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# Congregation For Public Health Examines Community Engagement Knowledge Of Program Administrators And Community Health Advisors Using Social Capital And Community Capacity

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CONGREGATION FOR PUBLIC HEALTH EXAMINES COMMUNITY ENGAGEMENT KNOWLEDGE OF PROGRAM ADMINISTRATORS AND COMMUNITY HEALTH ADVISORS USING SOCIAL CAPITAL AND COMMUNITY CAPACITY

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HEALTH EDUCATION AND HEALTH PROMOTION

## ABSTRACT

This research study was designed to examine and compare how community engagement knowledge of Program Administrators and Community Health Advisors (CHAs) can be shaped and affected by social capital and community capacity. This was achieved by analyzing the Congregations for Public Health's Search Your Heart Program. The analysis used a three one-way fixed-effects ANOVA model, one for each of the three research questions. Overall, the results showed that upon examination of each of the three relationship hypotheses there were no primary differences in average knowledge among the groups. The relationships were examined by characteristics such as project role, CHA training knowledge, years of volunteer experience, type of volunteer experience, and community engagement knowledge. At the end of the study, it was determined that the Program served as an excellent model for using CHAs in the promotion of community engagement. The presence of CHAs is proving to be beneficial in changing health outcomes when combined with concepts such as social capital and community capacity.

## DEDICATION

This dissertation is dedicated to the memory of the late Julia Perry Davidson. You were my light and my inspiration. Your love was never ending and unconditional. I am where I am because you worked hard and walked through hard times and rain to take care of “Your Girls”! I could not ask for three better sisters. Thank you to Ingrid, Mica, and Karen for having my back at all times.

To my other half, Roderick McCall, words cannot express how much I love you and appreciate all your hard work and support. When I thought I had lost it all, God brought you into my life. You are the rock that holds it all together. I can truly say that you are not only my husband, but my soul mate. I look forward to growing old gracefully with you!

To the best son in the whole wide world, I must say you are the greatest “R.J.” I thank you for being so understanding and the best study partner a mother could have. I’ll always remember how I held you in my arms as I studied late at night and into the wee hours of the morning. Although you were only a baby at the time, you even volunteered the use of your crayons to write my paper. I know that one day you will carry on the torch!

I also give thanks to all of my extended family and friends because you never let me give up. You always had a word of encouragement.

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# CHAPTER 1

# INTRODUCTION

## *Background*

Community Engagement, Social Capital (SC), and Community Capacity (CC) are considered to be primary concepts in the development and implementation of successful community based programs. In addition, these concepts are being widely used in the field of health education and health promotion to address a range of community issues (Speer et al., 2001). According to Speer and colleagues, community participation and empowerment are critical to health educators and in the development of local interventions and health programs. These interventions and programs should incorporate social cohesion and empowerment that embraces building community resource knowledge, encouraging community coordination and referral of services, promoting the utilization of resources, building community capacity and promoting civic engagement through resident participation.

In this research study, community engagement is used as a means to examine and compare community engagement knowledge and its relationship to SC and CC. Social Capital for the study is defined as the resources that are available within communities (Cannuscio, Block, & Kawachi, 2003). These resources can be economical, educational or social related activities or services. CC for the study is defined as a community's ability to define, address, sustain, and strengthen their ability to address needs and utilize resources (Potapchuk & Crocker, 1999). According to Okubo and Weidman (2001),

community engagement means involving residents with program administration, service delivery, governmental relations, and within the development and implementation of problem solving activities for health and/or social issues. These residents are often referred to as Community Health Advisors (CHAs). This concept of engagement is based on the belief that the presence of SC/resources and CC/ability aids program administration, community ownership, and community participation which leads to improved health outcomes. However, the building blocks for improved health outcomes must begin with developing an understanding of how SC and CC can assist in establishing and promoting community engagement.

SC can be linked to social and behavioral change at the individual, family, community and policy level. SC has been defined as the currency/resources produced and utilized by individuals and groups working together (Bloom, 1999). According to Bloom, the characteristics of SC bind the community members through trust, understanding, and reciprocal practice. In contrast, CC investigates whether or not community members possess the necessary skills and ability to use SC (Johnston & Benitez, 2003).Gaining an understanding of how SC and CC work together through community engagement can be complex in nature; however, the results may prove to be beneficial in improving program administration, program design and implementation, and individual and community health.

In order to gain a clear understanding of the collaborative efforts of SC and CC, it is necessary to first lay a foundation outlining their purpose, necessity and define community engagement. SC and CC are often viewed as the primary sources to providing health knowledge and information to others and is perceived as a means to improve or

maintain a community's quality of life (Print & Coleman, 2003). They can also be used as a mechanism to enhance health awareness and community engagement, which in turn generates answers and alternatives for living a healthy lifestyle. Community Engagement for this study is defined as the desire of individuals to engage in community decision-making and action for health promotion, health protection, and disease prevention (Centers for Disease Control and Prevention [CDC], 1995). If you combine community engagement with SC and CC, it provides an opportunity to examine a broad approach for community action. This is examined by comparing their knowledge regarding program administration, program design and implementation, community coordination and referral skills, ability to increase resident access to health services, and by identifying information and skills needed in order to assist other residents with making informed health choices. These choices include learning about preventive measures, gaining access to quality services, and taking advantage of available social and health related resources.

The use of CHAs extends into a similar relationship based on promoting open communication and community volunteerism. CHAs can be described as trained volunteers who help coordinate and reinforce the educational efforts of health care providers (Delbanco et al., 2001). It is an opportunity to link together all stakeholders such as families, individuals, government officials, business leaders and other community representatives. This type of unified approach is being expanded to include SS and CC because it requires self-examination, fosters an understanding of community issues, identifies community resources, improves the community's ability to identify and manage risk, and promotes community wide collaboration to address relevant health and social issues (Is-

rael et al., 1998). CHAs achieve this through their engagement in community based programs that promote training, education, and community-wide engagement.

Nationwide, communities are being forced to pay close attention to the outcry for help from individuals, parents, school administrators, and local leaders (Print & Coleman, 2003). Community members are crying out because they are in a war against time to prevent further increases in the number of community residents being affected by life situations such as drugs, poor nutrition habits, sexually transmitted diseases, violence, poverty, and declining economic and health conditions. These circumstances have lead to an increase in the number of students dropping out of high school, increase in community crime rates, increase in the rate of teen and unwed pregnancies, as well as a growing poverty rate and lack of involvement in community engagement (Guttman & Ressler, 2001). Alleviating these issues is not an easy task when you consider the current state of many communities. There are significant gaps in the understanding of the cultural, political and economic issues that need to be addresses in order to improve and maintain community well being**.** Through the assistance of trained CHAs and the combined efforts of SC and CC, this research study will assist in addressing these issues.

The process of increased community engagement must include a willing public and broad understanding of the issues. Citizens must recognize that there is a problem and at the same time, must have exposure to accurate and appropriate information and training. In addition, communities must have a place, space, or organizer to facilitate citizens coming together (Morse, 2004). Many federal, state, and foundational agencies provide financial funding and web-based resources that incorporate mechanisms for expanding community engagement, SC, and CC (Lasker & Weiss, 2003). For example, the pri-

mary focus areas for these funding agencies include programs geared toward training CHAs that promote early intervention techniques, prevention measures, and ideas for teamwork. These types of programs are essential when citizens contemplate their involvement and role in community engagement. In addition, the combination of these strategies helps them understand the influence of SC and CC along with its impact on training CHAs and the importance of good program administration. Together, they provide opportunities for collaboration at the community level in order to identify critical risk factors, promote the re-ordering of social and health priorities, provide a safer and healthier living environment, and provide opportunities for PAs and CHAs to work together in order to specify meaningful and measurable community goals (Potapchuk & Crocker 1999).

Although these benefits may seem like the best answers for improving all aspects of community living, these concepts also face their share of difficulties and criticisms (Bradley, 1999). For example, participants are often at odds regarding how much outside participation from other communities and/or agencies is necessary, who should participate in promoting community change and there is often conflict in identifying program administration, design and implementation strategies. The only general consensus that is reflected in current literature is the acknowledgement that there is a need for shared responsibility and a growing concern for generating further research into the combined efforts of CHAs, Community Engagement, SC, and CC.

*Study Purpose*

The purpose of the study was multifaceted. It was designed to examine and compare the community engagement knowledge of PAs and CHAs and how it can be shaped and affected by SC and CC. This was achieved by analyzing the Congregations for Public Health Search Your Heart Program. The goal was to assess the effectiveness of the American Heart's Search Your Heart CHA training by examining and comparing the community engagement knowledge of the PAs and CHAs. The intent of the research was to compare their knowledge regarding program skills, resources, capacity and expertise that may be needed for successful implementation and/or service delivery. This was related to SC because it identifies and compares knowledge regarding community resources that may or may not be understood in the initial design of the CHAs training. In addition, this research study investigated if the CHAs training along with program administration equipped volunteers with the skills and expertise needed in order to link residents to available health services and resources within the community. This leads to an examination of available internal and external resources that are present or absent within the community. It is an opportunity to compare program design and administration which is the responsibility of the PAs to implementation of task and activities which is the responsibility of the CHAs.

A final analysis was done to compare the effectiveness of the program design in building and expanding the PA's and CHAs' capacity to identify, maintain, and address health concerns and/or needs. This analysis provided an opportunity to do a comparison using a relationship scale. The relationship scale compared their perception of the program in regards to current operating status, commitment to community engagement, level

of participation, and their understanding of the program design, goal and services. Exploring SC and CC based on community engagement knowledge is important because it helps identify CHA-program characteristics and volunteerism characteristics that are beneficial to design, implementation, evaluation and sustainability. The results may also prove to be an asset for future replication in other rural communities.

*Research Questions*

The following research questions were the framework for this research study:

1. What is the relationship between the community engagement knowledge of the PAs and CHAs in respect to identifying and promoting the development of SC?

2. What is the relationship between the community engagement knowledge of the PAs and CHAs in respect to linking community residents to SC?

3. What is the relationship between the community engagement knowledge of the PAs and CHAs in respect to building and expanding the community's capacity to recognize, maintain, and solve health problems?

*Statement of the Problem*

Community Health Advisors, Community Engagement, SC, and CC are often included in community based programs and activities from an individual perspective. Although, they are considered to be assets to community survival and prosperity, there are problems identifying health education research and community based programs that examines, understands, and/or supports the collective efforts of CHAs, SC, CC, and community engagement. Past literature suggest that much of the emphasis are placed on the

availability of SC (resources), but the capacity (ability) to use, maintain, and expand such resources often goes unresearched (Wallis et al., 1998). The lack of research may be linked to a divided focus. Program Administration and CHA often work in isolation when carry out their roles and responsibilities. They can recognize the lack of engagement throughout the community, but only on limited occasions do they get an opportunity to compare their knowledge and perceptions in regards to program design and implementation, utilization of resources, and community capacity building. PAs and CHAs may consider capacity, access, and sustainability as the key differences between the haves and the have-nots, but they generally view it from a divided perspective. There is a history of beliefs that blame situations such as poverty, poor education, and a declining economy on the lack of SC, CC and community engagement (Bloom, 1999). However, there is a disconnect in recognizing their shared responsibility for these circumstances

Throughout the past decade, educators, community resident, and political leaders have worked to close the health divide by increasing funding and implementing programs aimed at encouraging and increasing community partnerships. However, society is starting to shift from this traditional thinking to a new trend that not only examines the impact of SC and CC on community engagement, but also analyzes how their combined efforts can benefit PAs in designing effective CHA training programs (Israel, 1998). It is an opportunity to transition program administration into community action. For example, in order to improve the quality of health care in many lower and middle class communities, there has been an increase in the use of CHAs. The general focus is to link and/or improve health status through the use of trained community residents who share a common vision for community change and a desire to participate in community engagement (Del-

banco et al., 2001). These residents are trained to assist community residents in accessing health and social resources. This also includes improving their capacity to understand and maintain such resources. However, there is a need to close the transition gap between PAs and CHAs by comparing their knowledge and perceptions on the shared impact of SC, CC and community engagement.

If CHAs and PAs are working to promote and assist individuals or families with making healthy lifestyle choices, then careful consideration must be given to determine how their combined presence and knowledge can serve as empowerment strategies for change. Research suggests that CHAs are imperative in improving a vast majority of economic and social issues (Schulz et al., 2001). However, is true success when social resources diminish because of a lack of use or understanding which may be linked to program administration? According to Putnam (1995), civic involvement can accumulate slowly; however, civic involvement can also be destroyed relatively rapidly when neglected (Putnam). The decay has also been linked to generational changes. For example, community and social volunteerism has declined and is being replaced with new ethical and social values that do not encourage the same civic involvement or loyalty (Putnam, 1995).

Many people agree that there should be an examination of community engagement, SC and CC; however, they disagree when asked if it requires an examination and clarification of all resources, roles, responsibilities, and program administration in order to be effective. Together, these concepts can provide answers to health related issues as they relate to access to program administration, health services, communication, cultural sensitivity, community engagement, and the development and redefining of policies at

the local and national level (Brach & Fraserirector, 2000). Although the use of community engagement alone cannot replace having the knowledge, skills, and aspiration for community transformation, when you combine it with SC and CC it can promote shared responsibility. This is important when one considers the current trend to incorporate the use of CHAs into all aspects of community living. Through the use of CHAs and key direction from PAs, a comparison and examination of community engagement knowledge, SC, and CC can play a critical role in improving program delivery and implementation. Their combined efforts will also lead to changing the quality of life for all individuals involved.

*Definitions*

SC can be defined as the resources available to individuals and groups through social connections and social relations within a community (Cannuscio, Block, & Kawachi, 2003). The availability of these resources provides citizens with access and the ability to live productive and meaningful lives. The end result of SC is trust, reciprocity, cooperation and communication (Bloom, 1999). The engagement and support of diverse community resources help develop and enhance learning opportunities. The benefits are linked to improving health, reducing crime, and encouraging continued volunteerism. Robert Putnam, Ph.D., a leading writer in the area of community and civic engagement shares this same viewpoint and provides further clarification to understanding SC. In his research, he has found that SC also provides bridges to opportunities in larger communities (1995). However, in order to fully understand its scope and utilization it is often coupled with community engagement. Community Engagement is often referred to in many

operative terms such as partnerships, collaborations, coordination, leadership development and organizational capacity building (Putnam, 1995).

This variation in terminology is also evidence of how widely SC is defined, measured and used. Therefore, should descriptions of SC be defined solely on the level of trust displayed among community members, levels of charitable contributions, volunteerism, available services, or time committed? While the answer to the question may vary, there is one common consensus found in the literature. SC is an important component to addressing community health and social needs (Browning & Cagney, 2003).

Community Capacity looks at a community's ability to define, address, sustain, and strengthen their ability to address health and social needs and utilize resources (Potapchuk & Crocker, 1999). These needs encompass a combination of elements, which affect community engagement. They include social, political, economical, physical, and psychological outcomes. These outcomes can have positive and negative consequences based on their level of engagement. CC is also considered to be a form of empowerment, which is essential when working to facilitate changes in lifestyle, attitudes, and health (Ansari, Phillips, & Zwi, 2002).

There are also many other working definitions of CC that are being used across academic disciplines. Potapchuk and Crocker (1999) referred to it as civic capital. According to their definition, CC is what a community produces when it shares resources among the people of the community. This effort is motivated by a compelling vision of the future, which includes deep reservoirs of trust among diverse stakeholders who enables inclusive and collaborative decision-making.

Potapchuk and Crocker (1999) also found civic capital to be a creator of the infrastructure of organizations and that it incorporated initiatives that developed the capacity of stakeholders to deepen their work and builds connections among programs. It can also meaningfully engage and encourage the public to build political will that drives community transformation forward and builds a system of supports that nurtures new leaders, provides training and resources where needed, and finally catalyzes continued efforts. These definitions show that defining CC can be complex in concept, but its complexity can be linked to a variety of limitations. The limitations are based on factors, which include a lack of local ownerships, coalitions becoming diffuse in focus, and programs that may have been developed in ways that reduces intensity (Spoth et al., 2004). Although, it can be easy to place total responsibility and blame on a single individual for acquiring and maintaining CC, research has shown that individuals thrive better when they are able to work in an inclusive setting in order to contribute their health knowledge, skills, and experience (Guttman & Ressler, 2001).

The field of health education and health promotion has seen an increase in participation and research regarding the use of CHAs (Delbanco et al., 2001). CHAs are considered to be a key aspect in promoting community engagement and changing health status. They offer an opportunity to provide support and assistance in communities where economic and social conditions often serve as obstacles in receiving and accessing quality health services (Schulz et al., 2001). Their roles and responsibilities often include transportation services, health education, referral services, emotional support, appointment scheduling, and conducting home visits. CHAs can also help to establish necessary

communication links between health providers and community residents by transmitting messages related to important health and social issues.

CHAs strong community ties allow them to bridge the gap between residents and nonresidents. Many residents feel a common bond and share a feeling of familiarity. There has been some disagreement regarding the role and effectiveness of CHAs (Brach & Fraserirector, 2000). In rural communities they have been found to be an asset because many residents do not have the geographical access or economic means to receive routine health care services (Brach & Fraserirector). In urban and rural settings, however, careful consideration must be given to the role of CHAs because in many instances they can aid or endanger the health of their clients. Some common errors and concerns include inadequate training, undefined roles and responsibilities, and over or under-diagnosing of medical conditions (Brach & Fraserirector).

*Principle Framework*

The principle framework for the study was based on how community engagement knowledge can be shaped and affected by SC and CC. In this research study, the Principles of Community Engagement (PCE) serves as the framework for examining community engagement knowledge of PAs and CHAs using SC and CC. It is an opportunity to investigate and compare their coordinated efforts regarding program resources, design, implementation, and capacity. It is important to note that these principles are not considered, presented or utilized as a foundational theory, but instead as guide for understanding health behavior. As stated by the CDC these principles represent the first time that

relevant theory and practical experience for community engagement have been synthesized and presented as practical principles, or guidelines (CDC, 1997).

The PCE was also used in this research study as an assistance tool for future planning, implementation, and evaluation. PCE's foundation is based on engaging the public in community decision-making and action for health promotion, health protection, and disease prevention (CDC, 1995). The CDC defined community engagement as the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interest, or similar situations with respect to issues affecting their well-being.

These principles can be better understood by exploring four primary factors that help define and describe the dimensions of community engagement. The four primary factors include people, location, connectors, and power relationships. People are important to these principles because it provides understanding and describes community characteristics based on factors such socioeconomic factors, demographics, health status, risk profiles, and cultural and ethnic characteristics. Location is defined as geographic boundaries. Connectors require an examination based shared values, interests, and motivating forces. The final factor, which is referred to as power relationships, is identified as communication patterns, formal and informal lines of authority and influence, stakeholder relationships, and resource flow (CDC, 1997; Veterans Hospital Administration, 1993).

Although there may be varying definitions of what a community is, there are concepts within the PCE that can serve as a framework for effective volunteerism and community engagement. This framework is based on improving long-term health through col-

laboration and creating an environment where individuals feel a sense of community membership. It also involves identifying goals, setting objectives, and ranking them based on community priority, needs, and wants. This is important in the study because such a bond can serve as the basis for examining and explaining CHA volunteerism and training in relationship to SC and CC.

The CDC (1997) also identified nine fundamental principles that provide insight to the process of community engagement. Community Engagement is important to the study because it helps identify factors important to encouraging participation in the CHAs training program. For example, are participants motivated or empowered based on shared interests, health perceptions, values, experiences or traditions? Although the developers did not provide a visual description of the principles, the nine fundamental principles can be viewed in Figure 1.

In relationship to Figure 1, principle 1, social ecology, is defined as dynamic interplay among individual, groups, and their social and physical environment. This involves interaction between the behavior and the environment. Learning can be bi-directional. Participants should be encouraged to be active learners and explore opportunities (new and old) within their environment. Within principle 2, cultural influence involves "the integrated pattern of human knowledge, belief, behavior, and material traits characteristics of a social group. This is important to community engagement since it helps to ensure that engagement activities are appropriate for that particular cultural context.

In principle 3, community participation promotes a sense of community through ownership and perceptions. It is an opportunity to focus on what community members be-

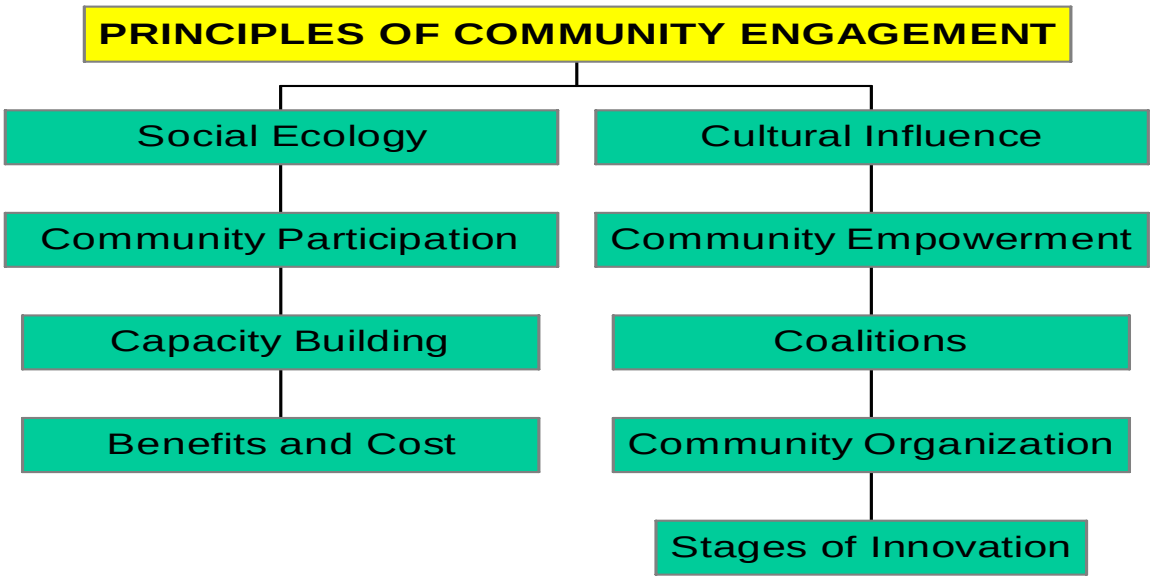


*Figure 1*. Principles of community engagement.

lieve or expect the results will be from their behavior. A hidden benefit is the encouragement of empowerment, which is principle 4. Participants must have the inner belief that they have the ability to act, make and maintain behavioral actions. Moving to principle 5, capacity building recognizes that before an individual or group can gain control or influence or become players and partners in community health decision-making, they may need resources, knowledge, and skills beyond those they already bring to a particular problem. This recognition also reconfirms that community engagement may require specific knowledge and skills in order to perform a behavioral action.

The combination of these previous principles is an enhancement to coalition building, which is found in principle 6. Coalition building is defined as the formal alliance of organizations, groups and agencies that have come together to work for a common goal. In order for coalition building to be effective, there must be a perception of interdependence and the ability to work toward common ground. This is includes the development of primary goals and perspectives that are distinct and continuous. The implications of these primary goals center on the encouragement of negotiation among interests and the development of the perception that there is an equal distribution of power among all the people. The use of these core principles help to ensure that community engagement strategies are appropriate and based on the needs and priorities of the community.

A few final principles that affect community engagement include benefits and costs, community organization, and stages of innovation. Benefits and cost involved an analysis of expected benefits. Participation was said to be more likely if benefits are viewed as outweighing the cost. Possible benefits identified included networking oppor-

tunities, access to information and resources, personal recognition, skill enhancement, and a sense of contribution and helpfulness in solving community problems. Cost was based on time required, lack of skills or resources needed for participation to basic burn-out. Community Organization related to the kinds of engagement activities that encouraged or supported social and behavioral change. Developers viewed this as an opportunity to bring about community change through basic principles, which included empowerment, community competence, active participation and "starting where the people are." This type of organization is also based on interaction and mobilization for common problems, goals and resources. The final principle of community engagement is stages of innovation. This principle is important to engagement because it states that all individuals within a community are not at the same stage of readiness for behavior change. Together these principles resulted in identifying the following recommendations, which are important to successful community engagement:

1. Be clear about the purposes or goals of the engagement effort, and the populations and/or communities you want to engage.

