

Capital Black Belt Project: A Faith-Based Intervention

ANTH 610/410: Community Health and Development

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A. Long Term Goals and Objectives

The specific aims of the proposed research are the following:¹

1. To enhance the ongoing activities of the Seat Pleasant (Maryland)-University of Maryland (UMCP—a glossary of acronyms are provided in Appendix 1) Health Partnership (hereafter referred to as the “SP-UMCP Partnership”, or simply the Partnership).
2. To expand the Partnership’s focus beyond Seat Pleasant to include neighboring communities in the Washington, DC metropolitan area that the PI refers to as the “Capital Black Belt” (CBB) because the populations throughout this area are more than 90% black.
3. To expand the present organizational representation of the Partnership by creating a coalition of the SP-UMCP Partnership with other community organizations, more university research and professional units, and various community health resources.
4. To complete the development and testing of a new comprehensive Community Based Participatory Research (CBPR) model titled the “Cultural Ecology of Health and Change” (the CEHC) through the design, implementation, and evaluation of an intervention that focuses on two primary factors that are related to obesity: diet and exercise.
5. To carry out the test intervention in Seat Pleasant because of the preliminary work carried out in this CBB community, and its small size allows some degree of control for testing a model that attempts to capture the complexity of factors that contribute to obesity and its co-morbidities (e.g., hypertension, diabetes, heart disease, stroke, and stomach and colorectal cancer).
6. To channel the test intervention through black churches because of the historical significance of churches in African American communities and because of their abilities to reach large numbers of people who are at higher risks for the conditions of concern.
7. To establish an ongoing data base for the CBB to inform the design of the test intervention and future interventions from the collection of data informed by the CEHC’s approach to comprehensive community assessment research.
8. As a component of the project’s community assessment research activities, to carry out a meta-analysis of “best practices” in diet and exercise intervention programs in

¹ These 11 specific aims are taken directly from Dr. Tony Whitehead’s proposal, dated April 2006.

community settings, specifically through churches, to be used to inform the design of the project's test intervention.

9. To complete the computerized and other CEHC tools that will facilitate the use of the model in CBPR efforts beyond Seat Pleasant and the other CBB communities
10. To develop strategies to seek complementary funding in order to create a supplementary project that will diffuse project successes beyond Seat Pleasant.
11. To establish at UMCP a model and capability that can provide ongoing and effective CBPR technical assistance beyond Seat Pleasant and the CBB communities.

B. Statement of Problem and Review of the Literature

Obesity often leads to subsequent health conditions such as hypertension, diabetes, heart disease, and stroke, as shown in several published studies and reports. Many health studies have also shown that prevalence of obesity and related conditions is higher in African Americans than in whites. Although it is known that some of the most effective preventative measures for obesity include increased physical activity, reduced intake of sodium, fats, and sugar, and an increased intake of fiber, many reports on dietary interventions indicate a lack in awareness of the social and cultural determinants of diet and exercise beliefs and practices. The focus of this study is to assess the complexity of these sociocultural beliefs and practices of diet and exercise, and to implement an appropriate intervention program through churches in the African American community, as these churches are able to reach large numbers of people and have historically played significant roles within African American communities.

Range of Interventions

There are a number of different ways to analyze strategies described in the literature on African Americans and obesity. In order to make valid comparisons, it is important to look at the goals discussed. Some articles have such a different intent from others that it would not make sense to attempt a direct comparison.

First, looking at the goals, two articles aim for a meta-analysis. They review the state of knowledge on the subject of African American obesity and interventions to reduce its prevalence. The approach that Kumanyika et al (2005) uses is to assemble a group of African American experts from a large variety of fields to make global recommendations regarding both content and form of future research. Banks-Wallace et al (2002) review eighteen studies on interventions aimed at increasing physical activity. Their strategy is to analyze literature for study design and outcomes in order to make recommendations for improved studies.

Six articles analyze a variety of factors that would play a part in designing a successful intervention. Looking at motivation for change is the subject of three of them. Wilson et al (2002) test two models of behavioral change to identify the most successful way to motivate adolescents to change diet and exercise behaviors. Coming from the other direction, two articles use focus groups to investigate motivation. Young et al (2001) include both eating and exercise behavior in their analysis, while Wilbur et al (2002) focus strictly on physical activity. In addition to individual factors that act as motivators, the Wilbur study expands the field to look at environmental and policy factors that play into motivation. One example is having safe areas to exercise.

Goldberg et al (1999) look beyond motivation to include perceptions of both community women (the target group) and community professionals in the health field (nutritionists). Their strategy also involves environmental factors: they count the types of markets and visit restaurants. Their strategy is the closest to an ethnographic approach found among these articles as they are using multiple sources and multiple methods to arrive at the best description of the issue.

Sloane et al (2006) hone in on the physical environment using surveys to assess the resources available for nutrition and recreation. Using dietary recall logs and activity monitors, Jago et al (2004) search for the connection between diet and exercise in preadolescents. While in some ways their study is the most scientific of this set of articles, it tells us the least in finding a correlation between dietary intake and physical activity but not being able to determine causality.

Resnicow et al (2000) write the only article among these that tests an intervention. They test a strategy that includes education to increase knowledge, training to increase skills, supervised exercise, and experiential learning around menu selection, shopping, and food preparation. Their goals are to see an increase on three measures of healthy eating and on two measures of physical activity.

The strategies among even these few articles vary widely. Some hope to improve the direction and quality of future research by providing an overview and critique. The bulk collect and analyze component issues. With better understanding of the multitude of factors at play, more successful interventions can be designed which can then be implemented and evaluated.

Faith-Based Interventions

The literature on community health interventions channeled specifically through or executed within faith-based organizations (FBOs) and churches is plentiful. A focus of such programs on African American communities is also apparent, due primarily to the traditional social function of churches within African American communities. Generally, these reports on these programs and studies can be divided into three thematic categories: the recruitment of churches and FBOs to participate in health interventions, the training of church and FBO staff to effectively implement intervention strategies into their existing social networks, and successful methodology to address sociocultural reasons for program efficacy.

