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Hear Our Voices: Case Study Connecting Under-Represented Communities to Research Legislators on Safe Routes to School and Active Transportation

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Abstract

Although research indicates the built environment influences the walkability of a geographic region among a general population, less is known about the built-environment influences among communities that face health and socio-economic disparities. Built-environment initiatives like Safe Routes to School and Active Transportation that do not take into account the unique assets/barriers of these communities can inadvertently widen disparities. With a health equity lens, this project focused on bridging information gaps that exist between underserved communities, research, and health policy-making. Community listening sessions focusing on Safe Routes to School/Active Transportation were held in the spring of 2014. Over 180 participants from some of Minnesota's communities of color (Native American, Somali/Oromo, and LGTBQ Two-Spirit) generated recommendations for policy and program decision-makers. These recommendations illustrated that in addition to the built-environment Safe Routes to School/Active Transportation address, public safety concerns needed to be addressed for successful implementation of Safe Routes to School and Active Transportation in their communities.

Introduction

Minnesota is repeatedly ranked as one of the healthiest states in the country (http://www.health.state.mn.us/ommh/publications/legislativerpt2013.pdf). This ranking, however, does not tell the whole story. Despite being healthy on average, Minnesota ranks among the states with the worst health disparities. This means that the opportunity to be healthy is not enjoyed equally by all Minnesotans. According to a recently released from the Minnesota Department of Health, examples that highlight such disparities include:

> African American and American Indian babies die in the first year of life at twice the rate of white babies. While infant mortality rates for all groups have declined, the disparity in rates has existed for over 20 years. American Indian, Hispanic/Latino, and African American youth have the highest rates of obesity. Gay, lesbian and bisexual university students are more likely than their heterosexual peers to have struggles with their mental health (http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf).

Despite health disparities nationally being highlighted as an issue decades ago (Nickens, 1986), they continue to persist. According to the 2014 Advancing Health Equity Report by the Minnesota's Commissioner of Health; they persist because of structural policies and programs that routinely advantage one mainstream population (Caucasian) and disadvantage others (minorities). These policies and programs reinforce the disparities by taking a one size fits all approach that does not take into account the unique needs, assets, and culture of other communities, these same communities that are afflicted with higher morbidity and mortality rates. This calls for an upstream approach that engages disadvantaged communities as policies and program are being planned and developed so that resulting health policies and programs address their specific needs in a way that is appropriate to them.

Currently in Minnesota, there are many health policy projects underway that communities affected by health disparities, if equipped with relevant research best practices, can help shape and influence. These include;

1. Statewide Health Improvement Program (SHIP). SHIP is a state initiative that works on policy, systems, and environmental factors that need to be in place for a healthier community. Activities include: Farm to School to promote healthy

eating; Safe Routes to School to have more kids walking to school to increase their physical activity; Physical activity in schools that are working to increase physical activity within the instructional setting; and Tobacco Free Campuses. SHIP was behind the University of Minnesota's going tobacco free this year.

2. Community Transformation Grant (CTG). This is a federally funded initiative from the Center for Disease Control that in Minnesota, works to expand efforts in tobacco-free living, active living and healthy eating, and quality clinical and other preventive services, all toward a goal of addressing health disparities, helping control health care spending, and creating a healthier future.

Unfortunately, many of the communities that are affected by health inequities are not engaged at these policy shaping discussions for the reasons discussed earlier. So, as certain communities become healthier by benefiting from the above policies and programs, others are at the wrong end of a widening health equity gap because they are not part of the conversation.

"Bridging the Gap" Project Overview

Current research (Gollust, Kite, Benning, Callanan, Weisman, & Nanney, 2014) examining ways in which childhood obesity research evidence is used in the policymaking process highlighted several gaps, including engaging communities to have influence on policy decisions. Since legislators are accountable to community demands, communities that are engaged and knowledgeable about policy-relevant research findings can have an influential role in helping to advocate for policies to improve health. There needs to be a connection between research and policy and, even more importantly, to eliminate health inequity disadvantaged communities must be a part of this connection from the beginning. Often when policy-shaping discussions are happening and when important research findings are being disseminated, they are done in a way that leaves out communities that are not connected for many reasons. This continues to reinforce health inequities because it produces an information gap that leaves these communities lagging. This project offered the opportunity for communities to provide input to real time state and local policy making. By engaging these communities at the beginning and tailoring the engagement process to their needs, our approach ensured they were part of health impacting conversations from the start.