2. Become knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts. Learn about the community's perceptions of those initiating the engagement activities.

3. Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.

4. Remember and accept that community self-determination is the responsibility and right of all people who comprise a community. No external entity should assume it can bestow to a community the power to act in its own self-interest.

5. Partnering the community is necessary to create change and improve health.

6. All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community approaches.

7. Community engagement can only be sustained by identifying and mobilizing community assets, and by developing capacities and resources for community health decisions and action.

8. An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community, and be flexible enough to meet the changing needs of the community.

9. Community collaboration requires long-term commitment by the engaging organization and its partners (CDC, 1997).

The CDC (1997) provided several case examples of successful implementation of the concepts and principles of community engagement. Although they did not incorporate all concepts and principles, each case used at least one of the concepts and/or principles of community engagement. Example 1 is the Thurston County Public Health and Social Services Department and the Assessment Protocol for Excellence in Public Health, Olympia, Washington. The Assessment Protocol for Excellence in Public Health was used by local health departments to examine and improve their ability to meet the health needs of their communities. Their approach involved establishing relationships within the

community and working with existing leadership to support the goals of their public health initiative. This collaboration resulted in the formalization of the Thurston County Community Health Task Force. They worked together to develop and publish a community health plan entitled "Strategies for a Healthy Future." It was owned and planned by the community.

The Church as a "Natural" Partner in Health Promotion, The Jackson County Health Advisory Council in Jackson County Florida provides a second example of the community engagement concepts and principles. The focus of this project involved the mobilizing of church leaders, officials from the county health and social service agencies, and public health educators. Their mobilization was prompted by the higher rates of heart disease, cancer, stroke, low birth weight babies, and other health problems among African Americans in rural Jackson County, Florida. They worked together to formulate an initiative based on a culturally appropriate version of Planned Approach to Community Health (PATCH). A health advisory council was formed and trained to design, implement, and evaluate local health promotion programs. An assessment of the program revealed raised community awareness, improved nutritional behaviors among some participants, and a decrease in blood pressure rates among some high-risk individuals.

A third example of the community engagement concepts and principles is the Community Self-Determination in Breast Cancer Research by the National Breast Cancer Coalition in Philadelphia, Pennsylvania. In this project, community members became their own advocates to mobilize resources. The focus is mobilization based on shared interests or experiences. Their key concepts focused on building and expanding CC, skills, and knowledge. In addition, they increased focused on funding for research, expanded re-

cruitment and training of scientist, and improved coordination among breast cancer research activities.

The final community engagement example is the North Carolina Community-Based Public Health Initiative in Chapel Hill, North Carolina. This collaboration involves 12 groups in North Carolina working together in underserved communities. The groups consist of community based organizations, local health agencies, public health educators and university departments. This partnership is referred to as the North Carolina Consortium. Their guiding principles state that participating community-based organizations should provide strong community support, the policy making body of each participating organization should approve any consortium initiative, the consortium should designate specific communities with which to work, all partners are committed to implementing the community based process and to acquiring needed resources, and each partner is willing to make the changes necessary in order for the community-based health initiative to become a reality.

Overall community engagement can give community members a clear understanding of their role and responsibilities for successful behavioral change and quality of life changes. Quality of life changes may not be visible for years. This is especially true for CHA training programs since over time their presence in the community may increase and/or decrease depending on the strength and interest of program participants, resources, social factors, capacity, and community priorities (Ansari et al., 2002). These principles have been provided as a tool for examining and comparing Community Engagement, SC and CC. In addition, it will assist PAs and CHAs by providing them with an opportunity

to compare the joint efforts of their roles and responsibilities. Collectively, these concepts can help shape and build community engagement.

The use of community engagement in all aspects of community living has proven to be an empowering tool for promoting social justices and informed decision making. It establishes linkages between community residents and community resources, and at the same time builds community commitment and capacity. The aim of community engagement also includes promoting shared responsibility. Shared responsibility is a critical component to promoting life long volunteerism. The benefits include increased knowledge and understanding of issues surrounding health education and health promotion. This type of awareness is the key to health prevention, treatment and maintenance.

In addition to promoting health education and health promotion, community engagement offers collaborative opportunities to encourage stakeholders to design community engagement programs that encourage wide input in program development, planning, implementation and sustainability (Farquhar et al., 2005). This type of networking is also beneficial to building bridges between community stakeholders. It promotes linkages of services and SC and encourages use of SC while providing community residents with the skills and knowledge they need for improving health outcomes (Farquhar et al.).

As stated previously, the primary goal of this research study was to determine how community engagement knowledge of PAs and CHAs are shaped and affected by SC and CC. The use of these principles was also beneficial to the research study because it laid the foundation for promoting active involvement based on empowerment and shared responsibility. This type of active involvement is primary to community change because it incorporates participation by community residents and leaders in all phases of

program planning, implementing, and evaluating. It offers a sense of community ownership that is focused on using all available resources and community engagement, as well as the building of CC. The overall benefit may also prove to be beneficial to effective replication in other communities throughout Alabama.

# CHAPTER 2

# REVIEW OF LITERATURE

The purpose and necessity of CHAs is reflected in past and current literature and this section provides a brief overview of the trends, viewpoints, and concerns. Their relationship and role in promoting community engagement, the utilization of SC and the expansion of CC is also reflected in the *Healthy People 2010: Health Objectives of the Nation*. The authors of *Healthy People 2010* designed the book with two primary focuses that include increasing the quality of healthy years lived and reducing health disparities. These indicators were selected with the intent of motivating individuals, groups and organizations to action. This action has evolved out of a need to develop community based health programs that utilize concepts based on community support, engagement and empowerment (United States Department of Health and Human Services [USDHHS], 2000).

When you consider the history and role of previous *Health People* reports, the information and collaborative relationships established have also been very instrumental in shaping the policies and health practices of our nation has a whole. However, rising health care costs and the consistent gap in health services among underserved populations reveal that there is still a need for additional support and resources (McGinnis, 2003).

The investigation of community engagement, SC, and CC in health education is more then basic collaboration; it means changing and expanding community engagement knowledge, improving ideas, and helping others to form new health habits. Ideally, the end result for all community engagement includes not only a lifestyle change, but also an

opportunity for empowerment. It has been said that knowledge is power and the key to success. Current health education and health promotion research provides evidence that supports this type of unified approach (McGinnis, 2003). It provides communities with preventive programs, alternative health options, and opportunities for multicultural involvement.

Although SC and CC are not considered to be entirely new concepts in the field of health education and health promotion, their reemergence has come at a time when educators and policy-makers are under growing pressure to provide spending and policy accountability measures. According to Potapchuk and Crocker (1999), social problems are interconnected to poor educational outcomes, struggling economies, festering crime, continuous changes in political leadership, and immigration concerns. However, current research has identified what is turning out to be a common theme throughout community engagement-based research. SC and CC are key components to positive health outcomes (Spoth et al., 2004).

Although many local communities throughout our nation are placing increased attention and spending in community based programs, there are still many problems and issues that are plaguing low and middle income communities. Current literature is shifting from a single focus, which promotes the establishment of community partnerships as the primary means of improving community living to a concept that examines the relationship and community engagement knowledge between SC and CC (Spoth et. al., 2004). According to sociologist James Coleman (as quoted in Wallis, Crocker, & Schecter, 1998), SC is a by-product of a wide variety of social relationships. He states that its presence can help facilitate actions via an exchange of information and/or through shared

norms and obligations. However, he also notes that these actions can be beneficial or harmful. This aspect brings into question a community's capacity to handle such actions if they will result in negative consequences (Wallis et al., 1998).

Negative consequences were defined as corruption, lack of reciprocity, and conflicts in vision (Putnam, 2000). Many feel that the overall result of social interaction should result in outcomes that are conducive to either maintaining or improving an individual, group, or community's quality of life. Putnam (1995) views SC from a different perspective. He defined it as "features of social organization, such as trust, social forums and networks, which can improve the efficiency of society by facilitating coordinated actions" (Putnam, 1995). Putnam's viewpoint is more widely utilized because it deals with the concept of reciprocity. Reciprocity is said to be a willingness to help others, which results in return help from others. The benefit of reciprocity is important to SC and CC because it builds social trust, encourages collective actions, promotes coordination and communication, amplifies reputations, reduces opportunism, embodies past success, and encourages future collaboration/engagement. This global approach encourages teamwork and social investment from all segments of the community. Putnam defines this type of interaction as civic engagement because it bridges other forms of capital through localized SC and generalized SC. Localized SC accumulated in the course of informal social interactions. This was what a family and people living in communities engage in through their daily lives. However, generalized SC involved external community resources that connect/bridge communities and organizations to others outside of their current environment (Putnam, 2000). These forms of capital included financial, physical, and human

capital. Civic engagement is a good example of the new trends and opportunities that are available through community/social investment.

Faith based initiatives is another popular trend in community/social research. Johnston and Benitez (2003) examined how faith communities can assist in building CC. This information is important because it provides insight and encouragement for community engagement/volunteerism. Participation was based on community location, population base and income. The initial process began with a needs assessment in order to identify health interests and concerns. All participating faith communities were able to develop programs unique to their faith groups.

In a review of the literature, Johnston and Benitez found communities to be a strong ally in increasing community engagement awareness and behavior change because they "start where the people are." Churches/faith communities were considered to be ideal leaders because they are natural partners for health education, offer opportunities for volunteerism and good will, serve as social centers and they increase credibility through the promotion of trust and security. The primary barriers found included lack of time by participants and volunteers for program development and conflicts in facility scheduling. This research study was funded via a grant in which faith communities and community resources were joined for implementation of a health ministry program. The program provided opportunities using a teamwork approach for capacity building through workshops and group work. Teamwork involved collaboration with area agencies and congregations to meet identified needs, provide technical assistance, enhancement or expansion of existing congregational programs, and development and submission of grant proposals to philanthropic organizations.

Program development for the faith project began with one primary question. How should faith groups work together or with other external social agencies to maximize behavioral or health outcomes within places of worship? The goal was to ensure ownership and the best way to do this would be to facilitate capacity building in order to maximize health/behavioral outcomes. In order to establish ownership, program development included committed volunteers and a director who was skilled at providing training and technical assistance. Building capacity also incorporated promoting and identifying funding support for future initiatives. However, each faith community was allowed to apply for one time mini-grant/ "seed" money up to a maximum of $1,600. Funding was limited in order to promote leverage of funds, in-kind contributions, donations and collaborations. Each faith community implemented a range of programs, which included exercise, nutrition, meal preparation and deliver, and after school programs.

Program evaluation was incorporated throughout the faith project. Its measurements were based on collaboration and assessment opportunities. These shared experiences allowed participants to examine their strengths, resources, and interact with others within the community. Combined these methods helped increase ownership, build capacity, increase community engagement and improve access. There were also opportunities for comparisons across other faith communities. This was achieved using a method called outcome engineering. It allowed all committees to view what other outside communities participating in the program were doing and it was utilized as a method of collaboration. However, outcome engineering was not widely used because many communities lacked access to computers/internet and often information on the internet/computer system was not detailed.

Overall, there were many lessons and problems reported by the faith project participants. Lessons learned included learning the value of listening to each other, allowing participants to work from their own value systems and doctrines of their faith, providing assistance at whatever level was necessary and recognizing the uniqueness of working with volunteers. In contrast, working with faith communities was not a simple process. The problems reported from working with diverse groups included faith communities entering the program at different levels, differences in culture, there were challenges in maintaining motivation and participation, and inconsistencies in focus.

A review of the literature then moved to an examination of the roles of community partners and its continual change across educational disciplines. For example, there is a call in public health for a renewed focus on community-based research, which incorporates an ecological approach (Israel et al., 1998). According to these authors, individuals are embedded within social, political and economic systems that shape behaviors and access to resources that are primary to maintaining health. This call to improve public health must include an integration of research and practice, increased attention to the complex issues that compromise the health of people living in marginalized communities, greater community involvement and control, increased sensitivity to and competence in working within diverse cultures, expanded use of both qualitative and quantitative research methods, and more focus health and quality of life. Collectively, these recommendations for integration reveal the need for trust, reciprocity, and continued research.

In order to narrow the gap between research and practice health providers, South Africa conducted a community participation study to compare the knowledge of health care professionals with those of the community members. A quantitative study was con-

ducted to compare how professional staff and community members working together in a collaborative effort appreciate the skills and abilities of each other. There were five domains of stakeholder expertise examined. They included Educational Competencies, Partnership Fostering Expertise, Community Involvement, Change Agents Proficiencies, and Strategic and Management Capabilities. According to study developers, the program's vision was to train health professionals in a more community-oriented and community-based fashion. Therefore, effective partnership could only be achieved if community partnerships had the capacity to participate along with being motivated and involved members. In order to be included in the survey, all participants had to have attended at least one partnership-related meeting. There were 301 health professionals surveyed and 367 community residents surveyed. Study findings revealed a 90% response rate by professional participants. In addition, there were higher participation rates from lower level female professional workers. Community members showed a larger number of physical participants involved in the study, but results showed professionals participated more often in implementing program activities and for longer periods.

Findings in the South Africa community participation study also revealed important information regarding skills, abilities/capacity and expertise. Community members surveyed gave high ratings to professional participants in relation to valuing their abilities and expertise as resource persons in the areas of budget management, policy formulation and introducing and managing change. However, these rates declined in regards to their ability to design relevant educational activities and working with community groups and underserved population. Professionals lacked mutual recognition of capacities and work. This view was consistent across the five domains of stakeholder expertise which in-

cluded: educational and partnership fostering skills; community involvement capabilities, change agents proficiencies; and strategic and management abilities. The overall findings suggested that in order to have a successful community partnership there must be (a) a shift of ownership and control away from the professional experts; (b) a sharing of skills and information in an empowering fashion; (c) a building of trust and rapport; (d) a mutual valuing of contributions, strengths, and assets; and (e) a transfer of technology and enhancement of CC to institutionalize interventions.

The primary aim of collaboration in the South Africa community partnership study involved collaboration based on shared goal setting, joint decision making and the processing of information based on ongoing exchanges among those involved. The end result of capacity building and mutual recognition was an opportunity to analyze and address the root cause of their situation.

The decline or lack of SC and CC is another growing concern among communities. This decline has been referred to as disengagement in civic involvement (Putnam, 2000). In his book, Putnam discusses how participation in a variety of organizations such as bowling leagues, League of Women Voters, PTAs, Boy Scouts, and the America Red Cross has declined and affected American democracy. The end result is a decrease in financial revenues, decrease in community engagement, lack of trust, limited or deficient resources, and a rise in social concerns such as crime and drugs. This is important to society according to Putnam because it tells us that we must question why democracy works in some places and not others. He found that the availability of social resources when combined with CC would result in civic participation. Through participation individuals learn “habits of heart” which he defines as listening, and the recognition that one

should take responsibility for their own views/opinions. It also provides an opportunity to discuss shared interest and learn from others while building valuable social skills. For example, in December of 1994, the New Jersey Enterprise Community through a grant from the U.S. Department of Housing and Urban Development agreed to participate in an evaluation that measured their growth of SC (Schulgasser, 1999). The study revealed limited growth in bonding and bridging SC. Schulgasser defined bonding as relationships that develop among similar groups. Bridging on the other hand was identified as relationships that develop among dissimilar entities throughout the larger urban system, which creates weak ties because they are not apart of internal network/bond. Bridging is said to link the social system outside of one's immediate neighborhood or community. In regards to bonding, SC did develop among the comprehensive community development nonprofits as opposed to social service providers. However, they did not do well in bridging individuals or social entrepreneurs. Overall, program developers did feel like they were able to "make a lot out of a little program" (Schulgasser, 1999). This type of research shows that while the results may not bring about overwhelming outcomes, the key is to explore and evaluate.

A primary aspect in exploring community change and its relationship with SC involves evaluating cause, effect, and motivation (Bloom, 1999). The National Civic League conducted such an investigation by linking theory with practice in order to identify the cause, effects and motivation behind SC. They identified a framework and tools for facilitating change which included mediation, leadership training, visioning, strategic planning, involving diverse members, implementing a continual review of the change process and the examination of their civic index. Civic Index was defined as a self-

assessment tool that communities used to explore and identify the components of their civic infrastructure. Civic infrastructure consisted of a collection of relationships which included networks, skills, abilities and processes. Collectively, they helped individuals to accomplish personal and professional goals, create change, and make decisions. In order to achieve these accomplishments civic infrastructure requires the support of SC. Strong SC builds strong civic infrastructure by working together it lays the foundation for trust, understanding and reciprocal practices among individuals.

This exploration of change is evident by the growing use of CHAs in the quest to improve health attitudes and outcomes (Brach & Fraserirector, 2000). For example, Schulz et al. (1999) conducted a case study with the East Side Village Health Worker Partnership. Through the utilization of lay health workers, they sought to reduce the disproportionate health risks experienced by residents of Detroit's east side. The results showed that they were able to make improvements in research methods, practice activities, and community relationships. These improvements included interpreting and disseminating results to the community, developing a shared vision of change and strengthening the relationship among health workers, steering committee members, academic organizations, practice organizations and community based organizations. These results provide additional information regarding the necessity and inclusion of CHAs in health education and health promotion programs and interventions. Community residents feel comfortable because they work with individuals they are familiar with and it in turn builds trust, bridges cultural gaps, improves the delivery of health information and serves as example for community empowerment.

Additional benefits can also be seen across professional disciplines. Gaffney and Altieri (2001) investigated CHAs from a different perspective and refer to them as community lay workers. They found community lay workers to be an important asset to designing clinical intervention strategies that promote infant health. Participants in their study were asked to rank order intervention strategies and identify the advantages and disadvantages of each method. Their results revealed there might be some concern regarding level of competency and personality conflicts. Overall, community lay workers provided beneficial health information, advice, and facilitated social networking. According to Brach and Fraserirector (2000), these health and social benefits also help to reduce and/or eliminate racial disparities in minority populations. In addition, they were found to be a great asset for bringing in individuals who had not previously sought care, contributed to clinician-patient communication and increased the likelihood of patient follow-up.

Although a majority of the literature supported the overall benefits to utilizing CHAs, it does not overlook the potential drawbacks and problems. Today, one of the most common examples of CHA implementation can be found in the Healthy Start Program (Howel, 1998). The program was developed to help reduce infant mortality in selected communities with disproportionately high levels of infant mortality. They are required by program design to involve communities in planning and implementation. However, some programs have found that the inclusion of CHAs can be difficult, labor intensive, involve small or limited monetary incentives, and it may create conflict with efficient program operation (Howell, 1998).

The use of CHAs is also being incorporated into various aspects of behavioral change research. CHAs were incorporated into an intervention study in order to test a CHA assessment instrument and examine the effects of CHA training on CHA knowledge, attitudes, and beliefs concerning environmental tobacco smoke (Rodriguez et al., 2003). The study recruited 11 participants from a Latino community. Prescreening requirements were based on their reasons for wanting to work as a CHA, their leadership potential, and their confidence in one's ability to affect community change. CHA training consisted of 20 hr of training over 8 sessions during a 1-month period. The goal was to prepare them to visit Latino households and work with a family member using behavioral problem-solving techniques to lower children's exposure to environmental tobacco smoke in the home. There were several behavioral theory constructs measured in the assessment survey, which included intentions, environmental constraints, anticipated outcomes, perceived normative pressure, self-standards, self-efficacy, emotional reaction, and skills/ability. Intentions measured a person's likelihood that they would perform the behavior in question. Environmental constraints were based on a set of circumstances that may allow or prevent the performance of the behavior in question. This was followed by anticipated outcomes, which involved expectancies or attitudes that a person holds about performing the behavior in question. Perceived normative pressure addressed the affects of social influence. This construct is beneficial to examining how people are potential sources of social influence that may be putting pressure on the individual either to perform or not to perform a given behavior. It was followed by examination of self-standards. Self-standard required a person to determine whether performance of a given behavior was consistent or inconsistent with one's self-image. The next construct exam-

ined self-efficacy. This was based on individual's capabilities of performing a given behavior. It was followed by emotional reaction. Strong emotional reactions could be invoked when thinking about performing a particular behavior. The final construct assessed skills/ability, which may or may not be necessary to perform a particular behavior. Additional information was collected regarding their knowledge about the role of CHAs.

Analysis for the environmental tobacco smoke study was done using a paired sample *t*-test. Findings showed post-training and emotional reactions related to community volunteerism for CHAs to be significantly higher than at pre-training. As a result, CHAs were more likely to expect their intervention efforts to have positive outcomes. The effectiveness of the intervention was attributed to similarities of demographics between the CHAs. Additional increases were found in the quality of related skills/abilities, positive self-standards for community volunteerism, perceived environmental constraints related to volunteering in one's community and general self-efficacy and self-esteem from pre to post testing. There was no significant difference found in CHAs knowledge regarding community volunteerism or Environmental Tobacco Smoke reduction from pre to prost-training. The lack of significance was attributed to possibly the way the constructs were measured and the fact that they may not have been adequately covered. Overall, the incorporation of CHAs in studies such as the environmental tobacco smoke study show how beneficial they can be in promoting health messages and the versatility of their use.

The University of Arizona conducted a similar tobacco cessation study. Their program focused on implementing a healthcare partnership to train Spanish-speaking Tobacco Free El Paso certified promontories to help identify tobacco users and offer to-

bacco cessation counseling services (Martinez-Bristow et al., 2006). These individuals were community health workers, or community outreach workers. In addition, to being respected members in their communities, they provided health related services and served as key facilitators between providers and targeted communities. Promontories were required to complete a 5-day training session along with participants from clinic partnerships which included Texas Tech University. According to Martinez-Bristow et al., the key findings show that the training sessions were simple to operate, the curriculum was understood by Spanish and English speaking participants, time was a limiting factor for instructors and participants, and participants acquired knowledge and confidence to offer tobacco cessation interventions to communities in need. Overall, this study revealed the importance of culturally sensitive training programs that utilize community health workers/advisors in promoting community engagement.

Elevating health disparities in minority communities is an on going concern. Poder es Salud (Power for Health) is a community based participatory prevention research project that seeks to reduce health disparities in African American and Latino communities (Farquhar et al., 2005). The program utilizes community health workers and popular education in an effort to build leadership and enhance community SC. The focus is to reduce inequities related to income, race, gender, ethnicity, and geographic location. Although, the project was initially funded in 2002 by the CDC, it is still on ongoing. Poder es Salud (Power for Health, 2002) focused on the following specific aims:

> 1. To identify culturally specific elements of an effective Community Health Worker intervention in the African American and Latino communities. 2. To identify supportive policies and environments that allows Community Health Workers and community members to effectively identify and address health issues. 3. To determine how SC both influences and results from an effective par-

> ticipatory approach to identifying and addressing health promotion and disease prevention. (p. 596)

These aims also included working to build a bridge between the two ethnic groups. The purpose was to address their shared problems and issues, which included discrimination, distrust, and increased competition between the two ethnic groups. The end result for all participants was strong social networks. Overall, there were many lessons learned. According to Farquhar et al. (2005) one of the primary lessons is that African American and Latino communities share some fundamental challenges related to health disparities. These challenges are based on how they identify health concerns, create solutions, and think about SC. However, these challenges vary among the two ethnic groups considerably. The study limitations pertained to participation. Participation was limited to African Americans and Latinos from a specific community and the information gathered may not have been inclusive of the full community. As result of these limitations, replication may be difficult.

An examination of community engagement should also investigate the impact on congregational members and the role of faith based community organizations. African American churches have a long standing tradition of providing charismatic leadership and services to their communities (Frederick, 2003).

A final and important component in the review of literature involved examining the National Community Health Advisor Study. Although CHA participation was documented throughout the United States in clinics, homes, community centers, and neighborhood streets, they were found to be a primary asset and response to family and community health needs. The basis of the study was to explore core role and job competency definitions, develop evaluation strategies for CHA programs, examine CHA career and

field advancement and explore the integration of CHAs within the changing health system, including managed care environments.