One key study in the recruitment of churches and FBOs for participation in community health interventions is that of Christensen et al (2005). This study presented data on the recruitment of religious organizations into a research project which was focused on dietary change in the Seattle area. Attempting to create a profile of a church or FBO that would be more likely to participate in and support the implementation of a community health intervention,

researchers found that the strongest predictors of participation were the size of the FBO and the number of years that the religious leader had been with the FBO. This study provides an interesting complement to the lessons learned by researchers of another study in Los Angeles.

Markens et al. (2002) assessed pastor-level factors that affected successful recruitment of African American churches for the implementation of community health promotion programs. Researchers found that while African American pastors were relatively open to participating in health promotion programs, their commitment to other issues can negatively influence their ability to participate. In addition, of significance is the finding that the history of minorities being underserved and exploited can lead to suspiciousness and reluctance to participate.

For the training of churches and FBOs to incorporate community health interventions into their existing practices and social networks, Watson et al (2003). investigated the role of small and medium-sized churches in health intervention efforts. They found that to effectively train clergy, information about ministers' own knowledge, attitudes, and behaviors regarding health indicators, the frequency with which they discuss these issues directly to the congregation or other FBO members, and the general organizational readiness to develop and implement interventions serve as the foundation for such an approach. Another study (Brown et al. 2006) developed specific methods for the training of churches and FBOs once they had been recruited for participation in a substance abuse community intervention program. Researchers found that providing quarterly workshops to FBOs on alcohol and drug related issues, providing individual technical assistance to FBOs, and providing community seminars on substance abuse prevention (as well as disseminating relevant literature to the wider community) proved successful in the implementation of the substance abuse prevention program.

As mentioned earlier, one key objective of research on health issues in African American communities is to develop culturally sensitive methodological approaches to address attitudes and behaviors at the root level. In a project aimed at teaching African American women in Arkansas how to screen for breast cancer, Hall et al. (2005) incorporated cultural knowledge into their methodology. By providing readable, culturally sensitive material, having presentations on screening techniques and facts made by African American health professionals from different disciplines, simplifying the written materials provided by the program so that they did not exceed a ninth-grade reading level, and providing visual aids which featured only African American women, researchers were successful in their efforts.

Another study assessed effectiveness of the Black Churches United for Better Health Project, which aimed to increase fruit and vegetable consumption. Campbell et al. (1999) were successful in enhancing the program's efficacy by conducting focus groups with FBO members, individual interviews with pastors, seeking ongoing feedback from FBO members, and working with pastors to incorporate spiritual themes in tailored messages, sermons, and other communications.

Dietary and Nutritional Interventions

A review of the literature finds that successful nutrition interventions use community resources, including church, work, and school groups while working with a university, a local health service center, and a local government agency. According to Di Sogra, Glanz and Rogers (1990), effective community nutrition interventions require nutrition and health professionals to

collaborate with organizations that host health programs. These organizations include workplaces, schools, and churches.

Through the National Cancer Institute-funded Partnership to Reach African Americans to Increase Smart Eating (PRAISE!) project, Ammerman et al. (2002) found that the nutrition intervention program developed and tested in partnership with sixty African American churches in North Carolina built on the strengths of the African American church to create a community-university partnership. This partnership focused on cultural relevance and long-term sustainability. Successful interventions included pastor health promotion workshops, media packets and inspirational booklets, health bulletins, food festivals and events

Using the church as an intervention host site, Chester, Himgurg, and Weatherspoon (2006) explain that nutrition and exercise interventions should focus on ways to improve the stress management, health responsibility, spiritual growth, interpersonal relations, and self-esteem of African American church members.

Within the workplace, integrating participants' work hours and gaining cooperation from managers have served in successful health outcomes. Braeckman et al. (1999) developed a nutrition intervention for white middle-aged laborers at four worksites in Belgium. Although participation was voluntary, the worksite managers encouraged their employees' attendance and allowed the laborers to take personal time off for counseling sessions. Throughout the campaign, mass media from posters to videos were used to stress the relation between cholesterol and heart disease and explain the importance of diet as a determinant of cholesterol. In addition, group educational sessions were offered at the worksites outside working hours. The intervention resulted in lower cholesterol levels through a lower fat diet and lower calorie intake.

Working in an Atlanta Job Corps Center, McLeod Dannelly et al. (2005) gained insight into the nutrition-related attitudes and motivations of overweight African-American adolescents and young adults. The participants recommended that nutrition interventions should address overeating, preparing and eating nutritional meals, emotional eating, and long-term consequences of a poor diet. In addition, these interventions should work with the participants' schedules, whether providing workshops and education sessions during lunch time or after hours.

Engaging young school children in health eating behavior has had successful results. Gortmaker et al. (1999) developed a joint intervention with the Harvard School of Public Health and Baltimore public elementary schools, where 91 percent of the students are African-American. Teachers taught the Eat Well and Keep Moving Program using educational materials, and the program also provided wellness programs for the teachers and school staff.

Focusing on low-income Latino children in Hartford, CT, Himmelgreen (2002) and Pérez-Escamilla (2002) discuss a joint effort by the University of Connecticut, the Hispanic Health Council, and the Cooperative Extension System to develop a nutrition intervention program. Children's puppet shows actively engage the audience in exercises and create villains that the children actively respond against. In collaboration with local schools, teachers evaluate the puppet shows and make suggestions that contribute to producing better informed shows.

The integration between participants and role models or teaches, as Lytle (2004) found, works better than solely targeting eating behavior. A two-year intervention program did not reach its objective of increasing adolescent students' intakes of fruits, vegetables, and lower fat foods. Lytle suggests that future work should consider the use of peer leaders, more intensive teacher training, ongoing formative assessment, and the testing of more powerful environmental change intervention strategies.

Overall, the need for integrating community resources with participants' needs may well create a successful nutrition intervention. Interventions need to be creative and culturally appropriate, while engaging the participants and working within their needs. Role models from pastors to teachers also need to be engaged. In the workplace, manager cooperation is key, as well as working within the participants' daily schedules. In schools, engaging children in activities and educating schoolteachers has worked well. In churches, integrating spirituality and allowing the participants' to choose what foods work well for them have proven successful.