Our community-academic partnership implemented a robust community engagement process connecting policy-relevant obesity research findings with disadvantaged communities to mobilize them toward impacting policy decisions, specifically the legislative 2014 target of Safe Routes to School.

All partners recognized they have unique expertise that when combined moves the needle toward health equity for all. Researchers affiliated with University of Minnesota Program in Health Disparities Research (PHDR), have been involved in a study funded by the National Institutes of Health on use of research evidence in policy making decisions. This project, while including policymakers, advocates, and state agency staff, did not include any underserved communities, an important oversight that this project corrects. The community partners were key in bringing the two together due to their strong relationship with PHDR and their communities. A community dialogue series platform brought all three together; research, community, and the 2014 policy initiative of Safe Routes to School. This project was "shovel ready" for implementation and could serve as a model for engaging disadvantaged communities in achieving health equity initiatives. The University of Minnesota IRB determined the project to be exempt.

The Policy: Safe Routes to School

With the growing rates of childhood obesity around the country (Ogden, Carroll, Kit, & Flegal, 2012), the American Heart Association in 2015 recommended that kids get about an hour of physical activity a day (http://www.heart.org/HEARTORG/GettingHealthy/HealthierKids/ActivitiesforKids/The-AHAs-Recommendations-for-Physical-Activity-in-Children_UCM_304053_Article.jsp). Increasing children's physical activity has been shown to decrease obesity. An 850-article literature review on the topic (Strong, Malina, Blimkie, Daniels, Dishman, Gutin, Hergenroeder, Must, Nixon, Pivarnik, J.M., Rowland, Trost, & Trudeau, 2005) concluded that 60 minutes or more of moderate to vigorous physical activity that was developmentally appropriate was recommended for school age youth. Most U.S. children did not meet the recommended one hour minimum of daily moderate-to-vigorous activity (Troiano, Berrigan, Dodd, Mâsse, Tilert, & McDowell, 2008).

Recent research has shown that Active Community to School and Safe Routes to School can provide a frequent opportunity for children to reg-

ularly obtain their moderate to vigorous activity (Mendoza, Watson, Nguyen, Cerin, Baranowski, & Nicklas, 2011). As a result of these research recommendations, there are national and state level initiatives to address environmental barriers to school age kids being able to walk or bike to school. Most of these efforts, including those in Minnesota, include infrastructure improvement; filling in side walk cracks; installing traffic control devices such as stop signs; and education campaigns. In 2014, when this project was being implemented, the Minnesota legislature was looking at whether to continue funding Safe Routes to School and at what level.

The Community Partners

Our partnership focused specifically on engaging communities that are often not part of the conversation on health policy change due to how, when and where these conversations are conducted. The community partners that were part of this project have roots with these communities. Along with the academic partner, PHDR, the other partners were: Women's Environmental Institute (WEI), Positive Images, Health Equity Working Group (HEWG), and Brian Coyle Community Center. The communities engaged and represented by these partners are Native American, Somali, Hmong, African American, and LGBTQ communities of color. These are communities (among others) that suffer from poorer health and are less connected than others due to a lack of access to information and resources. Together, we aimed to bridge the information gap that exists and enforces the health inequalities for these communities. Our engagement processes included staff with the same cultural backgrounds and speak the native language of the impacted community members, dialogue events located in the community, and information presented in a way that is understood by all. Lastly, the community's voice is combined with the research to meet the project objective of bridging the information gaps that exist between underserved communities, research, and health policy-making.