Although CHAs were said to be on the front line in public health, they faced on going battles to sustain programs, initiate new programs and CHAs lacked dependable support for themselves. Study findings also revealed important findings regarding CHA role and competencies, CHA evaluation strategies, CHA career and field advancement and a change in the role of CHAs in the Changing Health System (Figure 2). Having conducted an in-depth review of the literature, the study shifted focus and examined these trends and concepts in the following chapter. The primary intent was to build on past information and knowledge.

| NATIONAL CHA STUDY FINDINGS |
|---|
| **I. CHA Core Roles and Competencies** |
| • Bridging cultural mediation between communities and the health and social service systems<br>• Providing culturally appropriate health education and information<br>• Assuring that people get the services they need<br>• Providing informal counseling and social support<br>• Advocating for individual and community needs<br>• Providing direct service (such as first-aid and screening tests)<br>• Building individual and community capacity (such as helping individuals establish healthy lifestyles, helping communities address environmental health problems) |
| **II. CHA Evaluation Strategies**<br>• Poorly designed and implemented due to limited funds<br>• Inadequate skills<br>• Lack of time to show results<br>• Limited resources<br>• Difficult to document and promote the perceived positive impacts of CHA activities and the cost-effectiveness of CHA program. |
| **III. CHA Career and Field Advancement**<br>• Lack of career advancement opportunities for CHAs within programs<br>• Lack of external career ladders for those who choose to leave the field<br>• Lack of training and curriculum standards<br>• Lack of program protocols in such areas as hiring and supervision<br>• Need for inter-program and CHA network and leadership development that in turn leads advocacy efforts in the field |
| **IV. CHAs in the Changing Health Care System**<br>• Underdeveloped capacity in CHA programs and in Managed Care organizations to work together |

*Figure 2.* Important findings regarding CHA role and competencies, CHA evaluation strategies, CHA career and field advancement, and a change in the role of CHAs in the changing health system.

| NATIONAL CHA RECOMMENDATIONS |
|---|
| **I. CHA Core Roles and Competencies**<br>• Common definitions of CHA roles and competencies (could lead to greater integration of the CHA role into the health care continuum nationally)<br>• Utilization of the proposed core roles and competencies in service programs and ongoing research in this area to assure their continued accuracy and appropriateness |
| **II. CHA Evaluation Strategies** |
| • Access to shared evaluation methodologies for programs built on the proposed evaluation framework. (Note: Make evaluation essential and promote a CHA Research Agenda which addresses funding, partnerships, training, and technical assistance)<br>• Expand program evaluation and research efforts to examine more thoroughly such areas as CHA cost-effectiveness, role identification). |
| **III. CHA Career and Field Advancement**<br>• Voluntary national CHA credential to address the lack of boundaries and increase the understanding of CHA roles.<br>• Development of training standards and program practice guidelines<br>• Increased coordination of leadership in the field with CHA participation in setting policy for their discipline |
| **IV. CHAs and the Changing Health Care System**<br>• CHAs work to clarify their roles in various areas and identify appropriate funding streams to sustain them in each of these settings<br>• In the area of managed care develop educational materials and training sessions in order to prepare Managed Care Organizations to work with CHAs<br>• Capacity Building to aid CHA programs in contracting with Managed Care Organizations and to prepare CHAs to work for Managed Care Organizations themselves<br>• Coordinate leadership in the field to advance CHA work throughout the country and to strengthen the contribution which CHAs can make in the changing health care system |

# CHAPTER 3

# METHODOLOGY

## *Background*

This study was designed primarily to evaluate how the community engagement knowledge of PAs (CPH Board Members and Steering Committee Members) and CHAs (Neighborhood Outreach Specialists and CHA Volunteers) in the Congregation's of Public Health, Search Your Heart CHA Training Program can be shaped and affected by SC and CC. The Center for the Study of Community Health (CSCH) at the University of Alabama in Birmingham (UAB), School of Public Health provided information for this section, the population under study utilized the American Heart's Search Your Heart (SYH) Program. Search Your Heart is an evidence-based program created by the American Heart Association for implementation by faith based organizations. Under the direction of the UAB CSCH, the Congregations for Public Health (CPH), a non-profit corporation, adopted this program for use in the congregations and surrounding neighborhoods of eight member African American churches located throughout the Birmingham Metropolitan Area.

Cardiovascular disease (CVD) kills more Americans every year than any other disease, nearly 950,000 people annually. Search Your Heart encourages participants to change unhealthy lifestyles and develop heart healthy habits. African Americans are at greater risk of death and disability from CVD than any other population. The risks associated with CVD include heart attack, stroke, and high blood pressure. This is attributed

to the fact that reduced physical activity, high blood pressure, diabetes and obesity are more prevalent in the African American population. In order to reduce and/or eliminate these disparities Search Your Heart works to initiate positive lifestyle changes by training congregation coordinators to implement seven key modules (Figure 3).

Congregations for Public Health (CPH) began initially as a partnership between the UAB School of Public Health and communities of faith to identify and meet needs relating to health, social, economic, and educational deficiencies in their surrounding neighborhoods. CPH's current congregations and their surrounding neighborhoods are area 1: Faith Apostolic & Bryant Chapel A.M.E. serving Wenonah, Powderly, and Grasselli Heights; area 2: Lily Grove Baptist Church serving Druid Hills, Kingston and Avondale; area 3: First Baptist Church of Fairfield & Mount Moriah Missionary Baptist serving Fairfield & Pratt City; area 4: Tittusville A.O.H. Church of God serving Titusville & College Hills; area 5: Bethel Baptist Church, Berney Points serving West End; and area 6: Church of the Reconciler serving a homeless population in the downtown area. The eight member churches have become channels for health information, education, screening and referral, and one-on-one interventions to reduce risk factors associated with stroke and thus support stroke prevention (Figure 4; Appendix A)

Using the CHA approach, CPH serves more than 110,000 African American residents in Birmingham. The overreaching SYH health goals include (a) helping congregations empower themselves to take responsibility for their health; (b) implementing best practice interventions in nutrition, physical activity, and smoking cessation; and (c) promoting adherence to recommended medication instructions and lifestyle changes.

| SYH SEVEN KEY MODULES | |
|---|---|
| **High Blood Pressure** | • Regularly screening as many participants as possible for high blood pressure and documenting progress.<br>• Providing at-risk participants with referrals and resources that will help them understand how to lower their blood pressure. |
| **Stroke** | • Screening as many participants as possible for stroke risk factors using the American Stroke Association's "What's Your Risk of Stroke?" screening tool.<br>• Providing referrals and resources for those at risk for stroke to help them understand how to lower their risk. |
| **Cholesterol** | • Screening as many participants as possible for baseline cholesterol levels and document risk reduction progress.<br>• Educating participants about the relationship of high cholesterol to stroke and heart attack.<br>• Providing at-risk participants with referrals and resources that help them understand and lower their cholesterol levels. |
| **Physical Activity and Fitness** | • Educating participants about the benefits of physical activity.<br>• Providing tips on how to incorporate regular physical activity into busy lifestyles.<br>• Motivating participants to increase the time they spend in physical activity. |

*Figure 3.* Search Your Heart training congregation coordinators seven key modules.

| | |
|---|---|
| **Nutrition** | • Educating participants about the benefits of heart-healthy eating.<br>• Providing tips about how to incorporate heart-healthy eating into busy lifestyles.<br>• Motivating participants to change their eating habits while still enjoying traditional foods. |
| **Diabetes** | • Screening as many participants as possible for baseline blood glucose levels.<br>• Educating participants about the relationship of diabetes to stroke and heart attack.<br>• Providing at-risk participants with referrals and resources that help prevent or delay the onset of diabetes through healthy lifestyle changes. |
| **Stress** | • Educating participants about the relationship of stress to cardiovascular health.<br>• Providing tips on coping with stress.<br>• Educating participants about how to identify and respond to stress triggers. |

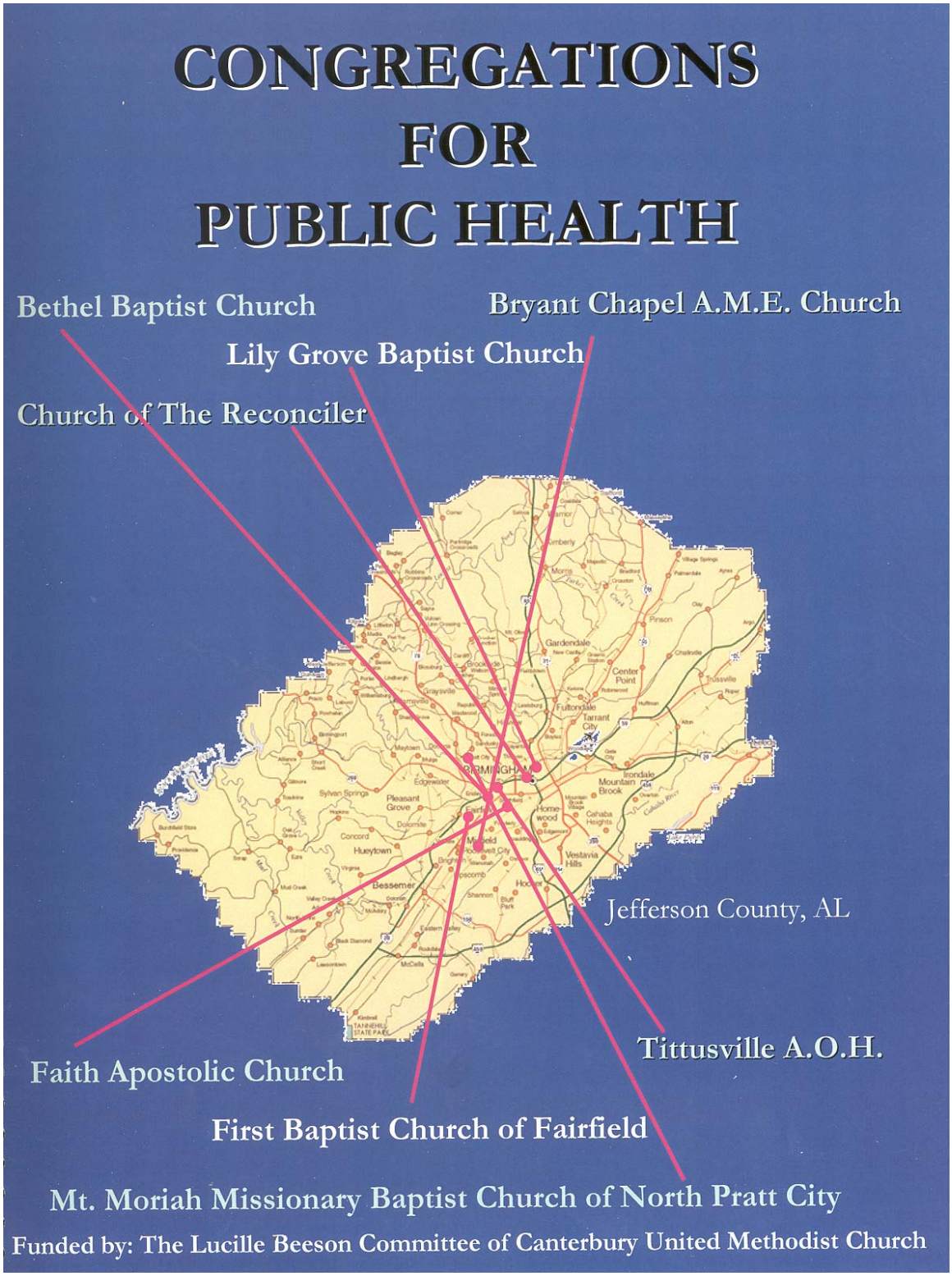


*Figure 4.* Locations of congregations for public health.

*CPH Organizational Structure*

The CPH Organizational Structure includes a CPH Board, Neighborhood Outreach Specialists (NOS), Steering Committee Members, and CHA Volunteers. They all play an important role in the Search Your Heart program by providing support through leadership, program coordination, resources, and volunteer manpower. The leadership/PA functions are carried out by the CPH Board Members and Steering Committee Members. However, the CHA responsibilities are carried out by the Neighborhood Outreach Specialists and the CHA volunteers.

The CPH Board of Directors is comprised of nine members. Their membership includes representatives from each of the eight Birmingham congregations, the Dean of the UAB School of Public Health, and other outside advisers for technical and administrative support including the Jefferson County Health Officer. The ministers who make up the CPH Board promote the overall Search Your Heart effort in their congregations and surrounding neighborhoods through sermons, personal encouragement, and public speaking engagements that focus on impact of stroke in the African American community.

Neighborhood Outreach Specialists are located at each church and they are responsible for creating the infrastructure necessary to implement SYH, including facilitating the work of the Steering Committee in creating a strategic plan, and identifying and recruiting volunteer teams (i.e., assessment, screening, education, public speaking, events, publicity, etc.). Currently, there are six Neighborhood Outreach Specialists. Neighborhood Outreach Specialists (NOS) (pronounced “nosies”) are employed by CPH and have received 80 hr in the Community Health Advisor Core Skills Curriculum.

Neighborhood Outreach Specialists currently involved in neighborhood asset mapping, health resource awareness and implementing health educational programs through volunteer networks. They also assist in the volunteer training and coordinate and supervise all volunteer activities.

The pastors and Neighborhood Outreach Specialist at each church select Steering Committees Members. There are approximately 55 Steering Committee Members. They are chosen from the congregation and community for their leadership, expertise, and access to resources. Steering Committee members help guide and advise the Neighborhood Outreach Specialist in the overall development and implementation of a strategic plan.

The final group of the organizational structure consists of approximately 70 CHA volunteers. Volunteers from each congregation and the community are recruited and matched to program activities and tasks depending on their interests and skills. In addition, CHA Volunteers provide training, supervision, and support in order to maximize their success in fully implementing Search Your Heart and coordinating specific behavioral interventions; that is, nutrition, physical exercise, smoking cessation, medication compliance, etc.

The primary groups surveyed for this research study included the CPH Board, Neighborhood Outreach Specialists, Steering Committee Members and the CHA Volunteers. However, they were not surveyed based on their individual group responsibilities, but instead based on their overall classification as being either a PA or a Community Health Advisor. The total number of survey participants targeted was 140. They were chosen because each group includes members from all eight-member congregations and their responsibilities directly affect program design or implementation. These responsi-

bilities are related to their administrative and volunteer functions. They also have direct contact and relationships with the community residents.

*Description of the City*

Birmingham is located at the southern end of the Appalachian Mountains. The natural geography has a heavy influence on the development of the city, which generally stretches southwest to northeast in the valley north of Red Mountain and has a total area of approximately 163 square miles. The city is comprised of 99 neighborhoods that are organized into 23 communities. Birmingham is crossed by Interstates 20, 59, and 65 and is served by a mid-sized international airport. The city is the central hub of Alabama's largest metropolitan area with a total population of over 1 million people. The city is also served by several hospitals as part of a growing medical care industry.

*Population and Income*

The City of Birmingham had a population of 242,820 in 2000 and was the 72nd largest city in the United States. Almost three fourths of people in the City of Birmingham are African American (73.5%), while most others are White (24.1%), and few are Asian (0.8%), American Indian (0.5%), or Hispanic (1.6%). With an African American population of 178,372 in 2000, Birmingham had the 17th largest number of African Americans of the cities in the United States. Birmingham also has a relatively high proportion of people 65 or older (13.5%) and 85 or older (1.9%), ranking the city 47th and 41st, respectively, in the United States. (CPH-UAB CSCH, 2003)

Compared to national averages Birmingham has lower household and per-capita incomes and a greater proportion of people with poverty status. In 1999, the median household income in Birmingham was $26,735 versus $41,994 for the United States. In the same year, Birmingham's median per-capita income was $15,663 compared to the U.S. median of $21,589. The proportion of people with poverty status in Birmingham (24.7%) is twice that of the U.S. population (12.3%). (CPH-UAB CSCH, 2003)

Within the city of Birmingham, there was also a large disparity between the incomes of Whites and African Americans. The 1999 median household income for Whites was $34,106, while for African Americans it was $23,843. The 1999 per capita income for Whites was $24,989, or about twice as much as African Americans, $12,724. The proportion of people with poverty status for African Americans (28.4%) was more than twice the rate for Whites (12.6%). (CPH-UAB CSCH, 2003)

*Risk Factors for Stroke*

Residents of Alabama have higher rates of risk factors associated with strokes than the United States. Although data are not available at the city level, the Behavioral Risk Factor Surveillance System reported on several risk factors for the state. In 2001, 31.6% of the adults in Alabama have been told they had high blood pressure, compared to 25.6% for the United States. In 2001, 32.9% of the adults in Alabama have been told that they have high cholesterol, compared to 30.2% of the United States. In 2002, proportionally more adults in Alabama were at risk for health problems from being overweight (62.7%) than the U.S. median (58.9%). In 2002, 8.5% of the adults had diabetes, compared to 6.7% for the United States. Fewer people in Alabama in 2002 participated in

physical activity than for the nation. Finally, in 2002, more residents of Alabama (24.4%) were current smokers, compared to 23.0% of the United States. (CPH-UAB CSCH, 2003)

African Americans in Alabama have higher rates for several risk factors than the overall population. Because the proportion of African Americans in Birmingham is high (73.5%), it follows that the city will generally have a higher rate of these risk factors than reported for the state as a whole. Looking specifically at African Americans in Alabama, 37.5% had high blood pressure, 68.8% are at risk for health problems from being overweight, 12.7% have diabetes, and only 62.6% participated in any physical activity. On the other hand, fewer African Americans had high cholesterol (27.5%) or were current smokers (21.5%).

The unit of analysis for this research study includes 9 CPH Board Members, 6 Neighborhood Outreach Specialists, 55 Steering Committee Members, and 70 CHA Volunteers located in Birmingham Metropolitan Area ($n$ = 140). The justification for selecting this population was based on program longevity, small population size, and the availability of participants in one central location.

*Survey Foundation*

The use of CHAs/Neighborhood Outreach Specialists/Volunteers is a growing trend in many low-income, rural and minority communities. This project is designed as a comparison study of how community engagement knowledge of CPH Board, Neighborhood Outreach Specialists, Steering Committee Members, and the CHA Volunteers can be shaped and affected by SC and CC. It is measured through a survey comparison of

community engagement knowledge utilizing the Congregations for Public health/Search Your Heart Program. A comparison is done between the PAs (CPH Board Members and the Steering Committee) and CHAs (Neighborhood Outreach Specialists and CHA Volunteers) in the Birmingham Metropolitan Area. Their responses are a reflection of their interactions as congregants and participants in the CPH/SYH Project.

The development of survey questions began with identifying three primary research questions. As stated in chapter 1, there is a growing need to identify health education research that examines, understand and explains the collective efforts of community engagement, SC and CC. Therefore, the following questions were designed to examine and compare whether or not the two groups possessed first a knowledge base about health resources, community issues, community needs, community dynamics and the CPH/Search Your Heart Program; second knowledge base regarding service coordination skills and community engagement, and third knowledge base regarding capacity building skills.

*Research Questions*

1. What is the relationship between the community engagement knowledge of the PAs and the Community Health Advisors in respect to identifying and promoting the development of SC?

2. What is the relationship between the community engagement knowledge of the PAs and the Community Health Advisors in respect to linking community residents to SC?

3. What is the relationship between the community engagement knowledge of the PAs and the Community Health Advisors in respect to building and expanding the community's capacity to recognize, maintain, and solve health problems?

It is within this framework that the research examines the relationship between the community engagement knowledge of the PAs and CHAs and how this relationship is shaped and affected by SC and CC. The survey instrument section provides a detail description on how these questions are answered.

Once the research questions were developed, the next phase included the design of a conceptual framework and study model, which gives a descriptive picture of the study design and helped laid the foundation for developing the survey instrument. Survey Questions were adapted from the Community Health Worker Evaluation Tool Kit (CHWETK, 2000) and the National CHA Study (University of Arizona, 1998). The National CHA Study was described previously in chapter 2. However, the Community Health Worker Evaluation Tool Kit and Questionnaire was chosen because often measurements of community engagement/community participation are difficult to measure and feedback is often reported in terms of participant views (Ansari, Phillips, & Hammick, 2001). Therefore, the National CHA Study developed several community based questionnaires that could be implemented with little or no assistance or redesign.

The Conceptual framework for the Community Health Worker Evaluation Tool Kit (CHWETK) was funded through grants from The Annie E. Casey Foundation to the University of Arizona Rural Health Office and the Southwest Center for Community Health Promotion of the University Of Arizona, College of Public Health. The design process initiated in 1988 at a focus group meeting held by the National Promoters, Com-

munity Health Worker Conference in Phoenix, Arizona. It was followed by several additional meetings with the CHW and Program Directors at the American Public Health Association (APHA) in D.C. of 1988, in 1999 at the Evaluation Experts and Community Health Worker - National Promoters Community Health Workers Conference, and in 1999 at two meetings of the Professional Evaluators and CHW was held at the APHA meeting in Chicago, IL. Participants developed the tool kit as a means to assist community health workers in the planning, design and implementation of practical/realistic evaluation. According to the tool kit developers there are 21 basic evaluation principles. They include making evaluation the success story one wants to tell, designing the evaluation when the program is planned, thus making evaluation a collaborative process, as well as making the Community Health Worker a focus of your evaluation through utilization of the Community Health Worker training evaluation. In addition, evaluation in the development phase should focus on end results, be kept simple, and document change. This will foster principles that uphold models of change, and avoid experimental designs that are not conducive to community-based research because the degree of control for these designs is lacking. After which, program developers must work on selecting realistic results, selecting appropriate types of results, and measuring unexpected results. This is necessary because the remaining principles require gathering baseline information, avoid redundant data collection, promote the use of standard forms whenever possible, use stories-pictures-photographs-videos and news articles to help tell the story, ask expert evaluators, choose an outside evaluator who is sympathetic to the Community Health Worker program, and finally measure and report success. Overall, the developers found the Community Health Worker Evaluation Took Kit to be a powerful learning tool for

practitioners in the planning, design, implementation and learning from social service program interventions. In addition, it was found to be an important step in building CC and strengthening community voice.

*Survey Framework*

In order to effectively evaluate all research questions, careful consideration was given to developing survey questions that addressed formative, process, and summative evaluation.

Formative, process and summative evaluation questions played an important role in developing sound evaluation questions in order to gain a clear understanding of the target audience's knowledge regarding SC, CC and the role of the CHAs. This is important because it helped to determine how to productively use the CHAs training program, communication channels, and resources. It was an opportunity to gather information at community/pubic meetings, conduct interpersonal observations at health/community events and collect surveys completed by the PAs and CHAs in the Birmingham Metropolitan Area. The Community Engagement Survey (CES) took advantage of these opportunities in order to conduct a baseline assessment and compare the congregant's prior knowledge, skills, perceptions, and attitudes about SC, CC and the perceived role of the Community Health Advisors.

Process evaluation questions were also included in the survey in order to compare whether training for both groups was administered according to design. The key questions focus on who the community health advisors are, what their role or position is, identifying when they perform their duties and responsibilities, and the location (s) they util-

ized to carry out their roles and responsibilities. This information was gathered from the CHAs, CPH Board Members, community/public meetings, feedback from prior research articles, and review of current program procedures and policies. Process evaluations are generally conducted periodically throughout any research project. The continuous use of process evaluation is to ensure that the program is being administered according to design. Incorporating good process evaluation questions is important to the research project success because it affects the outcome of the summative evaluation. We must be able to answer the question of why the program training worked or failed when comparing the two groups. If problems exist are they due to the program design which is the responsibility of the PAs or conflict in community engagement knowledge between the two groups? If these questions are answered quickly and clearly then CHAs benefit because changes can be implemented on an as needed basis. It helps avoid long-term problems in which the cause may or may not be readily identifiable. Additional information was gathered from the program policies, educational materials and their distribution patterns, program reports and minutes, and personnel procedures, which include reviewing time sheets and job descriptions. Through process evaluation questions the goal was to strive for quality performance and service quality in administering the program. Additional techniques for gathering information included conducting face-to-face interviews with community congregants, health organizations and community organizations. The research process included consulted all primary and secondary data sources when gathering and evaluating information. Primary sources include community congregants, staff and volunteer members, health/community organizations and program developers.

