on each other and the cumulative whole is greater than the sum of individual factors. For example, as neighbors gain more trust in each other, they are more likely to join collectively to take action, which can in turn result in achieving positive outcomes in the community.
- **Results may take a long time.** The Institute of Medicine suggests taking a "long view" of health outcomes.[85] Some of the factors may take a long time to establish, and once established health outcomes may take many years. However, because of the research basis of the factors, progress on each of them can be seen as benchmarks for better health and safety outcomes.
- **Factors must be considered in a cultural context.** For example, social services, food, and artistic opportunities all have cultural aspects that are determine appropriateness for those living in the community.
- **Community factors strengthen individual factors.** There is a reciprocal relationship between individual health and community resiliency: resilient communities foster healthy individuals and healthy individuals foster resilient communities. For example, the presence of social cohesion and trust may translate into more mentors and role models, increasing the chances that children will have relationships with caring adults.

Description of Resilience Factors

The term 'built environment' encompasses man-made physical components such as buildings and streets,[86] and includes land use, public transportation, and the style and permitted uses of businesses and residences. Decisions about the built environment influence a number of health indicators including physical activity, tobacco use, substance abuse, injury and violence, and environmental quality. The built environment impacts chronic disease, injury, and violence, which together are the leading causes of morbidity and mortality.

Land use, built environment, and zoning can have a positive impact on health and safety. For example, "Land-use patterns that encourage neighborhood interaction and a sense of community have been shown not only to reduce crime, but also create a sense of community safety and

security."[87] Further, good community design can contribute to a general increase in community networks and trust by creating a "neighborhood feel" through which people are encouraged to interact with each other in a safe environment. This combination of networks and trust is linked to increased physical and mental health, academic achievement, local economic development, and lower rates of homicide, suicide, and substance abuse. Residents of buildings with green space had a stronger sense of community, better relationships with neighbors, and reported less violence in dealing with domestic disputes.[88] Neighbors visit each other more on small streets with little traffic.[89]

1. **Activity Promoting Environment:** *Places in which people can safely participate in walking, biking, and other forms of incidental/recreational activity*.[90]

   Community design has a strong influence on physical activity levels, which impact obesity rates. Children's physical activity levels are positively associated with the number of play spaces near their homes.[91,92] According to the Centers for Disease Control and Prevention, people are more likely to be physically active if there are recreational facilities close to their homes, people walk up to three times more in neighborhoods with square city blocks as opposed to cul-de-sacs, more people walk or cycle in transit-oriented neighborhoods than car-oriented neighborhoods, and people are more likely to be physically active in neighborhoods that are perceived as safe.[93] Further, as more people choose walking and biking over driving, pollution related to automobiles drops.

   The Local Government Commission has highlighted other benefits of designing neighborhoods to support physical activity. In particular, there are economic benefits for communities, including increased property values, attracting tourism, and promoting retail sales.[94]

   - Related leading indicators include: physical activity, overweight/obesity, injury and violence, and environmental quality.

2. **Nutrition Promoting Environment:** *Availability and promotion of safe, healthy, affordable, culturally appropriate food.*[95]

   Nutrition levels are closely associated with major health outcomes, such as cardiovascular and other obesity-related diseases. While nutrition has largely been seen as an individual choice, elements within broader society and communities impact nutrition. Ensuring that people within neighborhoods have access to safe, healthy, affordable, culturally relevant food is an important priority.

   Findings from a 2002 study suggest the local food environment is associated with residents' recommended diets: The presence of supermarkets was associated with meeting dietary recommendations. When the number of proximate supermarkets is increased, individuals tend to meet dietary recommendations more successfully. In African American communities, there was a 32% increase in nutrition for each supermarket located within a census tract.[96] While gains were also made in white communities, they were substantially less (11%). It is believed that this may be accounted for by car ownership. Many large chain supermarkets

have abandoned the inner city, leaving corner stores that feature snack and processed foods rather than a variety of groceries and fresh produce.[97] A 1995 analysis of 21 major U.S. metropolitan areas found there were 30% fewer supermarkets in low-income areas than in higher-income areas. Studies have consistently shown that prices at small grocery and convenience stores can exceed those at chain supermarkets by as much as 48%. Smaller stores are less likely to offer the variety of products or the high product quality offered by most major supermarkets.[98,99,100] In a survey of food stamp recipients, USDA found that they were more likely to make just one major trip to the supermarket each month, usually after receiving their food stamps.[101] Thus they are more reliant on neighborhood stores for perishable items such as fresh fruits and vegetables.

Low-income households are less likely than more affluent households to have a car.[102] In a 1993 survey of South Central Los Angeles residents, 38% of households reported not having a car and 33% reported difficulty transporting groceries home from the store.[103] Neighborhood residents either get less for their money shopping at smaller neighborhood stores or they spend precious food dollars on transportation to obtain a better selection.[104,105]

Research is beginning to demonstrate that increasing access and affordability of healthy food can impact nutrition levels. Given other consequences of large supermarkets (traffic congestion, motor vehicle crashes, and pedestrian injuries associated with increased automobile use, and non-local ownership of businesses), it is critical to consider other opportunities to increase access and affordability without compromising other factors important to community residents. Supporting farmers' markets, working with corner stores to increase stock of fresh produce and other perishables, and offering access to garden space for those who come from farming traditions are all alternative methods for increasing access and affordability. They also provide more immediate solutions, as it can take up to 10 years before a supermarket opens its doors in a new location. (In recognition of the potentially deleterious impact of large chain supermarkets, one Baltimore neighborhood successfully rallied against the development of a new supermarket.[106]) Exploring tax incentives or other opportunities to increase the capacity of local merchants to carry affordable healthy food could be a viable option.

- Related leading indicators include: overweight/obesity.

3. **Housing:** *Availability of safe, affordable housing in the community.*

Poor and inadequate housing is associated with increased risk for injury, violence, exposure to toxins, molds, viruses, and pests,[107] and psychological stress.[108] Further, crowding in the home is associated with poor health outcomes, perhaps more so than density levels in the community as a whole.[109] Alternatively, adequate safe, affordable housing can promote positive outcomes within a community.

Well-designed building structures can reduce the risk of burns, falls, and other injuries, as well as the risk of exposure to toxins. Building design can also promote social interaction. Trust and social connections can be fostered by promoting stability, which in turn is predictive of collective efficacy, or the willingness to take action on behalf of the common

good. Home ownership, which correlates with stability, is also predictive of collective efficacy.[110] A focus on desirable housing can draw people to a community and build a solid tax base. For example, mixed income models have been promoted as a way to reduce urban flight, thereby preserving a tax base. Finally, the availability of safe and affordable housing can reduce stresses associated with living in unsafe, noisy, or overcrowded conditions or not being able to secure housing.

- Related leading indicators include: mental health, injury and violence, and environmental quality.

4. **Transportation:** *Availability of safe and affordable methods for moving people around.*

The ways in which people move around can impact a broad number of health outcomes. Well-connected and -operated public transportation systems can decrease reliance on cars and connect people in geographically isolated communities to jobs, food, physical activity areas, healthcare, education, and other needed services. A decreased reliance on motor vehicles positively impacts air quality, which in turn can improve asthma rates. Well-designed roads and automobiles decrease unintentional injury rates.

Americans use automobiles more frequently for trips than any other country in the world.[111] Americans also have the lowest percentages of bicycle and walking trips compared to other countries. In the United States, streets are designed with the primary intent of helping move automobile traffic along.[112] The current trend in transportation and community design in the United States favors automobile use and data reflect the present environment. However, over 25% of low-income households do not have an automobile, compared to 4% of other households. People in low-income households are twice as likely to walk compared to people in households of higher income.[113] According to Dr. Jim Sallis, a UCSD researcher on the relationship between physical activity and health, "Walking and bicycling for transportation has an enormous potential for changing the daily physical activity habits of large segments of the population."[114]

Acknowledging a lower rate of car ownership and higher levels of walking or need for public transportation in low-income communities has implications for community transportation approaches. For example, tree-lined streets that are narrow and curved with bicycle lanes and sidewalks discourage fast-moving automobile traffic, and this can reduce injury. Close proximity of parks and commerce may promote usage. Decreased use of private automobiles has other advantages as well, including reductions in tailpipe emissions that cause or exacerbate respiratory problems, runoff from paved areas, pedestrian and cyclist injury, and long commutes and traffic snarls that can induce stress.[115] In all transportation design, transportation services should also take into account the need to get to jobs, markets, and services.

- Related leading indicators include: physical activity, overweight/obesity, injury and violence, and environmental quality.

5. **Environmental Quality:** *Safe and non-toxic water, soil, indoor and outdoor air, and building materials.*

It has long been recognized that environmental toxins present in air, water, soil, and buildings can threaten health. How communities are developed and maintained, specifically in regards to transportation and land use, significantly affects environmental quality. While important strides have been made to reduce exposure to environmental toxins, several culprits still pose significant risk, including lead in soil and buildings, air pollution from motor vehicle traffic, and water pollutants such as oil and human waste.

Lead, a neurotoxin, is primarily found in paint, dust, and soil, and can also contaminate drinking water and food. According to the Environmental Protection Agency, lead affects about 900,000 children between the ages of one to five in the United States.[116] Higher blood lead levels remain more common among children in low-income and urban communities and in older housing.[117] In most urban areas, lead is particularly concentrated due to the accumulation of lead in soil and dust as a result of decades of leaded gasoline and paint use.[118] The health consequences of lead exposure among children include brain and nervous system damage, behavior and learning problems, slowed growth, and hearing problems. Evidence is also emerging that lead can harm adults, leading to reproductive problems, hypertension, digestive problems, nerve disorders, cognitive impairment, and muscle and joint pain.[119]

Air pollution has been linked with respiratory disease such as asthma, and is largely attributed to motor vehicle emissions.[120] According to the U.S. Department of Transportation, vehicle miles traveled in cars increased more than 270 percent between 1960 and 2000,[121] leading to both increased air pollution and a higher incidence of respiratory diseases.[122] A recent study estimated that in the summer of 1997 alone, over 6 million asthma attacks, 159,000 emergency room visits, and 53,000 hospitalizations were caused by smog pollution.[123] Research has also shown that in Austria, France, and Switzerland, automobile-related air pollution is responsible for more deaths than traffic accidents, resulting in health costs of more than $23.8 billion.[124]

The decreased green space and increased impervious man-made surfaces such as asphalt and concrete resulting from land development can disrupt natural water filtration processes and threaten water quality. Rainfall in areas with less vegetation and more man-made surfaces cannot be absorbed and filtered and more often mixes with surface pollutants such as oil and becomes storm water runoff. This unfiltered runoff reaches water sources such as streams and rivers more quickly than they can absorb it, and can result in waterborne disease outbreaks.[125] In addition, the overuse of onsite sewage treatment and disposal systems (OSTDS) in low-density suburban and rural residential areas can cause groundwater contamination; 450 million gallons of partially treated, non-disinfected wastewater is estimated to be discharged per day.[126]

Environmental quality tends to be worse in areas in which the population is either low-income or primarily people of color. A study by Lee, *et al*, in *Environmental Health Perspectives*, found that toxic sites are concentrated in areas where low income and minority

populations reside.[127] Further, low-income people of color may have higher exposure to toxins in their work environments and homes than other populations.[128]

The Bayview-Hunters Point area in San Francisco, California, is an example of how communities of color and low-income communities often experience greater level of risk due to environmental toxins. As of 1998, the area was primarily African American (61%) and Asian (22%), with approximately 25% of the population living below the poverty line and an unemployment rate of 13%. This area also houses 700 hazardous water facilities, 325 petroleum storage tanks, and 2 Superfund cleanup sites. Although direct causation cannot be drawn, data links hospitalization rates to the environment; hospitalization rates and environmental toxins are four times as high in the Bayview-Hunters Point area as in the rest of California.[129]

- Related leading indicators include: physical activity, overweight/obesity, injury and violence, and environmental quality.

6. **Product availability:** *Availability of beneficial products such as books and school supplies, sports equipment, arts and crafts supplies, and other recreational items; and limited availability or lack, of potentially harmful products such as tobacco, firearms, alcohol, and other drugs.*

Low-income communities and communities of color have greater access to alcohol and tobacco products due to the high prevalence of local liquor stores. Specifically, low socioeconomic status (SES) census tracts and predominately black census tracts have significantly more liquor stores per capita than more affluent communities and predominately white communities.[130] It has been suggested that the relatively high number of alcohol-related problems that African Americans experience is due, at least in part, to the high level of alcohol availability in low-income urban African American communities.[131] The fact that liquor stores are disproportionately located in low-income communities of color suggests that lower-income African American communities may contribute to the disproportionate share of alcohol-related problems experienced by residents of these communities.[132] Moreover, tobacco products, including cigars and cigarettes, are standard products sold in liquor stores and an increased number of alcohol outlets may correlate with increased access to tobacco.

Firearm availability is also disproportionately high in communities of color and low-income areas, leading to higher risk of violence in those neighborhoods. Youth in low-income communities and communities of color often recount stories of how easy it is to obtain a weapon, often a gun. As one youth resident of a low-income area of Oakland observed, "I can walk down to the corner and buy a gun, but I have to get on a bus to get school supplies."[133]

- Related leading indicators include: tobacco, substance abuse, and injury and violence.

7. **Appearance/Ambiance:** *Well maintained, appealing, clean, and culturally relevant visual environment.*

The overall appearance in a community impacts health outcomes. For example, one study found that "enjoyable scenery" is associated with higher levels of physical activity.[134] In general, a welcoming and culturally appropriate appearance can encourage people to go out, which in turn fosters social connections and physical activity and can translate into economic benefits. More specifically, appearance can impact both perceptions of safety and reductions in crime. The New York Times reported on one Chicago housing project that had been transformed through an award-winning architectural makeover. Prior to the renovation, tenants did not feel safe enough to sit outside their front door, where chain-linked fences enclosed corridors and created a prison-like environment. As the president of the Tenants' Association explains, "Nobody thought the idea of putting glass over the sides of the buildings would really work, but it changed everything. You couldn't help but see a rosier day." In addition to anecdotal praise, the head of the local Chamber of Commerce has found that reports of small theft and violence from the building have stopped. [135]

This example shows how physical environment can affect attitude, behavior, and subsequently health. In his article, "The Tipping Point," Malcolm Gladwell offers an explanation, using a theory from epidemiology: "…disorder invites even more disorder." As an example, Gladwell cites an experiment done by Stanford University psychologist Philip Zimbardo, who parked a car in Palo Alto, CA, and abandoned it there for a week. Palo Alto is a relatively affluent neighborhood, and the car was left alone. However, when Zimbardo then smashed one of the car windows and again abandoned it, the car was vandalized and destroyed within a few hours. [136]

Perhaps the simplest description of the relationship between aesthetics/ambiance and health comes out of a Crime Prevention Through Environmental Design (CPTED) paper, which states, "Aesthetic considerations are vital components in one's sense of quality of life."[137] While the above examples show how aesthetics can impact physical activity, crime, and violence, beautiful and clean environments are a health benefit in and of themselves, contributing to people's overall satisfaction with their lives. Attractive environs make it easier to get up in the morning and, in the case of the Chicago housing project, nicer to come home at night.

- Related leading indicators include: physical activity, overweight/obesity, mental health, and injury and violence.

Social Capital Factors

Research associates social capital with a number of health outcomes.[138] The Institute of Medicine recommends modifying social capital at community and neighborhood levels as a promising intervention to promote health.[139] Robert Putnam, a leading thinker on social capital, defines social capital as referring to "connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them." While social capital is not an unqualified good (strong networks and trust were used, for example, to orchestrate the September 11 attacks), in general, building strong social capital creates a win-win situation in the individual versus society debate. Individuals benefit through their social connections when networks are used to find a job, companionship, or support in times of need. As interactions between diverse

sets of people increase, a community moves towards a norm of generalized reciprocity: I'll do this for you without expecting anything specific back from you, in the confident expectation that someone else will do something for me down the road. Putnam argues that a norm of generalized reciprocity leads to a more efficient and stable community, just as paper money creates a more efficient and stable marketplace than barter does. Levels of social capital, according to Putnam, tend to go in cycles, so while he does not believe America has always been marked by a decline in the strength of communities, he does argue that the last third of the 20th century seemed to be on the downside of the curve.[140]

8. Social Cohesion and Trust: *Strong social ties among persons and positions, built upon mutual obligations, opportunities to exchange information, shared norms, and the ability to enforce standards and administer sanctions.*[141]

Strong social networks and connections correspond with significant increases in physical and mental health, academic achievement, and local economic development, as well as lower rates of homicide, suicide, and alcohol and drug abuse.[142,143] One study showed that children were mentally and physically healthier in neighborhoods where adults talked to each other.[144] Other research supports links between high levels of social support and a number of positive health benefits among Latinos.[145] Social cohesion may also be linked to tobacco use. For example, some have argued that Japan's "close-knit" society keeps levels of smoking relatively low despite the presence of cigarette vending machines throughout the country.[146]

Social cohesion and trust also impact nutrition. Findings from work at St. Louis University indicate that nutrition messages are most effective when delivered by trustworthy sources. If the intended audience does not trust the message being presented or the messenger who is delivering the information, members of that community are not likely to utilize the health information.[147]

Participation in cooperative networks fosters mutual trust and increases community members' willingness to intervene in the supervision of children, participate in community-building activities, and maintain public order. Participation also increases supportive relationships, such as sharing, reciprocity, and recognition that the needs of others are needs of all.[148,149] Such networks also produce and enforce social sanctions and controls to diminish negative behavior and reduce the incidence of crime, juvenile delinquency, and access to firearms within communities.[150, 151]

- Related leading indicators include: tobacco, substance abuse, mental health, and injury and violence.

9. Collective efficacy: *Social cohesion coupled with a willingness to intervene on behalf of the common good.*[152]

Collective efficacy goes a step further than social cohesion by implying a sense of informal social control present within the community. Collective efficacy within a community is based on sharing similar beliefs and the community's ability and tendency to intervene or act to achieve an intended effect.

Collective efficacy has been shown to be a "robust predictor of lower rates of violence."[153] For example, a neighborhood in South Central Los Angeles came together to put a stop to drive-by shootings. Residents worked together on a number of activities including outreach to local gangs to significantly reduce instances of gang-related gun violence in their streets.[154] Collective efficacy can also promote nutrition. For example, community support, advocacy, and ownership are key to a supermarket successfully locating and operating in a low-income community. An organized community constituency can pressure public agencies and political leaders to improve food access.[155] It is also possible that collective efficacy has a positive psychological affect on individuals—as they are empowered and gain some amount of control over their environment, they may be less likely to turn to escapes like tobacco and drugs.

In addition, there is anecdotal evidence that collective efficacy can play an important role in bolstering a number of community elements including design and zoning decisions, schools, and environmental quality.

- Related leading indicators include: Because it relates more generally to the effectiveness of a community to change its circumstances or environment, this factor could link to any of the leading indicators.

10. Civic Engagement/Participation: *Involvement in community or social organizations and/or participation in the political process.*

When a community has high civic engagement, people actively participate in the social and political networks that impact their lives. Chavis, *et al.*, explain the benefits of such an investment: "When people share a strong sense of community they are motivated and empowered to change problems they face, and are better able to mediate the negative effects things over which they have no control.[156] In other words, civic engagement provides people with a sense of empowerment. Perhaps the most basic form of civic engagement is voting, which has a direct and obvious impact on local policy decisions. Thus, high levels of civic engagement will lead to increased collective efficacy. Several researchers, including Putnam, argue that changes that benefit the community are more likely to succeed and more likely to last when those who benefit are involved in the process.[157] Civic participation also includes participation in community and service groups. These groups often have the goal of serving or contributing to the community, which promotes more positive outcomes.

Like most habits, civic engagement is best encouraged at a young age. Studies show that teens who are civically engaged are much more likely to be similarly engaged as adults. In addition, these same youth are more likely to succeed in school, avoid teen pregnancy and illicit drug use, and, be more hopeful about the future.[158] While these same studies point out that the correlations might be self-selecting (e.g., teens who avoid drugs are more likely to be the kind of youth who get involved), there are clear benefits for getting youth more engaged.

Civic engagement necessarily involves working with others towards specific goals and with the expectation that success is possible. This type of environment is highly supportive of key

resiliency factors for youth, such as having supportive relationships with peers and adults, having high expectations for oneself, and having opportunities for meaningful involvement.

- Related leading indicators include: Because it relates more generally to the effectiveness of a community to change its circumstances or environment, this factor could link to any of the leading indicators.

11. Positive Behavioral/Social Norms: *Shared beliefs and standards of behavior that encourage positive choices and support healthy environments.*

Norms can describe what actually occurs (i.e., descriptive) or can signify a standard of proper behavior (i.e., normative or prescriptive).[159] The social norms within a community or social network "may structure and influence health behaviors and one's motivation and ability to change those behaviors."[160] Current social norms and behavior contribute to many preventable social problems such as substance abuse, tobacco use, levels of violence, and levels of physical activity. For example, the problem of alcohol-related deaths or injuries on college campuses occurs largely because of "binge drinking" norms. Social norms may also play a role in sexual behavior, as in the case of teen pregnancy and when to become sexually active. If the social environment discourages healthy behavior, then programs focused on change at the individual level will not produce healthy behavior unless social norms are changed as well.[161] Thus, norms change is critical in advancing prevention.

For interventions to be effective, it is important to integrate an understanding of social/behavioral norms. For example, social norms related to smoking during pregnancy are important to consider particularly if targeting an intervention toward low-income women. According to Emmons, "Low-income and undereducated women are more likely to smoke during pregnancy but may not view smoking as a priority in light of other pressing life issues."[162] The positive social norms of not smoking during pregnancy are not as embedded in communities where everyday economic stressors are greater.

Campaigns, such as those targeting the acceptability of "drunk driving", have succeeded in changing norms surrounding driving while intoxicated. A combination of pressure from Mothers Against Drunk Driving (MADD) and other grassroots organizations and the media as well as support from legislators led to significant policy changes emphasizing that driving while drunk was no longer socially acceptable.

Similar successes have been made through social support networks that enable positive social norms to be developed and strengthened within the organization or community. An example of this is the social support and networks that are provided to African Americans through church activities.[163]

- Related leading indicators include: physical activity, overweight/obesity, tobacco, substance abuse, responsible sexual behavior, and injury and violence.

12. Positive Gender Norms: *Gender-specific, socioculturally determined standards of behavior that encourage positive choices, and create safe and supportive relationships between and within gender groups.*

Fostering positive gender norms within communities can promote respect and healthier behaviors. “Men’s health and women’s health are different and unequal. Different because there are biological factors which manifest themselves differently in terms of health and in the risk of illness. Unequal because there are other factors, partly explained by gender, which affect a person’s health in an unfair manner.”[164] Traditional beliefs about manhood are associated with a variety of poor health behaviors, including drinking, drug use, and high-risk sexual activity.[165] The behaviors that men engage in often affect the health and well-being of women, children, other men, and the community. For example, men are at fault in nearly eight of ten fatal automobile crashes. An estimated one in three adult women experiences at least one physical assault by her partner during adulthood. Men are also more often reported for the sexual abuse of children. Focusing on the improvement of men's health will therefore not only lead to improved health conditions for men and boys, but will also contribute to building healthier families and communities.

Men's health is related directly to gender norms. Perceptions of acceptable male behavior and expectations influence male behaviors. For example, male college students believe that other male college students drink more than they actually do. These same college students have been shown to increase their drinking behavior to what they believe is normative and more acceptable.[166] One domestic violence prevention campaign is using this phenomenon by publicizing the actual reality that five in six men do not abuse their partners, thus shifting the perception of normative behavior.[167]

Males, on average, die 7 years younger than females and have higher death rates for all 15 leading causes of death.[168] In every ethnic group, the age-adjusted death rate is at least 1.5 times greater for men than for women: 1.8 times greater for Hispanics; 1.7 times greater for African and Asian Americans; 1.6 times greater for European Americans; and 1.5 times greater for Native Americans.[169] Although a number of genetic and biological factors may contribute to this disparity, the explanatory power of these factors in predicting gender differences in morbidity and mortality is also comparatively small.[170][171] For example, suicide rates for males are 4 to 12 times higher than for females.[172] Males eat more fat and less fiber and they are more often overweight than women.[173] Males are also more likely to engage in risky behavior than females. For example males drive more dangerously, drive more frequently while under the influence of alcohol, and use seat belts less often than females. The result is 15-24 year old males are 3.5 times more likely to die in automobile accidents.[174] Males are also less likely to access health care for physical or emotional health needs.[175]

Despite this, there is some conflicting research about the role of gender norms on health outcomes. While a number of U.S. and Western European studies have down played the significance of gender, research from countries in which gender roles may be more differentiated indicate a clear relationship, specifically in relation to sexual behavior. For example, both men and women in Vietnam noted clear gender differences in sexual roles and expectations. The woman in a relationship is “expected to behave in a faithful and obedient manner vis-a-vis her husband.”[176] However, sexual roles and marital roles for the man are much more permissible of premarital and extramarital sex, greatly endangering partners by sexual promiscuity.

Gender norms for women in the United States include care taking responsibilities, sensitivity and openness in expressing emotional feelings, and more awareness for health and nutrition. Studies consistently indicate that women are more likely than men to engage in a variety of health promoting behaviors and to have healthier lifestyle patterns. Because of these innate characteristics, or norms, being a woman may, in fact, be the strongest predictor of preventive and health-promoting behavior.[177] Men are also less likely than women to engage in a variety of preventive and self-care techniques, and the failure to do so contributes to men's increased health risks. They are less likely than women to restrict their activities or stay in bed when they are suffering from acute or chronic conditions, and they are less likely to persist in caring for a major health problem. Periodic physicals and screenings, self-examinations are an important aspect of health-promoting behavior and early detection of disease—particularly for men, who see physicians less frequently than women. Men also believe less strongly than women do that they have control over their future health or that personal actions contribute to good health. The perception of health as internally controlled rather than controlled by luck or chance is often found to be associated with the practice of health-promoting behaviors.[178]

Because gender influences overall health and the prevalence of risk behaviors, prevention initiatives and interventions must take into account gender norms as well. For example "unisex prevention programs—largely developed without regard to gender, often with males in mind—fail to influence millions of girls and young women."[179] An example of preventative initiatives that take into account gender norms, specifically for men, is the organization Men Can Stop Rape (MCSR). MCSR seeks to: 1) increase men's involvement as allies with women in preventing rape and other forms of gender-based violence, 2) promote gender equity, 3) build men's capacity to be strong without being violent. MCSR is creating a groundswell of young men committed to speaking out about how to be empowered without overpowering others, holding their peers accountable for men's violence against women, and building healthy communities free of violence and gender inequity. This is reflective of an international trend in which men are taking more active roles in prevention, including in violence against women.

- Related leading indicators include: physical activity, overweight/obesity, substance abuse, responsible sexual behavior, and injury and violence.

Services and Institutions

This cluster refers to the availability of and access to high quality, culturally competent, appropriately coordinated public and private services and institutions. The range and quality of these services within a community represent an opportunity to overcome barriers to health and safety and to foster strengths. The availability of public and community-based services may be particularly important in low-income communities, as residents may not have access to or be able to afford paying for such services. Further, it is critical that community services be connected to broader systems and policy bodies, including those at the city, state, and federal levels in order to ensure that decisions that are made will have a positive impact on the community.

Although many people involved in prevention have begun relying less on government and more on foundations and grassroots efforts to promote health and safety, government is still a major source of economic support through the allocation of tax funds. Tax money far exceeds the amount of money contributed to serve the public good by charitable donations, foundations, and businesses. In fact, the combination of government funding with individual commitment and volunteerism is probably the most important resource in creating change for the common good. It is therefore incumbent on government to provide a range of quality services for people. In some cases, this means that different governmental agencies must work together. The responsiveness and effectiveness of local governance in meeting community needs is a critical factor in promoting health and safety outcomes.

Services for community members should be easily accessible and integrated when appropriate. Too often, people in need end up navigating a complicated and ambiguous web of services and being shuffled from one place to another without receiving the services they need. Integrating appropriate services may require sharing or coordinating data, cross-disciplinary training, and shared strategy planning.

Finally, community services and institutions may serve as the focal point from which community change can be planned and implemented. These places may have resources, including mandates and funding, staffing, facilities, connections beyond the community, and community support and credibility, to foster and engage the necessary momentum and participation. The capacity of such organizations to lead or catalyze such change is an important element in the community.

13. Public Health, Health, and Human Services: *Available, accessible, high quality healthcare, health promotion and wellness services, health-related services such as mental health and substance abuse prevention/intervention, public health, and social services.*

High quality health and human services can promote public health, foster community violence prevention efforts, and ensure that those in need have access to needed substance abuse treatment programs and mental health services. Effective health and human service institutions may play a valuable role in advocating for or ensuring needed services within a particular community as well. City and county public health, health, and human service agencies are charged with identifying and meeting the health and human service needs within the purview of their service. Communities can strengthen services or the level of services by working with these entities to make sure that they are addressing the priority needs of the community.

While health and human services are very important, it is critical that they not be seen as the only priority associated with positive health outcomes. While the premise of public health is to address the health needs of the entire population, frequently from a preventive perspective, health and human services frequently operate from a treatment perspective after the onset of symptoms. Health disparities cannot be eliminated merely by attention to treating people after the fact or one person at a time. As long as the overall distribution of disease and injury is greater in certain populations, a disproportionate number of people will continue to be

afflicted. (For a delineation of why medical treatment alone cannot eliminate health disparities, see Appendix E.)

- Related leading indicators include: Because it relates more generally to the effectiveness of a community to change its circumstances or environment, this factor could link to any of the leading indicators.

14. Public Safety: *High quality law enforcement and fire protection that has gained the trust of the community.*

Effective public safety services contribute to lower injury and violence rates within communities. In addition law enforcement may contribute to substance abuse prevention efforts. Law enforcement efforts to address violence and crime, as well as pedestrian safety, can foster perceptions of safety that may translate to increased levels of physical activity.[180]

Different approaches to law enforcement foster a range of attitudes about and interactions with law enforcement. Community Oriented Policing and Problem-Solving (COPPS) has been promoted as a "philosophy, management style, and organizational design that promotes proactive problem-solving and police-community partnerships to address the causes of crime and fear as well as other community factors."[181] This model has been shown to contribute to declining crime rates.[182] It is grounded in the need for partnership between law enforcement and the community and fosters trust and understanding.

- Related leading indicators include: physical activity, overweight/obesity, substance abuse, and injury and violence.

15. Education and Literacy: *High-quality and available education and literacy services across the life span that meet the needs of all people within the community.*

Adler and Newman's discussion of the 'actual determinants' of health demonstrate the strong relationship between health disparities and socioeconomic disparities.[183] They divide socioeconomic status into income, occupation, and education, with education being perhaps the most basic component. Indeed, lower education levels are associated with a higher prevalence of health risk behaviors such as smoking, being overweight, and low physical activity levels.[184] While some of the relationship can be explained through income levels, education shapes opportunities in relation to income and occupation. In addition to shaping these opportunities, education levels may also be linked to having better access to health information. Most studies have looked at the relationship between education level achieved and associated outcomes. However, there is evidence that focusing on education in the early years could also be valuable. For example, children who participated in the High/Scope Perry Preschool Project at ages 3 and 4 showed significant, long-lasting, positive outcomes. Participating children were more likely to graduate from high school, own a home, and earn more than $2000 a month, and less likely to be on welfare or be arrested by age 21.[185] In addition, the lifetime economic benefits to the participants, their families, and the community far exceeded the cost of the program. Net savings of the study were estimated at more than

$70,000 per participant in crime-related savings, with a total of $88,000 saved when welfare, tax, and other savings were taken into consideration.[186]

A community has a stake in the literacy levels of the people who live there and can play a role in fostering it. Recognizing that literacy is a need that spans over a lifetime and may particularly be an issue for specific groups within a community (e.g. refugee and immigrants), a community can map its literacy services and ensure that these meet the needs of community. Libraries and adult schools become important assets in this context.

Literacy levels impact health outcomes in a number of ways. First, literacy levels are correlated with income levels that are in turn correlated with health outcomes in general. Literacy is also correlated with delinquency.[187,188] Further, limited reading ability impacts health at every stage of the health care process. Education campaigns, designed to inform the public how to make healthy choices, can fail to reach those people with low health literacy levels. For example, one study found that nearly 40% of women who read below a fourth-grade level did not know the purpose of mammograms (compared with only 12% for those with a ninth-grade reading level or higher).[189] In this case, low literacy increases the risk for breast cancer, because these women are less likely to get early screening. During treatment, the inability to read or understand insurance forms, informed consent documents, or Medicaid rights and responsibilities, can all impair one's ability to obtain quality, affordable healthcare. And, after treatment, understanding prescriptions, instructions on medicine bottles, or appointment slips is critical for successful health maintenance. For example, according to one study, over half of asthma patients with a third grade reading level did not know they should stay away from allergens even when they take their asthma medication each day (compared to only about 10% for those with a high school graduate reading level).[190] One study shows "75% of American adults who report having a physical or mental health condition scored in the two lowest literacy levels of the National Adult Literacy Survey."[191]

- Related leading indicators include: Because it relates more generally to an individuals ability to act in his or her own best interest, this factor could link to any of the leading indicators.

16. Community-Based Organizations: *Effective non-profit, grassroots, community coalitions, and faith-based organizations within a community that fill service gaps, advocate for community needs, and promote health and safety for the community.*

Many community-based organizations fill important needs that otherwise may not be addressed within a community. The capacity of individual organizations may be an important gauge as to whether or not specific community needs are being met. These organizations often have the pulse of the community and its members. The relative capacity of these organizations to make an impact may well depend on how well focused they are on systems and policies outside the community that impact people within the community. A recent review of Comprehensive Community Building Initiatives (CCIs) found that many efforts laid a strong foundation for future efforts and increased local capacity. However, in general, they did not reach their overall goals because they were too specifically focused on the

neighborhood level without sufficient attention to and influence on city, state and federal structures and policies.[192]

- Related leading indicators include: Because it relates more generally to the effectiveness of a community to change its circumstances or environment, this factor could link to any of the leading indicators.

17. Cultural/Artistic Opportunities: *Abundant opportunities within the community for cultural and artistic expression and participation and for cultural values to be expressed through the arts.*

The presence of art and other cultural institutions contributes to an environment that is conducive to health and safety. In its draft report on Community Conversations For and With Youth, the Forum for Youth Investment includes opportunities such as theatres, museums, and music as key aspects of community.[193] Research has shown that various artistic outlets, such as gardens, murals, and music, promote a healing environment. This has been demonstrated in hospitals and other health care facilities, where the incorporation of arts into the building's spaces has reduced patient recovery time and assisted in relief for the disabled, infirm, or their caregivers[194]. The visual and creative arts enable people at all developmental stages to appropriately express their emotions and to experience risk taking in a safe environment. For those who have witnessed violence, art can serve as a healing mechanism. More broadly, art can mobilize a community while reflecting and validating its cultural values and beliefs, including those about violence. Also, artistic expression can encourage physical activity, as in the case of dance.

The social impact of the arts has been documented—high rates of cultural participation can increase social connections in communities.[195] A report commissioned by the Ottawa City Hall states that culture "provides benefits in terms of…social cohesion, community empowerment… health and well being and economic benefit."[196] Moreover, cultural institutions promote standards of behavior that can either promote or hinder health and well-being.[197] Finally, the arts and other forms of cultural expression can contribute to a feeling of community connectedness and solidarity, particularly after the experience of a traumatic event. This has been demonstrated in cities such as Oklahoma City and New York City, where the arts have served as a significant means for the community to experience healing and community connectedness.[198]

Artistic and cultural institutions also create environments that engage youth and other populations; cultural participation has been linked with lower delinquency and truancy rates in several urban communities.[199] For example, a study by Brice Heath, *et.al.*, showed that, compared to a national sample, at-risk youth working in the arts during their out of school hours were four times more likely to have won school-wide attention for their academic achievement, three times more likely to be elected to class office within their schools, four times more likely to participate in a math and science fair, three times more likely to win an award for school attendance, and over four times more likely to win an award for writing an essay or poem.[200] Positive gains were found in another study conducted in partnership by Americans for the Arts, the National Endowment for the Arts, and the U.S. Department of

Justice Office of Juvenile Justice and Delinquency Prevention, and three community arts groups. It was found that youth who participated in selected arts programs expressed anger appropriately, communicated effectively, increased their ability to work on tasks, engaged less in delinquent behavior, had fewer court referrals, and showed improved attitudes, improved self-esteem, greater self-efficacy, and greater resistance to peer pressure.[201]

Finally, promoting arts and cultural opportunities may have other advantages. For instance, city planners have recommended the placement of theatres and other artistic institutions within the center of downtown blocks. Such placement increases foot traffic in these areas, which can contribute to retail sales, decreased crime, and increased perceptions of safety.

- Related leading indicators include: physical activity, obesity/overweight, mental health, and injury and violence.

Structural Factors

Generally speaking, structural factors are those that represent broad systems or structures or are connected to them. There are a number of macro factors that impact communities directly and indirectly. These include 1) technology and product design, 2) global trade and business, 3) national and international politics, 4) socioeconomic structure and distribution of wealth, 5) media, and 6) racism, oppression, and discrimination. All of these are broad and influential factors. While the first three ultimately impact health and well-being at a community level, they are not considered here because they are largely beyond the scope of community level action. Elements of the final three are considered here to the extent that the way they plan out in communities may be influenced by community attention. In particular, this section addresses economic capital, media and marketing, and racial and ethnic relations.

18. Ethnic and Racial Relations: *Positive relations between people of different races and ethnic backgrounds.*

Efforts to promote healthy behaviors in low-income communities and improve the environment are often rendered ineffective because racism, bias, and discrimination can foster conflicts that leave the residents feeling powerless, divided, and alienated. Divisions among residents in these neighborhoods impede efforts to build trust and the sense of community required to effectively advocate for needed change. The impact of such conflict is manifested in a number of ways. Public institutions such as health clinics, schools, law enforcement, parks, etc. tend to be perceived as serving one group of residents to the detriment of the other, and they are viewed with mistrust by one or more segments of the population in a community. Human service and community-based programs may serve only one racial or ethnic group in a community, and they are rightly or wrongly perceived as favoring one group. Additionally, outside perceptions of community groups or coalitions can limit the effectiveness of their work.[202] Without a sense of community based on place rather than race or ethnicity, neighborhood efforts to address health related goals can be fractionalized. House and Williams summarize the wide impact of racial/ethnic relations: "…racial/ethnic status shape[s] and operate[s] through a very broad range of pathways or

mechanisms, including almost all known major psychosocial and behavioral risk factors for health."[203]

While racial discrimination, which can impact health in a number of ways, certainly can be traced beyond community boundaries, it is critical that communities address discrimination within their boundaries and foster positive ethnic and racial relations. To the extent that there are positive relations, people within diverse communities can work together to achieve change that will impact the overall well being of the community.

- Related leading indicators include: Because it relates more generally to the effectiveness of a community to change its circumstances or environment, this factor could link to any of the leading indicators.

19. Economic Capital*:* *Local ownership of assets or access to investment opportunities, as well as ability to make a living wage.*

The link between economic hardship and poor health is obvious to most: "Poorer people die younger and are sicker than richer people."[204] While the exact mechanisms between economic capital and health have not been identified, there is a strong correlation between economic factors and health and safety outcomes. Economic capital, including adequate living wage employment opportunities, job training, local ownership of businesses, homeownership, access to loans and investment capital can be encouraged and promoted at a local level. These activities promote local access to resources, the opportunity to increase local capital that can be reinvested into the community, and stability among residents. Increases in local business are associated with reduced crime, and achieving living wages may be correlated with reduced stress levels and better housing.

Therefore, improvements in economic capital can have far-reaching affects. As House and Williams explain, "…existing evidence strongly suggests that the nature of the socioeconomic…stratification of individuals can be changed in ways beneficial to health and, coincidentally, to a broad range of other indicators of individual and societal well-being."[205]

Economic capital also affects the ability of the community service organizations and institutions to serve community residents. As researchers at St. Louis University found, economic capital is directly tied to the effectiveness of community coalitions in rural Missouri to create change and improve community conditions.[206] In particular, in a community without economic capital, resources are too limited to make change.

- Related leading indicators include: Because it relates more generally to the effectiveness of a community to change its circumstances or environment, this factor could link to any of the leading indicators.

20. Media/Marketing: *Presence of responsible marketing and media that support healthy behaviors and environments through positive messages and role models.*

Media is omnipresent in U.S. society and includes television, film, music, print news and magazines, the Internet, video games, and numerous other industries. The overabundance of media entertainment directly and indirectly contributes to poor health. One study has concluded that for every hour of television that young people watch per week, their probability of obesity increases by 2%, both because they are less active and because television encourages overeating.[207] Young children between the ages of 2 and 5 spend approximately 27 hours per week watching television; on average, 3 of those 27 hours are commercials. Over half of advertisements targeting children are for food, especially foods high in fat and sugar and low in nutrients.[208] It has also been shown that violent television programs and video games produce a lower sensitivity to violence as well as contribute to violent behavior in youth.[209,210]

Media can have both positive and negative effects on sexual behavior, violence, obesity, mental health stigma, substance abuse, and other health threats. For instance, *sex* is the most popular search term used on the Internet today. Results could range from unwanted pornography, including pop up advertisements and unwanted sexual solicitations, to sites that promote healthy sexual behavior and provide young people with legitimate and appropriate sexual advice.[211]

Although public criticism of media violence is abundant, the U.S. Constitution makes it difficult to restrict access to such programs.[212] Further, airwaves are governed by federal policies that leave communities with little capacity to control media. However, local initiatives that engage the media as a partner in community health and well-being are critical and effective. "In view of research findings on ways of changing attitudes or behavior, violence prevention efforts seem more sure of success if they combine strategies to limit access to guns with comprehensive programs that use the proven power of television, videotapes, and films to change attitudes towards guns and violence."[213] This prevention strategy rings true for other health threats such as traffic safety, obesity, substance abuse, tobacco use, and physical inactivity. "[M]edia approaches should focus on increasing the reservoir of social capital by engaging people and increasing their involvement and participation in community life... mass media strategies should also provide citizens with the skills to better participate in the policy process to create these conditions [for people to be healthy]."[214]

Media strategies include civic journalism, media advocacy, and photovoice, or the use of photography for social change by marginalized and traditionally powerless groups. Media strategies could be used to limit the number of liquor distributors in an area or fast food billboard advertisements near schools, prohibit gun advertising in certain areas, or feature youth as assets and highlight community strengths and events. In Charlotte, North Carolina, a civic journalism project involved the newspaper, television and radio talk shows. The project was effective in focusing efforts on crime and violence in the local area, resulting in more than 700 groups and individuals volunteering to work on various community needs. The city responded by razing dilapidated buildings, clearing overgrown lots, and developing recreational facilities.[215] Local media outlets can also play a role in supporting community health through their advertising policies. For example, the Boston Globe set an internal policy to not accept advertising for firearms and gun shows.

Media literacy, "the process of critically analyzing and learning to create one's own messages in print, audio, video, and multimedia," is a promising strategy that is taking place in communities throughout the United States. Local groups working in schools and community centers teach youth and parents to be more critical television viewers and media consumers. Research shows the effectiveness of media literacy initiatives relevant to viewing violence in the media. "Children who learn about the techniques involved in producing violence for television are less susceptible to the negative effects of subsequent viewing of televised violence."[216]

- Related leading indicators include: physical activity, overweight/obesity, tobacco, substance abuse, mental health, responsible sexual behavior, and injury and violence.

VI. REVIEW OF EXISTING TOOLS

The purpose of this project was to develop a tool that captures community resilience factors and can be of use to communities in their efforts to reduce health disparities. The specific factors form the basis of the tool. In order to inform the development of the tool, a review of existing tools was undertaken. More than 90 tools were identified through a cursory Internet search. An overview of tools identified on specific factors is provided in the following section. The Aspen Institute has developed a database of community development instruments that was particularly useful. There was wide variation in the number and types of tools identified for each of the factors. However, there are a very large number of tools available on some of these factors and not all have been reviewed. Also the tools from the Aspen Institute database usually provide only a summary of the tool and not a complete list of the indicators. Most tools cover a specific issue or closely related issues, and none were identified that cover the range of factors delineated for T.H.R.I.V.E. The purposes of the instruments vary from academic research to state and national government studies to assessment tools for community planning. Most of the tools reviewed appeared to be interview-based, though some were observational, some review existing data, and some rely on participant written response.

Overview of Tools

While no tool was identified that assessed the range of community factors delineated above, several tools examined multiple factors. For example, the Rebuilding Community Initiatives tool has 95 items that cover economic capital, the built environment, and the integration of public services. The Neighborhood and Family Initiative Services tool broadly looks at active community environments and transportation. The Community Sustainability Assessment also covers broad range of issues through a series of checklists. In general, tools that were broader in scope had more general items. It is expected that, due to the broad range of factors, T*H*R*I*V*E will be more general, allowing communities to identify major priorities based on need and current status. Communities may then benefit from using more specific tools to hone in on specified priority areas. For example, if promoting physical activity through environmental design is prioritized, there are a number of tools and checklists that may be helping in highlighting specific needs.

One assessment tool that has been used to identify resilience factors is asset mapping. Perhaps the individual most associated with this process is John McKnight. McKnight focuses on mapping community assets, rather than community needs (as medical or penal models require). Through this process, communities identify strengths within the community such as safe places, community gathering places, local business assets,[217] economic capacities of local residents,[218] and consumer expenditures.[219] This mapping is focused upon community development and community building efforts.[220] According to John McKnight and John Kretzman, directors of the Asset-Based Community Development Institute at Northwestern University.[221]

> *Each community boasts a unique combination of assets upon which to build its future. A thorough map of those assets would begin with an inventory of the gifts, skills and capacities of the community's residents. Household by household, building by building, block by block, the capacity map-makers will discover a vast and often surprising array of individual talents and productive skills, few of which are being mobilized for community-building purposes.*[222]

Rather than focusing entirely upon the needs of the community, which has tended to lead to a narrow focus on the negative aspects of neighborhoods alone, asset mapping seeks to identify already existing associations, individuals and institutions upon which to strengthen the community.

There were several tools that were also identified that may provide content and background for the development of content items for T*H*R*I*V*E or for the accompanying training materials and/or preliminary guidelines for building community factors for community members. For example, Principles of Smart Growth or the Ahwahnee Principles provide an excellent framework.

Finally, there are a number of tools that have been developed to assist communities in planning processes, such as those developed by Prevention Institute (i.e. Spectrum of Prevention, Eight Steps to Effective Coalition Building, Collaboration Math). While searching for these was not the focus of the environmental scan, several were identified such as *The Community Toolbox: Bringing Solutions to Light*, which is maintained by the University of Kansas, Work Group on Health Promotion and Community Development and The North Carolina Citizen Planner Training Program. In developing materials for community pilot sites, such tools will be reviewed either to inform the development process or to provide as additional resources and contacts for communities.

Tools that Measure Factors in Specific Clusters

Built Environment Tools

There are quite a few tools that assess built environment factors. These tools tend to include issues of transportation, aesthetics, and an active community environment. These issues are often clustered together in the concept of “New Urbanism” which HUD has embraced (principles available on the web). The Ahwahnee Principles lay out a set of guidelines for community planning that will address the problems of congestion, air pollution, loss of open space, inequitable distribution of economic resources and the loss of a sense of community. The Community Image Survey includes a set of slides and is used to educate people about what

makes a community more livable. The Local Government Commission developed a workbook, Street Design Guidelines for Healthy Neighborhoods, which helps communities implement designs for streets that are safe, efficient and aesthetically pleasing. PlannersWeb has many useful tools and articles on zoning issues including guidelines and planning tools. The Local Government Commission has also developed a Policy-Maker's Guide to Transit-Oriented Development that encourages developers and urban planners to create transit-oriented communities. The North Carolina Citizen Planner Training Program is a fairly comprehensive community planning training that has 10 modules including zoning and transportation planning.

Several instruments were found that assess the "walkability" of a neighborhood in terms of the sidewalks and safety. They cover issues such as space to walk, ease of crossing the street, driver behavior, and perceptions regarding how pleasant the walk was.

There are a few assessments to measure food security (access to available, affordable, healthy culturally appropriate food). They are very comprehensive and supported by USDA research. Most of the measures of food security are done at a household level and the USDA has developed four categories of households: food secure, food insecure without hunger, food insecure with moderate hunger, and food insecure with severe hunger. Although the unit of analysis is the household, these measures have not been validated as a household screening tool and are intended to describe the food status of a community or population. USDA has also developed a comprehensive Community Food Security Assessment Toolkit. The toolkit includes these modules: Profile of Community Food Resources, Assessment of Food Resources Accessibility, Assessment of Food Availability and Affordability, Assessment of Community Food Production Resources.

In regards to housing, the website www.nlihc.org allows for viewing data for a state, county or metro area. For each area, the site calculates how much money a household must earn to afford a rental unit of various sizes at fair market rent. The hourly wage needed is also given. Another useful tool is the 2002 Advocates' Guide to Housing and Community Development Policy, which is a primer on all the various programs, and issues that could be considered when promoting affordable housing.

One of the most useful tools to assess environmental quality in a community is the website www.scorecard.org. On this site, one can type in a zip code and get a report for a particular county. The report includes toxic chemical releases and their sources, agricultural pollution, risks from hazardous air pollutants, Clean Air Act status, sources of land contamination (superfund sites), lead hazards, watershed indicators, and environmental justice.

The Block Booster Environmental Inventory assesses the physical environment of urban residential areas. The instrument measures physical incivilities (e.g. litter), territorial markers (e.g. gardens), and defensible space features (e.g. public lighting). In general, tools for measuring aesthetic appear to be aimed primarily at middle and upper middle socioeconomic groups. An assessment that accounts for cultural differences in aesthetics was not identified.

Social Capital Tools

There were many tools identified that measure social capital, many of which were for academic/research purposes. One apparent reason for the range of tools is the lack of consensus on the definition of social capital and related constructs. There are a wide range of tools that measure social cohesion and trust. These include measures of the sense of community-rootedness, sense of belonging, care for the community, social interactions, neighborhood stability and others. One particularly interesting tool tried to identify the physical and social predictors of people's confidence in their block.[223] Other tools examine social networks and use network analysis (which may be less relevant here). Still others take a more psychological approach by assessing an individual's psychological sense of community. Another tool, Measuring Social Capital in Five Communities in NSW, describes the eight elements that define social capital and some of the questions for each element. For research conducted in the Chicago Project on the Study of Human Development, five factors were used to measure social connectedness which were based on neighbors rating of likeliness to intervene in the following ways: 1) if children were skipping school, 2) if children were spray-painting graffiti on a building, 3) if children were showing disrespect to an adult, 4) if a fight broke out in front of their house, and 5) if the fire station closes to their home was threatened with budget cuts. To arrive at a measure of collective efficacy these factors were combined with five others: 1) if people around here were willing to help neighbors, 2) this is a close-knit neighborhood, 3) people in this neighborhood can be trusted, 4) people in this neighborhood generally don't get *al*ong with each other, and 5) people in this neighborhood do not share the same values.[224] The overlap demonstrated a relationship between the constructs but the factors were shown to be reliable. Many other tools that focus on social cohesion and trust also assessed some aspects of collective efficacy. One tool is used by communities to evaluate their civic infrastructure. Some of the measures used in the tool include resident activism, feelings of empowerment, willingness to intervene with children and perceptions of control.

Generally speaking, social norms are assessed in relation to specific behaviors. The Communication Initiative has identified three dimensions of social norms that may provide a useful framework: Norms on participation, Norms on leadership, and Norms about specific issues/programs. The Monitoring the Future project studies changes in the beliefs, attitudes and behavior of youth toward alcohol and drug use, tobacco use and other things. It's unclear whether this survey also includes items related to social norms. The website www.socialnorm.org provides general information about social norms and specific information on norms relating to alcohol, tobacco, academic performance, and sexual assault prevention. Only one tool was identified that addresses gender norms and it is not clear whether this is at a community or household level. This is the International Social Survey Program (ISSP), which has a module on Family and Changing Gender Roles. This seems to be primarily about labor force participation of women.

Services and Institutions

Very few tools were found that assess the quality of public services (though perhaps if one searched by a specific service, there might be more tools). One tool, Neighborhood and Family Initiative Survey by Robert Chaskin, covers a wide range of issues including satisfaction with transportation, parks, police, health services, and schools.

There seems to be consensus about the best way to measure adult literacy. The National Assessment of Adult Literacy measured three dimensions of literacy: prose literacy, document literacy, quantitative literacy. Prose literacy deals with the ability to read and understand texts, document literacy deals with the ability to use and understand forms and graphics such as maps, job applications, schedules; and quantitative literacy deals with understanding numbers, charts, time units etc. On a community level, under the lead of the local library, the City of Salinas, California mapped its literacy services. Comparing the number of existing services to the best estimates of need for services, the city was able to identify gaps and convened a broad group of stakeholders to address the gap.

