Creating Sustainable Healthy Changes in School: A Community-Based Participatory Research Approach

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Background

Despite over two decades of concentrated efforts on identifying and developing health interventions to reduce and eliminate health disparities, African American and Latino communities continue experience disproportionate morbidity and mortality burdens in the United States.[1] The fundamental conditions that make tackling persistent health disparities a challenge require long-term commitments in a world of short time and resource limited grants. As a result, many researchers and community leaders have come to utilize community-based participatory research (CBPR) approaches. The hope is that the resulting capacities or systems developed through the collaborative process are accepted and adopted by community members, address root causes or problems, and are sustainable over time and thus more likely to lead to discernable outcomes.[2] Among the challenges in designing sustainable, community-oriented interventions that reduce or eliminate health disparities are a lack of understanding among key stakeholders including community members and institutional partners about the priorities and interests of each and a lack of a shared commitment to common goals. Also, competing needs and conditions in the communities such as the lack of affordable housing, employment opportunities, and reliable public transportation systems vie for the attention and resources of community members and community leaders. Together these challenges along with others militate against the establishment and adoption of processes designed to create long-term structural changes in communities that correspond to health promoting conditions. Overcoming these challenges requires intentional work to develop a shared perspective and common language among partners, a forum for sharing and learning about organizing models, perspectives, and points of influence, and a dialogue about expectations for information collection and use. It is through this work that existing community and external resources can be can be mobilized in support of health interventions and institutionalized into sustainable practices and priorities that remain in the communities.

Methods

This case study examines how members of community-based organizations (CBOs) with independent missions and goals developed a shared perspective on health, and once established allowed each of the organizations to embrace a public health/prevention focus without compromising the unique mission and identity of each organization. We describe how the CBOs' existing organizing strategies corresponded to a social ecological approach to understanding health and influencing health outcomes. The CBO strategies for organizing and mobilizing members were consistent with a social ecological approach to health with the acknowledged multiple levels of influence on behavior, and thus the resulting health promoting activities and capacities were created at both the individual and at the community/policy levels. Consistent with organizing strategies with which the CBOs were very comfortable and committed to following into the future, the CBOs created new protocols resulting in sustainable structures enabling community members to make health-promoting activities part of their daily lives as well as to become part of the policy-making arm of local schools within their communities. Implications for using these techniques for other public health efforts are discussed.

The Project: *Partnership to Reduce Disparities in Asthma and Obesity in Latino Schools*

The goal of the *Partnership to Reduce Disparities in Asthma and Obesity in Latino Schools*, a NIEHS-funded initiative, was to explore how parent and community organizations in a large, urban district can influence schools and district-wide policies to establish a healthier environment for students residing in Latino communities. In recent years, the school environment has emerged as an important venue in which to address children's health.[3,4] In fact, the former Surgeon General acknowledged schools as key settings to address overweight and obesity in children and adolescents in the *Call to Action to Prevent and Decrease Overweight and Obesity*. More recently, schools were identified as a "prime target" for influencing the choices and behavior of parents and children and ultimately reducing obesity and promoting health.[6] Schools are uniquely positioned to prevent obesity by providing an environment that promotes healthy eating and active lifestyles in children. Thus, three of the specific objectives of the Partnership to Reduce Disparities were to: 1) Develop a better understanding of the impact of the school environment, and a large school district's policies

that influence this environment, on obesity and asthma; 2) Develop a common language between "professionals" and "community members/parents" that could be used to motivate school administrators to take action to improve the school environment, and; 3) Evaluate two different models of community organizing in a school-based setting. Project partners included The Healthy Schools Campaign (HSC), West Town Leadership United (WTLU), Little Village Environmental Justice Organization (LVEJO), and the University of Illinois (UIC).

Community Context, Health Disparities and Social Justice: Developing a common language

Increasingly, public health practitioners and researchers have focused on communities as receptive environments and locations for health interventions, and CBPR in particular has emphasized the community as integral to both collective and individual identity and action.[7] *The Partnership to Reduce Disparities* involved three CBOs, one a statewide organization devoted to improving school health environments and two neighborhood centered organizations located in two predominantly Latino neighborhoods.[8] Over the course of several months involving multiple meetings among the potential partners, a proposal was collectively developed and funded to create a partnership to reduce obesity and asthma in schools located in Latino communities.