The summative evaluation questions were part of the survey instrument as an assessment and comparison of the program training and their knowledge of SC and CC. Questions centered on performance review, program feedback reports and minutes from meetings and presentations, and program correspondence. A key indicator of program impact involved examining organizational and community supports that have been generated. The goal was to compare their response and determine if the program is working at its current stage. Did it increase or decrease the number of CHA/volunteer participants, organizations or agencies that support their cause? Additional questions examined the effect of the campaign design, goals, and objectives. The summative information was gathered to investigate whether or not the program caused a change in attitudes, beliefs, knowledge and social benefits between the CHAs and the PAs. As a result of the information gathered the survey strived to answer the following questions: How well were the goals and objectives met and did any of the changes made as a result of the formative and process evaluation questions have the desired impact? The summative evaluation questions should also be viewed from continual viewpoint and as a measure to assess the program effect and impact. In summary combining evaluation components with PCE can be beneficial to CHAs and PAs because it enhances program planning, implementation, and evaluation. In addition, to encouraging continuous learning, it also serves as a testament of program utilization, success and sustainability. Figure 5 illustrates the conceptual framework and study model used for this study.

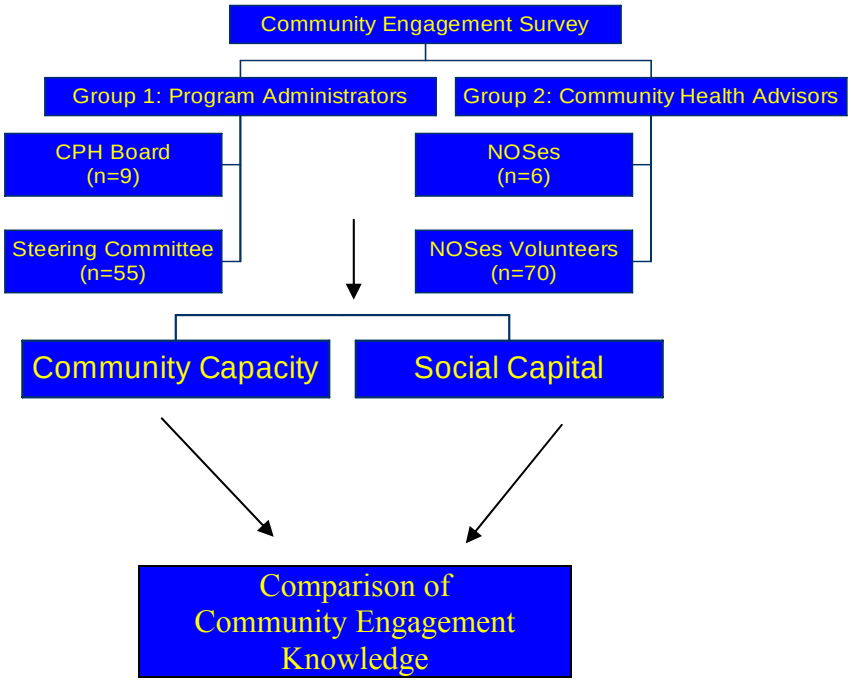


*Figure 5*. Conceptual framework and study model.

*Survey Instrument*

The survey was designed to examine how community engagement knowledge of PAs, and CHAs located in Birmingham, Alabama, can be shaped and affected by SC and CC. It included four distinct sections: SC, Community Engagement Coordination, CC and a Relationship Scale. Sections 1 through 3 were designed to give the reader a descriptive outlook of the research project. All questions were designed to describe and investigate current conditions and knowledge, as they exist. Section 4 was developed and designed as an analytical inventory scale to determine the relationship(s) that exist. The survey began with a brief paragraph describing the purpose of the survey, instructions for completion, and a statement for assurance of anonymity.

The first section of the survey, SC, focused on identifying study participant's role, assessing their understanding of the program design and vision, and as a mechanism, identifying community partnerships. This information was critical to the program success or failure because having sufficient workers with the expertise and leadership skills to implement the program is beneficial to the program's future growth and development (Figure 5).

Survey question 1 established an individual's current role in the program in order to determine group membership (PAs or CHAs).

Survey section 1, Social Capital (question 2-8), examined an individual's knowledge and experience in respect to identifying and promoting the development of social capital in a community. Survey section 2, Community Engagement Coordination (questions 9-13), examined an individual's knowledge in respect to identifying the available community resources and partners. Survey section 3 (questions 14-20) focused on com-

munity capacity. It examined an individual's knowledge of the community's capacity for program evaluation and sustainability. With the exception of past experience (questions 5 and 6), all questions were multiple-choice and based on the training materials for the CHA's (Community Health Advisors Core Skills Curriculum Guide).

Survey sections 1-3 were designed with the goal of determining whether there were average knowledge differences between the groups (PAs or CHAs). Using the Community Health Advisors Core Skills Curriculum Guide as a standard, each answer was graded and given a determined number of points, and then a score for each section was calculated adding all points from the questions within the section (for section 1-SC, more points were given to more experience). The maximum number of points and individual could obtain were 31, 26, and 33 for sections 1, 2 and 3, respectively. ANOVA models were used to determine if there were average differences between the groups for each section. Once the data was collected, two analyses were conducted. The first analysis included only surveys for which all questions in a section had been answered. The second analyses included surveys for which at least one question in a section had been answered.

Survey Section 4 was designed to compare perceptions of the CPH/SYH program between the two groups. The format of the questions in this section is based on a based on a Likert Scale design. This section was composed of 3 parts; Part 1 (questions 21-27) examined an individual's perceptions in regards to the program's development of social capital. Part 2 (questions 28-33) examined and individual's perceptions in regards to the program's performance in community engagement coordination. Part 3 (questions 34-41) examined and individual's perceptions in regards to the program's development of com-

munity capacity. Taking advantage of the ordinal nature of the answers (*Poor, Fair, Good, Very Good, and Excellent*), differences between the two groups are tested using Cochran-Mantel-Haenszel tests of association for 2 by 5 tables, with an ordinal scaled column variable. For this investigation the interest was in the association between perception of the program and group membership.

Once the questions were developed, they were submitted to the UAB Center for the Study of Community Health for expert review/approval. An in-depth review was conducted in order to investigate appropriateness, clarity, and relevance to the research study.

Survey section 1 (SC) and section 4, part 1 (SC), were designed to address research question 1, which asked about a relationship between the community engagement knowledge of the PAs and the CHAs in respect to identifying and promoting the development of social capital. A comparison of their knowledge and experience is beneficial to the research project because it helped to determine whether or not these skills, resources and techniques should be required as standard practice for similar programs or should they be specific for study participants in the population studied. A key aspect was to examine whether or not these characteristics of SC foster community commitment, promote personal investment, improve quality life and assist in meeting the essential needs of the community residents.

Survey section 2 (Community Engagement Coordination), and section 4, part 2 (Community Engagement Coordination), were designed to address research question 2, which asked about a relationship between the community engagement knowledge of the PAs and CHAs in respect to linking community residents to SC. The information col-

lected helped to identify and prioritize health concerns and knowledge. Linking residents to SC is necessary to examining community engagement knowledge because it provides information about resources that are vital to improving community life. The primary benefit would be an opportunity to work together as a community to influence social and health outcomes. In addition, it identifies whether or not community residents are being encouraged to utilize available resources. The end result is an opportunity to facilitate individual and agency interaction. It is not intended to be a measurement of the level or depth of interaction, but a measurement of knowledge and whether or not community congregants are familiar with and are they referred to available community organizations/resources. Congregants and agencies benefit from their collaborative interaction. These community benefits include social networking, economic stability, accountability, and employment training opportunities.

Section 3 and section 4, part 3, were designed to address research question 3, which asked about a relationship between the community engagement knowledge of the PAs and the Community Health Advisors in respect to building and expanding the community's capacity to recognize, maintain, and solve health problems. These parts of the survey assisted in answering the research question by examining what works, why it worked, how it works and whether or not it can be maintained for future success. In addition, they provided key information for replication across communities within and outside of the State of Alabama. The ultimate goal included building and promoting trust, respect, open communication, empowerment, improved health outcomes and improving quality of life. Figure 6 summarizes the design of the survey.

| Research Question | Survey Question and Topic | Range |
|---|---|---|
| | 1) Role or position in the program | 1, 2 = Program Administrator. 3, 4 = CHA |
| 1) Differences in knowledge between Program Administrators and CHAs in respect to identifying and promoting the development of social capital | 2) Goals of program | 0 -5 (5 = more goals identified) |
| | 3) Reasons to participate in program | 0 -4 (4 = more goals identified) |
| | 4)Barriers to community engagement | 0 -4 (4 = more barriers identified) |
| | 5) Experience 1 | 0 -5 (5 = more experience) |
| | 6) Experience 2 | 0-7 (7 = more experience) |
| | 7) Strategies for collecting information | 0 -3 (3 = more strategies identified) |
| | 8) CHA model's concepts | 0 -3 (3 = more concepts identified) |
| 2) Differences in knowledge between Program Administrators and CHAs in respect to linking and engaging community residents to social capital | 9) Promoters of community engagement | 0 -4 (4 = more promoters identified) |
| | 10) Agencies and programs for referrals | 0 -10 (10 = more agencies identified) |
| | 11) Resources the program has no access to | 0 -4 (different reasons for lack of access) |
| | 12) Participation in community education and events | 0 -7 (7 = more participation) |
| | 13) Projects community assists with | 0 -7 (8 = more projects identified) |
| 3) Differences in knowledge between Program Administrators and CHAs in respect to building and expanding the community's capacity to recognize, maintain, and solve health problems | 14) Reasons for strengthening community capacity | 0 -4 (4 = more reasons identified) |
| | 15) Core roles of CHAs | 0-7 (7 = more core roles identified) |
| | 16) Additional roles of CHAs | 0 -3 (3= more additional roles identified) |
| | 17) Core skill areas of CHAs | 0 -9 (9= more core skills identified) |
| | 18) Skills to build and maintain community capacity | 0 -3 (3= more skills identified) |
| | 19) Service coordination skills | 0 -4 (4= more skills identified) |

*Figure 6*. Survey design.

| Research Question | Survey Question and Topic | Range |
|---|---|---|
| | 20) Types of community knowledge needed by CHA's | 0 -3 (3= more types identified) |
| 1) Differences in perception between the Program Administrators and CHAs in respect to the program's performance in identifying and promoting the development of social capital | 21)Trust, reciprocity, mutual understanding | 1= Poor, 2=Fair, 3=Good, 4=Very Good, 5=Excellent |
| | 22) Clarity of program goals | |
| | 23) Sensitivity to needs of congregants | |
| | 24) Confidence in advice and assistance | |
| | 25.1) to 25.10) interaction with resources | |
| | 26) Most frequent concerns of congregants | 1 -9 (1=most frequent, 9= least frequent) |
| | 27.1) to 27.9) Educational topics most often discussed with congregants | 1=yes, 2= no |
| 2) Differences in perception between Program Administrators and CHAs in respect to the program's performance in linking and engaging community residents to social capital | 28)Community engagement achieved by the program | 1= Poor, 2=Fair, 3=Good, 4=Very Good, 5=Excellent |
| | 29) Program's ability to engage other organizations in the community | |
| | 30) Program's ability to promote diversity in community partners | |
| | 31) Program's ability to discuss community issues with elected officials | |
| | 32.1) Participation | 1= Low, 2= Expected, 3=High |
| | 32.2) to 32.5) Reasons for low participation (if perceived) | 1=yes, 2= no |
| | 33.1) to 33.6) Best strategies to promote community engagement | 1=yes, 2= no |

| Research Question | Survey Question and Topic | Range |
|---|---|---|
| 3) Differences in perception between Program Administrators and CHAs in respect to the program's performance in building and expanding the community's capacity to recognize, maintain, and solve health problems | 34.1) 34.2) NOS and CHAs performance<br>35) NOS and CHAs training<br>36) Incorporation of community capacity characteristics in the program<br>37) Current operation of the program<br>38) Program's ability to improve access to health care<br>39) Program's management ability for project evaluation<br>40) Programs' management ability for ongoing evaluation | 1= Poor, 2=Fair, 3=Good, 4=Very Good, 5=Excellent |
| | 41.1) to 41.4) Services underutilized | 1=yes, 2= no |

*Research Design*

Survey research was determined to be the most useful research design to ascertain differences in knowledge levels between the PAs (CPH Board Members and Steering Committee Members) and CHAs (Neighborhood Outreach Specialists and CHA Volunteers). To estimate average similarities and differences between the groups to determine whether there were average difference between the groups an ANOVA model was used; one for each of the three research questions. Although the survey framework and development is explained in more detail in the following sections, the answers of sections 1, 2, and 3 in the Community Engagement Survey are scored for each individual. The scores are based on the training materials for the CHAs (Community Health Advisors Core Skills Curriculum Guide); so each individual has three scores, one for each of the first three sections of the Survey. These scores serve as the outcome variable in the ANOVA models. The goal is to compare the average score in each section for PAs and for CHAs. In each of the three sections the following model was used:

$$y_i = \mu_0 + \beta x_i + \varepsilon_i, \quad i = 1,...,n, \quad x_i = 0,1$$

where, $y_j$ = score of the $i$th individual; $\mu_0$ = mean score of the reference group; $\beta$ = effect in score for the non-reference group; $x_i = 0$ if the $i$th individual is in the reference group, 1 otherwise; $\varepsilon_i$ = error term for the $i$th individual; and $n$ = number of individuals.

Before using this model to make inferences about differences in scores between the two groups, certain assumptions were made such as (a) the errors $\varepsilon_i$ are assumed to be randomly distributed with mean zero and common variance; and (b) the errors associated with any pair of subjects are assumed to be independent of each other.

Departures from these assumptions were explored before making inferences. A departure from normality, if it is not too extreme, might be tolerated by the ANOVA model, as inferences are made on the means of the groups, and the means follow a normal distribution more closely than the observations themselves (Sahai & Ageel, 2000), according to the Central Limit Theorem. The normality assumption is examined using a Normal Probability Plot of the residuals for each model. If the normality assumption is extremely violated, transformations on the data can be attempted.

Departures from the assumption of homogeneity of variances when the number of subjects in each group is different might result in biased analyses. Although in this investigation the expected group sizes do not differ greatly (64 PAs vs. 76 CHAs), if the common variance assumption is extremely violated, transformations on the data can be attempted as well. The common variance assumption is explored using a plot of the residuals against the predicted values for each model.

In case of extreme violations in the assumptions of the ANOVA model that can not be resolved by transformations on the data, non parametric procedures may be used. Specifically, the Kruskal-Wallis One-Way ANOVA by Ranks would be used for this investigation, if there are concerns with the validity of the conclusions derived from an ANOVA model due to extreme violations of its assumptions.

The questions on section 4 of the survey examined differences and similarities in perception of the CPH/SYH Program between the two groups, in regard to the three research questions. The nature of the data for the questions in section 4 is categorical. The answers for each of the three parts of section 4 are tabulated and summarized in histograms. Taking advantage of the ordinal nature of the answers (*Poor, Fair, Good, Very*

*Good, and Excellent*), statistically significant differences between the two groups are tested using Cochran-Mantel-Haenszel tests of association for 2 by 5 tables, with an ordinal scaled column variable (Stokes et al., 2002). The test statistic in this case is the "mean score statistic" and is distributed chi-square with one degree of freedom under the null hypothesis of no association between answers and group. For this investigation the interest is in the association between perception of the program and group membership (CHA or PA). The null hypothesis is that there is no association between the two groups and the answers, that is, there are no significant shifts of perception between the groups.

*Research Hypothesis*

For each of the first three sections of the survey, the research hypothesis was that there is a statistically significant difference in average knowledge scores between PAs and CHAs, that is, $H_A: \beta \neq 0$.

*Test Statistic*

The test statistic for the effect in a One ANOVA model is given by

$\frac{MS_{Model}}{MS_{Error}} \sim F(1,n-2)$, or equivalently, $\frac{\hat{\beta} - 0}{SE_{\hat{\beta}}} \sim t(n-2)$ under the null hypothesis

*Decision Rule*

The null hypothesis will be rejected if the derived t score value is equal or greater than the critical value, at $\alpha = 0.05$ and n-2 degrees of freedom.

*Survey Instrument Pilot Testing*

In order to establish instrument validity and reliability a baseline assessment of measurement was conducted through a pilot test. Therefore, since this study did not ask for measurements of standard or a change in opinions over time a similar a comparison group was chosen. The goal of the pilot was to assess survey questions clarity, fit, appropriateness and participant comprehension of the survey instrument.

Pilot test participants included Board Members and CHAs from the American Cancer Society (ACS) located in Birmingham, Alabama. Their overall program objective upon inception, involved working to eliminate cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer. This is being achieved by implementing programs related to community education, research advocacy and service. The ACS Jefferson/Shelby Unit has been active since 1966 with 770 community volunteers. In addition, there are 17 full-time employees and 47 board members all coming from the Jefferson/Shelby community. ACS was chosen for the pilot test because of the similarities to the Congregations for Public Health Program. For example, ACS participants received New Board Member Orientation Training, they have related program purposes, location offers limited travel for data collection, community residents share some of the same or similar health issues and/or characteristics and each program has years of existence. Participants surveyed in the pilot test included three ACS Board Members and three ACS Volunteers. Initially, pilot participants were notified by e-mail and followed up with a phone call to confirm there participation. The pilot took approximately 3 months to conduct because of time constraints or scheduling problems with the pilot participants. Individual interviews were conducted for each pilot participant at a lo-

cation of their choice. Participants were asked to provide feedback regarding the format, wording, clarity, ease and overall design. Upon completion, pilot test participants indicated that the average completion time of the survey was 30 min. The following modifications were incorporated into the survey based on pilot test responses and feedback from the UAB Center for the Study of Community Health and dissertation committee: formatting corrections, abbreviation use limited and/or removed, and definitions clarified.

Formatting corrections involved grouping all questions by category into four primary sections which included SC, community engagement, CC and an opinion scale. The next set of modifications involved limiting and/or removing abbreviations. Pilot participants found many of the abbreviations to be confusing and/or unnecessary because it made the sentence flow of the survey questions choppy. As result of this feedback, definitions were also added in order to enhance understanding and in order to accommodate the range in experience and training among participants. Final modifications involved minor changes in regards to spelling corrections, changing font sizes, and overall page layout.

*Protection of Human Subjects*

Institutional Review Board (IRB) approval was obtained from UAB. Informed consent was not a factor in this study because the data collected did not pertain to or require the release of personal/protected health information. However, the UAB IRB officials and UAB Center for the Study of Community Health were available to answer questions regarding their area of expertise (Appendix D).

*Data Analysis*

Data collected from the surveys were recorded and organized using SPSS v.11 for Windows, However, all data analyses were performed using SAS v.9.1 for Windows, because Cochran-Mantel-Haenszel tests of association for 2 by 5 tables, with an ordinal-scaled column variable, are available in SAS but not on SPSS.

# CHAPTER 4

# RESULTS

In this chapter, the overall descriptive information of the data is presented. The focus of the study was multifaceted. It was designed to examine and compare how community engagement knowledge of PAs and CHAs can be shaped and affected by SC and CC. This was achieved by analyzing the Congregations for Public Health's Search Your Heart Program. My primary goal was to assess the effectiveness of the American Heart's Search Your Heart CHA training by examining SC, CC, and community engagement knowledge of the PAs and CHAs. As stated in the initial overview of the study, the following research questions were used:

1. What is the relationship between the community engagement knowledge of the PAs and the Community Health Advisors in respect to identifying and promoting the development of SC?

2. What is the relationship between the community engagement knowledge of the PAs and the Community Health Advisors in respect to linking community residents to SC?

3. What is the relationship between the community engagement knowledge of the PAs and the Community Health Advisors in respect to building and expanding the community's capacity to recognize, maintain, and solve health problems?

The total number of participants targeted for the survey included 9 CPH Board Members, 55 Steering Committee Members, 6 Neighborhood Outreach Specialist, and 70

volunteers. Total number of participants targeted equaled 140. However, the total number of participants that completed surveys and the breakdown of participants can be viewed in Table 1.

Table 1

*Survey Participants by Group Membership*

| Group | Position title | Number of participants targeted | Number of surveys received *n* (%) |
|---|---|---|---|
| PAs | CPH board members | 9 | 6 (67) |
| | Steering committee members | 55 | 50 (91) |
| Total PAs | | 64 | 56 (88) |
| CHAs | Neighborhood outreach specialists | 6 | 7 (100) |
| | CHA volunteers | 70 | 30 (43) |
| Total CHAs | | 76 | 37 (49) |
| Total participants | | 140 | 93 (67) |

*Note.* CHA = Community Health Advisors; CPH = Congregations of Public Health.

Combined there were 56 CHAs (Board Members & Steering Committee Members) and 37 PAs (Neighborhood Outreach Specialists & Volunteers) that participated in this research study survey.

Overall, the results showed that upon examination of each of the three relationship hypotheses there were no primary differences in average knowledge between the groups. However, there were some significant relationships that are explained in further detail in this chapter. Differences in knowledge were examined using two key analyses. The first analysis represents knowledge scores from individuals that completed all questions within a section. Three ANOVA tests were utilized one for each of the first three

sections of the survey which included: social capital, community engagement coordination and community capacity.

A second primary analysis was also used in the study. However, in this research paper only analysis two will be expounded upon. This analysis used all information available regardless of the number of questions completed in each section. Figure 7 provides a visual diagram of the histogram of scores. The figure displays the basic measures of location and spread for the scores. Location is reported using the mean and median. In section 1 (SC), there were 87 people that completed all questions in this section. The group break-down divides into 35 Program Administrators (Board and Steering Committee Members) and 52 CHAs (Neighborhood Outreach Specialists and CHA Volunteers). The mean distribution/average score of the 87 was 13.67 with a median distribution score of 13.0. However, the data results revealed a minimum score of 2 and a maximum of 31. The measure of spread was reported using the standard deviation, which was 5.84 for section 1 (SC).

For section 2 (Community Engagement Coordination) of the survey using the second analysis, Figure 8 provides a histogram of the scores. In section 2, there were 87 people that completed all questions in this section. The group break-down divides into 35 Program Administrators (Board and Steering Committee Members) and 52 CHAs (Neighborhood Outreach Specialists and CHA Volunteers). The mean distribution or average score of the 87 participants was 9.64 with a median distribution score of 9.0. However, the data results revealed a minimum score of 1 and a maximum of 23. The measure of spread was reported using the standard deviation, which was 7.49 for section 2 (Community Engagement Coordination).