Structural Factors

There are a couple good tools to assess economic capital. The Asset Development Institute has developed an Asset Index, which assesses at individual level jobs, education, literacy, English competency and quality health insurance (as a proxy for access to health care). At a community level, the GAO has used a Survey of Community Development Financial Institutions (CDFI). The survey includes community development loan funds, credit unions, micro-enterprise loan funds, and venture capital funds. The Center for Community Economic Development has developed worksheets that compare a community's revenue and expenditures with other communities. The Community Resilience Handbook from Canada describes a thorough assessment to aid in strategic planning following significant economic shifts. The process is an extensive multi-month process that involves convening key stakeholders, focus groups, pen and paper assessments, and key informant interviews.

VII. COMMUNITY TOOLKIT FOR HEALTH AND RESILIENCE IN VULNERABLE ENVIRONMENTS (T*H*R*I*V*E)

T*H*R*I*V*E PILOT EVENT BACKGROUND

The T*H*R*I*V*E pilot events took place in Lordsburg, New Mexico with Hidalgo Medical Services (rural site), Del Paso Heights, Sacramento, CA with the Mutual Assistance Network (suburban site), and in East Harlem, New York with the New York City Health Department District Public Health Offices (urban site). The purpose of the T*H*R*I*V*E pilot events was to determine the tool's applicability and utility. Prevention Institute developed a list of criteria by which to select pilot testing communities. Selection criteria include community diversity, low-income communities, access to residents, capacity to make change, exiting partnerships, supports work of partner organization or coalition, community readiness for tool, and location to ensure geographic and demographic diversity of sites. Prevention Institute brainstormed possible sites based on existing contacts and recommendations from the Federal Office of Minority Health (OMH). Sites were also solicited from the Center's for Disease Control and Prevention (CDC) Racial and Ethnic Approaches to Community Health (REACH) 2010 meeting where we presented following identification of candidates. Interviews were then conducted with representatives from multiple organizations to access interest, capacity, and readiness for the tool. Based on the interviews Prevention Institute made recommendations to OMH and OMH made final pilot site selections. The first two pilot sites selected were Del Paso Heights, Sacramento, CA and New York. Based on feedback from the Project Expert Panel (PEP) at the March 2003 PEP meeting a rural site was added to ensure the tool's applicability and relevancy in rural communities. Pilot sites received seed funding of $10,000.00 for their participation,

which could go towards pilot event costs, next steps from the event, and promoting community resilience.

OVERVIEW OF COMMUNITY PILOT SITES

Hidalgo County, New Mexico (rural)

Hidalgo Medical Services (HMS) is a non-profit, community-driven healthcare and economic development organization that provides comprehensive primary medical and dental services to Hidalgo County residents. HMS is the primary medical, dental, and social services provider in the county.

Hidalgo County is made up of about 6,000 residents, half of whom are Latino. Over twelve percent of the population is over 65 years of age. More than twenty percent of the population lives below the poverty level. HMS developed LaVIDA (Lifestyles And Values Affecting Diabetes Awareness Project), which promotes diabetes awareness education and intervention in the form of cooking classes, support groups, and health promotion. LaVIDA has a local resource center that is accessed by the general public to learn more about diabetes prevention and management.

Del Paso Heights, Sacramento, CA (suburban)

Mutual Assistance Network of Del Paso Heights (MAN) is a nonprofit community development corporation that utilizes the skills and talents of the residents of the Del Paso Heights Neighborhood to expand and improve physical, public safety, and social conditions in the neighborhood, and stimulate and build self-help and mutual assistance programs that enable residents to work together to achieve good health and successful lives.

Del Paso Heights is a low-income multiethnic neighborhood in Sacramento, California with 13,941 residents, of these residents, 35% are African-America, 25% are Southeast Asian, 20% are Latino, 15% are Caucasian, and 5% are Samoan/American Indian. In terms of unemployment, violence, and education, Del Paso Heights exceeds other parts of Sacramento County. Del Paso Heights has existing partnerships with community-based organizations and the Department of Health and Human Services, Board of Supervisors, and other county offices. Del Paso Heights is a community that has taken steps to create positive and lasting change.

New York City District Public Health Offices (East Harlem, South Bronx, Central Brooklyn) (urban)

The New York City District Public Health Offices work to reduce illness and death by bringing public health professionals closer to the community they serve. Located in neighborhoods that have had persistent, across-the-board problems with community health, the District Public Health Offices host teams of health workers who work specifically within New York City communities to help make them healthier. The offices provide direct medical care to residents, and are responsible for their communities' health through research and tracking of diseases, as well as coordination with area health care providers. The District Public Health Offices maintains partnerships with hospitals, medical providers, community-based organizations, schools, as well as non-traditional partners such as employers and housing agencies.

The 2000 census reported that East Harlem has a population of 108,092 residents, 55% are Hispanic, 33% are African American, 6% are White and 3% are Asian. South Bronx has a

population of 290,052 residents, 43% are Hispanic, 28% are White, 21% are African American, and 5% are Asian. Central Brooklyn has a population of 317,296 residents, 80% are African American, 11% are Hispanic, 5% are White, and 1% is Asian. People that live in the above boroughs experience a greater burden of disease than other areas in New York. The District Public Health Offices reaches out to communities, facilitates their involvement, and enhances their capacity to respond to priority health issues.

DESCRIPTION OF PILOT EVENTS

The pilot event was standardized for all three sites to assess the tool's overall utility and applicability in different settings as it was designed and ratified by the PEP. A PEP subcommittee that included pilot site representatives developed the agenda. The pilot event agenda was split into two parts. The first part began with a welcome by the host and introductions, followed by a question to participants: "What is a healthy community or what does a healthy community look like?" The question was designed to gauge participant thinking on the topic, set a baseline, and outline a vision for a healthy community. The remainder of the day's activities would then question, reinforce, and/or refine this initial brainstorming. Participants then identified their major health concerns individually; as a group they then selected the priority health concerns that would be the focus of the remainder of the pilot event. Prevention Institute then provided a training on advancing a community resilience approach to closing the health gap. In particular, the training included a background on the value of prevention, a framework for focusing on community environmental and behavioral factors, and a delineation of the four clusters and twenty factors, linking each of them to the *Healthy People 2010 Leading Health Indicators* and major health concerns. Pilot participants then took the T*H*R*I*V*E tool and rated the priority level of the clusters and factors as high, medium, or low priority. In particular, they were asked to think about how important it would be to focus on a particular factor given their priority health concerns. Next, using the T*H*R*I*V*E tool, they rated how well the community was doing on each factor.

Prevention Institute then added, averaged, and assessed participants' input to determine overall priority ratings and assessments for each factor. While none of the factors were rated as low priority, clear priorities emerged at each site.

The second part of the agenda began with sharing the findings from the tool. Participants were given a chance to confirm or reject the overall findings, brainstormed criteria list, and as a group, to select their 3-6 top priority factors, which they would focus on for the remainder of the day.

Participants then had the opportunity to rename their priority factors based on how their community would define and describe these factors. In most cases, the names were left the same. However, some of them were modified, either to match existing language that was being used in the community for a specific factor or to reflect the culture, values, and emphasis of the community.

Next, participants developed local indicators for each priority factor. The indicators reflected the community's description of what the factor might look like if it were fully developed and promoting health and/or safety outcomes. Then, considering the indicators, participants assessed what's working and what needs improvement for each of the priority factors. This activity helped

participants identify strengths that can be built upon and gaps that need to be addressed as efforts move forward. There was then a discussion to identify key stakeholders that should be brought to the table and develop next steps that would build on the work of the day. Finally, there was an evaluation process, which started with participants first describing the event in three words or less. In addition, participants were asked to complete a written evaluation form to help strengthen presentation materials, the T*H*R*I*V*E tool, and the facilitated process. In order to better understand the outcomes of the community pilot events and the utility of the T*H*R*I*V*E tool, Prevention Institute staff conducted phone interviews in February 2004 with representatives from each of the T*H*R*I*V*E pilot sites. The interviews were conducted according to an interview guide that explored the pilot sites' general impressions of the T*H*R*I*V*E tool and pilot event, tool utility, and the impact of the event in the community.

PARTICIPANTS AND SITE GOALS

In order to ensure that the event met local needs, each site identified the purpose of the event locally and identified pilot event participants to ensure outcomes represented community needs. The purposes ranged from integrating pilot event outcomes into strategic plans to advancing more upstream approaches to health and addressing disparities. Participants varied by age and included both residents and service providers, such as public health, law enforcement, and transportation.

HMS integrated the pilot event into their strategic planning. Participants in the pilot event represented members of the health consortium, which includes: health, healthcare, law enforcement, transportation, and education. Del Paso Heights also viewed the pilot event as a part of their strategic planning process. In Del Paso Heights the pilot event was conducted to community members that were broken into two groups, adult and youth. The New York pilot event was viewed as an opportunity to train Community Health Workers (CHW) on a community resilience approach to health with the goal of them sharing the tool with community members at the appropriate time. In addition to CHW's the pilot event included State Office of Minority representatives, and public health officials.

EVENT OUTCOMES

Hidalgo County, New Mexico (rural)

The factors HMS prioritized were:

- Nutrition-Promoting Environment
- Transportation
- Positive Behavioral/Social Norms (alcohol-related)
- Education/Literacy
- Public Health/Health/Human Services

HMS changed nutrition-promoting environment to healthy food choices and positive behavioral/social norms to custumbres. Local indicators for each priority factor were then developed.

Factor	Indicators
Healthy Food Choices	• More people eating fruits and vegetables • Increased awareness of healthy choices in relation to health

	• Increased numbers of fruits and vegetables in local grocery stores • A farmer's market • Improved nutrition break menu • Increased numbers of healthy food options and portions
Transportation	• Increased numbers of riders • Increased number of transportation requests granted • Increased numbers of vans • Handicapped services included in transportation • Provides sustainable revenue • Fleet of caravans
Custumbres	• Promotion of alcohol and drug free activities • Decreased alcohol use among youth in the county • Increased price of alcohol • Decreased long-term healthcare costs • Decreased DUI's • Decreased Cirrhosis deaths (failure of the liver) • Decreased alcohol related crashes/fatalities • Increased age of alcohol onset
Education and Literacy	• Employable work force • Increased wages and wage levels • Vocational and technical apprenticeship opportunities • Increased percentage of high school literacy for job market • Life Skills curriculum in schools • Increased job stability • Increased number of people in college or technical schools • More businesses in Hidalgo County • Improved standardized test scores • Increased number of educational scholarships
Public Health/Health/Human Services	• School nurse in all schools • Increased number of health/healthcare providers • Extended hours for primary care • Improved Emergency Medical Services (EMS) • Detoxify center • Decreased number of county residents using drugs/alcohol

As a result of the pilot, HMS facilitated the tool for youth groups to help them prioritize specific issues they want to focus on. HMS has developed a teen center that is being built by youth, under the supervision of adult volunteers, which creates positive role models and mentors for youth. HMS has also used T*H*R*I*V*E to train over 50 of their partners on the importance of using a community resilience approach to address health and well-being. Within 4 months of the pilot event HMS developed a new transportation system called "Roadrunner," which is seven vans that transport community members throughout the county. They have also brought a farmer's market to Lordsburg through a partnership with farmers in Mexico. HMS felt that they had many things in place, but saw T*H*R*I*V*E's framework as a way to help them see the big

picture and to implement actions in a systematic way. Overall they found the process very helpful and will continue to use it in their strategic planning and training.

Hidalgo County incorporated the outcomes of the pilot event into their strategic plan. The following is excerpted from their plan, which was finalized after the pilot event.
"The Hidalgo County Health Consortium held several prioritization activities, both with the community and with the Consortium members, to review primary and secondary data and prioritize concerns. Community members and Consortium members had opportunity to identify and prioritize issues of importance by piloting a resiliency tool (T*H*R*I*V*E) created by the Prevention Institute of Oakland California and piloted here in Hidalgo County, New Mexico as well as Sacramento California and New York, New York. Because of the diversity of Hidalgo County's population and participants in the process, the resulting prioritized issues range from very broad impacts such as economic development to specific health status indicators and expansion of direct services. This aligns with our Vision of Health, which identifies health as more than the absence of disease, but rather a complete state of well being, including living conditions. Finally, the crosscutting issues are identified and prioritized annually at a regular Hidalgo County Consortium meeting. The Profile is updated on a regular basis.

Based on this information, the Hidalgo County Comprehensive Health Plan was developed by the Consortium to address prioritized issues. The Plan has been accepted an endorsed by the Hidalgo County Board of Commission. The Comprehensive Health Plan will assist the Hidalgo County Health Consortium and its systems approach community action teams in their aim and purpose. The Plan will also assist the Hidalgo County communities, programs and agencies in their planning and activities around HCHC prioritized health concerns and systems evaluation. The Plan is updated annually as new data becomes available and as results of objectives and activities are realized."

Del Paso Heights, Sacramento, CA (suburban)
The factors adult community members prioritized were:
- Nutrition-Promoting Environment
- Housing
- Education/Literacy

The factors youth community members prioritized were:
- Nutrition-Promoting Environment
- Education/Literary
- Community-Based Organizations
- Ethnic, Racial, Intergroup Relations

Del Paso Heights adult participants changed nutrition-promoting environment to supermarket, housing to affordable locally owned housing, and education/literacy to education and community awareness. Del Paso Heights youth participants changed nutrition promoting environment to markets and ethnic, racial, and intergroup relations to strong diverse relationships. Pilot site participants developed local indicators for each priority factor.

Factor	Adult Indicators	Youth Indicators

Supermarket / Market	• Supermarket is a member of local business association • Healthily and affordable food • Hires community residents • Clean • Provides other services • Supermarket is steward of the community • Meets the needs of low income community members • Accessible	• Variety of culturally diverse foods • Clean • Affordable prices • Convenient • Quality/fresh products • Sells nutritious products • Hires community residents
Locally Owned Housing	• Median price housing • Similarly sized houses • Owner-occupied housing • First time homebuyers are present in the neighborhood	
Education and Community Awareness / Education and Literacy	• Well informed neighborhood • Improved grade point averages • Increased civic participation • Emerging indigenous leadership takes the baton • Facilitate supportive learning environments • Safe schools	• Beautiful facilities • Utilizes current technology • Increased job-readiness • Reduced truancy • Higher graduation rates • Improved community awareness
Community-Based Organizations		• Community awareness and focus • Job opportunities • Stable funding • Recreational opportunities for different ages • Activities • Promotion of good educational outcomes
Ethnic, Racial, and Intergroup Relations		• Social cohesion • Diversity • Unity • Family understanding • Strong communication • Positive activities • Participation in community events by community members

From participation in the event, participants' ideas of what a healthy community looks like broadened from a focus on medical services. T*H*R*I*V*E was also seen as a way to use community members' ideas/strengths to move things forward. Youth in the community have

begun to incorporate the environmental approach described in T*H*R*I*V*E into their efforts to address violence in schools, now seeing violence as an issue that is impacted by environmental factors. Nutrition-promoting environment emerged as a major priority, and the community opened a farmer's market within 4 months of the event. This will be integrated into economic development efforts.

New York City District Public Health Offices (East Harlem, South Bronx, Central Brooklyn) (urban)

Each borough prioritized their top community factors, changed the names for some of the prioritized factors, and developed indicators for each prioritized factor.

The factors East Harlem prioritized were:

- Activity-Promoting Environment
- Nutrition-Promoting Environment
- Housing
- Education/Literacy
- Media/Marketing

East Harlem changed activity-promoting environment to physical activity, nutrition-promoting environment to nutrition-increased availability of healthy foods, and housing to decent and affordable housing.

The factors the South Bronx prioritized were:

- Activity-Promoting Environment
- Nutrition-Promoting Environment
- Public Health, Health, and Human Services
- Community-Based Organization

South Bronx changed activity-promoting environment to physical activity and sports, and nutrition-promoting environment to good eatin'.

The factors Central Brooklyn prioritized were:

- Activity-Promoting Environment
- Nutrition-Promoting Environment
- Housing
- Public Health, Health, and Human Services
- Community-Based Organization

Central Brooklyn changed activity-promoting environment to opportunities for physical fitness, and nutrition-promoting environment to opportunities for good nutrition.

Factor	East Harlem Indicators	South Bronx Indicators	Central Brooklyn Indicators
Physical Activity / Physical Activity and Sports / Opportunities for Physical Fitness	• Free physical activity programs in the schools • Reimbursable exercise prescription • Schools and daycares require physical activity • Increased number of parks	• Safe, Clean, well maintained parks, streets, schools and recreational facilities • Available resources for recreational facilities • Equally distributed physical activity (i.e. intramural sports, leagues, and midnight basketball)	• Affordable public and private gyms • Clean and safe parks • Bike laws • Community-based physical activity programs • Worksite wellness at all large employers • Sports leagues for girls and boys • Increased physical education in schools • Safe streets
Nutrition-Increased Availability of Healthy Foods / Good Eatin'/ Opportunities for Good Nutrition	• Large numbers of sites for fruits and vegetables • Healthier school food • Geographically accessible healthy food • Increased education about good nutritious cooking	• Available, affordable culturally appropriate foods • Accessibility of fresh fruits, vegetables and meats inside the community • Community knowledge around good nutrition	• Available high quality fruits and vegetables • Nutritious foods served at daycares and schools • Culturally appropriate food in the schools • Food co-op
Decent and Affordable Housing / Housing	• Aggressive code enforcement • Increased low-income housing • Quick housing repairs		• Affordable and adequate housing • Mixed income housing • Safe housing • No peeling paint • Smoke detectors • Window guards • Good garbage management • Local mechanism for tenants and landlords rights • Increased resident ownership
Public Health, Health,		• Community	• Clinical best practices

Human Services		knowledge of what services are available • Cultural and language appropriate services • Trained providers	including preventive services • Linkages within the clinical community • Universal healthcare • Coordination and responsive of multiple services
Education and Literacy	• Decreased dropouts • Increased school attendance • Increased attention to education for adults		
Community-Based Organizations		• Funding • Training and technical assistance for grant writing, data, and evaluation	• Robust collaborations • Funding • Central resource for capacity building • Evidence-based • Data driven • Evaluation
Media and Marketing	• Decreased alcohol and tobacco ads • Increased media coverage with healthy messages		

Participants from the New York site felt that the pilot event was worthwhile and provided a way to incorporate a resilience approach into their current work. Training participants emphasized that the tool is helpful for thinking about intervention approaches. Departments from the three attending boroughs were already focusing on upstream approaches and found the tool valuable for framing difficult concepts in a systematic way. The site said that T*H*R*I*V*E is an effective strategy tool that defines where public health can make its mark in the big picture.

EVALUATION OUTCOMES OF PILOT EVENTS

To get an immediate impression of the day, pilot site participants were asked to describe the day in three words before completing a detailed written evaluation (Please see Appendix E for complete pilot site reports), which served to strengthen presentation materials, the T*H*R*I*V*E tool and the facilitated process.

Hidalgo County, New Mexico (rural)

The three words HMS participants used in describing the day were: appreciative, beneficial, challenging, consistent direction, educational, fun, helpful, informative, interesting, organization, and validating. General impressions in the written evaluation around the most valuable aspect of the presentation, tool, and discussions include identifying and rating clusters and factors,

developing indicators and next steps, communicating with other members of the community, and provided a good method for evaluation and discussion.

Del Paso Heights, Sacramento, CA (suburban)
The three words adult community members used in describing the day were: right in tune to what we're doing as a community, wants to make community self-sufficient, very, very pleased, learn of things we need to include in program, impressive, helped to better neighborhood/community, allowed us to take back our neighborhoods, and learned a lot. The three words youth community members used in describing the day were: great, insightful, different way to look at the community, great way to look at community in different ways, eye-opening, we need to take action and get somewhere with it, surprising, not what I expected, provided information to help community and youth commission, eye opener, "surprised people outside community care to make Del Paso Heights better," and makes me want to look forward to the future. General impressions of adult community members in the written evaluation around the most valuable aspect of the presentation, tool, and discussions include the training on advancing a community resilience approach to closing the health gap. General impressions of youth community members in the written evaluation around the most valuable aspect of the presentation, tool, and discussions include discovering the major health issues of our community, the training on advancing a community resilience approach to closing the health gap, the specific description of the built environment cluster, and the importance of health.

New York City District Public Health Offices (East Harlem, South Bronx, Central Brooklyn) (urban)
The three words participants used in describing the day were: intense, stimulating team discussion, brought team together, informative, a lot of information to absorb, very interesting, just the beginning, a training experience, brainstorming and prioritizing, teamwork, good opportunity for discussion, thought provoking, very good session, and a method of re-thinking. General impressions in the written evaluation around the most valuable aspect of the presentation, tool, and discussions include the training on advancing a community resilience approach to closing the health gap, the concrete examples of the clusters and factors, opportunity to talk with other CHW's and discuss strategy, prioritizing the factors, renaming the factors, identifying what's working and what needs improvement, and developing next steps.

Prevention Institute developed pilot event reports for all three pilot sites, including separate reports in Sacramento for youth and adult participants. These pilot event reports were shared with the site hosts and then shared with the PEP in March 2004. PEP members had an opportunity to ask in-depth follow-up questions, and assess the value of the tool and lessons learned.

In order to better understand the outcomes of the community pilot events and the utility of the T*H*R*I*V*E tool, Prevention Institute staff conducted phone interviews in February 2004 with representatives from each of the T*H*R*I*V*E pilot sites: 1) Richard L. Dana from Del Paso Heights, California; 2) James Marrufo from Hidalgo County, New Mexico; and 3) Roger Hayes from New York City. The interviews were conducted according to an interview guide that explored the pilot sites' general impressions of the T*H*R*I*V*E tool and pilot event, tool utility, and the impact of the event in the community. The sites' responses are summarized below:

General impressions of the tool and its utility

Hidalgo County, New Mexico (rural): In general, the participants from Hidalgo County believe that T*H*R*I*V*E is a really good tool that is well thought-out. Further, they felt that it could work anywhere. Because the photos in the training tended to represent urban settings, the site has already changed some of the slides from the T*H*R*I*V*E training so that they more closely resemble the environment of a rural community.

Del Paso Heights, Sacramento, California (suburban): The T*H*R*I*V*E tool was described as very positive. Initially, the site had some concern about whether residents would be able to utilize the tool; however, all of the feedback received from participants has been positive. Residents felt that the T*H*R*I*V*E tool presented an important and different way of viewing the environmental factors that impact health. Residents primarily viewed it as a very powerful learning tool, while the agency viewed it primarily as a tool for strategic planning. Overall, the tool was described as "great."

New York City District Public Health Offices (East Harlem, South Bronx, Central Brooklyn) (urban): Participants from the New York site felt that the pilot event was worthwhile and provided a way to incorporate a resilience approach into their current work. Training participants emphasized that the tool is helpful for thinking about intervention approaches. Departments from the three attending boroughs were already focusing on upstream approaches and found the tool valuable for framing difficult concepts in a systematic way. The site said that T*H*R*I*V*E is an effective strategy tool that defines where public health can make its mark in the big picture. Overall, the site felt that the tool works and that it has utility for public health and government agencies and functions. While the department is committed to upstream approaches to health promotion, the site acknowledged challenges in identifying health issues beyond the mandate and current funding streams of the health department (e.g. housing, transportation, etc.), such as those identified in T*H*R*I*V*E.

Follow-up after the pilot event

Hidalgo County, New Mexico (rural): As a result of the pilot, the site identified the need for a mentoring program and has started a Big Brothers/ Big Sisters Program. Hidalgo County. The site has also shared the tool with its partners, training more than 50 people with it. All participants have found it very useful and some have begun to use it in their work. Youth from the community were inspired by the training to lead a discussion on youth programming through the Youth Empowerment Association of Hidalgo County.

Del Paso Heights, Sacramento, California (suburban): Nutrition-promoting environment emerged as a major priority for youth and adults and the site has actively pursued opening a farmer's market, which will happen in April 2004. Education also emerged as a major take-away theme and the agency is pursuing new funding in this area, particularly related to service learning and community service. Youth in the community have begun to incorporate the environmental approach described in T*H*R*I*V*E into their efforts to address violence in schools, now seeing violence as an issue that is impacted by environmental factors.

New York City District Public Health Offices (East Harlem, South Bronx, Central Brooklyn) (urban): The site is planning a joint meeting of participating health centers to plot out major structural issues where the departments can have an impact and to plan next steps. The site is embarking on a joint effort with public housing in Harlem where 1 in 4 Harlem residents reside.

Shifts in interest or engagement within the community as a result of the pilot and tool

Hidalgo County, New Mexico (rural): There has been a major shift primarily from a risk-based approach to a focus on resilience. There has also been a shift to focus more on the needs of young people and to identify and provide a range of needed youth services and programming.

Del Paso Heights, Sacramento, California (suburban): The tool has also helped community members structure their response to the different factors that are impacting their lives. One participant sits on the Redevelopment Advisory Commission and is using what he learned to incorporate health and public safety considerations into the work of the Commission. The pilot event reminded the host site that youth in the community view teen pregnancy as a big problem. Youth have reiterated their desire for a youth center in the community, which the site is working on developing. The site is trying to incorporate a health perspective into much of their programming.

New York City District Public Health Offices (East Harlem, South Bronx, Central Brooklyn) (urban): The tool and training has allowed participants to think about the importance of systems as well as promoting resilience. It has been helpful to frame the different layers that affect health and has given the department a way to think about these layers and its own contribution. Overall, it was additive and validating to current approaches and priorities. The challenge is to figure out how to incorporate such a broad approach from a health department given the limited mandate and resources of the department.

How a resilience approach can be used in the community

Hidalgo County, New Mexico (rural): The pilot event opened participants' eyes to resilience. As a result, they have begun to look at more studies on resilience and to think about how the findings of these studies can be used to shift the focus of our programming. They have described resilience as the future of their focus and orientation and that it will change the way they approach their work and fostering development in their young people.

Del Paso Heights, Sacramento, California (suburban): The host agency would like to use the T*H*R*I*V*E tool for planning with community members on an ongoing basis and to examine

whether it leads to a change in the way people think. The tool could help community members identify the environmental factors that they can address.

New York City District Public Health Offices (East Harlem, South Bronx, Central Brooklyn) (urban): The resilience approach has already been incorporated into the work of the department. T*H*R*I*V*E encourages ongoing emphasis and integration of resilience. Also, the department staff thinks a lot about systems and their relation to other systems and there may be room to incorporate this approach into some of the other systems.

Next steps that will take place in your community as the result of the event

Hidalgo County, New Mexico (rural): Hidalgo County is focused on placing more emphasis on creating youth initiatives and on making sure that the county's communities have something to offer youth.

Del Paso Heights, Sacramento, California (suburban): The community would like to begin to focus on housing and related issues, such as gentrification. In the coming year the area will likely experience a large influx of about 4,000 ethnic Hmong immigrants and community members would like to use this tool to come up with strategies for addressing the impact of their arrival on the community. The agency expects to continue to use the tool for ongoing strategy development and evaluation.

New York City District Public Health Offices (East Harlem, South Bronx, Central Brooklyn) (urban): The department plans to better incorporate the resilience and upstream approach into its work and to revisit the outcomes from the pilot process at upcoming staff meetings. It can use the tool to clarify ways of having an 'upstream' discussion in the community in a way that will enable the community to take healthy steps.

Increasing the utility of the tool and related materials

Hidalgo County, New Mexico (rural): The training materials need to be reflective of rural locales. It might be helpful to have a generic rural and a generic urban set of visuals. Also, communities should be encouraged to alter these generic formats so that the tool becomes something that they own. Case studies and success stories would be helpful for turning the information gathered by the tool into action.
Del Paso Heights, Sacramento, California (suburban): Communities can benefit from resources for follow-through once the factors have been identified. In addition, capacity building to complete the tool and conduct follow-through would be valuable.

New York City District Public Health Offices (East Harlem, South Bronx, Central Brooklyn) (urban): The tool can help to clarify the specific barriers to organizing community members around a particular issue.

LIMITATIONS

- While the community pilot sites were diverse, three sites cannot represent all sites in the United States.

- There was strong sentiment among the PEP about the importance of training and technical assistance for organizations that use T*H*R*I*V*E. Given the report-backs from the pilot sites and their assertion that the quality of training and depth of expertise was critical, panel members want to ensure the expertise of the contractors can be replicated.
- While piloted in an urban setting, the pilot testing did not include community members and it may be important to further explore utility with urban community members.
- One of the community pilot site criteria was readiness and capacity given the breadth of the tool, PEP members asserted the importance of a group being able to follow through with the findings and the value of resources, training, and technical assistance to do so.
- Language of the tool is designed for practitioners and local decision-makers and reflects the synthesis of the research, however, may not be appropriate for or resonate with all audiences due to language skills (i.e. immigrants and non English speakers), education level, and developmental level (i.e. youth). However, the process allows for participants to change the name of the identified priority factors.

TOOL MODIFICATIONS

Based on the pilot event the tool was modified to have more utility and to better reflect the goal of closing the health gap. Overall, modifications were minor due to extremely positive feedback from pilot event participants. The following changes were made and ratified by the PEP.

1. Directions in the tool for assessing community effectiveness was changed from participants rating how effective their community is at fostering each of the cluster areas and factors, particularly in relation to the highest priority health concerns in your community to rating how well developed each of the cluster areas and factors are in the community in general.
2. The factor *Aesthetics/Ambiance* in the Built Environment cluster was changed to *Appearance/Ambiance* to ensure community members understanding of the factor.
3. The cluster *Macro Factors* were changed to *Structural Factors*.
4. The factors in the Structural Factors cluster were re-organized from 1) *Economic Capital*, 2) *Media/Marketing*, and 3) *Ethnic/Racial Relations* to 1) *Ethnic/Racial Relations*, 2) *Economic Capital, and* 3) *Media/Marketing.*

PILOT SITE CONCLUSIONS

Overall, the pilot events confirmed that the T*H*R*I*V*E tool contributes to a broad vision about community health, confirms the value of upstream approaches, challenges traditional thinking about health promotion, organizes difficult concepts and enables systematic planning, has rural and urban applicability, has utility for practitioners and community members, and is a good tool for strategic planning at community and organizational levels.

VIII. PROMOTING COMMUNITY RESILIENCE: PRELIMINARY GUIDELINES

Community resilience: *the ability of a community to thrive and/or recover despite the prevalence of risk factors. Resilient communities take the necessary steps to create positive and lasting economic, social, and environmental change. A community resilience approach addresses the quality of the overall environment in which people live, work, go to school, and interact. Community resilience factors are those elements within a community that foster safety and well-being and negate the detrimental impact of risk factors. In fostering these factors, there is an implicit understanding that strengthening the environments in which people live will improve health and safety, while also fostering individual resilience factors.*

Preliminary guidelines: *a resource guide that serves as a starting point for coalitions, community leaders and decision makers, representatives, and community members to advance a community resilience approach and strengthen the 4 clusters and 20 factors delineated in T*H*R*I*V*E.*

***T*H*R*I*V*E: T**oolkit for **H**ealth and **R**esilience **I**n **V**ulnerable **E**nvironments; a community approach to address health disparities*

Introduction

These guidelines are for people who recognize the value of a community resilience approach and want to advance the capacity of their communities to strengthen the four clusters and twenty factors delineated in T*H*R*I*V*E . Therefore, this document describes samples actions, resources, tools, and community examples for each cluster and factor. In recognition that the use of the T*H*R*I*V*E toolkit takes place within a community process, these guidelines also provide *general* information designed to strengthen community resilience efforts including considerations about using the T*H*R*I*V*E toolkit, a description of a planning process and associated tools, issues to consider about every factor, and general tools and resources.

These guidelines are preliminary because they are intended as a starting point for community leaders, coalitions, and others who are committed to advancing community resilience and closing the health gap. Clearly there is great deal of research and practice emerging in this area. This knowledge and experience will form an even stronger base for effective community practice. Given the diversity of communities throughout the United States, each community will design solutions to meet its own unique needs; these guidelines are one initial source of information to inform that unique process.

The guidelines are designed as a resource guide. Rather than expecting that each person who picks this up will read them cover to cover, it was anticipated that individuals will go to specific places where they are in need of guidance. As such, specific tools, approaches, and resources are included within relevant sections and some resources are repeated in different sections. In some cases the information may be enough to help move an effort forward; in other cases the reader may need to look at sample tools and resources for additional information. For ease of use, general information is provided in the format of an FAQ (frequently asked questions).

Organization of the Guidelines

These guidelines are divided into two primary categories: 1) general information and considerations about advancing a community resilience approach, and 2) specific information to strengthen each of the clusters and factors.

Section 1: General information and considerations about advancing a community resilience approach
This section is designed to help users of the T*H*R*I*V*E toolkit think through an effective process including engaging the right stakeholders, selecting factors, implementing the range of necessary activities for success, and evaluation. It provides a) some considerations for community representatives about using the T*H*R*I*V*E toolkit and, once they have chosen to adopt a community resilience approach, provide b) information and tools for a successful planning, implementation, and evaluation process, c) considerations that should be taken into account in working on any or all of the factors, and d) general tools and resources about advancing a community resilience approach and closing the health gap.

Section 2: Specific information to strengthen each of the clusters and factors.
This section is designed as a starting point once a community or neighborhood has selected specific factors and is searching for effective ways to strengthen that factor. It provides information about addressing each of the clusters and factors including a) sample action items, b) sample tools and resources, and c) community examples.

SECTION 1: GENERAL INFORMATION AND CONSIDERATIONS ABOUT ADVANCING A COMMUNITY RESILIENCE APPROACH

Before using the T*H*R*I*V*E toolkit, it might be helpful to think through capacity issues and to understand how the process can be useful for the community. In addition, it is critical to anticipate the range of activities, partners, and resources that may be needed to ensure success. This section provides answers to frequently asked questions about these issues.

A) CONSIDERATIONS ABOUT USING THE T*H*R*I*V*E TOOLKIT

Is my community or organization ready to use T*H*R*I*V*E?
T*H*R*I*V*E has demonstrated that it can be a powerful catalyst and foster engagement and empowerment among participants; however, it is important that there is a capacity to build on that and carry it forward. It is critical that communities assess readiness and capacity before initiating the T*H*R*I*V*E process to ensure that follow-through will take place and credibility of the lead group(s) can be maintained. Issues of readiness and capacity may include organizational staffing to carryout recommendations, community buy-in of the approach, availability of training and technical assistance, and connectedness to major decision makers. Before using T*H*R*I*V*E it is important to assess these elements.

How can T*H*R*I*V*E help close the health gap in my community?

T*H*R*I*V*E can be a valuable tool in addressing specific ways to close the health gap by emphasizing a resilience approach and building on strengths in disenfranchised communities. Further, a community/environmental approach can be extremely valuable in addressing disparities in health because factors in the environment contribute to disparities. Those using T*H*R*I*V*E should identify the critical health gaps and design and shape a strategy specifically targeted to close that gap. T*H*R*I*V*E can help close the health gap by:

1) Changing the way people think about health and safety

- Promoting knowledge of and critical thinking about communities and community health
- Fostering an understanding of the value of community resilience approaches in addition to and support of medical treatment to close the health gap

2) Providing an evidence-based framework for change

- Laying out a framework and identifying a process for communities to make change
- Providing a framework that can be modified to embrace and reflect local nuances and culture
- Finding solutions that reflect the value and culture of people who live in the community while giving an evidence-based framework of factors that promote improved health outcomes

3) Building community capacity while building on community strength

- Encouraging communities to reflect on their own strengths and capacities
- Building local leadership skills and helping local leadership understand important community and health issues and how to advance them
- Understanding that part of community improvement includes fostering local businesses that are owned by local people and rooted in the culture and needs of the community, thereby increasing people's stake in the neighborhood and local ownership of assets in the neighborhood
- Fostering community ownership of a pro-active solution and creating a community network that can work on issues together

4) Fostering links to decision makers and other resources

- Building bridges from disenfranchised neighborhoods to enfranchised neighborhoods, which tend to have more access to resources and influence in local decision-making
- Creating a bridge to build trust and accountability with local decision makers and policy makers
- Fostering equal partnerships between communities and universities that want to work around health disparities by providing a framework for communities to prioritize and take action and for universities to assist by providing assessment and feedback through credible, and community-participatory based, evaluation.

B) PLANNING, IMPLEMENTATION, AND EVALUATION PROCESSES

What are the elements of a community planning process?

Elements of a community planning process include the following:

- *Needs assessment:* identifying the needs and assets of the community or neighborhood and the particular health concerns and disparities,

- *Strategic planning:* clarifying vision, goal, and directives, establishing decision making processes and criteria, fostering sustainability, and ensuring that resources are being appropriately used.
- *Building understanding about multiple determinants of health***:** raising awareness of the determinants of health and fostering buy-in into addressing them as an effective approach to improving health and safety outcomes
- *Partnership and coalition building:* determining and engaging the support of key stakeholders and decision makers, including community engagement
- *Prioritization:* selecting the appropriate factors and combination of factors
- *Comprehensive approaches:* implementing multifaceted activities to achieve desired outcomes
- *Evaluation:* ongoing assessment and evaluation of community efforts

What is the relationship between T*H*R*I*V*E and the elements of community planning process?

T*H*R*I*V*E is a framework for advancing a community resilience approach to reduce disparities in health. The tool and the planning process can help establish a broad community vision about health, prioritize specific factors that the community wants to strengthen, identify specific activities, and catalyze action. T*H*R*I*V*E is not an end in itself; rather it is a toolkit that can be used as part of a community movement to improve health.

The T*H*R*I*V*E toolkit can be used to inform all of the elements of a community planning process. For example, the information gleaned from the T*H*R*I*V*E tool can be part of the needs assessment and identify priority areas for action. It can also serve as a framework for strategic planning, help identify which partners to engage in a coalition, and provide the context for community participation. Materials in the toolkit supply the research basis of multiple determinants of health, provide sample activities for implementation, and can inform an evaluation plan. In addition, there are many specific tools that can provide guidance for each element. Some of these are detailed below.

Who should I include in the process?

There may be an existing coalition or community group that has the capacity and interest in advancing a community resilience approach to improve health and this could be a good place to start. If not, think about key stakeholders and invite them. No matter what, always ensure that individuals in the community have consistent venues to participate, and provide leadership in the process.

Addressing the T*H*R*I*V*E factors requires the mobilization of a broad array of activities, staff, and resources across multiple sectors. These include, but are not limited to public health, planning, public works, housing, transportation, parks and recreation, local business, media, law enforcement, economic development, and housing. It may be helpful for different sectors to be engaged at different times. For example, the group of people that agree on specific priorities may not be the same as is needed for successful implementation. Be prepared to identify and engage new partners throughout the process. Effective collaboration can be of value for a number of reasons, including: range of expertise, service access and usability, ability to draw on multiple

resources or funding streams, reduced duplication, breadth or depth of impact, credibility, and access to information.

Should I include the health sector?

Clearly the health sector, including public health and health care, is the sector with a mandate and funding streams to improve health outcomes. However, given what is known about the broad determinants of health, the health sector alone cannot address all of the factors that determine health outcomes. The health sector has a critical role to play in advancing awareness and understanding of the broad determinants and engaging the necessary players in a movement to truly improve health outcomes and close the health gap. T*H*R*I*V*E can help communicate this message and identify the necessary partners, such as public works, housing, transportation, economic development, and others.

In addition, the public's view of health often equates with treatment. For example, community members may not understand the public health emphasis on population-based approaches and may merely hold a public health department accountable for immunizations or diabetes management. And certainly, when people are in need of critical treatment, it is unlikely that they will prioritize long-term health approaches that T*H*R*I*V*E emphasizes. This can leave public health officials in the business of either solely focusing on short-term delivery needs or explaining attention to strengthening various community factors. In order to build community support for strengthening community factors, T*H*R*I*V*E training content can help foster an understanding of the relationship between individual health and health choices and the community environment. Further, it might be helpful to delineate the ways in which a community resilience approach, which emphasizes strengthening community factors, can support treatment outcomes. For example, from *Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities:*

> *Positive behaviors and environments … improve the success of treatment and disease management. For example, healthy eating and activity habits are not only critical for prevention but for disease management in diabetes, cardiovascular disease, HIV/AIDS, as well as cancer treatment. Improved air quality, indoors and outdoors, reduces asthma triggers. A reliable, affordable, and accessible transportation system transports people to screening and treatment appointments. Literacy improves the ability to read and understand prescription labels–both directions and warnings. Strong social networks are associated with people looking out for each other and taking care of each other during treatment and recovery*.[225]

What might I say to engage different stakeholders in a planning process centered on T*H*R*I*V*E?

Whether or not people will choose to participate in the process and/or provide the necessary resources for success will depend on many factors including understanding the need for the approach and the potential for impact. Below is some language that can be used or modified.

- T*H*R*I*V*E is an exercise that provides community residents with a way to identify and understand the multiple factors that affect our health. Participants can then prioritize the steps that might be taken to make their community a healthier place to live, leading to happier more productive community residents.

- Building health into a community is the focus of a recently released planning tool for use across America. The T*H*R*I*V*E tool allows citizens and city and local officials, as well as health experts, to use a cost savings method to effectively blend resources and services to reduce health disparities while promoting economic growth in communities. The T*H*R*I*V*E process engages community members, policymakers, and business representatives in efforts to promote healthy communities by improving the quality of health, safety, and education, while fostering economic growth.
- T*H*R*I*V*E is a planning tool designed to assist community groups, policymakers, and government agencies develop programs to reduce health disparities. Health disparities currently exist in abundance, and evidence suggests that many of the health issues facing communities of color cannot be addressed by medicine and healthcare alone. Through a step-by-step process groups are assisted in identifying various factors that affect the health of the community and develop short and long range strategies and programs.
- T*H*R*I*V*E is a powerful tool which can assist policymakers to prioritize limited resources in such a way as to improve the health of families and children in their communities. This tool allows community members, government agencies, and business representatives to talk about the community needs, identify health problems, and look for long and short term solutions that can be implemented.

How can I ensure an effective coalition?

There are tools to support effective and meaningful collaboration. One such tool, called *Eight Steps to Building an Effective Coalition*[226] delineates a set of steps and considerations for each one. The eight steps are:

- Step 1. Analyze the program's objectives and determine whether to form a coalition.
- Step 2. Recruit the right people.
- Step 3. Devise a set of preliminary objectives and activities.
- Step 4. Convene the coalition.
- Step 5. Anticipate the necessary resources.
- Step 6. Define elements of a successful coalition structure.
- Step 7. Maintain coalition vitality.
- Step 8. Make improvements through evaluation.

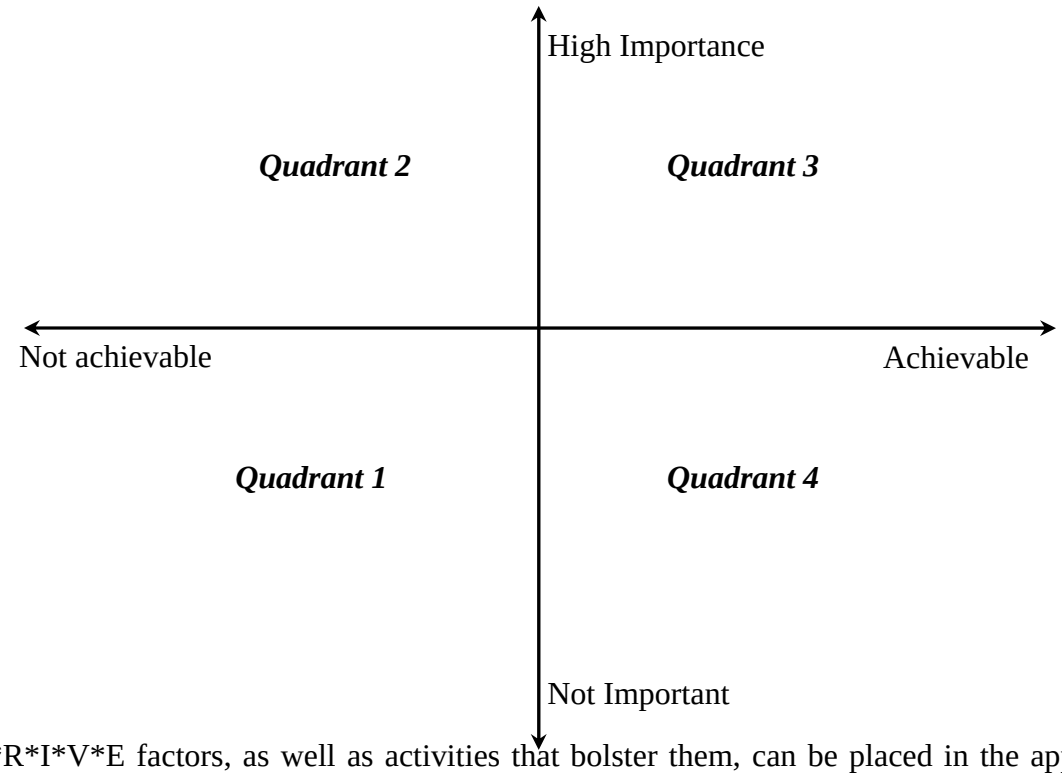
While working through these steps can improve the efficacy of ongoing partnerships there are challenges to establishing and maintaining ongoing partnerships that span systems and disciplines. Collaboration is more than meetings- it requires an understanding of which links are most critical and a strategic integration of multifaceted activities to achieve the broadest impact.

Developing meaningful collaboration requires a two-pronged effort: 1) establishing common ground between the vocabulary, data, and philosophies of different disciplines and 2) overcoming the structural, financial, and sometimes political divisions between different sectors. The kind of ongoing collaboration needed to effectively achieve family and community wellness and safety requires ongoing strategic coordination of multiple service delivery systems that affect communities and their residents.

How do we prioritize which factors to work on?

While all of the clusters and factors support health outcomes, it is unrealistic to expect that a community could address all of them simultaneously with equal attention and success. Therefore, it is critical that the community prioritize the set of factors it wants to emphasize. The T*H*R*I*V*E tool allows individuals to assign priority ratings to each factor of high (h), medium (m), and low (l). Once individuals have made these assessments, it is helpful to report back to the group on the group's average ratings, to confirm with the group that their combined ratings reflect the group consensus, and then engage the group in a process to select its highest priorities. To accomplish this, participants could set criteria for selection. Examples include:

- *Relevance to major health concerns*– Each of the factors is related to multiple health concerns; however consideration should be given the factors most directly associated with major health concerns or health gaps to address these in the most effective matter.
- *Community readiness and buy-in* – It is important that community members and stakeholders have the capacity to and interest in addressing a particular factor in order to make the needed changes.
- *The need to address gaps that aren't otherwise being filled* - Many public health and safety-related organizations conduct their own systems assessments at state and local levels as well as community asset assessments. Many of these tools and approaches include performance indicators/standards. These resources can provide useful information and reduce the need for local collection as well as help identify existing gaps
- *The need to build on success and/or existing efforts to maximize impact* - Most communities have successful coalitions or other efforts in place to improve community health outcomes. Rather than starting from scratch or reinventing the wheel, it may be more effective and efficient to identify successes and build on those in the community.
- *Consideration of cumulative effects* - Strengthening one factor may strengthen other factors thereby having a cumulative effect. The clusters and factors have an interactive and synergistic relationship with each other, which must be considered as strategies are developed and implemented.
- *Importance and Achievability*– One model to help communities select criteria is based on the work of Larry Green and Marshall Kreuter.[227] It takes into account importance and achievability. Each is represented on an axis, the two of which intersect to create four quadrants, shown in the following diagram.



T*H*R*I*V*E factors, as well as activities that bolster them, can be placed in the appropriate quadrant. They can then be assessed according to the following:

- *Quadrant 1*: Placement in this quadrant indicates that the factor, or activity, is both unimportant and unachievable and therefore there is no reason to consider them.
- *Quadrant 2:* Placement in this quadrant indicates that the factor, or activity, may be important but not achievable and therefore does not warrant further attention.
- *Quadrant 3*: Placement in this quadrant indicates that the factor, or activity, is both important and achievable. Further exploration is warranted.
- *Quadrant 4:* Placement in this quadrant indicates that the factor, or activity, is achievable but not very important. Given the achievability factor, the group may want to consider prioritizing this factor if, for example, achieving the associated outcomes could bring credibility to the group which could form the basis to attract resources or engage new members, or allow members of the existing group to feel a sense of accomplishment and empowerment, allowing them to address other issues that are of greater importance.

How can we maximize the impact of our efforts?

It is important to understand that research is still examining which environmental factors may have greater influence. However, it is clear that no single strategy, program, or policy is *the answer*. Multiple changes are needed to shift community norms towards healthier behaviors. Based on experience with other public health issues such as tobacco control, or reducing impaired driving, a variety of changes help to build momentum and gain traction and interest over time; incremental changes lead to others that ultimately change the overall dynamics.

To understand the necessary range of activities, practitioners have used the *Spectrum of Prevention*,[228] a tool that enables people and coalitions to develop a comprehensive plan while building on existing efforts. The *Spectrum* encourages movement beyond the educational or

"individual skill-building" approach to address broader environmental and systems-level issues. When the six levels are used together, they produce a more effective strategy than would be possible by implementing an initiative or program in isolation. The *Spectrum* has been used to advance multiple efforts including, but not limited to, violence and injury prevention, physical activity and nutrition promotion, sustainability of mental health promotion, and lead prevention.

Spectrum of Prevention

Level	Description
Influencing Policy and Legislation	Developing strategies to change laws and policies to influence outcomes in health, education and justice
Changing Organizational Practices	Adopting regulations and norms to improve health and safety and creating new models
Fostering Coalitions and Networks	Bringing together groups and individuals for broader goals and greater impact
Educating Providers	Informing providers who will transmit skills and knowledge to others
Promoting Community Education	Reaching groups of people with information and resources to promote health and safety
Strengthening Individual Knowledge and Skills	Enhancing an individual's capacity to prevent illness and injury and promote health and safety

Data and evaluation inform all levels of the *Spectrum*. Any proposed activity should be based on data showing 1) the issue is important, 2) the target population is appropriate, and 3) the intervention is promising. To develop a successful approach, it is essential to first review the data and determine an appropriate set of objectives. During implementation, ongoing evaluation of the overall approach and the individual activities at each level of the *Spectrum* will provide information necessary for making ongoing adjustments to the activities that are best suited to meet overall objectives.

How do we know if we are being effective?

Evaluation and assessment play an important role in ensuring that resources are being used in the most effective and efficient manner and that efforts are achieving the desired outcomes. Rather than waiting until the end of an initiative, ongoing evaluation can provide valuable feedback along the way, including identifying what needs to be changed. A good evaluation can include assessment of both the process, such as how effectively a collaborative is functioning, and of outcomes, such as whether or not the desired goal was achieved and if it made an impact.

Seeing improvements in some of the factors may take a long time, and once established, it may take years to see improvements in health outcomes. However, because of the research basis of the factors, progress on each of them can be seen as benchmarks for better health and safety outcomes.

The T*H*R*I*V*E tool can play a role in evaluation since it allows people to rate how well the community is doing on particular factors and includes a process for the community to establish its own indicators for each factor. The tool can be used at periodic intervals to assess progress on particular factors or all of them, particularly with respect to the established indicators.

Many public health and safety-related organizations conduct their own systems assessments at state and local levels as well as community asset assessments. Many of these tools and approaches include performance indicators/standards. These resources can provide useful information for evaluation. Also, the Community Toolbox has valuable evaluation tools and these can be found at http://ctb.ku.edu/.

C) CONSIDERATIONS FOR ANY OR ALL OF THE FACTORS

Are there specific people or needs we should take into account when selecting appropriate activities to strengthen the community?

Different people in the community have different needs based on such characteristics as age, cultural values, and physical ability. Strengthening the community environment includes paying attention to the range of needs in the community. This includes considering:

- *Cultural context:* Consider clusters and factors in a cultural context. Values, customs, and priorities vary from one culture to another and these differences must be accounted for in designing health strategies. Activities should be selected with great care and fit with the unique characteristics of local residents.
- *Developmental needs*: Consider clusters and factors in a developmental context. When designing strategies based on the clusters and factors, developmental needs should be taken into account. Seniors, adults, teens, and young children have different needs in relation to all of the factors. Further, representatives from different age groups should be included in the planning and decision-making processes to ensure that their needs and input is accounted for. Youth, for example, are an underutilized, yet a very valuable resource
- *Disability considerations*: 20% percentage of Americans live with disabilities, many of which are not obvious by sight, and the rate of disabilities are higher in communities of color. People with disabilities have certain needs for accommodation, which should be considered when delineating solutions. People with disabilities should also be included in the planning and decision-making processes.

Is there a chance we could do damage to the community or its members?

