2009 COMMUNITY HEALTH ASSESSMENT STUDY
CHILDREN’S HOSPITAL BOSTON

SUBMITTED TO:
Children’s Hospital Boston, Office of Child Advocacy

December 21, 2009

SUBMITTED BY:
Health Resources in Action, Inc.
TABLE OF CONTENTS

BACKGROUND .............................................................................................................. 1
   Overview Children’s Hospital Boston and Office of Child Advocacy .......................... 1
   Purpose and Goals of Assessment Study ............................................................... 1

METHODOLOGY ....................................................................................................... 2
   Study Approach and Community Advisory Board Engagement ............................. 2
   Research Methods .................................................................................................. 2
      Secondary Data Analysis .................................................................................... 2
      Qualitative Research ......................................................................................... 3
      Limitations ....................................................................................................... 5

FINDINGS .................................................................................................................... 5
   Community Social and Economic Context ............................................................. 5
      Age and Racial/Ethnic Composition .................................................................. 5
      Income, Poverty, and Employment ..................................................................... 8
      Educational Attainment and Academic Achievement ....................................... 10
      Housing and Transportation ........................................................................... 12
      Safety and Crime .............................................................................................. 14
      Access to Health Care ...................................................................................... 16
   Community Health Profile ................................................................................... 18
      Childhood Obesity, Physical Activity, and Nutrition ......................................... 18
      Asthma ............................................................................................................. 19
      Sexual Health and Teen Pregnancy ................................................................... 21
      Mental Health .................................................................................................. 24
      Alcohol, Tobacco, and Other Drugs .................................................................. 27
      Injury Prevention .............................................................................................. 28
      Chronic Diseases ............................................................................................. 30
      Oral Health ....................................................................................................... 31
      Early Childhood Health Issues ........................................................................ 32
   Community Assets and Programs ........................................................................ 34
      Current Assets and Programs ........................................................................... 34
      Gaps in Programs and Services ......................................................................... 35
   Community Suggestions for Future Programs and Services .................................. 37
      Community Engagement ................................................................................... 37
      Program Approaches ........................................................................................ 38
      Specific Health Issues and Suggestions ............................................................ 38
      Preferred Health Communication and Information Sources ............................ 39
   Perceptions of Children’s and Sponsorship of Community Programs .................... 41
      Perceived Strengths .......................................................................................... 41
      Perceived Challenges ....................................................................................... 41
      Program Sponsorship ....................................................................................... 42
   Best Practices of Community-Based Programs .................................................... 42

RECOMMENDATIONS ON STRATEGIC DIRECTIONS .......................................... 43
   Key Issues to Consider ........................................................................................ 44
   Potential Strategic Directions for Children’s Community Efforts ........................... 45
   Conclusion .......................................................................................................... 52

APPENDICES ............................................................................................................ 54
   Appendix A. List of Stakeholder Interviewees ...................................................... 54
   Appendix B. Interview Guide ............................................................................... 56
   Appendix C. Parent Focus Group Guide ............................................................... 59
   Appendix D. Youth Focus Group Guide ............................................................... 64
   Appendix E. List of Organizations Involved in Focus Group Recruitment ............... 70
   Appendix F. Environmental Scan of Current Programs ....................................... 71
BACKGROUND

Overview Children’s Hospital Boston and Office of Child Advocacy

Children’s Hospital Boston is a 396 bed comprehensive center for pediatric health care, the primary pediatric teaching hospital of Harvard Medical School, and the only free-standing independent children’s hospital in New England. Children’s has a long-standing commitment to community health and to its community benefit programming. Dating back to its opening, Children’s has worked to improve the health and well-being of children and families at the neighborhood level across the city of Boston. In 1993, this effort was formalized and added to the hospital’s mission. In 1999, the Office of Child Advocacy (OCA) was formed and developed its programming focus, including establishing a community health advocacy agenda and pursuing funding opportunities. Just as the hospital has a four-part mission encompassing community benefits, community benefit programs have their own four-part mission. For Children’s, the OCA community benefit mission means that the hospital:

1. serves as the community’s safety net hospital by caring for all children in Massachusetts regardless of their ability to pay;
2. focuses on the most pressing health care needs of children and families in local communities.
3. speaks out as a voice for children through public policy advocacy to change laws that will lead to improvements in the health and the lives of children and families, and
4. supports essential community partners—particularly community health centers, schools, community organizations.

Every three years, Children’s Office of Child Advocacy conducts a community assessment study to review community resources, assets, and challenges and develop an action plan to better respond to program, provider, and resident concerns in order to promote wellness in vulnerable populations and reduce health care disparities. Similar to previous years, in 2009, Children’s has undertaken a community assessment study to ensure that it is addressing the most pressing health concerns across Boston and its four priority communities—Roxbury, Mission Hill, Fenway, and Jamaica Plain.

Purpose and Goals of Assessment Study

In June 2009, Children’s contracted Health Resources in Action (HRiA), a non-profit public health organization in Boston, to conduct its community health assessment study. This report describes the process and findings from this effort. The community assessment study was undertaken to achieve the following goals:

- To identify met and unmet health needs
- To advance Children’s community benefit mission and fulfill the Attorney General’s community benefit mandate
- To enhance community engagement and collaborative efforts for future program planning
- To provide Children’s with strategic recommendations for future community programming and partnerships

The study aimed to engage stakeholders, organizations, and residents in the assessment process and utilized a mixed method approach to gathering data. Over a four-month data collection process, HRiA—in collaboration with Children’s—conducted focus groups and
interviews with community stakeholders, parents, and youth, analyzed existing quantitative data on neighborhood health, social, and economic indicators, compiled information on existing community programs and resources in its four priority neighborhoods (Roxbury, Mission Hill, Fenway, and Jamaica Plain), and reviewed findings from the published literature on community health programs in key health areas (obesity, asthma, mental health, and injury prevention). The findings detailed in this report aim to provide a comprehensive view of the needs and resources across Boston and within Children's priority communities, so that Children's can implement programs that provide coordinated care and influence social and systemic change in the community.

**METHODOLOGY**

**Study Approach and Community Advisory Board Engagement**

So that the process was informed by diverse perspectives, the community assessment study employed a participatory approach, when possible. This type of approach helps guide the research methods and questions so that they are salient to the community as well as aids in building support and buy-in at the community level for both the assessment study and subsequent planning processes. As part of this effort, Children's sought input from its community advisory board (CAB) members at several stages of the assessment study. CAB members engaged in two formal meetings during assessment planning, communicated with Children's through a number of emails, reviewed the list of potential stakeholders for interviews, provided suggestions on who to engage, and gave feedback on the stakeholder and focus group guides. In addition to CAB members, community-based organizations were involved in the qualitative research process, helping to recruit and hold the focus groups with parents and youth. Stakeholders who participated in the interviews also provided suggestions on other key community and organizational leaders whom HRiA should engage during this process.

**Research Methods**

The following section details the methods used for the various aspects of the community assessment study.

**Secondary Data Analysis**

In an effort to develop a social, economic, and health portrait of the City of Boston—with special attention to the primary communities of Roxbury, Mission Hill, Fenway, and Jamaica Plain—HRiA reviewed existing data drawn from state and local sources. Data comprised of self-reported responses from surveys (e.g., Boston Youth Risk Behavior Survey), state vital statistics, reported hospitalizations, and U.S. Census information. Sources of data included the U.S. Census, Massachusetts Department of Public Health, Boston Redevelopment Authority, Boston Public Health Commission, and Boston Police Department, among others. Data were compiled to provide a more comprehensive portrait of the city and Children’s priority neighborhoods. Data analyses were generally conducted by the original data source (e.g., U.S. Census, Massachusetts Department of Public Health). It should be noted that in several instances, current neighborhood level data were not available, and the most recent data source for this information was the 2000 U.S. Census. Additionally, the U.S. Census does not disaggregate the Roxbury and Mission Hill neighborhoods. While information for these neighborhoods is combined in U.S. Census data, differences between these two neighborhoods, as gleaned from other sources such as focus groups and interviews, are noted in this report where appropriate.
**Qualitative Research**

In addition to analyzing epidemiological data from Children’s priority neighborhoods, HRiA conducted qualitative research with community stakeholders and residents to gauge their perceptions of the community, their health concerns, what programming or services are most needed to address these concerns, and their perceptions of Children’s Hospital to accomplish this. To this end, HRiA conducted 27 interviews with community stakeholders, 6 focus groups with parents, and 4 focus groups with youth during the data collection period, with a total of 120 individuals participating in the qualitative research.

To gather information from leaders and organizational staff who work directly in the priority communities or on key children’s health issues across the city or state, HRiA conducted 27 interviews with a diverse range of individuals. HRiA and Children’s—in collaboration with CAB members—brainstormed to identify 124 individuals working across a range of sectors and neighborhoods. Among the potential respondents on the list, 46 individuals were contacted. A total of 27 completed interviews with 29 individuals were conducted either by phone or face-to-face. (One interview was conducted with three organizational staff members simultaneously.) Appendix A includes a list of the interviewees. Individuals interviewed included academics, health care providers, religious leaders, organizational directors, staff from city and state government, staff from community-based organizations and youth serving agencies, early childcare specialists, and school administrators, among others. Interviews lasted approximately 20-60 minutes and were led by experienced HRiA facilitators. A copy of the interview guide can be found in Appendix B.

Parents and youth were also engaged in the qualitative research process. In total, 10 focus groups—6 with parents and 4 with youth—were conducted across the four priority neighborhoods of Roxbury, Mission Hill, Fenway, and Jamaica Plain. Focus group discussions explored participants’ perceptions of their neighborhood, priority health concerns, suggestions for future programming and services to address these issues, and their perceptions of Children’s Hospital. The discussions probed specifically for feedback on the Children’s priority health issues (childhood obesity, asthma, mental health, and injury prevention) and also provided opportunities for participants to discuss their own health issues of concern. A semi-structured moderator’s guide was used across all discussions to ensure consistency in the topics covered. While similar, separate guides were used for the parent and youth focus groups so that they were age and developmentally appropriate. A copy of the parent focus group guide can be found in Appendix C and the youth guide in Appendix D.

Each focus group was facilitated by an experienced HRiA staff member, while a note-taker took detailed notes during the discussion. On average, focus groups lasted 90 minutes and included 8-12 participants. Before the start of the groups, all youth and parent participants were explained the purpose of the study and signed a consent form. They were also notified in writing and verbally that group discussions would remain confidential, and no responses would be connected to them personally. All youth and parent participants were provided a small stipend ($30) for their time.

Participants for the groups were recruited by community and social service organizations located in Roxbury, Mission Hill, Fenway, and Jamaica Plain, which were compensated $300 per group for their efforts. A list of the organizations involved in focus group recruitment can be found in Appendix E. The focus groups were intended to be inclusive, so organizations did not exclude participants if they did not live in the particular neighborhood. It was also a priority to recruit parents and youth from traditionally under-served populations. For example, of the six parent focus groups, two were conducted in Spanish. A
fluent Spanish-speaking HRiA staff member conducted these groups in Roxbury and Jamaica Plain with Spanish-speaking parents.

Table 1 describes the segmentation strategy used for the focus groups.

<table>
<thead>
<tr>
<th>Target Neighborhood</th>
<th>Roxbury</th>
<th>Mission Hill</th>
<th>Fenway</th>
<th>Jamaica Plain</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth</td>
<td>1 group</td>
<td>1 group</td>
<td>1 group</td>
<td>1 group</td>
<td>4 groups</td>
</tr>
<tr>
<td></td>
<td>(n=8)</td>
<td>(n=9)</td>
<td>(n=9)</td>
<td>(n=12)</td>
<td>(n=38)</td>
</tr>
<tr>
<td>Parents</td>
<td>2 groups</td>
<td>1 group</td>
<td>1 group</td>
<td>2 groups</td>
<td>6 groups</td>
</tr>
<tr>
<td></td>
<td>(1 English/1 Spanish)</td>
<td>(n=9)</td>
<td>(n=10)</td>
<td>(1 English/1 Spanish)</td>
<td>(n=17)</td>
</tr>
<tr>
<td></td>
<td>(n=17)</td>
<td></td>
<td></td>
<td></td>
<td>(n=53)</td>
</tr>
<tr>
<td>Total</td>
<td>3 groups</td>
<td>2 groups</td>
<td>2 groups</td>
<td>3 groups</td>
<td>10 groups</td>
</tr>
<tr>
<td></td>
<td>(n=25)</td>
<td>(n=18)</td>
<td>(n=19)</td>
<td>(n=29)</td>
<td>(n=91)</td>
</tr>
</tbody>
</table>

The collected qualitative information was analyzed thematically, where data analysts identified key themes that emerged across all groups and interviews. While neighborhood differences are noted where appropriate, analyses emphasized findings common across neighborhoods. Selected quotes – without personal identifying information – are presented in the narrative of this report to further illustrate points within topic areas.

Environmental scan

A review of programs focusing on childhood obesity, asthma, mental health, and injury prevention and implemented in the city of Boston and the four priority communities was conducted. The goal of this environmental scan was to develop an inventory of programs to assess the current landscape of activity in these areas. Information for this scan was gathered through the qualitative data collection from the stakeholder interviews and reviews of organizational websites and reports. This scan aimed to help identify which areas and populations are being served by current programs, where there are gaps, and where there may be openings for future partnerships and program expansion.

Literature review

To learn from other programs, HRiA also conducted a targeted review of the literature on best practices of community-based programs focusing on children or adolescents in urban areas. Programs with main outcomes related to Children’s four priority health areas (childhood obesity, asthma, mental health, and injury prevention) were selected. Studies were identified through searches in academic databases (e.g., PubMed, PsycInfo) and other web-based databases (e.g., Google Scholar) that include organizational reports. Search terms included, but were not limited to: “youth”; “children”; “adolescents”; “obesity”; “physical activity”; “nutrition”; “asthma”; “injury”; “home safety”; “auto safety”; “road safety”; “bicycle safety”; “sport safety”; “seatbelt”; “helmet”; “violence prevention;” “mental health”; “psychiatric”; “depression”; “suicide”; “ADHD”; “trauma”; “prevention;” “intervention”; “program”; “community”; “community-based”; “urban”; and “environment”.

HRiA reviewed the selected studies, identifying those with successful outcomes and elaborating on the programs’ key components and approaches, challenges encountered, and lessons learned. The review aimed to be strategic, with the goal of focusing on community-based programs in settings similar to those near Children’s and identifying the best practices and lessons learned which could inform Children’s future strategic planning.
Limitations

As with all research efforts, there are several limitations related to this study’s research methods that should be acknowledged. A number of secondary data sources were drawn upon for quantitative data in creating this report. Although all the sources used for this purpose (e.g., U.S. Census, Massachusetts Department of Public Health) are considered highly credible, sources may use different methods and assumptions when conducting analyses. For example, how sources define neighborhood boundaries may vary (e.g., U.S. Census data combines Roxbury and Mission Hill together).

Because of time needed for data collection and analyses, some of the quantitative information that is publicly available is not always the most current. For example, the most recent demographic and economic data available by neighborhood is from the 2000 U.S. Census. Similarly, many of the most recent health statistics publicly available are from 2005 or 2006. Because of small sample sizes or because geographic information was not noted, many of the secondary sources are not able to provide data that are specific by neighborhood. When this is the case, Boston city-wide data are presented in the report. Lastly, most of the quantitative data on health issues among youth are available for adolescents, but not younger children. The amount of information on children under 13 years old is limited.

Qualitative research also has several limitations. While the focus groups and interviews conducted for this study provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. Recruitment for focus groups was conducted by community organizations, and participants were those individuals already involved in community programming. Because of this, it is possible that the responses received only provide one perspective of the issues discussed. In addition, organizations did not exclude participants if they did not live in the particular neighborhood, so participants in a specific community’s focus group might not necessarily live in that area, although they did spend time there through the organization. Lastly, it is important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

FINDINGS

Community Social and Economic Context

Age and Racial/Ethnic Composition

“There is a lot of diversity...We learn a lot about different people. It’s welcoming, open, and friendly.” –Parent focus group participant, Fenway*

“My neighborhood is very divided. Going street by street ... It’s a weird mix of people, but they don’t mix. It’s good that there isn’t just one type of person in JP, but it’s bad that we aren’t mixed.” –Youth focus group participant, Jamaica Plain

Boston’s total population was estimated to be 600,980 people in 2007,^1^ a growth of 3.3% since 2000. Based on the most recent neighborhood level data available (2000 U.S. Census), Children’s priority neighborhoods collectively comprise 22% of Boston’s population,

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*Quotes from focus groups are based on detailed notes and not transcriptions. Because of this, quotes may not be the participants’ exact words.
divided as follows: Roxbury and Mission Hill (combined) make up 9.4%; Jamaica Plain (JP) houses 6.4%; and Fenway represents 6.1% of the city’s residents.\(^2\)

Figure 1 shows the distribution of age in the population across numerous Boston neighborhoods. While Roxbury has one of the largest percentages of children under 15 years old, other Boston neighborhoods, such as Mattapan, Roslindale, East Boston, and Hyde Park, also have very young populations. Of Children’s priority neighborhoods, the Roxbury/Mission Hill communities have the youngest population; more than a quarter of their residents (27%) are less than 15 years of age (compared to 16% city-wide). In contrast, older adolescents and young adults (ages 15-34) constitute the overwhelming majority (81%) of Fenway residents, with less than 3% under age 15. The age distribution in Jamaica Plain more closely mirrors the city-wide average: children under 15 years of age comprise 14% of JP’s population. Stakeholders participating in the interviews pointed out the intergenerational strengths found in Boston’s neighborhoods and that this bond across generations helps strengthen families and community connectedness.

Figure 1. Population of Children and Youth across Several Boston Neighborhoods, including Priority Neighborhoods, 2000\(^3\)

Stakeholders, parents, and youth alike commented on the diversity and “cultural richness” across Children’s priority neighborhoods. Many stakeholders further pointed to the voice and presence of cultural and faith-based groups as a source of strength in these communities. The distribution of people of color and various ethnic backgrounds differs dramatically by neighborhood. Table 2 provides the racial/ethnic characteristics of each neighborhood and of Boston city-wide. It should be noted that the U.S. Census considers race and ethnicity two separate categories which are not mutually exclusive, thus White and Black individuals may also be considered Hispanic/Latino.
Table 2. Boston Population by Priority Neighborhood and Race/Ethnicity, 2000 and 2007

<table>
<thead>
<tr>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>600,980</td>
<td>589,141</td>
<td>55,663</td>
<td>36,191</td>
<td>38,074</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% White</td>
<td>56.3</td>
<td>54.4</td>
<td>10.1</td>
<td>71.3</td>
<td>59.0</td>
</tr>
<tr>
<td>% Black/African American</td>
<td>23.5</td>
<td>24.9</td>
<td>65.5</td>
<td>7.5</td>
<td>18.0</td>
</tr>
<tr>
<td>% Asian</td>
<td>8.3</td>
<td>7.6</td>
<td>0.6</td>
<td>14.0</td>
<td>6.7</td>
</tr>
<tr>
<td>% American Indian</td>
<td>0.4</td>
<td>0.4</td>
<td>0.9</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td>% Other Race</td>
<td>8.9</td>
<td>7.9</td>
<td>15.9</td>
<td>3.7</td>
<td>11.5</td>
</tr>
<tr>
<td>% Two or more races</td>
<td>2.6</td>
<td>4.7</td>
<td>7.0</td>
<td>3.3</td>
<td>4.3</td>
</tr>
<tr>
<td>Hispanic/Latino Ethnicity</td>
<td>15.6</td>
<td>14.5</td>
<td>25.1</td>
<td>8.3</td>
<td>22.7</td>
</tr>
</tbody>
</table>

Jamaica Plain is noted for its racial/ethnic diversity. Among its residents, nearly 23% self-identified as Latino. Nearly one in five Jamaica Plain residents (18%) identified themselves as Black/African American and 7% as Asian. Although parents and youth both noted Jamaica Plain’s diversity, adolescent focus group participants described the neighborhood as “divided street by street” with Blacks and Latinos concentrated around the “main streets” and Whites on the “back streets.” Several youth commented that “people don’t mix.”

Fenway’s population is slightly less diverse than the other neighborhoods: 71% are White, 8% are Black, and 14% are Asian, while 8% identified themselves as Hispanic/Latino. Parents described the neighborhood as welcoming to different cultures. Residents further remarked that the presence of many students and universities impacts the community by introducing “bad influences” in terms of partying, substance use, noise, and lesser concern for maintaining a clean environment.

Roxbury and Mission Hill together include residents who are predominantly Black (66%) and Latino (25%), with a small White population (10%). Roxbury and Mission Hill youth described their communities as primarily Black, with many Latinos and a large population of teens. Roxbury residents also noted a strong presence of Cape Verdean residents in the neighborhood.

Many of Boston’s young children are being raised in culturally and linguistically diverse families. While approximately one quarter of all Boston residents are foreign born, 43% of Boston parents with young children (under age 5) were born in another country.6 City-wide, over one third of Boston residents speak a language other than English at home, yet almost half (47%) of all Boston households with children ages five and under report a primary language other than English. As Figure 2 shows, the most frequently spoken languages at home – other than English – among families with young children are Spanish (24%), Haitian Creole (6%), Portuguese (3%), and Vietnamese (3%). Stakeholders and parents pointed out that undocumented immigrants are the group most vulnerable to social, economic, behavioral, and health risks of inner city life. They indicated that these families face the brunt of the economic downturn with the loss of service jobs, encounter numerous language and cultural barriers to accessing services, and have limited access to social services due to their undocumented status.
A few stakeholders and youth were vocal on the issue of racism. These participants cited interpersonal racism and institutional racism as problematic in Children’s priority communities. In particular, participants remarked that people of color seem to be targeted by law enforcement as well as face additional barriers and discrimination to accessing financial and social services.

Income, Poverty, and Employment.

"People are middle class with some poor people in my neighborhood. But they just built condos. Some townhouses look good." – Youth focus group participant, Roxbury

"This community is a working community. We have lots of businesses here; they have all the people around here to work there. The small businesses help to support the community around here.” – Parent focus group participant, Jamaica Plain

The median household income in the city of Boston increased over the last decade from $39,629 in 2000 to $48,729 (Table 3). In 2000, the most recent year that neighborhood-level income data are available, Jamaica Plain’s median income ($41,524) as well as the distribution of residents’ income across the spectrum mirrored that of Boston city-wide. However, the median income of residents from Fenway ($25,356) and Roxbury/Mission Hill ($27,133) was much lower than that of Boston. The distribution of incomes in these neighborhoods also slightly differed than the larger Boston population, with a higher proportion of residents in these neighborhoods earning lower incomes (under $10,000 or under $25,000) and a lower percentage earning over $50,000.

| Table 3. Household Income by Priority Neighborhood, 2000 and 2007 |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Median Household Income | $48,729       | $39,629         | $27,133          | $25,356         | $41,524          |
| % Less than $10,000 | 13.8           | 15.5            | 23.0             | 27.4            | 14.4             |
| % $10,000-$24,999 | 16.9           | 18.0            | 23.5             | 22.1            | 16.9             |
| % $25,000-$49,999 | 20.2           | 26.5            | 29.2             | 25.7            | 27.6             |
| % $50,000-$74,999 | 16.3           | 17.3            | 13.8             | 13.0            | 17.2             |
| % $75,000 and over | 32.9           | 22.7            | 10.4             | 11.8            | 23.9             |
Parents and youth from all of Children’s priority neighborhoods, as well as stakeholders working in these areas, highlighted the impact of poverty on individuals, families, and their community. Stakeholders cited poverty and unemployment among the biggest community level problems, as they lead to idle time among young adults and increased violence and crime. Poverty was also cited as a significant individual stressor for families, as parents feel overwhelmed just to pay the bills each month. It was also considered one of the main barriers to obtaining adequate health care and other needed services. Many stakeholders further noted that low-income families are among those most vulnerable to the city’s major health threats. Many youth and adult focus group participants cited cost as a barrier to accessing community resources and identified a need for low or no-cost programming.

Although widespread across Boston’s inner city neighborhoods, the burden of poverty is disproportionately borne by children, particularly those living in female-headed households (Table 4). Almost one-third (31%) of Boston’s children lived in households whose income fell below the federal poverty level in 2007. An alarming 54% of households headed by women who had children under age five were living in poverty. For 2000, the most recent year neighborhood-level poverty data are available, geographic variations indicate that slightly greater proportions of Roxbury (34%) and Fenway (38%) children lived in poverty, while family households in Jamaica Plain were closer to the city-wide average; however, it is possible that Fenway’s high poverty rate may be due to the large university student population residing in the neighborhood.

Table 4. Poverty for Families and Individuals by Priority Neighborhood 2000 and 2007

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals: Total Population</td>
<td>608,352</td>
<td>589,141</td>
<td>55,663</td>
<td>36,191</td>
<td>38,074</td>
</tr>
<tr>
<td>% below poverty line (indiv poverty rate)</td>
<td>20.8</td>
<td>19.5</td>
<td>27.1</td>
<td>37.3</td>
<td>20.9</td>
</tr>
<tr>
<td>% &lt;18 yrs old, in poverty</td>
<td>31.0</td>
<td>25.9</td>
<td>33.7</td>
<td>37.7</td>
<td>29.8</td>
</tr>
<tr>
<td>% 18-64 yrs old, in poverty</td>
<td>18.0</td>
<td>11.2</td>
<td>23.5</td>
<td>38.4</td>
<td>19.0</td>
</tr>
<tr>
<td>% 65+ yrs old, in poverty</td>
<td>20.7</td>
<td>18.2</td>
<td>25.1</td>
<td>24.6</td>
<td>18.9</td>
</tr>
<tr>
<td>Total Number of Families</td>
<td>110,156</td>
<td>115,096</td>
<td>13,273</td>
<td>2,144</td>
<td>6,991</td>
</tr>
<tr>
<td>% of all families in poverty</td>
<td>16.7</td>
<td>15.3</td>
<td>24.7</td>
<td>19.1</td>
<td>15.6</td>
</tr>
<tr>
<td>% of families in poverty, with female-headed households &amp; w/children &lt;18 yrs old</td>
<td>44.5</td>
<td>37.4</td>
<td>39.2</td>
<td>35.5</td>
<td>43.1</td>
</tr>
<tr>
<td>% of families in poverty, with female-headed households &amp; w/children &lt;5 yrs old</td>
<td>53.6</td>
<td>45.6</td>
<td>46.7</td>
<td>50.0</td>
<td>26.5</td>
</tr>
</tbody>
</table>

Though not a topic discussed in every focus group, unemployment was frequently mentioned as a significant community challenge and family stressor by stakeholders. The recent economic downturn led to an increase in the monthly unemployment rate in the Boston metro area from 5.0% to 7.4% between October 2008 and January 2009. Additional data reveal racial disparities in employment levels. In 2007, Black males were four times as likely to be unemployed as White males; among Asian and Latino males, the rate was almost three times as high. The unemployment rate for Black and Latino women was almost three times the rate among White women. Even before the economic decline, two of Children’s priority neighborhoods, Fenway and Roxbury/Mission Hill, had higher rates of unemployment than the city-wide average (11% and 12%, respectively, vs. 7%).