Exercise Interventions

The literature on health interventions targeted specifically at improving exercise practices shows a correlation between low-income minority children, obesity and the frequency of television watching. According to Kuminyika et al (2006), low-income children watch more television and are exposed to commercials that advertise calorie-laden food. Also, low-income neighborhoods tend to have more fast food dinners. Likewise, Fleming et al (2002) says that children who watch television often will decrease the amount of television they watch if they maintain exercise programs. The Fleming study also says that school-aged children can have preconceived notions about health behaviors but can be influenced with age-appropriate intervention programs. Researchers found that the roles of the community health nurse and nurse practitioner are crucial because they yield great influence on communities, children and families.

Kuminyika also finds that children are deterred from physical activity because they feel the streets are unsafe and finds that intervention planners must consider the physical environment before advocating programs. He believes that the government should take this responsibility. Similarly, Miles et al (2006) finds that the perceived lack of safety in neighborhoods among low-income women will affect whether they choose to walk or not. Another factor in this decision is the proximity of family and friends. However, even a small amount of physical activity (without dietary restriction) can lead to significant weight loss.

Following this concept, Miller et al (1997) finds that even a fifteen-week diet or diet *plus* exercise intervention produced weight loss but that exercise was more effective as an intervention technique and follow up. Miller (2001) discusses how exercise and active living was the only variable that consistently showed effectiveness in mental, physical, psychological and behavioral outcomes. An exercise treatment program that was best for success included four stages: pre-evaluation, exercise, behavior plan and maintenance plan.

Vole (2005) also concludes that weight loss is a lifelong plan rather than a quick fix, or weight would be regained. Researchers stated that exercise increased weight loss and control, and that any exercise was better than none, although more was better. Lejuene et al (2003) discover that the greater the weight loss, the less weight one was likely to regain. Elaikim et al (2002) agree that children who lose more weight were more likely to maintain a program.

Kuminyika claims that parents contribute to childhood obesity and that breast-feeding is less common among low-income women. This results in a quicker change to solid food, which is often sugar-laden and unhealthy. This study found that schools have power to influence the behaviors of children, but that in low income areas, they are more concerned with preventing drug use and maintaining academic standards. Fleming finds that life choices begin in childhood and that healthy intervention must be integrated into family life. Additionally, Elaikim concludes that children whose parents were overweight were less likely to lose weight and that children

who maintained a fitness regimen for more than six months maintained lower body mass indexes.

On a more general fitness level, Boule et al (2000) find that interventions must be designed with attention to what is feasible, necessary, sustainable and safe. Increased volume of physical activity and increased resistance is most effect, but that a gradual increase is best for beginners to prevent injury. Also, multiple bouts of exercise throughout the day are just as effective as one long session. Like other studies, Boule finds that exercise interventions are most effective when paired with dietary interventions.

Interventions Aimed at Specific Subgroups

Another area of study within larger framework of health interventions is the focus on specific societal subgroups or specific populations as defined by gender, age, ethnicity, etc. Most apparent in the literature studies aimed at addressing the health issues and needs of women, children, and specific ethnic groups.

One key study on health interventions aimed at women is that by Haire-Joshu et al. Researchers report on the Eat Well, Live Well Nutrition Program (EWLW), a peer-delivered, community-based nutrition program developed by a partnership of Washington University and peer educators from Grace Hill Neighborhood Services, a social service agency located in African American neighborhoods in St. Louis. EWLW aims to reduce fat intake to 30% of total caloric input and to reduce weight, which will result in long-term effects such as a decreased risk of obesity, and therefore diabetes, among African American women. In the Program, peer educators teach participants to change specific dietary behaviors and patterns, in order to lower dietary fat intake. Throughout the process, peer educators assess participants' stage of readiness to reduce fat in their diets.

As for health interventions aimed at children, Batch et al. suggest that obesity interventions that have proven most successful include family support systems, developmentally appropriate approaches, long-term behavior modification, dietary change, increased physical activity, and decreased sedentary behavior. Obesity prevention in children and adolescents requires changes in both their microenvironment (housing, neighborhoods, and recreational opportunities) and their macroenvironment (food marketing, transport systems, urban planning). Most importantly, researchers conclude that behavior change interventions that involve the family as a support system are most likely to be successful.

Harrell et al. outline the effects of two types of elementary school-based interventions on children with multiple cardiovascular disease (CVD) risk factors. Both eight-week interventions consisted of a knowledge and attitude program and an adaptation of physical education. The classroom-based intervention was given by regular teachers to all children in the third and fourth grades. The risk-based intervention was given in small groups only to children with identified risk factors. Children in the control group received usual teaching and physical education, and both interventions produced large reductions in cholesterol compared with a small drop in the controls. There was a trend for systolic blood pressure to increase less in both intervention groups than in the controls, and both intervention groups had a small reduction in body fat and higher health knowledge than the control group. The primary outcome measure was cholesterol; additional measures included blood pressure, body mass index, body fat, eating and activity habits, and health knowledge. Both brief interventions improved the CVD risk of children with

multiple risk factors but the classroom-based approach was easier to implement and used fewer resources.

Another body of literature exists on health intervention programs aimed at specific ethnic groups. Shintani et al. describe the Waianae Diet Program, a community-based intervention strategy designed to be culturally appropriate using a pre-Western-contact Hawaiian diet to reduce risk factors in Native Hawaiians. A trial of the traditional Hawaiian diet fed ad libitum to Native Hawaiians with multiple risk factors for cardiovascular disease to assess its effect on obesity and cardiovascular risk factors, was conducted. The diet was low in fat, high in complex carbohydrates, and moderate in protein, and participants were encouraged to eat to satiety. Researchers indicate that the intervention was successful, as average weight loss was 7.8 kg and average serum cholesterol decreased 0.81 mmol/L, and blood pressure decreased an average of 11.5 mm Hg systolic and 8.9 mm Hg diastolic.

Story et al. emphasize the poor success rates of adult American Indian obesity treatment programs in the general population and the need for prevention approaches aimed toward American Indian children. Specifically, prevention programs are needed that encourage increased physical activity and healthful eating habits among young people and these interventions must be developed with full participation of the American Indian communities. Also focusing on the American Indian population, Teufel et al. describe the need for working with families of third-grade American Indian children to reinforce health behaviors being promoted by the curriculum, food service, and physical activity components of a school-based obesity prevention intervention. As shown to be successful in other health interventions, strategies were designed to create an informed home environment that is supportive of behavioral change.