The purpose of the T*H*R*I*V*E tool and associated process and materials is to help communities address disparities in health, promote health equity, and to improve long-term health outcomes in the local population. T*H*R*I*V*E has been shown to be an effective catalyst toward these goals. However, these goals are long-term and require long-term, deliberate action. In initiating and following through with this process, there are a number of considerations that communities should take into account to both reduce the risk of harm to the members of the community and to achieve maximum benefits of a community resilience approach. These include:

- *Unintended consequences:* Avoid unintended consequences by thoroughly thinking through the implications of an action. For example, large chain stores may be able to provide desired products; however they may bring with them traffic congestion and increased traffic and pedestrian injuries, while forcing locally-owned stores out of business. Selected actions should promote positive long-term health outcomes and do no harm in the short-term and long-term.
- *Reduce gentrification:* Improving community ambiance, opportunities, and health can change the make-up of the community. In particular it can result in displacement of people

who the tool is designed to help. Take steps to ensure that while improving the overall community the people in the community aren't pushed out. Current strategies to address this include promoting regional equity[229] and systematically fostering micro business development opportunities for people who live in the community.

D) SELECTED RESOURCES AND TOOLS FOR ADVANCING A COMMUNITY RESILIENCE APPROACH AND CLOSING THE HEALTH GAP

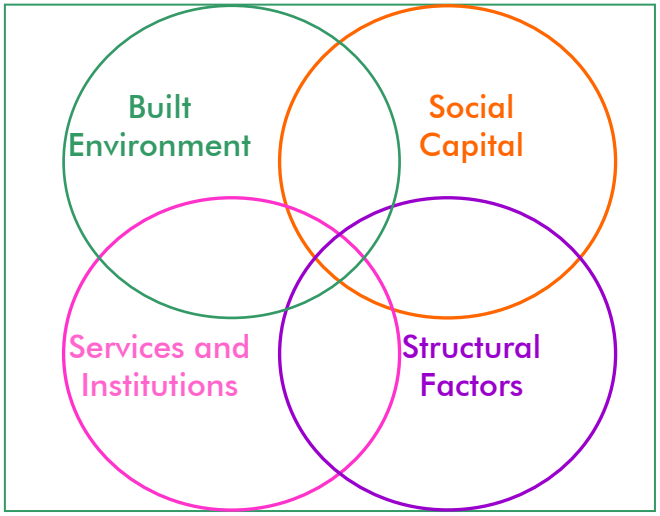
- **Prevention Institute**: Under contract with the Office of Minority Health, Prevention Institute developed the T*H*R*I*V*E tool and related products. The Institute is a nonprofit, national center dedicated to improving community health and well-being by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity, and youth development. The Institute provides tools and resources free of charge on its website, including resources on local policy development. www.preventioninstitute.org
- **Office of Minority Health, U.S. Department of Health and Human Services**: The Office of Minority Health provided the resources to develop and pilot the T*H*R*I*V*E tool. The mission of the Office of Minority Health (OMH) is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. www.omhrc.gov/omhhome.htm

- **The Aspen Institute's Roundtable on Comprehensive Community Initiatives: Measures for Community Research**: The Measures for Community Research data base is a collection of measures used to evaluate outcomes viewed as important by Comprehensive Community Initiatives (CCIs), public policy makers, program funders and experts in relevant research fields. This collection of measures covers eight substantive areas referred to as strands: Community Building, Economic Development, Employment, Education, Housing and Neighborhood Conditions, Neighborhood Safety, Social Services, and Youth Development. The database includes descriptions of primary data collection instruments, such as survey instruments, interview protocols, and self-assessment guides. In many cases, the actual instrument is also included and some can be downloaded free of charge. www.aspenmeasures.org
- **Center for Advanced Study in Nutrition and Social Marketing: Tools for Measuring Environmental Change**: This compilation of tools can be used to evaluate environmental factors such as walkability of a community, availability of healthy food in grocery stores, social supports for diet behaviors, or organizational characteristics of a worksite. These specific environments encompass the following topic areas: comprehensive, physical activity and diet, food retailers, work, church, physicians/medical care providers, food security, and school. http://socialmarketing-nutrition.ucdavis.edu/Tools/somarktools.php
- **Center for Civic Partnerships:** The Center provides intensive technical support, training and consultation services to over 100 organizations, collaboratives, cities and communities throughout the country and develops tools to help communities. www.civicpartnerships.org

- **Community Tool Box**: This web-based organization, *The Community Toolbox: Bringing Solutions to Light*, is maintained by the University of Kansas, Work Group on Health Promotion and Community Development. The Tool Box provides over 6,000 pages of practical skill-building information on over 250 different topics. Topic sections include evaluation, step-by-step instruction, examples, check-lists, and related resources. One toolbox, *Identifying Community Assets and Resources*, outlines the importance and effectiveness of emphasizing what a community has rather than what it is lacking. It focuses on the importance of using an asset and strengths based approach when trying to improve overall community well-being. http://ctb.ku.edu/
- **The Greenlining Institute:** A public policy and advocacy non-profit whose mission is to empower communities of color and other disadvantaged groups through multi-ethnic economic and leadership development, civil rights and anti-redlining activities. www.greenlining.org
- **National Association of City and County Health Officials (NACCHO)**: NACCHO is a national nonprofit organization representing local public health agencies (including city, county, metro, district, and Tribal agencies). www.naccho.org. They also have a website specifically for health disparities. http://www.naccho.org/search.cfm?topicID=21&numresults=all&showabstract=yes
- **National Charrette Institute:** Nonprofit educational institution that helps communities achieve healthy transformation through collaborative planning processes that harness the talents and energies of all interested parties. www.charretteinstitute.org/
- **National Governors Association, Center for Best Practices**: The association's ongoing mission is to support the work of the governors by providing a bipartisan forum to help shape and implement national policy and to solve state problems. www.nga.org
- **National Neighborhood Indicators Project**: The National Neighborhood Indicators Partnership (NNIP) is a collaborative effort by the Urban Institute and local partners to further the development and use of neighborhood-level information systems in local policymaking and community building. Available at: www.urban.org/nnip/index.htm
- **PolicyLink:** A national non-profit research, communications, capacity-building, and advocacy organization, dedicated to advancing policies to achieve economic and social equity based on the wisdom, voice, and experience of local constituencies. www.policylink.org
- **Task Force on Community Preventive Services:** The *Community Guide*'s Model for Linking the Social Environment to Health. By Laurie M. Anderson, PhD, MPH, Susan C. Scrimshaw, PhD, Mindy T. Fullilove, MD, Jonathan E. Fielding, MD, MPH, MBA, and the Task Force on Community Preventive Services. Am J Prev Med 2003;24(3S). pp. 12-20.
    - **U.S. Department of Health and Human Services, Health Resources and Services Administration:** Models that Work presents examples of effective approaches. www.hrsa.gov
- **World Health Organization (WHO), Health Impact Assessment (HIA)**: This website has information about health impact assessments. WHO supports the use of HIA because of its ability to influence policies, programs and/or projects, providing a foundation for improved health and wellbeing of people likely to be affected by such proposals. www.who.int/hia/en/

Section 2: Strengthening the Clusters and Factors

The T*H*R*I*V*E tool is designed to help practitioners, local decision-makers, coalitions, and residents to identify, assess, and prioritize key community resilience factors that promote health and well-being and, when strong, can help to close the health gap that divides health outcomes between the general population and racial and ethnic minorities. Once a community has selected particular factors, it must take action. This section provides information about each cluster and factor to help a community or neighborhood decide what action to take. For each cluster and factor, there are sample action items and tools and resources, as well as community examples.



Built Environment Factors*: *'Built environment' encompasses man-made physical components such as buildings and streets,[230] and includes land use, public transportation, the style and permitted uses of businesses and residences, and services that develop or maintain built environment factors.

Decisions about the built environment influence a number of health indicators. However, health and safety are rarely explicitly considered when making decisions about the built environment. Improving the built environment to promote health outcomes requires addressing zoning, planning, design, and tax incentives; developing and maintaining services related to the built environment; examining density and diversity of use; engaging community participation and ownership; fostering public health advocacy to improve built environment conditions; and training a broad range of professionals on how their sectors can promote or harm health. In addition, communities should consider how built environment factors promote or limit the capacity of people with disabilities. Communities should consider the use of health impact assessments in making decisions about the built environment. A key element in having a built environment that promotes health is having an overall plan that each sector can hook into in a coordinated manner. Many elements require specific skills and training, organizational mandates, significant funding or particular funding streams, and time. Building community support, engagement, and advocacy can help maintain a focus on the overall health of the community. Focusing on built environment elements is important not only when building from scratch but also with modifications and re-design. In both cases, it is helpful to ensure that representatives of the health sector provide input about health impact and that this information inform the process.

Sample Action Menu:

- Develop and institute policy initiatives that create *livable communities* and educate and involve community in the planning process.
- Develop mixed use built environments that incorporate residential, commercial, recreational and social uses with significant "green space."
- Develop community land trusts to preserve green space in urban and suburban communities and ensure maintenance of agricultural uses for land in rural and transitioning communities.
- Utilize design strategies that increase the number of safe playgrounds, transportation hubs with commerce, and walking trails in a community.
- Develop, rejuvenate, and redesign parks in ways that improve their utilization by the whole community.
- Improve community aesthetics by adding plants, trees and public art, developing local shops, community services, and parks in all neighborhoods, and promoting "micro-development" around transit stops.
- Promote community participation and community ownership in shaping the built environment.

Sample Resources and Tools:

- **American Planning Association (APA)**: APA is a nonprofit public interest and research organization committed to urban, suburban, regional, and rural planning. APA and its professional institute, the American Institute of Certified Planners, advance the art and science of planning to meet the needs of people and society. www.planning.org
- **The Block Booster Environmental Inventory**: Tool that assesses the physical environment of urban residential areas. The instrument measures physical incivilities (e.g. litter), territorial markers (e.g. gardens), and defensible space features (e.g. public lighting). www.aspenmeasures.org/download/bbei.pdf
- **Built Environment Community Profiles:** Funded by the Centers for Disease Control and Prevention and developed by Prevention Institute (2004), this series of community profiles describes successful community initiatives to change the built environment and delineates the relationship between these efforts and health outcomes. www.preventioninstitute.org
- **The Community Image Survey**: Tool that includes a set of slides and is used to educate people about what makes a community more livable. www.lgc.org/services/cis/index.html
- **The Community Sustainability Assessment:** Tool that covers broad range of issues through a series of checklists. http://gen.ecovillage.org/activities/csa/pdf/CSA-English.pdf
- ***Creating a Blueprint for Community Safety: A Guide for Local Action*** (1998). National Crime Prevention Council www.ncpc.org
- ***Creating Healthier Communities.*** by Tina Zenzola, MPH, Director Safe and Healthy Communities Consulting; ***The Orange County Planner***, April/May/June 2004; www.oc-apa.org
- ***Designing Safer Communities: A Crime Prevention through Environmental Design Handbook*** (1997) National Crime Prevention Council. www.ncpc.org
- ***Equitable Development Toolkit***. PolicyLink. www.policylink.org
- ***Going Local: Creating Self-Reliant Communities in a Global Age*****:** Edited by Michael Shuman, published by The Free Press in 1998.

- **International Health Impact Assessment Consortium (IMPACT):** An England-based consortium that brings together a team of highly experienced and knowledgeable specialists working in the field of health impact assessment. IMPACT offers services in research and development, consultancy and technical assistance, and education and training in HIA. www.ihia.org.uk/about.html
- **Local Government Commission**: Organization that provides resources and information about the design and the built environment. Documents of interest include *Street Design Guidelines for Healthy Neighborhoods*, which helps communities implement designs for streets that are safe, efficient and aesthetically pleasing and *The Ahwahnee Principles*, a set of guidelines for community planning that will address the problems of congestion, air pollution, loss of open space, inequitable distribution of economic resources and the loss of a sense of community. www.lgc.org
- **The Neighborhood and Family Initiative Services Survey**: Tool that examines active community environments and transportation and covers a wide range of issues including satisfaction with transportation, parks, police, health services, and schools. www.aspenmeasures.org/html/final_results.asp?table=instrument&id=146
- **The North Carolina Citizen Planner Training Program**: Community planning training with 10 modules including zoning and transportation planning. www.nc-apa.org/Citizen_Planner1.htm
- ***New Urbanism Principles*.** US Department of Housing and Urban Development. www.hud.gov
- **PlannersWeb:** Website with many useful tools and articles on zoning issues including guidelines and planning tools. www.plannersweb.com/
- **The Project for Public Spaces:** This organization has helped over 1,000 communities in 44 states and 12 countries improve their parks, markets, streets, transit stations, libraries and countless other public spaces. www.pps.org
- ***Promoting Regional Equity: A Framing Paper*.** Prepared by PolicyLink for A National Summit on Equitable Development, Social Justice, and Smart Growth www.policylink.org
- **Policy-Maker's Guide to Transit-Oriented Development:** Guide that encourages developers and urban planners to create transit-oriented communities. www.lgc.org/bookstore/land_use/publications/tod.html
- **The Praxis Project:** Organizations that supports and partners with communities to achieve health justice by providing resources and capacity for policy development, advocacy and leadership. www.thepraxisproject.org
- **Project for Public Spaces**: A nonprofit organization dedicated to creating and sustaining public places that build communities. www.pps.org
- **Rebuilding Community Initiatives:** Tool with 95 items that cover economic capital, the built environment, and the integration of public services. www.aecf.org/rci/

COMMUNITY EXAMPLE *Dudley Street Neighborhood Initiative*, Roxbury/North Dorchester, Massachusetts[1]

The Dudley Street Neighborhood Initiative (DNSI) is a nonprofit community-based effort in the Roxbury/North Dorchester area of Boston. It was formed in 1985 when city officials presented a plan to develop unused land in the Dudley Street area for corporate and other for-profit interests. Not wanting the land to be used for corporate redevelopment, community residents who had not been involved in shaping

[1] This community example was written with funding from The California Endowment.

the city's plan formed DSNI. In partnership with private, public, and nonprofit groups, forged a shared vision for the Dudley Street area.

DNSI worked with city officials to gain control over a portion of the unused land in the neighborhood. They achieved power of eminent domain over a 60-acre area called the *Triangle*, ensuring that Dudley Street residents would have a voice in planning redevelopment activities. DSNI partnered with government officials, community planners, architects, and youth to change zoning and other city regulations to close down hazardous and illegal dumping sites in the Dudley Street area. Additionally, DSNI worked with city representatives to clean up vacant lots, tow abandoned cars, and restore commuter rail service to the area, reconnecting the neighborhood to Boston with mass transit. DNSI also created additional housing, gardens, and parks. DNSI has established several community centers, which provide access to recreation, childcare, and computers.

DNSI has achieved major changes in the built environment that promote improved health outcomes. These include 1) Decreased environmental toxins by cleaning up dumping sites and closing down hazardous sites, *(environmental quality)*, 2) Increased availability of safe and affordable housing by building housing complexes for Dudley Street area residents *(housing)*, 3) Reestablished public transportation lines to connect the area with the rest of the Boston areas, which can promote access to jobs and needed services, *(transportation)*, 4) Increased opportunities for physical activity through developing parks and community centers, which can reduce the risk of chronic disease (*activity-promoting environments),* and 5) Improved the overall look and feel of the community by towing abandoned cars and creating community gardens and parks *(ambiance/aesthetic*), which can increase feeling of safety, promote crime reduction, and increase opportunities for physical activity. Further, many of these outcomes were achieved by mobilizing people in the community, including 6) Engaging community residents in advocating for zoning and planning changes (*collective efficacy)* and 7) Involving community residents in maintaining the organization and implementing its services (*civic engagement/participation).* These outcomes help promote sustainability of the effort and fostered both a sense of empowerment as well as a community capacity to make improvements. Finally, the effort has 8) Promoted economic development through job training and computer training at its community centers, establishing reliable transportation to jobs and other resources, and securing neighborhood property to benefit the community such as for housing (*economic capital)* .**For more information:** Dudley Street Neighborhood Initiative; 504 Dudley Street, Roxbury, MA 02119, 617.442.9670

21. Activity-Promoting Environment: *Places in which people can safely participate in walking, biking, and other forms of incidental and/or recreational activity.*

Designing neighborhoods that encourage activity is a strategy for increasing overall activity. While the term *physical activity* is often associated with scheduled exercise, a lifestyle that incorporates small amounts of activity throughout the day is also beneficial, and may be easier to maintain than scheduled exercise. Therefore, active neighborhoods need to both be conducive to walking and biking and offer attractive spaces for leisure-time activity. Neighborhood safety also contributes to a fuller range of outdoor physical activity options. Fostering active communities also includes ensuring the accessibility of facilities (such as cycle ways, footpaths, gyms, and

swimming pools); maintaining neighborhood aesthetics or character; encouraging mixed-use, denser neighborhoods; altering street design to be pedestrian and bike-friendly; planting trees and installing traffic calming devices or lighting.[231] (*See the Built Environment, Transportation, and Appearance/Ambiance descriptions and Sample Action Menu for more).*

Sample Action Menu[232]

- Develop safer routes for biking and walking to school as an initial focus for overall neighborhood improvements that encourage physical activity among children and adults.
- Establish attractive destinations such as parks, art, stores, and services
- Make existing parks safe and clean to encourage outdoor play. Provide funding to adequately maintain parks, playgrounds, and recreation areas. Provide equipment and make physical improvement to playgrounds.
- Open existing facilities such as schools and recreation centers for expanded drop-in hours.
- Invest in an infrastructure for youth that provides a variety of activity options including recreational activity, team sports, and classes such as martial arts and dance.
- Develop campaigns to raise awareness and motivation for physical activity
- Increase the number of play spaces for children and create recreational facilities near residential areas.
- Assure that streets, pedestrian paths and bike paths contribute to fully-connected and interesting routes to all destinations.
- Develop transit-oriented neighborhoods that include local commerce with transportation hubs
- Create bike and pedestrian-friendly routes by improving street design with curb extensions, enhanced medians, and traffic calming techniques; adopting policies and adequate funding that ensure consideration of bicycle and pedestrian needs in all transportation, land use, and zoning decisions
- Provide access to free or low-fee facilities, such as walking and biking trails.
- Negotiate with local gyms for reduced or sliding scale fees.
- Ensure funding to improve conditions of available playgrounds and recreation areas.
- Add programming and weekend and night hours to publicly-owned recreation facilities.
- Engage in multi-faceted strategies to address neighborhood safety concerns.
- Make sure that there are adequate places for people to walk with their dogs.
- Promote feelings of safety; e.g., install lighting, improve ambiance, remove graffiti.

Sample Resources and Tools

- **Active Living By Design:** A national program of The Robert Wood Johnson Foundation and part of the School of Public Health in Chapel Hill, North Carolina, this program establishes and evaluates innovative approaches to increase physical activity through community design, public policies and communications strategies. www.activelivingbydesign.org/
- **Active Living Leadership**: A national initiative funded by the Robert Wood Johnson Foundation to support government leaders as they create and promote policies, programs and places that enable active living to improve the health, well-being and vitality of communities. www.leadershipforactiveliving.org/
- **Community Walkability Assessment**: www.walkinginfo.org/pdf/walkingchecklist.pdf
- ***Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People* (2000).** Centers for Disease Control and Prevention. www.cdc.gov

- **The National Center for Walking and Bicycling:** A program of the Bicycle Federation of America, Inc. (BFA), this national, nonprofit's mission is to create bicycle-friendly and walkable communities. www.bikefed.org
- **Peaceful Playgrounds:** The purpose of the Peaceful Playground Program is to introduce children and school staff to the many choices of activities available on playgrounds and field areas. www.peacefulplaygrounds.com
- **Preschool Outdoor Environment Assessment Scale**: *Paying Attention to the Outdoor Environment Is as Important as Preparing the Indoor Environment* (May 2002), by Karen DeBord, Linda Hestenes, Robin Moore, and Nilda Cosco, in Young Children Vol. 57, No. 3, describes a new instrument to assess the quality of outdoor environments for preschoolers. The Preschool Outdoor Environment Assessment Scale covers five domains: physical environment, interactions, activity areas, program, and teacher/caregiver role. www.naeyc.org/resources/journal/item-detail.asp?page=2&docID=2716&sesID=1077207781169.
- **Prevention Institute:** A nonprofit, national center dedicated to improving community health and well-being by building momentum for effective primary prevention. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Papers of interest: *Environmental and Policy Approaches to Promoting Healthy Eating and Activity Behaviors*, www.preventioninstitute.org
- **The Strategic Alliance for Healthy Eating and Activity Environments:** The Strategic Alliance is shifting the debate on nutrition and physical activity away from a primary focus on personal responsibility and individual choice to one that examines corporate and government practices and the role of the environment in shaping eating and activity behaviors. Tools include Environmental Nutrition and Activity Community Tool (ENACT), a menu of options for local change based on best practices drawn from community efforts around the county. ENACT can be the cornerstone for policy change and can be used with a broad range of partners. www.eatbettermovemore.org

COMMUNITY EXAMPLE CALTrans Community Planning Project, Cutler/Orosi, California[2]

Concerned about high pedestrian injury rates, residents of Cutler and Orosi in Tulare County, California identified and implemented solutions through a series of community wide forums, focus groups, and workshops. Participants included representatives from church organizations, local activist groups, and local residents of the area. CALTrans provided funding through its community planning projects − community wide initiatives to make California communities more pedestrian and bicycle friendly through traffic calming measures. Since a majority of the residents are Spanish-speaking, events were conducted in both English and Spanish and translators were also provided. Outcomes of the planning project include: 1) Reduced risk of pedestrian injury by improving sidewalks (*transportation, activity-promoting environment), 2)* Increased opportunities for physical activity not only by sidewalk improvement but also through the creation of bike lanes on major roads (*transportation, activity promoting environment))*, which can reduce the risk of chronic disease, and 3) Increased accountability by establishing of a

[2] This community example was written with funding from The California Endowment.

nonprofit vision committee, charged with implementation of the final recommendations *(community-based organizations, collective efficacy)*.

2. Nutrition-Promoting Environment: *Availability and promotion of safe, healthy, affordable, culturally appropriate food.*

Increasing local access and affordability of healthy desirable food can impact the quality of a community's nutritional intake. No one approach will solve the problem of increasing access to nutritious foods. A combination of options, identified and developed with the engagement of community residents has the greatest opportunity to support low-income residents in having access to affordable, nutritious, and culturally appropriate foods. Successful ventures appear to receive some public or charitable investment, whether for equipment, site development, or training. For example, a network of farmers markets is more likely to succeed with ongoing fiscal support for management staff; farmers' fees are not sufficient to meet this cost. Another critical element of success is community support. Ventures developed with community input, or that reach out to community members once established, appeared to have a higher likelihood of long term success. Efforts to establish supermarkets (including independent grocers and national chains) and farmers markets appear to be viable. Supermarkets require greater investment of capital and a longer period to open. Farmers markets can be established more quickly, but provide primarily produce, and at limited hours. Pilot projects working with small stores and street vendors show potential to increase access to healthy food at affordable prices. Because these projects require less capital, and in many cases can build on existing infrastructure, they are a promising place for future efforts. While most households (at any income level) will not engage in food growing to meet family food needs, community gardens can serve as a very important resource for nutritious food for households with a recent tradition of food growing. Some of the successful larger gardens have attracted recent immigrants, and seniors who grew up growing food may also utilize them.[233] (*See the Built Environment cluster description and Sample Action Menu for more).*

Sample Action Menu

- Use transportation strategies to increase food access such as store initiated van services for customers from the store to the home; store initiated van services with a pick-up at home and drop-off at home; shuttle services from retirement complexes to stores and back home; enhanced transit programs including alternate or added bus routes to increase access to food owners; and home delivery services and home shopping online.[234]
- Recruit supermarkets by providing financial and regulatory incentives
- Encourage local restaurants to offer healthier menu options
- Institute a local farmers market with a strong sense of community ownership
- Make Food Stamps, Electronic Benefits Transfer, available as a payment option at farmers markets
- Promote community gardening and other forms of urban agriculture
- Adopt specific guidelines and provide training to school foodservice staff to improve the nutritional quality and appeal of meals
- Institute a farm to school program to incorporate fresh, local produce into school meals
- Encourage institutions to provide healthy options whenever meals, snacks, or refreshments are sold or provided. Limit or eliminate access to high sugar high fat food and beverages in snack bars, vending machines and other on-site sales

- Reject exclusive school and local government contracts between food and beverage corporations and schools.
- Prohibit all forms of commercialism on school grounds.
- Limit television advertising of unhealthy foods aimed at children.
- Provide neighborhood corner stores and street venders with training and equipment to increase stock of fresh produce and other healthy perishables. Facilitate relationships with alternative suppliers such as local farmers and CSA's to provide the produce and fresh foods.
- Develop community garden programs which involve youth and adults in gardening and that reconnect people with the experience of eating healthy unprocessed foods.
- Provide training, technical assistance, equipment, and other incentives to corner stores and street vendors to improve the availability of produce and other healthy food options.
- Consider food access as part of land use and economic development decisions.
- Restrict locations of fast food establishments near school property.
- Promote "family-friendly" grocery stores that limit marketing to children.
- Take on longer term solutions such as working to reverse "redlining" of underserved communities that has led to the absence of basic services taken for granted in more privileged communities, including grocery stores, bakeries, and specialty shops that provide nutritious food items.

Sample Resources and Tools

- **Center for Science in the Public Interest:** An advocacy organization that provides updated information about a variety of nutrition policy issues. Also educates the public through their award-winning Nutrition Action Healthletter, the largest-circulation health newsletter in the country. www.cspinet.org/about/index.html
- **Community Food Security Assessment Toolkit:** From the USDA, this toolkit includes the following modules: Profile of Community Food Resources, Assessment of Food Resources Accessibility, Assessment of Food Availability and Affordability, Assessment of Community Food Production Resources. www.ers.usda.gov/publications/efan02013/
- **Community Food Security Coalition**: A non-profit, North American organization dedicated to building strong, sustainable, local and regional food systems that ensure access to affordable, nutritious, and culturally appropriate food for all people at all times. www.foodsecurity.org
- **The Food Trust:** Organization that increases access to affordable and nutritious foods, improves the health of children and adults through better nutrition, supports local farms, and sustains the environment. www.thefoodtrust.org
- **Prevention Institute:** A nonprofit, national center dedicated to improving community health and well-being by building momentum for effective primary prevention. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Papers of interest: *Policy Approaches to Promoting Healthy Eating and Activity Behaviors* written for The California Endowment. www.preventioninstitute.org
- **The Strategic Alliance for Healthy Eating and Activity Environments:** The Strategic Alliance is shifting the debate on nutrition and physical activity away from a primary focus on personal responsibility and individual choice to one that examines corporate and government practices and the role of the environment in shaping eating and activity

behaviors. Tools include Environmental Nutrition and Activity Strategies Tool (ENACT), designed to help make changes on the local level to shift community norms and practices www.eatbettermovemore.org

COMMUNITY EXAMPLE *Garden of Eden*, St. Louis, Missouri[3]

The *Garden of Eden* is a community run grocery like facility established to serve the African American community in St. Louis. The project was initiated because local advocates and researchers identified obesity as a major health concern. Further, Abraham's Children (AC), a project of Interfaith Partnership of Metro St. Louis working with more than 45 churches, recognized a lack of healthy foods, particularly in the city. At the suggestion of one health advocate from an AC church, a diverse alliance established the *Garden of Eden.*

Funded by the Centers for Disease Control and Prevention, the effort has been a partnership between Abraham's Children, St. Louis University School of Public Health, and Health Works, a local business in St. Louis. The three entities entered into a joint decision making process, which requires approval by all the partners before moving forward. It also capitalizes on the strengths of each entity. For example, all partners developed a plan and applied for grants to support the project. A church donated the space in its basement to house the market. Local businesses have guided the design and layout of the market. A local supermarket chain, *SaveALot*, trained community members. Abraham's Children, which has lay health workers in each of its member churches, provides health counseling and information to members of participating congregations. Further, community members have contributed their understanding of community needs and strengths to the staffing and management of running the store. For example, they recommended that seniors in the community could be trained as nutrition educators. State and local minority health agencies have also lent their expertise to the effort.

The *Garden of Eden* is opening its doors in July 2003. Even before opening, the effort had already achieved four major outcomes. These are: 1) Increasing knowledge and skills regarding fruits and vegetables and physical activity (*nutrition- and activity-promoting environment*s); 2) Job training for community residents (*economic capital);* 3) Empowering residents as demonstrated by reports from members of the participating groups that they feel motivated and organized to address other health concerns in their community after having successfully implemented this project (*collective efficacy*). This was initiated by developing a community dialogue about the relationship between community resources (e.g. a market) and behavior (e.g. healthy eating); and 4) Establishing a community-run grocery like facility (*nutrition-promoting environment)*, which holds the promise of improving fruit and vegetable intake among African Americans in St. Louis. Over time, this can result in improved health outcomes such as reduced risk of chronic disease.

[3] This community example was written with funding from The California Endowment.

3. Housing: *Availability of safe, affordable housing in the community.*

Having safe, affordable housing is a basic need and is critical to good health. The design and structure of housing is important as well; good lighting can promote safety while poorly designed staircases can cause preventable injuries. Lead or other toxins present in the pipes or paint of the home environment can cause ill health. The location of the housing in itself is vital: housing should be within walking distance of healthy fruits, vegetables, and other wholesome products. The layout of the community is essential as well—wide sidewalks and plentiful green space make neighborhoods feel safe and walkable, while quickly moving traffic and a lack of sidewalks discourage outdoor walking and recreation.

Ensuring that people have housing that promotes health and safety outcomes requires ensuring that there is an adequate amount of housing, that housing options include mixed-income, that housing is maintained, that people who live in the housing have pride in where they live and are engaged in making and keeping it an appealing place to live. Pride comes from a sense of ownership, through participation in such things as design, maintenance, and appearance, as well as through actual ownership. (*See the Built Environment cluster description and Sample Action Menu for more).*

Sample Action Menu

- Amend city or regional zoning codes to create a "linkage ordinance" requiring developers of major commercial projects either to pay a specified fee to an affordable housing trust fund created by the city or to develop an equivalent value of affordable housing.[235]
- Offer tax exemptions for housing that is affordable to very low-income households.[236]
- Encourage the local housing and community development departments to offer financial incentives to for-profit and not-for-profit housing developers to construct multi-family housing, to renovate existing housing, to construct emergency shelters, and to create housing projects with pockets of low-income housing.[237]
- Create a "Livable Communities Fund" that provides funding for local municipalities to clean up land for redevelopment, to create more affordable housing, and to pursue demonstration projects that use land, services, and infrastructure efficiently.[238]
- Adopt an inclusive housing program that requires large developers to make a certain percentage of their units affordable in return for an increase in the allowed unit density.[239]
- Develop a coalition that can educate city councils, planning commissions, and community groups about housing affordability issues and can propose initiatives aimed at developing substantive solutions to local housing crises.[240]
- Adopt parallel sets of local zoning codes, one of which is old and one of which is based on "smart growth". The existence of parallel zoning codes will allow the market to sort out the successes of "smart growth" without having them prescribed by the government.[241]
- Develop a checklist for evaluating housing projects so that community residents can establish whether the physical characteristics of the project meet the needs of potential residents.[242]
- Work with residents of low-income neighborhoods to form a residents' association where homeowners and tenants can voice grievances and discuss solutions to some of the housing-related problems faced by their neighborhood.[243]
- Address aspects of housing conditions that may influence mental health, physical activity, and injury and violence.

- Encourage utilization of first time homebuyers' programs and examine alternative housing models such as co-housing and tenants-in-common.

Sample Resources and Tools

- **Association of Bay Area Governments**: The Association of Bay Area Governments (ABAG) is one of more than 560 regional planning agencies across the nation working to help solve problems in areas such as land use, housing, environmental quality, and economic development. www.abag.ca.gov/
- **Fannie Mae**: A Fortune 500, shareholder-owned company with a public-spirited mission: to tear down barriers, lower costs, and increase the opportunities for homeownership and affordable rental housing for all Americans, especially minorities. www.fanniemae.com
- **National Low-Income Housing Coalition's Advocates' Guide**: Website tool where data can be accessed for a state, county or metro area. For each area, the site calculates how much money a household must earn to afford a rental unit of various sizes at fair market rent. The hourly wage needed is also given. www.nlihc.org/advocates/index.htm
- **US Department of Housing and Urban Development (HUD):** HUD's mission is to increase homeownership, support community development and increase access to affordable housing free from discrimination. To fulfill this mission, HUD embraces high standards of ethics, management and accountability and forge new partnerships--particularly with faith-based and community organizations--that leverage resources and improve HUD's ability to be effective on the community level. www.hud.gov

COMMUNITY EXAMPLE *Diggs Town Public Housing Redevelopment Project,* Norfolk, Virginia

Diggs Town, a large low-income public housing project, was built in Norfolk, Virginia in 1950. Like many public housing projects, Diggs Town was built without much thought to constructional character or giving residents a sense of ownership of their community. Instead, Diggs Town appeared bleak—row after row of little box dwellings resting on patches of uncultivated land. Residents were experiencing many problems with violence, unemployment, drug use, and other crime. In 1990, the Norfolk Redevelopment and Housing Authority (NRHA) began the Diggs Town redevelopment project.[244]

The NRHA commissioned Urban Design Associates (UDA) to work with Diggs Town residents in the redevelopment of their community. The thought behind this was that if residents were engaged in the process, they would feel a sense of ownership of their community, and therefore take pride in its maintenance. Additionally, it was thought that the residents themselves would be the best "experts" on the housing project, because they were there every day, and could therefore assist UDA in identifying both the weaknesses and assets of the community. As partners in the redevelopment project, residents expressed the need for front porches—to have space where residence could socialize with each other.

The Diggs Town Public Housing Redevelopment Project produced the following outcomes 1) Improved public safety as indicated by decreased calls to police (*housing, public safety*), 2) Fostered a sense of ownership, pride, and collective upkeep through designating individual space and community gardens in common areas (*appearance/ambiance, collective efficacy*), 3) Established DEEDS (Diggs Town Economic Empowerment Demonstration) which integrates social services into Diggs Town with the goal of increasing the self-sufficiency of residents (*community-based organizations, economic capital*).

4. Transportation: *Availability of safe and affordable methods for moving people around.*

Transportation is vital for a well-functioning community. Strengthening transportation and transit requires examining density; implementing diverse options; identifying the range of needs, current options, and gaps; and ensuring that options meet the needs of people of different age groups and physical abilities. Transit-oriented approaches can aid in designing effective transportation systems within communities and to resources outside the community. Land use laws drive auto-oriented development and therefore addressing these laws can reduce reliance on autos and promote transit-oriented development. Urban, suburban, and rural communities face different needs and challenges in designing and delivering effective transportation systems and services. Rural communities have to be innovative because they lack the density to support frequent service. (*See the Built Environment and Activity-Promoting Environment descriptions and Sample Action Menu for more).*

Sample Action Menu

- Assess the transportation needs and gaps. First identify whether or not local agencies, such as clinics, bus companies, and school systems have conducted analysis, and first use these. Consider developing a transportation checklist to assess what is currently happening.
- Increase user rates on public transportation such as through convenient schedules and shifting norms about usage.
- Ensure reliable, frequent, and affordable transportation to schools, work, medical services, cultural events and institutions, and places for recreation and activity. In low-income neighborhoods, analyze the location of public transportation routes in relation to schools, businesses, day care, and health care centers in order to determine whether public transportation adequately serves low-income populations.[245]
- Involve communities in planning local transportation services. Develop a set of criteria that communities can use to evaluate efforts by the local transportation authority to comply with Title VI of the 1964 Civil Rights Act and involve low-income, communities of color in the design of local transportation projects. [246]
- Establish tax subsidies to support local transportation efforts.
- Consider shuttle services or use jitneys in rural areas.
- Develop transportation hubs with local commerce.
- Design tree-lined streets that are narrow and curved with bicycle lanes and sidewalks to discourage fast-moving automobile traffic.
- Use a safety checklist to evaluate the security of local transportation for individuals who are more vulnerable to assault. The checklist can be used to evaluate the lighting, escape routes, possible entrapment sites, and visibility at bus, subway or train stations as well as to develop a plan with transportation administrators for improving the safety of local public transportation.
- Work with local transportation officials to develop design guidelines for the local public transportation system that incorporate measures for safety promotion.[247]
- Identify high-crime transit lines in the community. Invite local politicians to ride these lines together with a group of residents and use this opportunity to discuss the importance of safe, accessible public transportation[248] and identify specific items that local politicians can work to improve.

- Develop a local ballot measure requiring elected officials to use public transportation a minimum number of days per week.[249]
- Lobby local transportation officials to more strictly regulate the display of images on public transportation that target women and children and that condone or encourage violence against them. Work with the transportation administration to develop a policy on advertising on public transportation vehicles or property.[250]
- Assess bussing policies and whether or not students are bussed long distances to go to schools. Work with school districts and parent teacher associations to ensure that students are allowed to go to nearby schools, if that is more suitable for parents.
- Consider free or reduced transit to and from local grocery stores, community events, and institutions such as schools and libraries.
- Explore opportunities to promote traffic calming to improve people's perceived and actual experience of getting to and from transit.
- Partner with local groups and resources such as local bicycle and pedestrian coalitions, local bus companies, school bus companies, fire departments, metropolitan transit authorities, metropolitan planning organizations, departments of motor vehicles, and air quality management districts

Sample Resources and Tools

- ***A Citizen's Guide to Transportation Decision Making.*** Federal Highway Administration and Federal Transit Authority www.fhwa.dot.gov/planning/citizen/
- **Federal Highway Administration (FHA):** Federal agency charged with the broad responsibility of ensuring that America's roads and highways continue to be the safest and most technologically up-to-date. Although State, local, and tribal governments own most of the Nation's highways, FHA provides financial and technical support to them for constructing, improving, and preserving America's highway system. Our annual budget of more than $30 billion is funded by fuel and motor vehicle excise taxes. The budget is primarily divided between Federal-aid funding to State and local governments and Federal Lands Highways funding for national parks, national forests, Indian lands, and other land under Federal stewardship. www.fhwa.dot.gov
- **Federal Transit Authority:** Federal agency that improves public transportation for America's communities through research, provision of technical assistance, data, and grant programs. www.fta.dot.gov
- **National Highway Traffic Safety Administration (NHTSA).** NHTSA, a part of the Department of Transportation, is headquartered in Washington, D.C., with regional offices located across the United States. NHTSA works closely with the Federal Motor Carrier Safety Administration to promote motor carrier safety. www.nhtsa.gov
- ***New Community Design to the Rescue*** (2001). National Governor's Association. www.nga.gov
- **Surface Transportation Policy Project**: The Project is a diverse, nationwide coalition working to ensure safer communities and smarter transportation choices that enhance the economy, improve public health, promote social equity, and protect the environment. www.transact.org
- ***Supporting Transportation Decision-making: An Overview to Metropolitan Planning.*** The Metropolitan Capacity Building Program**.** Presented by Federal Highway Administration and

Federal Transit Authority in association with The National Highway Institute. www.planning.org/resources-yc/mcb.htm

- ***Transportation and Environmental Justice*** *(2000)*. [Publication # FHWA-EP-01-010] Federal Highway Administration and Federal Transit Authority www.fhwa.dot.gov/environment/ej2000.htm
- **US Department of Transportation**. The mission of the Department is to serve the United States by ensuring a fast, safe, efficient, accessible and convenient transportation system that meets vital national interests and enhances the quality of life of the American people, today and into the future. www.dot.gov
- **Youth Educational Program**: Funded by the National Highway Traffic Safety Administration and developed by Prevention Institute, this toolkit provides information and resources to improve safety belt usage and reduce impaired driving among African American and Latino youth. www.preventioninstitute.org

COMMUNITY EXAMPLE Fruitvale Transit Village, Oakland, California

Fruitvale is a low-income, predominantly minority community in Oakland, California. In 1991, Bay Area Rapid Transit (BART) unveiled its plan to construct a large parking structure that would separate the Fruitvale BART station from the surrounding community. Upon hearing this news, the Unity Council (a community development corporation within Oakland created to provide space for working on issues impacting the Latino community within Fruitvale) organized community opposition to BART's plan. The Council and residents of Fruitvale insisted that there was a better way to develop the Fruitvale station. BART listened, and began working with the Unity Council to develop a new plan.

In 1992, the Unity Council held meetings to bring together various stakeholders. The success of the Fruitvale Transit Village Project has been attributed to the amount of collaboration that took place between stakeholders. Participants in these meetings were asked to name specific goals for the project. These included: improved public safety, increased availability of jobs in Fruitvale, increased number of services within the community, affordable housing, and improved air quality within the community through reducing pollutants from traffic. As a result of resident input, two new buildings were constructed for housing and office space, and a pedestrian walkway was built connecting the BART station area with the greater Fruitvale area.

The following outcomes were achieved as a result of the Fruitvale Transit Village Project, 1) Businesses were brought into the area and increased the availability of local jobs (*economic capital*), 2) Availability of public services (*public health, health, and human services*), 3) Reduction of air pollution resulting from traffic (*environmental quality*), 4) Engaged residents as part of the solution (*collective efficacy, civic engagement/participation*), 5) Affordable housing was located next to a major transportation site (*housing, transportation*), and 6) The project was designed with community input in the process and aesthetics were integrated into the planning process (*appearance and ambiance).*

5. Environmental Quality: *Safe and non-toxic water, soil, indoor and outdoor air, and building materials*.

The quality of environmental factors plays an important role in community health and well being. To promote safe environmental quality, community members should focus on the quality of the air, water and soil, as well as attempting to rid the area of toxins, reduce car use and tract housing, encourage sustainable agriculture, maintain open space, and develop green space. In order to protect and preserve their environment, community members can foster outreach and organize around relevant environment issues. (*See the Built Environment cluster description and Sample Action Menu for more).*

Sample Action Menu

- Map neighborhoods to identify sites that need clean-up and utilize decontaminated sites as a resource for the community.
- Create open green space, plant trees, and create 'pocket' parks.
- Identify, abate and reduce exposure to environmental toxins.
- Remove and reduce spread of asphalt so that natural water filtration processes are not threatened.
- Educate and organize community members around environmental issues and engage them in improving environmental quality.
- Test for and abate lead in housing.
- Test the water for toxins in apartment buildings and schools and change pipes and fixtures when needed.
- Encourage sustainable agriculture.
- Minimize tract housing development.
- Promote infill to reduce sprawl.
- Reduce pesticide exposure in agricultural areas.
- Assess air quality and identify funding opportunities from the air quality management district to identify ways to reduce particulate matter by reducing traffic

Sample Resources and Tools

- ***The Ahwahnee Principles*:** These lay out a set of guidelines for community planning that will address the problems of congestion, air pollution, loss of open space, inequitable distribution of economic resources and the loss of a sense of community. www.lgc.org
- **Californians for Pesticide Reform:** Provides information about the location and amount of pesticides used for agricultural applications in 1999 in all of California's 58 counties. www.pesticidereform.org/datamaps/maps.html, also visit www.pesticideinfo.org/Index.html to view an array of information from many different sources, including specific California pesticide use data and regulatory information.
- **Centers for Disease Control and Prevention, National Center for Environmental Health.** CDC's National Center for Environmental Health (NCEH) strives to promote health and quality of life by preventing or controlling those diseases or deaths that result from interactions between people and their environment. www.cdc.gov/nceh/
- **Center for Health, Environment and Justice (CHEJ):** A national environmental organization founded and led by grassroots leaders. After winning the federal relocation of residents victimized by toxic waste at Love Canal, Lois Gibbs and other local activists were inundated with calls from people around the country who were facing similar threats and wanted help. www.chej.org.
- **The Collaborative on Health and the Environment**: Tracks emerging scientific evidence on links between diseases, disorders and disabilities and possible environmental causes. www.protectingourhealth.org/
- ***Considering Cumulative Effects*:** Under the National Environmental Policy Act; Council On Environmental Quality Executive Office of the President; January 1997; http://ceq.eh.doe.gov/nepa/ccenepa/ccenepa.htm
- **Environmental Defense's Scorecard:** This site provides an assessment of environmental quality in a community. www.scorecard.org .

- **EnvironmentalHealthNews:** Daily publication to help increase public understanding of emerging scientific links between environmental exposures and human health. www.environmentalhealthnews.org/
- **Environmental Research Foundation (ERF) Newsletter:** Provides clear scientific information about human health and the environment www.rachel.org
- ***Fighting Childhood Asthma: How Communities Can Win:*** A PolicyLink Report, Fall 2002 www.calendow.org/reference/publications/pdf/disparities/Childhood_Asthma_Policy_Link.pdf
- **Marin Agricultural Land Trust (MALT):** Land trust focused on farmland preservation, MALT encourages public policies that support and enhance agriculture and has permanently protected 35,000 acres of land on 53 family farms and ranches. www.malt.org
- ***Roots of Change Report/Blueprint for Change:*** A report to increase awareness about the need for and the benefits of sustainable food systems, stimulate dialogue, and attract a wide array of stakeholders, opinion leaders, and decision-makers to the discussion. www.fawg.org/roots.html
- ***Transportation & Environmental Justice; Case Studies***: US Department of Transportation; Federal Highway Administration, Federal Transit Administration; December 2000; www.fhwa.dot.gov/environment/ej2.htm.

COMMUNITY EXAMPLE Cultivating Communities, Seattle Washington[4]

Cultivating Communities is a neighborhood gardening program for low-income communities in Seattle, Washington. The program was developed when Seattle Housing Authority (SHA) recognized that residents were planting gardens outside their homes, where the soil was potentially contaminated with lead. To address the problem, SHA partnered with the Department of Neighborhoods' *P-Patch* program, which helps Seattle residents develop unused plots of land in the city. Together they formed *Cultivating Communities* in 1995, adopting a proactive approach to working with low-income communities and immigrant populations. Seattle now has 17 community gardens in 4 SHA sites in different communities, providing lead-free organic gardening space for more than 120 families to grow food for family and friends. Two of the four participating communities, Rainer Vista and Yessler Terrace, have populations in which 50% of the residents are of Southeast Asian origin, many with agricultural backgrounds.

Cultivating Communities has leveraged local resources to support the community gardens, such as the *Neighborhood Matching Fund* (NMF) administered through Seattle city government. Applications to the *Cultivating Communities* program are available to any community group, which can form for the purpose of getting a community garden. *Cultivating Communities* also assists residents with grant management if needed. Currently, *Cultivating Communities* is transferring the management of existing gardens to community residents and establishing new gardens in recently redeveloped communities. *Cultivating Communities* also has two community-supported agriculture (CSA) enterprises that provide supplemental income for some families. Subscribers pay a set fee and receive a bag of fresh organic produce for 24 weeks. The interaction between customers and gardeners enables the gardeners practice their English skills and links them to the broader Seattle community, helping them adjust to life in the United States. Since most of the gardeners had little contact with each other when the

[4] This community example was written with funding from The California Endowment.

project began, the enterprise is also helping to build community among the gardeners themselves.

Cultivating Communities addressed a potentially harmful problem by building on the capacity and skills of residents and leveraging local resources. The program has resulted in multiple health-promoting outcomes. Most directly, these include 1) Decreased exposure to lead by providing lead-free gardening plots (*environmental quality); 2)* Decreased risk of chronic disease as a result of increased availability of healthy food (*nutrition-promoting environment);* and 3) Decreased risk of mental health problems and violence by promoting social connections and trust between community members (*social cohesion and trust).* In fact, residents have noted that relationships among neighbors have contributed to community building and crime prevention. Additionally, the program has achieved outcomes that indirectly promote health including 4) Increased economic opportunity through supplemental income development and increasing participant skills (*economic capital)*; 5) Opportunities to learn English (*education and literacy)*; and 6) Improved relations between different racial and ethnic groups (*racial, ethnic and intergroup dynamics).*

For more information: Cultivating Communities; (p) 206-684-0540; 700 3rd Ave 4th fl.; Seattle, WA 98104-1848; martha.goodlett@ci.seattle.wa.us; www.seattletilth.org/resources/csalist.html#9

6. Product availability: *Availability of beneficial products such as books and school supplies, sports equipment, arts and crafts supplies, and other recreational items; and limited availability or lack, of potentially harmful products such as tobacco, firearms, alcohol, and other drugs.*

Having health-promoting products available to a community -- and a limited availability of harmful products -- requires both creating a demand and simultaneously influencing which products are available. Both can be fostered through zoning and land use, tax incentives and subsidies, training purchasers and merchants, and creating community pressure. (*See the Built Environment and Nutrition-Promoting Environment descriptions and Sample Action Menu for more).*

Sample Action Menu:

- Work with policymakers and local elected officials to place restrictions on the density of alcohol outlets within a community.[251]
- Work with local merchants to increase availability of products that meet key community needs and provide technical assistance to them to address barriers to the provision of such goods.[252]
- Support indigenous entrepreneurship for individuals from impacted neighborhoods who know and are committed to addressing the community's needs. Help can come in the form of technical assistance, alternative financing, training, and mentorship.[253]
- Create incentives for businesses to provide needed products in under-resourced communities. Utilize Empowerment and Enterprise Zone strategies to promote business development.
- Lobby local and state government for the passage of a law prohibiting youth below the age of 21 from selling alcohol.[254]

- Work with local elected officials to restrict the sale of alcohol at community events and at locations that are publicly owned or are open to the public (ie parks, recreation facilities).[255]
- Support stores that sell necessities (school supplies, for example) to deliver products to people who may not otherwise be able to get them. In rural communities, engage shuttle and jitney services as delivery vehicles as well.
- Promote and support street markets that furnish healthy products.

Sample Resources and Tools

- **Berkeley Media Studies Group**: Organization that works with community groups, journalists and public health professionals to use the power of the media to advance healthy public policy. Resources and services include media advocacy planning, strategic consultation, training, case studies, framing memos, content analysis, and journalism education. www.bmsg.org.
- **Built Environment Community Profiles:** Funded by the Centers for Disease Control and Prevention and developed by Prevention Institute (2004), this series of community profiles describes successful community initiatives, including efforts to reduce alcohol density.www.preventioninstitute.org
- **Community Action Model:** See community example below. Available in English and Spanish at http://sftfc.globalink.org/capacity.html.
- **Million Mom March:** Movement dedicated to creating an America free from gun violence, where all Americans are safe at home, at school, at work, and in their communities. www.millionmommarch.org/
- **National Safe Kids Coalition: N**on-profit organization dedicated solely to the prevention of unintentional childhood injury — the number one killer of children ages 14 and under. www.safekids.org/**.**
- **Pacific Institute for Research and Evaluation: N**onprofit organization merging scientific knowledge and proven practice to create solutions that improve health, safety and well being for individuals, communities, nations and the world. www.pire.org/
- **The Praxis Project**: Supports and partners with communities to achieve health justice by providing resources and capacity for policy development, advocacy and leadership. Includes tools for tobacco control in communities of color. www.thepraxisproject.org/tools.html

COMMUNITY EXAMPLE San Francisco Tobacco Free Project Community Action Model, San Francisco California

In 1996, the San Francisco Tobacco Free Project (SFTFP) began funding local community-based organizations (CBOs) to work with community advocates to implement the five-step Community Action Model (CAM). CAM is being used to successfully address social determinants of tobacco related health disparities. It is designed to foster community engagement in engineering environmental change through policy development and change in organizational practices.

Based on the theory of Paulo Friere, the CAM model involves participatory action research, and builds on the strengths of a community to create change from within. SFTFP is a constituent part of a larger movement in prevention that is working to shift the focus away from changing individual behaviors and towards examining and shaping the environment in ways that support healthy choices. CAM provides a framework for community members to acquire the skills and resources to investigate the health of the

place where they live and then plan, implement and evaluate actions that change those places in ways that promote and improve health and community wellness.

The CAM is a community organizing approach that involves a five-step process. This process includes: 1) participating in skill based trainings about the model and choosing a focus area that has meaning to the community; 2) defining, designing and implementing a community diagnosis to find the root causes of a community concern or issue and the resources to overcome it; 3) analyzing the results of the diagnosis and preparing their findings; 4) selecting, planning, and implementing an achievable and sustainable action and/or activity to address the issue of concern, and 5) enforcing and maintaining the action to ensure that their efforts will be maintained over the long term.

Over a nine year period ending in 2004, thirty-seven projects have been or will be funded over six funding cycles. CAM projects implemented by local community-based groups to date have included a) a city wide ban on tobacco ads; b) development and passage of policies to ban tobacco food subsidiary products in San Francisco schools by the SFUSD school board; c) a smoke-free parks policy; d) improved regulation to prevent teen access to tobacco on the internet; and e) tenant-driven smoke free policies in multi-unit housing complexes. The many positive outcomes of CAM include 1) increased funding to activist-oriented CBO's (*economic capital; community-based organizations*), 2) lasting impact in developing both individual and organizational capacity to continue social justice work by creating environmental change through policies (*collective efficacy, services and institutions*), and 3) meaningful involvement of community members in creating quality and health-supporting local environments (*civic participation/engagement*).