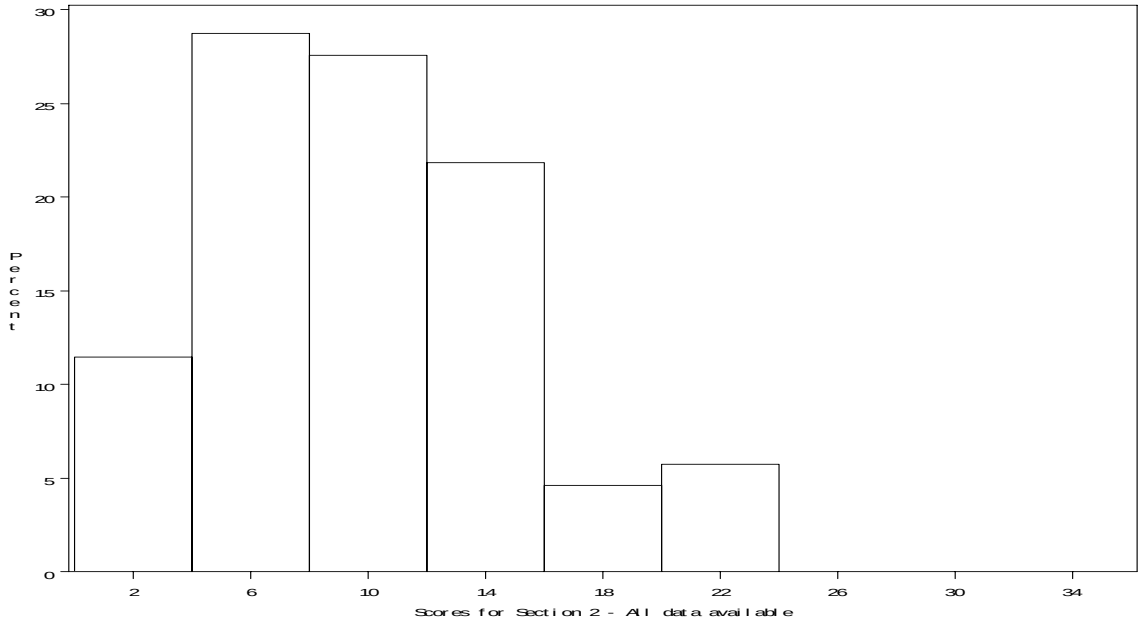


*Figure 7*. Distribution of scores for section 1 (SC; all data available).

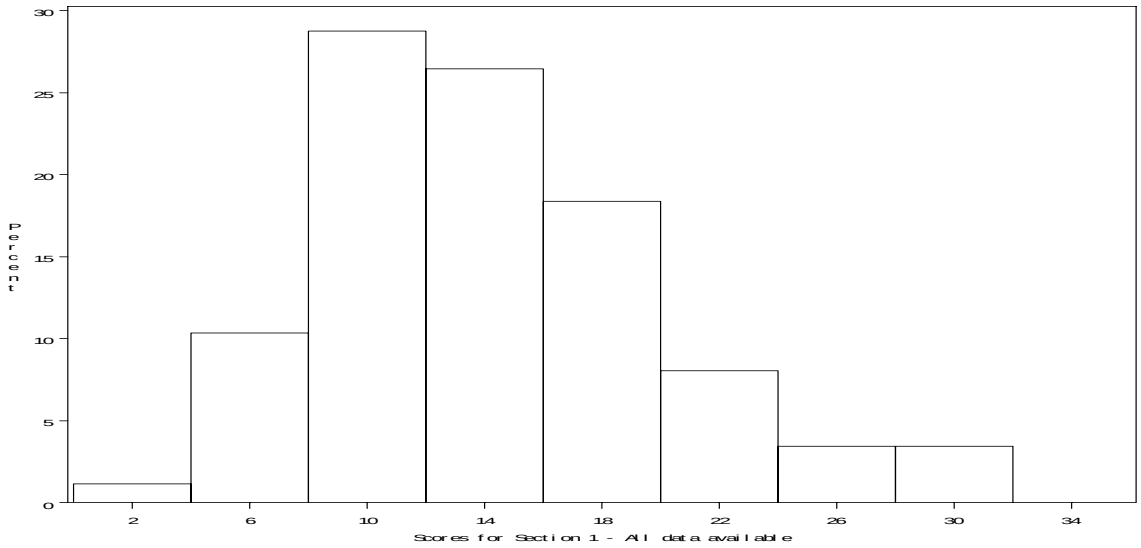


*Figure 8*. Distribution of scores for section 2 (Community Engagement Coordination; all data available).

In section 3 (Community Capacity) of the survey using the second analysis, Figure 9 provides another visual diagram of the histogram of scores. In section 3, there were 84 people that completed all questions in this section. The group break-down divides into 34 PAs (Board and Steering Committee Members) and 50 CHAs (Neighborhood Outreach Specialists and CHA Volunteers). The mean distribution or average score of the 84 was 21.29 with a median distribution score of 21.5. However, the data results revealed a minimum score of 7 and a maximum of 33. The measure of spread was reported using the standard deviation, which was 7.49 for section 3 (Community Capacity).

As mentioned previously, the results showed that upon examination of each of the three relationship hypotheses there were no primary differences in average knowledge between the groups. Based on the given model:

$$y_i = \mu_0 + \beta x_i + \varepsilon_i, \quad i = 1,...,n, \quad x_i = 0,1$$

where, $y_j$ = score of the $i$th individual; $\mu_0$ = mean score of the reference group; $\beta$ = effect in score for the non-reference group; $x_i = 0$ if the $i$th individual is in the reference group, 1 otherwise; $\varepsilon_i$ = error term for the $i$th individual and $n$ = number of individuals, Table 2 shows the $t$ values, corresponding to each of the t-tests applied.

The analysis of the differences in opinions is based on section 4 of the survey. This section was designed in a Likert-scale design in order to capture participant differences and similarities in perception of the CPH/SYH Program. In addition, it also provided feedback regarding participant relationships, satisfaction and understanding of the program goals, services, resources, and so on. The statistical analysis revealed six significant differences in perceptions between the CHAs and the PAs.

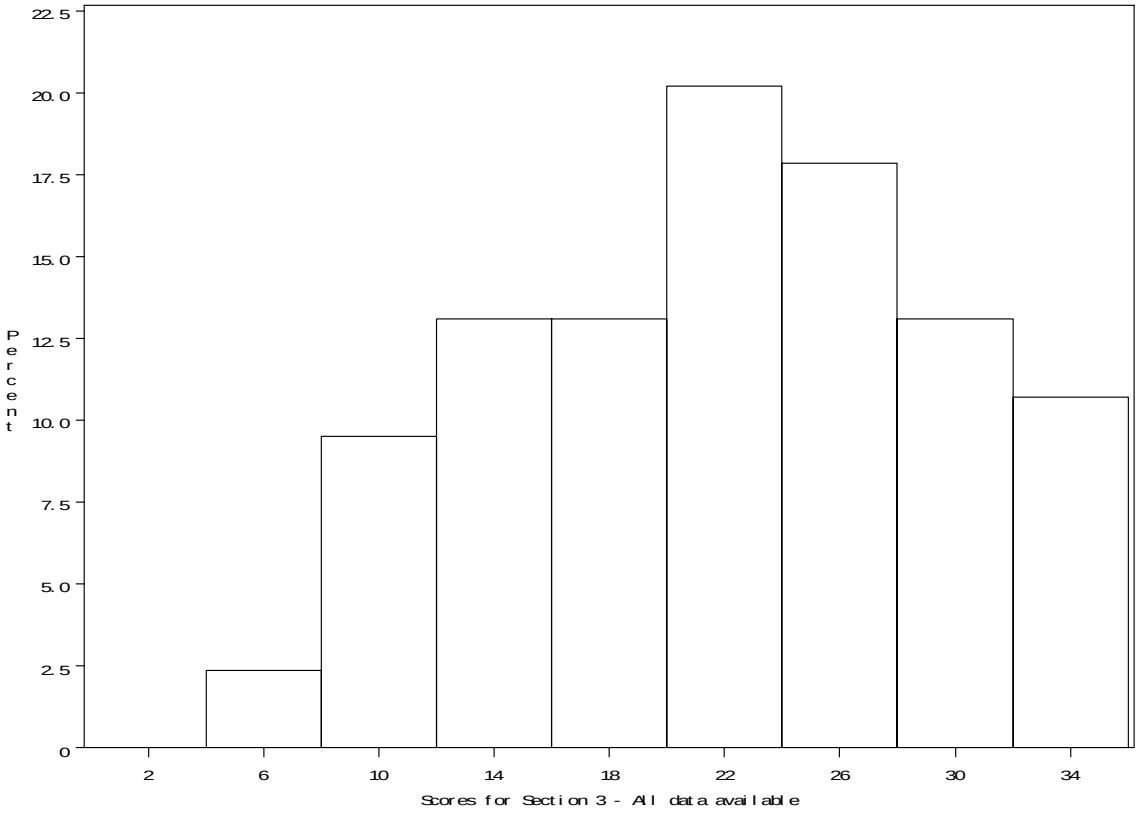


*Figure 9.* Distribution of scores for section 3 (Community Capacity; all data available).

Table 2

*Tests of Average Differences in Scores for Sections 1, 2 and 3*

| | Section 1* Social Capital | | Section 2* Community Engagement Coordination | | Section 3* Community Capacity | |
|---|---|---|---|---|---|---|
| Scores | CHAs n=11 | PAs n=23 | CHAs n=11 | PAs n=25 | CHAs n=34 | PAs n=50 |
| Average (sd) | 18.2 (6.5) | 17 (5.1) | 15.1 (4.6) | 13.2 (3.6) | 21.5 (7.4) | 21.2 (7.6) |
| Scores | CHAs n=35 | PAs n=52 | CHAs n=35 | PAs n=52 | CHAs n=34 | PAs n=50 |
| Average (sd) | 13.3 (6.5) | 13.9 (5.4) | 9.3 (5.4) | 9.8 (5.1) | 21.5 (7.4) | 21.2 (7.6) |

*T-tests. Differences not significant at alpha = 0.05

Survey Question 25, answer choice 3, was the first significant response. The question states: Please rate each of the following resources based on how well they interact/participate with the overall program with a rating scale from 1 (*Poor*) to 5 (*Excellent*). Answer choices included rating local retail, clinical/health services, housing assistance, emotional psychiatric services, educational services/assistance, public transportation services, civic/political leadership, recreational services, financial assistance/counseling, and employment. The significant answer choice was housing assistance with 38% of the CHAs rating housing assistance as poor, while the other 35% of CHAs and 51% of PAs rated it as good. When you do a comparison of the CHAs and the PAs, the PAs thought housing assistance in regards to interaction/participation in the program was better. Table 3 provides a visual comparison of the differences. The Cochran-Mantel-Haenszel Statistic P value for General Association is 0.0468. This is significant since the value is smaller than .05.

The second significant response was survey question 26, answer choice 5. The question asked if there were frequent concerns or type of advice sought by community

congregants/church members with a ranking scale of 1 (*the most frequent/important*) to 9 (*the least in regards to importance)*. Answer choices included ranking health, physical activity and fitness, transportation services, insurance, medication assistance, nutrition, community safety/crime, stress/emotions/feelings, and financial stability. The significant answer choice was medical assistance. Approximately 35% of the CHAs found that medical assistance was the most frequent/important concern or type of advice sought by community congregants/church members. However, when you compare their response to the PAs, only 19% of the PAs found medical assistance to be an important concern or type of advice sought by community congregants/church members. Table 3 provides a visual comparison of the rankings. The Cochran-Mantel-Haenszel Statistic P value for General Association is 0.0298. This is significant since the value is smaller than .05.

The third significant survey response was question 26, answer choice 8. The question asked what are the most frequent concerns or type of advice sought by community congregants/church members with a ranking scale of 1 (*the most frequent/important*) to 9 (*the least in regards to importance*). Answer choices included ranking health, physical activity and fitness, transportation services, insurance, medication assistance, nutrition, community safety/crime, stress/emotions/feelings, and financial stability. The significant answer choice was stress/emotions/feelings. Thirty-five percent of CHAs thought stress and emotions were less important versus 17% of PAs who ranked it as important. Further comparison also shows that 5.88 % of PA's ranked it as being a frequent/important concern while 0% of CHAs found it to be an issue that was frequent and/or important. There was no clear pattern among the PAs. Their opinion seems to be spread on the ranking scale, whereas the CHAs spread were shorter. It clustered toward the unimportant end of

the scale. Table 3 provides a visual comparison of the ratings. The Cochran-Mantel-Haenszel Statistic P value for General Association is 0.0211. This is significant since the value is smaller than .05.

The fourth significant survey response was question 30. This question asked participants to rate the CPH/SYH program's ability to promote commitment to community engagement that is inclusive and encourages diversity among all community partners with a rating scale of 1 (*Poor*) to 5 (*Excellent*). The CHA results showed a small range of variation which clustered in the good area. However, the PAs were more spread over the opinion scale and clustered between good and very good. 66% of CHAs felt the program did a good job of promoting commitment to community engagement while only 36% of PAs gave the program a good rating. Table 3 provides a visual comparison of the ratings. The Cochran-Mantel-Haenszel Statistic P value for General Association is 0.0437. This is significant since the value is smaller than .05.

The fifth significant survey response was question 32, answer choice 1. The question asked participants if they thought participant numbers were low, expected/ appropriate, or high with 60% of CHAs answering that participation turn out was as expected while 2% of CHAs thought it was higher than expected. When you do a comparison of the PAs you find that 60% thought participation turned out as expected while 17% thought participation was higher than expected. Table 3 provides a visual comparison of their responses. The Cochran-Mantel-Haenszel Statistic P value for General Association is 0.0235. This is significant since the value is smaller than .05.

The final significant survey response was question 41, answer choice 1. The question asked if services may be under used or under taught. Answer choices included indi-

vidual health (i.e., services to teach self-check for blood pressure, nutrition, and safety), leadership skills, communication techniques, and health treatment, prevention, and maintenance (i.e., clinic services). 91% of CHAs felt that individual health services were under utilized, while only 63% of PAs agreed with them. Table 3 provides a visual comparison of their responses. The Cochran-Mantel-Haenszel Statistic P value for General Association is 0.0043. This is significant since the value is smaller than .05.

In addition, to the earlier mentioned results, section 4 (Relationship Scale) provided opinion feedback in regards to congregant satisfaction and understanding of program resources/SC, community engagement, and program sustainability/CC. Three questions were selected from each area in order to give a general overview of participant opinions and satisfaction. Although none of the questions selected were found to be significant, the responses provide insight into the program success and lack of difference in knowledge among congregants.

Section 4, part 1 addressed SC. Again, the primary focus involved identifying study participant's role, assessing their understanding of the program design and vision, and as a mechanism to identify community partnerships. The questions selected for further review included numbers 22, 23, and 26.

Question 22 asked the participants to rate the clarity of the CPH/SYH project goal. Answer choices were rated on a scale ranging from 1 (*poor*) to 5 (*excellent*). The responses showed that the majority response for both groups CHAs and PAs was very good. Table 4 provides a visual breakdown of their responses.

Question 23 from the survey asked if the CPH/SYH program was sensitive to the needs of the congregants/church members. The responses showed that the majority

Table 3

*Questions That Resulted in Significant Differences Between Groups (CHAs or PAs)*

| Question | Answer | CHAs *n* (%) | PAs *n* (%) |
|---|---|---|---|
| Question $25_3$ (*p*-value* = 0.0486) | | | |
| Please rate each of the following resources [Housing Assistance] based on how well they interact/participate with the overall program | Poor | 12 (38.7) | 5 (11.1) |
| | Fair | 3 (9.6) | 11 (24.4) |
| | Good | 11 (35.4) | 23 (51.1) |
| | Very Good | 4 (12.9) | 4 (8.8) |
| | Excellent | 1 (3.2) | 2 (4.4) |
| Question $26_5$ (*p*-value* = 0.0298) | | | |
| What are the most frequent concerns [Medical Assistance] or type of advice sought by community congregants? | 1=Most frequent | 12 (35.2) | 10 (19.6) |
| | 2 | 1 (2.9) | 13 (24.4) |
| | 3 | 9 (26.4) | 5 (9.8) |
| | 4 | 5 (14.7) | 5 (9.8) |
| | 5 | 2 (5.8) | 4 (7.8) |
| | 6 | 3 (8.8) | 3 (5.8) |
| | 7 | 0 (0) | 4 (7.8) |
| | 8 | 2 (5.8) | 4 (7.8) |
| | 9= Least frequent | 0 (0) | 3 (5.8) |
| Question $26_8$ (*p*-value*=0.0211) | | | |
| What are the most frequent concerns [Emotions/feelings] or type of advice sought by community congregants? | 1=Most frequent | 0 (0) | 3 (5.8) |
| | 2 | 1 (2.9) | 3 (5.8) |
| | 3 | 2 (5.8) | 1 (1.9) |
| | 4 | 1 (2.9) | 8 (15.6) |
| | 5 | 7 (20.5) | 7 (13.7) |
| | 6 | 8 (23.5) | 5 (9.8) |
| | 7 | 3 (8.8) | 6 (11.7) |
| | 8 | 12 (35.2) | 9 (17.6) |
| | 9= Least frequent | 0 (0) | 9 (17.6) |
| Question 30 (*p*-value* = 0.0437) | | | |
| Please rate the CPH/SYH program's ability to promote commitment to community engagement that is inclusive and encourages diversity among all community partners? | Poor | 0 (0) | 1 (2.1) |
| | Fair | 3 (9.1) | 5 (10.2) |
| | Good | 22 (66.6) | 18 (36.7) |
| | Very Good | 4 (12.1) | 20 (40.8) |
| | Excellent | 4 (12.1) | 5 (10.2) |

Table 3 (Continued)

| | Answer | CHAs *n* (%) | PA *n* (%) |
|---|---|---|---|
| Question $32_1$(*p*-value*=0.0235) | | | |
| Do you think participant numbers are? | Low | 13 (37.1) | 11 (21.5) |
| | Expected | 21 (60.0) | 31 (60.7) |
| | High | 1 (2.8) | 9 (17.6) |
| $Q41_1$ (*p*-value*=0.0043) | | | |
| What services [Individual Health] may be under utilized and/or under taught? | No | 3 (8.8) | 17 (36.96) |
| | Yes | 31 (91.1) | 29 (63.04) |

*Note*. CHAs = Community Health Advisors; PA = Program Administrators. *CMH general association test, or CMH chi-square test.

response for both groups CHAs and PAs rated in a range between good and very good. Table 4 provides a visual breakdown of their responses.

Question 26 asked the participants what were the most frequent concerns or type of advice sought by community congregants/church members with a ranking scale of 1 (*the most frequent*) to 9 (*the least*). Table 4 provides a visual ranking of the answer choices for the CHAs and the PAs. Although, their answer choices did not show any significant differences, the most frequent concerns for both groups centered on health issues.

Section 4, part 2 of the research survey addressed Community Engagement Coordination. It included a description of the available community resources and partners. As stated previously, it is designed to be a measurement of the community's outreach and engagement activities. The information collected is helpful in identifying and prioritizing health concerns and knowledge. The questions selected for further review included numbers 28, 30, and 33.

Table 4

*Questions Chosen for Further Review From Section 4, Part 1*

| Question | Answer | Community Health Advisors *n* (%) | Program Administrators *n* (%) |
|---|---|---|---|
| Question 22 | | | |
| Please rate the clarity of the CPH/SYH projects goal? | Poor | 0 (0) | 1 (1.9) |
| | Fair | 3 (8.8) | 4 (7.6) |
| | Good | 13 (38.2) | 20 (38.4) |
| | Very Good | 14 (41.1) | 22 (42.3) |
| | Excellent | 4 (11.7) | 5 (9.6) |
| Question 23 | | | |
| To what degree do you feel that the CPH/SYH program is sensitive to the needs of the congregants? | Poor | 0 (0) | 1 (1.9) |
| | Fair | 2 (5.8) | 2 (3.9) |
| | Good | 12 (35.2) | 22 (43.1) |
| | Very Good | 14 (41.1) | 12 (23.5) |
| | Excellent | 6 (17.6) | 14 (27.4) |
| Question 26, frequency of concerns | | Combined rank by CHAs | Combined rank by PAs |
| Health (sickness/disease) | | 8 | 9 |
| Physical Activity & Fitness | | 6 | 4 |
| Transportation Services | | 5 | 7 |
| Insurance | | 4 | 5 |
| Medication Assistance | | 9 | 8 |
| Nutrition | | 3 | 3 |
| Community Safety/Crime | | 7 | 6 |
| Stress/Emotions/Feelings | | 2 | 1 |
| Financial Stability | | 1 | 2 |

*Note*. CHAs = Community Health Advisors; PA = Program Administrators.

Question 28 asked if the characteristics of community engagement are based on linking community stakeholders (individuals, families, government officials, business leaders and educational leaders etc.) to available health resources/services. How well do you feel this is being achieved in the CPH/SYH program? The answer choices ranged from 1 (*poor*) to 5 (*excellent*). Survey results can be viewed in Table 5. Based on their responses, CHAs and PAs felt the program did a good job in regards to community en-

gagement. This involved linking stakeholders to available resources such as clinical/health services, educational services/assistance, and civic/political leadership.

Question 33 from the survey asked the participants what strategies would best encourage community engagement in the program. Participants were asked to rank them in order of importance with 1 (*best*) through 5 (*least*). The answer choices included ranking transportation provided, child care provided, food or refreshments are made available, reminder calls or correspondence, Monetary incentives (e.g., raffles), and Other (please state). The survey results are shown in Table 5. These results show that a strong incentive for community engagement was childcare. In addition, both groups selected transportation as their least important incentive.

Table 5

*Questions Chosen for Further Review From Section 4, Part 2*

| Question | Answer | CHAs *n* (%) | PAs |
|---|---|---|---|
| Question 28 | | | |
| How well do you feel community engagement is being achieved in the CPH/SYH program? | Poor | 0 (0) | 1 (1.9) |
| | Fair | 6 (18.7) | 6 (11.7) |
| | Good | 17 (53.1) | 25 (49.1) |
| | Very Good | 4 (12.5) | 15 (29.4) |
| | Excellent | 5 (15.6) | 4 (7.8) |
| Question 33, strategies that would encourage participation | Combined rank by CHAs | Combined rank by PAs | |
| Transportation | | | |
| Childcare | 4 | 5 | |
| Food or refreshments | 3 | 4 | |
| Reminder calls | 2 | 2 | |
| Monetary incentive | 5 | 3 | |

*Note*. CHAs = Community Health Advisors; PA = Program Administrators.

Section 4, part 3 of the research survey focused on Community Capacity. As mentioned previously, it examines the community's capacity for program evaluation and sustainability. This is an opportunity to measure program performance and identify effective practices that may encourage or discourage community participation. The questions selected for further review included numbers 35, 37, and 40.

Question 35 asked how well the participants felt NOS and CHA volunteers had been trained to respond to community needs. The answer choices ranged from 1 (*poor*) to 5 (*excellent*). Overall, CHAs and PAs felt that the NOS and CHA volunteers were well trained in regards to being able to respond to community needs. Table 6 provides a visual diagram of their responses.

Question 37 asked participants to consider the CPH/SYH program design and rate how well the program was currently operating. Congregants rated the program from 1 (*poor*) to 5 (*excellent*). Their responses ranged between *good* and *very good* as shown in Table 6.

The final question selected for further review was number 40, which asked the participants to rate the CPH/SYH projects capacity for ongoing evaluation as a management tool to sustain the project. The answer choices ranged from 1 (*poor*) to 5(*excellent*). Table 6 shows their responses ranged between good and very good.

Although none of the additional questions were significant, the responses to these questions displayed how congregants share a common interest in community engagement for the sake of improving community health outcomes. However, it is also important to recognize that these interests may also originate out of numerous situations including personal, professional and/or cultural health circumstances.

Table 6

*Questions Chosen for Further Review From Section 4, Part 3*

| | Answer | CHAs *n* (%) | PAs *n* (%) |
|---|---|---|---|
| Question 35 | | | |
| How well do you feel NOS and CHA Volunteers have been trained to respond to community needs? | Poor | 0 (0) | 0 (0) |
| | Fair | 3 (8.8) | 2 (3.9) |
| | Good | 16 (47.1) | 22 (43.1) |
| | Very Good | 10 (29.4) | 20 (39.2) |
| | Excellent | 5 (14.7) | 7 (13.7) |
| Question 37 | | | |
| When you consider the CPH/SYH program design, please rate how well you think the program is currently is operating? | Poor | 0 (0) | 0 (0) |
| | Fair | 3 (8.8) | 4 (7.6) |
| | Good | 14 (41.1) | 16 (30.7) |
| | Very Good | 12 (35.2) | 27 (51.9) |
| | Excellent | 5 (14.7) | 5 (9.6) |
| Question 40 | | | |
| Please rate the CPH/SYH projects capacity for ongoing evaluation as a management tool to sustain the project? | Poor | 0 (0) | 0 (0) |
| | Fair | 3 (8.8) | 2 (3.9) |
| | Good | 16 (47.1) | 20 (39.2) |
| | Very Good | 12 (35.2) | 23 (45.1) |
| | Excellent | 3 (8.8) | 6 (11.7) |

*Note*. CHAs = Community Health Advisors; PA = Program Administrators.