C. Description of Seat Pleasant

Seat Pleasant, Maryland is a small city covering less than one square mile or 480 acres, bordering Washington, D.C., with a population of a little less than 5,000 residents, 97.5 percent of whom are African American. This predominantly black population is similar to its neighboring small Maryland cities and various neighborhoods in the eastern portion of Washington, DC. Dr. Whitehead refers to this entire area as the “Capital Black Belt” (CBB). While Seat Pleasant is the major focus of the proposed work, the project also proposes to develop strategies for networking with neighboring communities of the CBB. The primary rationale for this is that while these various small communities have different municipal boundaries, the lives of the people in these communities cross these boundaries daily. Moreover, many of the existing resources that the research proposes to take advantage of have as their mission a positive response to the health needs of residents of a number of these communities including Seat Pleasant.²

² This description is taken directly from Dr. Tony Whitehead’s proposal, dated April 2006.

D. Strategies

Pre-intervention Ethnography

Our strategy is to start with pre-intervention ethnography. Initially, we will evaluate the physical environment in Seat Pleasant for features that could prove to be assets or barriers in working with the community churches to implement a successful intervention to reduce obesity and its attendant health risks. It is important to understand the context in which dietary and exercise programs will be launched. The type and number of markets, the availability of quality produce, the distance involved, the pricing of healthy items, the type and number of restaurants all can have an impact on food shopping and dietary habits (Sloane et al. 2006). In addition, exercise can be affected by safety issues (Wilbur et al. 2002). Therefore, we will investigate whether parks, sidewalks in good repair, exercise facilities such as gyms or YMCA/YWCAs can be found in the community. It is beyond the scope of our pilot project to design interventions to address any deficiencies that might be found at this time. However, awareness of constraints or resources available to participants in the dietary and/or exercise interventions could prove useful. Mobilization to address any of these environmental issues could become a target of a future intervention.

Working with the Community Ministry of Prince George's County

One of the most important steps needed to prepare for a successful program is the identification and recruitment of individual congregations that are most suited for program implementation. In order to assess which churches will be most accepting and prepared for a health intervention program of this nature, the team of ethnographers, with the assistance of the Community Ministry of Prince George's County, will conduct one-on-one interviews with ministers to gain knowledge in three areas. First, a general assessment of the ministers' own knowledge, attitudes, and behaviors regarding the leading health indicators and complications of obesity will be carried out. Second, information on the frequency with which ministers discuss health issues from the pulpit will be gathered (participation observation may also be used to verify data gathered in this category). Third, an assessment of the congregations' organizational readiness to implement the intervention will be conducted. Congregations with any preexisting health programs, whose minister is knowledgeable on health issues and has historically discussed these issues using his or her leadership authority, and whose organizational structure is conducive to the implementation of a health intervention (clear leadership roles, existing modes of inter-congregational communication and dialogue, etc.) will be selected as initial locations for program implementation.

After isolating specific congregations through which to carry out the intervention, the team of ethnographers will also meet with ministers and other congregational leaders to address two potential concerns. As the literature shows, the over-commitment of black church leaders to other issues along with the suspicion stemming from a history of ethnic minorities being underserved and exploited can negatively influence their participation in community health initiatives (Markens et al. 2002). Thus, the team of ethnographers will work to convey the relevance of the intervention as a community priority which needs attention, both to ministers and other congregational leaders, rather than expecting immediate acceptance and willingness to participate. Also, the team will be prepared to address any issues regarding ethnicity that may

arise from conversations and interviews with congregational leaders. While unable to foresee any specific conflicts, the team will take the unified approach that the focus of the intervention on this specific community is due to the prevalence of obesity and related health complications found within.

Once we have developed a working relationship with leaders in the “pilot” churches, it is critical to evaluate the elements of the proposed interventions with church members. While we have combed the literature for successful strategies, we are aware that every community has its own culture and that success in Seat Pleasant will not be determined by what has worked in other communities. Focus groups will be used to test the local appropriateness and appeal of specific features of the health awareness segment, the dietary intervention segment, and the exercise intervention segment.

Phased Interventions

Phase I: Communicating the health awareness campaign

We propose using church material and expressive culture such as bulletin boards, newsletters, order-of-service programs, fans, bookmarks, and Web site to communicate health awareness campaign over the period of the pilot program. We would collaborate with a health communications expert, church pastor and staff (Health Action Team, or HAT), and selected church members to post announcements, flyers, and other graphically enticing educational material for all congregation members to read.

The messages would also include spiritual or biblically-inspired phrases. For instance, one message could be, “Have the faith to live healthily” with suggestions on using a low-costs oil such as canola to fry food instead of Crisco or higher fat oils, or in lieu of frying foods, baking or sautéing.

In order not to inundate church members with too much information at one time, we propose using the “drip, drip, drip” theory by which we would disseminate one piece of educational material weekly. This way, the information and exposure would build awareness among the congregation.

Working with the pastor directly to sponsor his role as health promotion leader and change agent, we will provide workshops to raise awareness and educate the pastor on nutrition and exercise messages and provide biblical health messages that he can incorporate in his sermons at least once a month throughout this pilot program.

Phase II: Church health fair

Working with the Prince George’s Hospital Center community liaison, we will conduct a health fair at the church to kick off the next intervention phases. At this one-day event, health professionals will provide free health screenings of blood pressure, body mass index (BMI), blood sugar level and we will obtain their personal and family medical histories, including smoking, known heart disease, diabetes, etc.. We will have a licensed phlebotomist to draw blood so that the attendees can have their cholesterol levels checked. The Prince George’s Hospital Center laboratory will test the blood and send results to the attendee with a

recommendation, if cholesterol levels are high, that the attendee see his/her doctor for a follow up.

In an effort to increase attendance, expensive door prizes such as flat screen TVs, mp3 players and DVD players, would be raffled. Also, free giveaways like healthy snacks would be provided throughout the fair.

If the resources are available, local community markets or Maryland farmers would provide fresh fruits and vegetables. The health fair would also offer fun fitness activities for the whole family including a double-dutch competition and hula hoop competition. This would also be an excellent opportunity for university dance groups to showcase their African dance skills and build up anticipation for the Phase IV exercise intervention.