For more information: San Francisco Department of Public Health Community Health Promotion & Prev. Branch Tobacco Free Project 30 Van Ness, #2300 San Francisco, California 94102 English: 1-800-662-8887; Spanish: 1-800-456-6386 Materials and curriculum about the CAM are available in English and Spanish at http://sftfc.globalink.org/capacity.html.

7. Appearance/Ambiance: *Well-maintained, appealing, clean, and culturally relevant visual and auditory environment.*

A welcoming and culturally appropriate appearance and 'community feel' can encourage people to go out, which in turn fosters social connections and physical activity and can translate into economic benefits. More specifically, appearance can impact both perceptions of safety and reductions in crime. Comfortable places to sit, shops, community gardens, and broad community participation in planning and creation can promote a safe, healthy environment. Community members can focus on removing blight and garbage, beautification, and maintenance. Neighborhoods should be designed as an appealing and interactive reflection of the people in the community. (*See the Built Environment Activity-Promoting Environment, Transportation, and Artistic/Cultural Opportunities descriptions and Sample Action Menu for more.)*

Sample Action Menu:

- Assess the physical space in the community (streets, sidewalk design, pace and frequency of traffic, green space, comfortable sitting places, desirable shops reflective of local culture and diversity, etc.)
  - Engage broad participation in the planning and creation of aesthetically pleasing places and ensure that local culture is reflected and that there are places or elements appealing to people of different ages.
  - Consider different sensory aesthetics such as visual and sound.
  - Remove elements that threaten the overall aesthetic/ambiance such as blight, garbage, and unwanted or offensive graffiti.
- Support and encourage activities that improve the overall aesthetic/ambiance such as planting trees and community gardens, painting murals, and holding clean-up days.
- Provide places for people with their pets.

Sample Resources & Tools:

- **The Block Booster Environmental Inventory:** Assesses the physical environment of urban residential areas. The instrument measures physical incivilities (e.g. litter), territorial markers (e.g. gardens), and defensible space features (e.g. public lighting). www.aspenmeasures.org/download/bbei.pdf
- ***Broken Windows' and the Risk of Gonorrhea:*** by Deborah Cohen, MD, MPH, Suzanne Spear, MA et al, *American Journal of Public Health*; February 2000, vol. 90. No. 2, pg 230.
- ***The Tipping Point: Why is the city suddenly so much safer – could it be that crime really is an epidemic?*** by Malcolm Gladwell; from *New Yorker*; June 3, 1996, pg 8-14

COMMUNITY EXAMPLE Housing, Chicago Illinois[5]

A Chicago housing project was transformed through an award-winning architectural makeover. Prior to the renovation, tenants did not feel safe enough to sit outside their front door, where chain-linked fences enclosed corridors and created a prison-like environment. In the process of the redesign, the chain link fences were eliminated and the buildings were enclosed with glass. The president of the Tenants' Association explained, "Nobody thought the idea of putting glass over the sides of the buildings would really work, but it changed everything. You couldn't help but see a rosier day."

Improving the ambiance of the community led to 1) a significant reduction in theft and violence in the building. In addition to anecdotal reports, the head of the local Chamber of Commerce has found that reports of small theft and violence from the building have virtually stopped. Improvements have created real changes in both the sense of safety within the complex and actual reduction in reports of some types of crime (*housing*, *public safety*). This improved sense of safety has created opportunities for interaction as people are comfortable being in the common spaces of the complex (*social cohesion and trust*) and are more comfortable walking around (*activity-promoting environment*).

[5] This community example was written with funding from The California Endowment.

Social Capital Factors: *Connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them.*

Research associates social capital with a number of health outcomes.[256] Modifying social capital at community and neighborhood levels may be a promising intervention to promote health.[257] While it is valuable in all communities, it may be a particularly important emphasis in efforts to reduce disparities. This is because communities that experience disparities have historically been disenfranchised and reversing a history such practices as neglect, disenfranchisement, redlining may require the collective support, power and advocacy of people within the community to demand change. There is a rich history of social movements in communities of color that have built on social capital factors such as indigenous leadership and civic participation. A social capital emphasis can also be placed on fostering relationships with networks outside the community, thereby increasing advocacy power and connecting the community to resources, such as financial opportunities or decision-making venues. Social capital can be promoted through community and building design, through events and programs designed to foster relationships and understanding, and through training to build up the capacity of community members to participate in the community and intervene when appropriate.

Sample Action Menu:

- Develop policies that require land use patterns that encourage neighborhood interaction and create a sense of community. Some communities are using expanded "green space" and the creation of community gathering points that are "neither home nor work."
- Create attractive environs that encourage the social interaction necessary for developing cohesion and trust.
- Assess and address the physical environment of residential neighborhoods by identifying assets that can be built upon and inventory challenges such as "physical incivilities" such as litter, territorial markers such as gardens, and defensible space features such as lighting.
- Promote integrated (intercultural, intergenerational, etc.) activities.
- Create opportunities for community members to become engaged in the community, in issues that affect the community, and with each other.
- Recognize and build indigenous leadership within communities.

Sample Resources and Tools:

- ***Bowling Alone: The Collapse and Revival of American Community***. By Robert Putnam, New York, NY: Simone & Schuster, 2000.
- **The Foundation Consortium:** An alliance of corporate, private, community and family foundations that share a common vision for California's children, families and communities. www.foundationconsortium.org
- ***Measuring Social Capital in Five Communities in NSW***: The paper provides a brief overview of the study of Social capital as the raw material of civil society. It measures how social capital is created from the myriad of everyday interactions between people. It is not located within the individual person or within the social structure, but in the space between people. It is not the property of the organization, the market or the state, though all can engage in its production. www.mapl.com.au/A2.htm.
- **Promising Practices Network** (PPN)**:** A network web site that highlights programs and practices that credible research indicates are effective in improving outcomes for children, youth, and families. The information offered is organized around three major areas: Proven

and promising Programs, Research in Brief, and Strengthening Service Delivery. www.promisingpractices.net.

- **Search Institute:** An independent, nonprofit organization whose mission is to advance the well being of adolescents and children by generating knowledge on developmental assets and promoting their application to social and health issues. www.search-institute.org/.

8. Social Cohesion and Trust: *Strong social ties among persons and positions, built upon mutual obligations, opportunities to exchange information, shared norms, and the ability to enforce standards and administer sanctions.*[258]

Enhancing social cohesion and trust involves building and fostering networks and relationships. To achieve this, communities can encourage interaction by sponsoring intergenerational activities, designing communities with common public spaces to encourage interaction, holding events that bring people together, and ensuring that community members identify with the community in which they live.

Sample Action Menu:

- Set up multiracial community task forces that engage in searching discussions about what racism is, how it affects the community, what solutions there might be and how to talk with the larger community about these issues.[259]
- Foster group process in programs as a conscious step towards transforming rigid and top-heavy initiatives into creative, flexible and responsive ones that emphasize relationships between individuals.[260]
- Develop neighborhood centers where people can interact and hold community meetings and events.
- Establish green spaces, comfortable sitting spaces, and community gardens where people can meet and converse.
- Hold annual community events and celebrations centered on themes of interest to members of the community.
- Encourage interaction through intergenerational and interracial activities as well as around common interests.
- Promote understanding across differences including culture, age, and disability.
- Set up mentoring programs through community churches and community-based organizations.
- Establish support groups/peer groups for community members experiencing similar circumstances (new parents, recent loss, etc.)
- Ensure that community events reflect the cultural diversity and values of the neighborhood, meet the language needs of community members, and hold appeal for people of different ages.
- Welcome new members of the community to the neighborhood and let them know about available resources and services.

Sample Resources and Tools:

- **America's Promise:** A collaborative network that builds upon the collective power of communities to help fulfill the Five Promises for every person; caring adults, safe places, a healthy start, marketable skills and opportunities to serve. If the Five Promises are consistently fulfilled, they can significantly advance the health and well-being of the next

generation – increasing the chances of youth becoming successful adults. www.americaspromise.org/

- **Big Brothers Big Sisters**: Organization that serves over 200,000 children, ages 6 through 18, in 5,000 communities across all 50 states. Big Brothers Big Sisters one on one mentoring helps at-risk youth overcome the many challenges they face. www.bbbsa.org
- **California Healthy Kids Survey:** Utilized by the California Department of Education and developed by WestEd, this measurement tool has many modules including a resilience module. Responses on this module correlate with academic achievement scores. www.wested.org
- ***Political Heat.*** by Malcolm Gladwell, *The New Yorker*; August 12, 2002, page 76: Review of a book about human and fiscal cost of a heat wave in Chicago, 1995; also see the actual book *Heat Wave: A Social Autopsy of Disaster in Chicago* (Chicago)
- **Search Institute:** An independent, nonprofit organization whose mission is to advance the well being of adolescents and children by generating knowledge on developmental assets and promoting their application to social and health issues. www.search-institute.org/.
- **Substance Abuse and Mental health Services Administration, Center for Mental Health Services**: SAMHSA's vision is a life in the community for everyone. SAMHSA's mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. www.samhsa.gov.

COMMUNITY EXAMPLE *Shreveport/Bossier Community Renewal*, Shreveport, Louisiana

Shreveport/Bossier Community Renewal (SBCR) is an effort to rebuild the social bonds within the Shreveport region of Louisiana, a low-income area with high crime rates. The theory upon which the project is founded is that building these relationships, and thereby strengthening community, is the *only* way that "society [can] realize the true sense of community that is necessary to make everything else work...."[261]

In 1992, SBCR founder/coordinator, Mack McCarter began meeting and building relationships with other Shreveport residents. McCarter had wanted to do something about the racial tensions and the resulting social problems within Shreveport, but wasn't clear on *how* to go about accomplishing this. Through partnering with the Black community, business, social and church leaders as well as other community residents, McCarter, began to understand that the *how* was through building relationships among neighborhood residents to create a "true" community. According to McCarter, "If there is no intentional methodology to connect people, we cannot assume it will happen." SBCR's methodology is comprised of 3 parts. 1) The Renewal Team that consists of individuals who register project volunteers 2) The Haven House Plan, which is a strategy for increasing the social cohesion on a neighborhood block 3) Internal Care Units, or Friendship Houses that are located within low-income neighborhoods. SBCR staff and their families live in these houses and develop relationships with other neighborhood residents through the offering of services out of their homes ranging from structured after-school programs to health care services.

Since its inception, SBCR has accomplished the following outcomes: 1) Fostered relationships between the faith community, business, universities, health care providers, community-based organizations, police, and community members (*services and institutions; health, public health, and social services; public safety; education and*

literacy; community-based organizations), 2) Improved interracial relations within Shreveport (*ethnic, racial, and inter-group relations*), 3) Developed a three part strategy to increase community cohesion that involved establishing neighborhood-based centers that provide services to residents (*services and institutions, community based organizations*). Additionally, SBCR has been the recipient of several accolades, including being chosen as one of 19 "Solutions for America" by the Pew Partnership for Civic Change, an All-American City award from the National Civic League, and a $728,000 grant from the Robert Wood Johnson Foundation who is also committed to funding a research project to further assess the worth of SBCR and promote it as a model program to other cities.

For more information: www.shrevecommunityrenewal.org

9. Collective Efficacy: *Social cohesion coupled with a willingness to intervene on behalf of the common good.*[262]

Collective efficacy within a community is based on sharing similar beliefs and the community's ability and tendency to intervene or act to achieve an intended effect. Collective efficacy may have a positive psychological affect on individuals and groups -- they may feel empowered as they gain some control over their environment. Strengthening collective efficacy involves building an understanding of issues, ensuring that people understand their role in shaping issues and their capacity to make change, fostering a sense of purpose and trust, and forming or connecting to a power base.

Sample Action Menu:

- Disseminate information within the community on problems and issues, which directly affect residents' quality of life. [263]
- Tell a story about the problem or issue at hand in such a way that it gets people's attention, influences behavior and compels people to take action. Determine which pieces of information are likely to have the greatest impact on individuals' willingness to take action to the common good. [264]
- Provide community members with an analysis of the costs of failing to take action around a specific problem affecting their community. [265]
- Describe the scope of the problem in a broader manner so that it becomes clear to all residents and community stakeholders that an issue, which appears to effect only a specific segment of the population, will directly impact the entire community. [266]
- Help community members define problems through processes that create understanding and ownership.
- Engage in a systematic effort to get to know community residents, business leaders and at-risk individuals on a personal level. Use these connections to find out how events in the community affect these individuals' lives, to build networks for information dissemination and to engage individuals in action on behalf of the common good. [267]
- Reframe larger issues in local terms in order to illustrate how a community can take specific actions that will contribute to progress on a larger scale. [268]
- Develop local leadership and engage in capacity building to strengthen community members' ability to address problems.

- Organize community constituencies to pressure public agencies and political leaders to improve community conditions.
- Establish action campaigns around specific issues and delineate opportunities and activities.
- Increase the capacity of community members to identify their own concerns and issues and take effective action.
- Ensure that community members understand their own value and capacity to create change.

Sample Resources & Tools

- **The Institute for the Study and Practice of Nonviolence*:*** Teaches the principles and practices of nonviolence to foster a community that addresses potentially violent situations with nonviolent solutions. www.nonviolenceinstitute.org
- **MADD**: A non-profit grass roots organization with more than 600 chapters nationwide whose mission is to stop drunk driving, support the victims of this violent crime, and prevent underage drinking**.** www.madd.org/home/.
- **Million Mom March:** Movement dedicated to creating an America free from gun violence, where all Americans are safe at home, at school, at work, and in their communities.

  www.millionmommarch.org/**The National Crime Prevention Council:** The

  Neighborhood Watch Organizer's Guide, provides a print-friendly selection of tips for

  organizing and directing a Neighborhood Watch group. www.ncpc.org**National**

  Organizations of Youth Safety: Marshals resources that save lives, prevent injuries and promote safe and healthy lifestyles among youth. www.noys.org
- **National Conference for Community and Justice**: A human relations organization dedicated to empowering leaders and communities to advocate, educate and resolve conflict related to issues of discrimination and oppression. Promotes understanding and respect across groups in order to acknowledge the dynamics of power and privilege and the role they play in creating attitudes, behavior, and practices that support systems of exclusion and oppression. www.nccj.org

COMMUNITY EXAMPLE Decreasing Community Violence, South Los Angeles California[6]

At the peak of the violence epidemic in the 1990's, drive-by shootings were common in some neighborhoods in South Los Angeles, a predominantly African American area of the city. Fearing their children would be shot in crossfire, parents would not let their children play outside. On streets that were particularly affected, neighbors came together to make their streets safe again. Residents worked together on a number of activities including outreach to local gangs. In taking collective action, they significantly reduced instances of gang-related gun violence in their streets and parents felt safe letting their children play outside again and move throughout the community. Major outcomes include 1) Reduced risk of death and injury from firearms through collective action (*collective efficacy)* and 2) Increased opportunities for children to play outside and move around throughout the community (*activity-promoting environment),* which can reduce the risk of chronic disease.

[6] This community example was written with funding from The California Endowment.

10. Civic Engagement/Participation: *Involvement in community or social organizations and/or participation in the political process.*

When a community has high civic engagement, people actively participate in the social and political networks that affect their lives. Civic participation also includes participation in community and service groups. These groups often have the goal of serving or contributing to the community, which promotes more positive outcomes. Communities can foster engagement and participation by increasing the skills of community members, assuring community members of their value, ensuring that community members know about opportunities to participate, and increasing opportunities to participate. Efforts can focus on identifying existing opportunities and strengthening these while identifying and filling gaps.

SAMPLE ACTION MENU

- Spend time listening to community residents, gathering insights and facts, and getting to work on the issues that matter the most to them.[269]
- Promote civic engagement through leadership development. More specifically, look for leadership potential among youth, provide members with hands-on experiences and opportunities for skill development, and give those in authority face-saving ways to retreat if necessary.[270]
- Set aside time among groups for analysis, reflection, review and documentation.[271]
- Gain allies by being allies – step out publicly for others who have supported you.[272]
- Engage youth in community participation.
- Encourage investigation about how government is addressing particular issues and how to get involved.
- Conduct training on democracy and citizen involvement.
- Sponsor voter registration/education drives and ensure that written and oral information is available in the languages used by community members.
- Recruit those affected by particular issues onto commissions and committees and train a diverse and broad number of community members to participate in such a capacity.
- Make it easy for community members to get involved by focusing on relevant issues, being clear about what people can do, holding meetings at accessible times and locations, addressing child care issues, and providing stipends or pay when possible.
- Create mentoring opportunities both cross age and "near peer."
- Establish action campaigns that engage community members in changing local policies.
- Establish and sustain apprenticeships, particularly for local political action.

Sample Resources and Tools

- **Americorps**: A network of national service programs that engage more than 50,000 Americans each year in intensive service to meet critical needs in education, public safety, health, and the environment. AmeriCorps members serve through more than 2,100 nonprofits, public agencies, and faith-based organizations. www.americorps.org/
- **Big Brother Big Sisters**: Serves over 200,000 children, ages 6 through 18, in 5,000 communities across all 50 states. Big Brothers Big Sisters one on one mentoring helps at-risk youth overcome the many challenges they face. www.bbbsa.org
- **The Corporation for National and Community Service**: Provides opportunities for Americans of all ages and backgrounds to serve their communities and country through three

programs: Senior Corps, AmeriCorps, and Learn and Serve America. www.cns.gov/about/principles/

- ***The Cost of A Volunteer: What it takes to provide a quality volunteer experience:*** The Grantmaker Forum on Community & National Service; March 2003; www.ncpc.org/ncpc/ncpc/?pg=2088-11616
- **The Institute for Democratic Renewal and Project Change** Anti-Racism Initiative. A Community Builder's Tool Kit (1998). www.projectchange.org/index.

COMMUNITY EXAMPLE LIFETIME, Oakland, California

LIFETIME is a non-profit organization based in Oakland, California that assists single mothers on welfare to obtain higher education and remain off of welfare and out of poverty permanently. Founder and director, Diana Spatz who had completed her BA while raising her daughter on welfare, established LIFETIME in 1996. LIFETIME began as a service-learning class at the University of California at Berkeley that Spatz taught to other student welfare mothers like herself, instructing them of their rights as welfare recipients, and forming support systems for them while they worked toward their degrees. Spatz's momentum grew, and soon her class became LIFETIME, the organization. Parent members participate in political education, leadership development, and advocacy training in order to become effective advocates for the policies that affect their lives.

LIFETIME has accomplished multiple outcomes that are related not only to promoting educational outcomes but also to engaging low-income mothers in political advocacy. Outcomes include: 1) Trained single mothers on welfare as advocates for their educational rights to ensure that they are able to obtain a higher education and remain off of welfare and out of poverty permanently (*economic capital*), 2) Provided services to over 400 parents to help them reach their higher education goals (*education and literacy*), 3) Involved these parents in advocating on behalf of policies that affect them under welfare law (*civic engagement/participation*). The parents' civic engagement efforts resulted in the changing the welfare policies in all of California's 58 counties, thereby increasing CalWORKs parent transportation support services (*transportation*), increasing parents' access to education (*education and literacy*), and winning accommodations for learning disabled parents (*built environment, services and institutions*).

For more information: www.geds-to-phds.org

11. Positive Behavioral/Social Norms: *Shared beliefs and standards of behavior that encourage positive choices and support healthy environments.*

Norms are shaped by family experiences, peers, media influences, and the environment. They can be influenced in each of these spheres through policies, organizational practices, and social norms campaigns. For example, seatbelt and child safety seat laws have changed norms about the use of passenger restraint devices; minimum drinking age laws, campaigns against drunk driving, and enforcement practices have changed norms about driving under the influence of alcohol; and laws restricting smoking in public places have changed norms about tobacco use. The social norms within a community or social network "may structure and influence health behaviors and one's motivation and ability to change those behaviors."[273] Social support networks enable positive social norms to be developed and strengthened within a family, organization, or community.

Sample Action Menu:

- Identify negative community norms and the context in which they function, and perhaps even serve an individual, family, or community.

- Develop social norming campaigns, such as those targeting the acceptability of "drunk driving", to change social norms.
- Engage youth in an examination of the social costs associated with certain behavioral norms. Describing the cost of bad outcomes and the trend lines for that cost can show youth the importance of adopting behavior norms that don't negatively impact their community.[274]
- Involve different factions of the community in identifying, addressing, and shifting norms in a positive direction.
- Seek out community leaders and build their capacity to affect positive change.
- Teach youth and children conflict resolution skills as a means of promoting alternatives to violence.[275]
- Work with youth, community members, school officials, and parents to develop a list of normative expectations that outline acceptable adult and youth behavior in relation to alcohol consumption.[276]
- Employ media literacy and advocacy strategies to promote understanding of the media by communities with the aim of influencing policy makers, the film industry, and news media.
- Encourage positive social and behavioral norms with regard to interaction and maintenance of the environment.
- Work with media outlets -- through engaging editorial boards, the entertainment industry, journalists, etc. -- to promote and understanding of their role in promoting norms and ensuring that positive norms are promoted.

Sample Resources & Tools:

- **Mothers Against Drunk Drivers:** A non-profit grass roots organization with more than 600 chapters nationwide whose mission is to stop drunk driving, support the victims of this violent crime, and prevent underage drinking**.** www.madd.org
- **Social Norms Link:** A website on Social Norms approach, sample issues, and links to related websites. www.socialnormslink.com
- **Students Against Drunk Drivers**: A peer leadership organization dedicated to preventing destructive decisions, particularly underage drinking, other drug use, impaired driving, teen violence and teen depression and suicide. www.sadd.org
- **The Monitoring the Future Project:** Conducted annually since 1980 by the University of Michigan for the National Institute on Drug Abuse, the Monitoring the Future project continues to show a trend of consistent improvement in college drinking behavior. www.socialnorm.org
- **Youth Educational Program**: Funded by the National Highway Traffic Safety Administration and developed by Prevention Institute, this toolkit provides information and resources to improve safety belt usage and reduce impaired driving among African American and Latino youth. www.preventioninstitute.org

COMMUNITY EXAMPLE Seat Belt Usage in a Latino Community, Pittsburg, California

Pittsburg, California is a city within Contra Costa County that has a large Mexican American population. Within this community, mothers were not putting their children in car seats while driving at the same rate as in the county overall. In response to this, the county targeted the cost associated with car seats as the problem. A policy was passed which provided money to make car seats available to low-income families. Under this policy, when people were stopped and ticketed for not placing their child in a car seat, a portion of the money raised went into a fund that purchased car seats for low-income families. However, this alone did not ensure that car seats were being used regularly within the Latino community of Pittsburg.

Through further research, the county discovered that Latina mothers expressed concern about placing their children in car seats, labeling the practice as cold and uncaring and stating that it felt awkward not to hold their children in their laps. Officials realized that the issue was not merely the cost of the car seats but beliefs and norms about their usage. As part of addressing this, they launched a campaign to shift the behavioral norms about using car seats. The county partnered with a local Latina comedian to create a public safety campaign that outreached to the Latino community, illustrating the importance of using car seats to keep children safe, and more importantly, emphasizing the nurturing aspects of putting children safely in child seats. The campaign featured the local comedian wearing a large car seat everywhere that she went—to the grocery store, the bank, and even at her wedding. The message portrayed was that at first a car seat may seem uncomfortable and foreign, but the more it is used, the more supportive and comfortable it becomes. The campaign ran in both English and in Spanish.

The following outcomes were achieved as a result of the county's efforts, 1) Established a funding stream to assist low-income families in the purchasing of car seats (*public safety, health, public health, and social services*); 2) Developed a plan that built on cultural values and beliefs to promote safer behavioral norms (*positive behavioral/social norms)*, and 3) Established a partnership between public health, the local media, and local advocates to shift behavioral norms (*services and institutions, media/marketing, positive behavioral/social norms*). This effort illustrates the need for multifaceted activities such as policies, addressing service gaps, working with community members, and using media to reach large numbers of people to shift norms.

12. Positive Gender Norms: *Gender-specific, socio-culturally determined standards of behavior that encourage positive choices, and create safe and supportive relationships between and within gender groups.*

Positive Gender Norms is a subset of *Social and Behavioral Norms* and is highlighted deliberately because of its importance and relevance to overall environment health and well-being. Fostering positive gender norms within communities can promote respect and healthier behaviors. Like social and behavioral norms, gender norms can be influenced through changes in policy and organizational practices and social norming. Families, peers, institutions, and the community play a significant role in propagating, supporting, and changing gender norms. (*See the Social and Behavioral Norms description and Sample Action Menu for more).*

Sample Action Menu

- Involve men as elements of the solution, not simply part of the problem.
- Develop community-level approaches to promoting gender-specific standards of behavior that encourage positive choices and create safe and supportive relationships between and within gender groups.
- Address traditional beliefs about manhood that are associated with a variety of poor health behaviors, including drinking, drug use, and high-risk sexual activity.[277]
- Examine the role that culture perceptions of men's role in the family unit play in determining individual behavior by encouraging men to draw on their families' histories as they learn to take responsibility for their own families. [278]
- Actively recruit fathers to participate in programs for parents by creating father-specific services and father-friendly environments rather than by delivering services as an extension of those already provided for mothers and children. [279]

- Support the efforts of fathers, who are in prison, to stay connected to their children. Organize events that provide opportunities for positive prisoner-child interaction as incentives for men to overcome personal problems and prepare for life outside of prison. [280]
- Provide pregnancy prevention for teen males by focusing on boys who are sexually active or are about to become sexually active. Develop a curriculum that includes topics of self-esteem, values, dating violence, healthy relationships, reproductive anatomy, contraception and STD's, goal setting and decision-making. [281]
- Design programs that target fathers-to-be by teaching fathers how to support the mothers of their children, how to nurture and care for their newborn child, and how to play a role in the promoting baby's health even during the prenatal period. [282]
- Teach fathers to negotiate the legal barriers to establishing their right to play a role in their child's life. Teach fathers how to establish paternity, how to gain paternity rights and to negotiate child support orders and visitation rights. [283]
- Assist fathers who do not have custody of their children in finding permanent employment. A father's ability to provide for his children financially is a key predictor of his degree of involvement in the children's lives. [284]
- Examine organizational practices that are exclusive of men and their positive role in the family and the community (e.g. maternal and child health at the exclusion of paternal health).
- Develop models that look at women's leadership development in journalism, business, media, etc.
- Provide examples of women as leaders, role models, and mentors.

Resources & Tools:

- ***Boys will be Men* (video):** A Documentary About Growing Up Male In America: Written, directed, and produced by Tom Weidlinger
- **Building Partnerships Initiative to End Men's Violence:** This effort has developed an online toolkit targeting those beginning to, or just thinking about, working with men and boys as part of violence prevention efforts. www.endabuse.org/bpi
- **Center on Fathers, Families and Public Policy:** A nationally-focused public policy organization conducting policy research, technical assistance, training, litigation and public education in order to focus attention on the barriers faced by never-married, low-income fathers and their families. www.CFFPP.org
- **Center for Health of Men, Boys and Society:** This website provides information regarding what is known about men's and boys' health, encouraging multifaceted strategies that effectively reduce health risks among men and boys and address prevalent social norms of masculinity that influence health.www.preventioninstitute.org/gender.html
- **Center for the Study of Sport in Society, Northeastern University:** Increases awareness of sport and its relation to society, and develops programs that identify problems, offer solutions and promote the benefits of sport. One of their programs is Mentors in Violence Prevention (MVP). The multi-racial, mixed gender MVP Program enlists high school, collegiate, and professional athletes in the fight against all forms of men's violence against women. www.sportinsociety.org
- **Men Can Stop Rape:** Empowers male youth and the institutions that serve them to work as allies with women in preventing rape and other forms of men's violence. Through awareness-to-action education and community organizing, the organization promotes gender equity and builds men's capacity to be strong without being violent. www.mencanstoprape.org

- **Men Overcoming Violence**: A resource center that supports men, challenges men's violence, and develops men's leadership in ending oppression in their lives, their families, and their communities. www.mensresourcecenter.org/move.html
- **Men's Health:** Consulting agency that educates the public about the psychological, social and behavioral influences on the health of men and boys — helping men live longer, healthier lives. www.menshealth.org
- ***Tough Guise: Violence, Media & the Crisis in Masculinity (video)***. Educational video geared toward college and high school students to systematically examine the relationship between pop-cultural imagery and the social construction of masculine identities in the U.S. at the dawn of the 21st century. Written by Jackson Katz & Jeremy Earp http://mediaed.org/videos/MediaGenderAndDiversity/ToughGuise

COMMUNITY EXAMPLE Men Can Stop Rape: The "Strengths Campaign," Washington DC

Men Can Stop Rape (MCSR) launched the "Strengths Campaign", a media education initiative designed to prevent rape and other forms of dating violence among DC high school youth. The campaign focused on shifting social and gender norms regarding date rape and relationship violence. The campaign develops awareness of the problem amongst young people and supports them with tools to move from "awareness into action". The theme of the campaign, "My Strength is Not for Hurting," is employed to 1) promote positive, non-violent models of male strength; 2) educate young men about their role as allies with women and girls in preventing rape and dating violence and helps them take action to end interpersonal violence. They also aim to 4) promote healthy relationships based on equality and respect, and 5) create safer school communities.

MCSR implemented a social marketing campaign and community organizing campaign to address these issues. They installed bus and bus shelter ads throughout the District of Columbia, posters in all DC public high schools, and developed a mini-magazine for students around campaign themes. They also provided tools for the youth to engage in action on these issues through training workshops entitled "Safe and Strong". Additionally, they provided resources to the adults working with young men in the schools through inclusive relationship-building efforts, including recruiting teachers and staff on their board, and providing guidebooks to all school personnel.

The Strength Campaign uncovered several key elements to successfully implementing this initiative. They included 1) the critical importance of reaching out to young men as potential allies (*social cohesion* and *collective efficacy*); 2) helping them redefine what it means to be a strong man by re-creating social norms related to respect towards and violence against women and girls (*positive behavioral and social norms* and *gender norms*); 3) examining the gender role and social norms pressure young men face to engage in risky behavior and linking that negative pressure to teen dating violence (*gender and social norms*); 4) the need to involve young people in the development of the campaign and effectively incorporate their concerns in shaping the messages of the campaign (*media/marketing*); and 5) building alliances and sustained partnerships with the school district and the school community (*social cohesion* and *collective efficacy*).

For more information: Men Can Stop Rape; www.mencanstoprape.org

Services and Institutions: *This cluster refers to the availability of and access to high quality, culturally competent, appropriately coordinated public and private services and institutions.*
Public and private services and institutions include local government, public health and health, social services, education, public safety, community groups and coalitions, community-based organizations, faith institutions, businesses, and arts institutions. Their effectiveness in promoting community wellness encompasses three domains: 1) management and administration, 2) the provision of quality services that address not only symptoms, but also underlying and contributing conditions, and 3) community and cultural competence.

Efforts that strengthen community services and institutions connect these institutions to broader systems and policy bodies, including those at the city, state, and federal levels in order to ensure that decisions made by these bodies will have a positive impact on the community. These efforts should also incorporate community representation and input; adopt an ecological approach to the family and community; ensure that staff members and service providers have a commitment to the community; train staff on the range of skills needed to be effective; strive to ensure that the staff is reflective of the community; coordinate appropriate efforts; continuously assess and strengthen services; address changing needs throughout the life span, and ensure that the range of services provided meets the range of needs in the community without unnecessary duplication.

Sample Action Menu

- Focus efforts on community health and well-being and not just individual health and well-being.
- Ensure that there are adequate services available and appropriate for all members of the community, including people with disabilities.
- Establish strong collaboration and coordination to ensure that services and institutions meet the needs of entire families, rather than individual members, and that vulnerable individuals do not fall through the cracks.
- Recruit and train people from the community to participate in advisory or decision-making bodies.
- Ensure that managers and administrators have the necessary skills to effectively run programs, manage budgets, supervise and motivate staff, and sustain quality within an organization.
- Provide staff training around cultural and community competency to ensure that services adequately meet the needs of the community.
- Recruit and promote staff members who identify with and are committed to the community's well-being.

Sample Resources and Tools

- **Forum for Youth Investment:** A nonprofit, nonpartisan organization dedicated to helping communities and the nation make sure all young people are ready by 21 — ready for work, college and life. This goal requires that young people have the supports, opportunities and services needed to prosper and contribute where they live, learn, work, play and make a difference. www.forumforyouthinvestment.org

- **Neighborhood and Family Initiative Survey:** Tool that examines active community environments and transportation and covers a wide range of issues including satisfaction with transportation, parks, police, health services, and schools. www.aspenmeasures.org/html/final_results.asp?table=instrument&id=146

13. Public Health, Health, and Human Services: *Available, accessible, high quality healthcare, health promotion and wellness services, health-related services such as mental health and substance abuse prevention/intervention, public health, and social services.*

High quality health and human services can promote public health, foster community violence prevention efforts, and ensure that those in need have access to needed programs and health services. To promote health and safety throughout the community, public health, health, and human services should be well-managed, should focus on the underlying contributors to illness in addition to addressing symptoms, should be grounded in an understanding of the community's needs and cultural beliefs, and should ensure access. (*See the Services and Institutions cluster description and Sample Action Menu for more).*

Sample Action Menu

- Promote a shared understanding of community health and needed strategies among both institutions and community members.
- Increase awareness about the importance of physical activity among clients, give clients monitors to track their physical activity, support relevant policies, and encourage walking groups.
- Create a vehicle for community input and ongoing community assessment through recruitment and training and providing opportunities for input such as on committees and commissions or in focus groups.
- Increase capacity of the community to provide advice and input through mentoring and training.
- Recruit and train people from the community to provide services. Establish scholarship funds to support community members.
- Use community outreach workers, such as promotoras, to promote the health and social needs of the community.
- Develop a master plan of existing and needed services and work with existing institutions to fill identified gaps or bring new services to the community.
- Provide staff training to increase organizational capacity to deliver high-quality services.
- Coordinate health and social service efforts to ensure an appropriate web of services. When appropriate, services should be integrated.
- Advocate at the local and state level for needed services within a particular community, such as good transportation, healthy food access, and safe walking areas.
- Ensure that services for community members are easily accessible. This means locating services within the community, linking with transportation services, and accounting for the needs of people of different ages and abilities.

Sample Resources and Tools

- **American Public Health Association:** APHA has been influencing policies and setting priorities in public health for over 125 years. Throughout its history it has been in the forefront of numerous efforts to prevent disease and promote health. www.apha.org

- **Centers for Disease Control and Prevention (CDC):** A Federal agency for protecting the health and safety of people - at home and abroad, providing information to enhance health decisions, and promoting health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States. Grant programs include Racial and Ethnic Approaches to Community Health (REACH 2010). www.cdc.gov
- ***Fighting Childhood Asthma: How Communities Can Win (2002).*** PolicyLink conducted research funded by The California Endowment including interviews and site visits to identify policy opportunities to diminish the asthma epidemic. www.calendow.org/reference/publications/pdf/disparities/Childhood_Asthma_Policy_Link.pdf
- **Kaiser Permanente Community Benefit Program:** Kaiser puts resources into to improving the health of the community, as well as the health of its members. www.kaiserpermanente.org/about/community/#benefit
- **Partnership for the Public's Health:** Initiative to improve community-based public health systems, practice and policy, funded by The California Endowment and implemented by the Public Health Institute. www.partnershipph.org
- **Rebuilding Community Initiatives:** Tool with 95 items that cover economic capital, the built environment, and the integration of public services. www.aecf.org/rci/
- **Turning Point:** An initiative of The Robert Wood Johnson Foundation and the W.K. Kellogg Foundation. Its mission is to transform and strengthen the public health system in the United States by making it more community-based and collaborative. www.turningpointprogram.org/
- **U.S. Department of Health and Human Services:** The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. www.hhs.gov
- **U.S. Office of Minority Health (OMH):** OMH works with Health and Human Services operating divisions and other Federal departments to improve collection and analysis of data on the health of racial and ethnic minority populations. It monitors efforts to achieve Healthy People 2010 goals for minority health. www.omhrc.gov/omhhome.htm

COMMUNITY EXAMPLE Project Brotherhood, Chicago Illinois

Project Brotherhood opened its doors as a health and human services provider to African American men in Chicago in 1998, supported by seed money from the Cook County Hospital. As a population, African American men have been largely ignored or poorly treated by the health community for a number of reasons. Achieving health equity for Black men has been made more challenging because of social and economic disparities, interpersonal and institutional racism, lack of jobs and affordable housing, poor access to quality educational and training opportunities, as well as, criminalization and incarceration of large numbers of. Project Brotherhood strives to address this history by providing multidisciplinary, holistic, and culturally appropriate prevention, intervention, and support services that support mental and physical health and overall well-being.

The services for men are provided on a drop-in basis. There is no need for an appointment for both physicals and lab tests, which are often needed in order to gain employment (supporting economic capital). Both primary and specialty health care are provided for free; allowing the low-income men that

Project Brotherhood primarily serves access to quality and culturally appropriate health care that they would ordinarily not have access to.

The majority of the staff is both African-American and male. This creates higher level of initial trust and a greater sense of partnership between staff and participants. As a way to break down the formal separation between doctor and patient, Thursdays are casual evenings when the doctors, staff and clients spend time with one another and participate in informal discussion groups. One of the many innovative and culturally relevant elements of Project Brotherhood, is the on-site barber who provides haircuts, counseling, and fosters a social environment. Future projects include expanding the youth programs, adding support groups for chronic diseases and expanding the economic development component.

Project Brotherhood's explicit mission is to address the physical and mental health needs of a neglected population of Black men in a culturally relevant manner. Outcomes include: 1) The break-down of social barriers to care (social cohesion, collective efficacy); 2) provision of resources needed to support employment of participants (economic capital); 3) provision of quality care with attention to the factors that impede utilization of care (health, public health, human services; community-based organizations; ethnic, racial and intergroup relations); and 5) provide an excellent example of how the aesthetic aspect of the familiar (on-site barber shop) can support mental health and social cohesion (aesthetic/ambiance).

For more information: Project Brotherhood, Woodlawn Health Center, Chicago IL 60637

14. Public Safety: *High quality law enforcement and fire protection that has gained the trust of the community*.

Effective public safety services contribute to lower injury and violence rates within communities. Different approaches to public safety can foster positive attitudes towards and interactions with law enforcement. Strengthening public safety efforts includes establishing a connection and trust with the community, fostering stewardship of the community among public safety providers, and ensuring that members of the community are involved in a decision-making capacity about public safety priorities, policies, and practices. (*See the Services and Institutions cluster description and Sample Action Menu for more).*

Sample Action Menu

- Recruit and train law enforcement officials from the community.
- Make sure that there are law enforcement officials of all ranks who can speak the languages of the community, which they serve.
- Train law enforcement officers to conceive of their role in the community more broadly, to regularly solicit community input, to integrate residents' problems and safety concerns into their work, and to take the time to develop positive relations with local residents.[285]
- Work with neighborhoods and community members to develop beats that are based upon the fabric of the community.[286]
- Ensure that residents are on the police commission and other decision-making bodies, which play a role in promoting safety. Train a broad number of community members to participate in this kind of capacity.
- Establish and maintain community-policing programs.

- Engage police officers and shrives as advocates for the community's needs.
- Work with police officials and local policy makers to examine the benefits of establishing an officer to citizen ratio.[287]
- Work with police officials and local policy makers to establish a system for monitoring police response times to reports of police misconduct.[288]
- Work with local police departments to provide citizens' academies in the languages of immigrant groups represented within the community.[289]
- Ensure that law enforcement efforts address crime in or around public transportation routes vital to low-income community members.[290]
- Institutionalize support of programs that engage law enforcement officials with members of the community, such as through the Police Activities League.

Sample Resources and Tools

- ***Community-Centered Policing: A Force for Change*** (2001) PolicyLink.www.policylink.org
- ***Community Oriented Policing and Problem Solving: Now and Beyond.*** Crime and Violence Prevention Center, Office of the Attorney, California Department of Justice. http://caag.state.ca.us/cvpc.
- **The Community Policing Consortium:** A partnership of five of the leading police organizations in the United States. These five organizations play a principal role in the development of community policing research, training and technical assistance, and each is firmly committed to the advancement of this policing philosophy. www.communitypolicing.org
- **Fight Crime: Invest in Kids**: A bipartisan, nonprofit anti-crime organization led by more than 2,000 police chiefs, sheriffs, prosecutors, victims of violence and leaders of police officer associations. www.fightcrime.org
- ***Guide for Implementing the Balanced and Restorative Justice Model*** (December 1998). US Department of Justice, Office of Juvenile Justice and Delinquency Prevention.
- ***Promising Strategies from the Field: Spotlight on Sheriffs.*** US Department of Justice, COPS Office. www.cops.usdoj.gov/Default.asp?Open=True&Item=816
- ***Six Safer Cities*****.** National Crime Prevention Council**.** www.ncpc.org
- ***Surveying Communities: A Resource for Community Justice Planners*****.** Bureau of Justice Assistance. www.ncjrs.org/pdffiles1/bja/197109.pdf.
- **The Urban Institute:** A nonprofit nonpartisan policy research and educational organization established to examine the social, economic, and governance problems facing the nation. The Institute provides valuable resources on prisoner re-entry including *Baltimore Prisoners' Experiences Returning Home* and "*Prisoners Once Removed Probes 'Indescribable Burden' of Imprisonment and Reentry on Children, Families, and Communities*. www.urban.org/
- ***When Law and Culture Collide: Handling Conflicts Between US Laws and Refugees' Cultures*** (1999). National Crime Prevention Council**.** www.ncpc.org

COMMUNITY EXAMPLE Community Policing Examples, Stamford, Connecticut

In Stamford, Connecticut, the police department has emphasized community-based policing efforts.[291] Officers were encouraged to develop creative solutions to the problems facing the community. For example, Latino day workers who were paid cash on a daily basis had become easy targets for

muggings. Officers developed a program to assist these individuals in setting up bank accounts to give them a safe place to keep their earnings. Officers also developed a program that provided music education to youth from low-income families. This program brought together music teachers and the Housing Authority to create the "Music Box," an apartment turned music studio.

The innovative policing style valued by the department lead to the following outcomes, 1) Fostered individual ownership of financial assets (*economic capital, public safety*), 2) Provided youth with an extracurricular music program (*cultural/artistic opportunities),* 3) Created a venue for police officers and youth to discuss what the youth see as being the most pressing problems within their community (*social cohesion and trust*).

15. Education and Literacy: *High-quality and available education and literacy services across the life span that meet the needs of all people within the community.*

Having high-quality education and literacy services includes decreasing truancy rates, dropout rates, and illiteracy. Achieving strong educational and literacy outcomes requires that schools are responsive to community and individual student needs, that services are culturally competent, that programs meet the range of developmental needs within a community, including the specific needs of adult immigrants. Communities can promote literacy by establishing literacy as a priority, by decreasing the stigma attached to illiteracy, by providing services at convenient times and accessible locations, and by infusing literacy into a range of community development efforts. (*See the Services and Institutions cluster description and Sample Action Menu for more).*

Sample Action Menu

- Establish universal pre-school and after school programs.
- Ensure that schools are welcoming places for family members and actively engage parents and other caregivers in decisions about school policies and curriculum.
- Work with schools to identify age-appropriate opportunities for meaningful student participation in decisions about school policies and curricula.
- Ensure that the educational curriculum is grounded in relevant culture and history.
- Acknowledge the different ways in which people learn and incorporate different teaching techniques into educational programs.
- Foster critical thinking skills.
- Focus on literacy through the lifespan and pay attention to the specific needs of immigrants and non-English speaking, monolingual members of the community.
- Map literacy services and ensure that these meet the needs of the community. Compare the number of existing services to the best estimates of need for services, identify gaps and convene a broad group of stakeholders to address the gap.
- Infuse literacy informally through local book clubs and various literary events.

Sample Resources and Tools

- **Chicago Public Schools:** Department of Early Childhood Education runs Child Parent Program Centers to promote children's academic success and to facilitate parent involvement. www.waisman.wisc.edu/cls/Program.htm
- **The National Assessment of Adult Literacy:** Measures three dimensions of literacy: prose literacy, document literacy, and quantitative literacy. http://nces.ed.gov/pubsearch/getpubcats.asp?sid=032

- **National Institute for Literacy:** National resource for adult education and literacy programs to strengthen literacy across the lifespan authorized by the U.S. Congress under two laws, the Adult Education and Family Literacy Act (AEFLA) in the Workforce Investment Act and the No Child Left Behind Act (NCLB). The AEFLA directs the Institute to provide national leadership regarding literacy, coordinate literacy services and policy www.nifl.gov
- **U.S. Department of Education:** The U.S. Department of Education's goal is to ensure equal access to education and to promote educational excellence throughout the nation. www.ed.gov

COMMUNITY EXAMPLE Cultivating Peace in Salinas, Salinas, California

Cultivating Peace in Salinas is a framework developed by the City of Salinas in collaboration with the Violent Injury Prevention Coalition and their foundation Partners for Peace, in an effort to improve health outcomes for children, youth and families. The framework grew out of a four month planning process, and focused primarily on reducing youth violence but also addressed overall community well being. Members of the *Cultivating Peace* collaborative understood that because violence is a complex issue, its solution must be comprehensive. In recognition of the relationship between literacy and violence prevention, the Salinas Public Library was involved in the violence prevention effort.

One of the identified goals of the violence prevention framework was to "Improve literacy rates for children and adults." Because Salinas can be characterized as a bilingual community, it faces unique challenges related to literacy. Forty-five percent of the residents of East Salinas do not speak English and the Salinas Union High School District has the highest percentage of limited English proficient (LEP) students in Monterey County.[292] Studies show that for Spanish speakers who are not literate in Spanish, that it is easier to become literate in a new language after becoming literate in one's native language.[293] As part of its contribution to the community's overall effort, the library conducted an inventory of the current literacy services that were being provided to Salinas' residents. Based upon national statistics, one of four U.S. residents are in need of basic literary assistance. When this number was applied to Salinas, the figure translated to 34,000 residents that were in need of such assistance; the literacy inventory indicated that only 15,429 residents were receiving it.

Mapping the community's literacy needs catalyzed the following outcomes: 1) Made literacy training available in Spanish as well as in English (*education and literacy*), 2) Involved businesses in providing incentives to employees to volunteer as tutors as well as in ensuring adequate reading skills among their workforce through the creation of the "Salinas Reads" program (*civic engagement/participation*). Once the inventory was completed, and the gap was realized, the collaborative began to work on narrowing the literacy services gap, with an emphasis on addressing the unique literacy needs of monolingual Spanish speaking adults and youth.

16. Community-Based Organizations: *Effective non-profit, grassroots, community coalitions, and faith-based organizations within a community that fill service gaps, advocate for community needs, and promote health and safety for the community.*

Many community-based organizations fill important needs that otherwise may not be addressed within a community. These organizations should be community-owned, culturally competent, and focus on systems and policies outside the community that impact people within the

community. In addition, ensuring effective services within a community includes training the leaders of organizations to be effective managers, appropriately linking community-based organizations to each other and other institutions, ensuring that the mission and purpose of local organizations fit with the values and needs of the community, and developing a community-wide plan that identifies existing efforts and gaps in services and eliminates unnecessary redundancies or efforts that cancel each other out. (*See the Services and Institutions cluster description and Sample Action Menu for more).*

Sample Action Menu

- Ensure that services address the priority needs of the community as defined by the community.
- Challenge services and institutions to better meet the community's needs.
- Map existing services, identify opportunities for collaboration, coordination, and/or integration, identify existing gaps, work with members of the community and other services and institutions to fill the gaps.
- Ensure that the entire mix of services appropriately meets the diversity of linguistic and cultural needs, ages, and physical abilities.
- Provide shuttle, work with transit agencies, or provide services in locales within walking distance of, or in, people's homes to ensure access.
- Create a community advisory board with oversight function of services and institutions.
- Create institutional and community support for collaboration and ensure that appropriate efforts are well-coordinated and that they build upon each other.
- Increase the management and administration skills of people within community organizations.
- Evaluate efforts and build upon success. Include clients and other community members in the design and implementation of the evaluation process. Ensure that evaluations inform the delivery of subsequent services.
- Focus attention on influencing city, state and federal structures and policies.[294]
- Increase the capacity faith-based organizations to address community problems in a manner that respects their traditions and gets to the core of the issue.
- Encourage stewardship among faith-based organizations.

Sample Resources and Tools

- ***Building Healthy and Safe Communities***: Principles for Designing and Delivering Successful Community Programs; includes "What Works! Principles for Community Building," Schoeberger, Ed. Northern California Council for the Community 50 California St. Suite 200, San Francisco, CA 94111-4696
- **The Carter Center, Not Even One:** Under the leadership of the faith community, this project brings together representatives in public health, law enforcement, education, business, and firearm victims, use public health research methods to review firearm related deaths of youth in their communities and identify strategies that could have prevented these deaths. These findings are then shared with community leaders and local agencies to help prevent similar outcomes in the future. – www.cartercenter.org
- **Faith in Place:** Calls religious and spiritual leaders from throughout the Chicago metropolitan region to gather in dialogue, prayer and action on issues of environmental sustainability. www.faithinplace.org .

- **The Management Center:** Nonprofit which instituted a number of projects, programs and publications that have become standards for the industry including the Annual *Wage & Benefit Survey for Northern California Nonprofits*; awards programs acknowledging excellence in nonprofit management and governance; training programs and a nonprofit employment service *Opportunity Knocks*. www.tmcenter.org
- ***The Tension of Turf*:** Article by Prevention Institute addresses how to make the inevitable turf struggles that arise work for the good of the coalition. www.preventioninstitute.org

COMMUNITY EXAMPLE Mutual Assistance Network of Del Paso Heights, Sacramento CA

Mutual Assistance Network (MAN) "views Del Paso residents not as passive recipients of services, but rather as experts in understanding, articulating and guiding the neighborhood revitalization process"[295] MAN has been providing economic development, employment & training service, as well as services for youth and families in the low income neighborhood of Del Paso Heights in Sacramento since 1992.

MAN's economic development division, in partnership with other organizations, recently built a mixed-use facility housing local community organizations, government agencies, as well as commercial, and retail businesses. The development is called "Neighborhood Central". The purpose is to promote local business development, job growth, local shopping and an arena for community interaction and connection. MAN also provides services in the areas of job development and training in order to give people the resources to gain steady and adequate employment. Through their employment services MAN assisted 265 residents with full-time and part-time jobs, 54 residents received promotion and raises and maintained a strong job retention rate in a twelve month period. As part of their economic development efforts, MAN launched a neighborhood farmer's market in Spring 2004.

MAN takes a cross-cutting approach to the development of economic capital in the Del Paso Heights community by incorporating the 1) the development of local businesses to serve community needs (*economic capital*), along with 2) employment development that supports residents in attaining a living wage through promotion and retention (*economic capital);* 3) the provision of needed health and social services (*health, public health, and human services*); 4) increased access to fresh produce (*nutrition-promoting environment)* and 5) opportunities for communities to come together in positive interaction (*social cohesion and trust*). The capacity to execute the project in coordination with other community-based agencies speaks to the collective efficacy of this historically under-resourced community.

For more information: Mutual Assistance Network 811 Grand Avenue, Suite A-3 Sacramento, Calif. 95838; (p) 916-927-7694; (f) 916-564-8443.
www.aecf.org/familiescount/2004/man.htm

17. Cultural/Artistic Opportunities: *Abundant opportunities within the community for cultural and artistic expression and participation and for cultural values to be expressed through the arts.*

The presence of art and other cultural institutions contributes to an environment that is conducive to health and safety. These institutions need support from the community and broader institutions and society. Part of building this and the vitality of arts institutions within communities means building an understanding of the multiple connections between arts and well-being -- for the community and its members. Artistic opportunities should span across the life-span and meet the needs of the entire community so that the diversity of the community -- in terms of culture, age, and physical ability -- is reflected in local arts. The visual and creative arts enable communities to play a key role in encouraging and promoting the value of the arts. Communities also have a role to play in manifesting the value of the arts and in supporting local artists, such as through Open Studios. (*See the Services and Institutions cluster description and Sample Action Menu for more).*

Sample Action Menu

- Promote a diverse definition of the arts and reveal the value of diversity in artistic expression.
- Promote community involvement in pursuing the arts.
- Ensure multi-generational cultural/artistic opportunities.
- Ensure that arts are visible in the community and reflect community realities.
- Ensure that art reflects and validates the cultural values and beliefs of the community.
- Ensure that community-based artistic programs are linked to larger art institutions.
- Ensure that cultural/artistic opportunities are well-managed.
- Work with larger art institutions to establish artistic and creative opportunities in the community.
- Work with large art institutions, local policy makers, and residents to bring "Big Art" (museums, orchestras, etc.) to low and middle-income communities.
- Nurture involvement in the arts through multigenerational mentoring, arts in the schools, making the arts visible in the community, and ensuring wide access to arts programs.
- Establish artistic outlets, such as gardens, murals, and music that promote a healing environment.
- Collect oral histories from individuals, who have been involved in a particular social issue (i.e. civil rights, education). Use these interviews as a mechanism for promoting discussion on how to approach an issue of concern to the community.[296]
- Create apprenticeships for community members to develop artistic skills.
- Implement a policy to receive a portion of every movie ticket sold in the community as an alternate source of funding for arts and culture.