Food stamp cases, another indicator of poverty, increased by 32% from January 2005 to January 2008: in total, there were 71,314 food stamp cases in Boston in January 2008. While all neighborhoods experienced an increase in food stamp cases during this period,
Roxbury, North Dorchester, and South Dorchester had the largest number of cases, accounting for about half of the food stamp cases in the city. Of Children’s priority neighborhoods, Fenway and Roxbury demonstrated the most dramatic increases in food stamp need between 2005 and 2008, with 51% and 43% respectively.15

Educational Attainment and Academic Achievement

“If you have a child in K-8, you don’t have to send them out of the neighborhood for school. We have it right here.” –Parent focus group participant, Mission Hill

“Staying in school is important. Nowadays, without a GED, you can’t even get a job at McDonalds. Try to go to college. If you can’t go to college, go to community college.” –Youth focus group participant, Roxbury

Several of the stakeholders interviewed identified inadequate public education and limited access to quality education as significant community challenges and family stressors. While education was brought up less frequently among parents and youth, several parents agreed with stakeholders who noted that “teens feel a lack of prospects” in these communities. One stakeholder, referring to the paucity of educational and future employment opportunities, described Boston’s inner city teens as “living in a failure environment”.

Academic achievement is unequally distributed among racial/ethnic and socioeconomic groups in Boston. This achievement gap was clearly demonstrated by scores on the reading portion of the 2007 third grade MCAS. Half as many low-income students earned a score of proficient or above, compared to students who were not considered to be low-income.16

Four-year high school graduation rates for students in Boston public schools depict educational disparities as well (Figure 3). Among the 2008 cohort, greater percentages of White (68%) and particularly Asian students (81%) completed high school in four years when compared to Black (60%) and Latino (50%) students. Students with limited English proficiency (45%) and special educational needs (37%) were the least likely to graduate high school in four years.17

Figure 3. Four-Year Graduation Rate by Race/Ethnicity, Boston Public Schools, 200818

The district-wide drop-out rate for Boston public high school students in grades 9-12 was 7.2% during the 2007-2008 school year, down among all racial groups from the recent peak of 9.4% during the 2005-2006 academic year. Consistent with recent years, Latino students had the highest drop-out rates in 2007-2008 (9.6%), followed by Black students (7%), then
Whites (5.4%), with the fewest drop-outs among Asian students (2.4%). Male students dropped out of school at slightly higher rates than female students. Of all students who entered 9th grade in 2003, 26% dropped out before completing high school in 2007. The overall drop-out rate among the 2008 cohort was 22%. Low income students accounted for 46% of all 2007-2008 year drop-outs.

In terms of completing high school and pursuing higher education, there are wide racial/ethnic gaps and geographic disparities in the adult population as well in Boston. In 2007, 56% of White adults and 50% of Asian adults living in Boston completed a bachelor’s degree or higher compared with 14% of Black and Latino adults. Over one-third of Latino adults and one quarter of Black and Asian adults achieved less than a high school diploma or GED. As Table 5 indicates, residents in the Roxbury/Mission Hill area were less educated than Boston residents overall or in the other priority neighborhoods: in 2000, 31% of adult residents in Roxbury had not completed a high school/equivalent education (compared to 21% city-wide) and only 9% earned a college degree (compared to 20% city-wide). In 2000, the education level of Jamaica Plain’s residents mirrored that of Boston city-wide, while Fenway was the neighborhood with the most highly educated adult population, with nearly 33% of its adult residents having earned a bachelor’s degree and 29% a graduate or professional degree.

Table 5. Education Level of Adult Residents, Boston and By Priority Neighborhood, 2000 and 2007

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Population 25 yrs and older</td>
<td>398,929</td>
<td>377,574</td>
<td>32,107</td>
<td>12,220</td>
<td>26,147</td>
</tr>
<tr>
<td>% Less than 9th grade</td>
<td>8.9</td>
<td>9.1</td>
<td>12.4</td>
<td>4.0</td>
<td>9.1</td>
</tr>
<tr>
<td>% 9th to 12th grade, no diploma</td>
<td>7.8</td>
<td>12.0</td>
<td>18.1</td>
<td>6.2</td>
<td>9.6</td>
</tr>
<tr>
<td>% High school graduate (includes equivalency)</td>
<td>25.5</td>
<td>24.0</td>
<td>32.5</td>
<td>11.4</td>
<td>16.3</td>
</tr>
<tr>
<td>% Some college, no degree</td>
<td>12.5</td>
<td>14.5</td>
<td>17.5</td>
<td>12.3</td>
<td>13.6</td>
</tr>
<tr>
<td>% Associate’s degree</td>
<td>4.9</td>
<td>4.9</td>
<td>5.4</td>
<td>3.9</td>
<td>4.0</td>
</tr>
<tr>
<td>% Bachelor’s degree</td>
<td>22.1</td>
<td>20.2</td>
<td>9.3</td>
<td>33.2</td>
<td>22.7</td>
</tr>
<tr>
<td>% Graduate or professional degree</td>
<td>18.2</td>
<td>15.3</td>
<td>4.7</td>
<td>29.0</td>
<td>24.7</td>
</tr>
</tbody>
</table>

Although the topic of education only came up in a few of the youth focus groups, when it was discussed, youth had strong feelings about the issue. When talking about the quality of their public high school education, a Boston teen commented “I know a lot of good schools in the ‘hood now,” to which a peer replied: “Every school is a good school. It’s the people in the school that make it bad.” A third student said “Not all of the schools are good in our neighborhood.” One Mission Hill student specifically cited the Tobin school as an important community resource for the quality and array of services offered. Several parents reiterated this sentiment since they were involved in Tobin’s family center. Stakeholders interviewed elaborated on the myriad challenges that schools are trying to address, including children in need of counseling and transitional services for social, emotional, and trauma issues. As one stakeholder commented, “There are families that can’t provide basic needs, clothes, shelter. Part of the challenge is to have enough service providers.” Inability to meet basic needs was frequently cited by stakeholders as interfering with education for inner city children and youth.

Despite the discouraging statistics, participants in youth focus groups overwhelmingly envisioned themselves pursuing higher education, primarily via college or vocational training. Several had entrepreneurial aspirations and shared dreams of wealth. They were oriented towards a range of occupations from professional to law enforcement, to athletics.
and entertainment. Very few were less optimistic, unable to predict their futures or resigned to continuing to live in poverty. It should be noted that the youth involved in the focus groups were highly engaged in their community and active with numerous youth-serving organizations.

However, there were varied opinions as to how well these adolescents felt they were being prepared for the future. Some youth participants questioned the utility and quality of their Advanced Placement classes, while others noted there were too few academically challenging classes or programs available. Some teens recognized academic scholarships offered by their schools, while others identified a need for additional support for struggling students. In terms of motivation, a few students acknowledged striving harder due to their competitive nature. Most students reported getting encouragement from a family member (most frequently mothers), and a desire to live up to expectations or “make [someone] proud.” Others cited pastors, teachers, mentors, and friends as their source of support.

Several parents and youth also noted that the schools in their community are considered hubs of activity and trusted sources for information. Several youth commented that they were involved in sports or after-school activities when their schools offered them. School was generally considered a safe, positive environment by many of the youth participating in the focus groups. They also saw adults in their school—teachers, the nurse, the librarian—as information disseminators. Some parents in the focus groups indicated that schools help to provide information on what is happening with their child and in the community. They are used to schools sending information home either through the mail or with their child or leaving automated messages on the answering machine for school-wide announcements.

**Housing and Transportation**

“As property values have gone up during the last few years due to the universities purchasing land, current residents have found it difficult to reside in their current homes due to the changing landscape and rising property prices.” –Parent focus group participant, Fenway

“In my neighborhood, I see more dumpsters, more trash, and more stores. The stores in my hood are spread apart. There’s lots of graffiti.” -Youth focus group participant, Roxbury

“This is a very diverse community with lots of different restaurants and activities. You can get around everywhere. Public transportation is really convenient.” –Parent focus group participant, Jamaica Plain

Most of the focus group participants described their neighborhoods as “mixed” as far as whether they included residential or commercial real estate. Many parents and youth noted that their communities included quiet sections of only houses, while many also had a “main drag” of stores and restaurants which were hubs of activity. Some focus group participants commented on the lack of cleanliness of their communities, describing them as “dirty,” while others, particularly those from Jamaica Plain, used the words “colorful” or “lively.”

Youth and adult residents alike, along with many stakeholders, described concerns related to the impact of gentrification occurring in the Roxbury, Jamaica Plain, and Fenway neighborhoods. Several stakeholders described an “incredible juxtaposition of institutions and poverty,” of “haves and have-nots,” and the growing income disparities within neighborhoods. Parents in the Fenway and Jamaica Plain focus groups pointed out that
increasing property values are making it more difficult for residents, even families with multi-generational community roots, to stay in their homes.

Recent economic trends have taken a toll on housing stability in Boston. Approximately two-thirds of Boston’s housing units are occupied by renters, although owner occupancy increased city-wide from 32% in 2000 to 38% in 2007 (Table 6). The Roxbury/Mission Hill (71%) and Fenway neighborhoods (89%) have even larger renter populations.

### Table 6. Home Occupancy by Priority Neighborhood, 2000 and 2007

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Housing Units</td>
<td>255,072</td>
<td>251,935</td>
<td>21,909</td>
<td>13,229</td>
<td>16,536</td>
</tr>
<tr>
<td>% Occupied housing units</td>
<td>91.0</td>
<td>95.1</td>
<td>91.5</td>
<td>97.5</td>
<td>95.2</td>
</tr>
<tr>
<td>% Owner-occupied</td>
<td>38.2</td>
<td>32.2</td>
<td>20.9</td>
<td>8.6</td>
<td>30.4</td>
</tr>
<tr>
<td>% Renter-occupied</td>
<td>61.8</td>
<td>67.8</td>
<td>70.6</td>
<td>89.0</td>
<td>64.8</td>
</tr>
</tbody>
</table>

Effects of the national foreclosure crisis have been felt throughout Boston. In 2008, foreclosure petitions were filed on almost 3% of all residential properties city-wide. This proportion increased to over 4% in the highest risk neighborhoods. Dorchester, Mattapan, and Roxbury were most affected and included 57% of all foreclosure petitions in Boston. Among these foreclosed units, nearly 20% alone were located in Roxbury/Mission Hill in 2008 (Table 7). This situation has a significant impact on renters in foreclosed properties. “Investor-owned foreclosures” is one proxy for tenant evictions caught in this type of situation, and 62% of all foreclosures in Boston were considered investor-owned. However, city officials estimate that an even higher proportion of foreclosures, approximately 77%, comprise of tenant-occupied units, since approximately 45% of foreclosures involved multi-family dwellings.

### Table 7. Number of Foreclosure Deeds by Priority Neighborhood, 2007 & 2008

<table>
<thead>
<tr>
<th></th>
<th>% Foreclosures Investor-Owned</th>
<th># Foreclosures in Boston</th>
<th># Foreclosures in Roxbury/Mission Hill</th>
<th># Foreclosures in Fenway</th>
<th># Foreclosures in Jamaica Plain</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>60%</td>
<td>703</td>
<td>124</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>2008</td>
<td>62%</td>
<td>1215</td>
<td>236</td>
<td>3</td>
<td>18</td>
</tr>
</tbody>
</table>

Due to the economic recession, housing crisis, and other factors, homelessness in Boston has been on the rise. Between 2007 and 2008, the number of homeless individuals increased by 11%. The number of homeless children increased dramatically between 2004 and 2008, from 20% to 30%.

Many focus group participants praised conveniences in their neighborhoods. Mission Hill residents described their area as a walking neighborhood and commented on the convenience of a centrally located grocery store and easily accessible public transportation. Likewise, Jamaica Plain residents described having access to a variety of stores and to convenient public transportation. Dorchester, Hyde Park and Roxbury residents noted their desire for more grocery stores and pharmacies yet conveyed the availability of buses in their communities. According to U.S. Census data, access to private transportation remained stable between 2000 and 2007 with 43% of Boston households reporting at least one vehicle, while just over one third of Boston’s households had no car. Notably, twice as many Fenway households lacked cars (63%) compared to the rate city-wide. Yet, most stakeholders, parents, and youth in the interviews and focus groups remarked that their specific neighborhoods have conveniently located public transportation lines via the T and buses. Transportation was cited as a barrier to accessing services only rarely, when focus
group participants noted the length of time it sometimes took to get from place to place via multiple bus routes.

Safety and Crime

"It’s better to be out during the day around my house. It’s not great to be out at night. There is a lot of ‘activity’ around at night. It’s dangerous. I have to worry when I walk home at night." – Youth focus group participant, Mission Hill

"As far as feeling safe, I have always lived in Roxbury. I must say I feel safe. Roxbury is always in the news, but nothing has happened to me to make me feel afraid of my community. I don’t experience that.” – Parent focus group participant, Mission Hill

“There are a lot of people looking out for you.” – Youth focus group participant, Roxbury

“Some people have a perception of Roxbury being a rough neighborhood; however, certain pockets are safer than others and families all know each other.” – Parent focus group participant, Fenway (of parent who noted living in Roxbury)

Safety concerns were prominent among focus group participants and were consistently highlighted in stakeholder interviews. Several stakeholders noted gangs, weapons, and increasing crime as key threats in these communities. Others referenced the lack of safety, security, and safe walking areas. One teen commented that “Nobody’s in a healthy environment if you live in certain neighborhoods.” Yet another talked about “being scared to walk on your doorstep.” Parents shared a concern that there is "no safe place for after school programs or activities.” Secondary data sources show that fewer than half of all Boston residents felt their neighborhood was very safe. An even lower proportion of residents in Mattapan, North Dorchester, and Roxbury (22%) described their neighborhoods as very safe.29

However, some focus group participants did not see safety as a major concern for them. They acknowledged that there was crime in their community, but they did not believe that they would be targets of it. Several youth and parents noted that they have lived in their neighborhoods for most of their lives, and people “all knew each other and looked out for one another.” This community cohesiveness acted as a protective factor, although some teens lamented that people also “knew everything about your business” in these instances too. Several youth participants remarked that they could identify who the criminal elements were in their community, and those individuals knew who the teens were as well. Because of this, these participants did not think they themselves would be victims of crime, but that others not from the community—who were not known elements—might be nervous to walk down streets in their neighborhood alone, and rightly so.

Parents and youth both pointed out that safety plummets in the evenings in their neighborhoods. Parents noted that there is “no protection in the public parks after 4pm” and that “past 6 or 7pm you are a little scared to be walking on streets.” Jamaica Plain parents pointed out that the area near the public housing project is particularly dangerous, as gangs in the community are “always fighting among each other over their territory.” One youth participant described how gang conflicts can lead to violence: “Gang violence starts with ‘you killed my brother and I am going to kill you’ – revenge. Also, gangs get mad at other gangs because of success, or if one gets caught, then one will get mad at the other for not getting caught.”
The role of police was not generally discussed among youth, although one teen believed that Boston police were racially discriminatory. He noted: "I listen to my older brother a lot who was in jail. He said that the police like pulling over dark people." However, several parents in Mission Hill and Roxbury focus groups remarked that it is important for police to be active in their community and their presence is slowly increasing. As one parent commented, "Police are watching out more than before." Parents also mentioned their own proactive efforts to improve safety, such as involvement in neighborhood watch programs.

Crime statistics validate residents’ concerns. Data from the Boston Police Department indicate that, in 2008, Area B (Roxbury, Mission Hill, Mattapan, and parts of Dorchester) had the highest percentage of reported rapes, robbery and attempted robbery, and aggravated assault. As Table 8 indicates, Roxbury and Mission Hill alone had the highest numbers of robberies and aggravated assaults compared to Children’s other priority neighborhoods. The burden of violence is not equally distributed across racial/ethnic lines. The 2007 homicide rate for Black residents was almost four times the rate for Latinos and the Boston overall rate.

Table 8. Number of Crimes, by Type, Boston City-wide and by Priority Neighborhood, 2008

<table>
<thead>
<tr>
<th></th>
<th>Boston</th>
<th>Roxbury/Mission Hill</th>
<th>Fenway, Back Bay, &amp; South End</th>
<th>Jamaica Plain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide</td>
<td>63</td>
<td>10</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Robbery</td>
<td>2,397</td>
<td>467</td>
<td>314</td>
<td>124</td>
</tr>
<tr>
<td>Rape</td>
<td>249</td>
<td>36</td>
<td>37</td>
<td>9</td>
</tr>
<tr>
<td>Aggravated Assault</td>
<td>3,917</td>
<td>813</td>
<td>347</td>
<td>195</td>
</tr>
<tr>
<td>Burglary</td>
<td>3,454</td>
<td>439</td>
<td>507</td>
<td>260</td>
</tr>
<tr>
<td>Larceny</td>
<td>16,243</td>
<td>1,675</td>
<td>3,788</td>
<td>933</td>
</tr>
<tr>
<td>Vehicle Theft</td>
<td>2,420</td>
<td>376</td>
<td>295</td>
<td>165</td>
</tr>
<tr>
<td>Total # of Crimes Reported</td>
<td>28,743</td>
<td>3,816</td>
<td>5,290</td>
<td>1,690</td>
</tr>
</tbody>
</table>

When discussing violence, stakeholders and focus group participants were mainly referring to gun violence. Secondary data reveal that many adolescents have access to guns, and gun violence is prevalent in many communities. In 2007, 25% of male public high school students in Boston (and 9% of female students) reported carrying a weapon at least once during the past month. Almost 30% of Roxbury residents reported that they believe gangs to be a problem in their neighborhood. Additionally, a greater proportion of Mattapan, North Dorchester, South Dorchester, and Roxbury residents (29%) reported gunshots and shootings as being a big problem compared to Boston residents overall (13%). Youth also face the brunt of much of this violence. Young Boston residents, ages 15-24, accounted for almost half of the reported nonfatal gunshot and stabbing incidents and 53% of homicides in 2007.

Safety fears also impact education: 8% of Boston public high school students in 2007 reported not going to school because they felt unsafe. A higher percentage of Black (11%) and Latino (9%) than White (2%) public high school students reported not going to school because of safety concerns, while 6% of all students reported being threatened or injured with a weapon at school. These percentages were consistently higher among males and among Black students.

However, as noted earlier, many adult and adolescent residents shared the feeling that there were “a lot people looking out for you” even if violence seemed pervasive. Such supports included the faith community, neighborhood watch programs, “nosey neighbors,” a
communal feeling (particularly in the Fenway), and added police presence. Service providers and stakeholders described residents of Boston’s inner city communities as “resilient”, “survivors”, and “activists.” Overall, 60% of Boston residents agreed or strongly agreed that there are adults in their neighborhood that can be counted on to look out for children and teens (Roxbury 51%, Fenway 49%, Jamaica Plain 59%).36

Access to Health Care

“It is an issue of the people providing the health care. I think our communities are overlooked, not given the same respect as in the suburbs. Doctors don’t care. They don’t listen, and they write down the wrong information.” –Parent focus group participant, Mission Hill

“I get free care [insurance] through the state. There are three health centers in the community, but they only offer private care. Most people can’t afford it.” –Parent focus group participant, Roxbury

“I use the clinics, but the clinics are worse than the hospitals...they rush you through a visit...each doctor’s appointment should be 30-45 minutes.” –Parent focus group participant, Mission Hill

Following the implementation of healthcare reform, 480,000 people in Massachusetts gained health insurance coverage, as of 2008.37 Rates of uninsured individuals dropped from 7% (2006) to 2.6% (2008) of the total Massachusetts population. Among minors in Massachusetts, 1.2% still did not have health insurance coverage in 2008.38 All of these children resided in households whose income was less than 300% of the federal poverty level. Among the general population, individuals of Hispanic ethnicity were three times more likely to be uninsured than non-Hispanics. In addition, uninsured individuals were much more likely to report their health status as fair or poor.38 Among insured children, 70% were covered by employer-sponsored insurance, 29% by public or other coverage, and 2% were Medicare recipients.

Boston-specific data regarding primary care utilization pre-date the implementation of Massachusetts Health Care Reform. In 2006, 84% of Boston residents had identified that they see a regular primary care provider. Latino (75%) and Asian (71%) groups were least likely to have primary care providers.39

When parents and youth in the focus groups discussed their own health care experiences, many indicated that they use the health centers in their community. They found that they were able to access these facilities for their families’ primary care needs, whether they had private or state health insurance. In several instances, they looked to the community health centers to offer health information and referrals on where to go for more specific services, such as the asthma clinic. However, even with this access to care and information, many parents noted several challenges to navigating the system, which are described in more detail later on in this section.

Inadequacy of coverage and cost have often been barriers to accessing appropriate health care among individuals who report having health insurance. As noted in Table 9, 9% of insured adults city-wide cited cost as a barrier to seeking care in 2006, with marked differences across racial/ethnic groups. Cost was most likely to keep Latinos from seeking care (20%), followed by Blacks (11%) and Whites (5%).40 An insightful youth participant urged hospitals to “Make it easier to get medicines ... make meds cheaper” and “help with health insurance.”
Stakeholders and parents pointed out that immigrant families, particularly those who are undocumented, are the most vulnerable and face the largest barriers to accessing healthcare. Not only is it difficult for these families to access the social safety net in this country because of their illegal status, but navigating our complicated health care system was cited as overwhelming. Even when immigrant patients could identify where to go for medical services or make an appointment after difficult interactions with front desk staff, they encountered limited interpreter services or difficulty in scheduling interpreter services once they showed up for their appointment. These situations all pose significant barriers for immigrants in accessing medical care.

Fragmentation of the health care system, the challenges of navigating the system, and inconsistent care (including lack of a medical home) were named by stakeholders as the top barriers for many residents in Children’s priority communities. Other obstacles (in order of frequency mentioned) included: lack of knowledge of health and developmental issues; poverty resulting in competing priorities/basic needs; “fear of giving information to strangers”/”mistrust for authority”; language/cultural issues; and logistics related to transportation and scheduling.

Several stakeholders involved in health and medical organizations explained that healthcare is a lower priority for families whose basic needs are unmet. Further, many parents face scheduling and financial barriers, such as the inability to take time off from work or to afford the co-pays for office visits and medications. Parents in the focus groups elaborated on this theme, alluding to: lengthy waiting periods to set up appointments, difficulty accessing urgent care, minimal staffing and long waiting rooms times upon arrival, unfriendly front desk staff, and the expense of recommended medications and supplies. While parents did not spend much time discussing medical care access, several of those who did indicated, as noted previously, that they used the health centers in their community. Not being able to get care was not an issue; the question was whether they wanted to deal with the challenges (e.g., lengthy waiting room times, rude front desk staff) in order to get care.

Several parents and youth also called attention to disparities in healthcare. Adult and youth focus group participants shared a consistent perception that impoverished and minority patients have restricted access, are shown less respect, and receive poorer quality health care. For example, comments from youth participants included: “Bad healthcare is a big issue.” “If you don’t have money, they won’t treat you.” And “It’s like for us minorities – we don’t get as good health care as other people get.” Parents echoed these sentiments, imparting their belief that health care providers “overlook our communities,” “don’t care or respect us,” rush through visits, “make up excuses,” and give unrelated and culturally inappropriate advice. Community members asserted that “people aren’t treated the same” when trying to seek care, in that those who have private insurance are shown better service. As one parent remarked, “Mass Health patients are overlooked because Mass Health doesn’t pay fully,” noting that she believed that patients with private insurance such as Blue Cross Blue Shield were prioritized when she visits the doctor.

### Table 9. Primary Care Utilization & Barriers, by Race/Ethnicity, 2005 & 2006

<table>
<thead>
<tr>
<th></th>
<th>Boston (%)</th>
<th>White</th>
<th>Black</th>
<th>Latino</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost considered barrier to seeing doctor, 2005 &amp; 2006</td>
<td>9.0</td>
<td>5.0</td>
<td>11.0</td>
<td>20.0</td>
<td>*</td>
</tr>
<tr>
<td>Residents with primary care provider, 2006</td>
<td>84.0</td>
<td>88.0</td>
<td>85.0</td>
<td>75.0</td>
<td>71.0</td>
</tr>
</tbody>
</table>

*Insufficient sample size for Asians in 2006*
Community Health Profile

Childhood Obesity, Physical Activity, and Nutrition

"Some of the children here have weight issues and the community should develop better programs to help children better manage their weight. Parents are also responsible for ensuring that their children get the necessary daily exercise to keep them healthy." -Parent focus group participant, Fenway

"We also have lack of good food in our stores. It’s really expensive. Or it’s just not in the stores. This leads to diabetes, obesity, etc.” -Youth focus group participant, Mission Hill

"I notice in school people don’t eat lunch and so even if you get free lunch you don’t want to eat it. When you don’t bring lunch from home and school lunch isn’t good, you eat a cookie.” -Youth focus group participant, Fenway

Obesity was listed as the top health concern for Children’s priority neighborhoods almost unanimously by stakeholders, parents, and youth, who cited poor dietary habits and lack of exercise as key contributors. There was a common feeling among youth that healthier foods are not affordable or available. As one teen noted: “We don’t have healthy foods near us. And healthy food is expensive.” Another agreed that "The prices of the bad foods are much cheaper and those foods are everywhere." Many of the young people pointed out the abundance of fast food restaurants in their neighborhoods. Another justified her eating habits as cultural: “We’re from the South. We’re big girls. We eat fried food; it’s a big part of our family.” Several participants cited enticing advertisements for unhealthy foods as problematic.