Phase III: Nutrition Intervention

After three months of the health awareness campaign, the project team would begin a nutrition intervention based on the successful National Cancer Institute-funded Partnership to Reach African Americans to Increase Smart Eating (PRAISE!) project (Ammerman et al. 2002).

The project team will produce and disseminate packets quarterly to the Health Action Team (HAT) to encourage and inspire church members to eat more fruits, vegetables, fiber and less fat. In an initial nutrition workshop, the project team would provide a sample packet with bulletin board and scripture-based health and nutrition messages, suggested activities, nutrition facts, certificates, and other graphic information. The packet would also include supplies needed to decorate the bulletin boards such as a food pyramid poster, colored paper, and other decorations.

With a certified nutritionist the HAT will then host a 12-week nutrition workshop for ten female church members³ on a weekday evening or weekend afternoon that the HAT has determined would work best for its membership. Individual nutrition classes would address overeating, emotional eating, long-term consequences of a poor diet, menu selection, and food shopping. These classes would emphasize the participants' spirituality and self confidence to have the faith to live healthily.

In addition to watching nutrition videos and discussing balance meals and portion control and tracking and evaluating their dietary intake through daily logs, the participants will bring in their own and/or their family's favorite recipe for the nutritionist to work with them in creating a low fat version. Provided the church has a kitchen, the participants will spend at least one class creating tasty low fat dishes. The participants will have the chance to sample different and new foods, share ways to make healthy food choices, and learn how to modify their meals.

At the last day of the nutrition workshop, the project team and HAT will host a graduation ceremony. A potluck comprised of the best tasting low-fat food the participants have

³ We recommend targeting women during this pilot program for a variety of reasons. As Dr. Whitehead has aptly coined, women church member hold a valuable place as the Key Kitchen People (KKP). As the KKP, they have influence over their church's kitchen and available resources. However, they may not head their households, especially if the male head has a strong say over what his wife, mother, or daughter must fix or offer for dinner. However, as we note in the nutrition intervention section, we feel that women may have the ability to influence their families' meals. In addition, we have noted in the literature that obese women are face more job prejudice and earn less money than "normal" weight women with comparable educations (O'Shea 2006). We feel that by targeting women, we hope to build their confidence and skills to live healthily and provide good-tasting, low fat options for meals that they family would enjoy eating.

learned to make themselves, the participants will have the chance to share their low-fat food with their fellow church members. The HAT will hand out certificates to each participant who completed the three-week course to celebrate each participant individually in front of the church membership. The materials handed out at the following Sunday program would also recognize the participants' success.

Also, the HAT and workshop participants could compile a recipe book of low fat recipes to be sold to the congregation. Not only a fundraising activity, the recipe book would provide inspiration to congregation members with biblical passages and education with healthy eating tips.

Phase IV: Exercise Intervention

After the completion of first nutrition workshop, the HAT would commence the three-month exercise intervention with the help of a dance and aerobics instructors. The HAT would start a 10,000-Steps Club for members who would like to increase their activity levels. The HAT would provide free pedometers to those members who attend the first meeting and instruct the participants on how to use them. The objective will be to raise awareness that daily activity, especially with sedentary office jobs, may not provide much cardiovascular benefit. The pedometers would show the participants just how many steps each takes per day with the goal of increasing activity to a healthy and active 10,000 steps per day.

If started in the summer months, the 10,000-Steps Club could gather weekday evenings to walk together around a local school track. The initial assessment of community resources would provide other suggestions for walking together in groups, such as local parks, as discussed above.

A dance instructor, either a church member or University of Maryland faculty member, would provide classes for women such as Afro-bics, hip hop, Afro-Caribbean, salsa, Afro-Cuban, belly dance, Afro-Brazilian, or other African American-sensitive classes. The classes would be held five times a week in a large room at the church, with the objective of participants attending at least six times in the three-month period. The classes would be at convenient times, such as weekday evenings or weekend afternoons, and the HAT would organize child care for adult mothers attending classes.

Monitoring

Monitoring, or continuous evaluation, is essential in order for us to determine which aspects of our community-based obesity intervention are proving to be successful and should be continued, and which aspects are failures and should be discontinued or reformed. Participant observation involves an ethnographer gaining an intimate familiarity with the group of participants and their behavior through intensive involvement with the group in their natural environment. This research method will be used throughout the dietary portion. This may involve an ethnographers participating in the healthy eating classes as students themselves, actually bringing their favorite low-fat dish to the food festival/graduation, taste-testing contests, etc. Participant observation will also be used throughout the exercise portion. The ethnographer may join the 10,000-Steps Club, walking groups, Afro-bics, dance classes, etc. Throughout the ethnographer's involvement, they will record their detailed observations and try to draw

conclusions based on them. They may conduct informal interviews with fellow participants to learn about the participants' opinions of the programs, their progress (or lack of), attendance rates, etc. These informal interviews may be conducted before the classes begin and after they have been completed. In addition, we will conduct focus groups after the first three months of both the dietary and exercise interventions. This monitoring will be facilitated by five community health experts/ethnographers.

Post-intervention Evaluation

Because our plan is to focus on health risks, we want to use a combination of risk factors that are commonly used to evaluate cardiovascular risk. Although weight or BMI alone would be easier to measure, those numbers do not tell the whole story. We are interested in obesity, not in and of itself, but because it is a risk factor for cardiovascular disease, specifically heart attack and stroke, and for diabetes. It has been shown that people can lower their risk for these serious diseases even short of attaining ideal weight (Van Gaal et al 1997). Several researchers have found that body image among African American women is not perceived to be problematic until a woman is already overweight, so achieving normal weight as medically defined may become a daunting task (Sánchez-Johnsen et al. 2004). Adding to the intense focus on weight alone which has become part of our society may prove counter-productive. Our rationale, therefore, is to take a more global approach in using BMI along with cholesterol levels, blood pressure readings, and age, sex, and history of smoking or known cardiovascular disease or diabetes to arrive at a more accurate and nuanced picture of health risk level. We will use validated risk calculators such as the Framingham Risk Calculator (Wilson 1998) and Diabetes Risk Calculator (Herman 1995). Thus we will have clear indicators of the impact of our interventions that can be compared across studies.