Healthy Schools Campaign (HSC), a 501(C)3 statewide organizations founded to improve student health and school health environments served as the catalyst for the collaboration. HSC's work in helping schools eliminate the use of environmental toxins in cleaning, use green design, and partner with local sources of organic food is grounded in the belief that healthy children thrive academically and otherwise in healthy environments. Initially, HSC used more traditional outreach techniques such as participation in health fairs and making presentations in schools to promote school health. These initial efforts failed to generate the desired parent interest and action in the communities where significant health disparities were present. Thus, instead of working through CBOs with existing health interests and alliances and encouraging them to become more active in the realm of school health, the HSC employed a strategy of seeking out CBOs that were first and foremost known for their organizing reputations reasoning that CBOs strong in community organizing and in leadership development would be well suited to foster parent leadership and action in creating school and district wide change. HSC identified two CBOs with strong reputations for community organizing which were located in two distinct Chicago communities, West Town and Little Village.

West Town is comprised of several distinct neighborhoods reflecting an ever-evolving composition of diverse ethnic groups. In the latter half of the twentieth century West Town became a popular settlement site for Latino immigrants, initially Puerto Ricans and later Mexicans and Guatemalans.[9] West Town is a rapidly gentrifying neighborhood, resulting in changing demographics with the Latino population declining from roughly 62% in 1990 to 47% in 2000.[10,11] Little Village or South Lawndale neighborhood is also considered a port of entry for Latino immigrants with 83% of its residents of Mexican heritage in 2000.[12] In addition to a host of other health disparities, both West Town and Little Village children experience much higher rates of overweight/obesity than do children nationwide.[13] In West Town about 49% and in Little Village about 40% of the children are obese or overweight, in comparison to 26% nationwide. In West Town approximately 20% of the children have been diagnosed by a physician as having asthma compared with 12% nationwide. Pediatric asthma rates in Little Village were about the same as national rates.

Both WTLU and LVEJO emerged as organizations in response to perceived needs in their respective communities to address issues they believed disproportionately affected Latinos and stem from pervasive social injustice experienced by many Latinos based on their ethnicity. The work of WTLU concerned immigrant rights and immigration reform, crime, affordable housing, employment, and equity in education. LVEJO had established projects related to environmental health such as a lead detection and removal programs and urban agriculture programs, but also devoted considerable organizational resources to increasing

public transit options within the community, youth programs, and immigrant rights. Thus both LVEJO and WTLU had a pre-existing race/ethnicity social justice framework through which members understood and explained the barriers they faced. These barriers include: "Anti-Latino" or "Anti-Brown and Black" immigration policies leading people to enter the U.S. illegally and tolerate abusive employment practices because they feared identification and deportation; race/ethnicity employment discrimination and high unemployment in surrounding communities of color; lack of police response to crimes committed within their communities and rampant police brutality; erosion of affordable housing and rapid gentrification that force Latinos out of the communities, dispersing them into far-flung suburbs and eroding opportunities for social support, and; a under-resourced school system that did not adequately prepare their children to compete for slots in good colleges and universities. A social justice framework identified the cycle of poverty and hand-to-mouth existence as deeply rooted in racism and discrimination.

Because both organizations had a well-developed social justice framework for interpreting social problems within their communities, they were highly receptive to discussions about "health disparities," which are discussed in the public health and medical literatures as resulting in part from pervasive racism and discrimination.[14,15,16,17,18,19] For members of LVEJO and WTLU, the fact that Latinos were more likely suffer from diabetes, asthma, hypertension, and a host of other medical conditions made sense to them just as Latinos were less likely to be employed, more likely to be stopped by the police, less likely to live near convenient public transportation, more likely to live by incinerators, and less likely to find quality affordable housing developed in their neighborhoods. In short, it was part of a persistent and consistent pattern of discriminatory conditions. During community presentations on asthma and obesity, community members and CBOs leaders frequently remarked that while they may have understood that an individual family member might have had diabetes or hypertension or asthma, the notion that *as a social group* Latinos were more likely to have these conditions both fit with a pre-existing social injustice framework. Because health, employment, housing, crime, and other disparities all shared the same root cause—race/ethnic social injustice—the partners found the shared perspective that allowed them to jointly interpret and understand health disparities as rooted in racial and ethnic discrimination. Furthermore, because community members understood the issue of health disparities through the framework of social injustice—that obesity and asthma were *collective problems*— the solution also required *collective action*. The routes to those collective actions, however, were to be paved with individual acts and were grounded in the organizing strategies and models of each organization.