Stakeholders’, parents’, and adolescents’ perception of obesity being a pervasive problem is validated by the statistics. In 2007, one-third (33%) of Boston public high school students were either overweight or obese compared to 28.8% of high school students in the state. As shown in Table 10, gender comparisons reveal that a higher percentage of female students in 2007 were considered overweight compared to males (22% of females vs. 15% males); however, more male students met the criteria for obesity (17% of males vs. 12% females). Latino and Black students in Boston had higher rates of obesity (16%) than White students (7%) or those of other races (9%). While neighborhood data are not available for youth obesity rates, among adults, residents of Roxbury (26%) and South Dorchester had the highest rates of obesity in Boston (overall city average, 18%). The Fenway (7%) and Jamaica Plain (13%) neighborhoods had considerably lower rates.

Table 10. Overweight and Obesity of Boston Students, by Gender and Race/Ethnicity, 2007

<table>
<thead>
<tr>
<th>Weight Status</th>
<th>Boston (%)</th>
<th>By Gender</th>
<th>By Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>White</td>
</tr>
<tr>
<td>Were overweight*</td>
<td>18.5</td>
<td>22.0</td>
<td>15.2</td>
</tr>
<tr>
<td>Were obese**</td>
<td>14.5</td>
<td>11.7</td>
<td>17.2</td>
</tr>
</tbody>
</table>

*Student were >= 85th percentile by < 95th percentile for body mass index, by age and sex, based on reference data.

**Students were ≥ 95th percentile for body mass index, by age and sex, based on reference data.

Many stakeholders stressed the importance of education around nutrition and fitness for both parents and children as well as the need for larger community changes around food, such as increased access to fruits and vegetables and decreased density of fast food.
establishments in these neighborhoods. Approximately 25% of adults and only 10% of high school students in Boston reported consumption of the recommended five or more servings of fruits and vegetables daily in 2007.45,46 This rate has been consistently low over the years studied. There were no significant differences across age groups, genders, or race/ethnicities. While less than 10% of students in Boston reported drinking the 24 ounces of milk recommended daily, 27% reported drinking at least one daily serving of sugared sodas.

Parents described their attempts to reduce or prevent weight issues for their children by trying to “limit sweets, juices, and fat and check calories” and encouraging children to drink more water. Some parents addressed the issue by bringing children to see a healthcare provider. A few parents had participated in educational programs about nutrition through “Healthy Kids, Healthy Future” (HKHF) and Head Start. They appreciated the introduction of specific strategies including “different ways to get more vegetables and fruits” and “how to portion children’s food.” They also valued efforts by these programs to address cultural norms such as “having to finish a full plate of food.” There was general agreement among the youth that “there should be more stuff for teenagers to teach them about eating healthy and making the food right choices.”

When discussing obesity in nearly all interviews and focus groups, parents, youth, and stakeholders mentioned that lack of activity is just as much of a contributing factor as poor nutrition. In 2007, only 30% of Boston public high school students met the federal activity guideline of accumulating 60 minutes or more of daily physical activity, compared to the state average of 41%.47 Among public high school students in Boston, a higher percentage of White students (40%) reported participating in regular physical activity compared to Black (29%) and Latino (27%) students.

Many stakeholders pointed to the lack of safe outdoor play space, yards, and playgrounds as a central factor limiting physical activity among Boston children. Additionally, several stakeholders interviewed for the assessment noted challenges community residents face in accessing existing community programs and services that promote fitness, barriers primarily including language/cultural issues and lack of knowledge about resources. Youth focus group participants also identified the need for education as well as increased access to “better foods and more places to go and work out.” A few youth blamed inactivity on laziness and cited themselves as examples—they knew it would be healthy to be more active, but they did not have the motivation. Still other teens aligned with the strong opinions expressed by stakeholders that the lack of safety in their communities was a significant contributing factor to inactivity, stating that “kids can’t go outside, so they stay home and eat, play video games.” One parent applauded the gym access offered by the HKHF program: “They offered us free gym in the community to take preschool children...to increase physical activity.”

Asthma

“What about pollution? There are a lot of buses out there. Not enough trees. There are problems with asthma, lung problems, etc.” -Youth focus group participant, Mission Hill

“My kids are asthmatic, and my son plays sports. He has to carry his pump wherever he goes and call me, especially on the hot days.” -Parent focus group participant, Jamaica Plain
"My sons and I are asthmatic. I moved from one place [in public housing] with mice and roaches to another place with them... and then you have talk to the management company to take out the carpet." - Parent focus group participant, Mission Hill

Adolescent and parent focus group participants were universally concerned about the ubiquity of asthma in their environment: "most of the people have asthma," and "it affects younger children the most." Likewise, stakeholders listed asthma among the top health concerns for children, particularly for pre-adolescents and young children in the priority communities. Concerns about environmental contributors to the disease were also raised by stakeholder and parents alike.

Secondary data substantiate the prevalence of asthma into Boston’s inner city neighborhoods and the disproportionate impact on the city’s youngest residents. As shown in Figure 4, the asthma hospitalization rate in children under age five (10 per 1,000) was four times the rate for Boston overall in 2007 (2.5 per 1,000). Within this age group, boys were more affected than girls (rates 12 vs. 8 per 1,000).

**Figure 4. Asthma Hospitalizations by Age Group, 2007**

The rate of asthma hospitalizations for young Black children was at least three times greater than the rates for White and Asian children. For combined years 2005-2007, children under five in Roxbury had the highest asthma hospitalization rate (15.2) among Boston neighborhoods, almost double the city-wide average rate (8.8 per 1,000). Asthma also affects numerous high school students in Boston, as 13% reported currently having asthma in 2007.

While several youth participants mentioned pollution and second-hand smoke as contributing factors to high asthma rates, several stakeholders and parents mentioned other environmental triggers in the home such as dust mites, mold, and rat/mouse droppings. They pointed to poor upkeep in housing units by landlords and management companies, and the difficulty of getting carpets removed from public housing or other housing complexes. For many parents and youth in the focus groups, asthma was an issue that struck close to home, with several participants in each group noting that they, a family member, or close friends were dealing with the condition.

Parents in focus groups explained that people need to get asthma information, admitting that they had little knowledge about treatment themselves. Teens agreed, suggesting "they should explain why people get asthma and what we can do to stop it." In addition to education, youth participants also expressed the need for healthy community activities appropriate for individuals with asthma. One commented on cost as a barrier to appropriate
pharmacologic treatment for asthmatics. In addition, several parents brought up the growing challenge of food allergies among children, stating that there is “not a lot of awareness about the seriousness of the food allergy problem.” Others agreed, citing examples of affected friends and relatives.

**Sexual Health and Teen Pregnancy**

“I think STDs/STIs are a big issue because you don’t know who has one. There are young kids, 12 year olds, having sex and they don’t know what can happen from being that way.” –Youth focus group participant, Fenway

“Most girls don’t know that ‘raw’ [having sex without a condom] is not always the healthy way to go. I went to the hospital and got that cured.” –Youth focus group participant, Roxbury

“These kids are more sexually active than their parents. I have two daughters in high school and four of her friends have children that are two years old.” –Parent focus group participant, Mission Hill

Unprompted in discussions by the facilitator, the issues of sexual health and teen pregnancy were brought up as significant health concerns in nearly every parent and youth focus group and many of the stakeholder interviews. Many youth recounted stories of friends and siblings who unknowingly found out they received a sexually transmitted infection (STI) from a partner. Many also knew personally or saw other teens in their community who were pregnant or were already parents. Parents in the focus groups were nervous about the seeming increase in sexual activity among today’s youth. Several parent focus group participants noted that they themselves became parents as teenagers and did not want the cycle to continue with their own children. Numerous stakeholders discussed the health impact of STIs, especially those that go undiagnosed for so long, and the social and economic impact of adolescent pregnancy—in the form of increased drop-out rates, fewer job prospects for young parents, and increased stress in the household.

Parents’, adolescents’, and stakeholders’ perceptions of sexually active teenagers were corroborated by the data. In 2007, more than half of Boston public high school students (56%) reported having had sexual intercourse, a statistic that rose with increasing student age (Figure 5). Among all students, 40% of those 13-15 years old reported ever having sex, compared to 59% of 16-17 year olds and 71% of those 18 years old or older. A higher percentage of male students were sexually active (64%) than female students (49%).
Among those who have had sex, there were gender differences in the number of sexual partners they report. While one quarter of sexually active high school students reported having had six or more lifetime sexual partners, on average, male students indicated a greater number of sexual partners than female students (Figure 6). Over a third of sexually active male students (36%) reported having had six or more partners, while only 10% of female students met that criterion.

Racial differences in sexual activity among youth were revealed in self-reported responses. In the 2007, 63% of Latino public high school students in Boston and 61% of Black students reported ever having sexual intercourse compared to 39% of White students and 37% of Other race students (Table 11). Black and Latino high school students were also more likely than their White or Other race counterparts to have had four or more sexual partners, currently be sexually active, or have had sex for the first time before age 13.

### Table 11. Sexual Behaviors among Boston High School Students, by Race/Ethnicity, 2007

<table>
<thead>
<tr>
<th></th>
<th>All Boston Students</th>
<th>White Students</th>
<th>Black Students</th>
<th>Latino Students</th>
<th>Other Race Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>% ever had sexual intercourse</td>
<td>56.0</td>
<td>39.0</td>
<td>60.8</td>
<td>63.1</td>
<td>36.7</td>
</tr>
<tr>
<td>% had 4+ sexual partners</td>
<td>22.1</td>
<td>8.4</td>
<td>26.9</td>
<td>24.6</td>
<td>10.7</td>
</tr>
<tr>
<td>% currently sexually active</td>
<td>39.1</td>
<td>28.9</td>
<td>41.4</td>
<td>45.0</td>
<td>22.8</td>
</tr>
<tr>
<td>% who had sex for first time before age 13</td>
<td>12.2</td>
<td>2.8</td>
<td>15.9</td>
<td>11.7</td>
<td>9.8</td>
</tr>
</tbody>
</table>
With this level of sexual activity as a backdrop, it is not surprising that youth participants and stakeholders unanimously identified STIs as a major problem in these communities. Several adolescents pointed to peer pressure as a causal factor for early sexuality and also noted that many teens do not use protection when they do have sex. Youth recognized that teens need accurate information about preventing sexually transmitted infections and offered some suggestions: “Have someone who has that disease talk to them about what it’s like to live with that disease” “Target kids at younger ages” and “Show pictures.” Parents were concerned as well, insisting that “parents need to learn how to talk to girls about sex.” Some of the youth remained skeptical however, predicting “people won’t listen.” Many were uncertain that youth would delay sexual activity, but they hoped that at least youth would adopt safer sex practices.

Concerns regarding STIs are corroborated by the quantitative data. Incidence rates of two sexually transmitted diseases, Chlamydia and gonorrhea, are on the rise and are spreading particularly rapidly among Boston youth. In 2007, 6% of Boston public high school students reported ever being told they had a sexually transmitted disease. Vital statistics information reveals that the overall rate of new Chlamydia infections was 66% higher in 2007 than in 1999, and gonorrhea cases climbed by 17% between 2006 and 2007. Adolescents ages 15-19 are afflicted by higher rates of new Chlamydia infections than any other age group in Boston, while half of all new Boston cases of gonorrhea in 2007 occurred in people under age 25. In contrast, the incidence rate for syphilis declined 38% from 2003 to 2007, and no cases of syphilis were reported among 15-19 year olds in 2007.²⁵

Certain Boston neighborhoods have shown themselves to be hot-spots for STIs. In 2007, the Mattapan, Roxbury, and South Dorchester neighborhoods each had Chlamydia incidence rates that were 30% higher than the average city-wide rate (717 cases per 100,000 population). The highest rates of new gonorrhea cases were found in South Dorchester and Mattapan in 2007. The Fenway neighborhood had Boston’s third highest rate of gonorrhea during the same time period. ⁵⁶

In addition to rising STI rates, many parents, youth, and stakeholders also perceived teen pregnancy as a significant health problem. Parents noted the profusion of young parents in their communities. Parent focus group participants remarked that teens “don’t know how to deal with” being parents, and they lamented the change in these teens’ futures. Several parents discussed how their own lives changed when they became teen parents themselves. Parents and service providers concurred that many teen parents are uninformed, lack support, and face substantial financial, housing, and emotional challenges.

Adolescent birth rates are rising in the city too. The birth rate in Boston for mothers under 18 years old increased by 12% from 2005 to 2007, the first increase after a decade-long downward trend. In 2007, 7.6% of new mothers in Boston were under age 20, and there were a total of 213 births to mothers younger than 18 years of age. Births to teen mothers continue to be more frequent among Blacks andLatinas than other racial/ethnic group (Figure 7).
Adolescent pregnancy presents health risks for both the expectant mother and baby. In 2007, the highest percentage of babies with low birth weights and the highest infant mortality rates resulted from deliveries by women ages 18-19 years. In the 15 to 17 year-old age group, Asian and Latino women had the highest percentage of infants with low birth weight.

Mental Health

"Depression is something people don’t think about, but it’s there." - Youth focus group participant, Fenway

"Teens are going through a transitional period and have trouble coping." - Parent focus group participant, Jamaica Plain

Mental health was the one of the most frequently identified community health problems among the stakeholders interviewed, second only to obesity and discussed with the same frequency as asthma and sexual health/teen pregnancy. Stakeholders primarily highlighted depression as a major concern and also discussed various other mental health concerns, such as trauma related to stress and living in violent circumstances as well as a range of learning and developmental disabilities.

Depressive symptoms affect many Boston students. Over one quarter of public high school students in 2007 reported symptoms of depression during the past year (feeling sad or hopeless for two weeks straight) (Figure 8). A slightly greater proportion of Latino students (29%) reported these symptoms than Black (25%) or White students (20%). It should be noted that in 2005, a much higher percentage of Latino students (36%) reported feeling sad or hopeless for two weeks straight.
There were also gender differences in these symptoms. In 2007, female students (31%) were more likely than males (21%) to report depressive symptoms and also to have seriously considered attempting suicide (14% of females: 7% of males) (Table 12). Yet, male students were more likely than female students to have had a suicide attempt treated by a doctor or nurse (4.6% vs. 3.1%, respectively). Overall, approximately 10% of Boston high school students in 2007 indicated that they had attempted suicide, with few gender differences on this indicator. Adolescent focus group participants conceded that there is “sort of a problem with mental health in our community,” and identified depression as common. Youth focus group participants acknowledged the silent nature of the disease: “Depression is hidden,” “Depression affects more people than you think,” and “People just don’t talk about it.” Many youth and parents noted that depression is pervasive, but there is still a stigma related to talking about it.

Table 12. Suicidal and Depressive Symptoms among Boston High School Students, By Gender, 2007

<table>
<thead>
<tr>
<th></th>
<th>All Boston Students</th>
<th>Female Students</th>
<th>Male Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>% seriously considered attempting suicide</td>
<td>10.5</td>
<td>13.6</td>
<td>7.4</td>
</tr>
<tr>
<td>% made a suicide plan</td>
<td>11.4</td>
<td>13.2</td>
<td>9.3</td>
</tr>
<tr>
<td>% attempted suicide</td>
<td>10.4</td>
<td>10.8</td>
<td>10.0</td>
</tr>
<tr>
<td>% had a suicide attempt treated by a doctor or nurse</td>
<td>3.8</td>
<td>3.1</td>
<td>4.6</td>
</tr>
</tbody>
</table>

The majority of youth in the focus groups described self-esteem as a major factor related to mental health and overall health: “It’s really about being comfortable with who you are as a person” and “not trying to be like someone else.” Some teens connected these identity issues to depressive symptoms. Stressors identified by teens included: peer pressure (related to sex), drugs (either taking drugs to escape depression or feeling depressed when unable to get drugs), sadness about material items that are unobtainable, and the discordance between one’s own body and media images of models or clothing designed for thinner people. Participants also mentioned pervasiveness of mental health issues throughout childhood and adolescence as well as intergenerational patterns that exist.

The experience of violence was consistently cited during stakeholder interviews and parent focus groups as a top health concern for adolescents (over age 13). It encompasses many
forms including domestic violence, dating violence, and trauma from living in violent surroundings. When discussing younger children, concerns related to bullying and the mental anguish of living in a violent community or violent home were mentioned. Stakeholders and parents alike questioned how these issues manifest later on in life and what type of coping strategies children are learning to deal with these related stressors.

A few youth participants and nearly all stakeholders mentioned the connection between depression and the experience of trauma. Many stakeholders emphasized the impact of the “social experience of stress” that results from living with in a violent neighborhood or violent home: “Domestic violence impacts a child's physical and mental health as well as school performance.” Another youth participant described witnessing street violence as an everyday occurrence: “In here I see a pin (shooting) every week or every other day. On Saturday they had a block party. One lady said she had four boys who all died from gunshot wounds.” Yet another teen described her active role: “I used to be bad, real bad. I used to be in a gang with 5 boys and 12 girls. I was the leader of the girls. We’d start trouble with someone who looks at you wrong or beat up on one person. After I lost my older brother who died right in front of me, I changed.”

Many stakeholders, parents, and youth talked about how stress is directly linked to people’s overall physical and mental health. Contributors to this daily experience of stress include issues of poverty, safety and violence mentioned above, as well as family instability. Stressors related to the scarcity of traditional family models were identified by several participants. Participants uniformly called attention to the strain of single parenting. Youth and stakeholders further delineated these situations naming divorce, separation or loss of a parent, parental abuse, addiction issues, domestic violence, and child abandonment and neglect as particular causes of stress. Several stakeholders noted that while many parents struggle, there are few support systems available. Secure homes and families surfaced as one ingredient of the recipe for a “healthy teen.” There was disagreement, however, about what constituted a healthy home. Teens agreed communication, understanding, patience, honesty and fun should be essential. One teen felt that having both parents was central, while another disagreed, adding “having both parents is a bonus.” Youth participants also pointed out the importance of having friends and responsible role models you can rely on and the protective positive impact of family support and expectations.

Teens noted the lack of community resources to address mental health, further observing that “teens need to know their resources” and “schools aren’t letting teens know about counseling and that you don’t have to be weird to go to counseling.” There was agreement among these adolescents that “it would be good if there were people you would feel comfortable talking to about your problems.” School health centers were singled out as a helpful, convenient resource by a few students. Parents were very cognizant of the limited resources available to address mental health problems, commenting that “our children have tough time getting appointments with psychologists.” They were also dissatisfied with how long it can take to get an appointment, commiserating that it is difficult for a parent to wait weeks for an appointment when concerned about a child.

Lastly, learning, language, and developmental delays were also brought up by several stakeholders and parents during the discussion of mental health and were described as widespread in these communities. Stakeholders related delays in development to a paucity of environmental enrichment and also noted that early learning disabilities go undiagnosed in many cases. There was some disagreement among parents about whether or not certain conditions such as attention deficit hyperactivity disorder were problematic. One or two parents acknowledged that their children were diagnosed with ADHD, while other parents
denied it was a problem, stating: “All kids have it, it’s natural for kids to be hyperactive,” and “it’s just part of the culture.”

Alcohol, Tobacco, and Other Drugs

“There are problems around certain streets because there are a lot of drugs, drinking even in the street...Kids aren’t being watched.” –Parent focus group participant, Jamaica Plain

“You can’t die from smoking weed, but you can die from smoking cigarettes. Our generation knows the bad side effects of smoking. Grown-ups smoking around children is really bad; it can lead to asthma. But you aren’t going to yell at your parents for smoking.” –Youth focus group participant, Fenway

Several stakeholders that were interviewed and numerous parents and youth in the focus groups mentioned alcohol, tobacco, and drugs as health concerns in their community. When talking about concerns such as obesity and asthma, many parents and youth discussed how these issues affected them and their families personally. However, when mentioning alcohol, tobacco, and other drugs, some participants recounted personal experiences, but most of the conversation related to the larger social ills in the community that these health issues exacerbate.

According to self-reported responses by youth, 66% of Boston public high school students in 2007 reported ever having at least one drink, while 44% had said they had tried a cigarette and 34% had used marijuana (Table 13). In these instances, White students were the group most likely to have tried any of these substances. Fewer than 4% of high school students reported ever having used cocaine or methamphetamines.

Table 13. Reported Tobacco, Alcohol, and Drug Use by Boston High School Students, by Race/Ethnicity, 2007

<table>
<thead>
<tr>
<th>% of students who have ever ...</th>
<th>All Boston Students</th>
<th>White Students</th>
<th>Black Students</th>
<th>Latino Students</th>
<th>Other Race Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tried cigarette smoking, even a puff</td>
<td>43.5</td>
<td>50.8</td>
<td>41.6</td>
<td>41.7</td>
<td>41.5</td>
</tr>
<tr>
<td>Had at least one drink of alcohol</td>
<td>65.6</td>
<td>81.2</td>
<td>56.9</td>
<td>73.0</td>
<td>59.9</td>
</tr>
<tr>
<td>Used marijuana</td>
<td>34.3</td>
<td>41.8</td>
<td>34.5</td>
<td>35.2</td>
<td>26.9</td>
</tr>
<tr>
<td>Used cocaine or crack</td>
<td>3.7</td>
<td>5.5</td>
<td>3.1</td>
<td>3.2</td>
<td>3.9</td>
</tr>
<tr>
<td>Used methamphetamines</td>
<td>2.7</td>
<td>1.1</td>
<td>2.6</td>
<td>3.3</td>
<td>2.5</td>
</tr>
</tbody>
</table>

In the focus groups, a few youth participants cited smoking and exposure to second-hand smoke as health problems. One teen worried: “My mother smokes cigarettes and I’m afraid I might get lung cancer or black lungs.” Several others discussed how their parents or other adults around them currently smoke, and it is difficult to watch or say anything when adults are engaged in the behavior. Many youth participants noted that young people today know about the dangers of cigarettes, but that it seems that those youth just do not care about the long-term health consequences of smoking.

Several parents, youth, and stakeholders also mentioned alcohol and drug use as commonplace in their neighborhood and discussed how this use is related to crime or depression. One parent’s comment received support from others: “Drugs are everywhere - at school, at train stations, parks, restaurants.” The abusing and selling of drugs in their neighborhoods were seen as major contributing factors to the crime rate and violence on city streets. Parents and youth in the focus groups talked about the young men on the
corner of certain blocks engaging in these illegal activities, and in many instances, are bringing in other “bad kids who don’t live in the neighborhood” into their area.

Stakeholders and parents also mentioned parental addiction to drugs and alcohol as another facet to this issue. The lack of role models or active parenting because of this disease has a significant impact on youth. One parent described how her mother was a drug addict for many years, and in order to get her mother’s attention, she ended up becoming a teen parent herself. She noted that her mother’s drug abuse affected the entire family.

In addition to its social and psychological impact, Boston also saw substance abuse as a contributing factor to many deaths in the city. Substance abuse-related mortality rate has more than doubled from 1999 (11.3 per 100,000 population) to 2007 (31.2 per 100,000 population). Among Boston’s neighborhoods, Fenway (44.7) and Roxbury (48.4) saw some of the highest death rates from substance abuse in the city (Figure 9).

**Figure 9. Substance Abuse Mortality by Neighborhood, 2007**

Several stakeholders and a few parents noted the difficulty in accessing resources for substance abuse addiction. Not only is it a stigmatizing issue, but finding resources is challenging due to lack of space, limited providers, and lack of insurance coverage. In 2008, 18,523 individuals in Boston were admitted to substance abuse treatment facilities, but these admissions varied by race/ethnicity, with 57.6% of admissions comprising of White patients and 22.5% and 16.0% comprising of Black and Latino patients, respectively.

**Injury Prevention**

"It is normal for kids to bump into things. It is part of being a kid.” –Parent focus group participant, Jamaica Plain

"Being scared to walk on your doorstep is a bigger issue than tripping and falling.” 
–Youth focus group participant, Roxbury

"My stresses when I was younger were because I watched my father beat up my mom when my brother was in her stomach.” –Youth focus group participant, Roxbury

Youth and parent focus group participants did not have much to say about preventing unintentional injuries, such as home, auto, or sports injuries. When asked about injury prevention, parents remarked that injuries at home occur because children are “experimenting.” Parents viewed such injuries as normative and emphasized that parents
“have to let them be kids.” A few youth participants shared stories of relatives who had been involved in car accidents.

Yet, many youth are engaging in behaviors that put them at risk for unintentional injuries. In 2007, approximately one in five Boston high school students reported rarely or never wearing a seat belt when riding in a car, and rates were even more pronounced among Latino students (26%) (Table 14). In 2003, the most recent year the question was asked, 88% of Boston high school students who rode a bicycle in the past 12 months said they rarely or never wore a helmet when they did so. Many youth are also putting themselves at risk by riding in a car with someone who has been drinking or driving themselves when drinking.