Sample Resources and Tools

- **Americans for the Arts:** Nonprofit organization for advancing the arts in America creating opportunities for Americans to participate in and appreciate all forms of the arts. www.artsusa.org
- **The National Endowment for the Arts:** A public agency dedicated to supporting excellence in the arts--both new and established--bringing the arts to all Americans, and providing leadership in arts education. - www.arts.endow.gov

- **National Neighborhood Indicators Project:** An exploratory and experimental effort to develop arts and culture neighborhood indicators for use in local planning, policymaking, and community building. www.urban.org/nnip/acip.html
- ***Creative Community: The Art of Cultural Development*** (2001). By Don Adams and Arlene Goldbard. The Rockefeller Foundation. www.rockfound.org/display.asp?Collection=3&context=0&DocID=426&Preview=0&ARCurrent=1
- **Youth Arts Toolkit: Arts Programs for Youth at Risk**: Originally designed as a print book with a companion video and diskette, this website was designed to take the kit's information and make it available to the broadest possible audience. www.artsusa.org/youtharts/index.asp

COMMUNITY EXAMPLE *East Bay Center for the Performing Arts,* Richmond California[7]

In 1968, five Richmond teachers searching for lasting and meaningful responses to deeply-entrenched disparities in social justice and educational opportunities got together to establish the East Bay Music Center to provide music lessons for 45 students in a rented church. To date the center continues to grow (it changed its name in 1976 to reflect its expanded vision), offering art and performance instruction in the belief that, when sensitively taught, the arts can become a powerful tool for helping individuals and communities actualize to their greatest potential. They also recognized that the arts can serve as a vehicle for social reconciliation and a practical model for meaningful collaboration. Since its founding, the East Bay Center for the Performing Arts has served more than 700,000 people.

The East Bay Center for the Performing Arts is an educational institution that integrates the vigor of a nationally recognized arts training and producing center with a strong commitment to the serving people from the local community. They provide quality programming, deep respect for community integrity, and their staff and students work together in a positive spirit imbued with joyfulness and hope.

Theatre production, private and group music lessons and performance opportunities, filmmaking classes, and ethnic dance classes and troupes are offered, and scholarships are offered on a sliding scale based on financial need, motivation, and commitment. EBCPA has expanded to offer classes at area schools, focusing especially on schools made up of students with limited resources and opportunities for arts education.

By making the art forms available to any who wish to participate (students range from age 5 to 80), EBCPA has become a cornerstone in the broader community's cultural and artistic life. EBCPA students and faculty have produced more than 42 original theater and film works on topics such as date rape, gang violence, race relations, substance abuse, AIDS, teen pregnancy, and youth achievement.

The EBCPA's programs 1) provide positive in-school, after-school, and summer arts programs (*cultural/artistic opportunities*); 2) increase the physical activity of young

[7] This community example was written with funding from The California Endowment.

people in an exciting and culturally appropriate manner (*activity-promoting environment*), 3) bring young people together in a neutral location and promote positive interaction in a community rife with neighborhood turf issues (*social cohesion and trust*); 4) help to foster a collective appreciation of cultural diversity and strengths, and celebrates the communities divers ethnic heritage and cultural history (*ethnic and racial relations*).

For more information: The East Bay Center for the Performing Arts; 339 11th Street, Richmond, CA 94801; Tel: (510) 234-5624; Fax: (510) 234-8206; www.eastbaycenter.org.

Structural Factors: *Structural factors are broad, influential systems or structures that, although primarily shaped nationally, play out a local level. Some structural factors that are more feasible in influencing through local community action include 1) racism, oppression, and discrimination, 2) socioeconomic structure and distribution of wealth, 3) media.*

While macro factors require influence at a national level for full-scale change, for certain factors there are important activities at a local level that mitigate or enhance their community effect. Macro-factors can be influenced at many levels, by policy makers, captains of industry, institutions, and by collectively organized and efficacious communities. Community efficacy, policies, norms, and expectations shape economic capital, media and marketing, and racial and ethnic relations. Strengthening these factors requires building awareness about the issues; building the capacity to take action; ensuring that actions are relevant to community needs, grounded in community values, and reflective of the community; focusing on policy and organizational practices; and assessing the current state of these factors along with identification of strengths, gaps, and needs.

Sample Action Menu

- Educate and train community members to understand how structural-factors play out at a local level and to take effective action in ensuring that the way these factors play out has a beneficial impact on health outcomes.
- Train community members on how to take effective action to strengthen structural factors in the community.
- Engage local and state policymakers as well as representatives of the business community in addressing structural factors at the community level.

Sample Resources and Tools

- **Joint Center for Political and Economic Studies**: An international, nonprofit institution that conducts research on public policy issues of special concern to black Americans and other minorities, it provides independent analysis through research, publications, and outreach programs. www.jointcenter.org.
- **National Association for the Advancement of Colored People (NAACP):** The NAACP ensures the political, educational, social and economic equality of minority groups and citizens; achieves equality of rights and eliminates race prejudice among the citizens of the United States. www.naacp.org
- **The Pew Charitable Trusts**: Serves the public interest by providing information, policy solutions and support for civic life. The Trusts makes investments to provide organizations

and citizens with fact-based research and practical solutions for challenging issues. www.pewtrusts.com

- **PolicyLink:** National nonprofit research, communications, capacity building, and advocacy organization enlarges the sphere of influence that affects policy so that those closest to the nation's challenges are central to the search for their solutions. www.policylink.org

18. Ethnic and Racial Relations: *Positive relations between and among people of different races and ethnic backgrounds.*

Relations between and among people take place in a context of institutional bias and discrimination. This context impacts how communities are served and how individuals are treated. Efforts to promote healthy behaviors in low-income communities and improve the environment can be made effective by addressing interpersonal, inter-group, institutional, and structural racism, bias, and discrimination. Communities can address racism, bias and discrimination by promoting trust and understanding between community members, by assessing and taking steps to understand institutional racism within the community, and by ensuring that community members understand the role that racism and economic and educational privilege plays in influencing both opportunity and institutional practices. Addressing other factors without addressing this critical issue can contribute to powerlessness, division, and alienation.

Sample Action Menu

- Address divisions among residents of neighborhoods that impede efforts to build trust and the sense of community required to effectively advocate for needed change.
- Ensure that CBO's and public institutions, such as health clinics, schools, law enforcement, and parks are not, whether actually or perceptually, serving one group of residents to the detriment of the other.
- Engage in activities, which build trust across segments of the population in a community.
- Build a sense of community based on place, rather than race or ethnicity. Otherwise, neighborhood efforts to address health related goals can be fractionalized.
- Create means for communities to begin to address discrimination within their boundaries and foster positive ethnic and racial relations.
- To the extent that there are positive relations, people within diverse communities can work together to achieve change that will impact the overall well being of the community.
- Form multiracial task forces to investigate examples of racism within the community's banking, education, health, legal system, criminal justice and social service systems and to identify first targets for action,[297] and create groups to monitor the practices of institutions that serve the community (i.e. the lending practices of banks in communities of color.)[298]
- Through regular public gatherings, familiarize community members with a shared analysis of racial and cultural needs and issues, discuss members' opinions of how institutional and structural racism work, develop common terminology about racism.[299]
- In a multiracial group, take time to examine individuals' theories about how the world works – whether change can be negotiated or must be forced, whether changes in attitude predict changes in behavior, and whether institutions can be trusted to work for the common good.[300]
- Examine whether and how issues of racism are embedded in community-building initiatives. Ask what constitutes success? By whose definition? How can we tell if we are on the right path? Whose voices count most when we analyze and interpret the data? Who gains the most from the project's success? etc.[301]

- Educate immigrants and their families by informing them of their legal rights and procedures for accessing needed services.[302]
- Set up multiracial community task forces that engage in searching discussions about what racism is, how it affects the community, what solutions there might be and how to talk with the larger community about these issues. (Community Builders Tool Kit)

Sample Resources and Tools

- ***The Color of Fear*** (video), Robert Almanzan, Documentary featuring men from a spectrum of racial backgrounds discussing issues of racial identification, stereotypes and the systems that perpetuate radicalized perceptions of individuals and their behavior. www.stirfryseminars.com/pages/coloroffear.htm
- **The Institute for Democratic Renewal and Project Change Anti-Racism Initiative***: Fifteen Tools for Creating Healthy, Productive Interracial/ Multicultural Communities: A Community Builder's Tool Kit.* www.race-democracy.org/pdf/toolkit.pdf
- ***Levels of Racism: A Theoretic Framework and a Gardener's Tale.*** by Camara Jones. Am J Public Health 2000; 90(8):1212-1215.
- **National Conference for Community and Justice**: A human relations organization dedicated to empowering leaders and communities to advocate, educate and resolve conflict related to discrimination and oppression. www.nccj.org
- ***Uprooting Racism: How White People Can Work for Racial Justice***, By Paul Kivel; New Society Publishers; Revised edition (May 1, 2002)

COMMUNITY EXAMPLE *Boston Public Health Commission's Undoing Racism,* Boston Massachusetts

Recognizing that "undoing racism," and embracing cultural diversity are keys to eliminating persistent health disparities in the city of Boston, the Boston Public Health Commission undertook a multi-faceted initiative that began with the simple but crucial first step of looking inward. Their "from the inside out" approach began with an institutional assessment in which the Commission asked the question, "how is racism at play here?" With the knowledge and awareness they gained from the assessment, the Commission could develop policies to dismantle institutional racism and mechanisms to assure they would be implemented, and serve as a model for the rest of the city. The core framework they adopted included: 1) building and supporting community partnerships; 2) promoting anti-racist work environments; and, 3) re-aligning external activities to address racism.

Key to this initiative were on-going workshops designed to educate, challenge and empower staff, contractors, community residents, and public health practitioners to undo institutional racism (*ethnic, racial, and inter-group relations*). The Commission focused on resident participation, leadership, and decision-making in a community needs assessment process that examined issues related to racism, as well as in designing, implementing and evaluating programs and services that are culturally and linguistically accessible (*public health, health, and human services*). This emphasis on resident involvement and leadership was critical to creating effective services, and also increased resident capacity for effecting change (*collective efficacy*). In addition, the Commission focused on assessing workforce composition, developing strategies for increasing diversity at all levels, and working with community residents, medical schools, teaching hospitals, and health centers to support "pipeline" efforts to create a more diverse workforce (*economic capital*).

For more information: Boston Public Health Commission: (617) 534-5395. www.bphc.org.

19. Economic Capital: *Local ownership of assets or access to investment opportunities, as well as ability to make a living wage.*

There are a number of ways that under-resourced communities can engage in increasing economic capital. Building economic capital requires an assessment of the current state of the community's economic health, building awareness among community members of issues related to economic development, as well as the capacity to take action in order to promote local ownership. Communities must also identify the strengths, needs and gaps in economic opportunity, which are shaping residents' ability to access investment opportunities. The impact of local policies and organizational practices on local economic development is also critical. More specifically, communities can work to reverse "redlining" (a practice that systematically avoids and removed potential investment in low-income and minority communities) by local businesses and banking institutions, to encourage businesses to develop a skilled, local workforce from which they can hire, to set local policy requiring that employers provide a living wage, to match educational resources to the local economy, to create opportunities for low-income residents to pursue career pathways, to increase opportunities for the local ownership of businesses and homes, and to encourage reinvestment of local resources back into the local economy.

Sample Action Menu

- Assess the hiring, purchasing, sales, training and investment practices of local business and work to modify those practices to better support the development of economic and human capital within the community .[303]
- Create a map of businesses within the community and use this map to generate a plan to improve the mix of business types in key business centers in your community and explore the possibility of developing unused and vacant property for new commercial ventures.[304]
- Create an inventory of the local investment activities of businesses in the community. Assess which businesses provide training opportunities for adults or youth, offer internships, sponsor community projects, sponsor local athletic teams, or encourage their employees to participate in community activities. Make this information available to community members and assist businesses that do not offer these services to initiate local investment activities.[305]
- Design a business-development project to support local residents in starting new businesses that fill assessed gaps in the local business community and answer to local residents' expenditure patterns. Provide training, assistance with obtaining small business loans, with identifying property that is available for retail space and in forming mentoring relationships with local business owners.[306]
- Survey residents on expenditure patterns and use the results to educate these individuals about the value to the community economy of making purchases from a local store or business. Design an education project that teaches residents about how important it is to retain as many dollars as possible within the local economy. Invite business owners to participate in this process so that they can better tailor their services to residents' needs. [307] [308]

- Develop a community map of individual capacities, including skills and work experience, entrepreneurial experience, training and educational experiences and civic or community-based experiences in order to identify potential enterprise development opportunities within the community.[309]
- Use the data gathered through an inventory of individual skills and capacities to initiate a network of mentors that can assist inexperienced or unskilled residents in starting a business or developing job-related skills. [310]
- Advocate for living wage jobs, organize for a local living wage ordinance that requires business to pay a sustainable wage and provide benefits to employees.
- Address the availability of loans and financing to local entrepreneurs and enterprises.
- Establish an on-going anti-racism training for bankers working in communities of color.[311]
- Assess the economic impact of business and development on community well-being using the genuine progress indicator (GPI).
- Explore economic incentives or other means of increasing the capacity of local merchants to carry affordable healthy food.

Sample Resources and Tools

- **Annie E. Casey Foundation:** Fosters public policies, human service reforms, and community supports that more effectively meet the needs of vulnerable children and families. Their Family Economic Success (FES) approach helps low-income working families build strong financial futures in strong neighborhoods by integrating three key areas: workforce development, family economic support, and community investment. www.aecf.org
- **The Asset-Based Community Development Institute Center for Urban Affairs and Policy Research:** A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities (1996), A Guide to Mapping and Mobilizing the Economic Capacities of Local Residents (1996), A Guide to Mapping Consumer Expenditures and Mobilizing Consumer Expenditure Capacities (1996). www.northwestern.edu/ipr/people/mcknight.html
- **The Asset Development Institute:** The Institute developed the Asset Index, which assesses individual level jobs, education, literacy, English competency and quality health insurance as a proxy for access to health care. www.centeronhunger.org/ADI/adiintro.html
- **The Center for Community Economic Development:** The Center has developed worksheets that compare a community's revenue and expenditures with other communities. www.uwex.edu/ces/cced/
- ***The Community Resilience Manual: A Resource for Rural Recovery & Renewal:*** Developed in Canada at the Center for Community Enterprise, this document provides a thorough assessment to aid in strategic planning following significant economic shifts. The process is an extensive multi-month process that involves convening key stakeholders, focus groups, pen and paper assessments, and key informant interviews. www.cedworks.com/communityresilience01.html
- **The Greenlining Institute**: A public policy and advocacy non-profit whose mission is to empower communities of color and other disadvantaged groups through multi-ethnic economic and leadership development, civil rights and anti-redlining activities. www.greenlining.org
- **Rebuilding Community Initiatives:** Tool with 95 items that cover economic capital, the built environment, and the integration of public services. . www.aecf.org/rci/
- **Redefining Progress:** Works with a broad array of partners to shift the economy and public policy towards sustainability. www.rprogress.org

- **Survey of Community Development Financial Institutions**: This survey includes community development loan funds, credit unions, micro-enterprise loan funds, and venture capital funds. www.aspenmeasures.org/html/final_results.asp?table=instrument&id=165
- ***The Thin Red Line: How the Poor Still Pay More*** (1993). By David Dante Trout. Consumers Union of U.S., Inc. West Coast Regional Office:
- **Urban Strategies Council:** The Council's mission is to reduce persistent poverty and help transform low-income neighborhoods into vibrant, healthy communities. www.urbanstrategies.org/

COMMUNITY EXAMPLE ***Pico Union/MacArthur Park Economic Development Zone,***
Los Angeles, California[8]

The Pico Union/MacArthur Park area of Los Angeles has a diverse Latino population, which comprises seventy-seven percent of the community. As part of Los Angeles' Economic Development Zone, the area has a program for its under-employed and unemployed residents. With city and county redevelopment funds, it provides educational training, employment services, and training that enables participants to become licensed to prepare, handle, and sell food products, and to establish self-employment and micro-business enterprises. Further, they have created a licensed vending program and opened a restaurant. These food outlets offer healthy tamales and other foods that reflect the culture of the people in the program and in the community. There are plans to replicate this program in a Korean neighborhood with Korean food. Outcomes include: 1) Job training and preparation for people with limited income opportunities and job skills (*economic capital), 2)* Increased availability of culturally appropriate, affordable prepared foods in the community (*nutrition-promoting environment).*

20. Media/Marketing: *Presence of responsible marketing and media that support healthy behaviors and environments through positive messages and role models.*

Increasingly, media outlets are consolidating and are national in scope. Despite these trends, there are still numerous opportunities to engage the media as a partner in promoting public health and safety outcomes. Similarly, marketing is national but plays out locally and communities can change local marketing patterns and have, at times, a statewide and national influence. Accomplishing this includes supporting communities in building partnerships with the media, in limiting the negative impact of the media on the community environment, in understanding the media, in understanding the relationship between the media and policy, and in developing the skills necessary to transform the media can have an impact on community wellness indicators, such as the prevalence of violent crimes and of marketing that promotes unhealthy behaviors and environments.

Sample Action Menu

- Encourage mentorship and development of journalists from the community.
- Encourage editorial boards of newspapers and magazines to set internal policies to not accept advertising for firearms and gun shows, alcohol, tobacco or other unhealthy and exploitative products.

[8] This community example was written with funding from The California Endowment.

- Work with media outlets to minimize marketing of junk food, alcohol, tobacco and weapons and other products that are negatively impacting community health.
- Educate communities to be media literate and to resist targeting by exploitative industries in their communities.
- Educate and organize communities to reject violent television, movies and games.
- Use media strategies to limit the number of liquor distributors in an area, fast food billboard advertisements and outlets near schools, prohibit gun advertising in certain areas, or
- Feature community assets and positive events in the media.
- Feature youth making positive contributions to the community and not just as problems or people to be feared.
- Work in local community institutions, such as schools, community centers, and faith-based organizations to teach youth and adults to be more critical television viewers and media consumers.
- Encourage the development of broad-based media strategies, such as civic journalism, media advocacy, and photovoice, or the use of photography, for social change by marginalized and traditionally powerless groups.
- Develop civic journalism projects involving newspaper, television and radio talk shows to focus on community concerns and health equity issues.
- Decrease the proliferation of billboards that promote harmful products and social norms.

Sample Resources and Tools

- **Asian American Journalists Association:** A non-profit membership organization with over 2,000 members in 19 chapters across the U.S. and Asia established to encourage Asian Pacific Americans to enter the ranks of journalism, to work for fair and accurate coverage of Asian Pacific Americans and to increase the number of Asian Pacific American journalists and news managers in the industry. www.aaja.org
- **Berkeley Media Studies Group:** Organization that works with community groups, journalists and public health professionals to use the power of the media to advance healthy public policy. Resources and services include media advocacy planning, strategic consultation, training, case studies, framing memos, content analysis, and journalism education. www.bmsg.org
- ***Media Advocacy and Public Health: Power for Prevention*.** By Wallack, Lawrence; Dorfman, Lori; Jernigan, David; Makani, Themba. (1993), Sage Publications: Newbury Park, CA.
- **Media Education Foundation:** Producer and distributor of educational videos designed to inspire students and others to reflect critically on the structure of the media industry and the content it produces. www.mediaed.org
- **National Association of Black Journalists**: An organization of journalists, students and media-related professionals that provides quality programs and services to and advocates on behalf of black journalists worldwide. www.nabj.org
- **National Association of Hispanic Journalists**: A national voice and vision for Hispanic journalists dedicated to the recognition and professional advancement of Hispanics in the news industry. www.nahj.org
- **National Federation of Community Broadcasters:** A National alliance of Stations, producers, and others committed to community radio. NFCB advocates for national public

policy, funding, recognition, and resources on behalf of its membership, while providing services to empower and strengthen community broadcasters through the core values of localism, diversity, and public service. www.nfcb.org

- **Native American Journalists Association**: Serves and empowers Native journalists through programs and actions designed to enrich journalism and promote Native cultures. www.naja.com
- **Praxis:** Organization that supports and partners with communities to achieve health justice by providing resources and capacity for policy development, advocacy and leadership. www.thepraxisproject.org
- **The National Alliance for Non-violent Programming:** A national not-for-profit network which helps build and support grassroots initiatives to promote and teach media literacy and non-violence in communities nationwide. www.killology.com/natall.htm
- **The Robert C. Maynard Institute for Journalism Education:** helps the nation's news media reflect America's diversity in staffing, content and business operations. Through its professional development programs, the Institute prepares managers for careers in both business- and news-sides of the journalism industry. Through its Total Community Coverage direct service programs, the Institute helps news organizations better reflect their diverse communities, improve communication with the public and uncover new business opportunities.www.maynardije.org/
- **The Society of Professional Journalists:** Dedicated to the perpetuation of a free press as the cornerstone of our nation and our liberty. The society has a Diversity Toolbox, a database searchable by common news topics, features qualified experts from demographic groups underrepresented in the news. The toolbox offers essays and links to resources that will help you broaden the perspectives and voices in your work. www.spj.org/diversity_toolbox.asp
- **Unity: Journalists of Color, Inc.:** A strategic alliance of journalists of color acting as a force for positive change to advance their presence, growth and leadership in the fast-changing global news industry. This alliance includes the Asian American Journalists Association, National Association of Black Journalists, the National Association of Hispanic Journalists, and the Native American Journalists Association. www.unityjournalists.org

COMMUNITY EXAMPLE *Vietnamese Health Promotion Project*, San Francisco California[9]

The Vietnamese Health Promotion Project was concerned about extremely high cervical cancer rates among Vietnamese immigrant women in San Francisco. Sponsored by the University of California, San Francisco, the project brings together university medical researchers and community residents to promote screening and early detection. In addition to getting the word out through Vietnamese radio, television and newspaper outlets, the project also employs lay health workers to bridge cultural and language gaps and encourages women to get Pap tests on a regular basis. Program data suggests that radio, television and newspaper ads are effective at getting the general word out about what cervical cancer is, why to be concerned about it, and about the Pap test. It is important to note that while the use of the media was important in and of itself, it was far more effective in conjunction with a campaign in which lay health workers conducted face-to-face outreach. Outcomes include 1) Earlier detection of cervical cancer among Vietnamese women in San Francisco (*public health, health, and*

[9] This community example was written with funding from The California Endowment.

social services), 2) Increased awareness about the problem of cervical cancer via the use of media (*media/marketing),* and 3) Increased knowledge and awareness of other health issues, such as smoking, asthma, and health insurance (*public health, health, and social services)*.

IX. NEXT STEPS

T*H*R*I*V*E offers communities an alternative way of viewing the environmental factors that influence health and well-being. The toolkit can be utilized as a learning tool, as a strategic planning tool and as a needs assessment tool. Expert panel members consider the community resilience assessment tool to be complete and feel that it has immense value and utility in diverse communities. Panel members expressed the importance of bringing T*H*R*I*V*E to various governmental agencies and community-based organizations. They asserted that the pilot events provide a strong case regarding T*H*R*I*V*E's applicability and utility in fostering and promoting healthy individuals and communities. Having concluded that the tool has utility and value, expert panel members emphasized the need to distribute the tool widely (outreach and dissemination), and to get it widely used effectively (bringing it to scale) and underscored their commitment in helping to distribute THRIVE. Also an important element that emerged is the long-term need for tracking the use of T*H*R*I*V*E and understanding how it is being used and to what effect. Each of these is described in more detail below. Expert Panel members think it is important to identify other opportunities and resources within OMH and in other places to accomplish the next steps that they recommended.

Outreach and Dissemination

Throughout the meeting, participants emphasized the need for outreach and dissemination to ensure that communities and diverse professionals know about T*H*R*I*V*E and its role in closing the health gap. Participants discussed how to infuse the approach and tool into their own sectors. Overall, their emphasis was on reaching a large and broad audience through an aggressive outreach plan.

Audience and venues: Members recommended that information about T*H*R*I*V*E and its utility be promoted widely among public health, medical professionals, transportation, housing, planners, social workers, local officials, community groups, etc. The panel recommended that information about T*H*R*I*V*E be shared with these multiple disciplines via conferences, newsletters, publications, and list serves. Panel members also suggested taking T*H*R*I*V*E to U.S. government agency directors through the Healthier US Initiative.

Materials: The panel discussed a range of materials that could draw attention to and promote use of T*H*R*I*V*E, including written and audio-visual. They recommended that the tool and collateral materials could be put on CD-ROM and the web to make them more accessible. They also recommended creating a video that highlights the power and efficacy of T*H*R*I*V*E. They thought that the pilot sites could be featured in the video, and that this would make the tool very appealing and allow people to see its power.

They recommended that materials be tailored to different audiences such as academia, public health, transportation, medical, and housing. One idea that emerged was to add the tailored

information, once developed, to the toolkit, so that communities could use the diversity of language in talking about T*H*R*I*V*E with the range of stakeholders they would want to engage. They recommended emphasizing the point in the materials that upstream prevention approaches are more cost effective than waiting until people are sick or injured. They also emphasized the need to bridge T*H*R*I*V*E with medical approaches and to promote how this approach is related to and can support medical approaches to health and closing the health gap.

Bringing T*H*R*I*V*E to Scale

There was strong sentiment around building a critical mass on community environmental approaches to health, and that T*H*R*I*V*E could be an important part of this. Panel members discussed the value of bringing T*H*R*I*V*E to scale, that is, advancing the T*H*R*I*V*E approach in communities throughout the country. They recommended capacity building (training and technical assistance) to help communities use the tool and the approach, and a data/evaluation component to track use and build a database of effective practices. They also recommended using the tool with local government officials to assess ways in which it could be most valuable with public officials in addition to the previously described audiences.

Training and Technical Assistance

Expert panel members asserted the importance of on-going training and technical assistance for organizations that use T*H*R*I*V*E. Given the report-backs from the pilot sites and their assertion that the quality of training and depth of expertise was critical, panel members agreed that Prevention Institute should facilitate on-going training and technical assistance or should train other individuals and/or organizations to facilitate trainings on T*H*R*I*V*E. One recommendation to ensure fidelity and quality was that a training certification program be developed to ensure full understanding of T*H*R*I*V*E and the approach, the value of prevention, the framework for focusing on community behavioral and environmental factors, and the delineation of the four clusters and twenty factors. Some panel members talked about conducting trainings on T*H*R*I*V*E with community partners and organizations. Panel members also expressed the importance of training around ways to build effective coalitions with sectors that cut across T*H*R*I*V*E.

Panel members thought it was important to figure out ways to bring training to many people and supported the idea of holding satellite trainings across the country. They also advanced the idea to develop a web-based component of T*H*R*I*V*E that includes a training component. The notion of creating a video training components of T*H*R*I*V*E was also promoted to ensure that the tool reaches a variety of learning styles.

Panel members recommended identifying and training existing groups such as the Racial and Ethnic Approaches to Community Health (REACH 2010) grantees, The California Endowment grantees, and other government and foundation grantees that work on health disparities.

Another important training venue that emerged was graduate and professional schools. For example, integrating the training into public health schools could be a way to build new skills and foster leadership among emerging public health practitioners. The panel also thought that such training would be relevant for and important in other kinds of education, such as for planners, medical practitioners, etc.

Evaluation and Data
Expert panel members emphasized the importance of an evaluation and data component that over time could track who is using the tool and how; case studies and success stories; long-term data; and the best and promising practices. This would build an even deeper understanding of the tool's utility, how community's are putting this approach into practice, what barriers they are facing, how they are overcoming them, and what additional resources and information they might need. Some members expressed a willingness to volunteer to work on this type of long-term evaluation strategy for T*H*R*I*V*E.

Next steps for the T*H*R*I*V*E tool include the development of two generic models of the tool, one of these models should be more appropriate for an urban setting, while the other should be more appropriate for a rural setting. The dissemination of the T*H*R*I*V*E tool is also extremely important. The tool should be disseminated to communities of color and low-income communities, to practitioners in the field of community development, to institutions of higher learning as well as students of public health and social welfare, as well as to any coordinating bodies for government and non-for-profit agencies. Creating a program for the training of trainers might be one strategy for facilitating the tool's dissemination. The publication of the T*H*R*I*V*E tool and the results of its pilot process will also contribute to this process. *What came out of the expert panel meeting?*

X. CONCLUSION

The U.S. has a history and continued fabric of deeply-rooted personal and institutional biases directed against people of color in key elements of community life, such as employment, housing, the justice and education systems- as well as public health and health care. Therefore, it is not surprising that there are disparities in health. Indeed, given the history of inequality and the resulting disparity in opportunity, health disparities are currently a predictable and persistent problem.

T*H*R*I*V*E provides a framework for identifying and addressing community conditions that can improve health outcomes and close the health gap. The framework translates research into a conceptual model that people can understand and into a tool that enables people to identify specific factors and concrete actions that will make a difference in communities. T*H*R*I*V*E works for a variety of health issues and fosters solutions that simultaneously address multiple health concerns. One of its unique contributions is its emphasis on resilience, building on community strengths and encouraging community leadership to foster positive change and close the health gap.

Most discussions about reducing health disparities focus on improving access to and quality of care. Clearly these are critical issues that must be remedied. However, it is also imperative to do whatever possible to reduce the number of people getting sick and injured *in the first place*. T*H*R*I*V*E is a framework for this type of prevention work at a community-, or population-, level. Further, the community resilience factors identified in T*H*R*I*V*E also support treatment outcomes. Positive behaviors and environments equally improve the success of treatment and disease management. For example, healthy eating and activity habits are not only critical for

prevention but for disease management in diabetes, cardiovascular disease, HIV/AIDS, as well as cancer treatment. Improved air quality, indoors and outdoors, reduces asthma triggers. A reliable, affordable, and accessible transportation system transports people to screening and treatment appointments. Literacy improves the ability to read and understand prescription labels– both directions and warnings. Strong social networks are associated with people looking out for each other and taking care of each other during treatment and recovery.

The T*H*R*I*V*E national expert panel identified ways that T*H*R*I*V*E can help close the health gap. There was clear consensus abound the importance of emphasizing a resilience approach and building on strengths in disenfranchised communities to reduce disparities. Further, the panel emphasized the need to track this approach and associated data overtime to build a stronger science and practice base for minority communities. Other ways the tool can be emphasized to help close the health gap included:

1) Changing the way people think about health and safety

- Promoting knowledge of and critical thinking about communities and community health
- Fostering an understanding of the value of community resilience approaches in addition to and support of medical treatment to close the health gap

2) Providing an evidence-based framework for change

- Laying out a framework and identifying a process for communities to make change
- Providing a framework that can be modified to embrace and reflect local nuances and culture
- Finding solutions that reflect the value and culture of people who live in the community while giving an evidence-based framework of factors that promote improved health outcomes

3) Building community capacity while building on community strength

- Encouraging communities to reflect on their own strengths and capacities
- Building local leadership skills and helping local leadership understand important community and health issues and how to advance them
- Understanding that part of community improvement includes fostering local businesses that are owned by local people and rooted in the culture and needs of the community, thereby increasing people's stake in the neighborhood and local ownership of assets in the neighborhood
- Fostering community ownership of a pro-active solution and creating a community network that can work on issues together

4) Fostering links to decision makers and other resources

- Building bridges from disenfranchised neighborhoods to enfranchised neighborhoods, which tend to have more access to resources and influence in local decision-making
- Creating a bridge to build trust and accountability with local decision makers and policy makers
- Fostering equal partnerships between communities and universities that want to work around health disparities by providing a framework for communities to prioritize and take action and for universities to assist by providing assessment and feedback through credible, and community-participatory based, evaluation.

Reactions from the pilot process and the expert panel confirm that his approach has great resonance. It links the ways that poverty, racism, and other forms of oppression play out at a community level to a practical approach to health promotion. Synthesis research by the Institute of Medicine and others has documented the powerful influence of social and environmental influences on health. Now that these factors are recognized, effective public health practice demands that they be addressed to reduce the prevalence of racial and ethnic disparities in health. T*H*R*I*V*E is one tool with demonstrated utility for doing so.

There is a great risk that prevalence of disparities may increase as the population becomes even more multicultural. As the country becomes increasingly diverse, the reality of a healthy and productive nation will increasingly rely on the ability to keep all Americans healthy and eliminate racial and ethnic disparities by improving the health of communities of color. Healthcare is among the most expensive commitments of government, businesses, and individuals. Illness and injury also generate tremendous social costs in the form of lost productivity and expenditures for disability, worker's compensation, and public benefit programs. Eliminating racial and ethnic health disparities is imperative both as a matter of fairness and economic common sense. This tremendous challenge can—and must—be met with a focused commitment of will, resources, and cooperation to make change happen.

XI. APPENDICES

Appendix A: Expert Panel Members

Anna Caballero
Mayor, City of Salinas
Executive Director, Cultivating Peace
Salinas, CA

Judy Corbett
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Local Government Commission
Sacramento, CA

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American Public Health Association
American Friends Service Committee
Associate General Secretary for Advancement
Washington, DC

Richard L. Dana
Executive Director
Mutual Assistance Network of Del Paso Heights
Sacramento, CA

Wayne Giles
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Division of Adult and Community Health
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Atlanta, GA

Roger Hayes, MA
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Hidalgo Medical Services
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Federal Highway Administration
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Robert D. Putnam, Ph.D.
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William J. Sabol, Ph.D.
Associate Director
Center on Urban Poverty and Social Change
Mandel School of Applied Social Sciences
Case Western Reserve University
Cleveland, OH

Marion Standish, JD
Senior Program Associate
The California Endowment
San Francisco, CA

Appendix B: Glossary of Terms

- **Assets:** *individual, association and organizational skills, talents, gifts, resources and strengths that are shared with the community.*[312]
- **Built environment:** *man-made physical components such as buildings and streets,*[313] *and includes land use, public transportation and the style and permitted uses of businesses and residences.*
- **Clusters:** *a group of terms that are related by an overarching idea; categories.*
- **Community:** *primarily a geographic reference that encompasses the places in which people live, work, and socialize and can include a neighborhood, city, or region.*[314]
- **Community assets**: *anything in a community that can be used to improve quality of community life.*[315]
- **Community building:** *the process in which people and organizations from across the community come together to envision how their ideal community should look and begin to develop plans to mobilize all of the community's resources in order to achieve their visions.*[316]
- **Community development:** *capacity building both inside and outside neighborhood boundaries for such things as employment, shopping, schooling (or even future housing), as long as members of the neighborhood benefit individually or collectively.*[317] *Community development is also asset building that improves the quality of life among residents of low- to moderate-income communities, where communities are defined as neighborhoods or multi neighborhoods.*[318]
- **Community resilience:** *the ability of a community to recover from and/or thrive despite the prevalence of risk factors.*
- **Community resilience factors:** *elements within a community that foster safety and well-being and negate the detrimental impact of risk factors.*
- **Determinants:** *conditions or factors that contribute to/result in health and safety outcomes.*
- **Environment:** *anything external to individuals shared by members of the community, including community behavioral norms.*[319]
- **Environmental conditions:** *Elements in the surrounding environment that impact health and safety either directly or indirectly.*
- **Protective factors:** *elements of an individual, community, or population group that support positive development and promote health and safety.*
- **Resilience:** *the ability to thrive despite the prevalence of risk factors.*
- **Resiliency:** *traits that support the healthy development of individuals, families, schools, and communities and build capacity for positive relationship and interactions.*[320]
- **Risk factors:** *anything that increases the probability of illness, injury, or death.*
- **Social capital:** *connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them.*[321]
- **Structural factors:** *systemic or structural issues that have an overarching effect. In T*H*R*I*V*E, only those structural factors whose effect can be addressed by community level interventions are addressed.*
- **Youth development:** *the process in which all young people are engaged to meet their needs, build skills and find ways to opportunities to make a difference in all of the areas of their lives — personal/cultural, social/emotional, moral/spiritual, vocational, cognitive and civic.*[322]

Appendix C: Pilot Site Agenda

A Community Approach to Eliminating Health Disparities
T*H*R*I*V*E: Toolkit for Health and Resilience in Vulnerable Environments

Pilot Site Training and Tool Implementation Agenda

9:00 Welcome and Introduction
Participants will introduce themselves and share at least one thing they hope to get from the day. A brief overview of the day will be provided, including major meeting goals.

9:15 What is a Healthy Community?
As an introduction to the day, participants will be asked to describe a healthy community. Key questions to consider: What does the community physically look like? How do people relate to each other? What kinds of opportunities are open to residents?

9:30 Major Health Concerns
Participants will discuss and confirm the community's priority health concerns. These priorities will serve as the basis for advancing a community resilience approach.

9:45 A Community Resilience Approach to Eliminating Health Disparities
This conceptual overview will highlight the role of primary prevention in eliminating health disparities, pathways between root factors and health disparities, the impact of the environment directly on health and in shaping behavior, and the opportunity for action at the community level. A resilience-oriented health disparities framework will be presented that includes twenty community factors in the following clusters: built environment, social capital, services and institutions, and macro factors. For each cluster, research will highlight the relationship between the factors and health outcomes.

10:15 Break

10:30 A Community Resilience Approach to Eliminating Health Disparities - continued

11:30 Prioritization and Assessment of Community Factors
*Considering the priority health concerns and using the T*H*R*I*V*E tool, participants will be asked to determine the relative priority of each factor and how well developed each of the cluster areas and factors is in the community.*

12:00 Working Lunch
During lunch, participants will be asked to form small groups and discuss the range of factors, focusing specifically on which factors they think are most important for addressing the major health concerns and how effective those factors currently are.

1:00 Findings from the T*H*R*I*V*E Tool and Small Group Discussions
*Prevention Institute will report back on how the group as a whole assessed both priority and development of the clusters and factors on the T*H*R*I*V*E tool. Each group will also be asked to report back on their conclusions and these will be used to confirm or modify the findings from the tool.*

1:45 Building Consensus: Priority Factors
During this session, participants will be asked to come to consensus about the top3- 6 factors for action in their community.

2:15 Customizing the Process: Renaming the Factors and Developing Community-Specific Indicators
Discussion will focus on customizing names for the priority factors and on creating community indicators for those factors.

2:45 Community Self-assessment: What's Working and What Needs Improvement?
Considering the indicators just defined, participants will assess what's working and what needs improvement for each of the prioritized factors. This will help identify strengths that can be built upon and gaps that need to be addressed.

3:20 Break

3:30 Next Steps: Expanding Partnerships and Moving Forward to Build Community Resilience
The group will delineate specific action steps that will advance a community resilience approach. Taking into account the priority health issues, priority factors, selected indicators, what's working and what needs improvement, the group should consider other stakeholders that should be brought to the table and appropriate next steps that will build on the work of the day

4:15 Evaluating the T*H*R*I*V*E Toolkit
*To help strengthen presentation materials, the T*H*R*I*V*E toolkit, and the facilitated process, participated are asked to complete an evaluation form.*

5:00 Adjourn

Appendix D: THRIVE Tool

THRIVE: Identifying Key Health Issues

A. For each of the following health problems, please indicate how much of a concern you think that issue is in your community. Put an 'X' in the box that most closely reflects your opinion. From left to right, your choices are: not a concern, slight concern, moderate concern, major concern, and don't know

	Not a concern	Slight concern	Moderate concern	Major concern	Don't know
Cardiovascular disease					
Diabetes					
Asthma					
HIV/AIDS					
Cancer					
Violence					
Traffic crashes and injury					
Infant mortality					
Substance abuse					
Mental illness					
Overweight/obesity					
Other:					
Other:					

Other:					
Other:					

B. Considering all of the health problems above, which three do you consider to be the most important for your community to address?

1.

2.

3.

THRIVE: Priority Ratings for Factors

Directions: Taking into account the highest priority health concerns in your community, please rate each of the following factors according to their priority of high (H), medium (M), and low (L). Specifically, the priority rating should indicate how important you think it is that your community addresses that particular factor.

H = High Priority M = Medium Priority L = Low Priority

Sample:	
H	**1. Activity Promoting Environment:** *Places to participate in incidental/recreational activity*

	CLUSTERS AND FACTORS
	A. BUILT ENVIRONMENT: *Man-made physical components*
	1. Activity-Promoting Environment: *Places to participate in incidental/recreational activity*
	2. Nutrition-Promoting Environment: *Safe, healthy, affordable, culturally appropriate food*
	3. Housing: *Availability of safe, affordable housing in the community*
	4. Transportation: *Availability of safe, affordable methods for moving people around*
	5. Environmental Quality: *Safe water, soil, air, and building materials*
	6. Product Availability: *Beneficial products; limited availability of harmful products*
	7. Appearance/Ambiance: *Appealing, clean, and culturally relevant environment*

	B. SOCIAL CAPITAL: *Social networks and norms of reciprocity and trustworthiness*
	10. Civic Engagement/Participation: *Involvement in organizations and political processes*
	12. Positive Gender Norms: *Gender-specific, socio-culturally determined standards*
	13. Public Health, Health, & Human Services: *Available, accessible, high quality services*
	14. Public Safety: *Law enforcement and fire protection that have the trust of the community*
	15. Education and Literacy*: Education and literacy services across the life span*
	16. Community-Based Organizations: *Effective non-profit efforts*
	17. Cultural/Artistic Opportunities: *Abundant opportunities for artistic expression*
	20. Media/Marketing: *Presence of responsible marketing and media*

THRIVE: Community Effectiveness Scores

Directions: Please rate each of the following factors according to how effective your community is at fostering it. Use the 5-point scale below to rate your community's effectiveness. Circle the number that most closely represents your rating of your community.

Key:

1 = Elements not in place and harmful to health or inappropriate for needs of community

2 = Few elements are in place, but needs improvement regarding quality, access, availability, and/or cultural and developmental appropriateness

3 = Some elements are in place and well developed. These elements are culturally appropriate and meet the range of developmental needs

4 = Many elements are in place and on the road to full development, but there is some room for improvement

5 = Meets range of developmental needs. Elements are culturally appropriate, accessible, and available to the community

Sample:

BUILT ENVIRONMENT: *Man-made physical components*

1. Activity-Promoting Environment: *Places to participate in incidental/recreational activity*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

2. Nutrition -Promoting Environment: *Safe, healthy, affordable, culturally appropriate food*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

Housing: *Availability of safe, affordable housing in the community*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

A. BUILT ENVIRONMENT: *Man-made physical components*

1. **Activity-Promoting Environment:** *Places to participate in incidental/recreational activity*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

2. **Nutrition-Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

3. **Housing:** *Availability of safe, affordable housing in the community*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

4. **Transportation:** *Availability of safe, affordable methods for moving people around*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

5. **Environmental Quality:** *Safe water, soil, air, and building materials*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

6. **Product Availability:** *Beneficial products; limited availability of harmful products*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

7. **Appearance/Ambiance:** *Appealing, clean, and culturally relevant environment*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

B. SOCIAL CAPITAL: *Social networks and norms of reciprocity and trustworthiness*

8. Social Cohesion and Trust: *Strong social ties among persons and positions*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***9.* Collective Efficacy:** *A willingness to intervene on behalf of the common good*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***10.* Civic Engagement/Participation:** *Involvement in organizations and political process*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***11.* Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***12.* Positive Gender Norms:** *Gender-specific, socio-culturally determined standards*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

C. SERVICES AND INSTITUTIONS: *Quality, culturally competent services & business*

***13.* Public Health, Health, & Human Services:** *Available, accessible, high quality services*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***14.* Public Safety:** *Law enforcement and fire protection that have the trust of the community*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

15.* Education and Literacy*: *Education and literacy services across the life span*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***16.* Community-Based Organizations:** *Effective non-profit efforts*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

17. Cultural/Artistic Opportunities: *Abundant opportunities for artistic expression*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

D. STRUCTURAL FACTORS: *Societal factors that can be influenced by community attention*

18. Ethnic, Racial, and Inter-group Relations: *Positive relations between different groups*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

19. Economic Capital: *Local ownership of assets or access to investment opportunities*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

20. Media/Marketing: *Presence of responsible marketing and media*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

Clusters and Factors: Quick Reference Definitions

A. BUILT ENVIRONMENT: Man-made physical components such as buildings and streets, including land use, public transportation, and the style and permitted uses of businesses and residences

1. **Activity-Promoting Environment:** Places in which people can safely participate in walking, biking, and other forms of incidental/recreational activity
2. **Nutrition-Promoting Environment:** Availability and promotion of safe, healthy, affordable, culturally appropriate food
3. **Housing:** Availability of safe, affordable housing in the community
4. **Transportation:** Availability of safe and affordable methods for moving people around
5. **Environmental Quality:** Safe and non-toxic water, soil, indoor and outdoor air, and building materials
6. **Product Availability:** Availability of beneficial products such as books and school supplies, sports equipment, arts and crafts supplies, and other recreational items; and limited availability or lack of potentially harmful products such as tobacco, firearms, alcohol, and other drugs
7. **Appearance/Ambiance:** Well maintained, appealing, clean, and culturally relevant environment

B. SOCIAL CAPITAL: Connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them

8. **Social Cohesion and Trust:** Strong social ties among persons and positions, built upon mutual obligations, opportunities to exchange information, shared norms, and the ability to enforce standards and administer sanctions
9. **Collective Efficacy:** Social cohesion coupled with a willingness to intervene on behalf of the common good
10. **Civic Engagement/Participation:** Involvement in community or social organizations and/or participation in the political process
11. **Positive Behavioral/Social Norms:** Shared beliefs and standards of behavior that encourage positive choices and support healthy environments
12. **Positive Gender Norms:** Gender-specific, socio-culturally determined standards of behavior that encourage positive choices, and create safe and supportive relationships between and within gender groups

C. SERVICES AND INSTITUTIONS: Availability of and access to high quality, culturally competent, appropriately coordinated public and private services and institutions

13. **Public Health, Health, and Human Services:** Available, accessible, high quality healthcare, health promotion and wellness services, health-related services such as mental health and substance abuse prevention/intervention, public health, and social services
14. **Public Safety:** High quality law enforcement and fire protection that has gained the trust of the community
15. **Education and Literacy:** High-quality and available education and literacy services across the life span that meet the needs of all people within the community

16. **Community-Based Organizations:** Effective non-profit, grassroots, community coalitions, and faith-based organizations within a community that fill service gaps, advocate for community needs, and promote health and safety for the community
17. **Cultural/Artistic Opportunities:** Abundant opportunities within the community for cultural and artistic expression and participation and for cultural values to be expressed through the arts

D. STRUCTURAL FACTORS: Broad or societal factors that play out in communities and may be influenced by community attention

18. **Ethnic, Racial, and Inter-group Relations:** Positive relations between people of different races and ethnic backgrounds
19. **Economic Capital:** Local ownership of assets or access to investment opportunities, as well as ability to make a living wage
20. **Media/Marketing:** Presence of responsible marketing and media that support healthy behaviors and environments through positive messages and role models

Appendix E: THRIVE Pilot Site Reports

A Community Approach to Eliminating Health Disparities

THRIVE: Tool for Health and Resilience in Vulnerable Environments

Pilot Site Report

Hidalgo Medical Services, Lordsburg, New Mexico

October 21, 2003

1) What is a Healthy Community?

The event began with a question designed to stimulate thinking, "What would a health -- or health-promoting -- community look like?" The question was designed to gauge participant thinking on the topic, setting a baseline, and/or to outline a vision for a healthy community. The remainder of the day's activities would then question, reinforce, and/or refine this initial brainstorming. Below is the list participants came up with.

Elements of a healthy community as brainstormed by participants:

- Youth use the resources and activities provided for them
- Alcohol, tobacco, and drugs are not abused
- Diabetes is not a concern
- Affordable housing and safe neighborhoods everywhere
- Vegetables and fruits are readily available
- There is safe and accessible transportation to get to medical services and other important places
- There are happy kids and families
- There are two-parent, stable families
- There are plenty of opportunities for education and higher education
- There are vocational program
- The people within community work together and utilize all their resources
- There is collaboration among the seven communities in the county
- More border patrol agents work AND live in Lordsburg
- More teachers live in the community
- There are plenty of doctors and professionals that serve the community, including in specialized medicine

2) Identifying Key Health Issues

In order to ensure that the day's findings addressed major health concerns, participants were asked to prioritize the major 3-5 health concerns for the community. Participants first individually completed the chart below (composite responses are provided) and then shared their priorities with the group. As a group, they selected the priority issues that would be the focus of the remainder of the day.

The following table represents the composite of individual responses on the worksheet:

	Not a concern	Slight concern	Moderate concern	Major concern	Don't know
Cardiovascular disease *		2		5	
Diabetes *			1	6	
Asthma		1	4	1	
HIV/AIDS	2	3	1		
Cancer		3	2	2	
Violence		3	1	3	
Traffic crashes and injury		3	2		1
Infant mortality		5	1		
Substance abuse *			1	6	
Mental illness			4	3	
Overweight/obesity		1	1	4	
Other: teen pregnancy			1	1	
Other: Pre-natal Care			1		
Other: Activities for families				1	

*** =** Represents the top health concerns chosen

The following list represents the responses that participants shared with the group when asked what the highest priority health concerns were for the community.

- *Substance abuse*
- *Teen pregnancy*
- *Domestic violence*
- Low immunization rates
- Inaccessible early prenatal care
- Not enough mental health services
- Inadequate number of health care professionals
- Problems with transportation services
- Unemployment rates are high
- People need more in-depth job training
- Border issues
  - -Public health
  - -TV
  - -Language
  - -Immigration.

Participants agreed on the following priority health concerns:

1. Cardiovascular disease
2. Diabetes
3. Substance abuse

3) Training on a Community Resilience Approach

Prevention Institute provided a training on advancing a community resilience approach to closing the health gap. In particular, the training included a background on the efficacy of prevention, a framework for focusing on behavioral and environmental factors, and a delineation of the four clusters and twenty factors, linking each of them to the Healthy People 2010 Leading Health Indicators and *major health concerns.*

4) Rating the Priority of Factors

Participants used the THRIVE tool to rate the priority level of each factor. In particular, they were asked to think about how important it would be to focus on a particular factor given their priority health concerns. The average of their priority ratings are summarized in the following chart.*

* In order to average the ratings, we assigned numerical ratings for calculation. They were then converted back into letters, with the addition of minuses and pluses when necessary.

Priority ratings: H = High Priority M = Medium Priority L = Low Priority

	CLUSTERS AND FACTORS
H -	**A. BUILT ENVIRONMENT:** *Man-made physical components*
H -	**1. Activity Promoting Environment:** *Places to participate in incidental/recreational activity*
H	**2. Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*
H -	**3. Housing:** *Availability of safe, affordable housing in the community*
H -	**4. Transportation:** *Availability of safe and affordable methods for moving people around*
M +	**5. Environmental Quality:** *Safe water, soil, air, and building materials*
M +	**6. Product availability:** *Beneficial products; limited availability of harmful products*
M	**7. Aesthetic/Ambiance:** *Appealing, clean, and culturally relevant visual environment*
H -	**B. SOCIAL CAPITAL:** *Social networks and norms of reciprocity and trustworthiness*
H -	**8. Social Cohesion and Trust:** *Strong social ties among persons and positions*
H -	**9. Collective Efficacy:** *A willingness to intervene on behalf of the common good*

H -	**10. Civic Engagement/Participation:** *Involvement in organizations and political process*
H -	**11. Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*
H	**12. Positive Gender Norms:** *Gender-specific, socioculturally determined standards*
H	**C. SERVICES AND INSTITUTIONS:** *Quality, culturally competent services & business*
H	**13. Public Health, Health, & Human Services:** *Available, accessible, high quality services*
H	**14. Public Safety:** *Law enforcement and fire protection that trust of the community*
H	**15. Education and Literacy:** *Education and literacy services across the life span*
H -	**16. Community-Based Organizations:** *Effective non-profit efforts*
M +	**17. Cultural/Artistic Opportunities:** *Abundant opportunities for artistic expression*
H -	**D. MACRO FACTORS:** *Structural factors that can be influenced by community attention*
H -	**18. Economic Capital:** *Local ownership of assets or access to investment opportunities*
M	**19. Media/Marketing:** *Presence of responsible marketing and media*
M	**20. Ethnic, Racial, and Intergroup Relations:** *Positive relations between different groups*

Based on individuals completing the tool, the following emerged as highest priority:

Built Environment
Activity-Promoting Environment
Nutrition-Promoting Environment
Housing
Transportation

Social Capital
Social Cohesion and Trust
Collective Efficacy
Civic Engagement/Participation
Positive Behavioral/Social Norms
Positive Gender Norms

SERVICES AND INSTITUTIONS
Public Health/Health/Human Services
Public Safety
Education/Literacy
Community-Based Organizations

MACRO FACTORS
Economic Capital

As a group, participants prioritized their top priority factors. They are:

- Nutrition-Promoting Environment
- Transportation
- Positive Behavioral/Social Norms
- Education/Literacy

- Public Health/Health/Human Services

5) Assessing Community Effectiveness Scores

Participants used the THRIVE tool to rate how well developed each of the cluster areas and factors are in the community. The below key represents the system developed for rating the clusters areas and factors.