Organizing Models and Social Ecological Framework

The organizing models of each CBO, while unique to each in some respects, directly corresponded to social ecological framework for understanding and influencing health outcomes. The social ecological or ecological perspective in health acknowledges the interaction between and interdependence of, factors within and across all levels of a health condition.[20] Thus, an ecological perspective recognizes that behavior affects and is affected by other levels of influence and that there is a reciprocal relationship between individuals and the social environment.[21] Moreover, while there has been considerable attention paid to developing health education and clinical interventions that influence individual knowledge, attitudes, and behaviors on achieving living healthier lives, there is a growing recognition of the need transform the social environment through community-level interventions such as those suggested by the Centers for Disease Control and Prevention (CDC) and the American Heart Association (AHA).[22,23] In the case of the *Partnership to Reduce Disparities* the utilization of the CBOs organizing techniques within the social ecological framework contributed to the development of sustainable practices at the individual and structural levels.

LVEJO Organizing Model

LVEJO uses a popular education model to build its organization and to accomplish its goals. [24,25] Popular education is an educational approach used to make participants more

aware of how the individual's experiences are connected to larger social issues. The Popular Education process begins by critically reflecting on, sharing, and articulating with a group or community what is known from lived experience. The participants critically examine and learn from the lessons of past struggles and from concrete everyday situations in the present. This cyclical process continues with analysis and reflection upon everyday experiences aimed at enabling people to discover solutions to their own problems and to specify a set of concrete actions to transform social conditions.[26,27]

As enacted by LVEJO, the Population Education approach uses a "one-on-one" organizing and outreach technique that relies on identifying the link between personal experience and self-knowledge with the larger society. First, LVEJO staff members begin by informally soliciting issues and concerns of community members in public spaces in the community such as schools and churches. Issues nominated by parents are diverse and have included crime and safety concerns, immigration issues, employment problems, and access to health care. LVEJO staff attempt to provide referrals and resources to address any concerns parents and community members may have. After the parents initial concerns were addressed, LVEJO staff members broached the issue of obesity by talking about their own struggles with weight and healthy eating since coming to the United States. One particularly effective technique involved using hand-drawn figures to illustrate a "stick" or ideal weight person and a rounded or overweight person. The LVEJO leader would then say "When I lived in Mexico, I looked like this *(pointing to the straight stick figure)*. After being in the U.S. a couple of years, I looked like this *(pointing to the rounded stick figure)*." In almost all instances those statements would be met by avid agreement to which the LVEJO leader would ask "How is your life different now in the U.S.? What do you eat that is different? Tell me about your usual day. How can we get back to this *(pointing to the straight stick figure)*? " In the course of the ensuing discussion community members would report a substantial decline in all forms of physical activity such as walking and playing out doors and in consuming healthy fresh foods and sharp increases in the use of automobiles and in the consumption of American fast food. In discussing how they could get back to a healthy weight LVEJO community leaders were able to solicit ideas from community members about what concrete actions would work for each of the community members. In short, each member developed a personal plan for themselves and for their families.

Once the issue of personal health was established and community members developed plans for leading healthier lives LVEJO staff members and community members engaged in communal activities that would help community members achieve their goals such as shopping for healthier foods and holding cooking classes in which community members would modify favorite recipes to reduce fat and increase fruits and vegetables. As parents were making immediate changes in their own personal and family lives, they and LVEJO staff jointly identified or developed community resources for promoting health involving broader social networks over time. Activities included aerobics classes (sponsored by a local health clinic), walking groups, and dancing classes using Kraft Foods' *Salsa, Sabor y Salud* (Food, Fun and Fitness). Other activities recognized existing knowledge and ability within the community such as "Family Fitness Day" at which a parent or a group of parents taught a lifetime fitness skill or sport such as volleyball, tennis, and soccer. In addition many parents had significant agricultural knowledge and skill.[28] In partnership with a local organization, Green Corps, which provided seeds and gardening hardware, parents planted community and home gardens.