Methods

Phase 1

The community and academic partnership submitted a grant application to the Blue Cross Blue Shield of Minnesota Center for Prevention and proposed to bridge persistent information gaps between researchers, communities, and policy-making bodies. After receiving the grant, partners convened for a kick-off meeting that was focused on communicating mutual understanding of the objectives of the grant mechanism and on the deliverables outlined in the grant application. Follow-up meetings were then scheduled with each partner to finalize a project work plan, establish a mutually agreed upon memorandum of understanding that highlighted how each of the partners and academic team would work together for a co-learning and co-empowering process, and to address anticipated logistical and technical needs.

Phase 2

All four community partners agreed to host in their respective communities with a goal of reaching 50 people each. It was also during this planning phase that community partners worked closely with the academic coordinator to augment their understanding of evidence based research focused on increasing physical activity. The academic partner, PHDR, agreed to provide a condensed summary of research that highlighted the benefits of SRTS (materials available upon request from authors). The summary was co-developed with the community coordinators so that it was in a format that was useful and understandable to respective communities.

Phase 3

Three out of the four partners were able to organize and facilitate convenings in their communities that reached their recruitment goals. The PHDR team made up of the project coordinator, the project manager and academic faculty whom were present at all convenings to transcribe the conversations that were taking place, to contextualize the objectives of the grant and to answer any questions community members had of the research. While all the community partners were able to adapt the questions for the dialogue as they saw fit for their communities, there was a set of general frame work questions that all the partners agreed upon:

1. What is happening in your community now (Safe Routes to School, Active Transportation)?
2. What are the main challenges to addressing these in your community? What do you want to tell policymakers/implementers about Safe Routes/Active Transportation and how it relates to your community?

3. What needs to be improved/addressed/acknowledged before these can be reality/improved in your community? What would you like to see happen?

The partners were free to frame these questions as they saw fit. One out of the three partners chose to focus on Active Transportation and not Safe Routes.

Phase 4

Partners then reviewed transcripts generated from the convenings and worked closely with a graphic designer to transform the data into engaging one page handouts geared for decision-makers that articulated the distinct needs (challenges, recommendations) of their communities as it related to active living and Safe Routes active issues.

The partnership then reconvened community members for another dialogue to present the one page hand outs and ask, Here is what you said as far as challenges and solutions, is that correct? What should we do next?

Project Measures

Measures of success were determined by the following guidelines

1. REACH: Convenings within each community that reached 50 people respectively.

2. REPRESENTATION: Convenings that reflected the identities of the intended audiences.

3. EXPECTATIONS: Meeting the objectives of communication to policy makers and timelines of the collaboratively developed work plans.

Reach: Three community organizations met and exceeded their recruitment goals for their convenings. Collectively, they exceeded their goals by approximately 22%. (On a goal of 150 people, we collectively reached approximately 184 people).

Representation: All three communities reached their intended demographics. Detailed breakdowns are listed below by community.

WEI/Little-Earth/Phillips Neighborhood: These convenings were held for the residents Little Earth and the Phillips neighborhoods. Approximately 34 community members from the neighborhood gathered for the first convening. The average participant age was 38–40 years of age. Participants in this convening comprised mainly of women (~75%) who identified as American Indian/Native American (~92%). Approximately 40% of the participants were parents with 38% of the parent participants having more than one child. Parent participants overwhelmingly had children who were between 7 months and 20 years of age. The second convening at Native American Community Development Institute (NACDI) also reflected the surrounding communities' racial and ethnic makeup. Thirty community members diverse in age and gender were part of the participant pool during this second convening.

Brian Coyle/Cedar Riverside Community. These convenings were held for residents of the Cedar Riverside Plaza. Two convenings were conducted one with youth (n=~10) and one with parents and grandparents (n=~55). Residents mainly comprised of Somalis who lived in the Cedar Riverside Plaza apartments.

Health Equity Working Committee/Two Spirit. This convening was held for LGB (Lesbian, Gay, Bisexual), Transgender/Gender non-conforming/Two-spirit Native Americans/people of color. The convening attracted more than 55 participants who represented a wide variety of age groups, sexual orientations, gender identities, and expressions. This convening was not restricted to individuals residing in a specific geographic location and attracted individuals from as far as Shakopee.