Key:
1 = Elements not in place; harmful to health or inappropriate for needs of community. There is either nothing in place that fosters health or what is in place is detrimental to the health of members of the community. **2 =** At most a few elements are in place, and they need improvement regarding quality, access, availability, and/or cultural and developmental appropriateness. There is inadequate development or quality of the factor to promote positive health outcomes. **3 =** Some elements are in place and well developed. These elements are culturally appropriate and meet the range of developmental needs. Factor meets some needs of the community. **4 =** Many elements are in place, but there is some room for improvement related to putting more elements in place and/or improving quality, access, availability, and/or cultural and developmental appropriateness. Factor is on the way to fully meeting the needs of the community. **5 =** Many elements are in place and are high-quality, accessible, available, and culturally and developmentally appropriate for the range of needs in the community. Factor fully meets the needs of the community.

Note: *The pink stars indicate the number of people who marked each score*

B. BUILT ENVIRONMENT: *Man-made physical components*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★★★ Moderately effective ★★ ★ Fully effective & developed

17. Activity Promoting Environment: *Places to participate in incidental/recreational activity*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★★★ Moderately effective ★ ★★ Fully effective & developed

***18.* Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★★ Moderately effective ★★★ ★ Fully effective & developed

***19.* Housing:** *Availability of safe, affordable housing in the community*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★★★★ Moderately effective ★ Fully effective & developed

20. Transportation: *Availability of safe and affordable methods for moving people around*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★★★★ Moderately effective ★★ Fully effective & developed

21. Environmental Quality: *Safe water, soil, air, and building materials*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★ Moderately effective ★★★★★ Fully effective & developed

22. Product availability: *Beneficial products; limited availability of harmful products*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★ Moderately effective ★★★ Fully effective & developed

23. Aesthetic/Ambiance: *Appealing, clean, and culturally relevant visual environment*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★★ Moderately effective ★★★★ Fully effective & developed

B. SOCIAL CAPITAL: *Social networks and norms of reciprocity and trustworthiness*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

★★★★ ★★

24. Social Cohesion and Trust: *Strong social ties among persons and positions*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective ★★★ ★ Fully effective & developed

★ ★ ★

***25.* Collective Efficacy:** *A willingness to intervene on behalf of the common good*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ Moderately effective ★★★★ Fully effective & developed

★

***26.* Civic Engagement/Participation:** *Involvement in organizations and political process*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed Moderately effective ★★ Fully effective & developed

★★ ★★

***27.* Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ Moderately effective ★ Fully effective & developed

★★ ★★

***28.* Positive Gender Norms:** *Gender-specific, socioculturally determined standards*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★★ ★ Moderately effective ★ Fully effective & developed

★★

C. SERVICES AND INSTITUTIONS: *Quality, culturally competent services & business*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

★ ★ ★

29. **Public Health, Health, & Human Services:** *Available, accessible, high quality services*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

★ ★ ★ ★ ★★

30. **Public Safety:** *Law enforcement and fire protection that trust of the community*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

★★ ★★★★★

31. **Education and Literacy*:*** *Education and literacy services across the life span*

1 _____ 2 _____ 3 _____ 4 _____ 5

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★ ★ ★

32. **Community-Based Organizations:** *Effective non-profit efforts*

1 _____ 2 _____ 3 _____ 4 _____ 5

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★ ★

17. Cultural/Artistic Opportunities: *Abundant opportunities for artistic expression*

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Not at all developed ★★★ Moderately effective — Fully effective & developed

★★★ ★

D. MACRO FACTORS: *Structural factors that can be influenced by community attention*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ Moderately effective ★★★ Fully effective & developed

21. Economic Capital: *Local ownership of assets or access to investment opportunities*

1 _____ 2 _____ 3 _____ 4 _____ 5

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★

22. Media/Marketing: *Presence of responsible marketing and media*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★★★ Moderately effective ★★★ Fully effective & developed

23. Ethnic, Racial, and Intergroup Relations: *Positive relations between different groups*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed Moderately effective ★★★★★★ Fully effective & developed ★

6) Customizing the Process: Renaming the Factors and Developing Community-Specific Indicators

While generally speaking the factors and the cluster names reflect the research, it is clear that communities may have words to describe a particular cluster of factor that is more reflective of local culture and language or in closer alignment with existing efforts and priorities. In recognition of this, participants were given the opportunity to rename their priority factors based on how their community would define and describe these factors. In addition, they developed local indicators for each priority factor. The indicators reflect the community's description of what the factor might look like if it were fully developed and promoting health and/or safety outcomes. The selected names and indicators are summarized in the following table.

Priority Factors	Community Names	Indicators
Nutrition-Promoting Environment	Healthy Food Choices	* More people eating fruits and vegetables * Increase awareness of healthy choices and relation to health * Increase numbers of fruits and vegetables in local grocery store. * Farmer's market * Improved nutrition break menu * Increase numbers of healthy food options and portions
Transportation	Transportation	* Increase numbers of riders * Serve a greater number of request * Up numbers of vans. * Handicapped services * Sustainable revenue producing * Fleet of PT Caravans.
Positive Behavioral/ Social Norms	Custumbres/ Customs	* Promote alcohol and drug free activities * Decrease youth that are drinking in the county * Increase price of alcohol * Decrease long-term healthcare costs. * Decrease DWI. * Decrease Cirrhosis deaths (failure of the liver) * Decrease alcohol related crashes/fatalities. * Increase age of alcohol onset.
Education/ Literacy	Education/ Literacy	* Expand employable work force * Increase wages and wage levels * Expand vocational and technical apprenticeships, * Increase percentage of high school literacy for job market. * Includes Life skills curriculum * Increase job stability * Increase number of people in college or technical schools * Encourage businesses to moves to Hidalgo * Increase standardized test scores * Increase number of scholarships
Public Health/ Health/	Public Health/ Health/	* School nurse in schools * Increase number of providers

Human Services	Human Services	*Extended hours for primary care * Enhanced EMS Services * Detoxify center in place. * Decrease number of county residents in drug alcohol use.

7) Assessing What's Working and What Needs Improvement

Considering the indicators, participants assessed what's working and what needs improvement for each of the 5 priority factors. This activity helped participants identify strengths that can be built upon and gaps that need to be addressed as efforts move forward.

Priority Factor	What's working	What needs improvement
Healthy Food Choices	* Big Brothers/ Big Sister Program * Education in General is good (K –12) * Life skills program * "Every 15 Minutes"	* Physical education, arts etc. were cuts because of budgets * Expanded vocational, technical apprenticeship * Job readiness * Need to increase the number of people in college and technical schools
Transportation	* Healthlink Van Concept * Neighborliness to around * Safe Ride (Medicaid) * Senior citizen van	* Healthlink van funding * Public transportation
Custumbres/ Customs	* Drive-Up liquor stores have been closed * Educational Programs * After-Prom parties	* Poor adult role models * Lack of in/out patient treatment facilities * Systems, laws and policies do not help in decreasing substance abuse * Substance use is associated with celebrations
Education/ Literacy	* Healthlink Van Concept * Neighbor-liness to around * Safe Ride (Medicaid) * Senior citizen van	* Same people at the table * Not enough people power * Substance abuse services * Lack of professionals * Improved communication and collaboration * Services to migrant community
Public Health/ Health/ Human Services	* Good primary care system * Good public health * Collaboration between different entities * Psychiatrists * Dental services	* Same people at the table * Not enough people power * Substance abuse services * Lack of professionals * Improved communication and collaboration * Services to migrant community

8) Identifying Next Steps and Partners

Taking into account the priority health issues, priority factors, developed indicators, what's working and what needs improvement, participants brainstormed other stakeholders that should be brought to the table and appropriate next steps to build on the work of the day. Below is a list of what participants came up with.

Next Steps

- Chamber of Commerce
- County Commission
- Put notes together to present info to chamber, commission, consortium meeting
- They have resources to access info on a variety of factors
- Build on tool pilot to revamp strategic plan.
- Look @ each factor in terms of who should be @ the table.
- Community meetings.
- Status report to take to the community.
- What has been firmly achieved in regards to economic development?
- Article in the paper about THRIVE outcomes

9) Evaluating the Pilot Event

To get an immediate impression of the day, participants were asked for three words to describe the day before completing a detailed evaluation. The results of each follow:

Words to describe the day:

- Appreciative
- Beneficial
- Challenging (X 3)
- Consistent
- Direction
- Educational
- Fun
- Helpful (X 2)
- Informative
- Interesting (X 2)
- Organization
- Validating

Pilot Evaluation Results

To help strengthen presentation materials, the THRIVE tool and the facilitated process, participants were asked to complete the below evaluation form. Participants were asked to circle the number that most closely represents their response to the question and add any additional information in the space provided.

Sample Rating Chart:

1	2	3	4	5	0
Not at all		Neutral		Very much so	Don't know

1a. Were your expectations for the day met?
AVERAGE RATING: 4.7

1b. What were your expectations of today's session?
- Wasn't sure what to expect
- Helpful tool to keep us focused on priorities for Hidalgo County
- Learn about the THRIVE assessment
- To learn what THRIVE was about
- I thought it would only be an overview, but I was impressed as to how in-depth this tool goes. Excellent!
- Know and understand THRIVE
- Expected more on how to foster risk reduction, resilience theory specifically, surprised at the "prevention" emphasis
- Would like to have addressed action steps—but need another full day!

2a. Overall, how valuable was the presentation, tool, and discussions for you?
AVERAGE RATING: 4.75

2b. What was the most valuable aspect of the presentation, tool, and discussions?
- Identifying factors, outcomes
- Very educational
- Factors and clusters
- Ratings for factors and clusters
- Community risks and relation factors
- Communication with other members of the community
- Systems process: believe it's a good method of providing basis for evaluation, discussion

2c. What was the least valuable aspect of the presentation, tool, and discussions?
- A little frustrated that most was based on urban experience

3a. Was the presentation about the relationship between community resilience and health valuable?
AVERAGE RATING: 4.9

3b. What kind of additional information would add value?
- Interesting to see how so many things are tied together
- Draw into similar styles of evaluation, I thought this was more new or different but found many similarities to other evaluation processes

4. How clear is the relationship between the 4 clusters and each of its corresponding factors?
AVERAGE RATING: 4.6

5a. Did the presentation provide the conceptual information you needed to complete the tool and participate in the subsequent discussions?

AVERAGE RATING: 4.7

5b. What kinds of materials and information would best prepare future participants to use the tool effectively?

- Local information, pertinent info
- For "Rural Settings" a rural presentation of info when you get it
- Concept of change or "change concepts;" evidence based programs [need presenters to] give little more explanation
- More discussion before filling out the tool. Seemed more like a lecture, and there was confusion as to how to fill it out.

6a. How useful did you find the tool?

AVERAGE RATING: 5

6b. What did you find most useful?

- Helping us to prioritize issue
- Material information
- Definitions, power point presentation
- Definitions
- How to identify key health concerns/issues
- Nice format for organizing thoughts into groups
- HML cluster rating

6c. What did you find least useful?

- None—all useful
- Little confusing on how to evaluate response
- Confusion regarding community effectiveness scores—hard to differentiate between community at large and specific three priorities

7a. How appropriate is the language of the tool for your community?

AVERAGE RATING: 4.1

7b. How can the language of the tool be adapted for your community?

- Local adaptation, as we did
- Words be put in Spanish
- Start using the tool, and how it works in our community
- Can and should be used for the HC Plan

8a. Did the tool include the range of factors that you think are important to promote community resilience and health?

AVERAGE RATING: 5

8b. Are there any other factors that you think are important to include in the tool?

- None, you have covered everything
- Border issues

8c. Are there any factors and/or clusters that should be rearranged and/or omitted?

- Struggling with "Substance Abuse"—All others seem to be outcomes, and S/A is seen as a behavior in most cases

9a. Did the day's activities progress in a manner that was logical and easy to understand (i.e. ranking community health issues, and prioritizing the 20 factors, who else needs to be at the table, next steps)?

AVERAGE RATING: 4.7

9b. How could the ordering of the day's activities be improved upon?

- Everything came together nicely
- No improvement. Facilitators stayed on track
- It all fell into place
- Less on AM presentation if possible, more on actual discussion of ways to gather results
- Separate Priority Ratings and Community Rankings—i.e. do ratings and THEN discuss rankings before filling out that section

10a. Can this tool be used to effectively promote positive health outcomes in communities?

AVERAGE RATING: 4.8

10b. How can this assessment tool be used to promote positive health outcomes in communities?

- Helping us in our strategic planning and goal setting
- Advertisement
- Prioritizing our needs
- Could be use coincidently with other Health Councils
- Guide toward reinforcing positive attitudes
- Good priority setting tool

10c. How do you think this tool could be used to assist communities, local government and/or service providers in their work?

- Train the trainer
- Identify needs: what is working and what is not working
- Show them the top needs in our community
- Utilize locally and present to other communities
- Clarity is <u>great</u>—could be used for all kinds of Strategic Planning needs

11a. Can this tool be used to create a paradigm shift in how communities address health issues?

AVERAGE RATING: 3.6

11b. How can the tool be used to create a paradigm shift in how communities address health issues?

- Shift form what is not working to what might work
- Stress the import, urgent, doable piece

12. Was today a motivational experience for you?

AVERAGE RATING: 4.4

13. What resources do you need in order to feel that you can use the tool independently and with confidence?

- I have all I need!
- More community involvement
- A practice tool that has been used in other communities
- You have provided what we need

14a. Do you anticipate challenges in incorporating a resilience approach to community health?

AVERAGE RATING: 3.6

14b. What do you anticipate will be the major challenges in incorporating a resilience approach to community health?

- Changing community norms!
- Having key personnel from Hidalgo County involved in this approach
- Getting community to buy in
- Community buy in, "long haul" mentality rather than quick fix
- Community buy in, understanding a resilience approach

14c. What additional assistance would be most helpful in overcoming these obstacles?

- Data, info on other sites
- More handouts
- Money, volunteers, community involvement
- Education, thought-provoking opportunities

15 What impact do you anticipate that a community resilience approach will have on your community and/or your organization?

- Tool to help community/organization thrive, succeed
- Positive approach, more education on the needs of the community
- Involvement, laziness
- This will provide an excellent jump-start for our Strategic Planning

16. Describe an action that you will take as a result of the information you heard about and discussed related to THRIVE?

- Will use tool with local government/ 501c3 Agencies
- I think if the Hidalgo Count Health Consortium could work this tool slowly to address local needs
- Cooperation between community volunteers
- This tool can be effective in our community meetings! Thank You—we appreciate your time & expertise!

Pilot Site Report
Del Paso Heights (Sacramento), California
October 25 and December 6, 2003
YOUTH REPORT

Day 1

1) What is a Healthy Community?
The event began with a question designed to stimulate thinking, "What would a health -- or health-promoting -- community look like?" The question was designed to gauge participant thinking on the topic, setting a baseline, and/or to outline a vision for a healthy community. The remainder of the day's activities would then question, reinforce, and/or refine this initial brainstorming. Below is the list participants came up with.

Elements of a healthy community as brainstormed by participants:
- Teen health clinics
- Gyms
- Recreational centers
- Teen centers
- Youth programs
- Programs where teens can express talents beyond sports

2) Identifying Key Health Issues
In order to ensure that the day's findings addressed major health concerns, participants were asked to prioritize the major 3-5 health concerns for the community. Participants first individually completed the chart below (composite responses are provided) and then shared their priorities with the group. As a group, they selected the priority issues that would be the focus of the remainder of the day.

The following table represents the composite of individual responses on the worksheet:

	Not a concern	Slight concern	Moderate concern	Major concern	Don't know
Cardiovascular disease		3	2		2
Diabetes			4	1	1

Asthma		2	2	1	
HIV/AIDS			2	2	2
Cancer			4		1
Violence *				5	
Traffic crashes and injury		1	2	1	
Infant mortality			3	1	2
Substance abuse *			2	4	
Mental illness		2	1		1
Overweight/obesity	1	2	1		1
Other: teen pregnancy *				3	
Other: traffic accidents					

* = Represents the top health concerns chosen

Participants agreed on the following priority health concerns:

4. Violence
5. Substance Abuse
3. Teen Pregnancy

3) Training on a Community Resilience Approach

Prevention Institute provided a training on advancing a community resilience approach to closing the health gap. In particular, the training included a background on the efficacy of prevention, a framework for focusing on behavioral and environmental factors, and a delineation of the four clusters and twenty factors, linking each of them to the Healthy People 2010 Leading Health Indicators and *major health concerns.*

4) Rating the Priority of Factors

Participants used the THRIVE tool to rate the priority level of each factor. In particular, they were asked to think about how important it would be to focus on a particular factor given their priority health concerns. The average of their priority ratings are summarized in the following chart.*

* In order to average the ratings, we assigned numerical ratings for calculation. They were then converted back into letters, with the addition of minuses and pluses when necessary.

Priority ratings: H = High Priority M = Medium Priority L = Low Priority

	CLUSTERS AND FACTORS
	A. BUILT ENVIRONMENT: *Man-made physical components*
H -	**1. Activity Promoting Environment:** *Places to participate in incidental/recreational activity*
H -	**2. Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*

M +	**3. Housing:** *Availability of safe, affordable housing in the community*
M +	**4. Transportation:** *Availability of safe and affordable methods for moving people around*
H	**5. Environmental Quality:** *Safe water, soil, air, and building materials*
M +	**6. Product availability:** *Beneficial products; limited availability of harmful products*
M +	**7. Aesthetic/Ambiance:** *Appealing, clean, and culturally relevant visual environment*
	B. SOCIAL CAPITAL: *Social networks and norms of reciprocity and trustworthiness*
H -	**8. Social Cohesion and Trust:** *Strong social ties among persons and positions*
M	**9. Collective Efficacy:** *A willingness to intervene on behalf of the common good*
M	**10. Civic Engagement/Participation:** *Involvement in organizations and political process*
M -	**11. Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*
M	**12. Positive Gender Norms:** *Gender-specific, socioculturally determined standards*
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M -	**17. Cultural/Artistic Opportunities:** *Abundant opportunities for artistic expression*
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H -	**20. Ethnic, Racial, and Intergroup Relations:** *Positive relations between different groups*

Based on individuals completing the tool, the following emerged as highest priority:

Built Environment
Activity Promoting Environments
Environmental Quality

Social Capital
Social Cohesion and Trust

SERVICES AND INSTITUTIONS
Public Health/Health/Human Services

Services and Institutions
Public Health, Health and Human Services
Education and Literacy
Community-Based Opportunities

Macro Factors
Economic Capital
Ethnic, Racial and Intergroup Relations

As a group, participants prioritized their top priority factors. They are:

- Ethnic, Racial and Intergroup Relations
- Education/ Literacy
- Nutrition Promoting Environment
- Community-Based Organizations

5) Assessing Community Effectiveness Scores

Participants used the THRIVE tool to rate how well developed each of the cluster areas and factors are in the community. The below key represents the system developed for rating the clusters areas and factors.

Key:
1 = Elements not in place; harmful to health or inappropriate for needs of community. There is either nothing in place that fosters health or what is in place is detrimental to the health of members of the community. **2** = At most a few elements are in place, and they need improvement regarding quality, access, availability, and/or cultural and developmental appropriateness. There is inadequate development or quality of the factor to promote positive health outcomes. **3** = Some elements are in place and well developed. These elements are culturally appropriate and meet the range of developmental needs. Factor meets some needs of the community. **4** = Many elements are in place, but there is some room for improvement related to putting more elements in place and/or improving quality, access, availability, and/or cultural and developmental appropriateness. Factor is on the way to fully meeting the needs of the community. **5** = Many elements are in place and are high-quality, accessible, available, and culturally and developmentally appropriate for the range of needs in the community. Factor fully meets the needs of the community.

Note: *The pink stars indicate the number of people who marked each score*

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1 — 2 — 3 — 4 — 5

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***34.* Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*

1 — 2 — 3 — 4 — 5

Not at all developed ★★ ★ ★★★★ Moderately effective Fully effective & developed

***35.* Housing:** *Availability of safe, affordable housing in the community*

1 — 2 — 3 — 4 — 5

Not at all developed ★ ★★★★ Moderately effective ★★ Fully effective & developed

36. Transportation: *Availability of safe and affordable methods for moving people around*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★ Moderately effective ★★ ★★ Fully effective & developed

37. Environmental Quality: *Safe water, soil, air, and building materials*

1 — 2 — 3 — 4 — 5

Not at all developed ★ ★★★★★ Moderately effective Fully effective & developed ★

38. Product availability: *Beneficial products; limited availability of harmful products*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★ ★★★ Moderately effective Fully effective & developed

39. Aesthetic/Ambiance: *Appealing, clean, and culturally relevant visual environment*

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B. SOCIAL CAPITAL: *Social networks and norms of reciprocity and trustworthiness*

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***42.* Civic Engagement/Participation:** *Involvement in organizations and political process*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★★ Moderately effective ★ Fully effective & developed

★ ★★

***43.* Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ ★★ Moderately effective ★★★ Fully effective & developed

***44.* Positive Gender Norms:** *Gender-specific, socioculturally determined standards*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★★ Moderately effective Fully effective & developed

★ ★ ★★

C. SERVICES AND INSTITUTIONS: *Quality, culturally competent services & business*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ Moderately effective ★ Fully effective & developed

45. **Public Health, Health, & Human Services:** *Available, accessible, high quality services*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ ★ ★ ★ ★ Moderately effective ★ Fully effective & developed

46. **Public Safety:** *Law enforcement and fire protection that trust of the community*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ ★ ★ ★ Moderately effective ★ ★ Fully effective & developed

47. **Education and Literacy:** *Education and literacy services across the life span*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ ★ ★ ★ Moderately effective ★ ★ Fully effective & developed

48. **Community-Based Organizations:** *Effective non-profit efforts*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ Moderately effective ★ ★ ★ ★ Fully effective & developed

17. Cultural/Artistic Opportunities: *Abundant opportunities for artistic expression*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ ★ ★ ★ ★ Moderately effective ★ Fully effective & developed

D. MACRO FACTORS: *Structural factors that can be influenced by community attention*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★★ Moderately effective Fully effective & developed

★

24. Economic Capital: *Local ownership of assets or access to investment opportunities*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★★★★★ Moderately effective Fully effective & developed

★

25. Media/Marketing: *Presence of responsible marketing and media*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ ★ Moderately effective Fully effective & developed

★ ★★★

26. Ethnic, Racial, and Intergroup Relations: *Positive relations between different groups*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed Moderately effective ★ Fully effective & developed

★ ★ ★★ ★

6) Evaluating the Pilot Event

To get an immediate impression of the day, participants were asked for three words to describe the day before completing a detailed evaluation. The results of each follow:

Words to describe the day:

- Great, insightful, different way to look at the community
- Great, different ways to look @ community
- Eye-opener, we need to take action and get somewhere with it
- Surprising, not what I expected
- Received information to help community and youth commission
- Eye opener
- "Surprised people outside community care to make Del Paso Heights better."
- *Makes me want to look forward to the future*

Pilot Evaluation Results

To help strengthen presentation materials, the THRIVE tool and the facilitated process, participants were asked to complete the below evaluation form. Participants were asked to circle the number that most closely represents their response to the question and add any additional information in the space provided.

Sample Rating Chart:

1	2	3	4	5	0
Not at all		Neutral		Very much so	Don't know

1a. Were your expectations for the day met?

AVERAGE RATING: 3.7

1b. What were your expectations of today's session?

- Didn't know what was supposed to happen
- I really didn't have any expectations, but I was happy with the outcome
- Didn't have any expectations
- Just to sit down and give you all information about the community. But I received information on how to look at the community.
- I really didn't know what to expect but I am really glad for what I received from the training.
- Well, it was surprising and stunning.

2a. Overall, how valuable was the presentation, tool, and discussions for you?

AVERAGE RATING: 4.4

2b. What was the most valuable aspect of the presentation, tool, and discussions?

- Discovering the major issues of our community
- Slide show
- The junk food and how it plays a key factor in our area
- Makes me believe I can make a difference in my community
- The description of the Built Environment

- Different aspects/perceptions of how nutrition and other ways to stay healthy affects life in general. Health is very important!
- The most was when we talked about how many people died of fries and dietary things

2c. What was the least valuable aspect of the presentation, tool, and discussions?
- All of it was important and valuable
- Really not anything. It was really good and I understood about 85% of it.

3a. Was the presentation about the relationship between community resilience and health valuable?

AVERAGE RATING: 4.2

3b. What kind of additional information would add value?
- A clearer picture of what our community is so we can compare and contrast
- I'm not sure because I'm not aware of what's available

4. How clear is the relationship between the 4 clusters and each of its corresponding factors?

AVERAGE RATING: 3.1

5a. Did the presentation provide the conceptual information you needed to complete the tool and participate in the subsequent discussions?

AVERAGE RATING: 3.9

5b. What kinds of materials and information would best prepare future participants to use the tool effectively?
- Actual studies done on DPH. Money for programs
- More information on it before coming
- I'm not sure what previous programs you've held, but I would like to know of them and also your expectations
- This info and different varieties of this stuff

6a. How useful did you find the tool?

AVERAGE RATING: 4.4

6b. What did you find most useful?
- The facts
- Slides
- Product availability
- The information on fast food
- Built Environment
- All of it
- How many people died of things, just watch what I do

6c. What did you find least useful?
- They were all very useful

7a. How appropriate is the language of the tool for your community?
AVERAGE RATING: 3.9

7b. How can the language of the tool be adapted for your community?
- Very well understandably to me
- Use smaller, less technical, basic words
- Don't know
- Put more in simpler terms
- Maybe if it were in simpler terms, used examples from our community. But overall the examples given were very helpful!
- Education and Nutrition

8a. Did the tool include the range of factors that you think are important to promote community resilience and health?
AVERAGE RATING: 4

8b. Are there any other factors that you think are important to include in the tool?
- Not that I can think of

8c. Are there any factors and/or clusters that should be rearranged and/or omitted?
- No, it's fine how it is

9a. Did the day's activities progress in a manner that was logical and easy to understand (i.e. ranking community health issues, and prioritizing the 20 factors, who else needs to be at the table, next steps)?
AVERAGE RATING: 4.1

9b. How could the ordering of the day's activities be improved upon?
- Snacks
- It's fine how it is
- I liked the ordering of it
- It was really good, actually.

10a. Can this tool be used to effectively promote positive health outcomes in communities?
AVERAGE RATING: 3.7

10b. How can this assessment tool be used to promote positive health outcomes in communities?
- It can be talked about but saying is easier than doing
- If the people know about it
- Let the community know about the health problems
- Follow what was written
- I'm not sure but I liked the definitions and explanations used for them. I know that there is a way.
- Follow guides and instructors

10c. How do you think this tool could be used to assist communities, local government and/or service providers in their work?

- It can be a backbone or more of a guideline
- By using it. People need to know about it.
- They should use things that work.

11a. Can this tool be used to create a paradigm shift in how communities address health issues?AVERAGE RATING: 2.6

11b. How can the tool be used to create a paradigm shift in how communities address health issues?

- By showing them areas that need improvement
- Don't know
- First I think we should make them aware then go on from there.

12. Was today a motivational experience for you?
AVERAGE RATING: 4.7

13. What resources do you need in order to feel that you can use the tool independently and with confidence?

- Statistics and time, adult intervention
- Money, media
- By knowing more information
- Better understanding
- More meetings (planning) and workshops definitely
- Well, just follow instructions and do my best

14a. Do you anticipate challenges in incorporating a resilience approach to community health?
AVERAGE RATING: 3.6

14b. What do you anticipate will be the major challenges in incorporating a resilience approach to community health?

- Acceptance and action
- Participation and dedication from the community
- Money, resources
- Resistance from community and support from community

14c. What additional assistance would be most helpful in overcoming these obstacles?

- I'm not sure yet
- Don't know
- A place to use our resources and funding for our ideas
- More community involvement
- People with experience and connections

15 What impact do you anticipate that a community resilience approach will have on your community and/or your organization?

- It will make people look at Del Paso Heights in a more positive manner
- A positive one. The community needs some positive insight
- I would like to have a grocery store and gym
- A pretty big one if they use it
- Good, positive one
- Well, just to make it look good.

16. Describe an action that you will take as a result of the information you heard about and discussed related to THRIVE?

- Inform others of what I learned and hopefully they will take it into consideration
- Protest the school's lunch policy
- Spread the word
- Tell other people about it

17. Other comments:

- The presentation was helpful, educational, and an eye opener. The presenters were clear and thorough.
- Great presentation
- Nice presentation
- Thanks for THRIVE

<u>Day 2</u>

1) Findings from the THRIVE Tool and Community Photos and Prioritization of Community Factors for Del Paso Heights

Participants were asked to share their photos and any thoughts or conclusions they had about the resilience factors in their community. The group confirmed or modified the findings from the tool. During this session, participants were asked to come to consensus about the top 6 factors for action in their community.

What is was like taking the photos:

- Was not easy because you had to think of a lot of things
- Wanted to take pictures all over
- Planned out picture, but regretted taking stuff that is not as important
- Not having camera to capture a motor-vehicle crash
- Overall priority ratings were true
- Though that nutrition/housing would be a higher priority

Environmental Quality:

- Dumping
- Community safety-as it relates to violence/substance abuse.
- Rating community
- Media/marketing
- Economic capital-in relation to new development.
- Argues with results/ next generation's responsibility to get results.

Observations of the photos or the process:

- Housing/streets w/ out sidewalks.
- Older looking housing.
- Overall appearance
- Empty fields could be used for activities
- Certain neighborhoods look the same because people think this is the way it is supposed to be.
- Hopelessness/complacency/passivity acceptance
- Own house/another house
- Starts at home, when kids growing up have a lack of respect for themselves
- Respect
- No place to be engaged
- Art
- People see community as having lack of diversity, which is not true

Ideas about community change:

- Ideas became more developed
- Makes me think why things are so important.
- Reinforced what is important.
- Thinking about all the fast foods, but there is no place to get ---

Surprises:

-Services/Inst. ----- more important.

-Thought there would be a lot more built environment pictures.

2) Customizing the Process: Renaming the Factors and Developing Community-Specific Indicators

While generally speaking the factors and the cluster names reflect the research, it is clear that communities may have words to describe a particular cluster of factor that is more reflective of local culture and language or in closer alignment with existing efforts and priorities. In recognition of this, participants were given the opportunity to rename their priority factors based on how their community would define and describe these factors. In addition, they developed local indicators for each priority factor. The indicators reflect the community's description of what the factor might look like if it were fully developed and promoting health and/or safety outcomes. The selected names and indicators are summarized in the following table.

Priority Factors	Community Names	Indicators
Ethnic, Racial and Intergroup relations	Strong, diverse relationships	* Social cohesion, diversity * Unity * Family understanding * Growing * Strong communication * Positive activates * People participation in community events

Education and Literacy	N/a	* Beautiful facilities * Current technology * More awareness about community * Job-readiness * Reduced truancy * Increase of graduation rates
Nutrition Promoting Environment	Markets	* Variety of culturally diverse foods * Clean *Affordable prices * Convenient * Quality/fresh products * Nutritious * Hires locally
Community-Based Organizations	N/a	* Community awareness * Community focused * Job opportunities * Stable funding * Recreational opportunities for different ages * Activities, activities, activities! * Promote educational outcomes

3) Assessing What's Working and What Needs Improvement

Considering the indicators, participants assessed what's working and what needs improvement for each of the 5 priority factors. This activity helped participants identify strengths that can be built upon and gaps that need to be addressed as efforts move forward.

Priority Factor	What's working	What needs improvement
Strong, diverse relationships	* Come together through events * Marketing of events * Services provided * People that care participate * Diversity Week at schools and other common interest programs	* Limited participation by some parts of the community * People scared to participate * People who do not care do not participate
Education and Literacy	* Technology * Tutoring Programs * Academic programs * Emphasis on reading * Facilities (i.e. cafeteria)	* Funding problems * EOP was discontinued * More support programs for children youth needed * Low graduation rates * Heating and cooling in the buildings * Bathroom problems
Markets	* All in the community * Convenient for small purposes * Carry food	* Not clean * Expensive * Bad quality * Not enough demand to keep prices low * Unsafe/gangs * Outside appearance is dirty
Community Based Organizations	* Provide jobs * Provide places to go * Venues to come together * Provide services * A few activities * Provide training	* Not enough activities * Lack of funding * Community not informed of CBO's * Lack of participation

4) Identifying Next Steps and Partners

Taking into account the priority health issues, priority factors, developed indicators, what's working and what needs improvement, participants brainstormed other stakeholders that should be brought to the table and appropriate next steps to build on the work of the day. Below is a list of what participants came up with.

Next Steps

- District Council Members
- School board
- People with money
- Chris Webber
- Parents
- Business owners
- People in the community
- Preachers
- James Shelby
- Models, people who run them, youth, youth groups
- All of us
- CBO's
    - Obtain funding
    - Draw a plan or outline for at least one year
    - Have a meeting w/ MAN heads
    - Establish committees for outreach, public relations etc.

5) Evaluating the Pilot Event

To get an immediate impression of the day, participants were asked for three words to describe the day before completing a detailed evaluation. The results of each follow:

Words to describe the day:

- Learning experience
- A lot to do in community
- Time to get to work
- Sparked me to want to volunteer again
- Wonderful
- Great experience
- Fun
- Learned more about what we can improve on in the community
- Eye opener
- Learning experience
- We have a lot of markets
- Youth/adults have a lot in common-we have a vision and are ready.

Pilot Evaluation Results

To help strengthen presentation materials, the THRIVE tool and the facilitated process, participants were asked to complete the below evaluation form. Participants were asked to circle the number that most closely represents their response to the question and add any additional information in the space provided

Sample Rating:

1	2	3	4	5	0
Not at all		Neutral		Very much so	Don't know

1a. Were your expectations for the day met?
AVERAGE RATING: 4.6

1b. What were your expectations of today's session?
- I would let out my opinions and let them be heard.
- Show off our pictures.
- To learn more about the community and its events and to raise awareness.
- Not very sure, but that we were going to go over the pictures.

2a. Overall, how valuable was the discussions for you?
AVERAGE RATING: 4.6

2b. What was the most valuable aspect of the discussions?
- Determining what was important to me.
- That the adults and youth have almost the same vision.
- We have a vision and we need some money. We can achieve our goals if we set our minds to it.
- On the supermarkets, where we talked about how dirty they are and how we can change it.
- The different changes needed in the community aren't just my concerns but of my peers and even adults.

2c. What was the least valuable aspect of the presentation, tool, and discussions?
- Writing

3a. Did the photos you took highlight any additional factors that you think are important to promote community resilience and health?
- No
- Yes
- Yes, some of the pictures did. We had to explain what we did which made a lot of sense.
- Not really

3b. If so, what?
- I think the photos I took are self-explanatory.

4a. Did the day's activities progress in a manner that was logical and easy to understand (i.e. prioritizing the 20 factors, developing indicators, who else needs to be at the table, next steps)?
AVERAGE RATING: 4.4

4b. How could the ordering of the day's activities be improved upon?
- I liked the way the day's activities were organized.
- It was cool.
- It was too time consuming.
- Not so long.

5. Was today a motivational experience for you?
AVERAGE RATING: 4.4

6. What impact do you anticipate that a community resilience approach will have on your community and/or your organization?
- Lack of participation.
- I feel like we can improve our community if we set goals.
- It will help us to improve the rate of our community growth.
- It will be very challenging at first, but with all the valuable things, I believe it will get easier.
- Make the community better in looks as well as education.

7a. Taking photos helped me understand how the factors play out in the community?
AVERAGE RATING: 4.4

7b. If so, how?
- How important looks are and that the conveniences of everyday needs are essential in a community.
- The pictures drew a picture for us. It helped me really see what we need.
- The visual helped to make a plan for the future.

8. Other comments:
- You both did very well.
- Thanks. You guys did a great job.
- Thanks. Nice experience.

Pilot Site Report
Del Paso Heights (Sacramento), California
October 25 and December 6, 2003
ADULT REPORT

DAY 1

1) What is a Healthy Community?

The event began with a question designed to stimulate thinking, "What would a health -- or health-promoting -- community look like?" The question was designed to gauge participant thinking on the topic, setting a baseline, and/or to outline a vision for a healthy community. The remainder of the day's activities would then question, reinforce, and/or refine this initial brainstorming. Below is the list participants came up with.

Elements of a healthy community as brainstormed by participants:

- Diverse communities
- Mental/physical health
- Close and convenient facilities for all communities and services
- Transportation to access services
- One-stop medical center
- Infrastructure kept clear

2) Identifying Key Health Issues

In order to ensure that the day's findings addressed major health concerns, participants were asked to prioritize the major 3-5 health concerns for the community. Participants first individually completed the chart below (composite responses are provided) and then shared their priorities with the group. As a group, they selected the priority issues that would be the focus of the remainder of the day.

The following table represents the composite of individual responses on the worksheet:

	Not a concern	Slight concern	Moderate concern	Major concern	Don't know
Cardiovascular disease *		1		1	
Diabetes *			1	2	
Asthma			2	2	
HIV/AIDS		1		3	

Cancer				3	
Violence *				4	
Traffic crashes and injury			1	2	
Infant mortality				2	1
Substance abuse *			1	3	
Mental illness			2	2	
Overweight/obesity			1	2	
Other: traffic crashes				3	
Other: anger confidence					

* = Represents the top health concerns chosen

Participants agreed on the following priority health concerns:

6. Cardiovascular disease
7. Diabetes
3. Violence
4. Substance abuse

3) Training on a Community Resilience Approach

Prevention Institute provided a training on advancing a community resilience approach to closing the health gap. In particular, the training included a background on the efficacy of prevention, a framework for focusing on behavioral and environmental factors, and a delineation of the four clusters and twenty factors, linking each of them to the Healthy People 2010 Leading Health Indicators and *major health concerns.*

4) Rating the Priority of Factors

Participants used the THRIVE tool to rate the priority level of each factor. In particular, they were asked to think about how important it would be to focus on a particular factor given their priority health concerns. The average of their priority ratings are summarized in the following chart.*

* In order to average the ratings, we assigned numerical ratings for calculation. They were then converted back into letters, with the addition of minuses and pluses when necessary.

Priority ratings: H = High Priority M = Medium Priority L = Low Priority

	CLUSTERS AND FACTORS
M +	**A. BUILT ENVIRONMENT:** *Man-made physical components*
M +	**1. Activity Promoting Environment:** *Places to participate in incidental/recreational activity*
H -	**2. Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*
H	**3. Housing:** *Availability of safe, affordable housing in the community*

H -	**4. Transportation:** *Availability of safe and affordable methods for moving people around*
M +	**5. Environmental Quality:** *Safe water, soil, air, and building materials*
M	**6. Product availability:** *Beneficial products; limited availability of harmful products*
M +	**7. Aesthetic/Ambiance:** *Appealing, clean, and culturally relevant visual environment*
M	**B. SOCIAL CAPITAL:** *Social networks and norms of reciprocity and trustworthiness*
M+	**8. Social Cohesion and Trust:** *Strong social ties among persons and positions*
M	**9. Collective Efficacy:** *A willingness to intervene on behalf of the common good*
M	**10. Civic Engagement/Participation:** *Involvement in organizations and political process*
M +	**11. Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*
M +	**12. Positive Gender Norms:** *Gender-specific, socioculturally determined standards*
M	**C. SERVICES AND INSTITUTIONS:** *Quality, culturally competent services & business*
H -	**13. Public Health, Health, & Human Services:** *Available, accessible, high quality services*
M +	**14. Public Safety:** *Law enforcement and fire protection that trust of the community*
M	**15. Education and Literacy:** *Education and literacy services across the life span*
M	**16. Community-Based Organizations:** *Effective non-profit efforts*
M	**17. Cultural/Artistic Opportunities:** *Abundant opportunities for artistic expression*
M +	**D. MACRO FACTORS:** *Structural factors that can be influenced by community attention*
M	**18. Economic Capital:** *Local ownership of assets or access to investment opportunities*
L +	**19. Media/Marketing:** *Presence of responsible marketing and media*
M	**20. Ethnic, Racial, and Intergroup Relations:** *Positive relations between different groups*

Based on individuals completing the tool, the following emerged as highest priority:

Built Environment
Nutrition-Promoting Environment
Housing
Transportation

Services and Institutions
Public Health/Health/Human Services

As a group, participants prioritized their top priority factors. They are:

- Housing
- Education/ Literacy
- Nutrition Promoting Environment

5) Assessing Community Effectiveness Scores

Participants used the THRIVE tool to rate how well developed each of the cluster areas and factors are in the community. The below key represents the system developed for rating the clusters areas and factors.

Key:
1 = Elements not in place; harmful to health or inappropriate for needs of community. There is either nothing in place that fosters health or what is in place is detrimental to the health of members of the community. **2 =** At most a few elements are in place, and they need improvement regarding quality, access, availability, and/or cultural and developmental appropriateness. There is inadequate development or quality of the factor to promote positive health outcomes. **3 =** Some elements are in place and well developed. These elements are culturally appropriate and meet the range of developmental needs. Factor meets some needs of the community. **4 =** Many elements are in place, but there is some room for improvement related to putting more elements in place and/or improving quality, access, availability, and/or cultural and developmental appropriateness. Factor is on the way to fully meeting the needs of the community. **5 =** Many elements are in place and are high-quality, accessible, available, and culturally and developmentally appropriate for the range of needs in the community. Factor fully meets the needs of the community.

Note: *The pink stars indicate the number of people who marked each score*

D. BUILT ENVIRONMENT: *Man-made physical components*

1 — 2 — 3 — 4 — 5

Not at all developed ★ Moderately effective ★ Fully effective & developed

49. Activity Promoting Environment: *Places to participate in incidental/recreational activity*

1 — 2 — 3 — 4 — 5

Not at all developed ★★ ★ Moderately effective ★ ★ Fully effective & developed

***50.* Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*

1 — 2 — 3 — 4 — 5

Not at all developed ★ ★★ Moderately effective ★ Fully effective & developed ★

***51.* Housing:** *Availability of safe, affordable housing in the community*

1 — 2 — 3 — 4 — 5

Not at all developed ★ ★ Moderately effective ★ Fully effective & developed

52. Transportation: *Availability of safe and affordable methods for moving people around*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★★ Moderately effective ★ Fully effective & developed

53. Environmental Quality: *Safe water, soil, air, and building materials*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★ Moderately effective ★ ★ Fully effective & developed

54. Product availability: *Beneficial products; limited availability of harmful products*

1 — 2 — 3 — 4 — 5

Not at all developed ★ ★★ Moderately effective ★ ★ Fully effective & developed

55. Aesthetic/Ambiance: *Appealing, clean, and culturally relevant visual environment*

1 — 2 — 3 — 4 — 5

Not at all developed ★ ★★★ Moderately effective ★ Fully effective & developed

B. SOCIAL CAPITAL: *Social networks and norms of reciprocity and trustworthiness*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ Moderately effective ★ ★ Fully effective & developed

56. Social Cohesion and Trust: *Strong social ties among persons and positions*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★★★ Moderately effective ★ Fully effective & developed

***57.* Collective Efficacy:** *A willingness to intervene on behalf of the common good*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ Moderately effective ★ Fully effective & developed ★

***58.* Civic Engagement/Participation:** *Involvement in organizations and political process*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ Moderately effective Fully effective & developed ★ ★ ★

***59.* Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ ★ Moderately effective ★ ★ Fully effective & developed

***60.* Positive Gender Norms:** *Gender-specific, socioculturally determined standards*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ ★ ★ Moderately effective Fully effective & developed ★

C. SERVICES AND INSTITUTIONS: *Quality, culturally competent services & business*

1 — 2 — 3 — 4 — 5

Not at all developed ★ Moderately effective ★ Fully effective & developed

★

61. **Public Health, Health, & Human Services:** *Available, accessible, high quality services*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★ Moderately effective Fully effective & developed

★ ★

62. **Public Safety:** *Law enforcement and fire protection that trust of the community*

1 — 2 — 3 — 4 — 5

Not at all developed ★ Moderately effective Fully effective & developed

★★ ★ ★

63. **Education and Literacy*:*** *Education and literacy services across the life span*

1 — 2 — 3 — 4 — 5

Not at all developed ★ Moderately effective Fully effective & developed

★★ ★ ★

64. **Community-Based Organizations:** *Effective non-profit efforts*

1 — 2 — 3 — 4 — 5

Not at all developed ★ Moderately effective ★ Fully effective & developed

★ ★★

17. Cultural/Artistic Opportunities: *Abundant opportunities for artistic expression*

1 — 2 — 3 — 4 — 5

Not at all developed ★ Moderately effective ★ Fully effective & developed

★ ★ ★

D. MACRO FACTORS: *Structural factors that can be influenced by community attention*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed ★ Moderately effective ★★ Fully effective & developed

27. Economic Capital: *Local ownership of assets or access to investment opportunities*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed ★★★ ★ Moderately effective ★ Fully effective & developed

28. Media/Marketing: *Presence of responsible marketing and media*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed ★★★ ★ Moderately effective Fully effective & developed ★

29. Ethnic, Racial, and Intergroup Relations: *Positive relations between different groups*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed ★★★ Moderately effective ★ Fully effective & developed

6) Evaluating the Pilot Event

To get an immediate impression of the day, participants were asked for three words to describe the day before completing a detailed evaluation. The results of each follow:

Words to describe the day:

- Right in tune to what we're doing as a community.
- Wants to make community self-sufficient.
- Very, very pleased. Learn of things we need to include in program.
- Impressed me.
- Do something to better neighborhood/community.
- Take back our neighborhoods.
- *Learned a lot and care.*

Pilot Evaluation Results

To help strengthen presentation materials, the THRIVE tool and the facilitated process, participants were asked to complete the below evaluation form. Participants were asked to circle the number that most closely represents their response to the question and add any additional information in the space provided.

Sample Rating Chart:

1 ——— 2 ——— 3 ——— 4 ——— 5 0

Not at all Neutral Very much so Don't know

1a. Were your expectations for the day met?
AVERAGE RATING: 5

1b. What were your expectations of today's session?
- How this program could improve this community
- Community awareness
- Get idea how we better our community
- To learn of the project
- I didn't really have any expectations. I was just excited and enthused that we were going to talk about our neighborhood.

2a. Overall, how valuable was the presentation, tool, and discussions for you?
AVERAGE RATING: 5

2b. What was the most valuable aspect of the presentation, tool, and discussions?
- The screen showing the different areas of community
- The presentation as a whole
- The presentation how we can help
- Different subject
- I think as a whole the whole aspect of what we learned and explored today was very helpful.

2c. What was the least valuable aspect of the presentation, tool, and discussions?
- All information was pertinent
- I didn't find anything that was not valuable today.

3a. Was the presentation about the relationship between community resilience and health valuable?
AVERAGE RATING: 3.8

3b. What kind of additional information would add value?
- A longer session
- At this time the presentation was most effective
- I think just about everything was covered

4. How clear is the relationship between the 4 clusters and each of its corresponding factors?
AVERAGE RATING: 4

5a. Did the presentation provide the conceptual information you needed to complete the tool and participate in the subsequent discussions?
AVERAGE RATING: 4.6

5b. What kinds of materials and information would best prepare future participants to use the tool effectively?
- As the pilot continue materials and information will be enhanced as more input is gathered
- Pictures talking out ideas

- Verbal information
- I think that the materials and information that I received today would also help future participants.

6a. How useful did you find the tool?
AVERAGE RATING: 5

6b. What did you find most useful?
- The knowledge already known by the organization
- How to be in
- Everything (2 responses)

6c. What did you find least useful?
- Nothing

7a. How appropriate is the language of the tool for your community?
AVERAGE RATING: 3.5

7b. How can the language of the tool be adapted for your community?
- Easily
- Better teaching
- I don't know

8a. Did the tool include the range of factors that you think are important to promote community resilience and health?
AVERAGE RATING: 5

8b. Are there any other factors that you think are important to include in the tool?
- Church to be involved
- Not at this time
- I'm sure there are, but I can't think right now.

8c. Are there any factors and/or clusters that should be rearranged and/or omitted?
- None

9a. Did the day's activities progress in a manner that was logical and easy to understand (i.e. ranking community health issues, and prioritizing the 20 factors, who else needs to be at the table, next steps)?
AVERAGE RATING: 4.8

9b. How could the ordering of the day's activities be improved upon?
- Again, at this stage of the pilot, no improvement is necessary
- Be prepared

10a. Can this tool be used to effectively promote positive health outcomes in communities?
AVERAGE RATING: 4.75

10b. How can this assessment tool be used to promote positive health outcomes in communities?

- Make it available to the total community
- Through education
- Let people know about health
- If people know what is going on in their neighborhood, than we can all work together.

10c. How do you think this tool could be used to assist communities, local government and/or service providers in their work?

- Getting the information to the appropriate agencies
- Don't know

11a. Can this tool be used to create a paradigm shift in how communities address health issues?AVERAGE RATING: 4.25

11b. How can the tool be used to create a paradigm shift in how communities address health issues?

- Again by putting the information out in the communities
- Don't know

12. Was today a motivational experience for you?

AVERAGE RATING: 4.75

13. What resources do you need in order to feel that you can use the tool independently and with confidence?

- At this time the tools given are sufficient
- Don't know

14a. Do you anticipate challenges in incorporating a resilience approach to community health?

AVERAGE RATING: 3.75

14b. What do you anticipate will be the major challenges in incorporating a resilience approach to community health?

- Trust
- The living condition

14c. What additional assistance would be most helpful in overcoming these obstacles?

- Helping schools and churches to be informed
- The community trusting the organization and their motives for sharing the information
- All the area get involved

15 What impact do you anticipate that a community resilience approach will have on your community and/or your organization?

- Will cause the committee share and encourage others to get involved

- A positive one
- To see things changing in the area
- I hope that it has a great impact on my community

16. Describe an action that you will take as a result of the information you heard about and discussed related to THRIVE?

- To be a spokesperson for THRIVE and what they stand for
- I will be more observant about what is going on in my community.

17. Other comments:

- Seeing that improvement is being made in Del Paso Height
- Thank you for your concern

DAY 2

1) Findings from the THRIVE Tool and Community Photos and Prioritization of Community Factors for Del Paso Heights

Participants were asked to share their photos and any thoughts or conclusions they had about the resilience factors in their community. The group confirmed or modified the findings from the tool. During this session, participants were asked to come to consensus about the top 6 factors for action in their community.

Process of taking photos:

- Took positives then negatives
- A lot of construction and building occurring.
- Hope in needed things for all ages.
- Youth excited about adults taking pictures.
- Youth aware of changes occurring.
- Pictures of structures, boarded up housing
- Del Paso Heights is on its way up with enthusiasm in community.
- People from other neighborhoods are dumping in Del Paso Heights.
- Pictures of older housing that are deteriorating.
- Newer housing.
- Senior cleaners organization-distribute food for disadvantaged people.

Which photos stood out for you?

- Building and development in those things are improving.
- Growth.
- Filling vacant lots.
- Boarded up houses rented to low-income families.

Are these factors that stood above others?

- Services such as the supermarket have to be present for people to want to access housing or move in to the community.
- Need transportation to get to further services.
- Address aging population to address developmental needs.

Did your ideas about what was important change as you were taking photos or did you have the chance to think more since our first meeting?

-A lot of new homes have for rent signs, which means people in the community do not own homes.

-Increasing local ownership.

1) Gentrification-address guidelines in housing factor of built environment.
2) Avoid unattended consequences by thoroughly thinking through the implications of an action.

Why did you pick these photos?

- Improving educational facilities.
- Adult entertainment. Store-product availability.
- Engage community input, part & by in throughout the process. Consider in a developmental context.
- Hope/things improving/growth.
- Accessibility.
- Gentrification/ up local ownership
- Housing-blight/dump issue
- Supermarket (local business)
- Education/literacy (boys + girls club)
- Across the lifespan

2) Customizing the Process: Renaming the Factors and Developing Community-Specific Indicators

While generally speaking the factors and the cluster names reflect the research, it is clear that communities may have words to describe a particular cluster of factor that is more reflective of local culture and language or in closer alignment with existing efforts and priorities. In recognition of this, participants were given the opportunity to rename their priority factors based on how their community would define and describe these factors. In addition, they developed local indicators for each priority factor. The indicators reflect the community's description of what the factor might look like if it were fully developed and promoting health and/or safety outcomes. The selected names and indicators are summarized in the following table.