# CHAPTER 5

## SUMMARY

This research study was designed to examine and compare the community engagement knowledge of PAs and CHAs using SC and CC. The study results showed that upon examination of each of the three relationship hypotheses there were no primary differences in average knowledge between the groups (CHAs and PAs). In addition, the survey provided extensive feed back regarding the identification and understanding of program resources/SC, the benefits and need for community engagement, and the impact of the program on sustainability/CC.

As stated in the literature review, the combined efforts and benefits of SC, community engagement, and CC are numerous. However, this research builds on the foundation that the combined efforts of these characteristics are unlimited when you incorporate the use of community residents who are willing to dedicate the time and energy required for changing community health outcomes. The utilization of CHAs in community based studies, as shown in this research study, can be a beneficial asset to program administration, program design and implementation, and service delivery. In addition, it is also becoming an important component to securing grant funding from local, state, and federal agencies (Lasker & Weiss, 2003).

*Strengths and Implications*

The CPH/SYH Project is credited with being one of the largest and longest running community based CHA programs in the area. This longevity may be credited to the programs on going recruitment of community volunteers, the promotion of community health awareness activities, continuous CHA training programs, a common health agenda, and their desire to increase community health education knowledge. In addition, the project has strong interaction and oversight from the Center for the Study of Community Health at UAB. Their monthly health initiatives include programs related to prescription drug education, promoting good nutrition habits, diabetes awareness, and teaching community congregants how to conduct routine high blood pressure checks. If you do a comparison of the roles and competencies recommended by the National CHA Study you will find many of them are currently being incorporated into the activities and events promoted by the CPH (Figure 10).

The benefits of these interactions can also be linked back to the characteristics found in the PCE because they share a common desire for improved health outcomes based on active engagement within their community. Again, the fundamental concepts of PCE include social ecology, community participation, capacity building, benefits and cost, cultural influence, community empowerment, coalitions, community organization, and stages of innovation. If you compare these principles to the CPH/SYH Project, you will find the characteristics of PCE incorporated throughout the project. For example, social ecology speaks to congregants having the opportunity for dynamic interplay within their environment. On a monthly basis, there are opportunities to attend culturally related health seminars for strokes, diabetes, nutrition, and high blood pressure maintenance.

| COMPARISON OF NATIONAL ROLES & COMPETENCIES TO CONGREGATIONS FOR PUBLIC HEALTH | |
|---|---|
| **National CHA Core Roles and Competencies** | **CPH Role and Competencies** |
| • Bridging cultural mediation between communities and the health and social service systems<br>• Providing culturally appropriate health education and information<br>• Assuring that people get the services they need<br>• Providing informal counseling and social support<br>• Advocating for individual and community needs<br>• Providing direct service (such as first-aid and screening tests)<br>• Building individual and community capacity (such as helping individuals establish healthy lifestyles, helping communities address environmental health problems) | • Partnerships have been established with the local American Heart Association and the Magic City Stroke Prevention Project<br>• Monthly and continuous health events to date include:<br>o Diabetes Health Fair at Bethel Baptist Church<br>o Blood Pressure Checks at Faith Apostolic Church, Lily Grove Baptist Church, First Baptist Fairfield Church, and Bethel Baptist Church<br>o NOS participate in weekly strategic planning sessions<br>o Monthly CPH Board Meetings are held at Bethel Baptist Church<br>o Physical Fitness, Stress Reduction, and Nutrition Classes are held at individual churches<br>• Program personnel includes Administrative oversight via a Program Manager with the Center for the Study of Community Health<br>• Annual CPH Volunteer Appreciation Dinners are held for Steering and Volunteer Committee Members<br>• CHA's and PAs have received over 80 hours of training<br>• There is ongoing recruitment for Steering and CHA Volunteers<br>• There is ongoing volunteer and Search Your Heart Training<br>• Phase II Community Survey Project – under development for implementation in 2006/2007 |

*Figure 10.* Comparison of national CHA study to CPH.

It is an opportunity for active learning. Congregants not only learn how to properly measure their blood pressure, but also proper techniques for preparing nutritional and/or diabetic compliant meals. The hidden benefits also include community participation and organization. As shown in the demographic information, the majority of the congregants are African American families, which indicates many of them may be at risk for health problems such as overweight, low physical activity, poor nutritional habits, high cholesterol, absence of adequate medical treatment and cultural/hereditary traits. These seminars empower congregants by teaching them that they have the ability to act and maintain behavioral actions. It builds their capacity to maintain these behaviors by giving them the resources, knowledge and skills needed for preventing, maintaining or treating their medical condition(s).

Community organizations such as Magic City Stroke Prevention and the American Heart Association have joined forces to provide congregants with the information they need in order to achieve long term cost benefits. The end result is improved quality of life, cost savings on medical bills and/or insurance, and improved standards of health care. PCE provides a health framework that is useful when examining and improving community/individual health behavior.

The benefits of this study are numerous. Although the results did not indicate any primary differences in average knowledge among the groups, their willingness to participate provides insight into the combined efforts of SC, CC, community engagement, and the use of CHAs. Together, these concepts promote positive collaboration/community engagement among all community congregants. It is an opportunity to enhance knowledge, change attitudes and beliefs, and motivate individuals to improve and/or change

health outcomes. It is also an opportunity to test program administration through implementation.

In chapter 1, SC was defined as the currency or resources produced and used by individuals and groups working together (Bloom, 1999). Through CPH, participants have access to SC in the form of program staff, printed materials, health services, health agencies, and organized CHA training. These resources are beneficial because they enhance program success, provide congregants with accurate health information, increases understanding of program goals, and serve as a support system for program implementation. These resource assets in turn lead to an examination of CC, which investigates whether or not community member's posses the necessary skills and ability to use SC. Their intensive training is primary to sustainability because it provides education, skill enhancement, community empowerment and provides hands-on experience in regards to community engagement.

Community engagement is not a new concept as stated previously; rather it is an old practice that promotes ownership, open communication, and networking between community residents and resources. It is an idea that has been tried, tested, and reshaped for a new generation. It is a key layer in the foundation of Congregations for Public Health. Through the use of paid and unpaid volunteers, the program uses individuals who are dedicated to change, will to collaborate and committed to serving and helping others. These individuals are identified as CHAs. They are community residents chosen for a variety of community engagement characteristics, which includes their familiarity with the community and residents, friendship, trust, leadership skills and belief in reciprocity.

*Study Limitations*

Although the total number of surveys completed and returned was good, there were some observed limitations. The first limitation pertained to survey length. Survey design focused on developing and incorporating a variety of questions that would provide a broad range of responses and insight into the program success and future. Although a great deal of feed back was collected, in some instances congregants were overwhelmed with the survey length. It took approximately 4 months to issue, collect, and analyze all surveys. The average time taken to complete the seven-page survey was 30 min. Although the initial surveys were administered at the beginning of the community meetings or events, because of the survey length and completion time, the research survey presentations were eventually moved to the end of the program agenda.

A second limitation observed pertained to program training. Initially all members recruited to the program received extensive CHA training. However, as the program continues to evolve and members continue to matriculate in and out of the program, new member training faces a slight challenge. This challenge involves identifying and implementing training classes for new congregants. In the initial stages of program development, congregants had an opportunity to participate in large group training sections. They initially received over 80 hr of training. However, as the number of new congregants that matriculate in the program are smaller and the time of matriculation varies, smaller training groups may or may not be feasible when you consider time, location and the number of participants per session. There were approximately four congregants who declined participation because of being new to the program and time constraints. Participants felt

their lack of or limited training would not allow them to provide adequate feed back that would be beneficial to the survey research.

Although they may seem to be minor in nature, there were some additional observations that may or may not be considered limitations, but are important to note. In addition, these situations are often typical to most community-based programs (National CHA Study, 1998). First, participant numbers were smaller than typical health and/or clinical research studies. This may be caused by years of declining community involvement; however, there is an increasing push to encourage communities and their citizens to have a more informed say (Morse, 2004). Second, congregants often served multiple roles. In this research study, there were several members who severed on the initial steering committee, but they also worked with the program as community volunteers. Third, the number of congregants and churches in the project has changed slightly. Currently, there are six active churches involved in the CPH/SYH Project. However, it is important to note that CPH continuously promotes and encourages full and ongoing participation in the project regardless of an individual's and/or church's depth of participation. Therefore, it is necessary to point out that congregant/church numbers did fluctuate during this research study.

*Future Implications*

Where do we go from here? The potential of this study is limitless; however, a primary challenge will be to increase the awareness of community engagement and its benefit to volunteerism. As demonstrated in the review of the literature, the growth of technology has resulted in an electronic reliant generation. We rely upon cell phones,

computers, high speed internet connections, cable and satellite television, ipods, and blackberry's to keep us connected to our community and the outside world. As society ages and technology continues to advance, they will become either friend or foe. We can avoid the clash if we focus on designing health education/health promotion programs and interventions that incorporate components for participant retention, increased presence of CHAs in research, continuous CHA training, networking with other educational and health disciplines, increased cross community interaction, and program replication.

The implications from this research study extend beyond CPH. Programs such as this serve as a model demonstration for building and promoting community ownership, health awareness, and community engagement. Through active engagement PAs and CHAs benefit from extensive training and continuous learning opportunities. Participants are learning to work based on collaboration and not individual role isolation. They are able to gain a broader understanding of the combined efforts of Community Engagement, SC & CC. The results provide leaders with indicators of what works, why it works, and it offers practical guidelines/principles for closing the gaps in community health. Although the existence of health disparities is common knowledge among health educators, the challenge also includes securing funding resources for long-term sustainability. Eliminating many of these health issues will require support from funding resources that are willing to assist with supplies, staff, health programs/services, and participant engagement incentives.

*Conclusion*

Overall, the lack of differences and program success may be a result of program characteristics such as program design, prior experience of volunteers, the CHA training program, committed university support, a joint desire for improved health outcomes, and enhanced health knowledge. In addition, the congregant perception/feedback may prove to be a great asset to future programming and development.

The knowledge and insight gained from this research study is immeasurable. There were many challenges and situations that could be altered given hind-sight; however this study was intended only as a starting point for generating further and future conversations.

# REFERENCES

American Heart Association. (2003). *Search your heart coordinator's guide. 1997-2003.* Washington, D.C.: Author.

Ansari, W., Phillips, C. J., & Hammick, M. (2001). Collaboration and partnerships: Developing the evidence base. *Health and Social Care in the Community, 9*(4)*,* 215-227.

Ansari, W., Phillips, C. J, & Zwi, A. B. (2002). Narrowing the gap between academic professional wisdom and community lay knowledge: Perceptions from partnerships. *Public Health, 116,* 151-159.

Best, A., Stokols, D., Green, L. W., Leischow, S., Holmes, B., & Buchholz, K. (2003). An integrative framework for community partnering to translate theory into effective health promotion strategy. *American Journal of Health Promotion, 18*(2)*,* 168-172.

Bradley, R. (1999). Collaboration, complexity, and chaos. *National Civic Review, 88*(3)*,* 203-206.

Bloom, D. A. (1999). Exploring community change: Cause, effects, and motivation. *National Civic Review, 88*(4)*,* 293-301.

Brach, C., & Fraserierector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*(Sup1)*,* 181-217.

Brown, T. (1997). Opportunities for health and education to work together. *Health Education, 4,* 146-248.

Cannuscio, C., Block, J., & Kawachi, I. (2003). Social capital and successful aging: The role of senior housing. *Annual of Internal Medicine, 139*(5)*,* 395-399.

Centers for Disease Control and Prevention. (1997). *Principles of community engagement*. Retrieved April 12, 2004, from http://www.cdc.gov/phppo/pce/

Congregations for Public Health -UAB Center for the Study of Community Health. (2003). Funded by: Lucille Stewart Beeson Committee of Canterbury United Methodist Church.

Coleman, J. (1994). Social capital in the creation of human capital. *American Journal of Sociology, 4,* S95-S120.

Delbanco T, Berwick D. M., Boufford, J. I., Edgman-Levitan, S., Ollenschlager, G., Plamping, D., et al. (2001). Healthcare in a land called PeoplePower: Nothing about me without me. *Health Expectations, 4*(3)*,* 144-150.

Farquhar, S. A., Michael, Y. L., & Noelle, W. (2005). Building leadership and social capital to create change in two urban communities. *American Journal of Public Health, 95*(4)*,* 596-601.

Gaffney, K. F., & Altieri, L. B. (2001). Mother's ranking of clinical intervention strategies used to promote infant health. *Pediatric Nursing, 27*(5)*,* 510-515.

Guttman, N., & Ressler, W. H. (2001). On being responsible: Ethical issues in appeals to personal responsibility in health campaigns. *Journal of Health Communication, 6,* 117-136.

Howel, E. M., Devaney, B., McCormick, M., & Raykovich, K. T. (1998). Back to the future: Community involvement in the Healthy Start Program. *Journal of Health Politics, Policy and Law, 23,* 291-317.

Institute of Medicine. (1988). *The future of public health.* Washington D.C.:National Academy Press.

Johnston, G. N. L., & Benitez, B. (2003). Faith: A project in building community capacity. *American Journal of Health Studies, 18*(3)*,* 138-145.

Lasker, R. D., & Weiss, E. S. (2003). Broadening participation in community problem solving: A multidisciplinary model to support collaborative practice and research. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 80*(1)*,* 14-53.

Littleton, M. A., Cornell, C. E., Dignan, M., Brownstein, N., Raczynski, J. M., Stalker, V., et al. (2002). Lessons learned from the Uniontown community health project. *American Journal of Health Behavior, 26,* 34-42.

Lochner, K., Ichiro, K., & Kennedy, B. P. (1999). Social capital: A guide to its measurement. *Health and Place, 5,* 259-270.

Martinez-Bristow, Z., Sias, J. J., Urquidi, U., Feng, C., (2006). Tobacco cessation services through community health workers for Spanish-speaking populations. *American Journal of Public Health, 96*(2), 211 -213.

McGinnis, J. M. (2003). A vision for health in our new century. *American Journal of Health Promotion, 18*(2)*,* 146-145.

Morse, S. (2004). Practicing democracy: How communities come together to solve problems. *National Civic Review, 93*(2)*,* 31-41.

National Cancer Institute. (2003). *Theory at a glance: A guide for health promotion practice*. NIH Publication #95-3896. Revised 1997. Retrieved April 12, 2004, from http://oc.nci.nih.gov/services/Theory_at_glance/HOME.html

Potapchuk, W. R. (1999). Building an infrastructure of community collaboration. *National Civic Review, 88,* 165-170.

Potapchuk, W. R., & Crocker, J. P. (1999). Exploring the elements of civic capital. *National Civic Review, 88,* 175-202.

Print, M., & Coleman, D. (YEAR). Towards understanding of social capital and citizenship education. *Cambridge Journal of Education, 33*(1)*,* 123-149.

Putnam, D. (2000). *Bowling alone: The collapse and revival of American community*. New York: Simon & Schuster.

Putnam, R. (1995). Bowling alone: America's declining social capital. *Journal of Democracy, 6,* 65-78.

Raczynski, J. M., Cornell, C. E., Stalker, V., Phillips, M., Dignan, M., Pulley, L., et al. (2001). A multi-project systems approach to developing community trust and building capacity. *Journal of Public Health Management Practice, 7,* 10-20.

Rodrigues, V. M., Conway, T. L., Woodruff, S. I., & Edwards, C.C. (2003). Pilot test of an assessment instrument for Latina community health advisors conducting an ETS intervention. *Journal of Immigrant Health, 5*(3)*,* 129-137.

Rogers, E. (1995). *Diffusion of innovations* (4th ed.). New York:Free Press.

Sahai H., & Ageel, M. (2000). *The analysis of variance: Fixed, random, and mixed models*. Boston: Birkhauser.

Schulgasser, D. M. (1999). Making something out of almost nothing: Social capital development in Newark, New Jersey. *National Civic Review, 88,* 341-351.

Schulz, A. J., Israel, B. A., Parker, E. A., Lockett, M., Hill, Y., & Will, R. (2001). The east side village health worker partnership: Integrating research with action to reduce health disparities. *Public Health Reports, 16,* 548-557.

Speer, P. W., Jackson C. B., & Peterson, N. A. (2001). The Relationship between social cohesion and empowerment: Support and new implications for theory. *Health Education & Behavior, 28*(6)*,* 716-732

Spoth R., Greenberg, M., Bierman, K., & Redmond, C. (2004). PROSPER community university partnership model for public education systems: Capacity building for evidence-based, competence-building prevention. *Prevention Science, 5*(1)*,* 31-39.

Stokes M. E., Davies, C. S., & Koch, G. (2000).*Categorical data analysis using the SAS System* (2nd ed.). Cary, NC: SAS Institute Inc.

United States Department of Health and Human Services. (2000*). Healthy People 2010: Understanding and improving health.* Washington, D.C.: U.S. Government Printing Office.

University of Alabama. (2004). Alabama Maps. Retrieved April 12, 2004, from http://alabamamaps.ua.edu/counties/wilcox.pdf

University of Arizona-Annie E. Casey Foundation. (1998). *The final report of the national community health advisor study*. Phoenix, AZ: Author.

University of Arizona Rural Health Office and College of Public Health. (2000). *Community health worker evaluation toolkit.* Phoenix, AZ: Author.

Wallis, A., Crocker, J. P., & Schecter, B. (1998). Social capital and community building: Part one. *National Civic Review, 87*(3)*,* 253.

Voluntary Hospitals of America, Inc. (1993). *Community partnerships: Taking charge of change through partnership.* Irving, TX: Author.

# APPENDIX A

# NATIONAL COMMUNITY HEALTH ADVISOR STUDY

NATIONAL COMMUNITY HEALTH ADVISOR STUDY
SURVEY

A) Are you a Community Health Advisor/Outreach Worker? Yes _____ No _____

B) Do you supervise Community Health Advisors/Outreach Workers?
Yes_____ No_____

C) If you supervise Community Health Advisors, have you ever been a Community Health Advisor/Outreach Worker? Yes_____ No_____

If you answered yes to any of these questions, please fill out the survey. The survey is confidential and will not be linked to individuals.

I. INFORMATION ABOUT YOU

1) What is your Job Title? _____

2) How old are you? _____

3) What is your gender? Male ____ Female_____

4) What is your race/ethnicity? ___ African American ___ Non Hispanic / White
___ Native American ___ Asian/Pacific Islander
___ Hispanic ___ Other:_____

5) How long have you been a CHA and/or a CHA program supervisor? ____Years

II . INFORMATION ABOUT PROGRAM, AGENCY, AND POPULATION(S) SERVED

1) Community Health Advisor (CHA) Program name:_____

2) Where is your program located? City_____ State_____

3) How long has the CHA program been in existence? ____Years

4) How is your CHA program funded? (check all that apply)

| | Private funds | Public funds |
|---|---|---|
| Local funding: | ___ | ___ |
| State funding: | ___ | ___ |
| Federal/Nat'l funding | ___ | ___ |

Other (specify): _____

Don't Know ___

5) How many CHAs currently work in your program? _____
Women _____ Men _____

6) What health problems and issues does your program address? (List them in order of their importance in your program. Examples are: violence, housing, HIV/AIDS, etc.)

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7) What geographic areas does your program serve? (check one)
Rural ___ Urban ___ Both ___

8) Where do the CHAs in your program work? (check all that apply)
___ Homes ___ Migrant labor camps ___ Religious organizations
___ Schools ___ Community centers ___ Shelters
___ Clinics/hospitals ___ Worksites ___ Other _____

9) What populations is your program designed to serve?
Ethnicity: (check all that apply)
___ African American ___ Non Hispanic / White
___ Native American ___ Asian/Pacific Islander
___ Hispanic ___ Other _____

Population: (check all that apply)

Population groups:
___ Men
___ Women
___ Families
___ Pregnant women
___ Gay/Lesbian/Bisexual
___ Other: _____
___ Other _____

Age groups:
___ Infants (0-11 months)
___ Children (1-12)
___ Adolescents (13-19)
___ Adults (20-65)
___ Seniors (65+)

10) Are the CHAs in your program from the same racial/ethnic group(s) as the people they serve? (choose one
Yes ___ No ___ In some cases but not all ___

11) Is the CHA supervisor in your program of the same racial/ethnic groups(s) as the people they supervise?
Yes ___ No ___ In some cases but not all ___

III. QUALIFICATIONS, SKILLS AND ACTIVITIES OF CHAs
The purpose of the following section is to begin to define core roles and competencies of CHAs.

1. What activities do CHAs in your program most frequently carry out? Please list ten activities

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

2) What personal qualities does a person need in order to be an effective CHA? Please rate the following

qualities as 1 (very important), 2 (somewhat important), 3 (not important). Then please add your own ideas and rate them as well.

| | Very Important | Somewhat Important | Not Important |
|---|---|---|---|
| 1. Member of the community being served | 1 | 2 | 3 |
| 2. Share values and experience of the people being served | 1 | 2 | 3 |
| 3. Respected by peers in the community | 1 | 2 | 3 |
| 4. Commitment to serve the community | 1 | 2 | 3 |
| 5. Seen as a leader by community | 1 | 2 | 3 |
| 6. Bilingual/bicultural (in communities where English language is not dominant) | 1 | 2 | 3 |
| 7. Is a caring person | 1 | 2 | 3 |
| 8. Other (specify) _____ | 1 | 2 | 3 |
| 9. Other (specify) _____ | 1 | 2 | 3 |

3) What skills and abilities does a person need to have or develop in order to be an effective CHA? Please list ten skills

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

4. What is the best way/ways for a person to develop the skills s/he needs to be an effective CHA? (Please check all that apply)

___life experience
___training designed especially for CHAs
___"shadowing" or being mentored by an experienced CHA
___formal education
___other_____
_____

5. In addition to helping families and individuals one at a time, do CHAs in your program make an impact on the community as a whole by promoting changes at a community level and through advocacy for programs and policies? Yes____. No____

If so, how?_____
_____
_____

IV. VALIDATING THE CHA ROLE

Across the country many CHA programs are exploring ways to strengthen the role of CHAs. As a part of this discussion, some are exploring the development of minimum standards for CHA training and also certification for CHAs. The next questions are intended to identify various opinions about this issue.

1) Do you see the CHA role as professional?

Yes ___ No ___

Comments _____

_____

_____

2) Do you support the development of standards for training for CHAs?

Yes ___ No ___ Not sure ___

Why or why not? _____

_____

_____

3) Do you support the development of a state or national certification program for CHAs?

Yes ___ No ___ Not sure ___

Why or why not? _____

_____

_____

V. TRAINING OF CHAs

CHAs are trained for their work in many ways; we are interested in knowing what your program offers an requires

1) What kind of training does a CHA get in your program?

_____Experience on-the-job
_____Formal training in a school/college
_____Training on-the-job:
_____ Other: (please specify)_____
_____ Other: (please specify)_____

2) In which 5 areas have CHAs in the program received the most training?

1. _____
2. _____
3. _____
4. _____
5. _____

3) What kinds of recognition do CHAs receive for completing training for your program? (check all that apply)

___ Graduation ceremony
___ Certificate(s) from program
___ Certificate from outside institution From whom?_____
___ Academic credit (i.e., from a community college)
___ Pay increases
___ Other (specify) _____
___ None of the above

**VI. SUPERVISING CHA PROGRAMS**

Many special questions and skills are needed to coordinate CHA programs. The next questions will help identify these as well as some of the challenges facing supervisors and ways to overcome them.

1) Does the supervisor/s of your CHA program have other major responsibilities besides supervision of the CHA program(s)?

Yes_____ No_____

2) Please list the three most important **personal qualities and skills** which a person must possess or develop in order to be an effective CHA supervisor.

1._____
2._____
3._____

3) What are the three most important problems of supervising CHA programs?

1._____
2._____
3._____

4) How could supervision of CHAs in your program be improved?