Many interventional studies fail to include follow-up data. No intervention of this nature can truly be judged successful unless positive results can be sustained for at least six months, preferably one year. Our plan is to evaluate immediately post-intervention, again at the six months post-intervention and finally at one year post-intervention. Even if the intervention is not entirely successful, this duration of follow-up will further the research efforts to craft community-based programs.

E. Personnel and Other Resources needed to Achieve Project Goals and Overall Objectives

Throughout the course of the pilot program, many people will be needed to fulfill important roles so that strategies can be implemented. For each of these roles, priority will be given to members of the community and various congregations. In the best situation, community members will be trained in some of these areas, and will want to contribute to the program. Recruiting people within the congregations is important because these people have established credibility among their neighbors and church members. Women will be more likely to engage in church-sponsored health activities that are led by people they know and trust. If people within the congregation are not found, perhaps some would be willing to be trained to fulfill these roles.

The program creators do not wish impose outside ideas on any unwilling members or wish to make any participants feel uncomfortable.

In addition, priority will also be given to faculty, staff and associates at the University of Maryland to help build the partnership between the university and the Seat Pleasant community.

If willing participants are not found within the Seat Pleasant community or University of Maryland, an effort will be made to find the most qualified and credible personnel.

For the first phase of the pilot program, a team of five ethnographers (1) will be needed to assess the community. This team will be qualified anthropologists, preferably from the University of Maryland. This team will assess the resources and assets of the Seat Pleasant community, while working with the Prince George's County Ministries. (10)The members will also study the physical environment so that they can create the strategies that are most applicable to the environment. They will also survey the attitudes and behaviors of community members. This team will conduct ethnographic research primarily using participant observation, in-depth interviews and focus groups. The team will be adept in qualitative research methods.

For the second phase of the program, the campaign on health awareness, the focus will be on a communications team. An important member of this team will be a full-time communications professional (2) who will create the campaign and health information tactics. This expert will need the help of the church secretary, so that the messages may be properly displayed within church publications. A small support staff (3), made up of church members, would be helpful as well. This staff would ideally be selected by the pastor (4). These people, as part of the Health Action Team (HAT), would give ideas and help develop creative strategies used in the campaign. Additionally, the communications expert would need the scientific expertise of a nutritionist (5) and physiologist (6).

Before the implementation of phases three and four (the dietary and exercise interventions), professionals will be needed at the health kickoff event. The Prince George's Center staff (7) would be the ideal professionals to perform health examinations.

For the dietary intervention, the nutritionist (5) will again be needed. Ideally, this will be an African-American community member to serve as a consultant and teacher. Again, the pastor (4) will be needed to oversee and help implement the program.

For the exercise intervention, a physiologist (6) will be needed for consultation. Also, this person will, if possible, teach some exercise programs and recruit church members to teach them as well. A facilitator (8) will be needed to oversee the 10,000-Steps Club. This is a very instrumental important member of the program, and should be a church member with who is credible and flexible to different ideas and roles. In addition, a dance instructor (9) will be needed to teach the dance classes.

The ethnography team will conduct the monitoring of the program throughout its duration and will conduct the post-intervention assessment (1).

In addition to specific personnel needed for each phase of implementation, relationships with Seat Pleasant health and ministry officials are necessary.

Possible Personnel Contacts: (refer to Human Resources Matrix for specific contact information)

- (1) Dr. Tony Whitehead and associates/students
- (2) Communications professional, potentially within community or from the University of Maryland Department of Communication
- (3) Support staff, church members
- (4) Pastor(s) of congregations
- (5) Nutritionist (from UMD Health School of Agriculture and Natural Resources, department of nutrition)
- (6) Physiologist (from UMD School of Health and Human Performance, department of Kinesiology)
- (7) Staff, Prince George's County Hospital Center
- (8) Facilitator (as chosen from community)
- (9) Dance Instructor from UMD (College of Arts and Humanities, department of Dance)
- (10) Prince George's County Ministries

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I. Community and University Coalition Partners

| Organization's Name & Contact Information | Contact Person(s), Title(s) & Information | Description of Programs/ Activities |
|---|---|--|
| University of Maryland's Cultural System Analysis Group (CuSAG) | Dr. Tony Whitehead Director, CuSAG Dept. of Anthropology, 0123 Woods Hall University of Maryland College Park, MD 20742. 301405-1419 twhite@anth.umd.edu http://www.cusag.umd.edu | |
| Seat Pleasant –University of Maryland Health Partnership (SPUMHP) | Ms. Evelyn King Chair, Board of Directors, (SPUMHP) Retired Health Policy Analyst, 129 69 th Street Seat Pleasant, MD 20743 301-336-0410 (H); 301-350-0864 (F) Eking789@comcast.net | The City of Seat Pleasant (Maryland) and the Department of Public and Community Health at the University of Maryland formed a Health Partnership in 1999. Since then, other units at the University of Maryland have joined the Health Partnership. This partnership has as its intent the improvement of the health of Seat Pleasant residents, and the enhancement of learning and research for students and faculty of the University of Maryland. These goals will be achieved by students and faculty providing to Seat Pleasant residents health education services that might not otherwise be available. At the same time, students and faculty will learn from Seat Pleasant residents and will integrate and apply components of the health education curriculum at the community level. |