Table 14. Risky Behaviors Related to Injuries among Boston High School Students, by Race/Ethnicity, 2007

<table>
<thead>
<tr>
<th>Behavior</th>
<th>All Boston Students</th>
<th>White Students</th>
<th>Black Students</th>
<th>Latino Students</th>
<th>Other Race Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>% who rarely or never wore a seat belt while riding in a car driven by someone else</td>
<td>20.4</td>
<td>11.8</td>
<td>18.4</td>
<td>25.8</td>
<td>22.4</td>
</tr>
<tr>
<td>% who rarely or never wore a bicycle helmet (among those who rode a bicycle in past 12 months) (2003 data)</td>
<td>87.5</td>
<td>79.1</td>
<td>89.5</td>
<td>90.8</td>
<td>81.4</td>
</tr>
<tr>
<td>% who rode 1+ times in last 30 days in a car by someone who had been drinking alcohol</td>
<td>23.1</td>
<td>24.6</td>
<td>19.3</td>
<td>28.8</td>
<td>18.8</td>
</tr>
<tr>
<td>% who drove a car 1+ times in last 30 days when had been drinking alcohol</td>
<td>5.2</td>
<td>5.4</td>
<td>3.4</td>
<td>7.9</td>
<td>4.2</td>
</tr>
</tbody>
</table>

Overall, injuries are the leading cause of death in Massachusetts for children ages 1-14 years old. In 2007, there were 41 injury deaths in Massachusetts to children in this age group, with a rate of 3.8 deaths for every 100,000 children. Transportation-related injuries and suffocation were the leading causes of injury death for Massachusetts children ages 1-14 years old. In Boston, injuries were a contributing factor for numerous emergency room visits, as seen in Figure 10. While the rate for emergency room visits (among all ages) for injuries was 109.7 per 100,000 population for Boston city-wide in 2007, Roxbury/Mission Hill experienced a much higher rate (165.7).
Injuries associated with violence concerned stakeholders, parents, and youth to a greater extent than unintentional injuries. Stakeholders cited violence as the top health concern in the adolescent age group. The data supports the prevalence of violence among Boston teens as well. In 2007, the highest rate of nonfatal assault-related gunshot and stabbing injuries occurred among those ages 15-19 (over three times the rate for Boston overall). The 2007 rate for nonfatal assault-related gunshot and stabbing victims was highest for Boston’s Black residents, 11 times the rate for Whites and more than twice the city-wide rate. Latino residents had the second highest rate. Residents of North Dorchester and Roxbury had the highest rates of nonfatal assault related gunshot and stabbing injuries among all Boston neighborhoods in 2007, more than twice the rate for Boston overall.

Some stakeholders mentioned the concern related to intimate partner violence and family violence as health concerns among children and youth. Unfortunately, many of these incidents go undiagnosed because of the stigma surrounding them. However, Boston youth are affected: one in eleven public high school students reported being physically hurt by a date or someone with whom they were going out. While a few stakeholders were concerned about violence within the family or intimate relationships, this issue was rarely mentioned among parents and youth in the focus groups, who cited community level violence as their main concern.

**Chronic Diseases**

“My great-grandmother and grandfather died of cancer and diabetes. A lot of people don’t think about it until it happens to them. That’s not good though because then you are trying to figure out solutions, but you need to be prepared in the first place.”

–Youth focus group participant, Fenway

“We have diabetes and high blood pressure in my family, so I worry about it.”

–Youth focus group participant, Mission Hill

Concerns about the prevalence of chronic diseases in Children’s priority communities were aired by stakeholders as well as youth focus group participants. Stakeholders
overwhelmingly listed diabetes as the most pressing chronic disease, followed by hypertension, cancer, and cardiovascular disease. Adolescent participants were primarily worried about diabetes and cancer. These teens noted the susceptibility of children, teens, and adults in their communities to diabetes and cited many examples of affected family members. Of note, cases of diabetes among Boston public high school students (5% of the student population) were distributed fairly evenly across racial groups in 2007. Regarding cancer, teens were most concerned about lung cancer among their family members who smoked, while several stakeholders highlighted the pervasiveness of breast and prostate cancers, particularly among Black and Latino adult populations in these communities. These specific issues were less frequently mentioned by parents.

**Oral Health**

"*I worry about dental care. I try to limit my children’s sweets or get juice with less sugar.*" – Parent focus group participant, Jamaica Plain

A few parents and stakeholders considered oral health to be an important community health problem, with its major impact among pre-adolescent children. One stakeholder pointed out that oral health problems are more prevalent than asthma in these communities, including such issues as: low oral health literacy, availability of sealant, access to and availability of dental care, and need for health promotion around dental hygiene and good nutrition.

The percentage of Boston adults who reported having dental insurance in 2005 was 63%. As Table 15 shows, city-wide, 71% of residents of residents reported seeking dental care in the past year. The distribution of dental visits was similar among most racial groups with the exception of Latinos (61%). The most common barriers cited among adults who had not visited a dentist with the past year were low priority and cost.

**Table 15. Dental Care Utilization by Race/Ethnicity, 2005**

<table>
<thead>
<tr>
<th></th>
<th>Boston (%)</th>
<th>White (%)</th>
<th>Black (%)</th>
<th>Latino (%)</th>
<th>Asian (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult residents who reported visiting the dentist in past year</td>
<td>71.0</td>
<td>74.0</td>
<td>70.0</td>
<td>61.0</td>
<td>71.0</td>
</tr>
</tbody>
</table>

Young children across the state and in the larger Boston metropolitan area encounter a number of oral health conditions. In Suffolk County (in which Boston is located), nearly one in five kindergartners and 6th graders—and one in three 3rd graders—suffer from untreated tooth decay (Table 16). Additionally, children in Suffolk County across several grade levels are more likely than children statewide to experience dental caries, or cavities. For example, 57% of 3rd graders in Suffolk County have experienced dental caries compared to 41% of 3rd graders in Massachusetts.
Table 16. Oral Health Indicators among Children in Massachusetts and Suffolk County, by Grade, 2007

<table>
<thead>
<tr>
<th></th>
<th>MA (%)</th>
<th>Suffolk County (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reports not having regular dentist</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td>10.5</td>
<td>*</td>
</tr>
<tr>
<td>3rd grade</td>
<td>7.8</td>
<td>*</td>
</tr>
<tr>
<td>6th grade</td>
<td>6.6</td>
<td>*</td>
</tr>
<tr>
<td><strong>Untreated Decay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td>15.0</td>
<td>18.0</td>
</tr>
<tr>
<td>3rd grade</td>
<td>17.0</td>
<td>31.0</td>
</tr>
<tr>
<td>6th grade</td>
<td>11.0</td>
<td>20.0</td>
</tr>
<tr>
<td><strong>Pain in Teeth or Mouth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>3rd grade</td>
<td>5.0</td>
<td>7.0</td>
</tr>
<tr>
<td>6th grade</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td><strong>Caries Experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td>28.0</td>
<td>32.0</td>
</tr>
<tr>
<td>3rd grade</td>
<td>41.0</td>
<td>57.0</td>
</tr>
<tr>
<td>6th grade</td>
<td>34.0</td>
<td>43.0</td>
</tr>
</tbody>
</table>

Among the few stakeholders and parents who mentioned oral health, lack of providers and insurance were mentioned as significant barriers to seeking dental care. Also, many noted that parents do not consider oral health to be a top health concern, so they are more likely to put energy into seeking services for other health and social issues for their family. However, a few parents did mention that they actively try to get dental care for their children or take actions at home, such as serving young children juice or drinks with a lower sugar content.

**Early Childhood Health Issues**

"*In the community, there are a lot of young parents. They are not knowledgeable about early child development and don’t know how to deal with it."* - Parent focus group participant, Jamaica Plain

"*For real young ones, I worry about lead in the homes or in schools. It might lead to children acting differently – abnormal.*" - Parent focus group participant, Roxbury

Many of the overall health concerns that parents and stakeholders mentioned for older youth were also issues among young children. For example, asthma was considered highly prevalent among young children. While parents and stakeholders were somewhat concerned about obesity and depression among very young children, they did not see these issues as commonplace among this age group. However, many parents and stakeholders indicated it is important to address early signs and symptoms of these conditions at young ages. Shielding children from violence, teaching positive coping strategies, being physically active, feeding young children healthy foods, and teaching positive lifestyle habits at a very young age will help alter the trajectory for many health conditions as these young children grow into adolescents.

A few stakeholders and parents noted the importance of seeking out care and starting healthy habits from birth. While adolescent pregnancy is a significant risk factor for children and their mothers, most babies born in Boston are from adult mothers. As Figure 11 shows,
24% of babies born in 2007 were among mothers 25-29 years old and 39% were among mothers 30-34 years old.

**Figure 11. Boston Births by Maternal Age, 2007**

![Figure 11. Boston Births by Maternal Age, 2007](image)

A percentage of babies across Boston start out life with health risk factors. Approximately 10% are born low birth weight and preterm (Table 17), although there are geographic variations in these outcomes. Whereas Jamaica Plain had only 6% of babies born low birth weight and approximately 9% born preterm, Roxbury/Mission Hill had rates of 12% for low birth rate and 14% for preterm.

**Table 17. Birth Outcomes, Boston City-Wide and Target Neighborhood, 2007**

<table>
<thead>
<tr>
<th></th>
<th>Boston</th>
<th>Roxbury/Mission Hill</th>
<th>Fenway</th>
<th>Jamaica Plain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth weight</td>
<td>9.6%</td>
<td>12.3%</td>
<td>11.6%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Preterm births</td>
<td>10.7%</td>
<td>13.8%</td>
<td>10.1%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Infant Mortality (count)</td>
<td>N=134</td>
<td>n=22</td>
<td>&lt;5 total</td>
<td>&lt;5 total</td>
</tr>
</tbody>
</table>

There were also racial/ethnic differences in several risk factors related to pregnancy. While 8.2% of births in Boston were to mothers who received inadequate or no prenatal care, this percentage was much higher among Blacks (10.6%) and Asians (8.6%) than Latinos (7.7%) and Whites (6.2%). While 3.3% of births in Boston were among mothers with gestational diabetes, Asians encountered the highest rate of this condition. Smoking while pregnant is another major risk factor to the health of a child, and the proportion of births to White children was the highest for this risk factor (4.9%).

**Table 18. Health Risk Factors during Pregnancy, 2007**

<table>
<thead>
<tr>
<th></th>
<th>Boston</th>
<th>White</th>
<th>Black</th>
<th>Latino</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td>% births with inadequate or no prenatal care</td>
<td>8.2</td>
<td>6.2</td>
<td>10.6</td>
<td>7.7</td>
<td>8.6</td>
</tr>
<tr>
<td>% births among mothers with gestational diabetes</td>
<td>3.3</td>
<td>2.7</td>
<td>3.8</td>
<td>3.2</td>
<td>5.5</td>
</tr>
<tr>
<td>% births to mothers who smoked during pregnancy</td>
<td>3.7</td>
<td>4.9</td>
<td>3.4</td>
<td>3.2</td>
<td>1.2</td>
</tr>
</tbody>
</table>
Community Assets and Programs

Current Assets and Programs

"The organizations here are very informative; there are lots of flyers that communicate events and activities in the community." -Parent focus group participant, Jamaica Plain

"There are a lot of resources to help the community; for example, the CORI march was here to help people in my community to get jobs." -Youth focus group participant, Roxbury

While many of the stakeholders, parents, and youth mentioned challenges that their communities face—such as violence, poverty, and numerous health issues—participants across the focus groups and interviews also discussed the strengths and assets that exist. In many cases, stakeholders, parents, and youth could all name at least one organization in their community that was working on some of the critical health issues that were covered in the discussions.

A review of existing programs and services related to Children’s four priority health issues (obesity, asthma, mental health, and injury prevention) also reveals a plethora of organizations already working on these topics. Appendix F provides a detailed listing and description of each of these programs, which were identified through the stakeholder interviews, resident focus groups, and searches through web pages and organizational reports. This environmental scan reveals that obesity prevention is the health area where most of the community-based programming is focused. Some resources are offered on asthma and youth empowerment/mental health issues as well, but not nearly to the same degree as obesity. A mix of programming exists across Boston, with some developed to target specific neighborhoods, while others cater to Boston city-wide. Similarly, many of the programs are sponsored by individual community-based organizations, while large city agencies such as the Boston Public Health Commission also are involved in providing several programs and services. Roxbury and Jamaica Plain are the neighborhoods that house the most programs, while programs specific to Fenway appear to be limited.

One notable gap identified by the scan of current programming and services was the limited number of activities focusing on young children and “tweens”. Most of the programming available targeted teenagers, except for some obesity-prevention programs or asthma and injury prevention services that also focused on parents of young children. The dearth of programming for younger children and tweens was a theme also reiterated by parents.

Parents and youth in the focus groups cited the community-based organizations and health clinics in their neighborhood as being a positive source of information and services. Several parents of young children cited the Head Start program as being especially helpful for them. As Table 19 shows, there are 28 Head Start programs in Boston, 6 of which are early Head Start programs (focusing on 0-3 year olds). Of the 28 early or regular Head Start programs in the city, more than 20% are located in Roxbury/Mission Hill.
Table 19. Head Start Programs, by Priority Neighborhood

<table>
<thead>
<tr>
<th>Program</th>
<th>Boston</th>
<th>Roxbury/Mission Hill</th>
<th>Fenway</th>
<th>Jamaica Plain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Head Start</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Head Start</td>
<td>22</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Many stakeholders, parents, and youth also cited the health centers in their community as providing services they use, not surprising since there are 27 such health centers across Boston. While some focus group participants were not always happy with the wait or friendliness of front desk staff, they still used the community health center regularly for their primary care needs. They also named these centers as being important sources of health information and sponsors of prevention programming. The environmental scan in Appendix F shows that this is also the case, as numerous health centers do offer youth programs focusing on obesity prevention and asthma.

In addition to the community-based organizations in their neighborhoods, parents, youth, and stakeholders mentioned other facilities and establishments which are hubs of activity. Schools were seen as a trusted source of information by parents. For example, several parents in a focus group were actively involved in the Tobin School’s family center, where they could gather socially as well as receive information about services. Youth also trusted the health information they received in school, such as from the nurse. Youth and parents also mentioned that the strip of local businesses “on the main drag” provided an area that was a hub of activity. Information could be disseminated there, people could easily meet up, and customers could shop and feel happy to support local businesses. Parents, in particular, mentioned community centers in their neighborhoods as providing safe, reliable space for after-school and weekend programming and offering an array of services. Numerous parents and youth in the focus groups also commented that the health centers in their community are convenient and provide consistent care. While some participants preferred more time with their provider or that the front desk staff be more welcoming, they did note that the health centers in their community are conveniently located and are trusted sources of health information. Many participants would be eager to access educational services or health promotion programming sponsored by these health centers.

Numerous parents and stakeholders discussed that residents themselves are a significant asset of these communities. Intergenerational bonds, community cohesiveness, cultural diversity, and engagement in civic and religious organizations were all cited as being great strengths at the local level. Some parents noted that their communities may not be the wealthiest financially, but they make up for this in “cultural richness.” Parents and stakeholders indicated that neighbors look out for one another, serving as a protective factor against the violence and crime that sometimes seems pervasive. Additionally, many residents are active in neighborhood life, and they want to—and expect to—be engaged when any major new initiative is discussed for their residential area.

**Gaps in Programs and Services**

"People need more stuff to do. That’s why so many people are on the street. They need after-school programs. If I wasn’t involved in Sociedad Latina, then I’d probably not be doing much – I’d just be chilling and not doing anything. I think more programs would be helpful." -Youth focus group participant, Mission Hill

"There is a lack of after-school programs for children and adolescents, and parents often have to resort to putting their children either with a babysitter or in front of a
television after school. Teenagers would be less inclined to get into trouble if they had something to do after school.” -Parent focus group participant, Fenway

As noted previously, from the overview of current programming and services provided on obesity, asthma, mental health, and injury prevention located in Appendix F, few programs are specific to the Fenway neighborhood and most programs focus on adolescents. Young children, tweens, and their parents are not targeted by many of the services already in existence. Additionally, while many programs have numerous partnerships with other community organizations and medical institutions, it does not appear that staff from the many programs even within the same community talk to each other. This was a theme reiterated by parents and especially stakeholders: Numerous programs and services exist, but they are fragmented and not coordinated.

In the focus groups and interviews, stakeholders, parents, and youth discussed some of the gaps in the current landscape of programming and services in their community. Below are the key issues that emerged during these conversations, while Appendix G provides a more detailed list of the responses on this issue.

- **Lack of communication**: Limited communication and marketing of current programs; no single central disseminator cited
- **Reach of various target populations**: Limited health education/prevention programs that target specific populations such as immigrants, pre-teens or early adolescents (specifically ages 11-15 years old), and parents and youth together
- **System navigation**: Shortage of culturally and linguistically appropriate health promotion services; dearth of supports to help new and undocumented immigrants understand and access health and social services; limited or inconvenient interpreter services for medical appointments
- **Limited programs on specific topic areas**: A need for services for youth that specifically address safe sex practices, mental health issues, and healthy eating habits
- **Increasing access or minimizing barriers to programming**: Few free or inexpensive youth recreational facilities; insufficient availability of after-school programming; lack of affordable child care options for parents

Limited child care was a barrier cited by several parents when discussing whether they could access health-related programming and services in their community. For example, parents could not attend programs that were geared only for them if they could not find suitable care for their children during that time. Additionally, parents of multiple children who span the age range encountered similar barriers. A few parents mentioned that there were programs for parents and their teenagers which they were interested in attending together. But, these parents also had a young child and, therefore, could not attend the program because it was not appropriate to bring the young child nor was child care available for them.

Additionally, even when programs and services are available in their community, many parents and youth noted that they sometimes do not hear about them until after the fact. There is limited or inconsistent communication about these programs, and no central location or entity responsible for disseminating this information into the community.

Lastly, parents indicated that it was critical for programs and organizations to address the cultural needs of the community. In some cases, program sponsors seem to be setting the agenda without engaging the community first. Parents also noted that it was important that, even in the details, programs understand the clients they serve. One parent indicated that
she attended a nutritional cooking class in her community to learn about healthy lifestyle issues. The class was geared towards working class families, but she recounted that the healthy recipes suggested by the instructor involved ingredients that were unfamiliar to participants, not available in the neighborhood’s grocery stores, or too expensive.

Community Suggestions for Future Programs and Services

“Don’t assume that the community wants this program. You need to ask them.”  
-Youth focus group participant, Fenway

“People need to understand the culture and issues of the community, because people need to be comfortable and treated well.” -Parent focus group participant, Jamaica Plain

“Programs focused on prevention and education are needed; not just treating the illnesses but preventing them from happening.” –Parent focus group participant, Roxbury

“In a community with a high obesity rate, there should be a free community center with a weight program specifically to deal with obesity. It should offer a free workout with a child for an hour.” -Parent focus group participant, Mission Hill

“We need programs that educate but that are also fun and interactive for both parents and kids.” -Parent focus group participant, Roxbury

Community Engagement

Parents, youth, and stakeholders were asked for their suggestions on future health programming that was needed in their community. A few general themes emerged around the program planning process when discussed in focus groups and interviews. First and foremost, community members and stakeholders value transparency and community involvement in program development. Diversity and inclusion of community stakeholders continue to be of primary importance to community members. Youth participants’ comments illustrate this point: “Find out about the community – who’s there, what they need.” “You need to talk to people in the community. Make people a part of it.” “Talk to people in the community and see if they want to help start it, especially people who are respected in the community.” Parents expanded on these sentiments, sharing their resentment of funders “telling neighborhoods what needs to be done,” and adding that external stakeholders should only be brought in “after the community decides what needs to be done.” Stakeholders also reiterated this theme and stressed the importance of engaging community residents and an array of diverse gatekeepers from the beginning of the process.

Community members of all ages felt that linguistically and culturally appropriate programming approaches are critical. Youth and parents agreed that a range of community members should participate in program development including teens, families, teachers, local business owners, hospitals, community service organizations, and housing managers. Potential funding partners named by community residents included: hospitals, universities, private donors, foundations, and the Boston Red Sox.
Program Approaches

It should be noted that while parents and youth were interested in receiving more programming on health, many stakeholders noted that additional or new programming in these communities is not needed. Stakeholders mentioned that numerous organizations at the community level are already working on these issues, and the challenge is more related to lack of funding, coordination, and communication than anything else. They suggested more capacity building and professional development be given to staff, additional funding for scaling up existing programs, and a more coordinated effort across programs and organizations could help current efforts reach a larger audience.

When asked to describe how programs and services should be framed, parents desired dynamic program leaders who are experienced, knowledgeable about the community, and invested in programmatic goals. Parents further noted the importance of engaging role models for children. Youth elaborated that celebrities or athletes with roots in the community would attract participation and aid in promoting health messages. Adolescents further specified that using young spokespersons who have been affected by a particular health problem would be effective (e.g., young athletes who play sports while managing asthma). Teens also mentioned their desire for friends to participate. Another key theme among all participants was that programs need to be more affordable, preferably free of charge, to allow for greater access. The need for greater marketing and visibility of services was highlighted by all groups as well.

In terms of program characteristics, youth and parents described programs that offer active and educational components and involve parents. Both age groups requested programs that are fun and interactive with an emphasis on prevention. Parents suggested after-school and evening programming for children and teens, and shorter, more frequent sessions with after-hours options to allow working parents to participate. It was noted that broad geographic eligibility (not restricted to residents of a specific neighborhood), available childcare, food, and financial incentives were likely to enhance parental participation.

Specific Health Issues and Suggestions

Parents and adolescents focused on the need for more education about many of the health topics covered in the focus groups. Emphases in discussions were on teaching strategies for prevention/health promotion and increasing familiarity with warning signs and symptoms of conditions such as asthma. Some respondents felt strongly that parents and teens should be offered separate educational arenas, while others suggested components that bring parents and children together to increase communication and bonding. Selected health issues reflect community priorities, as described in the Community Health Profile section of this report, and include: obesity prevention, asthma, sexuality, and mental health.

Focus group participants provided some specific programmatic suggestions for services that focused on individual topic areas. Not all topics were covered in each of the focus groups, but overall some key recommendations from parents and youth emerged. These include:

**Obesity prevention programming suggestions:**
- Provide cooking classes for children and adults: Hands-on skill building, teach families to make healthy, culturally appropriate foods that look and taste good and are not expensive
- Provide culturally sensitive nutrition education: Label reading 101, teach families how to identify appealing healthy foods and choose healthy snacks
• Increase access to better foods at lower prices
• Increase access to free/affordable venues for exercise
• Offer sports/activity programs for youth alone or youth and parents together
• Partner with schools

**Asthma programming suggestions:**
• Educational programs that discuss the impact of asthma, risk factors, and prevention strategies
• Provide gym or fitness classes at a slower pace for asthmatics (adults and youth)
• Create fun activities for kids with asthma
• Facilitate access to medicines: price control, subsidies, advocacy with health insurers
• Provide a specialty asthma clinic that can be accessed without a referral and offers free care
• Offer a mobile asthma clinic/van that comes to the neighborhood on a set schedule
• Develop home-based environmental interventions to reduce asthma triggers, including home visitors that make changes within the home environment (e.g., rip up carpets)
• Create a Children’s-branded communication campaign on asthma prevention and management

**Sexual health programming suggestions:**
• Educate children at younger ages
• Train parents on how to talk to children of various ages about sex
• Provide targeted education about prevention of sexually transmitted infections to children/youth using visual aids and an affected spokesperson
• Create workshops for girls to bolster self-esteem and self respect
• Offer support and educational services for young parents

**Mental health programming suggestions:**
• Increase community access to and availability of mental health professionals
• Increase community access to and availability of neurology/child development services
• Offer screening and assessment for mental health conditions, learning disabilities, etc.
• Offer school, organizational, and medical staff training on recognizing depression and other mental health conditions among youth
• Expand trauma services at neighborhood health clinics

**Other specific recommendations:**
• Provide youth violence prevention interventions
• Partner with community service organizations to meet the basic needs of families
• Focus on chronic disease prevention: diabetes, hypertension
• Offer education and clinical services for oral health
• Start a mentoring program
• Resume the peer leadership program
• Partner with schools to provide health workshops for students, parents, and teachers on various health issues
• Help plan safe playgrounds
• Create employment opportunities for youth

**Preferred Health Communication and Information Sources**

Parents and youth were asked how they preferred to receive information about health topics as well as new programming and activities on these issues. Transmitting health information through schools was the most frequently chosen vehicle for communicating health facts or programming announcements to parents. Parents in particular desired that written materials
be sent home with students. One parent introduced the idea of utilizing automated telephone calls such as those used in her child’s school to disseminate information. Several parents agreed with this suggestion since they are used to receiving messages and updates from the school in that manner. Teachers and school nurses were also named by teens as trusted resources for health information. Some youth in the focus groups also noted that school-based clinics are helpful resources and good ways to disseminate health information.

Most parents and some youth also agreed that posting flyers in various locations—such as banks, grocery stores, light posts, recreation centers, and public transportation—would catch their eye. However, these would need to be areas where a lot of people congregate. Disseminating information through community-based organizations and agencies, as well as through health and faith based organizations, was also seen as a valuable channel by both parents and youth. Youth and parents suggested spreading the word about future programs through churches, youth-serving agencies (such as the ones hosting the focus groups), neighborhood health clinics, HeadStart programs, schools, and community centers.

When asked how they wanted to hear about health programming, most youth emphasized electronic communication as an effective way to reach local teens, specifically cell phones and the social networking websites Facebook and MySpace (equally) and Twitter. If their friends or a respected individual sent the links to them, they would be likely to sign up for a Facebook group related to the event or program. Parents in the focus groups indicated that Internet-based outreach methods would not be preferable for them.

Several parents and some youth would be interested in hearing about programs if they received the information by word-of-mouth from trusted sources. These sources included clergy, physicians, friends, family members, school administrators and teachers, and neighborhood leaders. A small minority of youth and parent focus group participants advocated for providing incentives and free promotional items as marketing devices. Notably, parents underscored the necessity of presenting information in Spanish and other languages to be as inclusive as possible to the diversity of area residents.