Expectations. Three of the four partners and the PHDR team met the expectations outlined in our respective work plans. Major timelines and due dates were observed and the PHDR team ensured the compilation of relevant policy research and the transcription of data from the convenings was completed in a timely manner and sent back to the community partners. Currently, all three community organizations that were able to mobilize a convening have been able to work with a communications consultant to translate their findings into engaging one page handouts for policy makers. Two of the three organizations have presented their findings to policy makers.

Project Findings

While there were some uniqueness to each of the communities' needs and assets, there were similarities in their recommendations for what SRTS and Active Transportation should look like in their communities. Generally, these needs showed that in addition to the built environment infrastructure challenges that SRTS and Active Transportation address, there were other needs that needed to be taken into account before these community members would send their kids walking or biking or to school or the LGBTQ communities of color would ride the bus or walk. These concerns focused largely on crime safety concerns.

Concerns

Collective Recommendations to Decision-Makers

1. Infrastructure Safety Recommendations:
   Mend cracked sidewalks and other hazards.
   Install proper crossing signs.
   Enforce existing no-smoking codes on community properties.
   Improve lighting.
   Conduct audits to identify bus routes and stops with the most use/need.
2. Crime Safety Recommendations:
   Increasing positive police presence and interactions.
   Train police officers and bus drivers on cultural competency; work to eliminate homophobia and transphobia.
   Create structured opportunities for groups to walk to school together.
   Allow adult parents or elders, hired and trained in appropriate intervention techniques as bus monitors, to ride and participate in school bus transport.
3. Education, and Socioeconomic Recommendations:
   Educate community members on how to read/use crossing signs and identify safe routes.
   Engage the community in designing solutions at the planning levels
   Campaign to normalize presence of LGBTQ Two Spirit residents (e.g., bus stop posters)

Table 1. Concerns by Community

Community	Concerns
Cedar-Riverside	Cracked sidewalks. Lack of lighting and lack of signage for proper crossing. General lack of understanding on how to read and follow signage. Inconsistent de-icing and plowing months. Lack of green spaces in the neighborhood. Kids have to walk through cigarette smoke, triggering Asthma and other health issue. Overcrowded school buses leading to fighting.
Little Earth/ East Phillips	Sexual trafficking solicitation and threats of sexual violence. Physical and verbal fighting on the school bus. No effective adult intervention controls enroute or at bus stops in the neighborhood. A lack of effective support from police and others in dealing with these safety issues.
LGBTQ Two Spirit	Gender- and sexuality-based hate crimes. Poorly lit roads, bike routes (such as Chicago Avenue), and enclosed bus shelters. A lack of confidence in the ability of police officers and bus drivers to address these barriers. A lack of cultural competence noting incidents of homophobia and transphobia perpetrated by those in authority.

Impact and Success

Each of the communities participating in this project has a story that shows success:

1. Brian Coyle was able to secure a pilot grant to address the tobacco issue in their neighborhood that was identified through this project.
2. Health Equity Working Group and its partners were reached out to by the office of a city council member to present their finding from this project at the council members' Trans Equity Summit in 2014.
3. Phillips/Little Earth has already started a process with the Minneapolis School Board to change a rule that does not allow parents/elders to ride the school bus with students to help address the lack of safety on school buses. This was a big issue that kept coming up in the dialogues.

Partners were also asked to present project findings at the National Conference of State Legislatures – National Caucus of Native American State Legislators held in Minneapolis, Minnesota (2014).

Conclusion

Our community-academic partnership model successfully engaged communities, incorporated research and stories, and resulted in ongoing discussions with various decision-makers to inform current policy discussions. This community engagement project highlighted the fact that a one size fits all approach for health policies and programs likely only deepens existing health inequities. This is especially important as substantial funds are being dedicated to Safe Routes to School and Active Transportation initiatives both federally and at the state level. As public health researchers and professionals, it is imperative to keep the macro view in perspective, engage in ethical non-hierarchical collaborations with communities and that we understand there is no one solution; rather there are many solutions that have to be implemented simultaneously so that all communities can be healthy and benefit from public health initiatives equally.

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