Priority Factors	Community Names	Indicators
Housing	Affordable, locally owned housing	* Median priced * Current populace are the homeowners * Similarly sized * Owner-occupied * 1st time homebuyers in the neighborhood
Education and Literacy	Education and community awareness	* Well informed neighborhood * Improve GPA * Civic participation * Emerging indigenous leadership to take the baton * Facilities support learning environment

		* Safe schools
Nutrition Promoting Environment	Supermarket	* Member of local business association * Healthily, affordable food * Hired locally * Clean * Other services * Steward of the community * Meets needs of low income community *Accessible

3) Assessing What's Working and What Needs Improvement

Considering the indicators, participants assessed what's working and what needs improvement for each of the 5 priority factors. This activity helped participants identify strengths that can be built upon and gaps that need to be addressed as efforts move forward.

Priority Factor	What's working	What needs improvement
Affordable, locally owned housing	* Zoning laws in place * Housing being built * Community members on RAC	* Compliance with zoning laws * Renting of housing vs. ownership * Boarded up homes * Dumping * No sidewalks * Lack of affordability * Not enough community engagement
Education and community awareness	* School facilities improving * GPA's improving * Youth involvement in school/ local government * Youth not burned out/ cynical	* Civic engagement * Not enough local in-put around schools * Lack of awareness/understanding * People are not voting
Supermarket	* Farmer's market	* Does not have a supermarket * Lose of Save Max/food locker * Ma and Pop stores are no expensive * No refrigeration

4) Identifying Next Steps and Partners

Taking into account the priority health issues, priority factors, developed indicators, what's working and what needs improvement, participants brainstormed other stakeholders that should be brought to the table and appropriate next steps to build on the work of the day. Below is a list of what participants came up with.

Next Steps

- Sit on commissions/decisions-making bodies
- Code enforcement officials
- Area manager/city council members and local supervisor at table

- City manager?
- Local police, health professionals
- Need a full R.A.C.
- Need business owners
- Increase awareness in community
- Get more people from community involved
- Get back to participants
- Get media involved
- Continue discussions

5) Evaluating the Pilot Event

To get an immediate impression of the day, participants were asked for three words to describe the day before completing a detailed evaluation. The results of each follow:

Words to describe the day:

- Quite informative
- Unilateral
- Able to voice opinion
- Hope
- Express feelings and those feelings were heard.
- Same wavelength
- Feels like an advocate for the community.
- Good baseline

Pilot Evaluation Results

To help strengthen presentation materials, the THRIVE tool and the facilitated process, participants were asked to complete the below evaluation form. Participants were asked to circle the number that most closely represents their response to the question and add any additional information in the space provided.

Sample Rating Chart:

1	2	3	4	5	0
Not at all		Neutral		Very much so	Don't know

1a. Were your expectations for the day met?
AVERAGE RATING: 5

1b. What were your expectations of today's session?
How our suggestions would be used

2a. Overall, how valuable was the discussions for you?
AVERAGE RATING: 5

2b. What was the most valuable aspect of the discussions?

- Community involvement.

- Everything we discussed was of great importance.

2c. What was the least valuable aspect of the presentation, tool, and discussions?
I didn't find anything not valuable.

3a. Did the photos you took highlight any additional factors that you think are important to promote community resilience and health?
- No
- Yes

3b. If so, what?
- I think the photos I took are self-explanatory.

4a. Did the day's activities progress in a manner that was logical and easy to understand (i.e. prioritizing the 20 factors, developing indicators, who else needs to be at the table, next steps)?
AVERAGE RATING: 5

4b. How could the ordering of the day's activities be improved upon?
- The day's activities were very good.
- I think that the activities cannot be improved upon.

5. Was today a motivational experience for you?
AVERAGE RATING: 5

6. What impact do you anticipate that a community resilience approach will have on your community and/or your organization?
- More community awareness.
- I hope that it has a great impact.

7a. Taking photos helped me understand how the factors play out in the community?
AVERAGE RATING: 5

7b. If so, how?
- Taking photos showed me what is needed to provide a healthy, safe, and important community.
- It opened my eyes to a lot of things that were going on in my neighborhood. Both positive and negative.

8. Other comments:
THRIVE is a very good needed entity and I wish them the much success.

Pilot Site Report
District Public Health Office, New York City
December 11, 2003
CENTRAL BROOKLYN

1) What is a Healthy Community?
The event began with a question designed to stimulate thinking, "What would a health -- or health-promoting -- community look like?" The question was designed to gauge participant thinking on the topic, setting a baseline, and/or to outline a vision for a healthy community. The remainder of the day's activities would then question, reinforce, and/or refine this initial brainstorming. Below is the list participants came up with.

Elements of a healthy community as brainstormed by participants: (Same as the two other burrows)

- Safe Streets
- Decent Housing
- Opportunities for Physical Activity/Nutrition
- Absence of fast food
- Healthier fast foods
- Good air quality & safe H20
- Green Lawns
- Easy Access to healthcare (comprehensive)
- Social supports/cohesion
- Work together
- Education

2) Major Health Concerns
Participants discussed and confirmed participating districts' (South Bronx, Central Brooklyn, and East Harlem) priority health concerns. These priorities served as the basis for advancing a community resilience approach that meets the needs of the represented districts.

Healthy Problems in Central Brooklyn

- Asthma
- Physical Activity/ nutrition
- Housing
- Rats

3) Training on a Community Resilience Approach
Prevention Institute provided a training on advancing a community resilience approach to closing the health gap. In particular, the training included a background on the efficacy of prevention, a framework for focusing on behavioral and environmental factors, and a delineation of the four clusters and twenty factors, linking each of them to the Healthy People 2010 Leading Health Indicators and major health concerns.

4) Rating the Priority of Factors

Participants used the THRIVE tool to rate the priority level of each factor. In particular, they were asked to think about how important it would be to focus on a particular factor given their priority health concerns. The average of their priority ratings are summarized in the following chart.*

** In order to average the ratings, we assigned numerical ratings for calculation. They were then converted back into letters, with the addition of minuses and pluses when necessary.*

Priority ratings: H = High Priority M = Medium Priority L = Low Priority

	A. BUILT ENVIRONMENT: *Man-made physical components*
H	**1. Activity Promoting Environment:** *Places to participate in incidental/recreational activity*
H	**2. Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*
H	**3. Housing:** *Availability of safe, affordable housing in the community*
L	**4. Transportation:** *Availability of safe and affordable methods for moving people around*
L	**5. Environmental Quality:** *Safe water, soil, air, and building materials*
M	**6. Product availability:** *Beneficial products; limited availability of harmful products*
M	**7. Aesthetic/Ambiance:** *Appealing, clean, and culturally relevant visual environment*
M	**B. SOCIAL CAPITAL:** *Social networks and norms of reciprocity and trustworthiness*
L +	
M	**9. Collective Efficacy:** *A willingness to intervene on behalf of the common good*
M -	**10. Civic Engagement/Participation:** *Involvement in organizations and political process*
H -	
M -	**12. Positive Gender Norms:** *Gender-specific, socioculturally determined standards*
H -	**C. SERVICES AND INSTITUTIONS:** *Quality, culturally competent services & business*
H -	**13. Public Health, Health, & Human Services:** *Available, accessible, high quality services*
M -	**14. Public Safety:** *Law enforcement and fire protection that trust of the community*

M -	**15. Education and Literacy***: Education and literacy services across the life span*
H -	**16. Community-Based Organizations:** *Effective non-profit efforts*
M -	**17. Cultural/Artistic Opportunities:** *Abundant opportunities for artistic expression*
M	**D. MACRO FACTORS:** *Structural factors that can be influenced by community attention*
H -	**18. Economic Capital:** *Local ownership of assets or access to investment opportunities*
M	**19. Media/Marketing:** *Presence of responsible marketing and media*
M -	**20. Ethnic, Racial, and Intergroup Relations:** *Positive relations between different groups*

Based on individuals completing the tool, the following emerged as highest priority:

BUILT ENVIRONMENT

Activity Promoting Environment
Nutrition Promoting Environment

Social Capital
Positive Behavioral/Social Norms

SERVICES AND INSTITUTIONS

Public Health, Health and Humans Services
Community Based Organizations

Macro Factors
Economic Capital

As a group, participants prioritized their top priority factors. They are:

- Nutrition-Promoting Environment
- Activity-Promoting Environment
- Public Health, Health and Human Services
- Community Based Organizations
- Housing

5) Assessing Community Effectiveness Scores

Participants used the THRIVE tool to rate how well developed each of the cluster areas and factors are in the community. The below key represents the system developed for rating the clusters areas and factors

Key:
1 = Elements not in place; harmful to health or inappropriate for needs of community. There is either nothing in place that fosters health or what is in place is detrimental to the health of members of the community. **2 =** At most a few elements are in place, and they need improvement regarding quality, access, availability, and/or cultural and developmental appropriateness. There is inadequate development or quality of the factor to promote positive health outcomes. **3 =** Some elements are in place and well developed. These elements are culturally appropriate and meet the range of developmental needs. Factor meets some needs of the community. **4 =** Many elements are in place, but there is some room for improvement related to putting more elements in place and/or improving quality, access, availability, and/or cultural and developmental appropriateness. Factor is on the way to fully meeting the needs of the community. **5 =** Many elements are in place and are high-quality, accessible, available, and culturally and developmentally appropriate for the range of needs in the community. Factor fully meets the needs of the community.

Note: *The pink stars indicate the number of people who marked each score*

E. BUILT ENVIRONMENT: *Man-made physical components*

1 — 2 — 3 — 4 — 5

Not at all developed ★★ Moderately effective ★ Fully effective & developed

65. Activity Promoting Environment: *Places to participate in incidental/recreational activity*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★ Moderately effective Fully effective & developed

***66.* Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*

1 — 2 — 3 — 4 — 5

Not at all developed ★★★ Moderately effective Fully effective & developed

***67.* Housing:** *Availability of safe, affordable housing in the community*

1 — 2 — 3 — 4 — 5

Not at all developed ★ Moderately effective ★ ★ Fully effective & developed

68. Transportation: *Availability of safe and affordable methods for moving people around*

1 — 2 — 3 — 4 — 5

Not at all developed Moderately effective ★★ ★ Fully effective & developed

69. Environmental Quality: *Safe water, soil, air, and building materials*

1 — 2 — 3 — 4 — 5

Not at all developed Moderately effective ★ ★ ★ Fully effective & developed

70. Product availability: *Beneficial products; limited availability of harmful products*

1 — 2 — 3 — 4 — 5

Not at all developed ★ ★ Moderately effective ★ Fully effective & developed

71. Aesthetic/Ambiance: *Appealing, clean, and culturally relevant visual environment*

1 — 2 — 3 — 4 — 5

Not at all developed ★ Moderately effective ★ ★ Fully effective & developed

B. SOCIAL CAPITAL: *Social networks and norms of reciprocity and trustworthiness*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★★★★

72. Social Cohesion and Trust: *Strong social ties among persons and positions*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★★★

***73.* Collective Efficacy:** *A willingness to intervene on behalf of the common good*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★

***74.* Civic Engagement/Participation:** *Involvement in organizations and political process*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★★★

***75.* Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★★★

***76.* Positive Gender Norms:** *Gender-specific, socioculturally determined standards*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★★★

C. SERVICES AND INSTITUTIONS: *Quality, culturally competent services & business*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ Moderately effective ★ ★ Fully effective & developed

77. **Public Health, Health, & Human Services:** *Available, accessible, high quality services*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ ★ Moderately effective ★ Fully effective & developed

78. **Public Safety:** *Law enforcement and fire protection that trust of the community*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ Moderately effective ★ ★ Fully effective & developed

79. **Education and Literacy*:*** *Education and literacy services across the life span*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ Moderately effective ★ ★ Fully effective & developed

80. **Community-Based Organizations:** *Effective non-profit efforts*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed Moderately effective ★ ★ Fully effective & developed

17. Cultural/Artistic Opportunities: *Abundant opportunities for artistic expression*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★★ Moderately effective Fully effective & developed

D. MACRO FACTORS: *Structural factors that can be influenced by community attention*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed ★ Moderately effective ★★ Fully effective & developed

30. Economic Capital: *Local ownership of assets or access to investment opportunities*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed ★★ Moderately effective Fully effective & developed

★

31. Media/Marketing: *Presence of responsible marketing and media*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed Moderately effective ★ ★ ★ Fully effective & developed

32. Ethnic, Racial, and Intergroup Relations: *Positive relations between different groups*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed Moderately effective ★ ★ ★ Fully effective & developed

6) Customizing the Process: Renaming the Factors and Developing Community-Specific Indicators

While generally speaking the factors and the cluster names reflect the research, it is clear that communities may have words to describe a particular cluster of factor that is more reflective of local culture and language or in closer alignment with existing efforts and priorities. In recognition of this, participants were given the opportunity to rename their priority factors based on how their community would define and describe these factors. In addition, they developed local indicators for each priority factor. The indicators reflect the community's description of what the factor might look like if it were fully developed and promoting health and/or safety outcomes. The selected names and indicators are summarized in the following table.

Priority Factors	Community Names	Indicators
Housing	N/a	* Affordable, adequate housing * Mixed income housing * Safe * No peeling paint * Smoke detectors, window guards, good garbage management * Local mechanism for tenants and landlords rights * More resident ownership
Public Health, Heath and Human Services		* Clinical best practices including preventive services * Linkages within the clinical community * Universal healthcare * Coordination and responsive of multiple services
Community Based Organizations		* Robust collaborations * Adequate funding * Central resource for capacity building- funding opportunities * Evidence-based, data driven, and evaluation
Activity-Promoting Environments	Opportunity for Physical fitness	* Adequate number of affordable public and private gyms * Adequate amount of clean and safe parks * Bike laws * Community based physical activity programs * Worksite wellness at all large employers * Sports leagues for girls and boys * Increase physical education in schools * Safe streets * Food co-op
Nutrition Promoting Environments	Opportunity for good nutrition	* Available of high quality fruits and vegetables * Food served at daycares and schools is nutritious *Culturally appropriate food in the schools

7) Assessing What's Working and What Needs Improvement

Considering the indicators, participants assessed what's working and what needs improvement for each of the 5 priority factors. This activity helped participants identify strengths that can be built upon and gaps that need to be addressed as efforts move forward.

Priority Factor	What's working	What needs improvement
Public Health, Health and Human Services	* Lack of coordination among various social services	* Lack of funding opportunities
Community Based Organizations		* Coordination of CBO's and health department
Opportunity for Physical fitness	* High demands for programs	* Not enough physical education in the schools * Safety of parks and places to be active
Opportunity for good nutrition		* Foods in the schools * More green markets
Housing		* Not enough low-income housing

8) Identifying Next Steps and Partners

Taking into account the priority health issues, priority factors, developed indicators, what's working and what needs improvement, participants brainstormed other stakeholders that should be brought to the table and appropriate next steps to build on the work of the day. Below is a list of what participants came up with.

Next Steps:

- Partner with PE teachers
- Get parents involved
- Conduct focus groups
- Contact Parks and Recreation department
- Coordinate better with CBO's

9) Evaluating the Pilot Event

To get an immediate impression of the day, participants were asked for three words to describe the day before completing a detailed evaluation. The results of each follow:

Words to describe the day:

(Same as the other burrows)

- Intense
- Stimulating team discussion
- Getting team together
- Informative
- A lot of information to absorb
- Very interesting
- Just the beginning
- A training experience
- Brainstorming and prioritizing
- Teamwork
- Good opportunity for discussion
- Thought provoking
- Very good session
- Method of re-thinking

Pilot Site Report
District Public Health Office, New York City
December 11, 2003
SOUTH BRONX

1) What is a Healthy Community?
The event began with a question designed to stimulate thinking, "What would a health -- or health-promoting -- community look like?" The question was designed to gauge participant thinking on the topic, setting a baseline, and/or to outline a vision for a healthy community. The remainder of the day's activities would then question, reinforce, and/or refine this initial brainstorming. Below is the list participants came up with.

Elements of a healthy community as brainstormed by participants: (Same as the two other burrows)

- Safe Streets
- Decent Housing
- Opportunities for Physical Activity/Nutrition
- Absence of fast food
- Healthier fast foods
- Good air quality & safe H20
- Green Lawns
- Easy Access to healthcare (comprehensive)
- Social supports/cohesion
- Work together
- Education

2) Major Health Concerns
Participants discussed and confirmed participating districts' (South Bronx, Central Brooklyn, and East Harlem) priority health concerns. These priorities served as the basis for advancing a community resilience approach that meets the needs of the represented districts.

Health Problems in South Bronx

- Teenage Pregnancy
- Rats
- Physical Activity
- Clinical Services

3) Training on a Community Resilience Approach
Prevention Institute provided a training on advancing a community resilience approach to closing the health gap. In particular, the training included a background on the efficacy of prevention, a framework for focusing on behavioral and environmental factors, and a

delineation of the four clusters and twenty factors, linking each of them to the Healthy People 2010 Leading Health Indicators and *major health concerns.*

4) Rating the Priority of Factors

Participants used the THRIVE tool to rate the priority level of each factor. In particular, they were asked to think about how important it would be to focus on a particular factor given their priority health concerns. The average of their priority ratings are summarized in the following chart.*

** In order to average the ratings, we assigned numerical ratings for calculation. They were then converted back into letters, with the addition of minuses and pluses when necessary.*

Priority ratings: H = High Priority M = Medium Priority L = Low Priority

	A. BUILT ENVIRONMENT: *Man-made physical components*
H -	**1. Activity Promoting Environment:** *Places to participate in incidental/recreational activity*
H -	**2. Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*
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L +	**4. Transportation:** *Availability of safe and affordable methods for moving people around*
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M +	**6. Product availability:** *Beneficial products; limited availability of harmful products*
M	**7. Aesthetic/Ambiance:** *Appealing, clean, and culturally relevant visual environment*
M	**B. SOCIAL CAPITAL:** *Social networks and norms of reciprocity and trustworthiness*
M +	
M	**9. Collective Efficacy:** *A willingness to intervene on behalf of the common good*
H -	**10. Civic Engagement/Participation:** *Involvement in organizations and political process*
M +	
M +	**12. Positive Gender Norms:** *Gender-specific, socioculturally determined standards*
H -	**C. SERVICES AND INSTITUTIONS:** *Quality, culturally competent services & business*
H -	**13. Public Health, Health, & Human Services:** *Available, accessible, high quality services*

L +	**14. Public Safety:** *Law enforcement and fire protection that trust of the community*
M	**15. Education and Literacy:** *Education and literacy services across the life span*
H -	**16. Community-Based Organizations:** *Effective non-profit efforts*
M -	**17. Cultural/Artistic Opportunities:** *Abundant opportunities for artistic expression*
H -	**D. MACRO FACTORS:** *Structural factors that can be influenced by community attention*
M +	**18. Economic Capital:** *Local ownership of assets or access to investment opportunities*
M +	**19. Media/Marketing:** *Presence of responsible marketing and media*
M	**20. Ethnic, Racial, and Intergroup Relations:** *Positive relations between different groups*

Based on individuals completing the tool, the following emerged as highest priority:

BUILT ENVIRONMENT

Activity Promoting Environment
Nutrition Promoting Environment

Social Capital
Civic Engagement/Participation

SERVICES AND INSTITUTIONS

Public Health, Health and Humans Services
Community Based Organizations

As a group, participants prioritized their top priority factors. They are:

- Nutrition-Promoting Environment
- Activity-Promoting Environment
- Public Health, Health and Human Services
- Community Based Organizations

5) Assessing Community Effectiveness Scores

Participants used the THRIVE tool to rate how well developed each of the cluster areas and factors are in the community. The below key represents the system developed for rating the clusters areas and factors

Key:
1 = Elements not in place; harmful to health or inappropriate for needs of community. There is either nothing in place that fosters health or what is in place is detrimental to the health of members of the community. **2 =** At most a few elements are in place, and they need improvement regarding quality, access, availability, and/or cultural and developmental appropriateness. There is inadequate development or quality of the factor to promote positive health outcomes. **3 =** Some elements are in place and well developed. These elements are culturally appropriate and meet the range of developmental needs. Factor meets some needs of the community. **4 =** Many elements are in place, but there is some room for improvement related to putting more elements in place and/or improving quality, access, availability, and/or cultural and developmental appropriateness. Factor is on the way to fully meeting the needs of the community. **5 =** Many elements are in place and are high-quality, accessible, available, and culturally and developmentally appropriate for the range of needs in the community. Factor fully meets the needs of the community.

Note: *The pink stars indicate the number of people who marked each score*

F. BUILT ENVIRONMENT: *Man-made physical components*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ Moderately effective ★ Fully effective & developed

81. Activity Promoting Environment: *Places to participate in incidental/recreational activity*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ Moderately effective ★★ Fully effective & developed

***82.* Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ Moderately effective ★ Fully effective & developed

***83.* Housing:** *Availability of safe, affordable housing in the community*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★ Moderately effective ★★ Fully effective & developed

84. Transportation: *Availability of safe and affordable methods for moving people around*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed Moderately effective ★★ Fully effective & developed

★

85. Environmental Quality: *Safe water, soil, air, and building materials*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ Moderately effective ★ Fully effective & developed

86. Product availability: *Beneficial products; limited availability of harmful products*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ Moderately effective ★ Fully effective & developed

87. Aesthetic/Ambiance: *Appealing, clean, and culturally relevant visual environment*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed ★★ Moderately effective ★ Fully effective & developed

B. SOCIAL CAPITAL: *Social networks and norms of reciprocity and trustworthiness*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

88. Social Cohesion and Trust: *Strong social ties among persons and positions*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

***89.* Collective Efficacy:** *A willingness to intervene on behalf of the common good*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

***90.* Civic Engagement/Participation:** *Involvement in organizations and political process*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

***91.* Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

***92.* Positive Gender Norms:** *Gender-specific, socioculturally determined standards*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

C. SERVICES AND INSTITUTIONS: *Quality, culturally competent services & business*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

★ ★ ★

93. **Public Health, Health, & Human Services:** *Available, accessible, high quality services*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — ★ — Moderately effective — ★ ★ — Fully effective & developed

94. **Public Safety:** *Law enforcement and fire protection that trust of the community*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — ★★ — Moderately effective — ★ — Fully effective & developed

95. **Education and Literacy*:*** *Education and literacy services across the life span*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — ★ ★★ — Moderately effective — Fully effective & developed

96. **Community-Based Organizations:** *Effective non-profit efforts*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — ★★ — Fully effective & developed

★ ★★

17. Cultural/Artistic Opportunities: *Abundant opportunities for artistic expression*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — ★ — Moderately effective — ★ — Fully effective & developed

★

D. MACRO FACTORS: *Structural factors that can be influenced by community attention*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★ ★ ★

33. Economic Capital: *Local ownership of assets or access to investment opportunities*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★ ★ ★

34. Media/Marketing: *Presence of responsible marketing and media*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★ ★ ★

35. Ethnic, Racial, and Intergroup Relations: *Positive relations between different groups*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

★ ★ ★

6) Customizing the Process: Renaming the Factors and Developing Community-Specific *Indicators While generally speaking the factors and the cluster names reflect the research, it is clear that communities may have words to describe a particular cluster of factor that is more reflective of local culture and language or in closer alignment with existing efforts and priorities. In recognition of this, participants were given the opportunity to rename their priority factors based on how their community would define and describe these factors. In addition, they developed local indicators for each priority factor. The indicators reflect the community's description of what the factor might look like if it were fully developed and promoting health and/or safety outcomes. The selected names and indicators are summarized in the following table.*

Priority Factors	Community Names	Indicators
Public Health, Health and Human Services	N/a	* Community knowledge of what service s are available * Cultural and language appropriate services * Training for providers
Community Based Organizations	N/a	* Availability of funding * Availability of training and technical assistance regarding grant writing, data, and evaluation
Activity-Promoting Environments	Physical Activity and Sports	* Safe, clean, well maintained parks, streets, schools and recreational facilities * Available resources for recreational facilities * Equally distributed physical activity (i.e. intramural sports, leagues, midnight basketball)
Nutrition-Promoting Environment	Good Eatin'	* Available, affordable culturally appropriate foods * Accessibility of fresh fruits, vegetables and meats inside the community * Community knowledge around good nutrition

7) Assessing What's Working and What Needs Improvement

Considering the indicators, participants assessed what's working and what needs improvement for each of the 5 priority factors. This activity helped participants identify strengths that can be built upon and gaps that need to be addressed as efforts move forward.

Priority Factor	What's working	What needs improvement
Public Health, Health and Human Services	* Available and accessible * Available Health insurance * Available health services * Community knowledge	* Community Knowledge * More services in schools * Built trust with community * Improvement in the community
Community Based Organizations	* A lot of CBO's * Diversity of CBO's * Easily accessible * Resource for Literature and materials	* Better CBO's * More community awareness of CBO's * More organized * Linkages of CBO's
Physical Activity and Sports	* Funding of two parks * Identification of school activity needs	* Sustainability/ identification of additional facilities *Equally distributes or duplicative to other communities * Physical activity in the high school, middle school and elementary
Good Eatin'	* Nutrition class in parks * Identifying areas for additional green markets * Vendor training	* More green markets * Better choices for school lunches * More education and media promotion of healthy foods

8) Identifying Next Steps and Partners

Taking into account the priority health issues, priority factors, developed indicators, what's working and what needs improvement, participants brainstormed other stakeholders that should be brought to the table and appropriate next steps to build on the work of the day. Below is a list of what participants came up with.

Next Steps:

- Expanding park activities to other locations
- Increase awareness about activities
- Getting the schools to better promote physical activity
- Advertise about the Bronx Dept. of Public Health Services
- More active with CBO's
- Identify community nutrition needs
- More involved with the schools, daycare, and after school programs
- Conduct focus groups

9) Evaluating the Pilot Event

To get an immediate impression of the day, participants were asked for three words to describe the day before completing a detailed evaluation. The results of each follow:

<u>Words to describe the day:</u>

(Same as the other burrows)

- Intense
- Stimulating team discussion
- Getting team together
- Informative
- A lot of information to absorb
- Very interesting
- Just the beginning
- A training experience
- Brainstorming and prioritizing
- Teamwork
- Good opportunity for discussion
- Thought provoking
- Very good session
- Method of re-thinking

Pilot Site Report
District Public Health Office, New York City
December 11, 2003
EAST AND CENTRAL HARLEM

1) What is a Healthy Community?
The event began with a question designed to stimulate thinking, "What would a health -- or health-promoting -- community look like?" The question was designed to gauge participant thinking on the topic, setting a baseline, and/or to outline a vision for a healthy community. The remainder of the day's activities would then question, reinforce, and/or refine this initial brainstorming. Below is the list participants came up with.

Elements of a healthy community as brainstormed by participants: (Same as the two other burrows)

- Safe Streets
- Decent Housing
- Opportunities for Physical Activity/Nutrition
- Absence of fast food
- Healthier fast foods
- Good air quality & safe H20
- Green Lawns
- Easy Access to healthcare (comprehensive)
- Social supports/cohesion
- Work together
- Education

Major Health Concerns
Participants discussed and confirmed participating districts' (South Bronx, Central Brooklyn, and East Harlem) priority health concerns. These priorities served as the basis for advancing a community resilience approach that meets the needs of the represented districts.

Health Problems in East and Central Harlem

- Physical Activity/Nutrition
- Asthma

3) Training on a Community Resilience Approach
Prevention Institute provided a training on advancing a community resilience approach to closing the health gap. In particular, the training included a background on the efficacy of prevention, a framework for focusing on behavioral and environmental factors, and a delineation of the four clusters and twenty factors, linking each of them to the Healthy People 2010 Leading Health Indicators and major health concerns.

4) Rating the Priority of Factors

Participants used the THRIVE tool to rate the priority level of each factor. In particular, they were asked to think about how important it would be to focus on a particular factor given their priority health concerns. The average of their priority ratings are summarized in the following chart.*

* In order to average the ratings, we assigned numerical ratings for calculation. They were then converted back into letters, with the addition of minuses and pluses when necessary.

Priority ratings: H = High Priority M = Medium Priority L = Low Priority

H -	**A. BUILT ENVIRONMENT:** *Man-made physical components*
H -	**1. Activity Promoting Environment:** *Places to participate in incidental/recreational activity*
H	**2. Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*
H -	**3. Housing:** *Availability of safe, affordable housing in the community*
M	**4. Transportation:** *Availability of safe and affordable methods for moving people around*
H -	**5. Environmental Quality:** *Safe water, soil, air, and building materials*
M +	**6. Product availability:** *Beneficial products; limited availability of harmful products*
M +	**7. Aesthetic/Ambiance:** *Appealing, clean, and culturally relevant visual environment*
M +	**B. SOCIAL CAPITAL:** *Social networks and norms of reciprocity and trustworthiness*
H -	
H	**9. Collective Efficacy:** *A willingness to intervene on behalf of the common good*
H -	**10. Civic Engagement/Participation:** *Involvement in organizations and political process*
H -	
M -	**12. Positive Gender Norms:** *Gender-specific, socioculturally determined standards*
M-	**C. SERVICES AND INSTITUTIONS:** *Quality, culturally competent services & business*
H -	**13. Public Health, Health, & Human Services:** *Available, accessible, high quality services*

M +	**14. Public Safety:** *Law enforcement and fire protection that trust of the community*
H -	**15. Education and Literacy:** *Education and literacy services across the life span*
M +	**16. Community-Based Organizations:** *Effective non-profit efforts*
M	**17. Cultural/Artistic Opportunities:** *Abundant opportunities for artistic expression*
L +	**D. MACRO FACTORS:** *Structural factors that can be influenced by community attention*
M +	**18. Economic Capital:** *Local ownership of assets or access to investment opportunities*
H	**19. Media/Marketing:** *Presence of responsible marketing and media*
M +	**20. Ethnic, Racial, and Intergroup Relations:** *Positive relations between different groups*

5) Assessing Community Effectiveness Scores

Participants used the THRIVE tool to rate how well developed each of the cluster areas and factors are in the community. The below key represents the system developed for rating the clusters areas and factors

Key:
1 = Elements not in place; harmful to health or inappropriate for needs of community. There is either nothing in place that fosters health or what is in place is detrimental to the health of members of the community. **2 =** At most a few elements are in place, and they need improvement regarding quality, access, availability, and/or cultural and developmental appropriateness. There is inadequate development or quality of the factor to promote positive health outcomes. **3 =** Some elements are in place and well developed. These elements are culturally appropriate and meet the range of developmental needs. Factor meets some needs of the community. **4 =** Many elements are in place, but there is some room for improvement related to putting more elements in place and/or improving quality, access, availability, and/or cultural and developmental appropriateness. Factor is on the way to fully meeting the needs of the community. **5 =** Many elements are in place and are high-quality, accessible, available, and culturally and developmentally appropriate for the range of needs in the community. Factor fully meets the needs of the community.

Note: *The pink stars indicate the number of people who marked each score*

G. BUILT ENVIRONMENT: *Man-made physical components*

1 — 2 — 3 — 4 — 5

Not at all developed — Moderately effective — Fully effective & developed

97. Activity Promoting Environment: *Places to participate in incidental/recreational activity*

1 — 2 — 3 — 4 — 5

Not at all developed — Moderately effective — Fully effective & developed

***98.* Nutrition Promoting Environment:** *Safe, healthy, affordable, culturally appropriate food*

1 — 2 — 3 — 4 — 5

Not at all developed — Moderately effective — Fully effective & developed

***99.* Housing:** *Availability of safe, affordable housing in the community*

1 — 2 — 3 — 4 — 5

Not at all developed — Moderately effective — Fully effective & developed

100. Transportation: *Availability of safe and affordable methods for moving people around*

1 — 2 — 3 — 4 — 5

Not at all developed — Moderately effective — Fully effective & developed

101. Environmental Quality: *Safe water, soil, air, and building materials*

1 — 2 — 3 — 4 — 5

Not at all developed — Moderately effective — Fully effective & developed

102. Product availability: *Beneficial products; limited availability of harmful products*

1 — 2 — 3 — 4 — 5

Not at all developed — Moderately effective — Fully effective & developed

103. Aesthetic/Ambiance: *Appealing, clean, and culturally relevant visual environment*

1 — 2 — 3 — 4 — 5

Not at all developed — Moderately effective — Fully effective & developed

B. SOCIAL CAPITAL: *Social networks and norms of reciprocity and trustworthiness*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

104. Social Cohesion and Trust: *Strong social ties among persons and positions*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***105.* Collective Efficacy:** *A willingness to intervene on behalf of the common good*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***106.* Civic Engagement/Participation:** *Involvement in organizations and political process*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***107.* Positive Behavioral/Social Norms:** *Shared beliefs and standards of behavior*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

***108.* Positive Gender Norms:** *Gender-specific, socioculturally determined standards*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

C. SERVICES AND INSTITUTIONS: *Quality, culturally competent services & business*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

109. **Public Health, Health, & Human Services:** *Available, accessible, high quality services*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

110. **Public Safety:** *Law enforcement and fire protection that trust of the community*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

111. **Education and Literacy*:*** *Education and literacy services across the life span*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

112. **Community-Based Organizations:** *Effective non-profit efforts*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

17. Cultural/Artistic Opportunities: *Abundant opportunities for artistic expression*

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all developed — Moderately effective — Fully effective & developed

D. MACRO FACTORS: *Structural factors that can be influenced by community attention*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

36. Economic Capital: *Local ownership of assets or access to investment opportunities*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

37. Media/Marketing: *Presence of responsible marketing and media*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

38. Ethnic, Racial, and Intergroup Relations: *Positive relations between different groups*

1 ——— 2 ——— 3 ——— 4 ——— 5

Not at all developed — Moderately effective — Fully effective & developed

6) Customizing the Process: Renaming the Factors and Developing Community-Specific *Indicators While generally speaking the factors and the cluster names reflect the research, it is clear that communities may have words to describe a particular cluster of factor that is more reflective of local culture and language or in closer alignment with existing efforts and priorities. In recognition of this, participants were given the opportunity to rename their priority factors based on how their community would define and describe these factors. In addition, they developed local indicators for each priority factor. The indicators reflect the community's description of what the factor might look like if it were fully developed and promoting health and/or safety outcomes. The selected names and indicators are summarized in the following table.*

Priority Factors	Community Names	Indicators
Education/Literacy	Education/Literacy	* Fewer dropouts * Increased school attendance * Increased attention to education for adults
Media/Marketing	Media/Marketing	* Fewer alcohol ads * Fewer cigarette ads * More media coverage with healthy message
Activity-Promoting Environment	Physical Activity	* Free physical activity programs in the schools * Reimbursable exercise prescription * Schools and daycares required physical activity * Parks increase
Nutrition-Promoting Environment	Nutrition-Increased Availability of Healthy Foods	* Large numbers of sites for fruits and vegetables * Healthier school food * Geographically accessible health food * More education in good nutritious cooking
Housing	Housing-Decent/Affordable Housing	* Aggressive code enforcement * More low-income housing * Faster repairs

7) Assessing What's Working and What Needs Improvement

Considering the indicators, participants assessed what's working and what needs improvement for each of the 5 priority factors. This activity helped participants identify strengths that can be built upon and gaps that need to be addressed as efforts move forward.

Priority Factor	What's working	What needs improvement
Education/Literacy		* Increased school attendance * Attention to adult education
Media/Marketing		* Less alcohol ads * Less cigarette outlets * More media coverage to healthy choices
Activity-Promoting Environments	* Parks that increase places for people to be physically active	* Free physical activity programs in the county * NYCHA system to access physical activity *Physical activity in the schools/daycares * Reimbursable physical activity prescriptions
Nutrition- Promoting Environment		* Healthier school food * Geographically accessible healthy food * More education and good nutritious cooking
Housing		* Aggressive Code enforcement * Faster repairs * More low-income housing

8) Next Steps: Expanding Partnerships and Moving Forward to Build Community Resilience

Taking into account the priority health issues, priority factors, developed indicators, what's working and what needs improvement, participants brainstormed other stakeholders that should be brought to the table and appropriate next steps to build on the work of the day. Below is a list of what participants came up with.

- Partner with physical activity teachers
- Hold focus groups around how to frame the issues with different populations groups
- Need to get parents involved
- Need to get school administrators involved
- Partner with parks departments
- Partner with after school programs

9) Evaluating the Pilot Event

To get an immediate impression of the day, participants were asked for three words to describe the day before completing a detailed evaluation. The results of each follow:

Three words to describe the day:
(Same as the other burrows)

- Intense
- Stimulating team discussion
- Getting team together
- Informative
- A lot of information to absorb
- Very interesting
- Just the beginning
- A training experience
- Brainstorming and prioritizing
- Teamwork
- Good opportunity for discussion
- Thought provoking
- Very good session
- Method of re-thinking

Pilot Evaluation Results

To help strengthen presentation materials, the THRIVE tool and the facilitated process, participants were asked to complete the below evaluation form. Participants were asked to circle the number that most closely represents their response to the question and add any additional information in the space provided.

NYC (Bronx, Brooklyn and Harlem)

Sample Rating Chart:

1	2	3	4	5	0
Not at all		Neutral		Very much so	Don't know

1a. Were your expectations for the day met?

AVERAGE RATING: 3.8

1b. What were your expectations of today's session?

- Better understanding of community resilience
- Didn't have much expectations
- Came in open minded, no expectations
- Not a whole lot of expectations- more interesting in learning about this tool
- The hard work between groups
- To understand THRIVE
- Identify powerful tool to shift health discussions to include upstream factors
- Outcomes and interest of all DPHOs

- Hoping for a new twist on health disparities
- Get exposure to new community resiliency
- A chance to brainstorm with the other DPHOs
- To gain information
- Getting a better idea of how to think about "upstream" in a systematic way
- To cover the upstream issues elated to health disparities and applying to planning for action

2a. Overall, how valuable was the presentation, tool, and discussions for you?
AVERAGE RATING: 4.3

2b. What was the most valuable aspect of the presentation, tool, and discussions?
- Cluster approach
- The breakdown of factors in the clusters
- Discussion with group
- Mostly the opportunity to sit with folks and discuss strategy
- Very visual
- Identifying primary factors
- Grouping of numerous factors
- How things were broken down in categories
- Pin pointing and narrowing down what topics we want to pursue in our neighborhood
- What works and what needs improvement
- Great start for thinking about our community
- Discussion about housing environment improvement and nutrition combined with physical activities
- Factors and clusters piece
- Breaking down the four separate categories
- Nice to have concrete examples of upstream issues summarized in one place. Tool helped organize discussion

2c. What was the least valuable aspect of the presentation, tool, and discussions?
- Discussion on community health problems, wanted more solutions
- Renaming the factors
- Renaming segment
- Trying to list community-specific realities " what works, what doesn't work" and next steps- those require more thought and time
- Relationship between groups
- None I can think of
- Little rational for skipping root causes a little too long on examples
- Introduction
- The length…soo long!
- Some of the basics we already know

3a. Was the presentation about the relationship between community resilience and health valuable?
AVERAGE RATING: 4.4

3b. What kind of additional information would add value?

- We need more on changing behavior
- More info about community health
- More case study discussion
- Way to maintain the resilience alive
- Strengths, empowerment
- Better explanation of the different factors in the social cluster
- I think the concept of resilience still needs more explanation

4. How clear is the relationship between the 4 clusters and each of its corresponding factors?

AVERAGE RATING: 4.2

5a. Did the presentation provide the conceptual information you needed to complete the tool and participate in the subsequent discussions?

AVERAGE RATING: 4.1

5b. What kinds of materials and information would best prepare future participants to use the tool effectively?

- Contrasting visuals
- Maybe some review articles on social --, again, depends on the audience…
- Info about community health
- Can't think of any
- Again more specific projects
- Possibly sharing of implementation model
- Not everything the tool could provide- just info about the community
- Understanding
- A little clearer explanation of the purpose of the group exercises

6a. How useful did you find the tool?

AVERAGE RATING: 3

6b. What did you find most useful?

- Clusters
- Prioritize and assessment of community factors and building
- Clusters
- Nice little organization of upstream factors
- You can use the tool identify indicators and determine those factors that work and those that don't work
- Provided framework for thinking about upstream factors
- Reference definitions
- Tallying- realized our team was on the same page
- A great start for brainstorming
- The break down
- Clusters -> priority process -> indicators good flow
- Provided structure for discussions and planning

6c. What did you find least useful?

- Renaming the factors
- It seems too limited to really be a planning tool
- Nothing I can think of
- Not enough linkage between priorities/priority setting and gap analysis
- Some of the presentations piece
- This long evaluation
- Renaming
- N/a
- Probably the last cluster- too broad

7a. How appropriate is the language of the tool for your community?

AVERAGE RATING: 3.5

7b. How can the language of the tool be adapted for your community?

- Define concepts, Spanish
- It is very scientific and would need to be used more in layman terms for our community
- Language is appropriate for professionals but might hinder the processes with community individuals. Make it less academic.
- Would need to be more specific (using examples) if it were to be used by community partners
- The language can be adapted by community health professionals but must be redefined for the understanding of the community they work in.
- Just in other languages- Spanish
- Translating into Spanish
- Have a focus group and have the community pick name
- Lower level
- Less academic- but this is community specific
- Maybe needs to be simplified (language)

8a. Did the tool include the range of factors that you think are important to promote community resilience and health?

AVERAGE RATING: 4.2

8b. Are there any other factors that you think are important to include in the tool?

- Community based health government concepts
- Everything in the tool is "upstream" doesn't include individuals based factors
- The factors on the tool seem all inclusive of those that I could think about
- Even more grass root approach. There is talk about pulling up bootstraps. What about those who don't have any boots.
- None
- Mental health, hardiness
- Perhaps on violence there was not enough especially role of drugs, alcohol and guns

8c. Are there any factors and/or clusters that should be rearranged and/or omitted?

- I would make social capital first. If you don't have the communities interest then…
- No
- None
- Just better clarity about collective work/ civic engagement
- Last cluster doesn't hold together as well as others

9a. Did the day's activities progress in a manner that was logical and easy to understand (i.e. ranking community health issues, and prioritizing the 20 factors, who else needs to be at the table, next steps)?

AVERAGE RATING: 3.5

9b. How could the ordering of the day's activities be improved upon?

- N/a
- No comment
- No suggestion
- It was fine as is
- Depending on audience, maybe lesson background and more on next steps
- The order was fine, but the process was too long

10a. Can this tool be used to effectively promote positive health outcomes in communities?

AVERAGE RATING: 3.9

10b. How can this assessment tool be used to promote positive health outcomes in communities?

- Simplify and use community groups
- Make it shorter
- Raising awareness of upstream factors
- As a planning tool. As an evaluation of what works and what doesn't
- Starting point for planning
- Help community to prioritize the projects better
- Focus groups
- Considering all aspects of health
- To get people talking
- Involving the community and ask the community need
- Identify, create and usage
- Definitely but legends on TIME! No clear correlation between improving resilience and getting better outcomes
- To initiate discussion and introduce upstream/prevention ideas to the communities

10c. How do you think this tool could be used to assist communities, local government and/or service providers in their work?

- Involve residents in health planning
- Help them to think "outside" the traditional services mindset. See the relationship of health to these factors
- Helps with planning and clarifying next steps

- To encourage them to work through a particular health problem, illustrating how individual factors and health care are only part of the problem and that upstream factors also matter
- The tool can be used to prioritize health concerns in communities by all stakes
- Reframe "actual causes" to include "underlying causes" in planning/priority setting
- Same as above (Help community to prioritize the projects better)
- Looking at resources and what issues need to be addressed
- As a framework for prioritizing issues
- Prioritize issues
- Help prioritize
- Good for planning and getting people to think outside of the box (i.e. service providers)
- Structure planning discussions; expand upon traditional approaches to public health

11a. Can this tool be used to create a paradigm shift in how communities address health issues?AVERAGE RATING: 3.5

11b. How can the tool be used to create a paradigm shift in how communities address health issues?

- If simplified, can refocus attention
- Hope that is would. Believe changing what government and other groups spending their money on will be more effective in creating that shift. More money spent on services and treatment
- See above (Reframe "actual causes" to include "underlying causes" in planning/priority setting)
- Not sure
- Focus
- Focus on other contributing factors to health
- Creating different programs and involving everyone in the community if possible
- To look more into prevention/education as oppose to waiting for an epidemic and then reacting
- Depending on community's priorities- again if people can see how looking at resilience improves local support in the long run
- See above (Structure planning discussions; expand upon traditional approaches to public health)

12. Was today a motivational experience for you?
AVERAGE RATING: 3.5

13. What resources do you need in order to feel that you can use the tool independently and with confidence?

- More hands on
- Script
- Information or material on other places that have used the tool
- Not sure
- I need to know my community better
- Support from higher ups
- More experience

- Perhaps how to use the tool in shorter form or skipping some parts and lengthening others
- Some of the slides might be nice

14a. Do you anticipate challenges in incorporating a resilience approach to community health?

AVERAGE RATING: 4

14b. What do you anticipate will be the major challenges in incorporating a resilience approach to community health?

- Problems are big, must focus on what's doable
- Tyranny of the urgent is priority over what is important or beneficial long term
- The ability to engage the "right" folks for a prolonged discussion with no "concrete" deliverables. Planning is not embraced.
- Articulating specific avenues for intervention and a role for government health in addressing social determinants
- Barriers to areas that the healthy dept has so much interest in promoting, but has little control over
- Most issues outside the realm of current public health practice
- Community by-in
- The communities adapting new behaviors
- Moving from a primary model and considering long term strategies that may not have immediate effects
- Support from CBOs and grantors
- Funds
- For some issues we've got good momentum (physical activities). For others it probably seems to difficult (housing policy)
- Funding, bou-in, getting away from the pressure to respond to crises and urgent needs

14c. What additional assistance would be most helpful in overcoming these obstacles?

- Need examples
- Specific information on successful programs/interventions
- Assistance from other agencies working in the local community
- Sharing models of effective interventions/programs. Specific activities to address factors
- Support from central office
- A shorter tool
- More hard data on the link between prevention and decrease health outcomes
- If community (CBOs) buys into it
- Try to have the same kind of session with school and CBOs
- Linkage
- Partnering with local organizations. Political support. Community leadership
- Examples of others using the approach successfully

15 What impact do you anticipate that a community resilience approach will have on your community and/or your organization?

- Tool for planning
- Hope that it would have a great positive impact

- It would be helpful in engaging “non-traditional” community health partners
- Will help us prioritize our health issues/concerns
- Depends! Could be negative/positive depending on what their needs are
- It will help to get CBO thinking
- Catalyst for undertaking a very difficult mission
- Hard to tell
- I hope it would be a positive one
- More than anything it will challenge us to rethink stakes
- It is consistent with the approach we have been using. As far as the community- it could provide an opportunity for groups with very different areas of interest to work together- brining together the community

16. Describe an action that you will take as a result of the information you heard about and discussed related to THRIVE?

- Increase community involvement in health planning
- Deciding on deliverables priorities. Our office will also engage “key players” in the dialogue
- More strategizing with the planning team
- Will use the tool to try to rate some of the health issues we try to address
- Increase of our work on underlying factors
- The fact that we were encouraged to develop “what works” and “what needs improvement” is an important look at where we are in our projects
- Presented to CBO
- Encourage tree-planting
- Identify a priority, establish indicators, decide on next step
- Set going on attacking community partners to our efforts

113. Other Comments:

- Thank you
- The evaluation is a little to long. Four pages are a bit overwhelming at the end of the day.
- Thanks for an enjoyable and informative session!
- Wonder whether the list of factors and the upstream perspective could be integrated into existing, more thorough planning tools rather than as a stand-alone tool that is somewhat limited.
- Thanks!

Appendix F: Why quality medical care alone will not eliminate disparities[323]

- **Medical care is not the primary determinant of health**
  Of the 30-year increase in life expectancy since the turn of the century, only about five years of this increase are attributed to medical care interventions.[324] Even in countries with universal access to care, people with lower socioeconomic status have poorer health outcomes.[325] Blum asserts that the most important determinant of health is environmental conditions, followed by lifestyle. Medical care ranks third as a determinant of health.[326]

- **Medical care treats one person at a time**
  By focusing on the individual and specific illnesses as they arise, medical treatment does not reduce the incidence or severity of disease among groups of people. According to the Institute of Medicine, "…one-to-one interventions do little to alter the distribution of disease and injury in populations because new people continue to be afflicted even as sick and injured people are cured."[327] And as long as there is a disparity in the occurrence of diseases, low-income people of color are most likely to be a disproportionately affected.

- **Treatment does not always restore health**
  Medical care is usually sought after people are sick. Many common chronic health problems, such as heart disease, diabetes, asthma, and HIV/AIDS, are never cured. Further, medical care can help some people recover from acute conditions such as injury and contagious disease, however, often they would be far better off never experiencing them in the first place because of things like lost wages, persistent pain or symptoms, and emotional suffering. Therefore it is extremely important to prevent acute and chronic conditions from occurring in the first place.

- **There are disparities in medical treatment**
  A growing body of evidence shows that people of color experience disparities in treatment across all socioeconomic levels.[328] Therefore, even if the medical care infrastructure could address the sheer number of people being sick, it is unlikely that the outcomes would be as positive for people of color as for the general population.

- **Treatment itself can cause additional diseases**
  "Iatrogenics" refers to the impact of the treatment and the treatment environment in creating other diseases—for example, contracting pneumonia while in the hospital, developing stomach ailments from medications, or being injured in car crashes resulting from too many medications.

- **Medical care is very costly**
  Treatment requires enormous resources that could otherwise benefit communities in other ways. The U.S. spends nearly one trillion dollars a year on diagnosing and treating disease. It is estimated that nearly 70% of all medical care spending is used for chronic and *preventable* diseases and injuries.[329] Most medical profits go to large national pharmaceutical and hospital corporations and do not stay in the community, and many people, particularly low wage earners, need to commit large percentages of their pay to medical care. Further, low-income people of color are not as frequently the benefactors of the large investment in medical spending.

- **Improved care alone won't eliminate disparate levels of poor health**
  In England, for example, the establishment of universal health coverage was actually followed by an increase in health disparities.[330] While well-intentioned, the flaw of this National Health Service plan was that it failed to take into account the broader social and economic factors that lead to incidence of disease and injury in the first place. In other words, health disparities exist because more people in certain population groups are getting sick, not because fewer of them are getting well.

Appendix G: Why a community resilience approach can help eliminate disparities

- **For individuals to be healthy, they need healthy communities**
  Communities have strengths and assets that, when fostered, can provide an environment that promotes health and well-being. However, certain groups of people live in vulnerable environments in which there may be greater health risks. Therefore, it is critical to enhance the positive elements that will enable people to thrive in spite of risks or to more easily recover from them.

- **Health disparities, by definition, affect groups/populations of people, not individuals**
  Health disparities are measured in population groups. In order to eliminate them, it is critical to focus on population-based strategies, rather than focus on members of the population one person at a time. A community resilience approach allows for community-level action that will benefit the population within the community.

- **The absence of risk does not equal health; a community resilience approach goes beyond risk**
  Addressing risk factors results in the absence of factors that threaten health and safety, however, it does not necessarily achieve the presence of conditions that support health. For example, the proliferation of fast food and junk food is a significant risk factor for poor nutrition and steps to minimize marketing and availability are important aspects of an overall approach. However, it is equally important to ensure that there is availability of safe, healthy, affordable and culturally appropriate food in a community as well.

- **A community approach minimizes 'blaming the victim'**
  This approach recognizes the role of the environment in shaping healthy behavior choices. Behavior is typically constructed in individualist terms, leaving many to conclude that poor health is the result of poor or ill-informed choices. However, researchers are increasingly recognizing the relationship between behavior and environment in determining health outcomes, acknowledging the limits of efforts that focus solely on individual behavior change. A disproportionate number of poor and minority population groups are getting sick, and it is unethical to “blame the victim” by focusing solely on individual choice.

- **Eliminating health disparities means ensuring fewer people get sick, not just more people get well**
  Until the underlying factors that lead to health disparities are addressed, low-income people of color will experience disproportionate rates of poor health and injury. By addressing the ways in which root factors play out at a community level, there is an opportunity to ensure that people do not get sick in the first place, thereby reducing disparity.

- **A resilience approach is based on the unique culture of the community**
  Different ethnic and racial groups have unique values, perspectives, assets, and living styles. A resilience approach builds on what is already working within cultures.

- **A community resilience approach is responsive to the range of developmental needs**
  Every community must address a range of developmental needs, from the very young to the elderly. A community resilience approach enables a community to take these into account and develop solutions that benefit all.

- **A community resilience approach meets community needs for wellbeing by**

strengthening the overall environment within a community
A community resilience approach identifies the needs within a community that support overall well being. The approach acknowledges the direct impact of the environment on health as well its impact on behavior, which in turn affects health outcomes. Attention is then given to strengthening the environment. Action includes eliminating risk factors (toxic sites), building on existing assets (local businesses or CBO's), and fostering a range of factors that will enable all of the people within a community to achieve health and safety.