Parents and youth also indicated that they heard a lot about health through their local media. They suggested marketing programs, activities, or health messages through the following specific media outlets:

**Television:**
- BNN
- Local news, particularly piggybacking on the morning weather report
- Noticias Unvision, Nueva Inglaterra, for Spanish-speaking parents

**Newspapers:**
- The Metro – free paper at the T (most popular)
- Bay State Banner
- Boston Globe
- Boston Herald
- La Semana, El Mundo, for Spanish-speaking parents

**Radio:**
- 94.5, Kiss 108, for teens
- 680 WRKO, 94.7 magic 106.7, kiss 108, for parents
- 1600, 1200, 1430, 890 La Mega, for Spanish-speaking parents

**Transit:**
- Posters on the T trains and buses; at bus/T stops in the neighborhood;
- Advertisements on the outside of buses whose routes go through the neighborhood
Perceptions of Children’s and Sponsorship of Community Programs

“People respect Children’s – that would be a good thing if they were involved in neighborhood programs. I think people would bring their child to the program because people really know and respect the name.” -Youth focus group participant, Mission Hill

“Children’s should get out of their building and into our community. A very appropriate role for Children’s to play is in prevention.” -Parent focus group participant, Roxbury

“I’d attend a program more if it’s sponsored by Children’s because you know their reputation. Children’s has to be good for the kids.” -Parent focus group participant, Mission Hill

“These external community participants like Children’s should only be brought in after the community has come together to decide what needs to be done within our communities. We resent the notion that funding partners would tell us what needs to be done in our neighborhoods.” -Parent focus group participant, Fenway

Perceived Strengths

Stakeholders, parents, and youth were asked about their perceptions of Children’s Hospital Boston and their efforts in the community. Hardly any individuals, except for a few stakeholders whose organizations are already Children’s partners, knew about the OCA office or its community programming. However, stakeholders, parents, and youth were generally positive when talking about Children’s overall. Children’s has an excellent reputation among community residents and stakeholders alike. Parents and youth praised the hospital’s clinical expertise, caring staff, customer service, and colorful welcoming environment. Parents trust Children’s to care for their children and particularly commended the social work department, Halloween parties and generous Christmas gifts. Some parents recounted times when they needed to bring their children to the hospital for care and noted the quality of care they received was exceptional.

Stakeholders commended Children’s specialized care, depth of clinical services, collaborative spirit, and presence in and long-term commitment to the community. They further described Children’s as a respected, innovative, well-funded institution with great intentions, strong influence, and brand recognition. A few stakeholders singled out Children’s work with children with ADHD and those with special needs, as exceptional. Some felt that Children’s was passionate, sensitive, and inclusive when working with the community, “providing access to resources that otherwise wouldn’t be there.” The summer jobs program was noted to be a strong success. Children’s partnerships with the Martha Eliot Community Health Center and other community organizations were also viewed in a positive light among those who knew about them.

Perceived Challenges

There was a range of opinions among stakeholders regarding how well Children’s has been meeting the community’s needs. Some were supportive and complimentary; others remarked that the needs of these communities were too great for any one institution to successfully address. Others believed that Children’s efforts fell short and suggested: expanding community partnerships, investing additional capital, widening the catchment area, and inviting community input in the planning, development, and sustainability of the
programs. One particular grievance was a perception that Children’s has “not dealt well with communities of color” (e.g. particularly, a cultural mismatch between staff and clients at Martha Eliot Community Health Center).

Some stakeholders shared the view that sometimes Children’s can be seen as paternalistic and unacquainted with community needs. These individuals stressed the importance of using an inclusive, participatory approach from the very beginning. One person remarked: “At times it has felt like there were limited opportunities for input in the design of the programs.” Another suggested that Children’s focuses on understanding and enhancing existing community programs, stating that “sometimes the needs of these agencies fall through the cracks and there isn’t a place for their voices to be heard.” Another related a feeling of mistrust of the community research that is conducted, while one individual expressed the hope that this current assessment study “really leads to Children’s asking ‘what can we do better or more of?’ rather than justifying what they are already planning to do.” There was a strong desire among stakeholders to build authentic connections between community organizations and Children’s, and many stakeholders were interested in their organizations being a part of this process.

The majority of parents, youth, and stakeholders were unfamiliar with Children’s specific community initiatives. Participants suggested that Children’s focus on outreach to increase visibility of the office and their specific programs. Other challenges identified were: inadequate diversity at management levels and access barriers (services that “do not reach people who need it most.”). One stakeholder remarked that Children’s community programs were “not really based on what they do best [providing health care],” while another felt they were too clinically focused.

Clinically, community residents noted a few key areas of Children’s that seem to be challenging, particularly the long waiting periods in the emergency department and the dental department’s approach which was described as “not very kid-friendly.” Stakeholders indicated that Children’s could improve connections to primary care, linkages between specialties, care coordination, application of the medical home model, and integration of children with disabilities as well as should expand availability of its pediatric mental health services.

Program Sponsorship

While a few participants discounted the importance of the sponsor of programming in their community, parents and youth were uniformly receptive to program sponsorship by Children’s, noting its excellent reputation and credibility. Nearly all participants said that they did not care who the sponsor was or that they would be more likely to be involved in a program if it were sponsored by Children’s. None indicated that that they would be less likely to attend because of Children’s involvement. Notably, parents expressed a desire to be involved in the decision-making processes at all steps of program development, while teens suggested that collaborations with other large hospitals or local health service organizations would be advantageous.

Best Practices of Community-Based Programs

Studies and reports describing successful community-based programs in the areas of youth obesity, asthma, mental health, and injury prevention were reviewed for this report in order to identify their programmatic approaches, best practices, and challenges encountered. A description of each of the programs and their key findings/lessons learned can be found in Appendix H. These programs all took place in urban settings with similar audiences or client
bases to Children’s. Programs were identified that were community-based, open to a wide range of individuals, and focused on prevention or management of these specific conditions.

While each program is different, common findings, best practices, and lessons learned emerged across the various studies on all these health topics. Key themes that were consistent across all studies include the following:

- **Programs were most successful when a trained community resident led the activities or provided the information.** The utilization of lay health workers, parents, or other local informational gatekeepers for youth was a key component of programs that saw successful outcomes and high participation rates. Who the information disseminators or activity leaders are could vary, but the important aspect was that these individuals lived in the community, were known to youth, and were trained in health education by program planners. When program planners used their own staff or hospital personnel as information disseminators, program retention rates dropped.

- **Community engagement is critical throughout the process, especially during the program development phase.** Several asthma and obesity-related studies noted that engaging active community members as well as potential end users of the program from the very beginning helps with program effectiveness. Having community input during the development of the program can help ensure that it is addressing community needs, is culturally competent, and has buy-in from key audiences. Also, employing a community-based participatory research approach when collecting evaluation data further empowers participants.

- **It is important for programmatic approaches to be sensitive to cultural and social norms.** Along with engaging the community, many programs that saw success specifically addressed the cultural values and norms of the specific population in the community. Whether it was addressing religious beliefs, offering bilingual materials, focusing on activities or foods that are culturally acceptable, or supporting parent-child interaction, several programs incorporated strong cultural or community norms into their approaches. End users reacted positively to these strategies, and evaluation results showed success in their outcomes.

- **Addressing the numerous factors that affect a particular health outcome by using a comprehensive approach treats health in a more holistic way.** Several programs acknowledge that these health issues do not occur in a vacuum. Mental health factors intersect with childhood obesity; financial constraints and housing issues affect asthma; cultural beliefs have an impact on injury prevention practices; job opportunities affect community violence rates. Several successful programs across these multiple health issues took into account parents’ and adolescents’ cultural, social, economic, and medical needs when developing health interventions. A few of these programs aimed to address some of the larger underlying issues related to these conditions or at least deal with their peripheral factors.

**RECOMMENDATIONS ON STRATEGIC DIRECTIONS**

This research has identified a number of key themes and perspectives related to the health concerns in Children’s priority communities, strengths and gaps in current programming and services, suggestions for future programming, and Children’s current and future role in the community. As Children’s moves forward in its strategic and program planning process, it will be important to consider its growing role in the community and the most effective way to provide coordinated care at the community level. This process should also recognize that
Children’s is currently involved in a number of community programs and focuses its community health efforts around the issues of asthma, mental health, obesity, and injury prevention - the areas identified in the last community health needs assessment as the most pressing health concerns for Boston children and families. Current Children’s community programming includes, but is not limited to, the following:

- **The Community Asthma Initiative** improves the quality of life for children with asthma living in Jamaica Plain, Roxbury and Dorchester by offering one on one case management and home visits, educational training, and support as well as advocacy initiatives.

- **Children’s Hospital Neighborhood Partnerships (CHNP)** provides mental health services in 15 Boston schools and 5 community health centers. A 30 member CHNP team of social workers, psychologists, psychiatrics, researchers, and educators provide culturally appropriate services with an emphasis on prevention along with intervention efforts and consultation and trainings for school staff.

- **Children’s Martha Eliot Health Center (MEHC),** located in Jamaica Plain, not only provides health services but also programs that help improve children’s school performance, teach families about how to prepare nutritious foods, and support victims of trauma and violence.

- **Through the hospital’s Fitness in the City Program,** Children’s provides support to 11 Boston community health centers for their efforts to reduce health disparities by providing culturally appropriate obesity prevention and management programs.

Future outreach into the community will build upon Children’s expertise to continue work on these issue areas. The following discussion elaborates on some key issues based on the assessment research findings that Children’s may want to consider in this process as well as recommendations on strategic directions for Children’s related to roles, programming, and partnerships.

**Key Issues to Consider**

- **Children’s is not currently perceived as taking a strong leadership role in the community.** Across all the focus groups and interviews conducted, Children’s was seen as providing strong clinical care in the Longwood Medical Area. The institution was known for its top medical services, but few stakeholders or residents knew of its community health programming. The institution was not seen as a strong or active leader on the ground, in the community. While Children’s may already be engaged in numerous activities with specific organizations in their priority neighborhoods, these efforts were not known by many nor was Children’s seen as an active community partner.

- **Engaging stakeholders and community members from the very beginning will be critical.** One theme that emerged throughout the focus groups and interviews was that parents, youth, community leaders, and organizational staff want to—and expect to—be involved in program planning from the very beginning. Some stakeholders and parents noted that Children’s can sometimes be viewed as paternalistic at the community level. It will be critical to engage community groups across a range of sectors from the inception of the program planning process. Stakeholders and residents desire a sense of ownership over large programs and initiatives, and, without their support and buy-in, programs will not be successful. Additionally, community engagement from the inception will help ensure that approaches, messages, and materials will be culturally appropriate.
• Many organizations and agencies are already working on these same issues, and they may be concerned about competition and duplication.

It will be critical for Children’s to be sensitive to the work that is already being conducted by numerous organizations in these communities. With the current lack of coordination of these efforts, it may be easy to duplicate already existing activities. Groups may also be concerned about competition for clients and funding. Current programs may not be able to continue if their client pool is lured to another initiative. Similarly, with the current economic downturn, funding is even scarcer for community-based organizations. Adding similar programs in the same area will only make applying for funding more difficult for these entities. Opportunities for coordination and partnerships exist to minimize duplication and competition, and many organizations seem open to this. However, it will be important to approach that role with sensitivity.

• Although numerous services exist, they are still not reaching many populations who need them the most due to fragmentation and lack of communication.

One key issue that emerged out of the stakeholder interviews was that current programming is fragmented, and organizations are not coordinated with each other. This causes duplication of efforts, problems with communication to end users, and many potential participants falling through the cracks. While several health programs exist in these communities, parents and youth in the focus groups emphasized that many people are not being reached and additional services are needed. Lack of coordination among efforts, limited communication and marketing, and barriers to program utilization among residents are all significant challenges to reaching the populations that still need services. Many current programs do not address many of the issues that make it difficult for residents to access programs even when they do hear about them. These issues include lack of child care, language/cultural barriers, inconvenient locations and times, and eligibility restrictions (e.g., must have a child of a specific age; must live in a certain geographic area).

• Health is not always treated in a comprehensive manner.

All of the health issues discussed in the focus groups and interviews are complex, multi-faceted, and greatly impacted by larger social, economic, and cultural factors. While medical services are available for direct care of these issues, one theme that emerged was that programs and services need to approach these health concerns in a holistic, comprehensive manner. For example, parents discussed that when they have a child with asthma, they need to go to the asthma clinic for direct medical care, the schools or community centers to find out about appropriate fitness services for their children, a public health agency to discuss environmental triggers and availability of home inspections, and the housing management company to ask for their carpets to be ripped up. Not only are all these services not coordinated with each other, but they also are not dealing with the larger upstream social and economic factors that impact asthma prevention and management in families and communities. Addressing the multiple domains that affect health across multiple levels of influence will be critical in providing coordinated care and services within the community.

Potential Strategic Directions for Children’s Community Efforts

Based on the research findings from this assessment study, HRiA proposes a number of strategic directions which Children’s may want to consider. These recommendations focus on Children’s role in the community and the way its community benefits office may want to approach future initiatives. It will be critical for Children’s to take into account the issues outlined above (in Key Issues to Consider) which can be integrated into each of the approaches and strategic directions discussed in the following section.
• **Increasing communication and visibility of Children’s efforts in the community.**

While Children’s already is working on several initiatives in the community and partnering with numerous community-based organizations, the stakeholders and parents involved in this research effort knew little about Children’s community work by OCA. While Children’s as an institution was known as providing sophisticated clinical care, Children’s community-based work was virtually unknown, except by a few stakeholders who work for organizations who are already partners with Children’s.

For Children’s to take on any new successful initiative or to scale up existing programs, it will be critical for the institution to be seen as an active player in the community. Increased communication and marketing around Children’s current community efforts to a wide range of stakeholders and residents and building in an intense marketing plan for any new initiative will be important for Children’s to be considered an active, known partner at the community level.

Some specific examples for this approach would include:

- Partner with community-based organizations to develop more intense marketing and communication strategies for existing and future efforts that are targeted to specific communities.
- Develop more branded programs and campaigns. Individual initiatives can have their own brand that can be recognizable and attention-grabbing, but initiatives should also be linked to the larger Children’s brand to ensure consistency and the initiative’s connection to the institution.
- Build stronger relationships with staff and directors from organizations across multiple sectors (e.g., housing, economic and community development, government, schools). Stakeholders from a range of agencies were open and eager to work with Children’s and strengthen their current ties to the organization. Many did not know what work Children’s was currently doing; relationships can be strengthened with staff from these organizations, who can also serve as disseminators of information about Children’s to their own partners and clients.
- Sponsor summits, conferences, and trainings within these communities for organizational staff. These events can be Children’s-branded and should be held in locations within the priority neighborhoods. Events can serve different purposes, depending on what seems appropriate for Children’s role. For example, conferences and training sessions can serve as an opportunity for Children’s to disseminate its expertise to community-based organizations and provide professional development and skill-building sessions for staff. On the other hand, summits can offer the opportunity for Children’s to serve as coordinator/convener (discussed in more detail below) and allow organizations to focus on specific issue areas, conduct strategic planning sessions, and network with like-minded individuals.

Potential partners to help in the area of increased communication and marketing strategies are similar to those discussed in other recommendations. These would include staff from a range of sectors and organizations, such as:

- Community-based organizations (e.g., Jamaica Plain Tree of Life/Arbol del Vida; Hyde Square Task Force)
- Housing, resident, and management companies (e.g., Mission Main Tenants Association)
- Youth-serving agencies (e.g., Head Start programs)
- Schools (e.g., nursing and wellness coordinators at Boston Public Schools)
Children’s Hospital Boston, Community Assessment Study – Dec. 2009
Submitted by Health Resources in Action

- Community health centers (e.g., Shelbourne Health Center; Dimock Health Center)

Example effort:
Numerous stakeholders that were interviewed for this study did not know about Children’s community outreach efforts. An intense relationship-building effort by OCA staff with directors from local organizations could help improve Children’s visibility through a more personal touch than larger branded campaigns. Setting up brown bag lunches for neighborhood organizational staff, small leadership retreats for organizational directors, and one-on-one meetings with staff and leaders from a variety of agencies and organizations who do not typically partner with Children’s—particularly community development corporations, schools, and community centers—can help promote a dialogue between these entities and Children’s. Children’s staff can use these opportunities to hear about the strategic directions and programming of these organizations and can inform them about Children’s outreach activities. These sessions can open up a dialogue, help with marketing, and serve as a brainstorming opportunity about potential partnerships in the future.

- **Being a leader in advocating a systems approach.**

One key theme that emerged from this research was that the health issues that many community members and youth are encountering are complex and impacted by a number of upstream social, economic, and cultural factors. Research participants recognized that Children’s provides excellent clinical care to individual patients, and some stakeholders knew that it is involved in programming in the community. However, both of these approaches do not address the larger factors that influence population health on a grander scale.

While Children’s may already be working to advocate for changes in several health policies, these activities were not well known at the community level. In addition to increasing communication about Children’s existing efforts in this area, it may help to engage partners at the community level to help move the agendas forward to impact the upstream factors that impact population health. Developing strong partnerships with decision-makers and active leaders in the community can help build a more grassroots movement to push policies, practices, and regulations forward at the neighborhood, city, and state level. Some areas in which Children’s want to focus are:

- **The built environment.** A neighborhood’s current infrastructure has a major impact on health. Adequate lighting on streets, well-maintained playgrounds, usable sidewalks, and open, green space are just a few areas of the built environment that can affect area rates of physical activity, asthma, and violence. Increasing access to healthy foods and safe, recreational spaces can make a much larger impact on neighborhood health than smaller, individualized programs. Children’s can continue its work on the city and state level as well as further engage neighborhood adults and youth to aid in advocacy efforts in the community to ensure that the built environment promotes a healthy environment.

- **Healthy homes model.** Several health groups in the area (e.g., Boston Urban Asthma Coalition) are moving towards applying a healthy homes model in their work to decrease environmental triggers of several health issues among children. The healthy homes model engages numerous partners (e.g., housing agencies, health organizations, tenant groups, business community) to address home-related health issues more comprehensively. Strategies aim to educate tenants and landlords and address issues of second-hand smoke, mold, lead, and pest management simultaneously. Children’s has an opportunity to offer its clinical
expertise in asthma and other conditions as well as partner with existing organizations to help bolster these strategies at the local level.

- Regulations/policies. As in the issues addressed above, while Children’s is already working with policy-makers at the state and city level, it may be helpful to engage community members and youth in neighborhoods to bolster grass-roots support for health policy change. If policymakers hear and see advocacy efforts from community residents on potential policies such as food stamp policies or taxes on junk food, it may help move the agenda forward. Children’s prestige can aid smaller, local efforts with visibility, funding, and marketing.

- Potential partners in these areas could include:
  - Local organizations focusing on grass-roots advocacy with adults and youth (e.g., Fenway Civic Association, Hyde Square Task Force, Sociedad Latina)
  - Policy makers/legislators (e.g., Boston city council)
  - Business community (e.g., small business associations)
  - Health payors (e.g., Blue Cross Blue Shield)
  - City planners (e.g., Boston Redevelopment Authority)
  - Housing agencies (e.g., Boston Housing Authority)
  - Community coalitions (e.g., Boston Urban Asthma Coalition; Asthma Regional Council)
  - Academic institutions (e.g., Northeastern University Institute on Urban Health Research)

Example effort:
A number of community-based organizations promote grass-roots advocacy efforts. For example, the youth-serving agency in Mission Hill, Sociedad Latina, works with youth leaders to get them involved in identifying priority health issues in their community and helps them develop action steps towards making social change in these areas. One project has involved youth leaders conducting small-scale assessments of the advertising of junk food, alcohol, and tobacco products in their neighborhood in corner stores and billboards. Youth have collected information on the breadth of this type of advertising and have presented their findings at city council meetings to advocate for more regulation and oversight. This is one example of a community-based organization that not only promotes youth leadership but also encourages grass-roots advocacy on many of Children’s priority health issues. Strengthening partnerships with organizations such as Sociedad Latina would help Children’s engage the community and tackle these health issues through policy efforts at the local level.

- Serving as community convener and supporter.
Numerous stakeholders repeatedly mentioned that these neighborhoods already have several existing programs focusing on these health issues. However, many of these programs are fragmented, uncoordinated, and under-funded. This situation provides an opportunity for Children’s to serve as an active convener, coordinator, and strategic planner to help support and bolster existing programs. It also allows Children’s to make a larger impact on these health issues by employing a more strategic approach rather than focusing on specific individual programs in neighborhood pockets.

It should be noted that many stakeholders said that they would welcome this role for Children’s, but that it would need to be approached with sensitivity. It was seen that Children’s community programming could provide training, professional development, strategic planning, and coordinating expertise, but that the institution would need to be perceived as an active, equal partner in these efforts. Community-based organizations wanted to come to a consensus together on how best to coordinate these efforts, with
Children’s helping these strategies become a reality. They did not want Children’s to be driving the agenda. With this approach in mind, a great opportunity exists for Children’s to help area organizations bolster their efforts to ensure that they are not duplicating programs among each other, that they are reaching the population segments most in need, and are coordinating communication, marketing, and programmatic approaches with each other.

Ways in which Children’s can provide support for these efforts include:

- Collaborating with organizations to develop a broad framework for current and future programs. Children’s can provide the strategic planning and research expertise to aid organizations with developing a broad framework that can help guide them in current and future efforts. By working within the same larger framework, organizations can be more coordinated and minimize duplication. This framework would need to be developed using a participatory approach with all area organizations. Children’s can guide this effort by providing expertise, offering meeting funds, and serving as an objective convener/facilitator. It will be important to ensure that the key players on these issues are invited to any next steps in this process. A number of organizations are already working on these specific topics at the community level. Some of these key organizations include, but are not limited to:
  - Obesity prevention: Boston Public Health Commission, Action for Boston Community Development (ABCD), Boston Collaborative for Food and Fitness, Sociedad Latina, Bikes Not Bombs, Mission Hill Health Movement, Boston Youth Sports Network, health centers such as Dimock Health Center
  - Childhood asthma: Boston Urban Asthma Coalition, Boston Asthma Initiative, Committee for Boston Public Housing (coalition of numerous organizations interested in the issue), Boston Housing Authority
  - Mental health and youth empowerment: Hyde Square Task Force, Jamaica Plain Tree of Life Coalition, Boys and Girls Clubs, Massachusetts Society for the Prevention of Cruelty to Children, health centers such as Martha Eliot Health Center, Project RIGHT, Youth Development Network, Family Services of Greater Boston, YMCAs

- Integrating non-health agencies into the conversation. When discussing a larger, coordinating framework for area organizations to tackle specific health issues, it will be important to include non-health agencies at the table. Housing agencies, economic development organizations, and schools either work with the same clients or are involved in issues that have a direct or indirect impact on neighborhood health. Integrating these organizations into initiatives and discussions at the very beginning will help in promoting a more coordinated approach.
  - Organizations that have not been as involved in larger community health programming but will be important to engage in future conversations include: schools (both at the district level and specific schools), housing and tenant organizations (e.g., Mission Main Tenant Task Force), religious organizations, academic researchers involved in community-based research (e.g., Northeastern’s Center for Community Health Education and Research), economic and community development agencies (e.g., Fenway Community Development Corporation), and the small business community.
Providing staff training. As discussed previously as part of a larger communication strategy, many organizations are eager for additional staff training and professional development led by Children’s. While this effort can help with Children’s marketing in the community, it also provides a needed service for local organizations. These community-based agencies are stretched with lack of funds and personnel. Many staff need to take on several roles, so they are eager to receive additional training when possible, particularly when it is free of charge.

Leveraging funds and resources. Children’s was viewed as a prestigious, wealthy institution that could help smaller community-based organizations secure additional funds for its current programming. Whether it is Children’s dispersing the funds itself or lending its name as an active partner for organizations to use with external funding sources, local organizations and agencies were hoping that strengthened relationships with Children’s would help them gain additional funds to continue or expand programming and personnel.

Scaling up existing successful programs. Through additional funding, more coordinated efforts, and greater staff capacity, Children’s can aid current organizations in scaling up existing programs that are already achieving success with a small client base or within a specific geographic area. Children’s can help bolster these efforts by bringing on additional partners, leveraging funds, expanding programmatic reach, and adding greater name recognition in marketing efforts.

There are numerous potential partners that could be involved in these efforts. Many of the stakeholders interviewed indicated that they would be interested in future partnerships with Children’s and saw it as important that the institution strengthen its relationship with a range of agencies. Some potential partners in coordinating future efforts could include:

- Economic development organizations (e.g., Jamaica Plain Neighborhood Development Corporation)
- Health centers (e.g., Martha Eliot Health Center)
- Youth-serving agencies (e.g., Head Start Program, Project RIGHT)
- Health coalitions (e.g., Boston Urban Asthma Coalition, Jamaica Plain Tree of Life/Arbol del Vida)
- Schools (e.g., individual schools as well as administrators at the district level)
- Housing agencies and management companies (e.g., Boston Housing Authority, Academy Homes)

Example effort:
While coordinating and convening activities should involve an array of community-based organizations, one example of this type of effort on a smaller scale is to partner with the Massachusetts League of Community Health Centers. Throughout the qualitative research, stakeholders and parents repeatedly mentioned the importance of Children’s working with community health centers, namely Dimock Health Center, Whittier Street Health Center, and Martha Eliot Health Center. While efforts to engage the Executive Director and programming staff at each of these specific centers will be important, a more strategic role might be for Children’s to develop a stronger partnership with the overarching Massachusetts League of Community Health Centers. Through this partnership, Children’s can work together with the League to convene staff from area health centers, provide technical assistance on health promotion and prevention, offer trainings and staff development workshops, help disseminate best practices, and coordinate with center leaders on how community programming can be consistently developed and expanded through the health centers in Children’s priority neighborhoods.
• **Providing needed health promotion and educational programming.**

While many stakeholders recommended that Children’s not provide new programming in these neighborhoods since so many organizations are already involved in these issues, parents and youth noted that they saw a role for additional efforts. Clearly, current programming is not always reaching all segments of the population, particularly those most vulnerable to certain health issues and those least active within their communities. At this point, it does not necessarily seem appropriate for Children’s to create entirely new programs to combat these issues because of the plethora of current agencies. However, scaling up existing programs to reach a larger client base or developing supplementary activities to current efforts may be helpful.