As parents became more involved in the developing healthier lifestyles in their own homes and with their neighbors, many began to recognize and address community and structural barriers to healthy lifestyles. For example, when parents and community members found that local grocery stores within Little Village did not carry fresh produce or other healthy Mexican foods, as a group they visited the grocery stores and negotiated with owners to carry additional items. Parents conducted a survey of elementary school children about

what foods were offered in the schools, what was consumed, and how well the children liked the food, recognizing that most children ate two meals a day at school. Based on the survey results and other nutrition information, parents and community leaders met with school principals and school district officials and secured a commitment to open salad bars, allow schools to eliminate whole and chocolate milk from the menu, and increase the availability of healthier, culturally appropriate foods in neighborhood schools. The parents and community members reasoned with school officials that it put parents in a very awkward position—even was hypocritical—to promote the consumption of more fresh fruits and vegetables and less fat and meats at home while the schools continued to serve highly processed vegetables and fruits, breaded and fried meats, hamburgers, hot dogs, and whole and chocolate milk. Finally, when parents and community members discovered that an earlier decision to have a "closed campus" under the rationale of enhanced school safety eliminated outdoor AND indoor recess and that many schools had received a waiver eliminating the need for the state required physical education under the professed need for additional instructional time for meeting the standards of No Child Left Behind, they became actively involved in efforts directed toward requiring recess and physical education in all public schools in Chicago.

Thus the popular education organizing approach accomplished several goals. First, it allowed community members to identify the problem, the causes of the problem, and potential individual and structural solutions, thereby creating a sense of self-efficacy among community members regarding matters of health. Next, because the technique emphasizes the link between individual and community/structural levels of understanding and action, community members were able to work **simultaneously** toward proximal and short-term changes (e.g., adding two fruits and one vegetable) and longer-term changes (e.g., changing elementary school policy to return outdoor recess). By working toward individual and community/structural change, LVEJO and community members were able to keep motivation high by being able to show success in practicing the process of making changes while recognizing that the community/structural barriers may take longer to modify in ways that would support and enhance a healthy community environment. The popular education technique reinforced that each person can have responsibility for making healthy choices only when there are true choices—without real opportunities to eat healthier foods or to exercise admonitions to do are revealed as insensitive and ignorant of community conditions. Finally, because the popular technique connects personal experience with the larger society, it was necessary that parents personally felt engaged and committed to improving their own home health environments before they felt they could honestly advocate changes for their children's school health environment. This reinforced the health messages and modeling of healthy lifestyles in the two environments in which children spend most of their waking hours.

WTLU Organizing Model

WTLU uses what it terms a "Family-Focused Leadership and Organizing" model to build its organization and to accomplish its goals. This model too recognizes that change is more likely to occur when multiple levels of influence converge rather than conflict or are absent. The "Family-Focused Leadership and Organizing" model involves three stepped phases designed prepare laypeople to take social and political action of increasing magnitude in terms of garnering support and resources. At each phase participants are encouraged to focus on goals that affect and engage more people within the community and require different skills. Participants must successfully complete each phase of training and demonstrate skills before moving on to the next training phase. Phase I training focuses on influencing one or two conditions most proximal to the trainees and involves their participation *as individuals*, participating in classrooms as teacher aides, in community festivals, and working with other parents to create safer passages around their children's schools. In Phase II, trainees focus on building a constituency to help achieve goals affecting more than goals. Phase II training consists of workshops in methods of community outreach and planning, specifically in participating in door-to-door outreach and convenience sample surveys to build relationships

within the community and to involve other parents and stakeholders. When an expanded constituency is achieved the leadership trainees and supporting participants work together to achieve three to five longer-term goals reflecting *collective or organizational activities* in service to a broader community. The final phase trains parent leaders to be active community organizers and direct program initiatives. Phase III Training includes parents who wish to become Phase I and Phase II leadership trainers, to open and govern schools as community centers, and to collaborate across communities to influence public policies that affect schools/communities resource allocation. Parent leaders who complete the final phase often take *substantial leadership positions in collective or organizational activities* that are community-wide and cross-communities policy change.