_____
_____
_____
_____

**VII. CAREER ADVANCEMENT OF CHAs**

The goal of this section is to collect information that can be used to promote CHAs as members of the health care team while maintaining their community base.

1) What types of agency meetings do CHAs in your program attend? **(check all that apply)**

___ One-on-one supervisory meetings
___ Case management meetings
___ CHA program team meetings
___ General staff meetings
___ Clinical team meetings
___ CHA specific in-service trainings
___ General agency in-service trainings
___ Other (specify) _____

2) How many hours per week are CHAs supposed to work in your program?

___ average hours per week

3) Are CHAs in your program paid?

Yes ___ No ___
The hourly wage rate for CHAs in our program is $_____ to $_____

4) Are CHAs in your program eligible for benefits? **(please check all that apply)**

____ Health insurance ____ Sick/vacation leave ____ Pension plan/Retirement account

5. If CHAs have left your program since it began, what have they done after leaving? (check all that apply)

___ Left the workforce
___ Pursued further education
___ Taken another job at our agency
___ Other (specify) _____
___ Taken another job outside our agency
___ Don't know
___ None have left

6. What are the greatest obstacles to the career advancement of CHAs?

1._____
2._____
3._____

7. What opportunities does your program provide for CHAs in your program to advance professionally?

1._____
2._____
3._____

VIII. WORKFORCE RELATIONS OF CHAs

The next several questions deal with how CHAs are perceived by others in the health care field. The purpose of the question is to identify strategies for strengthening relationships.

1) How would you describe the working relationship between CHAs and the following groups? Please rate each relationship as 1 (good), 2 (fair), 3 (poor), or NR (no relationship).

| | Good | Fair | Poor | |
|---|---|---|---|---|
| 1. Allied Health Workers and Paraprofessionals | 1 | 2 | 3 | NR |
| 2. Health educators | 1 | 2 | 3 | NR |
| 3. Nurses | 1 | 2 | 3 | NR |
| 4. Social Workers | 1 | 2 | 3 | NR |
| 5. Physicians/Mid-level Practitioners | 1 | 2 | 3 | NR |
| 6. Administrators | 1 | 2 | 3 | NR |
| 7. Other _____ | 1 | 2 | 3 | NR |

2) With which groups would you most like to strengthen the CHAs' working relationship?

1._____
2._____
3._____

3) What are the greatest obstacles to CHAs and CHA programs taking a more prominent role in the health care system? (Check only the top three)

____Lack of stable funding
____Lack of understanding about CHAs and the contribution they make
____Hostility/competition with other health care workers
____Lack of solidarity among CHA programs
____Racism
____Classism
____The fact that CHA services are not reimbursable in most states
____Other (specify) _____

4) Do you network with other CHAs and other CHA programs outside your agency?

____Yes No____

If yes, please describe. _____

VIII. THE ROLE OF CHAs IN THE HEALTH CARE SYSTEM

Managed Care Organizations (MCOs)/Health Maintenance Organizations (HMOs) are now interested in providing services to Medicaid recipients and other vulnerable populations traditionally served by CHAs

1) Do you think CHAs can help people enrolled in MCOs/HMOs?
___Yes ___No
If yes, how_____

2) Has your CHA program attempted to contract with an MCO/HMO in your community?
Yes ___ No ___ Don't know ___

If yes, did you encounter any of the following barriers?
___MCOs/HMOs do not understand the CHA role
___No clear mechanism for reimbursement
___The community we serve is not a priority for local MCO/HMOs
___It is not easy to identify who to work with at MCO/HMOs.
Are there any other barriers? _____

3) Are CHA services reimbursable to your program through Medicare or Medicaid?
Yes ___ No ___ Don't know ___

IX. EVALUATION

The purpose of this section is to find out how programs keep track of the activities they carry out and the effects that these activities have.

1) What kinds of information about activities does your program collect? (check all that apply)

__ information about CHAs (such as age, sex, race/ethnicity, etc.)
__ methods utilized to recruit CHAs
__ number of CHAs trained
__ amount of training provided to CHAs
__ information about clients (such as age, sex, type of housing, employment, race/ethnicity, etc.)
__ Client/participant recruitment methods
__ number of clients/participants served
__ number of classes/community presentations made by CHAs
__ number of home visits made
__ number of referrals made by CHAs
__ number of meetings with other agencies
__ number of community meetings organized
__ number of screenings facilitated by CHAs
__ materials distributed by CHAs
__ publicity about program (for example, newspaper articles, public service announcements)
__ other _____

2) What kind of information about changes does your program collect? (check all that apply)

For CHAs:

__ changes in attitudes and knowledge
__ changes in self-esteem
__ changes in abilities to meet clients' needs
__ changes in abilities as leaders

For Clients / Participants:

__ changes in attitudes, knowledge, skills, or intentions to change behavior
__ changes in health status
__ changes in access to services
__ changes in use of services
__ changes in appropriate use of prescribed medication and activities
__ satisfaction with CHA services

For Communities:

__ changes which promote health (for example, more smoke-free buildings, more bike paths, increased availability of fresh produce)
__ changes in abilities to recognize and work together to solve health problems
__ changes in practices, policies or programs by the sponsoring agency
__ changes in practices, policies or programs by other community agencies
other _____
_____

3) Please check the methods you use to collect information:

__ forms
__ CHA log books
__ interviews with CHAs or clients
__ focus groups
__ surveys
__ other _____
__ tape recordings
__ medical chart reviews
__ communication with clinicians
__ tests before and after health ed. classes
__ computer

4) What do you do with the information that is collected? (Please check all that apply)

__ we use it to make changes to improve our program
__ we use it to write reports for funders
__ we use it to write grants for more funding
__ we send it to local, state, and national agencies (i.e. state health departments)
__ we keep it on file in a computer
__ we use it to write articles for publication
__ we use it to provide feedback to the community
__ none of the above

5) Are CHAs involved in developing the evaluation of your program?
Yes_____ No_____

Is there anything else you would like to share with us regarding your experience in CHA programs?

_____
_____
_____
_____

Thank you very much for filling out the questionnaire. Please mail it in the enclosed envelope which has prepaid postage or mail it to the following address:

Community Health Advisor Study/Rural Health Office
2501 E. Elm
Tucson, AZ 85716

We would like to add you to our growing list of Community Health Advisors and Community Health Advisor programs. Please send us your name, address and telephone number if you would like to be part of this database. Please indicate if you would like to receive a copy of the survey results.

Name_____

Address_____

_____

Phone_____

I would like a copy of survey results Yes _____ No_____

# APPENDIX B

# COMMUNITY ENGAGEMENT SURVEY

# *COMMUNITY ENGAGEMENT SURVEY*

***Purpose*: An examination of community engagement knowledge using social capital and community capacity. In this study community engagement is defined as the desire to engage in decision making and action for health promotion, health protection and disease prevention.**

***The survey is confidential and will not be linked to individuals.***

***SECTION ONE: SOCIAL CAPITAL***
***(Identification of the role, needs, resource, goals & skills of the program and population served.)***

1. What is your role or position with the Congregation for Public Health/Search Your Heart Program (CPH/SYH)?

_____ CPH/SYH Board Member
_____ Steering Committee Member
_____ Neighborhood Outreach Specialists
_____ CHA Volunteers

2. What is the goal of the CPH/SYH program? **(Check all that apply)**

_____ Health information/education _____ Health promotion
_____ Leadership skills
_____ Communication techniques
_____ Community engagement coordination (i.e. health screening & referral)

3. Social Capital has been defined as the resources available to individuals and groups through social connections and social relations within a community. Please select the reason that best represents why you participate in the CPH/SYH program: **(Check all that apply)**

_____Community empowerment
_____Opportunity to interact with community residents and organizations
_____Increased knowledge about community resources and services
_____Enhance my own skills in community/partnership work and volunteerism

4. Social Capital can be utilized as a mechanism to enhance health awareness and community engagement. Which of the following items serves as the strongest barrier to promoting community engagement in the CPH/SYH program? **(Check all that apply)**

_____Level of education accomplished by congregants/church members
_____Economic status of congregants/church members
_____Occupational constraints (i.e. time/convenience) of Congregants/church members
_____Social relations among congregants/church members

5. Do you have past experience in health related volunteer work?

_____Yes _____No

If the answer is yes, how many years of experience do you have in health related volunteer work?
_____ 1-3 _____4-6 _____7-9 ____ 10 or more

***If the answer is no, skip to question number six***

6. In your past experience with health related volunteer work, did you assist with: **(Check all that apply)**

_____Developing and implementing seminars, workshops and/or conferences
_____Recruitment for community partnerships (i.e. local agencies and businesses)
_____Recruitment for community engagement/participation
_____Secure funding
_____ Program educational activities
_____Transportation assistance
_____Training

7. According to the Community Health Advisors Core Skills Curriculum Guide understanding your community is critical to reaching your target population. One strategy for gathering information about the resources, individuals, and services that are available within your local community is referred to as:

____Strategic planning
____Asset mapping
____Community analysis

8. According to the Community Health Advisors Core Skills Curriculum Guide, the Community Health Advisors program is based on a three way partnership between nonprofit agencies, service providing agencies, and the local community. Please identify the CPH/SYH concept of operation.

____ Bringing people together
____ Neighborhood outreach
____Educating and empowering "Natural Helpers"

***SECTION TWO: COMMUNITY ENGAGEMENT COORDINATION***
**(Outreach & Engagement Strategies)**

9. Community Engagement has been defined as the desire to engage in decision making and action for health promotion, health protection and disease prevention. Please check the initiatives that serve as the strongest promoter for community engagement? **(Check all that apply)**

_____Building of political will/leadership
_____Promotion of local ownership
_____Access to community resources/services
_____Strengthening of social relations among resources/services

10. Please check the agencies and/or community programs that you refer clients to. **(Check all that apply)**

_____Senior Companion Services
_____ Congregate Meal Program
_____ Positive Maturity
_____ Food Stamp
_____ Indigent Care Program
_____ Retired & Senior Volunteer Program
_____ Senior Citizens Services of AL
_____ Campbell's Personal Support
_____ JCDH Dental Clinic
_____ JCDH/Health Clinic

11. Are there community resources/agencies that the CPH/SYH program does not have access to?

_____Yes _____No

If yes, please check the reason that best represents lack of access? (check only 1)
_____ Agency contacted, but they were not interested in participating
_____ Lack of interest by community residents to utilize resource/agency
_____ Time constraints (CPH/SYH has been in existence for only a few years, we will be contacting agency in near future)

12. During the last 2 years of participation in the CPH/SYH program have you ever attended and/or participated in educational seminars or training workshops sponsored by participating community agencies?

_____Yes _____No

If yes, please check the answer that best represents the number of events you attended?
_____ 1-3 _____ 4-6 _____ 7 or more

13. Check the processes in which community members/constituency/collaborators assist with**: (Check all that apply)**

_____ Assessing needs
_____ Implementing project
_____ Assessing program impact
_____ Funding
_____ Designing project
_____ Monitoring project
_____ Providing health services
_____ Providing program gifts or incentives

***SECTION THREE: COMMUNITY CAPACITY***
***(Evaluation and Sustainability)***

14. Community Capacity has been defined as having the ability to address, sustain, and strengthen health and social needs. Why is it important to the CPH/SYH program? **(Check all that apply)**

_____ Improved community health
_____ Improved community relations
_____ Improved community safety
_____ Improved access to resources/services

15. According to the Community Health Advisors Core Skills Curriculum Guide, there are several core roles and responsibilities that Community Health Advisors perform. Please use the following list to identify the core roles and responsibilities. **(Check all that apply)**

____ Serving as bridges and cultural mediators
____ Providing health education and information
____ Assuring that individuals actually obtain services
____ Providing informal counseling and social support
____ Advocating
____ Providing direct clinical services
____ Enhancing individual and community ability

16. According to the Community Health Advisors Core Skills Curriculum Guide there are several core roles and responsibilities that Community Health Advisors must perform in order to build and sustain community capacity. Please use the following list to identify the primary roles and responsibilities performed. **(Check all that apply)**

____Sharing prevention and screening information
____Teaching concrete skills essential to maintaining good health
____Helping individuals change their unhealthy behavior

17. According to the Community Health Advisors Core Skills Curriculum Guide there are several primary skill areas. Please use the following list to identify the primary skill areas. **(Check all that apply)**

____Communication skills
____Interpersonal skills
____Knowledge base
____Service coordination
____Skills to build capacity
____Advocacy skills
____Teaching skills
____Organizational skills
____Supervisory skills

18. According to the Community Health Advisors Core Skills Curriculum Guide, there are several important skill concepts that are necessary in order to build and sustain community capacity. Please use the following list to identify the primary skill concepts. **(Check all that apply)**

____Empowering individuals to identify their own problems
____Working with individuals to identify strengths and resources to address problems
____Leadership skills

19. According to the Community Health Advisors Core Skills Curriculum Guide, understanding community services is also important in growing a comprehensive Community Health Advisors program. Please use the following list to identify the service coordination skills needed. **(Check all that apply)**

____Identifying and accessing resources
____Networking and building coalitions
____Making appropriate referrals
____Providing follow up

20. According to the Community Health Advisors Core Skills Curriculum Guide, Community Health Advisors need several types of knowledge and understanding to be successful. **(Check all that apply)**

____Broad knowledge about the community
____Knowledge about specific health issues (i.e. diabetes, heart attacks, strokes)
____Knowledge of health and social service systems (i.e. senior services, indigent care, health clinics)

***SECTION FOUR: Relationship Scale***

***Please rate the following questions on a scale of 1- 5. Place a check mark in the box that best matches your perceptions. There are no right or wrong answers. We only want your opinion so that we can continue to improve the program. How would you rate the following characteristicss of the CHA program?***

***Scale: 1 Poor 2Fair 3Good 4Very Good 5 Excellent***

**PART ONE: SOCIAL CAPITAL**

21. The characteristics of social capital are based on feelings of trust, reciprocity/supportive exchange, and mutual understanding. Please rate how well these characteristics are incorporated into the CPH/SYH Program.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

22. Please rate the clarity of the CPH/SYH project goals?

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

23. To what degree do you feel that the CPH/SYH program is sensitive to the needs of the congregants/church members?

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

24. Please rate how confident you are in the CPH/SYH's ability to give advice or assistance to community congregants/church members on health and community issues.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

25. Please rate each of the following resources based on how well they interact/participate with the overall program: **(Rating scale: *1* Poor *2* Fair *3* Good *4* Very Good *5* Excellent )**

_____Local Retail
_____Clinical/Health Services
_____Housing Assistance
_____Emotional/Psychiatric Services
_____Educational Services/Assistance
_____Public Transportation Services
_____Civic/Political Leadership
_____Recreational Services
_____Financial Assistance/Counseling
_____Employment

26. What are the most frequent concerns or type of advice sought by community congregants/church members? **(Rank them in order of importance from 1- 9. 1 being the most frequent and 9 being the least.)**

_____Health (sickness/disease)
_____Physical Activity & Fitness
_____Transportation Services
_____Insurance
_____Medication Assistance
_____Nutrition
_____Community Safety/Crime
_____Stress/Emotions/Feelings
_____Financial Stability

27. Check the educational topic most often discussed with community congregants/church members. **(Check all that apply)**

_____Stroke
_____Physical Activity & Fitness
_____Nutrition
_____Diabetes
_____Elderly Assistance/Services
_____Cholesterol
_____Community Safety/Crime
_____Emotions/Feelings
_____Stress
_____Housing Needs (i.e. senior care, repairs, and financial)

**PART TWO: COMMUNITY ENGAGEMENT COORDINATION**

28. The characteristics of community engagement are based on linking community stakeholders (individuals, families, government officials, business leaders and educational leaders etc.) to available health resources/services. How well do you feel this is being achieved in the CPH/SYH program?

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

29. Please rate how confident you are in the CPH/SYH program's ability to bring businesses, elected officials, citizen groups, faith-based organizations, schools, and others to the table.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

30. Please rate the CPH/SYH program's ability to promote commitment to community engagement that is inclusive and encourages diversity among all community partners.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

31. Please rate how confident you are in the CPH/SYH project's ability to discuss community issues with elected officials and/or community agencies.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

32. Do you think participant numbers are?

_____ Low
_____ Expected/appropriate
_____ High

If you thought participant numbers were lower than expected, what do you think the reasons are?
_____Lack of transportation
_____Lack of childcare
_____Conflicting schedules with school or work
_____Lack of enough available staff and volunteers
_____Other, please state _____

33. What strategies would best encourage community engagement in the program? **(Please rank them in order of importance with 1 being the best and 5 being the least)**

_____Transportation provided
_____ Child care provided
_____ Food or refreshments are made available
_____ Reminder calls or correspondence
_____ Monetary incentives (e.g., raffles)
_____Other, please state _____

**PART THREE: COMMUNITY CAPACITY**

34. Please read the following job descriptions for the NOS and CHA Volunteers. Do you think they adequately reflect the actual job responsibilities/duties? Rate them using the following scales:

**Neighborhood Outreach Specialists**: currently involved in neighborhood asset mapping, health resource awareness and implementing health educational programs through volunteer networks. They also assist in the volunteer training and coordinate and supervise all volunteer activities.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**CHA Volunteers**: provide training, and support in order to maximize their success in fully implementing Search Your Heart and coordinating specific behavioral interventions i.e., nutrition, physical exercise, smoking cessation, medication compliance, etc.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

35. How well do you feel NOS and CHA Volunteers have been trained to respond to community needs?

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

36. The characteristics of community capacity are based on improving social, political, economical, physical, and psychological outcomes. Please rate how well you think these characteristics are being incorporated into the program goals.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

37. When you consider the CPH/SYH program design, please rate how well you think the program is currently operating.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

38. Please rate the CPH/SYH program's ability to improve access to health care services.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

39. Please rate the CPH/SYH projects capacity for project evaluation as a management tool to sustain the project.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

40. Please rate the CPH/SYH projects capacity for ongoing evaluation as a management tool to sustain the project.

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

41. What services may be under utilized and/or under taught? **(Check all that apply)**

_____Individual health (i.e. services to teach self-check for blood pressure, nutrition, and safety)
_____Leadership skills
_____Communication techniques
_____Health treatment, prevention, and maintenance (i.e. clinic services)

# *COMMUNITY ENGAGEMENT SURVEY*

***(Data Dictionary)***

***Purpose: An examination of community engagement knowledge using social capital and community capacity. The survey is confidential and will not be linked to individuals.***

**Note: [Variable name], {variable value}, ('correct' answer for score)**

***SECTION ONE: SOCIAL CAPITAL***
***(Identification of the role, needs, resource, goals & skills of the program and population served.)***

**[Q1]** 1. What is your role or position with the Congregation for Public Health/Search Your Heart Program (CPH/SYH)?

__**{1}**___ CPH Board Member
__**{2}** ___ Steering Committee Member
__**{3}**___ Neighborhood Outreach Specialists
__**{4}**___ CHA Volunteers

**[Q2]** 2. What is the goal of the CPH/SYH program? (Check all that apply) **{0,1,2,3,4,5}**

____ Health Information/Education _____ Health Promotion **(more better)**
_____ Leadership Skills
_____ Communication Techniques
_____ Community Engagement Coordination (health screening & referral)

**[Q3]** 3. Social Capital has been defined as the resources available to individuals and groups through social connections and social relations within a community. Please select the reason that best represents why you participate in the CPH program: (Check all that apply) **{0,1,2,3,4}** **(more better)**

_____ Community Empowerment
_____Opportunity to interact with community residents and organizations
_____Increased knowledge about community resources and services
_____ Enhance my own skills in community/partnership work and volunteerism

**[Q4]** 4. Social Capital can be utilized as a mechanism to enhance health awareness and community engagement. Which of the following items serves as the strongest barrier to promoting community engagement in the CPH/SYH program? (Check all that apply) **{0,1,2,3,4}** **(more better)**

____ Level of Educational Attainment of Congregants
____ Economic Status of Congregants
____ Occupational Constraints (i.e. time/convenience) of Congregants
____ Social Relations Among Congregants

**[Q5_1]** 5. Do you have past experience in health related volunteer work?
__**{1}**__ Yes __**{0}** __ No **(yes better)**

**[Q5_2]** If the answer is yes, how many years of experience do you have in health related volunteer work?
**{0}** __**{1}**__ 1-3 __**{2}**__ 4-6 __**{3}**__ 7-9 __**{4}**__ 10 or more
**(more better)**
***If the answer is no, skip to question number six***

**[Q6]** 6. In your past experience with health related volunteer work, did you assist with: (Check all that apply) **{0,1,2,3,4,5,6,7}** **(more better)** **Depends on whether Q5_1=yes**

_____Developing & Implementing Seminars, workshops and/or conferences
_____Recruitment for Community Partnerships
_____Recruitment for Community Engagement/Participation
_____Funding
_____ Program Educational Activities
_____Transportation Assistance
_____Training

**[Q7]** 7. According to the Community Health Advisors Core Skills Curriculum Guide understanding your community is critical to reaching your target population. One strategy for gathering information about the resources, individuals, and services that are available within your local community is referred to as:

_____Strategic Planning **{0,1,2,3}** **(more better)**
_____Asset Mapping
_____Community Analysis

**[Q8]** 8. According to the Community Health Advisors Core Skills Curriculum Guide the CHA program is based on a three way partnership between nonprofit agencies, service providing agencies, and the local community. Please identify the CHA model's concept of operation.

_____Bringing people together **{0,1,2,3}** **(more better)**
_____Neighborhood Outreach
_____Educating and empowering "Natural Helpers"

***SECTION TWO: COMMUNITY ENGAGEMENT COORDINATION***
**(Outreach & Engagement Strategies)**

**[Q9]** 9. Community Engagement has been defined as the desire to engage in decision making and action for health promotion, health protection and disease prevention. Please check the initiatives that serve as the strongest promoter for community engagement? (Check all that apply)

_____Building of political will **{0,1,2,3,4}** **(more better)**
_____Promotion of local ownership
_____Access to community resources/services
_____Strengthening of social relations among resources/services

**[Q10]** 10. Please check the agencies and/or community programs that you refer clients to. (Check all that apply) **{0,1,2,3,4,5,6,7,8,9,10}** **(more better)**

_____Senior Companion Services
_____ Congregate Meal Program
_____ Positive Maturity
_____ Food Stamp
_____ Indigent Care Program
_____ Retired & Senior Volunteer Program
_____ Senior Citizens Services of AL
_____ Campbell's Personal Support
_____ JCDH Dental Clinic
_____ JCDH/Health Clinic

**[Q11_1]** 11. Are there community resources/agencies that the CPH/SYH does not have access to?
__**{1}**__ Yes __**{0}**__ No

**[Q11_2]** If yes, please check the reason that best represent lack of access? To analyze in section 4
__**{1}**__ Agency contacted, but they were not interested in participating
__**{2}**__ Lack of interest by community residents to utilize resource/agency
__**{3}**__ Time constraints CPH will be contacting agency in near future

**[Q12_1]** 12. Have you ever attended and/or participated in educational seminars or training workshops sponsored by collaborating community agencies?