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| | | |
|--|---|---|
| Community Ministries of Prince Georges County (CMPGC) | Jimmie L. Slade Chair, Board of Directors, 301-627-3147 jaslade@verizon.net Rev.Terrence Collins Exec Dir., Community Ministry of PG County 311 68 th Place Seat Pleasant, MD 20743 301-499-2319; Fax 301-499-2915; tdcollins@cmpgc.org www.cmpgc.org | Community Ministry of Prince George's County has been awarded the Smoking Cessation/Community contract for July 2006-2007. In partnership with 100 churches, CMPGC will be strengthening Prince George's County Tobacco Control through its Faith-Based Partnership. It is the hope to end the use of tobacco across the County." The body is the temple and the best place to build the body is through our partnership to strengthen the temple." The partnership will work to "STOMP" out tobacco use throughout the County. We are recruiting 100 churches to help us to make Prince George's County "Free Indeed of Tobacco." |
| Prince George's County Health Department, Center for Lifestyle Initiatives (CHLI) | Ms. Melony G. Griffith Program Director, CHLI, Prince George's County Health Department 1701 McCormick Drive, Suite 210 Largo MD, 20774 301-883-3153; Fax: 301-883-7893; ggriffith@co.pg.md.us | <ul style="list-style-type: none">• Educational presentations to groups such as civic associations, work groups and faith-based organizations on the topics of nutrition and physical activity• Printed health education materials• Health fair and event support• Referrals to other County and Health Department services |
| Dimensions Health Systems, Prince George's County Hospital Center | 3001 Hospital Drive Cheverly, MD 20785 www.dimensionshealth.org | <p>The Senior Health Center, under the medical direction of a board-certified family practice and geriatric medicine physician, provides primary and continuing comprehensive medical and nursing services.</p> <p>These services are provided to Prince George's County residents 55 years and older who are in need of personalized healthcare. Services are provided to persons with disabilities as well to persons of low and moderate levels of income.</p> <p>The Center is funded by a Development of Housing and Urban Development Community Development Block Grant and managed by Gladys Spellman Specialty Hospital and Nursing Center, an affiliate of Dimensions Healthcare System. Free transportation to the Senior Health Center from many areas in Prince George's County is available upon request.</p> <p>The following are some of the services provided at the Senior</p> |

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Health Center:

- Blood and Urine Testing
- Complete Physical Examination
- Diabetic and Hypertension Screening and Treatment
- EKG's, PAP Smears, and Rectal Examinations
- Early Dementia Screening
- Geriatric Assessment
- Limited Transportation to and from the Senior Health Center
- Podiatry Services
- Primary Medical Care
- Preventive Care
- Referrals
- TB, Pneumonia and Influenza (flu) vaccinations
- Walk-in Blood Pressure Checks

Health Action Forum of Prince George's County (HAF)

[Not found through Internet research]

University of Maryland Department of Public and Community Health (DPCH)

School of Health and Human Performance
University of Maryland, College Park
[http://Human Health and Performance.umd.edu/dpch/](http://HumanHealthandPerformance.umd.edu/dpch/)
jerry@umd.edu

University of Maryland's Engaged University Initiative

Dr. Sam Maullo, Board Chair
Engaged University Initiative (EUI), Democracy Collaborative and the CoRal (Community Research and Learning) Network
11241 Tawes Hall
College of Agriculture & Natural Resources
University of Maryland
(202) 687-3582
info@coralnetwork.org
<http://www.coralnetwork.org/network/index.html>

The EUI is working to help refocus the institution's commitments and resources (human, intellectual, financial) to build toward a civic engagement service that will be relevant to land-grant universities nationally.

The CoRal Network is a consortium of community-based organization and higher education institutions in the Washington DC metro area engaged in community-based learning and research to promote positive social change and advance their social justice missions in the national capital region.

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University of Maryland's African American Studies Department (AASD)
Dr. Sharon Harley,
Chair, AASD
University of Maryland, College Park
sharley@aasp.umd.edu

University of Maryland's Nyumburu Cultural Center
Dr. Ron Siegel
Director, Nyumburu Cultural Center
301-314-7758
<http://www.nyumburu.umd.edu/>
nyumburu@umd.edu

B. Local Scientific Advisory Committee (LSAC)

| Name and Title | Contact Info | Project Roles |
|---|--|---|
| Tony Whitehead, Ph.D. Professor, Medical Anthropology Department of Anthropology University of Maryland Anthropology Director, Cultural Systems Analysis Group | Dept. of Anthropology, 0123 Woods Hall University of Maryland College Park, MD 20742. 301-405-1419; twhite@anth.umd.edu ; http://www.cusag.umd.edu | Primary Investigator, Overall Project Director, Capital Black Belt Project |
| Kim Nickerson, Ph.D. Assistant Dean, University of Maryland College of Behavioral and Social Sciences (BSOS) Assistant Dean, Department of Public and Community Health | 2141 Tydings Hall University of Maryland College Park, MD 20742 (301) 405-7599 knickerson@bsos.umd.edu | Co-Investigator. Will provide health disparity expertise and assistance in identifying and recruiting other members of the LSAC |
| Jerrold Greenberg, Ph.D. Professor, Department of Public and Community Health, School of Health and Human Performance | 2375 Human Health and Performance Building University of Maryland College Park, MD 20742 (301) 405-2524 jerry@umd.edu | Will bring senior health education and survey research expertise to project |

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| | | |
|---|--|---|
| <p>Carolyn C. Voorhees, Ph.D. Research Associate Professor, University of Maryland Department of Public and Community Health</p> | <p>2358 Human Health and Performance Building University of Maryland College Park, MD 20742 (301) 405-3466 ccv@umd.edu</p> | <p>Will contribute to the design, implementation and evaluation of the diet and exercise components of the proposed project's intervention programs</p> |
| <p>Sharon Desmond, Ph.D. Associate Professor, Department of Public and Community Health</p> | <p>2358 Human Health and Performance Building University of Maryland College Park, MD 20742 (301) 405-2526 desmond@umd.edu</p> | <p>Will bring senior health education expertise to project</p> |
| <p>Min Qi Wang, Ph.D. Professor, Department of Public and Community Health</p> | <p>2373 Human Health and Performance Building University of Maryland College Park, MD 20742 301-405-6652 mqw@umd.edu boekeloo@umd.edu</p> | <p>Will bring bio-statistical expertise to project</p> |
| <p>Bradley Boekeloo, Ph.D. Professor Department of Public and Community Health</p> | <p>rfeldman@umd.edu</p> | <p>research interest in: behavioral intervention research</p> |
| <p>Robert Feldman, Ph.D. Professor Department of Public and Community Health</p> | <p>eglover1@umd.edu</p> | <p>healthy eating, Hispanic, African studies</p> |
| <p>Elbert Glover, Ph.D. Professor Department of Public and Community Health</p> | <p>dhoward1@umd.edu</p> | <p>obesity</p> |
| <p>Donna Howard, PhD. Associate Professor Department of Public and Community Health</p> | <p>edhsu@umd.edu</p> | <p>community-based health, minority health</p> |
| <p>Chiehwen Hsu, PhD. Assistant Professor Department of Public and Community Health</p> | <p>estina@umd.edu</p> | <p>health disparities, minority health</p> |
| <p>Estina Thompson, PhD. Associate Professor Department of Public and Community Health</p> | <p>[1245 Architecture Building University of Maryland</p> | <p>social inequities</p> |
| <p>Alex Chen, Ph.D. Professor, Department of Urban Studies and</p> | <p>[1245 Architecture Building University of Maryland</p> | <p>Dr. Chen will bring GIS expertise to the Capital Black Belt project.</p> |