The WTLU process clearly involves a hierarchy of skills, commitment, and leadership responsibilities at each level of training. An essential component is that at each level of training, the trainee is encouraged to identify the goals and outcomes that are specific to the goals they want most achieve at that level. Each community member with whom WTLU comes in contact is considered and treated as a potential community leader, but the first step is to become an agent of change within one's immediate environment. Thus, all potential community leaders engage in making changes within their own lives—in the context of this project learning to modify recipes to include less fat and more fruits and vegetables, to become more physically active, to serve their children skim and low-fat milk rather than whole, to play soccer or kick ball with their children and take family walks—before moving on to the next level of training and community action. Because each movement from Phase I to Phase III involves trainees engaging in increasingly formalized efforts to influence policies that govern larger and larger social/political systems, the levels at which community members were planning and working to exert influence moved to broader community and social institutions. Those who complete the final phase of training are encouraged to become active community leaders in securing public and private funding for community initiatives as well as influencing policies affecting the community. Thus the final phase of training results in highly skilled, activist members of the CBO who focus on structural solutions to community problems that involve negotiation with existing institutions.

The process by which leaders realize each phase of leadership development corresponds directly to a social ecological approach to health and thus for WTLU members, the approach was familiar and acceptable to members. Because WTLU's mission and approach to developing leaders is predicated on the concept of mutually reinforcing spheres of influence of individual action and social action for change in addition to helping participants take healthy individual actions WTLU and its partner CBOs reasoned that establishing a protocol for changing school policy at the local level was a necessary but not sufficient condition for improving the school health environment.

Speared-headed by WTLU with the support of LVEJO and HSC, the partners determined that one method of institutionalizing health as an important component of planning and policymaking for local schools would be to become part of the policymaking body of local schools. Unlike other public school systems where nearly all responsibility and power resides in a district's central administration, these powers were shifted to local school communities in 1988 under a school reform initiative. Under this movement to local control, each of the schools formed an elected Local School Council (LSC), comprised of parents, teachers, community members, and a student representative. LSCs were vested with a number of powers including the authority to hire and fire principals and to approve school spending and improvement plans. Thus any policy or program change that affected the local school health environment would have to involve LSCs. Thus, the Partnership determined that training community members who were already involved in the Partnership's activities to become members of LSC would foster the inclusion of improving the school's health environment on the LSC. Over the two-week training period, representatives from the three CBOs trained over thirty community members to become LSC members. As of this

writing, thirty Partnership-trained parents and community members are serving on their LSCs, and more than half of them have instituted action plans for developing, implementing and evaluating local school wellness plans that emphasize increased physical activity and healthier eating throughout the school day.

Similar to the popular education organizing technique employed by Little Village, the "Family-Focused" organizing approach used by West Town began with community members identifying problems, causes of the problems, and potential individual and structural solutions, and creating a sense of self-efficacy among community members regarding health. The training protocol begins with personal actions targeted on making changes in areas closest to the trainees and thus emphasizes individual level change. In subsequent trainings, the link between individual and community/structural levels of understanding and action become more pronounced, and similarly to the popular education approach, WTLU community members were able to work **simultaneously** toward proximal and short-term changes and longer-term changes (i.e., locating a health clinic at a community school). Again, motivation was kept high by working simultaneously toward individual and community/structural change by showing success in achieving short-term goals while working collectively to overcome community/structural barriers.

Both organizations started by identifying individuals who *might be* interested in changing some element of their community or environment. Through a series of one-on-one contacts and community-centered encounters over time, community members gained more in-depth knowledge of the issues and of organizing strategies that can be used to bring about change at the structural level. In all cases the CBOs accepted as important and valid any of the concerns that were of interest to members of the community—they rarely started with health and never began by talking about obesity. Only after relationships were developed and solidified and the CBOs were able to help the individuals did they eventually broach the issues of food, nutrition and exercise. By starting with targets close to community members—such as serving as a teachers' aide or joining a walking group—CBOs were able to reinforce the notion that change was achievable. By working collectively, the CBOs were able to draw on each others strengths and the power of the group ("junto prodemos") to challenge powerful local institutions. By understanding the importance of social structure and institutions on individual choice and opportunities, the CBOs were able to identify points of entry to become part of the very institutions they were trying to change without abandoning their primary commitments to making school environments healthier for their children. The level of sophistication of the CBOs, reflected in their organizational missions and successes in domains outside of health, contributed to their eagerness to work toward implementing trainings and collective actions that contributed to the project's sustainability. Even after the initial funding for the Partnership has ended, there will still be trained LSC members committed to creating healthier schools, community members practicing healthier behaviors in their homes and communities, a training protocol that has been replicated and disseminated well beyond the initial two communities and two schools, and six new CBOs in partnership with the original three committed to health as an issue of social justice for their communities.