Some specific examples of the topics, strategies, and approaches in which Children’s might want to consider becoming involved include the following:

- Focusing on prevention activities related to obesity/physical/nutrition, youth violence, sexual health and self-esteem, and asthma management
- Providing safe, fun after-school activities for youth in these areas, which could include
  - Cooking classes to discuss healthy eating and which provides information and recipes that are culturally sensitive and financially appropriate for the audience
  - Peer mediation programs to discuss positive coping and anger management strategies to prevent youth violence
  - Programs for young girls on self esteem and pregnancy prevention strategies (including honest sexual health information)
  - Fitness classes for non-athletes which focuses on making activity fun and interactive
  - Educational classes for young parents on parenting strategies as well as providing financial and other life-skills information
  - Mentoring and jobs-skills training for youth to prepare them better for employment after school
- Incorporating community role models into program activities. Spokespeople could include those who are considered successful in the neighborhood, such as local athletes or business owners. Other spokespeople could include community members who have overcome the specific health issues, such as residents who have lost weight, athletes who manage their asthma, and former gang members who have reformed their violent ways.
- Supporting the family-child dynamic by promoting family togetherness and communication. There was a desire from parents that some future programs encourage parents and children to attend together to foster communication about these important issues. On the other hand, some parents also were interested in parent-only programming that helped parents learn the information and communication skills to talk to their children about sensitive topics such as sexual health.
- Focus programming on younger children and tweens. While adolescents in the focus groups were eager to be involved in new programs, parents noted that there was a dearth of activities for younger children and pre-adolescents. The environmental scan also demonstrated that fewer programs, particularly in the area of obesity prevention and mental health, target younger children. Elementary and middle school years are critical times for children to develop positive lifestyle habits and skills, and there is an opening in the programming environment to reach children at this age.
Expanding current clinical and educational services into the community. In addition to prevention programs, parents and stakeholders expressed a need for additional clinical services related to these specific health issues to be more widely available in the community. Specifically, providing home-based environmental interventions (including home visitors) to reduce asthma triggers, offering a mobile asthma van that comes to the neighborhood, and providing more trauma and mental health services at neighborhood clinics and schools were strategies named that would fill a current need. In particular, it will be important for staff for these expanded services to reflect the racial, ethnic, and linguistic diversity of the populations they serve.

Potential partners in these activities could include:
- Schools (e.g., Tobin School in Mission Hill)
- Health centers (e.g., Martha Eliot Health Center, Dimock Health Center)
- Youth serving agencies (e.g., YMCA, Sociedad Latina, Hyde Square Task Force, United Way)
- Community centers (e.g., Mission Hill Community Center)
- Government agencies (e.g., Boston Public Health Commission)
- Community organizations (e.g., Bikes not Bombs, My Town)
- Community coalitions (e.g., Boston Collaborative for Food and Fitness)

Example effort:
Parents and youth both indicated that schools are an important establishment in their lives. When discussing needed programs, many mentioned after-school programming as an important component of prevention efforts. Having Children’s engage schools to help develop or expand programs will be critical in these types of initiatives. There are several ways in which Children’s can accomplish this. One opportunity would be to work with administrators at the district level of Boston Public Schools. This would include the BPS Wellness Coordinator, the BPS Director of Health Services, BPS Director of Food and Nutrition Services, as well as academic administrators. Developing partnerships with these departments can help establish district-wide initiatives in which Children’s can be a part. This approach could lead to a more coordinated, comprehensive effort across the division and also promote more consistent and widespread health information dissemination. Efforts could include how Children’s could assist in incorporating health messages within the classroom and in the cafeteria, providing staff and teacher training on best practices and disease prevention issues, and developing after-school activities on specific topics that also are complementary to what students are learning during the school day. However, there may also be some schools within Children’s priority neighborhoods, such as Frederick Middle School in Roxbury or Tobin School in Mission Hill, that are especially open to developing or expanding specific programs within their facility. In this case, Children’s may want to consider reaching out to the principal or school nurse of that specific school to discuss how to promote wellness activities within the school day or develop health programs on specific topics after-school.

Conclusion

While Boston city-wide and the specific neighborhoods of Roxbury, Mission Hill, Fenway, and Jamaica Plain have numerous health concerns and challenges that they are encountering, they also are areas full of cultural richness, community cohesiveness, and a network of organizations and agencies that are passionately trying to serve their residents. However, some health problems are pervasive, and current programs and initiatives are not always reaching the populations most in need. Children’s Hospital Boston is viewed as providing extraordinary clinical care, but is less known for its community-based efforts. Children’s is
poised to take a leadership role in future initiatives, as stakeholders, parents, and youth view it as a credible, trustworthy institution that cares for children and families. It will be critical for Children’s community benefits office to increase its visibility and name recognition around its community health work and build off of the strong assets (e.g., current organizations and programs; active residents who desire a sense of ownership) already in existence in these communities. It is recommended that Children’s look beyond developing specific, individual programs and address these important health issues using a long-term, coordinated, strategic approach by engaging and partnering with organizations, agencies, and community residents early on in the strategic planning process.
## APPENDICES

### Appendix A. List of Stakeholder Interviewees

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<tr>
<th>Name</th>
<th>Title/Role</th>
<th>Organization/Institution</th>
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<tbody>
<tr>
<td>Deborah Allen, ScD</td>
<td>Director</td>
<td>Bureau of Child, Adolescent &amp; Family Health, Boston Public Health Commission</td>
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<tr>
<td>Ed Barnes</td>
<td>Summer Jobs Program</td>
<td>City of Boston</td>
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<tr>
<td>Jill Carter</td>
<td>Wellness Coordinator</td>
<td>Boston Public Schools</td>
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<tr>
<td>Yi-Chin Chen</td>
<td>Director of Life Long Learning &amp; Economic Development</td>
<td>Hyde Square Task Force</td>
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<tr>
<td>B. Susan Fencer</td>
<td>Acting Assistant Director, Health Services</td>
<td>Boston Public Schools</td>
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<tr>
<td>Ralph Fuccillo</td>
<td>President</td>
<td>DentaQuest Foundation</td>
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<tr>
<td>Daphne Griffin</td>
<td>Executive Director</td>
<td>Boston Centers for Youth and Families</td>
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<tr>
<td>Alex Lawrence</td>
<td>Parker Hill/Fenway Neighborhood Service Center</td>
<td>Action for Boston Community Development</td>
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<tr>
<td>Myechia Minter-Jordan, MD</td>
<td>Medical Director</td>
<td>Dimock Health Center</td>
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<td>Dinanyili Paulino-Rodriguez</td>
<td>Associate Director</td>
<td>Sociedad Latina</td>
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<tr>
<td>Lindsay Rosenfeld, ScD, SM</td>
<td>Associate Research Scientist</td>
<td>Institute on Urban Health Research</td>
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## Appendix B. Interview Guide

Health Resources in Action  
Children’s Hospital Assessment Study  
Stakeholder Interview Guide

### Goals of the interviews:
- To identify the met and unmet health needs in CHB’s priority communities
- To gain an understanding of current programming around CHB’s priority health issues
- To identify opportunities for partnerships with area organizations

**[NOTE: THE QUESTIONS IN THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.]**

### I. BACKGROUND (3 minutes)

- **Hello. My name is __________, and I am a researcher with Health Resources in Action, a non-profit public health organization in Boston. Thank you for speaking with me today.**

- **We have been hired by Children’s Hospital Boston for this project. Children’s Hospital is undertaking a comprehensive community assessment effort to gain a greater understanding of the health issues of Boston families and its specific neighborhoods, how those needs are currently being addressed, and whether there might be opportunities for Children’s Hospital to address these issues in the community by providing programs and services. For this assessment, Children’s Hospital is looking to engage a range of stakeholders involved in children’s health and social issues across Boston. In addition, we also will be talking to parents and youth from a number of different neighborhoods to get their perspective on these issues and identify the health concerns in their communities.**

- **The information you provide is a valuable part of this assessment as we try to understand community strengths and needs related to children’s health. Your feedback today will help Children’s Hospital in identifying priority issues for future programming, services, and partnerships.**

- **Our interview will last about 25-30 minutes. Interviews like this one are being conducted with a range of individuals, from health organization staff to community leaders to child care providers to religious leaders, just to name a few.**

- **After all of the interviews are done, we will be writing a summary report of the general opinions that have come up. This report will help guide us in developing recommendations for the community benefits program at Children’s Hospital. In our report, we are going to write about the general themes that came up in the interviews. We will not include any names or identifying information. All names and responses will remain confidential. Nothing sensitive that you say here will be connected to directly to you in our report.**

**[CORE QUESTIONS FOLLOW; ADDITIONAL QUESTIONS MAY BE ADDED OR TAILORED TO MEET THE SPECIFIC POSITION/ROLE OF THE INTERVIEWEE]**
II. THEIR ORGANIZATION/AGENCY (5-10 minutes)

1. Can you tell me a bit about your organization/agency?
   a. What type of programs/services do you provide? What communities or neighborhoods do you work in?
   b. Who are the main clients/audiences for your programs? [PROBE: AGE, SOCIOECONOMIC STATUS, RACE/ETHNICITY]
   c. How long has your organization been working in [SPECIFIC NEIGHBORHOOD OR COMMUNITY]?
      i. What are some of the biggest challenges your organization faces in providing these programs/services in the community?
   d. Do you currently partner with any other organizations or institutions in any of your programs/services? [PROBE ON WHICH ORGANIZATIONS; FOR HOW LONG THEY HAVE PARTNERED, ETC.]
      i. Has your organization ever partnered with Children’s Hospital before? [IF SO, PROBE IN WHAT CAPACITY/PROGRAM]

III. COMMUNITY ISSUES (10-15 minutes)

2. How would you describe the community/neighborhood which your organization serves?
   a. What do you consider to be the community’s strongest assets/strengths?
      i. What are some of its biggest problems/concerns?
         1. What are some of the biggest stressors or challenges that families in this community face today?
   b. What do you think are the most pressing health concerns in the community?
      i. Who do you consider to be the populations in the community most vulnerable to these issues?
   c. What do you think are the most pressing health concerns in the community for younger children, those under age 13? How about for adolescents?
      i. Are there specific groups of children who are most vulnerable to these issues?
   d. From your experience, what are families’ or parents’ biggest barriers to addressing these issues?
      i. [PROBE: Barriers to accessing medical care, barriers to accessing preventive services or programs, barriers to receiving information on these issues, etc.]
   e. What programs/services are you aware of in the community that address some of these health issues? [PROBE FOR SPECIFICS]

f. From your experience, what are the most effective ways that programs can provide information to or communicate with parents? To youth?

IV. PERCEPTIONS OF CHB AND ITS PROGRAMS (10 minutes)

3. What have you heard about Children’s Hospital’s programs in the community? Are you aware of any of their community benefits programming? [PROBE FOR SPECIFICS]

   a. What is your perception of Children’s Hospital and their community benefits programming (if known)?
      
   i. What do you see as its strengths?
   
   ii. What do you see as its challenges/limitations?

   b. What do you consider Children’s Hospital’s role to be in the community?

   c. To what extent do you think Children’s Hospital is currently meeting the health concerns of your community/the community your organization serves?

4. How do you see Children’s Hospital becoming more engaged in the community to address these concerns?

   a. Are there specific health issues in the community in which Children’s Hospital should take a lead in addressing?

   b. Are there any specific organizations in the community in which you see as being a good fit for partnership with Children’s Hospital to address these health concerns?
      
   i. With whom? Around which programs or issues? [PROBE FOR SPECIFICS, PARTICULARLY THOSE AROUND ASTHMA, OBESITY, INJURY PREVENTION, AND MENTAL HEALTH]

5. We’re going to be conducting these interviews with a number of people around Boston and specifically in the neighborhoods of Roxbury, Jamaica Plain, Mission Hill, and Fenway. In your opinion, are there specific people that we should be talking to? Do you have any strong recommendations of specific individuals that are critical to include on our interview list with whom to have this same type of conversation? [CHECK TO SEE IF ANY RECOMMENDATIONS]

V. CLOSING (2 minutes)

Thank you so much for your time. That’s it for my questions. Is there anything else that you would like to mention that we didn’t discuss today? Thank you again. Have a good afternoon.
Appendix C. Parent Focus Group Guide

Health Resources in Action
Children’s Hospital Assessment Study
Parent Focus Group Guide

Goals of the focus groups:
• To identify the perceived health needs and assets of the community
• To gain an understanding of current programming around CHB’s priority health issues
• To identify areas of opportunities for future CHB programming and partnerships

[NOTE: THE QUESTIONS IN THE FOCUS GROUP GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

[MODERATOR: BEFORE GROUP BEGINS, ASK PARTICIPANTS TO SIGN CONSENT FORM.]

I. BACKGROUND (3 MINUTES)

Welcome everyone. My name is ___________, and I work for Health Resources in Action, a non-profit public health organization in Boston.

I’d also like to introduce some colleagues today: _______________ from my organization and ________________ from Children’s Hospital. They are involved with me on this project and are here to observe and take notes during our discussion, so that I can have my hands and attention free as we talk.

Before we begin, I’d like to explain a few things about how this discussion will work.

• We’re going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. We just want to know what each of you thinks about the issues we will be discussing. Please be as honest as you can. Please feel free to share your opinions, both positive and negative.

• Children’s Hospital is conducting what is called a community assessment, which is the reason we are having this group. Children’s wants to gain a greater understanding of the health issues facing Boston families, how those needs are currently being addressed, and how Children’s Hospital can help in these areas. For this assessment, Children’s Hospital is talking to parents like yourselves, youth, and a number of individuals who work with children and families. The information you provide is a valuable part of this assessment. Your feedback today will help Children’s Hospital in identifying areas for future programs and services.

• We will be conducting several of these discussion groups all around Boston. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, I might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In our report, nothing you say here will be connected to your name.
• You might also notice that I have a stack of papers here. I have a lot of questions that I’d like to ask you tonight. I want to let you know that so if it seems like I cut a conversation a little short to move on to the next question, please don’t be offended. I just want to make sure we cover a number of different topics during our discussion tonight.

• Lastly, please turn off your cell phones, beepers, or pagers or at least put them on vibrate mode. The group will last only about 80-90 minutes. If you need to go to the restroom during the discussion, please feel free to leave, but we’d appreciate it if you would go one at a time.

II. INTRODUCTION AND WARM-UP (5-10 MINUTES)

1. Now, first let’s spend a little time getting to know one another. Let’s go around the table and introduce ourselves. Everyone is here tonight because you are a parent. Please tell me: 1) Your first name; 2) what neighborhood you live in; 3) how many children you have and their ages; and 4) something about yourself – such as what activities you like to do with your children in your spare time. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY AND HEALTH PERCEPTIONS (25-30 MINUTES)

2. Tonight, we’re going to be talking a lot about the community or neighborhood that you live in. How would you describe your community?

3. What are some of the biggest strengths of your community? What are the most positive things about it?
   a. What are some of the biggest problems or concerns in your community?

4. What do you think are the most pressing health concerns in your community?
   i. Who do you think deals with these issues the most? Which groups or types of people?
   a. As a parent, what do you think are the most pressing health concerns in your community for younger children, those under age 13? How about for teenagers?
   ii. Who do you think deals with these issues the most? Which groups or types of children/adolescents?
   iii. [IF NOT ALREADY MENTIONED] In your opinion, how much of a concern is asthma to the children living in your community? How about obesity? Mental health issues such as depression or attention deficit disorder? Injuries such as car accidents, sports injuries, or injuries in the home?
   b. As a parent, what are the biggest concerns you have for your younger children/adolescents [SELECT DEPENDING ON PARENT GROUP] and their health?
   iv. What are some things that you do or have done to try to prevent these issues – or at least reduce your family’s risk?
5. Let’s talk about issues that are even broader than health. Just thinking about day to day life – working, getting your kids to school, things like that – what are some of the challenges or struggles you deal with on a day to day basis? What causes stress in your life?

a. How do you deal with these challenges?

b. In general, what issues or problems cause your child to miss school or for you to miss work?

IV. PROGRAMS/SERVICES IN THE COMMUNITY (15-20 MINUTES)

6. Before we talked about the different health concerns you have for children/teens/families in your community. Do you know of any programs or services in your community that focus on these specific issues? [PROBE FOR SPECIFICS]

a. Have you or your children ever been a part of these programs? What were they like?

i. How did you get connected to these programs? How did you initially hear about them?

ii. How satisfied were you with the programs?

iii. How do you wish they were different? What do you think the programs could have done differently?

7. Thinking about the list of health concerns related to children, teens, and families that we talked about: What kinds of programs or services would you want to see in your community to address these issues? [GO THROUGH SAME SET OF QUESTIONS BELOW MULTIPLE TIMES FOR THE DIFFERENT HEALTH ISSUES PREVIOUSLY MENTIONED]

a. What is your vision for these programs? What do they look like? [PROBE FOR SPECIFICS]

i. Who do you think should sponsor them?

ii. Who would be involved in developing them? In participating in them?

iii. Would these be totally new programs or would they be building off of something that already exists in the community?

b. [IF NOT MENTIONED, GO THROUGH SAME SET OF QUESTIONS SPECIFICALLY FOR ISSUES OF: ASTHMA, CHILDHOOD OBESITY, MENTAL HEATLH (E.g., depression, ADHD, etc.), AND INJURY PREVENTION (E.g, car accidents, sports injuries, injuries in the home)]

8. If an organization was going to develop these types of programs in your community, what advice would you have for the program planners?

a. Are there specific things that they would need to know about or do in the community when thinking of developing these types of programs?
V. CHB PERCEPTIONS AND HEALTH INFORMATION (10-15 MINUTES)

9. Before today’s discussion, how many people here had heard of Children’s Hospital?
   a. What is your impression of Children’s Hospital? If you had to pick a few words to describe your perception of it, what would you say?

   b. If you heard that some of the programs we just mentioned before were going to be developed in your community and that they were sponsored by Children’s Hospital, would that make you more or less interested in the program? Why?

   c. What do you think the role of Children’s Hospital should be in your community? What could or should the institution be doing at the community or neighborhood level?

10. If a program wanted to get health information out to parents on children and family issues, what would your advice be? What is the best way to reach parents with information about some of the issues we talked about earlier in our discussion? [PROBE FOR SPECIFICS: SPECIFIC LOCAL NEWSPAPERS, RADIO STATIONS, ETC.]
   a. How about if a program wanted to invite parents and families to become involved, what is the best way to reach parents with this type of information? [PROBE FOR SPECIFICS: SPECIFIC MEDIA, WORD OF MOUTH – I.E., WHO ARE THE COMMUNITY GATEKEEPERS FOR THIS INFO?]
      i. What is the best way to inform parents about a new program and get them excited about it?

11. I’m nearly all done with my questions today. I just want check to see if my colleagues have any additional last questions they want to ask. [CHECK WITH CHB OBSERVER FOR 1-2 ADDITIONAL QUESTIONS]

VI. ACCESSING HEALTH CARE (5 MINUTES)

12. I just have a few additional brief questions. If your children had a minor health issue that needed a doctor’s care or prescription medicine – such as an ear infection – where would you go for this type of medical care? [PROBE IF THEY GO TO PRIVATE PRACTICE, COMMUNITY HEALTH CLINIC, E/R, ETC]
   a. In general, how often do your children usually go to a health care provider for minor health issues or check-ups? [BRIEF]

   b. Have you ever experienced any problems in trying to get medical care for your children? Like what? [PROBE FOR BARRIERS: INSURANCE ISSUES, LANGUAGE BARRIERS, LACK OF TRANSPORTATION, ETC.]

VII. CLOSING (2 MINUTES)

Thank you so much for your time and sharing your opinions. Before we end the discussion, is there anything that you wanted to add that you didn’t get a chance to bring up earlier?

As I mentioned before, we are conducting these groups all around Boston with parents and youth and we’re also talking to people who work at organizations. After all this is over, we’re going to be writing up a report. Children’s Hospital wants to share these report
findings with youth, parents, and others in the community either through community meetings or by sending out a summary of the report to people who are interested. We have a sign-up sheet here if you are interested in finding out more about the end result of this effort. If you want to be told about a community meeting where these findings will be discussed or receive a summary of the report, feel free to provide your name and contact information. If you are not interested, you do not have to sign up. [PROVIDE CONTACT SHEET FOR INTERESTED PEOPLE]

I want to thank you again for your time. And we'd like to express our thanks to you. [DISTRIBUTE STIPENDS AND HAVE RECEIPT FORMS SIGNED].

We also have some health informational materials available if you are interested in taking them. It is up to you. [SHOW WHERE HANDOUTS OF MATERIALS ARE FOR PEOPLE TO TAKE VOLUNTARILY].

Thank you again. Your feedback is going to help Children’s Hospital in their program planning in neighborhoods such as yours. We greatly appreciate your time and sharing your opinions.
Appendix D. Youth Focus Group Guide

Health Resources in Action  
Children’s Hospital Assessment Study  
Youth Focus Group Guide

Goals of the focus groups:
- To identify the perceived health needs and assets of the community
- To gain an understanding of current programming around CHB’s priority health issues
- To identify areas of opportunities for future CHB programming and partnerships

[NOTE: THE QUESTIONS IN THE FOCUS GROUP GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

[MODERATOR: BEFORE GROUP BEGINS, ASK PARTICIPANTS TO SIGN CONSENT FORM.]

I. BACKGROUND (3 MINUTES)

Welcome everyone. My name is ___________, and I work for Health Resources in Action, a non-profit public health organization in Boston.

I’d also like to introduce some colleagues today: _____________ from my organization and ______________ from Children’s Hospital. They are involved with me on this project and are here to observe and take notes during our discussion, so that I can have my hands and attention free as we talk.

Before we begin, I’d like to explain a few things about how this discussion will work.

- We’re going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. We just want to know what each of you thinks about the issues we will be discussing. Please be as honest as you can. Please feel free to share your opinions, both positive and negative.

- Children’s Hospital is conducting what is called a community assessment, which is the reason we are having this group. Children’s wants to gain a greater understanding of the health issues facing Boston families, how those needs are currently being addressed, and how Children’s Hospital can help in these areas. For this assessment, Children’s Hospital is talking to youth like yourselves, parents, and a number of individuals who work with youth and families. The information you provide is a valuable part of this assessment. Your feedback today will help Children’s Hospital in identifying areas for future programs and services.

- We will be conducting several of these discussion groups all around Boston. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, I might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In our report, nothing you say here will be connected to your name.
• You might also notice that I have a stack of papers here. I have a lot of questions that I’d like to ask you tonight. I want to let you know that so if it seems like I cut a conversation a little short to move on to the next question, please don’t be offended. I just want to make sure we cover a number of different topics during our discussion tonight.

• Lastly, please turn off your cell phones, beepers, or pagers or at least put them on vibrate mode. The group will last only about 80-90 minutes. If you need to go to the restroom during the discussion, please feel free to leave, but we’d appreciate it if you would go one at a time.

II. INTRODUCTION AND WARM-UP (5 MINUTES)

1. Now, first let’s spend a little time getting to know one another. Let’s go around the table and introduce ourselves. Please tell me: 1) Your first name; 2) what grade you are in; 3) what neighborhood you live; and 4) something about yourself – such as what you like to do for fun in your free time. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY PERCEPTIONS (15 MINUTES)

2. Tonight, we’re going to be talking a lot about the community or neighborhood that you live in. How would you describe your community? Tell me a bit about it.

   a. Who lives there? What are the people like?

   b. What does the neighborhood look like? Are there a lot of shops or mainly houses? If you walked down some of the main streets, what would you see or hear?

   c. How long have you lived there?

   d. Where are your favorite places in your neighborhood to go with friends after school, on weekends, etc.?

      i. How about the places you like to go with your family?

3. What are some of the things you like best about your neighborhood? What are the most positive aspects about it? Why?

   a. If you were talking to a friend who was thinking of moving to Boston, would you recommend that he or she lives in your neighborhood? Why/why not? What would you tell him/her?

   b. What are some of the things you like least about your neighborhood? What are the most negative aspects about it? Why?

      i. How much do you worry about these issues?

      ii. How do you deal with these issues?
IV. HEALTH PERCEPTIONS WITH ACTIVITY (25-30 MINUTES)

4. We’re going to move the conversation towards health and do a brief activity. There are 3 pieces of paper on the wall. Each piece of paper has a question on it. I’d you to get in groups around each piece of paper – at least 2 people in each group. I’m going to give you a few minutes to talk about the question on the paper, and then I’d like you to write your group response on the paper.

After a few minutes, I’m going to call “time,” and each group is going to move to the next piece of paper on the wall. Read the question and then read what the group before you wrote down. Talk about the question and the previous group’s response, and then write—below the other group’s answers—some additional thoughts your group had about the question.

After I call “time” again, your group will then move to the next piece of paper and do the same thing. So, by the end, each group will have discussed each of the questions and provided some type of response. We’ll then talk about your answers as a group.

[DO ACTIVITY; GIVE GROUPS ABOUT 5 MINUTES PER QUESTION; TOTAL ACTIVITY TIME=15 MINUTES; DISCUSSION TIME= 10-15 MINUTES]

Questions for activity:

a. What makes a teenager healthy?

b. Do you consider your community to be a healthy community? Why/why not?

c. What are the biggest health problems in your community among children and teenagers?

5. Now, let’s discuss some of your answers to these questions. [FOR EACH QUESTION, REFER TO RESPONSES ON PAPER AND ASK FOR FEEDBACK/ELABORATION]

a. What makes a teenager healthy?

b. Do you consider your community to be a healthy community? Why/why not?
   
   iii. [PROBE] In what way is your community healthy/unhealthy?

   c. What are the biggest health problems in your community among children and teenagers?

   i. [PROBE] Who do you think encounters these issues the most? Which groups or types of children/teens?

6. [IF NOT ALREADY MENTIONED] Let’s talk about some specific health issues. In your opinion, how much of a problem is asthma to the young people living in your community? How about obesity? Mental health issues such as depression or attention deficit disorder? Injuries such as car accidents, sports injuries, or injuries in the home?

a. How much do you worry about your own health? How about your family’s?
   
   i. Are there specific issues that you are most worried about—either for yourself or your family? What are you most concerned about?
1. What are some things that you do or have done to try to prevent these issues—or at least reduce your risk of them?

V. PERSONAL EXPERIENCES AND COMMUNITY (10-15 MINUTES)

7. I’d like you to think about when you were younger—or think about your younger sisters or brothers if you have them. What are some of the stresses you had in your life back then? What made it hard just to deal with things day to day?

a. How did you manage these challenges or stresses? How did you get through it to be where you are today?

   i. How much support did you get from your family? From friends? From the community?