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| | | |
|---|---|--|
| Planning University of Maryland | College Park, MD 20742 (301) 405-6789 achen@umd.edu | |
| Sonia Flynn Keiner Community Education Organizer The Engaged University Initiative University of Maryland | 1231D Tawes Fine Arts Building University of Maryland College Park, MD 20742 (301) 314-2744 skfly@bsos.umd.edu | Ms. Flynn Keiner will assist in identifying community organizations in the Capital Black Belt area to establish a community-based partnership to address relevant health issues. |
| Elaine Tharrington, RN Dimensions Health System Maternal Child Health Department Prince George's Hospital Center Maternal Child Health Department Prince George's Hospital Center | 3001 Hospital Drive Cheverly, MD 20785 Elaine.Tharrington@dimensionshealth.org (301) 325-6451 | Ms. Tharrington will provide health education expertise to the project. |
| Jeannette Harris Faculty Research Assistant Department of Kinesiology University of Maryland, Baltimore | 2809 Boston St., Suite 7 Baltimore, MD 21224 jeharris@umd.edu (410) 563-6200 ext. 205 | Ms. Harris will provide chronic disease health education expertise. |
| Marian L. Batts-Turner, MSN, RN, CDE Research Associate in Medicine Project Sugar 2, Project Director Johns Hopkins Hospital and Health System | 2809 Boston St., Suite 7 Baltimore, MD 21224 (410) 563-6220 ext. 212 mlbatts@jhmi.edu | Ms. Batts-Turner will provide diabetes health education expertise on this project. |

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III. National Professional Advisory Committee (NPAC)

| Name and Title | Contact Info | Project Roles |
|---|---|--|
| Dr. John Hatch, North Carolina General Baptist State Convention | | Provide Expertise on Institutionalizing Health Programs within broad Faith-Based Systems |
| Dr. Eugenia Eng, Department of Health Behavior and Health Education and, University of North Carolina School of Public Health (UNCSPH) | Department of Health Behavior and Health Education, School of Public Health University of North Carolina Chapel Hill North Carolina Genieng@aol.com ; | Provide expertise in CBPR and design, implementation, and evaluation of community based initiatives (CBI). |
| Dr. Alice Ammerman, Department of Nutrition, UNCSPH), | Department of Nutrition School of Public Health University of North Carolina Chapel Hill North Carolina Alice Ammerman alice_ammerman@unc.edu | Provide expertise in nutrition and designing, implementing, and evaluation of nutrition based CBIs, including through faith-based organizations. |
| Dr. Barbara Israel, Department of Health Behavior and Health Education, University of Michigan's School of Public Health (UMSPH) | Department of Health Behavior and Health Education, School of Public Health, University of Michigan, Ann Arbor, MI ilanais@i.imap.itd.umich.edu ; | Provide expertise in CBPR and design, implementation, and evaluation of community based initiatives (CBI). |
| Dr. Robert Goodman, Professor and Chair, Department of Behavioral and Community Health Sciences, University of Pittsburgh's School of Public Health (UPSPH) | Graduate School of Public Health 208 Parran Hall, Pittsburgh, PA 15261; Phone: 412-624-3100; Fax: 412-648-5975; E-mail: rmg16@pitt.edu | Provide expertise in CBPR and design, implementation, and evaluation of community based initiatives (CBI). |
| Dr. Kenneth R. McLeroy, Ph.D. Associate Dean, Texas A & M University's School of Rural Public Health (TAMUSRPH) | School of Rural Public Health Room 275, 1266 Texas A & M University College Station, TX 77843, kmcleroy@srph.tamhsc.edu | Provide expertise in CBPR and design, implementation, and evaluation of community based initiatives (CBI). |
| Dr. Robert Aronson, University of North Carolina at Greenboro's Department of Public Health Education (UNCGDPHE), School of Health and Human Performance | Department of Public Health Education, School of Health and Human Performance, University of North Carolina Greensboro, North Carolina Robert Aronson rearonso@uncg.edu | Provide expertise in CBPR and design, implementation, and evaluation of community based initiatives (CBI). |

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Dr..Daniel L. Howard, Ph.D. Associate
Professor, and Director of Shaw University's
Institute for Health, Social, and Community
Research

Shaw University, 118 E. South Street
Raleigh, NC 27601, (919) 546-8256
(phone); (919) 546-8755 (fax)
howardd@shawu.edu

Provide expertise in health disparities epidemiology, and
the development of health disparities infrastructure.

Dr. Moses Goldmon, Director, ARMI, Shaw
University's Divinity School

Shaw University, 118 E. South Street,
Raleigh, NC 27601
mgoldmon@shawu.edu

G. Timeline

We expect each stage of the program to last approximately three months. This includes pre-intervention ethnography, general health awareness, a dietary intervention, and an exercise intervention. Therefore, the entire pilot should last approximately one year, plus the duration of the post-intervention evaluation stage. Depending on the success of the pilot program, future interventions may last approximately two years.

H. Project Limitations

It is not only possible, but probable that we will run into various limitations throughout the course of this program. We may have trouble locating, contacting, and soliciting help from the necessary personnel. Everyone we are planning to involve in the program is extremely talented and probably very busy as well. They may have one or more jobs, children, community activities, etc. In addition, although we are expecting some amount of funding, we may not be able to provide them with sufficient compensation for their contributions. It may be difficult to find sources that will fully fund the program as we have it planned. For example, the funding source may not allow us to change our program as we see fit; rather they may expect that we achieve the specific goal with which we began. Our program may not be welcomed in the community and therefore we may see low interest and low participation. Or we may see high rates of attrition throughout the course of the program for various reasons. While interest may be high, the community may not be available to participate. Community members may have little to no free time to dedicate to the program, or they may even have physical disabilities that prohibit them from participating. The physical environment of the community may prevent the success of our program as well. For example, there may not be enough safe areas for participants to walk, affordable grocery stores, etc.

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