Discussion

One of the central tenets of CBPR is to identify and build on existing strengths within the community.[29,30] In addition to adhering to this principle on moral grounds, the practical implication of doing so is that if the endeavor truly builds and does not merely replicate existing services and resources is that the research program or partnership becomes one of leveraging existing resources in service of achieving a new objective for all of the partners and especially for the CBOs. By adding non-redundant health and wellness information to a tried and true method for reaching out into the community and supporting indigenous leadership development, the *Partnership to Reduce Disparities* capitalized on the strength of weak ties.[31] That neither WTLU nor LVEJO had any pre-existing commitment on developing and implementing health programs was not a barrier to their participation in a health

promotion intervention. In fact, that the CBOs were able to identify a new need in their communities, provide a network and referrals to help to address those needs, and create a leadership development protocol to institutionalize parental health advocacy as a focal point of school policy gave the CBOs a new venue through which they could better serve their communities. Health was a way of drawing new community members in as well as providing new resources to already engage community members. The achievement of the CBOs' goals and work toward fulfillment of their missions allowed them to reconcile what might have become competing demands for their resources and forced them to choose between health and addressing other important community needs.

Health became important to the CBOs only when CBOs members were convinced that health and issues associated with health were truly relevant to community members. Only then could health become assimilated into the missions of the CBOs thereby increasing the probability that the goals of the *Partnership to Reduce Disparities* would be pursued through continued efforts on the parts of the CBOs. The relevance of health was apparent as it was discussed in terms of health disparities because health disparities resonated with lived experiences of community members. In the case studies discussed here most important to the CBOs was not that health disparities exist or the strengths or weakness of the various explanations of the causes of health disparities but rather what was to be **done** in the face of such disparities: the CBOs applied their organizing techniques to health and fostered the development of individual, social and institutional actions designed to create sustained social change. It was the same approach that WTLU and LVEJO used in countless other campaigns and so the tools for doing the work and perhaps more importantly that the CBOs had practiced implementing those tools across a wide range of issues reduced the need for external resources for training and supporting change on health

In identifying CBOs with whom to partner the HSC intentionally selected CBOs with solid records in community organizing their communities, were "known" to other CBOs and community activists in a large urban area, and had experience in engaging in collective action for changes in policies. The decision to select two groups that had similar organizing approaches—connecting individual action to social structure and policy change—fostered an early consensus among the CBOs regarding the necessity of concomitant efforts at the individual and policy levels. In contrast to CBOs that are primarily service providers organizing CBOs are devoted to and structured to develop community leaders to carry out the work of accomplishing policy change. It is by building local leadership skills and knowledge with the goal of realizing locally driven policy changes that a sustained commitment is achieved.

It is possible that the secular trend of an increased interest in health, specifically in the growing problem of obesity, might have led members of the two communities discussed in this case study to embrace the issue of health irrespective of the workings of the *Partnership to Reduce Disparities*. However, instantiation of issue salience at an individual level does always translate into the creation of institutional changes that solidify the position of a topic on a policymaking body's agenda. In the case discussed here the success of this approach depends in part of the continued role of LSC in making school health policy, the continued interest of trained community members, and an ability to retain health as an agenda item in the face of competing issues and demands of schools as deliberated in the LSCs.

For public health practice, the case study described here illustrates how the CBPR principle of building on existing community assets can result in the development of sustainable protocols that are driven by the community and, with the support of evidence-based health information from other partners and adapted for local conditons, can be used to improve community health environments. It also suggests that a reflective discussion of CBOs' missions and strategies can reveal commonalities with robust public health frameworks, such as a social ecological approach to understanding health, and thus facilitate consensus in collaboratively developing a plan for intervention. Finally, when seeking community partners for

health interventions potential partners need not demonstrate expertise in or interest health to be effective in developing health interventions. Rather, selecting an organization without an existing commitment to health may result in reaching community members who are outside the range of existing health information dissemination vehicles. Finally, while deployable their very existence, when working with communities touched by health disparities the link between those disparities and social injustice provides a bridge in understanding among public health professionals and community members.

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