8. I’d like you to think about the future – what five years from now might look like. What do you think your community or neighborhood will be like five years from now?

a. What do you think you will be doing five years from now?

   i. Where do you think you will be living? What will you be doing – Working? Going to school? Something else?

   ii. How well do you think the people, programs, and schools in your community are preparing you for that time five years from now? Why/why not?

   1. In what way do you or do you not feel prepared?

   2. What kinds of things do you think would help prepare you for that time five years from now — to become a healthy adult?

VI. PROGRAMS/SERVICES IN THE COMMUNITY (10-15 MINUTES)

9. Before we talked about the different health issues in your community. Do you know of any programs or services in your community that focus on these specific issues? [PROBE FOR SPECIFICS]

a. Have you or your family ever been a part of these programs? What were they like?

   i. How did you or your family get connected to these programs? How did you initially hear about them?

   ii. What did you think of them? How happy were you with the programs?

   iii. How do you wish they were different? What do you think the programs could have done differently?

10. Thinking about the health issues and concerns that teens have today: What kinds of programs or services would you want to see in your community to address these issues? What solutions would you recommend? [GO THROUGH SAME SET OF QUESTIONS BELOW MULTIPLE TIMES FOR THE DIFFERENT HEALTH ISSUES PREVIOUSLY MENTIONED]
a. Tell me a bit about these programs or ideas. What is your vision for them? What do they look like? [PROBE FOR SPECIFICS]
   
   i. Who do you think should sponsor them?
   
   ii. Who would be involved in developing them? In participating in them?
   
   iii. Would these be totally new programs or would they be building off of something that already exists in the community?
   
   iv. Do you think people your age be involved in helping to get these ideas off the ground? How could they help?

b. [IF NOT MENTIONED, GO THROUGH SAME SET OF QUESTIONS SPECIFICALLY FOR ISSUES OF: ASTHMA, CHILDHOOD OBESITY, MENTAL HEALTH (E.g., depression, ADHD, etc.), AND INJURY PREVENTION (E.g, car accidents, sports injuries, injuries in the home)]

11. If an organization was going to develop these types of programs in your community, what advice would you have for them?

   a. Are there specific things that they would need to know about or do in the community if starting to develop these programs?

VII. CHB PERCEPTIONS AND INFORMATION DISSEMINATION (5 MINUTES)

12. Before today’s discussion, how many people here had heard of Children’s Hospital?

   a. What do you think of Children’s Hospital when you hear its name? If you had to pick a few words to describe your perception of it, what would you say?

   b. If you heard that some of the programs we just mentioned before were going to be developed in your community and that they were sponsored by Children’s Hospital, would that make you more or less interested in the program? Why?

13. Who are the individuals in your community that people your age respect or listen to the most?

   a. Would you go to these people to get information about a health issue? Why/why not?

   b. Where do you get most of your health information? [PROBE: FRIENDS, FAMILY, DOCTOR, TV, INTERNET, ETC.]

   c. Who do you trust the most for health information or advice? Why?

   i. Who do you trust the least? Why?

14. If a program wanted to get health information out to teens in your community, what would your advice be? What is the best way to reach teens with information about some of the issues we talked about earlier in our discussion? [PROBE FOR SPECIFICS: SPECIFIC LOCAL NEWSPAPERS, RADIO STATIONS, ETC.]
d. How about if a program or service wanted to invite teens to become involved in it, what is the best way to reach them with this type of information? [PROBE FOR SPECIFICS: SPECIFIC MEDIA, WORD OF MOUTH – I.E., WHO ARE THE COMMUNITY GATEKEEPERS FOR THIS INFO?]

i. What is the best way to inform teens about a new program and get them excited about it?

15. I’m nearly all done with my questions today. I just want check to see if my colleagues have any additional last questions they want to ask. [CHECK WITH CHB OBSERVER FOR 1-2 ADDITIONAL QUESTIONS]

VIII. HEALTH CARE ACCESS AND EXPERIENCE (5 MINUTES)

16. If you had a minor health issue that needed a doctor’s care or prescription medicine, where would you go for this type of medical care? Is there a regular doctor that you go to? [PROBE IF THEY GO TO PRIVATE PRACTICE, SCHOOL-BASED HEALTH SERVICE, SCHOOL-BASED HEALTH SERVICE, COMMUNITY HEALTH CLINIC, E/R, ETC]

a. Have you or your family ever wanted to get medical care but weren’t able to? What things got in your way? [PROBE FOR BARRIERS: INSURANCE ISSUES, LANGUAGE BARRIERS, LACK OF TRANSPORTION, ETC.]

IX. CLOSING (2 MINUTES)

Thank you so much for your time and sharing your opinions. Before we end the discussion, is there anything that you wanted to add that you didn’t get a chance to bring up earlier?

As I mentioned before, we are conducting these groups all around Boston with parents and youth and we’re also talking to people who work at organizations. After all this is over, we’re going to be writing up a report. Children’s Hospital wants to share these report findings with youth, parents, and others in the community either through community meetings or by sending out a summary of the report to people who are interested. We have a sign-up sheet here if you are interested in finding out more about the end result of this effort. If you want to be told about a community meeting where these findings will be discussed or receive a summary of the report, feel free to provide your name and contact information. If you are not interested, you do not have to sign up. [PROVIDE CONTACT SHEET FOR INTERESTED PEOPLE]

I want to thank you again for your time. And we’d like to express our thanks to you. [DISTRIBUTE STIPENDS AND HAVE RECEIPT FORMS SIGNED].

We also have some health informational materials available if you are interested in taking them. It is up to you. [SHOW WHERE HANDOUTS OF MATERIALS ARE FOR PEOPLE TO TAKE VOLUNTARILY].

Thank you again. Your feedback is going to help Children’s Hospital in their program planning in neighborhoods such as yours. We greatly appreciate your time and sharing your opinions.
Appendix E. List of Organizations Involved in Focus Group Recruitment

- Sociedad Latina, Mission Hill
- Tobin School, Mission Hill
- Project RIGHT, Roxbury
- St. Mary’s of the Angels Church, Roxbury
- My Town, Fenway
- Fenway Family Coalition, Fenway
- Head Start Program, Jamaica Plain
- Hyde Square Task Force, Jamaica Plain
### Appendix F. Environmental Scan of Current Programs

#### Local Community Programs Related to Youth Obesity

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Organizational Sponsor or Funder</th>
<th>Neighborhood Focus</th>
<th>Program Goals/Services Provided</th>
<th>Audience or Clients</th>
<th>Known Partners</th>
<th>Citation/Link for More Information</th>
</tr>
</thead>
</table>
| Action for Boston Community Development, Inc. (ABCD) | Example funders include:  
• National Grid  
• Boston Red Sox  
• Bank of America  
• Bingham McCutchen  
• BCBS MA  
• Children’s Hospital Boston  
• J. Bancroft Cox Charitable Trust  
• Partners Healthcare | Allston/  
Brighton  
Charlestown  
Dorchester  
East Boston  
Hyde Park/Roslindale  
Jamaica Plain  
Mattapan  
North End  
Roxbury  
South Boston  
| Bikes Not Bombs | Individuals | Services across Boston  
Located in Jamaica Plain | Programs: Earn-a-Bike (for boys & Girls) & Girls in Action (Girls-only version of Earn-a-Bike)  
Students attend spring, summer or fall courses whereby they leave with a bicycle paid for through vocational training including: community service work, studies about bike mechanics, bike safety and environmental issues & complete repairs on their bicycle | Youth age 12-18 years | Not Specified | Link to youth programs: [http://www.bikesnotbombs.org/youth](http://www.bikesnotbombs.org/youth) |
| Body by Brandy: 4 Kidz Fitness Studio | Children’s Hospital Boston  
Individually paid memberships | Roxbury | Goals: To address childhood obesity  
Program Components:  
Cardiovascular training, strength training, flexibility exercises and nutrition education  
Classes: Dance, Tae Kwon Do & Boxing | Youth who live in Roxbury and/or receive care from Children’s Hospital Boston or it’s affiliates  
Fitness in the City: Free 12 week program for children who go to Children’s Hospital Boston or affiliated health centers  

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Children's Hospital Boston, Community Assessment Study – Dec. 2009  
Submitted by Health Resources in Action
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<tr>
<td>Boston Collaborative for Food and Fitness</td>
<td>• W.K. Kellogg Foundation</td>
<td>• Boston city-wide with specific focus in:</td>
<td>• A collaboration of organizations designing a comprehensive city-wide plan to address obesity in Boston. Approaches include: promoting physical activity by increasing the availability of public space; promoting locally grown, affordable, healthy food.</td>
<td>• Kids age 8-12 who are overweight; n=15 at each location</td>
<td>• 52 organizations including health care providers, businesses, local universities, youth-organizations, city agencies, health insurers, and nonprofits.</td>
<td>• Link: <a href="http://www.masspreventIoncenter.orG/Food_and_fitness/food_and_fitness.html">http://www.masspreventIoncenter.orG/Food_and_fitness/food_and_fitness.html</a></td>
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<tr>
<td>(Currently housed at Boston Public Health Commission)</td>
<td></td>
<td>• Dorchester • Mattapan • Jamaica Plain • Mattapan • Roxbury</td>
<td></td>
<td>• High school students (age 16-18) lead programs</td>
<td>• Dot Well Mattapan Community Health Center • Dorchester Family YMCA • Roxbury Family YMCA • Oak Square Family YMCA</td>
<td></td>
</tr>
<tr>
<td>Boston Medical Center: Fantastic Kids program</td>
<td>• Boston Medical Center</td>
<td>• Dorchester • Mattapan • Roxbury • Brighton</td>
<td>• Nutrition &amp; physical activity program to support children in reaching and maintaining healthy weights by teaching self-management skills in a positive environment • Trains high school youth to promote healthy eating habits and physical activity for participants, peers, family members, and their community • Gender-specific groups meet twice weekly for 2 hours over 12 weeks • Activities include: Nutrition education (healthy snack preparation &amp; selection), physical activity (swimming &amp; dancing), youth development sessions, field trips, family events</td>
<td>• 70 schoolyards at Boston Public Schools serving kindergarten-high school-age students</td>
<td>• Boston Greenspace Alliance • Land Use Task Force</td>
<td>• No direct link to BMC description of Program</td>
</tr>
<tr>
<td>Boston School Yard Initiative</td>
<td>• City of Boston • Boston School Yard Funders Collaboration (private organizations) i.e., Children's Museum, Arnold Arboretum at Harvard University, Massachusetts Audobon Society, among others</td>
<td>• Boston City-wide</td>
<td>• Public-private partnership to revitalize Boston schoolyards</td>
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<tr>
<td>Boston Youth Sports</td>
<td>• Barr Foundation • Located in</td>
<td>• Boston City-wide</td>
<td>• Goal: Promotes youth sports as a means of youth development and</td>
<td>• Youth</td>
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<tr>
<td>Network</td>
<td></td>
<td>Dorchester</td>
<td>physical activity</td>
<td></td>
<td></td>
<td><a href="http://bostonyouthsports.org/default.asp">bostonyouthsports.org/default.asp</a></td>
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</table>
| Dimock Center: SmartKids After School Program | • Not specified | • Located in Roxbury | • Mission: To provide a safe and nurturing environment for children and families  
• Program: One-year after school program that addresses the academic needs of children through academic enrichment, culture and arts, physical activity, computer lab and library activities | • School-age children and their families | • Not specified | [http://dimockcenter.org/childandfamilydev.html](http://dimockcenter.org/childandfamilydev.html) |
| Dudley Street Neighborhood Initiative | • Salvation Army (Gift from Joan Kroc) | • Roxbury  
• North Dorchester | • Goal: Revitalization of Roxbury & N. Dorchester while offering affordable housing and does not displacing residents through community organizing and empowerment  
• Development of Kroc Community Center which will include 3 gyms, a library, an aquatics center, visual arts center & learning center | • Dudley Neighbors, Inc.  
community land trust  
Nonprofit organizations  
Community Development Corporations  
Residents  
Businesses  
Religious Institutions | • Berklee College of Music  
Music & Youth Initiative  
Jamaica Plain (Hyde/Jackson Square) | [http://www.dsni.org/](http://www.dsni.org/) |
| Hyde Square Task Force | • Berklee College of Music  
• Music & Youth Initiative | • Jamaica Plain (Hyde/Jackson Square) | • Community-based organization  
• Arts in the Summer program: 6-week summer camp that engages youth in dance, music, & sports  
• Kennedy After School Program: engage students in Afro-Latin contemporary dance classes  
• Learn Through Dance: Afro-Latin contemporary dance classes  
• Women Engaged in Physical Activity: Offers culturally relevant physical fitness & health awareness  
• 320 youth daily, totaling 800 youth annually  
• Summer Camp: Youth grades 1-8  
• Kennedy After School Program: Youth grades 1-5  
• Learn through Dance: Youth grades 4-5  
• Women Engaged in Physical Activity: girls & women age 6-18 years | • Berklee College of Music | [http://www.hydesquare.org/](http://www.hydesquare.org/) |
| Jamaica Plain Unidos/United | (not indicated) | • Jamaica Plain | • Goal: Address the needs of youth by connecting them to services offered by partner organizations &  
• Youth (age 14-22 years) who live, work, and play in  
• Bikes Not Bombs  
• Boston After | • Berklee College of Music | [http://www.jpuu.org/](http://www.jpuu.org/) |
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<tr>
<td>Jump Up and Go! Healthy Choices</td>
<td>Blue Cross Blue Shield Massachusetts</td>
<td>Located in Fenway</td>
<td>Prevention &amp; control of overweight in children &amp; youth</td>
<td>Unknown</td>
<td>School &amp; Beyond • Ensuring Stability through Action in Our Community (ESAC) • Family Services of Greater Boston • Hyde Square Task Force • JP Tree of Life/Arbol de Vida • South Street Youth Center • Southern Jamaica Plain Health Center • Spontaneous Celebrations • Teen Empowerment</td>
<td><a href="http://www.bluecrossma.com/common/en_US/myWellbeingIndex.jsp?levelTwoCategory=Jump%2bUp%2band%2bGo%2521&amp;repId=%252Fcommon%252Ffen_US%252Frepositories%252FCategoryMenuRep">Link</a></td>
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<tr>
<td>Martha Eliot Health Center: I’m IN Charge (INC)</td>
<td>Recent Contributors: • Citizens Bank Foundation • The Louise Crane Foundation • Grants, private &amp; corporate donations, contracts, contributions from partners</td>
<td>Jamaica Plain</td>
<td>• Diabetes prevention Program Goals: Create a community-based service that is culturally relevant to the needs of Latino and African American youth &amp; their families; develop the knowledge &amp; resources of pediatric and adolescent primary care physicians to address weight management with patients; create partnerships with community organizations to promote healthy eating and physical activity among youth</td>
<td>Overweight youth of color, age 10-19, who are at risk for developing type 2 diabetes</td>
<td>Unknown</td>
<td>Link: <a href="http://www.childrens">http://www.childrens</a> hospital.org/g/clinicalse rvices/Site 2274/main pageS2274 P1sublevel16Flevel21 .html</td>
</tr>
<tr>
<td>Mission Hill Health Movement</td>
<td>Mass College of Pharmacy and Health Services • Harvard School of Public Health • Harvard Medical School • Harvard School of Dental Medicine • Joslin Diabetes Center • Dana-Farber Cancer Institute</td>
<td>Mission Hill</td>
<td>• Organize walking groups</td>
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<tr>
<td>Sociedad Latina</td>
<td>Roxbury/Mission Hill</td>
<td>Youth community organizing program: Youth identify priority community concerns to be addressed to improve community health &amp; well-being including regulation of storefront advertising of junk food and tobacco and alcohol products Sugar-Free Summer Program: Reduce consumption of sugar-sweetened beverages at events</td>
<td>Youth between 14-21 years of age</td>
<td>Youth between 14-21 years of age</td>
<td>Healthy Mission Hill Initiative Children’s Hospital Task Force Boston Impact Advisory Group</td>
<td>Link: <a href="http://sociedadlatina.org/">http://sociedadlatina.org/</a></td>
</tr>
<tr>
<td>Urban League</td>
<td>Individual members</td>
<td>Eastern Massachusetts, particularly: Roxbury, Dorchester, Mattapan, Jamaica Plain, South End</td>
<td>Goal: Increase economic self-reliance of communities of color through the delivery of services &amp; programs by addressing civil rights issues affecting their lives Camp Atwater: Sponsor youth to attend a 2 week summer camp in Western MA that promotes physical activity and social development</td>
<td>Low- and moderate-income families in Roxbury, Dorchester, Mattapan, Jamaica Plain, &amp; the South End Camp Atwater: youth, age 8-15 years</td>
<td>Urban League Guild Urban League Young Professionals Network</td>
<td>Link: <a href="http://www.ulem.org">www.ulem.org</a></td>
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## Local Community Programs Related to Asthma

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<tr>
<td>Alternatives for Community &amp; Environment (ACE): Roxbury Environmental Empowerment Program (REEP)</td>
<td>Unknown</td>
<td>New England; primarily Roxbury neighborhood for REEP program</td>
<td>ACE Mission: To build the power of communities of Color to eliminate environmental racism and classism and achieve environmental justice. Youth develop leadership through environmental justice curriculum, leadership training, youth-led community organizing &amp; Civic engagement. Helps youth to identify and understand problems in the community, organize around these issues &amp; empower them to improve community quality of life by educating community members about links between environment &amp; asthma, and working with City of Boston and local developers to address environmental racism</td>
<td>5-7 teens participate in 3-year internship to develop leadership skills Workshops &amp; Tours: 15-20 workshops &amp; environmental justice tours annually, engaging 300-400 youth 2-4 month in-school program &amp; curriculum in 3-4 Roxbury public schools (5th-12th grade) reaches 75-100 youth.</td>
<td>Unknown</td>
<td>Link: <a href="http://www.ace-ej.org/">http://www.ace-ej.org/</a></td>
</tr>
<tr>
<td>Asthma Prevention and Management Initiative</td>
<td>Tufts Medical Center</td>
<td>Chinatown</td>
<td>To reduce health disparities in the Asian Community</td>
<td>Asthmatic youth</td>
<td></td>
<td>Link: <a href="http://www.tuftsmedicalcenter.org/AboutUs/CommunityHealthPrograms/efault">http://www.tuftsmedicalcenter.org/AboutUs/CommunityHealthPrograms/efault</a></td>
</tr>
<tr>
<td>Boston Asthma Initiative (Formerly Jamaica Plain Asthma Initiative)</td>
<td>Unknown</td>
<td>Jamaica Plain, Roxbury, Dorchester, Mattapan</td>
<td>Goal: Address childhood asthma in school &amp; at home Home visits including education re: asthma triggers in the home Provide referrals to services, housing, legal agencies Work with schools to reduce asthma triggers in schools Swim program for children with asthma</td>
<td>Children with asthma</td>
<td>Residents, Community Based Organizations, Brigham &amp; Women’s Hospital, Children’s Hospital Boston, Faulkner</td>
<td>Link: <a href="http://www.esacboston.org/bai/history.html">http://www.esacboston.org/bai/history.html</a></td>
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<tr>
<td>Boston Swimming Program: &quot;Kids with Asthma Can ... Swim!&quot;</td>
<td>• Boston Public Health Commission Asthma Prevention and Control Program</td>
<td>• Community Centers throughout Boston</td>
<td>• Goal: Asthma education &amp; exercise through swimming&lt;br&gt;• Program: Asthma education and swim lessons at Boston Community Center Pools&lt;br&gt;• Provides portable curriculum kit to train community center staff and peer health educators</td>
<td>• Boston children with Asthma, age 8-12 years</td>
<td>• Children's Hospital Boston and its affiliated health centers&lt;br&gt;• Boston area community centers</td>
<td>• Kids Can Swim Link: <a href="http://apha.confex.com/apha/129am/techprogram/paper_30694.htm">http://apha.confex.com/apha/129am/techprogram/paper_30694.htm</a></td>
</tr>
<tr>
<td>Boston Urban Asthma Coalition</td>
<td>• Various grants</td>
<td>• Boston, especially minority neighborhoods of Roxbury, Dorchester &amp; Jamaica Plain</td>
<td>• Goal: Asthma control in Boston&lt;br&gt;• Collaboration between organizations and Boston residents&lt;br&gt;• Educate community groups through discussions about asthma management, housing rights, and the need for healthy schools, with the goal of developing advocates for families and communities&lt;br&gt;• Advocacy for healthy schools, healthy homes, access to care, &amp; quality of care</td>
<td>• Boston residents including children with asthma (age 0-18) and their families&lt;br&gt;Staff at Boston Public Schools</td>
<td>• Massachusetts Healthy Schools Network (MHSN)&lt;br&gt;• Affordable Housing Advocates&lt;br&gt;• City of Boston Inspectional Services Department&lt;br&gt;• City of Boston Department of Neighborhood and Development</td>
<td>• Link: <a href="http://www.buac.org/home.html">http://www.buac.org/home.html</a></td>
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<tr>
<td>City Life/Vida Urbana</td>
<td>• United Way MA Bay&lt;br&gt;• Boston Bar Association&lt;br&gt;• Catholic Campaign for Human Development&lt;br&gt;• Clipper Society&lt;br&gt;• Commonstream Foundation&lt;br&gt;• Hyams Foundation&lt;br&gt;• The Lenny Zakim Fund&lt;br&gt;• Miller Foundation&lt;br&gt;• Racial Justice Collaborative&lt;br&gt;• Solidago Foundation</td>
<td>• Jamaica Plain (especially Jackson Square &amp; Egleston Square Neighborhoods)&lt;br&gt;• Roxbury</td>
<td>• Community-based organization that advances anti-displacement&lt;br&gt;• Healthy Homes, Healthy Families: Educate families about the connection between housing conditions and family health including childhood asthma</td>
<td>• Low-income Latino tenants</td>
<td>• Southern Jamaica Plain Health Center&lt;br&gt;• Brookside Community Health Center&lt;br&gt;• Martha Eliot Health Center&lt;br&gt;• Whittier Street Health Center</td>
<td>• Link: <a href="http://www.clvu.org/healthy_homes.html">http://www.clvu.org/healthy_homes.html</a></td>
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<tr>
<td>Committee for Boston Public Housing</td>
<td>• W.K. Kellogg Foundation&lt;br&gt;• U.S. Environmental Protection Agency</td>
<td>• Residents of Boston Public Housing developments located in Roxbury</td>
<td>• Goal: Improve quality of life of public housing residents through organizing, advocacy, and delivery of services&lt;br&gt;• Collaborate to study the effect of highway pollution on health of</td>
<td>• Boston Housing Authority&lt;br&gt;• Local Tenant Organizations&lt;br&gt;• Boston Inspectional</td>
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<td>• Link: <a href="http://www.cbphi.org/index.html">http://www.cbphi.org/index.html</a></td>
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<tr>
<td>Mission Hill Health Movement</td>
<td>(Community Institutions = Sponsor?) • Mass College of Pharmacy and Health Services • Harvard School of Public Health • Harvard Medical School • Harvard School of Dental Medicine • Joslin Diabetes Center • Dana-Farber Cancer Institute</td>
<td>Mission Hill</td>
<td>• Air Quality Survey that measures air quality along a specific route &amp; counts traffic</td>
<td>• High school students administered the air quality survey</td>
<td>• City of Boston • Mission Hill Main Streets • Boston Self-Help • The Alliance to Defend Health Care • Mission Hill/Fenway Neighborhood Trust, Inc. • Mission Hill Neighborhood Housing Services • Community Alliance of Mission Hill • Reading is Fun • Sociedad Latina • Mission Safe</td>
<td>Link: <a href="http://www.mhhm.org/">http://www.mhhm.org/</a></td>
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</table>

public housing residents
- Healthy Housing initiative including: pest management & education, asthma management, child lead and injury prevention, mitigate mold & air quality issues

Known Partners:
- Services Department
- Boston Public Health Commission
- Boston Urban Asthma Coalition
- MA Dept. of Health
- The Medical Foundation
- Tufts University School of Medicine
- Boston Center for Youth & Families
- Boston Public Schools
- Boston City Council
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<td></td>
<td></td>
<td>• Boston Collaborative for Food &amp; Fitness</td>
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## Local Community Programs Related to Mental Health and Youth Empowerment