- **A community resilience approach changes conditions shaped by oppression, poverty, and economic disparity**
  The root factors of health disparities such as oppression, discrimination, and poverty play out at the community level, which results in the populations of some communities being at higher risk for a range of poor health and safety outcomes. By strengthening key community factors, the impact of these root factors will be minimized.

- **Multiple health and safety concerns are addressed simultaneously and *before* the onset of symptoms**
  By going 'upstream' from injury and illness, a community resilience approach enables communities to design effective strategies that prevent multiple health and safety problems. A focus *before* the onset of symptoms translates into more cost-effective interventions. A good solution solves multiple problems.

Appendix H: About Prevention Institute

Prevention Institute based in Oakland, California is a non-profit national center dedicated to improving community health and well-being by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity, and youth development. For more information, visit: www.preventioninstitute.org.

References

[1] House James S, Williamsn David R. Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health. Smedley Brian D, Syme Leonard S, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington, DC. National Academy of Sciences; 2000:81-83.
[2] Satcher D. Eliminating racial and ethnic disparities in health: the role of the ten leading health indicators. *Journal of the National Medical Association.* 2000;92(6):315-318.
[3] Smedley, Stith, Nelson. *Unequal Treatment.* Institute of Medicine. 2003
[4] Duhl L. In Kurland J ed., *Public Health Reports*. v 115(2-3): Cary, NC: Oxford University Press; 2000.
[5] House James S, Williamsn David R. Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health. Smedley Brian D, Syme Leonard S, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington, DC. National Academy of Sciences; 2000:81-83.
[6] National Institutes of Health. Addressing Health Disparities: The NIH Program of Action. What are health disparities? Available at: http://healthdisparities.nih.gov/whatare.html. Accessed January 14, 2002.
[7] http://www.cdc.gov/nchs/data/hus/tables/2002/02hus030.pdf. Accessed June 24, 2003.
[8] http://www.cdc.gov/nchs/data/hus/tables/2002/02hus031.pdf. Accessed June 24, 2003.
[9] Moss N. Socioeconomic disparities in health in the US: an agenda for action. *Social Science and Medicine*. 2000;51:1627-1638.
[10] Pincus T, Esther R, DeWalt DA, Callahan LF. Social conditions and self-management are more powerful determinants of health than access to care. *Annals of Internal Medicine*. 1998;129:406-411.
[11] Murray-Garcia J, Herd D, Morello-Frosch R, Smith S. *An Annotated Bibliography: Multicultural Health: Setting the Stage for Innovative and Creative Approaches*. Woodland Hills, Calif: The California Endowment; 1999:9,11.
[12] Cheadle A, Wagner E, Koepsell T, Kristal A, Patrick D. Environmental indicators: a tool for evaluating community-based health-promotion programs. *Am J of Prev Med.*. 1992;8:345-350.
[13] Blum HL. Social perspective on risk reduction. *Family and Community Health*. 1981;3(1):41-50.
[14] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[15] McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA*. 1993:270:2207-2213.
[16] Adler NE, Newman, K. Socioeconomic disparities in health, pathways and policies. *Health Affairs.* 2002:21(2):60-76.
[17] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[18] Wilkinson R. 2000 in Larry Wallack's keynote address at the Oregon Prevention Conference, November 19, 2002; Eugene, OR.
[19] Satcher D. Eliminating racial and ethnic disparities in health: the role of the ten leading health indicators. *Journal of the National Medical Association.* 2000;92(6):315-318.
[20] McGinnis, M, Williams-Russo, P, and Knickman, JR. The case for more policy attention to health promotion. *Health Affairs.* 2002; 21(2): 78-93.
[21] "Promoting Health: Intervention Strategies from Social and Behavioral Research." *Institute of Medicine.* (2000). National Academy Press website. Available at: http://www.nap.edu/openbook/0309071755/html/1.html, accessed December 20, 2002.
[22] Blum, Henrik L. "Social Perspective on Risk Reduction." *Family and Community Health*. 3:1, May 1981, pg. 44.
[23] Schmid TL, Pratt M, Howze E. Policy as intervention: environmental and policy approaches to the prevention of cardiovascular disease. *AJPH.* 1995;85(9):1207-1211.
[24] Schultz A, Parker E, Israel B, Fisher T. Social context, stressors, and disparities in women's health. *JAMWA.* 2001;56(4):143-149.
[25]Lantz PM, House JS, Lepkowski JM, Williams DR, Mero RP, Chen J. Socioeconomic factors, health behaviors, and mortality. *JAMA.* 1998;279(21):1703-1708.
[26] Adler NE, Newman, K. Socioeconomic disparities in health, pathways and policies. *Health Affairs.* 2002;21(2):60-76.
[27] Lantz PM, House JS, Lepkowski JM, Williams DR, Mero RP, Chen J. Socioeconomic factors, health behaviors, and mortality. *JAMA.* 1998;279(21):1703-1708.
[28] Schultz A, Parker E, Israel B, Fisher T. Social context, stressors, and disparities in women's health. *JAMWA.* 2001;56(4):143-149.

[29] Jackson SA, Anderson RT, Johnson NJ, Sorlie PD. The relations of residential segregation to all-cause mortality: a study in black and white. *AJPH.* 2000; 90(4):615-617.
[30] Jackson SA, Anderson RT, Johnson NJ, Sorlie PD. The relations of residential segregation to all-cause mortality: a study in black and white. *AJPH.* 2000; 90(4):615-617.
[31] Schultz A, Parker E, Israel B, Fisher T. Social context, stressors, and disparities in women's health. *JAMWA.* 2001;56(4):143-149.
[32] Geronimus A. Understanding and eliminating racial inequalities in women's health in the United States: the role of the weathering conceptual framework. *JAMWA.* 2001;56(4):133-136.
[33] Norton A. Low-income childhood linked to later heart risks. *British Medical Journal.* 2002;325:805-807.
[34] A social environmental approach to health and health interventions. Smedley Brian D, Syme Leonard S, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington, DC. National Academy of Sciences; 2000:3.
[35] *Tobacco use Among U.S. Racial/Ethnic Minority groups: African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: a report of the Surgeon General.* Atlanta, Georgia: US Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.
[36] *Tobacco use Among U.S. Racial/Ethnic Minority groups: African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: a report of the Surgeon General.* Atlanta, Georgia: US Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.
[37] Shorty L. Great american smokeout: Is it anti-Indian? Available at: http://www.okit.com/news/2002/novdec/tobacco.html. Accessed January 23, 2003.
[38] *Tobacco use Among U.S. Racial/Ethnic Minority groups: African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: a report of the Surgeon General.* Atlanta, Georgia: US Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.
[39] Curry SJ, Wagner EH, Cheadle A, Diehr P, Koepsell T, Psaty B, McBride C. Assessment of community-level influences on individuals' attitudes about cigarette smoking, alcohol use, and consumption of dietary fat. *Am J of Prev Med.* 1993;9(2):78-84.
[40] Emmons KM. Health behaviors in a social context. In: Berkman LF, Kawachi I, eds. *Social Epidemiology.* New York: Oxford University Press; 2000:242-266.
[41] *Active Community Environments (factsheet).* Centers for Disease Control and Prevention. June 2000.
[42] Dellinger AM. Barriers to children walking and biking to school—United States, 1999. *Morbidity and Mortality Weekly Report.* 2002;51(32):701-704.
[43] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Build Environment on Public Health.* Washington D.C.: Sprawl Watch Clearinghouse Monograph Series. p. 1-19.
[44] Backett KC, Davison C. Lifecourse and lifestyle: the social and cultural location of health behaviors. *Social Science Medicine.* 1995;40(5):629-38.
[45] Morland K, Wing S, Roux AD. The contextual effect of the local food environment on residents' diets: the atherosclerosis risk in communities study. *AJPH.* 2002;92(11):1761-1768.
[46] Nestle M. *Food Politics: How the Food Industry Influences Nutrition and Health.* Berkeley and Los Angeles, Calif. University of California Press, Ltd; 2002.
[47] *Television and the Family* (brochure). American Academy of Pediatrics. Elk Grove Village, IL. Division of Publications; 1999.
[48] Safe and Smart: Making After-School Hours Work for Kids. June 1998. Available at http://www.ed.gov/pubs/SafeandSmart/chapter1.html. Accessed January 23, 2003.
[49] Backett KC, Davison C. Lifecourse and lifestyle: the social and cultural location of health behaviors. *Social Science Medicine.* 1995;40(5):629-38.
[50] Schmid TL, Pratt M, Howze E. Policy as intervention: environmental and policy approaches to the prevention of cardiovascular disease. *AJPH.* 1995;85(9): 1207-1211.
[51] Scenic America. Facts for action: Alcohol billboards: assistance for communities in adopting ordinances. Available at: http://www.scenic.org/fact11.htm. Accessed January 23, 2003.
[52] Center for Science in the Public Interest. Strategizer Technical Assistance Manual 32: Alcohol advertising: Its impact on communities, and what coalition can do to lessen that impact. Available at: http://www.cspinet.org/booze/Alcohol_Advertising.pdf. Accessed: January 23, 2003.

[53] Perry CL. Preadolescent and adolescent influences on health. In: Smedley BD, Syme SL. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington D.C.: National Academy Press; 2000:217-53.
[54] *Television and the Family* (brochure). American Academy of Pediatrics. Elk Grove Village, IL. Division of Publications; 1999.
[55] *Television and the Family* (brochure). American Academy of Pediatrics. Elk Grove Village, IL. Division of Publications; 1999.
[56] Designing safer communitites: a crime prevention though environmental design handbook. Washington D.C: National Crime Prevention Council; 1997.
[57] Local Government Commission, Center for Livable Communities. *Designing safe streets and neighborhoods.* Fact Sheet.
[58] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Build Environment on Public Health.* Sprawl Watch Clearinghouse Monograph Series. Washington D.C.. p. 1-19.
[59] Slaby RG. Media violence: Effects and potential remedies. In Katzmann G ed. *Securing Our Children's Future: New Approaches to Juvenile Justice and Youth Violence.* Washington D.C.: The Brookings Institution; 2002:305-37.
[60] Slaby RG. Media violence: Effects and potential remedies. In Katzmann G ed. *Securing Our Children's Future: New Approaches to Juvenile Justice and Youth Violence.* Washington D.C.: The Brookings Institution; 2002:305-37.
[61] Putnam R. Social capital measurement and its consequences. *ISUMA.* 2001;2(1);ISSN 1492-0611.
[62] Buka S. Results from the project on human development in Chicago neighborhoods. Presented at: 13th Annual California Conference on Childhood Injury Control; October 25-27, 1999; San Diego, CA.
[63] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Build Environment on Public Health.* Sprawl Watch Clearinghouse Monograph Series. Washington D.C.. p. 1-19.
[64] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Build Environment on Public Health.* Sprawl Watch Clearinghouse Monograph Series. Washington D.C.. p. 1-19.
[65] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[66] Adler NE, Newman, K. Socioeconomic Disparities In Health, Pathways And Policies. *Health Affairs.* 2002:21(2):60-76.
[67] Buka S. Results from the project on human development in Chicago neighborhoods. Presented at: 13th Annual California Conference on Childhood Injury Control; October 25-27, 1999; San Diego, CA.
[68] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[69] Interview with Anita Hicks, M.S.W. November 21, 2002. Program supervisor, *The Incredible Years*, Osborn, AZ
[70] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. November 2002. Oakland, CA
[71] Bradley RH, Whiteside L, Mundfrom DJ, Casey PH, Kelleher KJ, Pope SK. Early indications of resilience and their relation to experiences in the home environments of low birthweight, premature children living in poverty. *Child Development*. 1994;65;346-360.
[72] Smith C, Lizotte AJ, Thornberry TP, Krohn MD. Resilient youth: identifying factors that prevent high-risk youth from engaging in delinquency and drug use. In Hagan J ed. *Delinquency in the Life Course: Contextual and Dynamic Analyses.* Greenwich, CT: JAI Press; 1995:217-247.
[73] Pollard JA, Hawkins JD, Arthur MW. Risk and protection: are both necessary to understand diverse behavioral outcomes in adolescence? *Social Work Research*. 1999;23(3):145-158.
[74] Smith C, Lizotte AJ, Thornberry TP, Krohn MD. Resilient youth: identifying factors that prevent high-risk youth from engaging in delinquency and drug use. In: Hagan J, ed. *Delinquency and Disrepute in the Life Course: Contextual and Dynamic Analyses*. Greenwich, Conn: JAI Press; 1995:217-247.
[75] Pollard JA, Hawkins JD, Arthur MW. Risk and protection: are both necessary to understand diverse behavioral outcomes in adolescence? *Social Work Research*. 1999;23(3);145-158.
[76] Mangham Colin, McGrath Patrick, Reid Graham, Stewart Miriam. Atlantic Health Promotion Research Centre, Dalhousie University. *Resiliency: Relevance to Health Promotion Discussion Paper*. 1995. Available at: http://www.hc-sc.gc.ca/hecs-sesc/cds/publications/resiliency/preamble2.htm. Accessed December 6, 2002
[77] What is the Community Resilience Project? Available at: http://www.communityresilience.com/WhatisCRP.htm. Accessed December 21, 2002.
[78] The Center for Community Enterprise. *Community Resilience Manuel.* 2000.

[79] National Charrette Institute. *Healthy Communities.* Available at: http://www.charretteinstitute.org/healthy.html. Accessed October 4, 2002.
[80]National Charrette Institute. *Healthy Communities.* Available at: http://www.charretteinstitute.org/healthy.html. Accessed October 4, 2002.
[81] Benard, B., Davis, R., Sullivan, A., Cohen, L. Unpublished draft. 2000. Prevention Institute, Oakland, CA.
[82]Mills, Roger, The Understanding Behind Health Realization: A Principle Based Psychology, p. 5., Oct. 2002.
[83] Berkowitz B, Wadud E. Identifying community assets and resources. Available at: http://ctb.lsi.ukans.edu/tools/en/sub_section_main_1043.htm. Accessed: December 2, 2002.
[84] Wallack, L, Dorfman, L. *Issue (1)*. Berkeley, Calif: Berkeley Media Studies Group; January 1997.
[85] A social environmental approach to health and health interventions. Smedley Brian D, Syme Leonard S, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Wahington, DC. National Academy of Sciences; 2000:6.
[86] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Build Environment on Public Health.* Sprawl Watch Clearinghouse Monograph Series. Washington D.C.. p. 1-19.
[87] Calhoun J. National Crime Prevention Council. New Partners for Smart Growth: Building Safe, healthy, and Livable Communities 2nd annual conference flyer. 2002.
[88] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Build Environment on Public Health.* Sprawl Watch Clearinghouse Monograph Series. Washington D.C.. p. 1-19.
[89] *Land Use Planning for Safe, Crime Free Neighborhoods.* Local Government Commission Center for Livable Communities. Avaliable at: http://www.lgc.org/freepub/PDF/Land_Use/focus/plan_safe_neighborhoods.pdf.
[90] *Active Community Environments* (factsheet). Centers for Disease Control and Prevention. June 2000.
[91] Sallis JF, Nader PR, Broyles SL, *et.al*. Correlates of physical activity at home in Mexican-American and Anglo-American preschool children. Health Psychol 1993; 12:390-8.
[92] Klesges RC, Eck LH, Hanson CL, *et.al*. Effects of obesity, social interactions, and physical environment on physical activity in preschoolers. Health Psychol 1990;9:435-49.
[93] *Active Community Environments* (factsheet). Centers for Disease Control and Prevention. June 2000.
[94] Local Government Commission, Center for Livable Communities. *Focus on Livable Communities: The Economic Benefits of Walkable Communities.* Fact Sheet.
[95] *Household Food Security in the United States in 1995, Summary Report of the Food Security Measurement Project.* Office of Analysis and Evaluation, Food and Consumer Service, US Department of Agriculture; 1997.
[96] Morland K, Wing S, Roux AD. The contextual effect of the local food environment on residents' diets: the atherosclerosis risk in communities study. *AJPH.* 2002;92(11):1761-1768.
[97] Ashman L, de La Vega J, Dohan M, Fisher A, Hippler R, Romain B. *Seeds of Change: Strategies for Food Security for the Inner City*. Los Angeles, Calif: Southern California Interfaith Hunger Coalition; 1993.
[98] Weinberg Z. No place to shop: food access lacking in the inner city. *Race, Poverty & the Environment*. 2000.
[99] Hoats K. *The Cost of Being Poor in the City: A Comparison of Cost and Availability of Food in the Lehigh Valley.* Lehigh, Pa: Community Action Committee of the Lehigh Valley; 1993.
[100] Weinberg Z. No place to shop: food access lacking in the inner city. *Race, Poverty & the Environment*. 2000.
[101] Weinberg Z. No place to shop: food access lacking in the inner city. *Race, Poverty & the Environment*. 2000.
[102] Cotterill RW, Franklin AW. *The Urban Grocery Store Gap*. Storrs: Food Marketing Policy Center, University of Connecticut; 1995. Food Marketing Policy Issue Paper No. 8.
[103] Ashman L, de La Vega J, Dohan M, Fisher A, Hippler R, Romain B. *Seeds of Change: Strategies for Food Security for the Inner City*. Los Angeles, Calif: Southern California Interfaith Hunger Coalition; 1993.
[104] Ashman L, de La Vega J, Dohan M, Fisher A, Hippler R, Romain B. *Seeds of Change: Strategies for Food Security for the Inner City*. Los Angeles, Calif: Southern California Interfaith Hunger Coalition; 1993.
[105] California Food Policy Advocates. *Improving Access to Food in Low-Income Communities: An Investigation of Three Bay Area Neighborhoods*. San Francisco, Calif: California Food Policy Advocates; 1996.
[106] Betty Robinson, Director, Citizen Housing and Planning Association, Baltimore, MD. personal interview. December 5, 2002
[107] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[108] Geronimus A. Understanding and eliminating racial inequalities in women's health in the United States: the role of the weathering conceptual framework. *JAMWA.* 2001;56(4):133-136
[109]Adler NE, Newman, K. Socioeconomic disparities in health, pathways and policies. *Health Affairs.* 2002;21(2):60-76.

[110] Sampson RJ, Raudenbush SW, Earls F. Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science.* 1997;277:918-924.
[111] Frank LD, Engelke P. How land use and transportation systems impact public health: A literature review of the relationship between physical activity and built form. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2000.
[112] Frank LD, Engelke P. How land use and transportation systems impact public health: A literature review of the relationship between physical activity and built form. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2000.
[113] Surface Transportation Policy Project. Dangerous by design: pedestrian safety in California. September 2000
[114] Sallis J, Bauman A, Pratt M. Environmental and policy interventions to promote physical activity. *Am J Prev Med*. 1998;15(4)379-97.
[115] Jackson RJ, Kochtitzky C. "Creating a Healthy Environment: The Impact of the Built Environment on Public Health." Centers for Disease Control andPrevention. 2001.
[116] US Environmental Protection Agency. Lead in paint, dust, and soil: basic information. Available at: http://www.epa.gov/opptintr/lead/leadinfo.htm#facts. Accessed January 6, 2003.
[117] Centers for Disease Control and Prevention. Blood Lead Levels in Young Children, United States and Selected States, 1996-1999. MMWR. 2000;49:1133-1137.
[118] Mielke HW. Lead in the inner cities. *American Scientist*. January-February 1999; 87;62-73.
[119] US Environmental Protection Agency. Lead in paint, dust, and soil: basic information. Available at: http://www.epa.gov/opptintr/lead/leadinfo.htm#facts. Accessed January 6, 2003.
[120] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Built Environment on Public Health.* Washington, DC: Sprawl Watch Clearinghouse; 2001.
[121]. US Department of Transportation, Bureau of Transportation Statistics. *National Transportation Statistics 2001* [online report]. Bureau of Transportation Statistics Web site; July 2002. Report No. BTS02-06:Table 4-11. Available at: http://www.bts.gov/publications/nts/html/table_04_11.html. Accessed January 9, 2003.
[122] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Built Environment on Public Health.* Washington, DC: Sprawl Watch Clearinghouse; 2001.
[123] Abt Associates. *Out of Breath: Health Effects from Ozone in the Eastern United States* [online report]. Abt Associates Web site; October 1999. Available at: http://www.abtassoc.com/reports/ozone.pdf. Cited by: Stanfield B, Farleigh A, Porreco G. *Danger in the Air: Unhealthy Smog Days in 1999* [online report]. Public Interest Research Group Web site; January 2000. Available at: http://www.pirg.org/reports/enviro/smog/#footnotes. Accessed January 7, 2003.
[124] World Health Organization, European Region. Third ministerial conference on environment and health, London. Available at: http://www.who.dk/london99/transporte.htm. Cited by: Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Built Environment on Public Health.* Washington, DC: Sprawl Watch Clearinghouse; 2001.
[125] State of Pennsylvania, 21st Century Environment Commission. Redefining progress: recommendations from the 21st century environment commission to Governor Tom Ridge. Available at: http://www.1000friends.org/sprawl.htm. Cited by: Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Built Environment on Public Health.* Washington, DC: Sprawl Watch Clearinghouse; 2001.
[126] Florida Department of Community Affairs, Department of Environmental Protection, and Department of Health. *Onsite Sewage Treatment and Disposal in Florida: Draft Background Paper for the Governor's Study of Onsite Sewage Treatment and Disposal Systems* [online report]. Florida Conflict Resolution Consortium Web site. Available at: http://consensus.fsu.edu/OSTDS/ostds_background.html. Accessed January 7, 2003.
[127] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[128] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[129] Rojas, Aurelio. *High Rates of Disease in Bayview Study lends weight to pollution fears.* San Francisco Chronicle. www.sfgate.com, June 9, 1998.
[130] Laveist Thomas A, Wallace John M. Health risk and inequitable distribution of liquor stores in African American neighborhood. *Social Science & Medicine.* 2000;51: 613-617.
[131] Laveist Thomas A, Wallace John M. Health risk and inequitable distribution of liquor stores in African American neighborhood. *Social Science & Medicine.* 2000;51: 613-617.

[132] Laveist Thomas A, Wallace John M. Health risk and inequitable distribution of liquor stores in African American neighborhood. *Social Science & Medicine.* 2000;51: 613-617.
[133] Youth participant, Youth Alive, Oakland, CA, 1996.
[134] Jackson, Richard J. "Creating a Healthy Environment: The Impact of the Built Environment on Public Health." Centers for Disease Control and Prevention. Available at: http://www.sprawlwatch.org, accessed December 19, 2002.
[135] Blair, Gwenda. "Out of the Ashes, Cinderella." *The New York Times* website. Available at: http://www.nytimes.com/2003/01/02/garden/02ARCH.html?pagewanted=1&8hpib, accessed January
[136] Gladwell, Malcolm. "The Tipping Point." *The New Yorker*. June 3, 1996.
[137] Parker, John. "Safe Spaces & Places: Reducing Crime by Urban Design." Council of Europe International Conference on the Relationship Between the Physical Urban Environment and Crime Patterns. Available at: http://new.cpted.net/reference/pdf/parker-safer_spaces.pdf, accessed January 21, 2003.
[138] A social environmental approach to health and health interventions. Smedley Brian D, Syme Leonard S, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington, DC. National Academy of Sciences; 2000:11.
[139] A social environmental approach to health and health interventions. Smedley Brian D, Syme Leonard S, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington, DC. National Academy of Sciences; 2000:10.
[140] Putnam, Robert. *Bowling Alone: The Collapse and Revival of American Community.* New York, NY: Simone & Schuster, 2000.
[141] Sabol WJ, Coulton CH, Korbin JE. Building Community Capacity for Violence Prevention. Presented at: National Network for Applied Research on Violence Prevention Workshop; January 17-18, 2002; San Diego, CA.
[142] Wandersman A, Nation M. Urban neighborhoods and mental health: psychological contributions to understanding toxicity, resilience, and interventions. *American Psychologist.* 1998;43:647-656.
[143] Buka S. Results from the project on human development in Chicago neighborhoods. Presented at: 13th Annual California Conference on Childhood Injury Control; October 25-27, 1999; San Diego, CA.
[144] Wilkenson R. Income inequality, social cohesion, and health: clarifying the theory – a reply to Muntaner and Lynch. *International J of Health Services.* 1999;29:525-545.
[145] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[146] Kawachi, I. and Berkman, L. "Social Cohesion, Social Capital, and Health." In: Berkman LF, Kawachi I eds. *Social Epidemiology.* New York: Oxford University Press; 2000
[147] Personal communication, Elizabeth Baker, Feb. 13, 2003.
[148] Putnam R. Social capital: measurement and consequences. *ISUMA* [serial online]. 2001;2:41-51. Available at: http://isuma.net/v02n01/putnam/putnam_e.shtml. Accessed March 18, 2002.
Putnam [149] Sampson RJ, Raudenbush SW, Earls F. Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science.* 1997;277:918-924.
[150] Putnam R. Bowling alone: America's declining social capital. *J of Democracy.* 1995;6:65-78.
[151] Veenstra G. Social capital and health. *ISUMA* [serial online]. 2001;2:72-81. Available at: http://isuma.net/v02n01/veenstra/veenstra_e.shtml. Accessed March 18, 2002.
[152] Sampson RJ, Raudenbush SW, Earls F. Neighborhoods and violent crime: a multilevel study of collective efficacy. *The Am Assoc for the Advancement of Science.* 1997;277(5328:15)918-924.
[153] Sampson RJ, Raudenbush SW, Earls F. Neighborhoods and violent crime: a multilevel study of collective efficacy. *The Am Assoc for the Advancement of Science.* 1997;277(5328:15)918-924.
[154] Shaw, Khaleed. Presented at *Youth Crime and Violence In California: From Evidence to Policy.* March 7, 2002. Pasadena CA
[155] Pothukuchi K. Attracting grocery retail investment to inner-city neighborhoods: Planning outside the box, Wayne State University, Detroit, MI.
[156] Chavis, *et.al.*. "Sense of community in the urban environment: a catalyst for participation and community development." *American Journal of Community Psychology*. 1990; 18(1):55-81. In: "Principles of Community Engagement." Centers for Disease Control and Prevention Public Health Practice Program Office. Atlanta, GA, 1997.
[157] "Principles of Community Engagement." Centers for Disease Control and Prevention Public Health Practice Program Office. Atlanta, GA, 1997.

[158] Zaff, Jonathan F. and Michelsen, Erik. "Encouraging Civic Engagement: How teens are (or are not) becoming responsible citizens." *Child Trends Research Brief.* Oct. 2002. Available online at: www.childtrends.org.
[159] Margolis H. Equilibrium norms. *Ethics.* 1990:100(4): 821-837.
[160] Emmons KM. Health behaviors in a social context. In: Berkman LF, Kawachi I eds. *Social Epidemiology.* New York: Oxford University Press; 2000:pg. 251.
[161] Bauman Adrian. Creating a supportive environment for change... 1999-need full citation
[162] Emmons KM. Health behaviors in a social context. In: Berkman LF, Kawachi I eds. *Social Epidemiology.* New York: Oxford University Press; 2000:pg. 255.
[163] Emmons KM. Health behaviors in a social context. In: Berkman LF, Kawachi I eds. *Social Epidemiology.* New York: Oxford University Press; 2000:242-266.
[164] Rohlfs.C. Borrell M, Fonseca C. Género, desigualdades y salud pública: conocimientos y desconocimientos. *Gaceta Sanitaria*, suplemento 3 2000 ; 14: 60-71.Accessed 2.19.03 at: http://search.doyma.es/cgi-bin/wdbcgi.exe/ctx_doyma/buscador.listado_izq?query=Rohlfs+
[165] Eisler RM. The relationship between masculine gender role stress and men's health risk: the validation of construct. In: Levant RF, Pollack WS, eds. *A new Psychology of Men.* New York: Basic Books; 1995:207-225.
[166] Will Courteney, www.menshealth.org. add full citation
[167] Dean Peacock, add full citation
[168] *Advance Report of Final Mortality Statistics, 1992.* Hyattsville, MD: US Dept. of Health and Human Services; 1995. Public Health Service; Publication PHS 95-1120.
[169] Courtenay WH, McCreary DR, Merighi JR. "Gender and ethnic differences in health beliefs and behaviors. J of Health Psychology: 7(3) 219-231. London: 2002.
[170] Courtenay WH, McCreary DR, Merighi JR. "Gender and ethnic differences in health beliefs and behaviors. J of Health Psychology: 7(3) 219-231. London: 2002.
[171] Kandrack M, Grant KR, Segall A. Gender differences in health related behavior; some unanswered questions. *Soc. Sci. Med.* 1991;32:579-590.
[172] *Vital Statistics of the United States, 1990. Vo 2: Mortality, Part A.* Hyattsville, MD: Department of Health and Human Services, Public Health Service; 1994.
[173] WHC unpublished data; 1996
[174] *Advance Report of Final Mortality Statistics, 1992.* Hyattsville, MD: US Dept. of Health and Human Services; 1995. Public Health Service; Publication PHS 95-1120.
[175] Johnson ME. Influences of gender and sex role orientation. *J Psychol.* 1998;122(3):237-241.
[176] Go VF, Quan VM, Chung A, Zenilman J, Hanh VT, Celentano D.Gender gaps, gender traps: sexual identity and vulnerability to sexually transmitted diseases among women in Vietnam.Department of Epidemiology, Johns Hopkins University School of Hygiene and Public Health, Baltimore, MD. Accessed 2.19.03 at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12144153&dopt=Abstract
[177] Courtenay WH, McCreary DR, Merighi JR. "Gender and ethnic differences in health beliefs and behaviors. J of Health Psychology: 7(3) 219-231. London: 2002.
[178] Courtenay WH, McCreary DR, Merighi JR. "Gender and ethnic differences in health beliefs and behaviors. J of Health Psychology: 7(3) 219-231. London: 2002.
[179] Kenen J. Study: Girls' Addiction Risks Different from Boys. Accessed at: http://story.news.yahoo.com/news?tmpl=story2&u=/nm/20030205/sc_nm/health_addiction_dc_1. 2/19/03.
[180] *Active Community Environments* (factsheet). Centers for Disease Control and Prevention. June 2000.
[181] Community Oriented Policing and Problem Solving: Now and Beyond, Crime and Violence Prevention Center, California Attorney General's Office, July 1999.
[182] Brann, J. Where We've Been… Where we're Going: The Evolution of Community Policing in Community Oriented Policing and Problem Solving: Now and Beyond, Crime and Violence Prevention Center, California Attorney General's Office, July 1999.
[183] Adler NE, Newman, K. Socioeconomic disparities in health, pathways and policies. *Health Affairs.* 2002;21(2):60-76.
[184] Lantz PM, House JS, Lepkowski JM, Williams DR, Mero RP, Chen J. Socioeconomic factors, health behaviors, and mortality. *JAMA.* 1998;279(21):1703-1708.
[185] High/Scope Educational Research Foundation. Available at: http://www.highscope.org/research/Perry%20fact%20sheet.htm.
[186] High/Scope Educational Research Foundation. Available at: http://www.highscope.org/research/Perry%20fact%20sheet.htm.

[187] Citizens Commission on Human Rights. Illiteracy and crime--an international problem. Available at: http://www.cchr.org/educate/iandc.htm. Accessed May 24, 2002.
[188] Ontario Literacy Coalition. Literacy and crime. Available at: http://www.lindr.on.ca/fact_sheets/literacy_crime/literacy_cirme.htm. Accessed May 24, 2002.
[189] Greenberg D. Health literacy statistics. [Health Literacy Toolbox 2000 website]. Available at: http://www.prenataled.com/healthlit/hlt2k/script/ht2_a_2.asp, Accessed November 26, 2002.
[190] National Institute for Literacy website. Available at: http://www.nifl.gov/nifl/facts/health.html, Accessed November 26, 2002.
[191] Greenberg D. Health literacy statistics. [Health Literacy Toolbox 2000 website]. Available at: http://www.prenataled.com/healthlit/hlt2k/script/ht2_a_2.asp, Accessed November 26, 2002.
[192] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[193] Community conversations for and with youth- working paper. The Forum for Youth Investment. Washington D.C.; The Cady-Lee House: 2002.
[194] www.ncartsforhealth.org/Scope_of_Arts_for_Health.pdf.; accessed 12/20/02
[195] Stern MJ, Seifert SC. Working Paper #13- Cultural participation and communities: The role of individual and neighborhood effects. Social Impact of the Arts Project, University of Pennsylvania: 2000.
[196] Key Points in Support of the V.P.I. Available at www.them-art.com/VPL-keypoints.rtf. Accessed December 20, 2002.
[197] Stern MJ, Seifert SC. Working Paper #13- Cultural participation and communities: The role of individual and neighborhood effects. Social Impact of the Arts Project, University of Pennsylvania: 2000.
[198] www.ncartsforhealth.org/Resource.htm; 12/20/02
[199] Stern MJ, Seifert SC. Working Paper #13- Cultural participation and communities: The role of individual and neighborhood effects. Social Impact of the Arts Project, University of Pennsylvania: 2000.
[200] Brice Heath, S., Soep, E. & Roach, A. (1998). Living the Arts Through Language and Learning: A Report on Community-based Youth Organizations. In Americans for the Arts MONOGRAPHS, V2(7).
[201] Catterall, J.S. Involvement in the Arts and Success in Secondary School. In Americans for the Arts MONOGRAPHS, V1(10).
[202] Personal communication, Elizabeth Baker, Feb. 13, 2003.
[203] House JS, Williams DR. Understanding and reducing socioeconomic and racial/ethnic disparities in health. In: Smedley BD, Syme SL, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington D.C.: National Academy Press; 2000:81-124.
[204] Deaton, Angus. "Policy Implications of the Gradient of Health and Wealth." *Health Affairs.* March/April 2002. Available online at: www.healthaffairs.org.
[205] House JS, Williams DR. Understanding and reducing socioeconomic and racial/ethnic disparities in health. In: Smedley BD, Syme SL, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington D.C.: National Academy Press; 2000:81-124.
[206] Personal communication, Elizabeth Baker, Feb. 13, 2003
[207] Dietz W. "Television, Obesity, and Eating Disorders," Adolescent Medicine: State of the Art Reviews, Vol. 4, October 1993.
[208] Kotz, K. & Story, M. (1994). Food Advertisements during children's Saturday morning television programming: Are they consistent with dietary recommendations? Journal of the American Dietetic Association, Volume 94, Number 11: 1296-1300.
[209] Zuckerman DM. Media violence, gun control, and public policy. *Am J of Orthopsychiatry.* 1996:66(3):378-89.
[210] Brown JD, Witherspoon EM. The Mass Media and American Adolescents' Health. [UNC Chapel Hill website]. November 1998. Available at: http://www.unc.edu/courses/jomc145/witherspoon.html. Accessed December 13, 2002.
[211] Brown JD. Mass media influences on sexuality. *J of Sex Research.* 2002:39(1):42-45.
[212] Zuckerman DM. Media violence, gun control, and public policy. *Am J of Orthopsychiatry.* 1996:66(3):378-89.
[213] Zuckerman DM. Media violence, gun control, and public policy. *Am J of Orthopsychiatry.* 1996:66(3):378-89.
[214] Wallack L. The role of mass media in creating social capital: a new direction for public health. In: Smedley BD, Syme SL, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington D.C.: National Academy Press; 2000:337-365.

[215] Wallack L. The role of mass media in creating social capital: a new direction for public health. In: Smedley BD, Syme SL, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington D.C.: National Academy Press; 2000:337-365.
[216] Brown JD, Witherspoon EM. The Mass Media and American Adolescents' Health. [UNC Chapel Hill website]. November 1998. Available at: http://www.unc.edu/courses/jomc145/witherspoon.html. Accessed December 13, 2002.
[217] Kretzmann JP, McKnight JL, Puntenney D. A guide to mapping local business assets and mobilizing local business capacities. Chicago; ACTA Publications: 1996.
[218] Kretzmann JP, McKnight JL, Puntenney D. A guide to mapping and mobilizing the economic capacities of local residents. Chicago; ACTA Publications: 1996.
[219] Kretzmann JP, McKnight JL, Puntenney D. A guide to mapping consumer expenditures and mobilizing consumer expenditure capacities. Chicago; ACTA Publications: 1996.
[220] While community based mapping projects are widely used in community development and empowerment efforts internationally, my focus here is on community mapping in urban U.S. settings.
[221] The very comprehensive Asset-Based Community Development Institute website is located at http://www.nwu.edu/IPR/abcd.html.
[222] Kretzmann, John & McKnight, John P. "Assets-based community development: The Role of Nonprofit Organizations in Renewing Community". *National Civic Review 85(*4): 23-30.
[223] D Perkins and B Brown, 1994
[224] Sampson RJ, Raudenbush SW, Earls F. Neighborhoods and violent crime: a multilevel study of collective efficacy. *The Am Assoc for the Advancement of Science.* 1997;277(5328:15)918-924.
[225] California Campaign to Eliminate Racial and Ethnic Disparities in Health. *Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities.* November 2003. Prevention Institute and American Public Health Association. Oakland , CA. p.15
[226] "Developing Effective Coalitions: An Eight Step Guide" leads advocates and practioners through the process of coalition building, from deciding whether or not a coalition is appropriate to selecting the best membership and conducting ongoing evaluation. It is available at no cost at www.preventioninstitute.org
[227] Personal interview with Larry Green, April 2003. Based on the Public Health Model PRECEDE-PROCEED: PRECEDE and PROCEED are acronyms for public health models that describe a health promotion-planning framework.
[228] Cohen L, Swift S. The spectrum of prevention: developing a comprehensive approach to injury prevention. *Injury Prevention.* 1999;5:203-207.
[229] Policylink. *Equitable Development Toolkit.* Available at: http://www.policylink.org/EquitableDevelopment/. Accessed June 18,, 2004.
[230] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Build Environment on Public Health.* Sprawl Watch Clearinghouse Monograph Series. Washington D.C. p. 1-19.
[231] The Designing for Active Recreation Fact Sheet (PDF) summarizes the scientific studies from the health field about the types of environments that are "activity friendly." The Designing for Active Transportation Fact Sheet (PDF)summarizes the current state of research into the way community design is related to whether people walk or bicycle to get to where they're going. www.activelivingresearch.org/index.php/What_We_are_Learning/117
[232] *Environmental and Policy Approaches to Promoting Healthy Eating and Activity Behaviors,* Prevention Institute, www.preventioninstitute.org
[233] *Environmental and Policy Approaches to Promoting Healthy Eating and Activity Behaviors,* Prevention Institute, www.preventioninstitute.org
[234] The Community Food Security Coalition. *Homeward Bound, Food-related transportation Strategies in Low Income and Transit Dependent Communities.*: The UCLA Pollution Prevention Education and Research Center; 1996.
[235] Theory in Action, "Commercial Development Funds Housing and Job Training" http://www.abag.ca.gov/planning/theoryia/housboston.htm
[236] Theory in Action, "Enterprising Department Increases Affordable Housing Stock" http://wwww.abag.ca.gov/planning/theoryia/houssanjose.htm
[237] Theory in Action, "Enterprising Department Increases Affordable Housing Stock" http://wwww.abag.ca.gov/planning/theoryia/houssanjose.htm
[238] Theory in Action, "Regional Fund Spurs Housing, Development and Revitalization" http://www.abag.ca.gov/planning/theoryia/houstwincities.htm

[239] Theory in Action, "Density Bonuses Exchanged for Affordable Housing", http://wwww.abag.ca.gov/planning/theoryia/housmontgomery.htm
[240] Theory in Action, "Trade Association Advocates Affordable Housing, Public Transit" http://www.abag.ca.gov/planning/theoryia/houssvmg.htm
[241] Hirschhorn, Joel S. and Souza, Paul (2001), *New Community Design to the Rescue*, National Governors' Association: Washington, DC. P. 53-54
[242] Hirschhorn, Joel S. and Souza, Paul (2001), *New Community Design to the Rescue*, National Governors' Association: Washington, DC P. 39
[243] Theory in Action, "Trade Association Advocates Affordable Housing, Public Transit" http://www.abag.ca.gov/planning/theoryia/houssvmg.htm
[244] Bothwell, S., Gindroz, R., & Lang, R. 1998. Restoring community through traditional neighborhood design: a case study of Diggs Town public housing. Housing Policy Debate, Vol 9 (1). Available at: http://www.fanniemaefoundation.org/programs/hpd/pdf/hpd_0901_bothwell.pdf. Accessed June 22, 2004.
[245] "Transportation and Environmental Justice" (2000) *U.S. Department of Transportation*, p. 2-3
[246] "Transportation and Environmental Justice" (2000) *U.S. Department of Transportation*, p. 7-7
[247] "Moving Forward: Making Transit Safer for Women" (1989) Metro Action Committee on Public Violence Against Women and Children, p. 63
[248] McCormick, Ed "City Honchos Rarely Board Muni's Most Perilous Buses" August 11, 1994, *San Francisco Examiner* A-5
[249] McCormick, Ed "City Honchos Rarely Board Muni's Most Perilous Buses" August 11, 1994, *San Francisco Examiner*. A-5
[250] "Moving Forward: Making Transit Safer for Women" (1989) Metro Action Committee on Public Violence Against Women and Children, p. 14
[251] Stewart, Kathryn "Preventing Underage Alcohol Access: Policy and Enforcement" (2002) *The Prevention Researcher*, vol. 9, no. 3.
[252] L.A Times, Brotherhood Campaign & Liquor Stores.
[253] Troutt, David Dante. The Thin Red Line: How the Poor Still Pay More. Consumers Union, 1993
[254] Stewart, Kathryn "Preventing Underage Alcohol Access: Policy and Enforcement" (2002) *The Prevention Researcher*, vol. 9, no. 3
[255]Stewart, Kathryn "Preventing Underage Alcohol Access: Policy and Enforcement" (2002) *The Prevention Researcher*, vol. 9, no. 3
[256] A social environmental approach to health and health interventions. Smedley Brian D, Syme Leonard S, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research*. Washington, DC. National Academy of Sciences; 2000:11.
[257] A social environmental approach to health and health interventions. Smedley Brian D, Syme Leonard S, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research*. Washington, DC. National Academy of Sciences; 2000:10.
[258] Sabol WJ, Coulton CH, Korbin JE. Building Community Capacity for Violence Prevention. Presented at: National Network for Applied Research on Violence Prevention Workshop; January 17-18, 2002; San Diego, CA.
[259] Community Builders Tool Kit
[260] Empowerment as an Approach to Poverty
[261] Montgomery, J. 2002. *Planning Index*. p.17.
[262] Sampson RJ, Raudenbush SW, Earls F. Neighborhoods and violent crime: a multilevel study of collective efficacy. *The Am Assoc for the Advancement of Science.* 1997;277(5328:15)918-924.
[263] Gordon, Diana (1973) City Limits: Barriers to Change in Urban Government, New York: Charterhouse
[264] Spicer, David Eddy (1993) *Facing the Problem of Second-Hand Smoke: The Office on Smoking and Health's Decision*, Cambridge: John F. Kennedy School of Government, Harvard University
[265] Gordon, Diana (1973) City Limits: Barriers to Change in Urban Government, New York: Charterhouse
[266] Gordon, Diana (1973) City Limits: Barriers to Change in Urban Government, New York: Charterhouse
[267] Heymann, Philip B. (1998) *A Community Responds: Boston Confronts an Upsurge of Youth Violence*, Cambridge: John F. Kennedy School of Government, Harvard University)
[268] The Forum for Youth Investment (2002) Community Conversations for and with Youth: Bringing New Discipline to Community Conversations to Connect the Dots and Add up the Pieces, httm://www.forumforyouthinvestment.org

[269] "A Community Builder's Tool Kit", The Institute for Democratic Renewal and Project Change Anti-Racism Initiative. 1998
[270]"A Community Builder's Tool Kit", The Institute for Democratic Renewal and Project Change Anti-Racism Initiative. 1998
[271] "A Community Builder's Tool Kit", The Institute for Democratic Renewal and Project Change Anti-Racism Initiative. 1998
[272] "A Community Builder's Tool Kit", The Institute for Democratic Renewal and Project Change Anti-Racism Initiative. 1998
[273] Emmons KM. Health behaviors in a social context. In: Berkman LF, Kawachi I eds. *Social Epidemiology.* New York: Oxford University Press; 2000:pg. 251.
[274] *Journal for the Community Approach*, "Best Practices/ Promising Practices" vol.5.4, Spring 2001.
[275] "Building Healthy and Safe Communities" (1994) *Northern California Council for the Community*, p 36.
[276] Stewart, Kathryn. "Preventing Underage Alcohol Access: Policy and Enforcement" (2002) *The Prevention Researcher*, vol. 9., no. 3.
[277] Eisler RM. The relationship between masculine gender role stress and men's health risk: the validation of construct. In: Levant RF, Pollack WS, eds. *A new Psychology of Men.* New York: Basic Books; 1995:207-225.
[278] Green, Jacqueline and O'Connell, Jonathan, (2002) "Promoting Responsible Fatherhood in California: Ideas and Options, *The Social Policy Action Network*
[279] Baron, Juliane and Sylvester, Kathleen (2002) "Expanding the Goals of Responsible Fatherhood Policy: Voices from the Field in Four Cities", *Social Policy Action Network and the National Practitioners Network for Fathers and Families*, p.
[280] Green, Jacqueline and O'Connell, Jonathan, (2002) "Promoting Responsible Fatherhood in California: Ideas and Options, *The Social Policy Action Network*
[281] Kandrack M, Grant KR, Segall A. ("Gender Differences in Health Related Behavior; Some Unanswered Questions." *Social Science Medicine*, 1991; 32:579-590.)
[282] Green, Jacqueline and O'Connell, Jonathan, (2002) "Promoting Responsible Fatherhood in California: Ideas and Options, *The Social Policy Action Network*
[283] Green, Jacqueline and O'Connell, Jonathan, (2002) "Promoting Responsible Fatherhood in California: Ideas and Options, *The Social Policy Action Network*
[284] Baron, Juliane and Sylvester, Kathleen (2002) "Expanding the Goals of Responsible Fatherhood Policy: Voices from the Field in Four Cities", *Social Policy Action Network and the National Practitioners Network for Fathers and Families*, p. 8
[285] "Neighborhood Problem Solving: Engaging Communities as Partners" (2001) *PolicyLink*, p. 9
[286] "Neighborhood Problem Solving: Engaging Communities as Partners" (2001) *PolicyLink*, p. 10
[287] "Neighborhood Problem Solving: Engaging Communities as Partners" (2001) *PolicyLink*, p. 84
[288] "Neighborhood Problem Solving: Engaging Communities as Partners" (2001) *PolicyLink*, p. 115
[289] "Neighborhood Problem Solving: Engaging Communities as Partners" (2001) *PolicyLink*, p. 112
[290] *Active Community Environments* (factsheet). Centers for Disease Control and Prevention. June 2000.
[291] West, M.H. 2001. *Community-Centered Policing: A Force for change*. Policy Link. 2001. p. 22.
[292] Applied Survey Research, The Tellus Project: Improving the Quality of Life in Monterey County, August 1996
[293] Cohen, L. and Erlenborn, J. 1999. Cultivating Peace in Salinas: A Violence Prevention Framework. Prevention Martella Printing: Salinas, CA.
[294] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[295] Mutual Assistance Network Annual Report 1999-2000. Mutual Assistance Network
[296] "Creative Community: The Art of Cultural Development" (2001) *The Rockefeller Foundation*
[297] "Fifteen Tools for Creating Healthy, Productive Interracial/ Multicultural Communities: A Community Builder's Tool Kit", *The Institute for Democratic Renewal and Project Change Anti-Racism Initiative*, p. 11
[298] "Fifteen Tools for Creating Healthy, Productive Interracial/ Multicultural Communities: A Community Builder's Tool Kit", *The Institute for Democratic Renewal and Project Change Anti-Racism Initiative*, p. 13
[299] "Fifteen Tools for Creating Healthy, Productive Interracial/ Multicultural Communities: A Community Builder's Tool Kit", *The Institute for Democratic Renewal and Project Change Anti-Racism Initiative*, p. 13
[300] "Fifteen Tools for Creating Healthy, Productive Interracial/ Multicultural Communities: A Community Builder's Tool Kit", *The Institute for Democratic Renewal and Project Change Anti-Racism Initiative*, p. 19

[301] "Fifteen Tools for Creating Healthy, Productive Interracial/ Multicultural Communities: A Community Builder's Tool Kit", *The Institute for Democratic Renewal and Project Change Anti-Racism Initiative*, p. 30
[302] "Building Healthy and Safe Communities" (1994) *Northern California Council for the Community*, p. 54
[303] Kretzmann, John P. and McKnight, John L., (1996), A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities, ACTA Publications: Chicago.
[304] Kretzmann, John P. and McKnight, John L., (1996), *A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities*, ACTA Publications: Chicago.
[305] Kretzmann, John P. and McKnight, John L., (1996), *A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities*, ACTA Publications: Chicago.
[306] Kretzmann, John P. and McKnight, John L., (1996), *A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities*, ACTA Publications: Chicago.
[307]Kretzmann, John P. and McKnight, John L., (1996), *A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities*, ACTA Publications: Chicago.
[308] Brotherhood Crusade Merchant Education Project
[309] Kretzmann, John P. and McKnight, John L., (1996), *A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities*, ACTA Publications: Chicago.
[310] Kretzmann, John P. and McKnight, John L., (1996), *A Guide to Mapping Local Business Assets and Mobilizing Local Business Capacities*, ACTA Publications: Chicago.
[311] "Fifteen Tools for Creating Healthy, Productive Interracial/ Multicultural Communities: A Community Builder's Tool Kit", *The Institute for Democratic Renewal and Project Change Anti-Racism Initiative*, p. 13
[312] Connecticut Assets Network. *Glossary of Terms.* Available at: http://www.ctassets.org/library/glossary.cfm. Accessed on February 11, 2003.
[313] Jackson RJ, Kochtitzky C. *Creating a Healthy Environment: The Impact of the Build Environment on Public Health.* Sprawl Watch Clearinghouse Monograph Series. Washington D.C.. p. 1-19.
[314] PolicyLink. Reducing health disparities through a focus on communities. A PolicyLink Report. Oakland, CA: 2002.
[315] Berkowitz B, Wadud E. Identifying community assets and resources. Available at: http://ctb.lsi.ukans.edu/tools/en/sub_section_main_1043.htm. Accessed: December 2, 2002.
[316] Connecticut Assets Network. *Glossary of Terms.* Available at: http://www.ctassets.org/library/glossary.cfm. Accessed on February 11, 2003.
[317] Ferguson Ronald F, Stoutland Sara E. Introduction. In: Ferguson Ronald F, Dickens William T, eds *Urban Problems and Community Development*. Washington, DC: Brookings Institution Press;1999:4.
[318] Ferguson Ronald F, Stoutland Sara E. Introduction. In: Ferguson Ronald F, Dickens William T, eds *Urban Problems and Community Development*. Washington, DC: Brookings Institution Press;1999:4.
[319] Cheadle A, Wagner E, Koepsell T, Kristal A, Patrick D. Environmental indicators: a tool for evaluating community-based health-promotion programs. *Am J of Prev Med.*. 1992;8:345-350.
[320] *What Factors Foster Resiliency Against Violence?* Preventing and Reducing School Violence. Fact Sheet #5.
[321] Putnam, Robert. *Bowling Alone: The Collapse and Revival of American Community.* New York, NY: Simone & Schuster, 2000.
[322] Forum for Youth Investment. *Our Ideas About Youth.* Available at: http://www.forumforyouthinvestment.org/ideasabout.htm. Accessed on February 11, 2003.
[323] *Preventive Analysis: Utilizing a Primary Prevention Approach in the Elimination of Health Disparities* Prevention Institute report prepared for The California Endowment:2002.
[324] Peters RM. The negative effect of the clinical model of "health": implications for health care policy. *Journal of Health Care Finance*. 1998;25:78-92.
[325] Pincus T, Esther R, DeWalt DA, Callahan LF. Social conditions and self-management are more powerful determinants of health than access to care. *Annals of Internal Medicine*. 1998;129:406-411.
[326] Blum HL. Social perspective on risk reduction. *Family and Community Health*. 1981;3(1):41-50.
[327] "Promoting Health: Intervention Strategies from Social and Behavioral Research." *Institute of Medicine.* (2000). National Academy Press website. Available at: http://www.nap.edu/openbook/0309071755/html/1.html, accessed December 20, 2002.
[328] add citation
[329] "Promoting Health: Intervention Strategies from Social and Behavioral Research." *Institute of Medicine.* (2000). National Academy Press website. Available at: http://www.nap.edu/openbook/0309071755/html/1.html, accessed December 20, 2002.

[330] Adler NE, Newman, K. Socioeconomic Disparities In Health, Pathways And Policies. *Health Affairs*. 2002:21(2):60-76.