__**{1}**__ Yes __**{0}**__ No **(more better)**

**[Q12_2]**
If yes, please check the answer that best represents the number of events you attended?
**{0}** __**{1}**__ 1-3 __**{2}**__ 4-6 __**{3}**__ 7 or more **(more better)**

**[Q13]** 13. Check the processes in which community members/constituency/collaborators assist with: (Check all that apply) **{0,1,2,3,4,5,6,7,8}(more better)**

_____ Assessing needs
_____ Implementing project
_____ Assessing program impact
_____ Funding
_____ Designing project
_____ Monitoring project
_____ Provide Health Services
_____ Providing Program gifts or incentives

***SECTION THREE: COMMUNITY CAPACITY***
***(Evaluation and Sustainability)***

**[Q14]** 14. Community Capacity has been defined as having the ability to address, sustain, and strengthen health and social needs. Why is it important to the CPH/SYH program? (Check all that apply)
**{0,1,2,3,4}(more better)**
_____ Improved community health
_____ Improved community relations
_____ Improved community safety
_____ Improved access to resources/services

**[Q15]** 15. According to the Community Health Advisors Core Skills Curriculum Guide there are several core roles and responsibilities that CHAs perform. Please use the following list to identify the core roles and responsibilities. (Check all that apply)
**{0,1,2,3,4,5,6,7}(more better)**
____ Serving as bridges and cultural Mediators
____ Providing health education and information
____ Assuring that individuals actually obtain services
____ Providing informal counseling and social support
____ Advocating
____ Providing direct clinical services
____ Enhancing individual and community ability

**[Q16]** 16. According to the Community Health Advisors Core Skills Curriculum Guide there are several core roles and responsibilities that CHAs must perform in order to build and sustain community capacity. Please use the following list to identify the primary roles and responsibilities performed. (Check all that apply) **{0,1,2,3}(more better)**

____Sharing prevention and screening information
____Teaching concrete skills essential to maintaining good health
____Helping individuals change their unhealthy behavior

**[Q17]** 17. According to the Community Health Advisors Core Skills Curriculum Guide there are several primary skill areas. Please use the following list to identify the primary skill areas. (Check all that apply) **{0,1,2,3,4,5,6,7,8,9}(more better)**

____Communication skills
____Interpersonal skills
____knowledge base
____Service Coordination
____Skills to build capacity
____Advocacy skills
____Teaching skills
____Organizational skills
____Supervisory skills

**[Q18]** 18. According to the Community Health Advisors Core Skills Curriculum Guide there are several important skills concepts that are necessary in order to build and sustain community capacity. Please use the following list to identify the primary skill concepts. (Check all that apply)
**{0,1,2,3}(more better)**
____Empowering individuals to identify their own problems
____Working with individuals to identify strengths and resources to address problems
____Leadership skills

**[Q19]** 19. According to the Community Health Advisors Core Skills Curriculum Guide understanding community services is also important in growing a comprehensive CHA program. Please use the following list to identify the service coordination skills needed. (Check all that apply).
**{0,1,2,3,4}(more better)**
____identifying and accessing resources
____Networking and building coalitions
____Making appropriate referrals
____providing follow up

**[Q20]** 20. According to the Community Health Advisors Core Skills Curriculum Guide CHAs need at several types of knowledge and understanding to be successful. (Check all that apply)
**{0,1,2,3}(more better)**
____Broad knowledge about the community
____Knowledge about specific health issues
____Knowledge of health and social service systems

***SECTION FOUR: Relationship Scale***

***Please rate the following questions on a scale of 1- 5. Place a check mark in the box that best matches your perceptions. There are no right or wrong answers. We only want your opinion so that we can continue to improve the program. How would you rate the following qualities of the CHA program.***

***Scale: 1 Poor 2Fair 3Good 4Very Good 5 Excellent***

**PART ONE: SOCIAL CAPITAL**

**[Q21]** 21. The characteristics of social capital are based on feelings of trust, reciprocity/supportive exchange, and mutual understanding. Please rate how well these characteristics are incorporated into the CPH/SYH Program.
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q22]** 22. Please rate the clarity of the CPH/SYH projects goal?
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q23]** 23. To what degree do you feel that the CPH/SYH program is sensitive to the needs of the congregants?
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q24]** 24. Please rate how confident are you in the CPH's ability to give advice or assistance to community congregants on health and community issues?
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q25_1] to [Q25_10]** 25. Please rate each of the following resources based on how well they interact/participate with the overall program: (Rating scale: ***1*** Poor ***2*** Fair ***3*** Good ***4*** Very Good ***5*** Excellent ) **{1,2,3,4,5}**

_____Local Retail **[Q25_1]** _____Public Transportation Services **[Q25_6]**
_____Clinical/Health Services **[Q25_2]** _____Civic/Political Leadership **[Q25_7]**
_____Housing Assistance **[Q25_3]** _____Recreational Services **[Q25_8]**
_____Emotional/Psychiatric Services **[Q25_4]** _____Financial Assistance/Counseling **[Q25_9]**
_____Educational Services/Assistance **[Q25_5]** _____Employment **[Q25_10]**

**[Q26_1] to [Q26_9]** 26. What are the most frequent concerns or type of advice sought by community congregants? (Rank them in order of importance from 1- 9. 1 being the most frequent and 9 being the least.) **{1,2,3,4,5,6,7,8,9}**

_____ Health (sickness/disease) **[Q26_1]**
_____Physical Activity & Fitness **[Q26_2]**
_____Transportation Services **[Q26_3]**
_____Insurance **[Q26_4]**
_____Medication Assistance **[Q26_5]**
_____Nutrition **[Q26_6]**
_____Community Safety/Crime **[Q26_7]**
_____Stress/Emotions/Feelings **[Q26_8]**
_____Financial Stability **[Q26_9]**

**[Q27_1] to [Q27_9]** 27. Check the educational topic most often discussed with community congregants. (Check all that apply) **{0=Not checked,1=checked}**

_____Stroke **[Q27_1]**
_____Physical Activity & Fitness **[Q27_2]**
_____Nutrition **[Q27_3]**
_____Diabetes **[Q27_4]**
_____Elderly Assistance/Services **[Q27_5]**
_____Cholesterol **[Q27_6]**
_____Community Safety/Crime **[Q27_7]**
_____Emotions/Feelings **[Q27_8]**
_____Stress **[Q27_9]**
_____Housing needs **[Q27_10]**

**PART TWO: COMMUNITY ENGAGEMENT COORDINATION**

**[Q28]** 28. The characteristics of community engagement are based linking community stakeholders (individuals, families, government officials, business leaders and educational leaders etc.) to available health resources/services. How well do you feel this is being achieved in the CPH/SYH program?
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q29]** 29. Please rate how confident are you in the CPH/SYH program's ability to bring businesses, elected officials, citizen groups, faith-based organizations, schools, and others to the table?
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q30]** 30. Please rate the CPH/SYH program's ability to promote commitment to community engagement that is inclusive and encourages diversity among all community partners?
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q31]** 31. Please rate how confident are you in the CPH/SYH project's ability to discuss community issues with elected officials, and/or community agencies?
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q32_1]** 32. Do you think participant numbers are? **{1,2,3}**

_____ Low
_____ Expected
_____ High

**[Q32_2] to [Q32_5]**
If you thought participant numbers were lower than expected, what do you think the reasons are?
**{0=Not checked,1=Checked}**
_____Lack of transportation **[Q32_2]**
_____Lack of childcare **[Q32_3]**
_____Conflicting schedules with school or work **[Q32_4]**
_____Lack of enough available staff and volunteer **[Q32_5]**
_____Other, please state _____ **[Q32_6]**

**[Q33_1] to [Q33_6]** 33. What strategies would best encourage community engagement in the

program? (Please rank them in order of importance with 1 being the best and 5 being the least)
**{1,2,3,4,5}**
_____Transportation provided **[Q33_1]**
_____ Child care provided **[Q33_2]**
_____ Food or refreshments are made available **[Q33_3]**
_____ Reminder calls or correspondence **[Q33_4]**
_____ Monetary incentives (e.g., raffles) **[Q33_5]**
_____Other _____ **[Q33_6]**

**PART THREE: COMMUNITY CAPACITY**

34. Please read the following job descriptions for the NOS and CHA Volunteers, do you think they adequately reflect the actual job responsibilities/duties? Rate them using the following scales:

**[Q34_1]** **Neighborhood Outreach Specialists**: currently involved in neighborhood asset mapping, health resource awareness and implementing health educational programs through volunteer networks. They also assist in the volunteer training and coordinate and supervise all volunteer activities.
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q34_2]** **CHA Volunteers**: provide training, and support in order to maximize their success in fully implementing Search Your Heart and coordinating specific behavioral interventions i.e., nutrition, physical exercise, smoking cessation, medication compliance, etc.
**{1,2,3,4,5}**
□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q35]** 35. How well do you feel NOS and CHA Volunteers have been trained to respond to community needs?
**{1,2,3,4,5}**
□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q36]** 36. The characteristics of community capacity are based on improving social, political, economical, physical, and psychological outcomes. Please rate well you think these characteristics are being incorporated in the program goals.
**{1,2,3,4,5}**
□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q37]** 37. When you consider the CPH/SYH program design, please rate how well you think the program is currently is operating?
**{1,2,3,4,5}**
□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q38]** 38. Please rate the CPH/SYH program's ability to improve access to health care services?
**{1,2,3,4,5}**
□1 Poor □2Fair □3Good □4Very Good □5 Excellent

**[Q39]** 39. Please rate the CPH/SYH projects capacity for project evaluation as a management tool to sustain the project?
**{1,2,3,4,5}**

| | | | | |
|---|---|---|---|---|
| □1 Poor | □2Fair | □3Good | □4Very Good | □5Excellent |

**[Q40]** 40. Please rate the CPH/SYH projects capacity for ongoing evaluation as a management tool to sustain the project?
**{1,2,3,4,5}**

□1 Poor □2Fair □3Good □4Very Good □5Excellent

**[Q41_1] to [Q41_4]** 41. What services may be under utilized and/or under taught? (Check all that apply) **{0=Not checked,1=checked}**

_____Individual Health **[Q41_1]**
_____Leadership Skills **[Q41_2]**
_____Communication Techniques **[Q41_3]**
_____Health Treatment, Prevention, & Maintenance **[Q41_4]**

**[Problem] {0=survey OK for analysis, 1=Survey missing more than 50% of answers}**

# APPENDIX C

# COMMUNITY HEALTH WORKER EVALUATION

Latino Health Access

# Community Survey*

**SECTION I. FAMILY INFORMATION**
(collect information for each individual family member)

**Family Code:** _____ (Zip Code - Family ID)

1. How many members of your family live here (including yourself)? →
2. How many women between the ages of 13 and 45 live here? →
3. How many men above the age of 18 live here? →
4. How many children below age 5 live here? →
5. What is your family's annual income? →

| | | |
|---|---|---|
| 1. $ 0 - $4,999 | 7. $30,000 - $64,999 | 13.$60,000 - $64,000 |
| 2. $ 5,000 - $9,999 | 8. $35,000 - $39,999 | 14.$65,000 - $69,000 |
| 3. $10,000 - $14,999 | 9. $40,000 - $44,999 | 15.$70,000 - $74,999 |
| 4. $15,000 - $19,999 | 10.$45,000 - $49,999 | 16.$75,000 - $99,000 |
| 5. $20,000 - $24,999 | 11.$50,000 - $54,999 | 17. $100,000 or more |
| 6. $25,000 - $29,999 | 12.$55,000 - $59,000 | 18. Don't know/no answer |

Assign a code to each person (child or adult) interviewed for this survey

1=male
2=female

1 = Mexico
2 = USA
3 = El Salvador
4 = Guatemala
5 = Other

1 = no insurance
2 = Medi-Cal
3 = Emergency Medi-Cal
4 = Medicare
5 = MSI
6 = private insurance
7 = Healthy Families
8 = Other

1 = labor
2 = housewife
3 = service
4 = student
5 = agriculture
6 = professional
7 = doesn't work
8 = Other

1 = less than 9 yrs
2 = 9-12 yrs., no diploma
3 = high school graduate/GED
4 = SOME COLLEGE, NO DEGREE
5 = Associate degree
6 = Bachelor's degree
7 = Master's or Phd

| Code | Gender | Age | Native Country | Years in the U.S. | Years in S.A. | Years at current address | Months at current address | Health Insurance | Occupation | Education | Alcohol Use | Tobacco Use |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
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| | | | | | | | | | | | | |

| | 1st Visit | 2nd Visit | 3a Visit |
|---|---|---|---|
| Time | | | |
| Date | | | |
| | | | |

1 = does not drink
2 = drinks socially
3 = drinks everyday
4 = drinks on weekends

1 = smokes
2 = does not smoke

Interviewer (this section): _____

* *Form is available in Spanish*

SECTION II. INFORMATION ON WOMEN

Family Code: _____ Respondent's Code: _____

1. How would you rate your health status?
   [1] very healthy [3] fairly healthy [5] I don't know
   [2] healthy [4] not healthy

2. Do you receive medical care?
   [1] yes [2] no

3. Who provides medical services to you? (check all that apply)
   [1] community clinic [3] private physician [5] I don't know
   [2] hospital [4] other_____

4. What problems have prevented you from going to a doctor? (check all that apply)
   [1] child care [3] no insurance [5] other _____
   [2] transportation [4] no money

5. Are you currently married?
   [1] yes
   [2] Single
   [3] Separated
   [4] Divorced
   [5] Widowed
   [6] Other_____

6. Is your husband living with you?
   [1] yes [2] no

7. Do you perform a breast self-exam on a monthly basis?
   [1] yes [2] no [3] occasionally

8. Have you had a mammogram?
   [1] yes, when did you have your last mammogram? ☐☐ ☐☐
   month year
   [2] no [3] I don't know **(Go to Question 10)**

9. What was the result of your mammogram?
   [1] normal [3] I don't know [5] not applicable
   [2] abnormal [4] I don't remember

10. Have you had a pap smear test in the last year?
   [1] yes [2] no [3] I don't know **(Go to Question 12)**

11. What was the result of your pap smear test?
   [1] normal [3] I don't know [5] not applicable
   [2] abnormal [4] I don't remember

12. Are you or have you ever been pregnant?
   [1] yes [2] no ***(skip to question 32 on next page)***

SECTION II. INFORMATION ON WOMEN (continued)

13. How old were you during your first pregnancy? ☐

14. How many pregnancies have you had? ☐

15. How many pregnancies have you had in the USA? ☐

16. In how many of these pregnancies did you obtain prenatal care? ☐

17. In what month of your most recent pregnancy did you seek prenatal care? ☐

18. How many spontaneous abortions have you had? ☐

19. How many still births have you had? ☐

20. How many children weighed <2,500 grams or <5.5 lbs? ☐ If not applicable, check here ☐

21. Are you presently pregnant?
[1] yes [2] no *(skip to question 24)*

22. How many months are you pregnant? ☐

23. Have you sought prenatal care during this pregnancy?
[1] yes [2] no

24. In which month of your most recent pregnancy did you begin prenatal care? ☐

25. Why did you not seek prenatal care in your most recent pregnancy? (check all that apply)
[1] don't have money [5] don't have anyone to take me
[2] don't know where to go [6] don't know city
[3] don't need it [7] I am undocumented
[4] don't speak English [8] other _____

26. Where did you get prenatal care (in U.S)?
[1] community clinic [3] private physician
[2] hospital [4] other_____

27. Have you gone to pregnancy classes?
[1] yes [2] no

28. Did you drink alcohol during your most recent pregnancy?
[1] yes [2] no

29. Did you smoke during your most recent pregnancy?
[1] yes [2] no

30. Did you consume drugs during your most recent pregnancy?
[1] yes [2] no

SECTION II. INFORMATION ON WOMEN (continued)

31. Have you had any of the following complications during your most recent pregnancy? (check all that apply)

[1] high blood pressure
[2] diabetes physician
[3] miscarriage risk
[4] multiple pregnancies
[5] hemorrhage
[6] urinary tract infection
[7] anemia
[8] premature birth
[9] STD
[10] RH factor
[11] none of the above

32. Have you been sexually active (vaginal intercourse) for the past one year?

[1] yes [2] no

33. Are you using some type of birth control method?

[1] the pil
[2] condom
[3] I.U.D.
[4] diaphragm
[5] vasectomy
[6] Norplant
[7] injection
[8] abstinence
[9] withdrawal
[10] tubal litigation
[11] rhythm
[12] foam
[13] other_____
[14] don't use any

34. Where do you receive family planning services? (check all that apply)

[1] County
[2] community clinic
[3] private physician
[4] other_____
[5] Other services but none of the above
[6] I don't receive services

35. Who decides on family planning issues?

[1] you [2] your partner [3] both [4] not applicable

36. Have you ever been physically abused by your husband, partner, or father of your children?

[1] yes [2] no [3] no answer

Observations _____

Interviewer (this section): _____

SECTION III. INFORMATION ON CHILDREN

Family Code: ____ Respondent's Code: ____

1. How many children you care for are 5 years old or younger? ☐

2. How many of these children (age 5 or under) were born in the USA? ☐

3. How many of these children have experienced the following?
(write the number of children in the boxes. If unknown, leave blank)
   a. born at home (US births only) ☐
   b. born with low birth weight (all births) ☐
   c. was not breast-fed (all births) ☐
   d. premature (all births) ☐
   e. complications during labor (all births) ☐

4. How many of these children have any of the following? (check all that apply)
   a. whooping cough ☐
   b. tetanus ☐
   c. diphtheria ☐
   d. polio ☐
   e. hepatitis ☐
   f. measles ☐
   g. tuberculosis ☐
   h. mumps ☐
   i. German Measles ☐
   j. chicken pox ☐
   l. I don't know (check box) ☐

5. Does anyone in your family have (or has had) active TB?
   [1] yes ☐ no ☐ I don't know

6. For the majority of the time, who takes care of the children?
   [1] mother [4] grandparents [7] friends [10] other _____
   [2] father [5] aunts/uncles [8] child care ctr. _____
   [3] mother & father [6] minors under 15 [9] stay home by themselves

7. Do you use a child safety seat in your car for your children?
   [1] yes [2] no

8. How many children died before the age of 5? If not applicable, check here

9. Has any child died from drowning?
   [1] yes [2] no [3] I don't know

10. How many children you care for are followed up in a Well Child Health Prog. (CHDP)? ☐

11. How many of these children have a medical provider? ☐

12. Do you consider the children five years of age and under to be healthy?
   [1] yes [2] no [3] I don't know

13. Have you taken any of the children for medical care to places other than a clinic, a hospital or a doctor (e.g. a gift shop, an herb store, etc.)?
   [1] yes [2] no [3] I don't remember

14. Do you give the children medicine (antibiotics, injections, etc.,) without going to a doctor? (does not refer to over-the-counter medications such as aspirin, Tylonol, cough syrups, etc.)
   [1] yes [2] no [3] I don't remember 4 I don't know

15. Do you take your children to Tijuana or other border towns in Mexico to receive medical care?
   [1] yes [2] no [3] I don't know

**SECTION IV. IMMUNIZATION INFORMATION**

Family Code: ☐☐☐☐☐☐

1. Child's Mother's name _____ Code (mother): ☐☐☐

2. Child's name _____ Code (child): ☐☐☐

3. Child's Age ☐☐

4. Date of birth ☐☐ ☐☐ ☐☐☐☐
mo. day yr.

5. Is your child up to date with his or her immunization?
[1] yes [2] no [3] I don't know

6. Why is your child not completely immunized? (if answer to question 5 is "no")
[1] don't know where to go [3] don't have money [5] don't know about vaccination
[2] unfamiliar with city [4] not interested [6] I don't know
7 other _____

7. In what country was your child immunized?
[1] USA [3] Latin America [5] USA and another country
[2] I do not remember [4] I don't know [6] not applicable

8. Do you have your child's immunization record?
[1] yes [2] I can't find it [3] no [4] don't know

*Question 9 to be answered by the public health nurse*

9. Is the child up to date with immunizations for his or her age?
[1] yes [2] no [3] could not verify

Signature _____

## SECTION V. COMMUNITY PERCEPTIONS

Family Code: _____ Respondent's Code: _____

1. Sex [1] male [2] female

2. Age _____

3. What is your perception of the following problems in your community?

| | no problem | slight problem | serious problem | I don't know |
|---|---|---|---|---|
| a. Consumption of drugs | [0] | [1] | [2] | [8] |
| b. Sale of drugs | [0] | [1] | [2] | [8] |
| b. Sale of drugs | [0] | [1] | [2] | [8] |
| b. Sale of drugs | [0] | [1] | [2] | [8] |
| b. Sale of drugs | [0] | [1] | [2] | [8] |
| b. Sale of drugs | [0] | [1] | [2] | [8] |
| b. Sale of drugs | [0] | [1] | [2] | [8] |
| b. Sale of drugs | [0] | [1] | [2] | [8] |
| b. Sale of drugs | [0] | [1] | [2] | [8] |
| b. Sale of drugs | [0] | [1] | [2] | [8] |
| c. Alcoholism | [0] | [1] | [2] | [8] |
| d. Drive-by shooting | [0] | [1] | [2] | [8] |
| e. Domestic violence | [0] | [1] | [2] | [8] |
| f. Teen pregnancies | [0] | [1] | [2] | [8] |
| g. Children out of school | [0] | [1] | [2] | [8] |
| h. Children alone at home | [0] | [1] | [2] | [8] |
| i. Loitering | [0] | [1] | [2] | [8] |
| j. Crime | [0] | [1] | [2] | [8] |
| k. Gangs | [0] | [1] | [2] | [8] |
| l. Graffiti | [0] | [1] | [2] | [8] |
| m. Firearms | [0] | [1] | [2] | [8] |
| n. Lack of cleanliness | [0] | [1] | [2] | [8] |
| o. other_____ | | [1] | [2] | |
| p. other_____ | | [1] | [2] | |

4. When you call the police for assistance do they arrive fast enough?
   [1] yes [3] I don't know
   [2] no [4] not applicable

5. When there is an emergency in the community, do the fire department and ambulance arrive fast enough?
   [1] yes [3] I don't know
   [2] no [4] not applicable

**SECTION V. COMMUNITY PERCEPTIONS (continued)**

**6. Do you go to the public parks in your neighborhood with your family?**

[1] no [2] a few times a year
[3] 1 or 2 times a month [4] more than 2 times a month

Which parks?

_____
_____

**7. Why don't you go to public parks? (check all that apply)**

[1] I don't like them [4] they are unsafe [7] other_____
[2] they are dirty [5] I don't know where they are
[3] gangs [6] I don't have time [8] not applicable

**8. Do the schools have programs to assist your children with their homework after school?**

[1] yes [2] I don't know [3] no [4] not applicable

**9. Do you participate in any of your child's school programs?**

[1] no [2] sometimes [3] frequently [4] N/A

**10. Are your children in a sport or recreational activities?**

[1] yes [2] no [3] I don't know

**11. Do you consider your community to be healthy?**

[1] yes [2] no [3] I don't know

**12. Can you identify the leaders in your community?**

[1] yes [2] no [3] I don't know

names:

_____, _____
_____, _____
_____, _____

**13. What organizations do you know that help your community?**

_____
_____
_____
_____

**14. Can you do something about your community?**

[1] yes [2] no [3] I don't know

# APPENDIX D

## INSTITUTIONAL REVIEW BOARD APPROVAL FORM

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

*Institutional Review Board for Human Use*

Form 4: IRB Approval Form
Identification and Certification of Research
Projects Involving Human Subjects

UAB's Institutional Review Boards for Human Use (IRBs) have an approved Federalwide Assurance with the Office for Human Research Protections (OHRP). The UAB IRBs are also in compliance with 21 CFR Parts 50 and 56 and ICH GCP Guidelines. The Assurance became effective on November 24, 2003 and expires on February 14, 2009. The Assurance number is FWA00005960.

| | |
|---|---|
| Principal Investigator: | MCCALL, KIMBERLY P |
| Co-Investigator(s): | |
| Protocol Number: | X040901002 |
| Protocol Title: | *Congregations for Public Health Examines Community Engagement Knowledge of Program Administrators and Community Health Advisors Using Social and Community Capacity* |

The IRB reviewed and approved the above named project on 09/13/06. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services. This Project will be subject to Annual continuing review as provided in that Assurance.

This project received EXPEDITED review.

IRB Approval Date: 9-13-06

Date IRB Approval Issued: 09/13/06

Marilyn Doss

Marilyn Doss, M.A.
Vice Chair of the Institutional Review
Board for Human Use (IRB)

Investigators please note:

The IRB approved consent form used in the study must contain the IRB approval date and expiration date.

IRB approval is given for one year unless otherwise noted. For projects subject to annual review research activities may not continue past the one year anniversary of the IRB approval date.

Any modifications in the study methodology, protocol and/or consent form must be submitted for review and approval to the IRB prior to implementation.

Adverse Events and/or unanticipated risks to subjects or others at UAB or other participating institutions must be reported promptly to the IRB.

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