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<tr>
<td>Dimock Center: Youth Development &amp; Enrichment Services</td>
<td>Boston; located in Roxbury</td>
<td>Mission: Support youth to navigate adolescent development through comprehensive health, education, &amp; recreation programs both on the Dimock campus and locations in Boston Goals: promote self-esteem, responsibility, &amp; learning to empower youth to make healthy lifestyle choices</td>
<td>Youth, age 6-19</td>
<td>Not specified</td>
<td><a href="http://dimockcenter.org/childandfamilydev.html">Link: http://dimockcenter.org/childandfamilydev.html</a></td>
<td></td>
</tr>
<tr>
<td>Family Services of Greater Boston</td>
<td>Boston City-Wide Located in Jamaica Plain</td>
<td>All-Stars: group program focused on delaying and preventing high risk behaviors among adolescents including substance use, bullying, violence and premature sexual activity</td>
<td>Inner-city Boston neighborhoods Infants, children, youth, families</td>
<td>Boston Public Schools Community Centers Neighborhood health clinics</td>
<td><a href="http://www.fsgb.org/">Link: http://www.fsgb.org/</a></td>
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<tr>
<td>Martha Elliot Health Center (MEHC): Harvard Mentoring Program</td>
<td>Recent Contributors:</td>
<td>Jamaica Plain, Martha Elliot Health Center Community</td>
<td>Mission: Enhancing opportunities of minority youth by fostering relationships with medical and dental students. Mentoring Program: Weekly, year-long mentorship program Youth improve academic skills, develop relationships with mentor, explore opportunities in the medical field &amp; receive support pertaining to adolescent issues</td>
<td>Young teens from the community (around MEHC)</td>
<td>Harvard Medical School</td>
<td>Link: <a href="http://www.childrenshospital.org/clinicalservices/Site2274/mainpageS2274P1sublevel16Flevel20.html">http://www.childrenshospital.org/clinicalservices/Site2274/mainpageS2274P1sublevel16Flevel20.html</a></td>
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<tr>
<td>Martha Elliot Health Center (MEHC): Just in Time (JIT) Mental Health and Crisis Intervention Center</td>
<td>Recent Contributors:</td>
<td>Jamaica Plain</td>
<td>Mission: Help adolescents with everyday struggles and crises Program: Social worker is available to meet with youth during designated walk-in clinical hours; social workers meets individually with adolescent and makes appropriate referrals</td>
<td>Adolescents experiencing crisis (i.e., wanting to engage in violence, recent unprotected sexual activity, an argument with a parent or guardian)</td>
<td>Not Specified</td>
<td>Link: <a href="http://www.childrenshospital.org/clinicalservices/Site2274/mainpageS2274P1sublevel16Flevel22.html">http://www.childrenshospital.org/clinicalservices/Site2274/mainpageS2274P1sublevel16Flevel22.html</a></td>
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<td>Program Name</td>
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<td>Tree of Life/Arbol de Vida</td>
<td>Community-building grant</td>
<td>Jamaica Plain</td>
<td>Mission: To empower JP residents to promote their health and well-being</td>
<td>Spanish-speaking parents &amp; grandparents</td>
<td>Residents &amp; Community Organizations</td>
<td>Link: <a href="http://ksgaccman.harvard.edu/hotc/DisplayOrganization.asp?id=458">http://ksgaccman.harvard.edu/hotc/DisplayOrganization.asp?id=458</a> (Program information obtained from interviews)</td>
</tr>
<tr>
<td>Project Right (Rebuild &amp; Improve Grove Hall Together)</td>
<td>Boston Public Health Commission</td>
<td>Roxbury North Dorchester (i.e., Grove Hall area)</td>
<td>Community Advocacy Organization addressing neighborhood stabilization, economic development, &amp; capacity building in the community Programs: Green Space Improvements Work with BPHC to develop programs addressing health disparities, neighborhood wellness, infectious disease, substance abuse &amp; violence Connects residents with community services (i.e., youth after school programs, youth outreach, violence prevention programs)</td>
<td>Youth residents of Grove Hall</td>
<td>Boston Public Health Commission, Blue Hill Avenue Initiative Task Force, Tenant Associations (i.e., Boston Ten Point Coalition, MassHousing)</td>
<td>Link: <a href="http://www.projectright.org/">http://www.projectright.org/</a></td>
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<td>Center for</td>
<td>Numerous supporters</td>
<td>Throughout Boston &amp;</td>
<td>Teens engage in community- and</td>
<td>Boston adolescents</td>
<td>Urban-Suburban</td>
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Children’s Hospital Boston, Community Assessment Study – Dec. 2009
Submitted by Health Resources in Action
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<td>Teen Empowerment</td>
<td>and grantees</td>
<td>Somerville, including:</td>
<td>school-based work to identify</td>
<td>Exchange</td>
<td>Boston Police Department</td>
<td><a href="http://www.teenempowerment.org/supporters.html">http://www.teenempowerment.org/supporters.html</a></td>
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<td>• Bowdoin/ Geneva area in Dorchester</td>
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### Local Community Programs Related to Injury and Violence Prevention

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<th>Known Partners</th>
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<tr>
<td>Action fo Boston Community Development, Inc./SiHLE</td>
<td>Unknown</td>
<td>• Boston City-wide</td>
<td>SiHLE: a social skills training intervention for African American girls and young women focusing on learning to value themselves and realize their value to both family and community.</td>
<td>African American girls and young women</td>
<td>•</td>
<td><a href="http://www.bostonabcd.org/programs/health-services/SiHLE.html">Link</a></td>
</tr>
<tr>
<td>Boston Society of Vulcans/Urban Public Safety Coalition</td>
<td>Unknown</td>
<td>• Boston City-wide • Organization is located in Roxbury; Community Educators are based in Dorchester • Urban Public Safety Coalition, which installs car seats is located in Dorchester</td>
<td>Community-based nonprofit organization of Black &amp; Latino firefighters who deliver injury prevention, safety/wellness education programs in the following areas: fire safety, CPR, First Aid, Bike Safety, car seat safety, injury prevention, disaster preparedness, &amp; violence prevention</td>
<td>High-risk, disadvantaged &amp; youth communities including senior citizens, low-income families, and families with children in Boston</td>
<td>• American Red Cross • American Heart Association • Department of Public Health Fire Injury Prevention Program • Boston Public Health Commission • Urban Public Safety Coalition</td>
<td><a href="http://www.bostonvulcans.org/BSV-Home.html">Link</a></td>
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<td>Program Name</td>
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| Injury-Free Coalition for Kids   | • Children’s Hospital Boston                     | • Boston area, Jamaica Plain                                                        | • Car-seat Safety Program: Educational workshops for parents re: car seat installation. Participating parents receive a free car seat or booster seat.  
• Sports Helmet Program: Distribute sports helmets to children whose families cannot afford them  
• Safe Homes: For families with children <5 years old. Conduct home assessment & provide educational materials & safety products pertaining to fires, scalds, poisoning, falls  
• Parents of infants, toddlers, and children who should ride in a booster seat  
• 200 car seats distributed in FY08  
• Home Safety: High-risk low-income families in the Boston area | • Martha Elliott Health Center  
• Children’s Hospital Primary Care Center |                                                                                      |                                                                                                    | [Link](http://www.injuryfree.org/site_display.cfm?PermanentId=380E2B2C-A355-42D4-96E6FC529C09D6F6) |
| Street Safe Boston (City of Boston) | • Boston Foundation                               | Five StreetSafe Boston Focus Communities:  
• South End/Lower Roxbury  
• Dudley Square area in Roxbury  
• Grove Hall area in Roxbury  
• Bowdoin Street & Geneva Ave. sections of Dorchester  
• Morton & Norfolk Street sections of Dorchester | • Mission: Multi-year youth development & safety initiative to dramatically reduce youth violence in Boston neighborhoods disproportionately and persistently affected by high rates of crime  
• Connecting youth population to programs & services  
• Street Level Gang Intervention: Train and deploy trained SafeStreet Boston Streetworkers with street credibility to establish relationships with youth to intervene in violence, resolve conflicts, and connect youth to appropriate programs and services  
• Neighborhood Based Delivery: Multiple-agency neighborhood organizations provide alternative programming and social services for proven-risk youth. Programming includes: workforce, education, legal services, housing services, family services, re-entry, mental health services, and recreation.  
• Adolescents in Boston at-risk for youth violence and gangs | • Lead Partners:  
• The Black Ministerial Alliance of Greater Boston  
• Inquilinos Boricuas en Accion (IBA)  
• YMCA of Greater Boston  
• Boston Centers for Youth & Families  
• Boys & Girls Clubs of Boston  
• Community Partners:  
• Boston Housing Authority  
• Boston Medical Center  
• Boston Police Department  
• BPHC  
• City of Boston  
• Department of Youth Services | [Link](http://www.tbf.org/Content.aspx?ID=9398) |
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<td>• Boston Ten-Point Coalition</td>
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Appendix G. More Detailed Responses on Gaps in Current Programming

In many of the interviews and focus groups, stakeholders, parents, and youth discussed some of the gaps and challenges in accessing current services and programming. Below is a more detailed description of some of the themes that emerged related to these issues.

Lack of communication

- Limited communication and marketing of current programs. Finding out about current services can be difficult, and many parents and youth do not know who to ask for this type of information.
- No single central disseminator of program information. End users hear about current services inconsistently and sometimes after the fact. There does not appear to be a single source that they access for this type of information.

Reach of various target populations

- Limited programs for immigrants, specifically undocumented residents. Undocumented immigrants face numerous additional challenges to access services and programs because of cultural/language barriers and lack of trust of large institutions. Few programs specifically focus on their unique needs.
- Limited programs for pre-teens/tweens. Several programs seem to address issues for children and older adolescents but pre-teens or early adolescents (specifically ages 11-15 years old) do not necessarily have many services that are geared towards them. This is a critical time as youth are leaving childhood and entering adolescence, and health and social programs can help them address many of the issues they are facing.
- Age restrictions in general. Some current programs restrict attendance to specific age groups. This is especially challenging for parents who have more than one child and want to bring both to the program.
- Parents and youth together. Parents noted that they would like to attend programs with their children to increase communication and bonding. However, few programs seemed to focus on both audiences at the same time.

Health care system navigation

- Shortage of culturally and linguistically appropriate health promotion services. Boston has a diverse population where various cultures have different values and attitudes around specific health issues. Parents and stakeholders noted that it is critical that services address these health issues in a culturally-sensitive manner.
- Limited or inconvenient interpreter services for medical appointments. While interpreter services are available for medical appointments, they are not always the easiest or most convenient to set up.
- Dearth of supports to help new and undocumented immigrants understand and access health and social services. It is difficult for most patients to navigate the health care system, and non-native English speakers encounter even more challenges. There did not appear to be a strong support system in helping immigrants understand how to access services, especially if they do not have the proper paperwork.
- Rude or unwelcoming staff at health centers. Some parents noted that they were dismayed about accessing services at their local health center because front desk staff were sometimes unwelcoming and unhelpful during interactions.

Limited programs on specific topic areas

- A need for services for youth that specifically address safe sex practices. According to parents, youth, and stakeholders, there are not many current programs that provide medically accurate, comprehensive information on safe sex practices for youth. Parents thought this was especially important for girls, along with discussions about self-esteem.
• Scarcity of pediatric mental health services. Other than going to the hospital, many parents did not know how to access mental health providers for children. This was not an issue that is talked about in the community much. It did not seem like there were many services that could help youth in dealing with depression, anger management issues, or trauma.
• Educational programs on healthy eating habits. Parents and youth noted that there are some programs in the community that try to educate parents and/or youth on obesity-related issues, but these programs are minimal. Topics such as how to read a food label, how to cook healthy with available ingredients, and the importance of eating healthy were key issues that they hoped current programming would address.

Programming approaches
• Youth-based, interactive approach needed. Several youth noted that some programs are not enticing for youth. These programs need to be interactive, get youth involved in issues that they care about, and involve youth in the development of activities.
• Lack of incentives for youth involvement. Youth wanted opportunities to meet role models (e.g., athletes, rappers) and be enticed with other incentives such as food at program meetings, which current programs do not always do.

Barriers to accessing programming or services
• Few free or inexpensive youth recreational facilities. According to several stakeholders and parents, many recreational facilities in their community are too expensive for families afford and use.
• Lack of affordable child care options for parents. It is difficult for parents to access services that focus only on them when they cannot find affordable care for their young children during that time.
• Inconvenient transportation options for many locations. Public transportation is available, but it requires users to take multiple bus routes which is inconvenient and time consuming.
• Parents not prioritizing health needs due to economic downturn. While parents want to be involved in various health programs and to access services, the current recession has put additional strain on their families. Putting food on the table and paying the bills each month end up becoming a greater priority than more long-term health issues such as obesity prevention.
• Few locations or facilities where children can play/be physically active outside that are also considered safe. Several parents and youth noted that violence can be a significant concern in their community. Because of this, several participants noted that they do not feel comfortable accessing certain free facilities where they could be active such as playgrounds and parks in their neighborhood due to safety concerns.
• Inconvenient times of current programs. Parents noted that they needed programs available at different times of the day. Many parents have evening jobs and so they are only available to participate in programs in the morning. However, many parents wanted programs to be more available in the evening. Youth and parents both commented that current amount of after-school programming seemed to be insufficient. That is, too many youth have free time during the after-school hours.
• Geographic restrictions. Some current programs restrict participation to residents of certain neighborhoods. Parents noted that this limited the number of programs that are available to them. Because Boston is so densely populated, some parents may live within certain geographic boundaries, but be closely aligned with two different neighborhoods. They wanted to be able to access services in both areas.
Appendix H. Literature Review Detailed Findings

Programmatic Findings on Youth Obesity


Program name: Project KidFIT

Sample/Setting
- 3 Houston, Texas park centers
- 120 minority (61% African American; 39% Hispanic) 6-12 yr old children (77 boys and 43 girls)
- Approximately 71% of these children were at risk for overweight and 54% were overweight.

Program Description
- An after-school intervention lasting 6 weeks based in city parks.
- The primary goal of this program was to instill the benefits of daily physical activity and good nutritional choices in its participants and to give both the youth and their parents and to support a long-term healthy lifestyle.
- Physical activity curriculum: Provided 90 minutes of various structured physical exercises (e.g. outdoor fitness drills, Pilates training, agility ladder training, obstacle courses, resistance training, physio balls, and group games) to youth twice a week
- Nutrition education curriculum (created by a staff nutritionist at Texas Children’s Hospital): Offered 30 minutes of classroom nutrition education that was designed to be fun and interactive. The curriculum was delivered in a classroom setting at selected community centers.
- Reduced bus fares (60% off) were issued to children participating in the pilot project at the kick-off event.
- Every participant received a certificate and a T-shirt after completing the program; no additional incentives or awards were provided.
- This was a collaborative program with Houston Parks and Recreation Department, Texas Children’s Hospital, Baylor College of Medicine, and the Houston Metropolitan Transit Authority.

Key Findings and Lessons Learned
- Compared to baseline, overweight children in the program decreased their BMI levels
- Significant improvements were seen in all children (regardless of weight status) in flexibility, muscular endurance, and muscular strength. Nutrition knowledge also increased by the end of program.
- According to the authors, the key to the program’s success was close collaboration among medical and research professionals with expertise in nutrition training and curriculum development, trained fitness professionals knowledgeable and experienced in working with children in a physical fitness setting and involved in the program design, and a city organization to provide marketing support and transportation services.
- Although parents were invited to participate in the program, parental attendance and involvement were extremely low possibly due to the time (after-school) of the program.

**Sample/Setting**
- Low-income inner-city elementary-aged schoolchildren (99% of children were African American at both schools)
- 2 matched low-income, minority neighborhoods in New Orleans that were approximately 1 mile apart but were separated by a canal.

**Program Description**
- This program provided a safe, supervised schoolyard. On days when school was in session, the school-yard was open after school hours (usually 3:00 PM, until 5:30 PM or dark). It was open on Saturdays and on Sundays. During the summer, the schoolyard was open on the same days and hours as during the school year. The schoolyard at the comparison school remained locked when school was not in session.
- The intervention schoolyard included an installed play structure with impact-absorbent surfacing, large paved areas in which basketball hoops were stationed and a 4-square court was painted, and an open grassy field. The research project provided and maintained ample sports equipment such as footballs, basketballs, playground balls, hula hoops, jump ropes, Frisbees, and parachutes. A compact disk player and radio was also provided to supply music for dancing, and a sprinkler was installed during the summer months.
- No fees were charged to children or their parents.
- Children were required to check in with an attendant when they entered the yard each day to verify parental permission, but afterward they could enter and exit freely.
- Three to 4 attendants (almost all of whom were teachers) were paid to prevent fights or bullying among children, prevent vandalism or theft of recreational equipment, and prevent adults or children outside of the designated age range from entering the schoolyard.
- Attendants did not organize, require, or even suggest specific activities to children.

**Key Findings and Lessons Learned**
- After the schoolyard was opened, a mean of 71.4 children used it on weekdays and 25.8 used it on weekends during the school year. When observed, 66% of these children were physically active. The number of children who were outdoors and physically active was 84% higher in the intervention neighborhood than the comparison neighborhood. Survey results showed that children in the intervention school reported declines relative to the children in the comparison school in watching television, watching movies and DVDs, and playing video games on weekdays. No significant intervention effects were found for body weight, BMI or any other measures of body composition.
- It cost the project $49,000 per year for the schoolyard staff, but the authors believe that the program can be “implemented for less in many schoolyards by employing fewer staff”

Program name: Stanford GEMS (Girls health Enrichment Multi-site Studies)

Sample/Setting
- Sixty-one 8-10-year-old African-American girls and their parents/guardians.
- Low-income neighborhoods of Oakland and East Palo Alto, California

Program Description
- This was a 3-month after-school dance classes and a family-based intervention.
- The treatment intervention (based on Bandura's social cognitive theory) consisted of after-school dance classes (i.e. African dance, Hip Hop, and Step) offered 5 days per week at 3 community centers in the target neighborhoods.
- Sessions started with a healthful snack and an hour-long homework period; they ended with a 30-minute talk about the meaning of dance in the girls’ live and in African American community/ culture.
- Classes were led by female African American college students and recent college graduate, recruited from dance organizations/troupes at nearby universities and local communities.
- The “active” control intervention consisted of disseminating newsletters and delivering health education lectures promoting healthful eating and physical activity.
- Families were paid $25 after completing the baseline measures and $75 after completing the follow-up measures.

Key Findings and Lessons Learned
- Recruitment and retention goals were exceeded. High rates of participation were achieved for assessments and intervention activities, except where transportation was lacking. All interventions received high satisfaction ratings.
- At follow up, girls in the treatment group, as compared to the control group, exhibited trends toward lower body mass index and waist circumference, increased after-school physical activity; and reduced television, videotape, and video game use.
- The treatment group reported significantly reduced household television viewing and fewer dinners eaten while watching TV. Treatment group girls also reported less concern about weight and a trend toward improved school grades.
- The program planner highlight that extensive formative research and pilot testing was conducted in the study communities. They state, “We believe this contributed to our successful and rapid recruitment of eligible girls and families, and the outstanding retention rate over the 3-month study. Focus groups and small feasibility trails also enabled us to identify specific potential benefits that would motivate both girls and their parents/ guardians to participate in the assessments and the propose intervention activities”.

Children’s Hospital Boston, Community Assessment Study – Dec. 2009
Submitted by Health Resources in Action

Program name: Memphis GEMS (Girls Health Enrichment Multi-site Studies)

**Sample/Setting**
- 60 African-American girls, aged 8 to 10 years, with a body mass index (BMI) > or = 25th percentile of the CDC growth charts, along with their parents/caregivers
- Community centers in Memphis, Tennessee

**Program Description**
- This was a culturally relevant, family-based intervention based on social cognitive theory and family systems theory. Girls and their families were recruited through PSAs on several local African American radio stations and flyers distributed at local elementary schools.
- The active interventions involved highly interactive weekly group sessions with either girls (child-targeted program) or parents/caregivers (parent-targeted program). The active interventions were designed with awareness of the importance of positive body image. Content focused on knowledge and behavior change skills to promote healthy eating and increased physical activity.
- The child-targeted intervention: Weekly, 90-minute intervention sessions, with a 15-minute opening and ending discussion. Dance and hip hop aerobics was the main physical activity component (30 minutes). A variety of nutrition components (30 minutes) were offered, including discussions, taste-testing, food preparation activities, food-art, a modified Farmer’s Market, and basic label reading skills. Healthy snacks and child-friendly recipes were offered at each session. Incentives were given to participants.
- The parent-targeted intervention: Weekly, 90-minute intervention sessions, with a physical activity dance component (25 minutes), a didactic nutrition segment (25 minutes), a segment alternating food preparation and nutrition-related games (25 minutes), and a 15-minute wrap-up session. Incentives were provided.
- The comparison intervention focused on global self-esteem. Nutrition and physical activity were not addressed in this condition.

**Key Findings and Lessons Learned**
- The intervention met all recruitment, retention, implementation, and participation goals, and was given high rating by both participants and interventionists.
- With respect to the comparison intervention, girls in both the child-targeted and parent-targeted interventions demonstrated a trend toward reduced body mass index and waist circumference.
- Girls in the active intervention groups reduced their consumption of sweetened beverages by 34%, increased their level of moderate-to-vigorous activity by 12%, and increased their serving; of water by 1.5%.
- A major program challenge is that only 3 participants provided blood, although program planners developed a well-thought out blood collection protocol (which took into account the “historical distrust of medical research among some African Americans”).
Program name: Stanford Sports to Prevent Obesity Randomized Trial (SPORT)

Sample/Setting
- 21 children in grades 4 and 5 with a body mass index at or above the 85th percentile
- Low-income, racial/ethnic minority community in northern California

Program Description
- The intervention consisted of a coed after-school soccer sport team program. The control group consisted of an after-school health education program.
- The soccer program was initially offered 3 days per week but was increased to 4 days a week during month 5 of the study at the request of participating children and parents. One day per week was game day, with the other days being practice days.
- Sessions started with a homework period, followed by approximately 75 minutes of activity. The activity period began with a supportive, team-building check-in followed by 15 minutes of warm-up and stretching. The remainder of practice was devoted to learning soccer skills in the context of fun skill-building exercises and concluded with a scrimmage. Practices were structured to promote positive experiences through sport with an emphasis on respect for self and others, inclusion, and teamwork. Shin guards, uniforms, and water bottles were provided to each player. Each practice ended with a celebratory cheer and recognition of individual players’ efforts and teamwork.
- Matches involving the children, their parents, and the coaches were held quarterly. At the conclusion of the program, children received certificates of accomplishment and medals.
- Trained Stanford University undergraduate and medical students served as volunteer coaches and homework tutors.
- Children were recruited through primary care physician offices and clinics, schools, and community centers.

Key Findings and Lessons Learned
- All 21 children completed the study. Compared with children receiving health education, children in the soccer group had significant decreases in body mass index at 3 and 6 months and significant increases in total daily, moderate, and vigorous physical activity at 3 months.
- Child and parent responses to the soccer and health education programs were enthusiastic.
- The authors noted that offering an intervention on-site at schools may overcome barriers to attendance seen in more traditional weight management programs located at medical centers, which may be less accessible to low-income, racial/ethnic minority populations.

Program name: WIN (Washington Heights-Inwood Network) for Asthma Program

Program Description
- Program based at New York Presbyterian Hospital
- Collaborators include Northern Manhattan Asthma Basics for Children Initiative
- Families with children with asthma recruited through day care centers and schools and referrals from community based organizations.
- Families received home environmental assessments

Key Findings and Lessons Learned
- According to WIN program staff, in first group of students, hospitalizations were reduced by 85%, emergency room visits by 66%, and the number of missed school days was reduced by 42%.


Program name: KP Kids

Program Description
- Multidisciplinary approach involving pediatricians, registered dietitians, registered nurses. Exercise physiologists, and behaviorists.
- Parents and children attended 6 weekly educational sessions, 1.5 hours in length, during which 30 minutes each were devoted to physical activity, nutrition, and behavior change education.
- Nutrition sessions included information about planning meals, age specific meal plans, label reading, and preparing healthy foods.
- Behavioral sessions focused on implementing change, setting goals, and developing new habits.
- Parents received information about obesity and its complications.

Key Findings and Lessons Learned
- Results at 6 months revealed statistically significant changes in children’s behavior.
- Fruits and vegetables consumed increased from 2.3 to 2.8 servings.
- Soda and fruit juice consumption decreased from 2 to 1.54 servings per day.
- Junk food consumption decreased and hours spend watching TV or playing videos games decreased from 3.1 to 2.92 hours.
- Children increased their hours of exercise per week from 2.25 to 2.55 hours.
- 1 year follow up did not show that these differences were maintained over time.
- Researchers noted “that the most effective way to implement evidence-based multidisciplinary prevention programs may be through community-based outreach.” Program implementers planned to work on developing programs at local YMCAs and family clinics.
Programmatic Findings on Asthma


Program name: The Neighborhood Asthma Coalition (NAC)

Sample/Setting
- 8 St. Louis, Missouri neighborhoods, 4 served by Grace Hill Neighborhood Services, 4 outside of the Grace Hill service area
- Low income, African American children, 5 to 14 years old with at least 1 incident of acute care (emergency department visit or hospitalization)

Program Description
- The Neighborhood Asthma Coalition (NAC) was a community-based intervention that was conducted through a well-established neighborhood organization.
- The program was developed to emphasize neighbor-to-neighbor support and encouragement of asthma management through the Grace Hill Wellness Initiative, which included neighbor involvement in governance through neighborhood-based Wellness Councils.
- The NAC included promotional campaigns to increase awareness, asthma management courses (based on the American Lung Association Open Airways program) in schools and neighborhood settings.
- Residents were involved in planning programs, training of neighborhood residents to implement asthma management classes, recruitment of neighborhood residents to assist in NAC activities, and recruitment of neighborhood residents to act as Change Asthma with Social Support (CASS) workers, providing basic education and support to parents and children.
- Potential participants were identified from medical records and called for further screening.
- This program was conducted by Grace Hill Neighborhood Services, an established health and social service agency serving low income neighborhoods in St. Louis.

Key Findings and Lessons Learned
- Acute care rates decreased for both the NAC and control groups from the year before intervention to the last year of intervention, with no significant differences between the NAC and control groups.
- Participation in NAC programming affected the acute care outcome; the NAC-low participation and control groups did not differ but the NAC-high participation group differed significantly from the pooled control and NAC-low participation groups in reductions in acute care rates.
- Evaluations included quarterly telephone interviews to assess asthma attitudes and management and sites of care. The primary outcome was acute care. Audits of acute care sites covered 12 months before initiation of the NAC through 3 years of the program. Repeated-measures analysis of variance was used to evaluate the effect of NAC on changes in acute care rates between baseline measurements and the end of treatment. Analysis of covariance was also used to examine the effects of treatment group assignment and level of participation in NAC. Structural equation modeling was used to analyze the role of participation in NAC within the context of other factors related to changes in acute care rates.
• Both contacts with NAC staff members and attendance at educational events were associated with changes toward stronger views that asthma can be managed (partial correlation = .27 and partial correlation = .24, respectively). Structural equation modeling demonstrated that participation in the NAC was associated with positive changes on the Index of Asthma Attitudes scale and lower rates of acute care. Social isolation was associated with greater participation in the program and thus reduced care rates.

• Authors noted a low percentage of high participators. This was attributed to a significant episode of asthma morbidity.

• According to authors, “the limitation of NAC effectiveness to subjects with appreciable participation suggests that interventions to reduce morbidity rates must be designed to increase the involvement of parents and other caregivers. One approach may involve increased use of lay health workers, such as the CASS workers in this program. CASS workers were able to learn about asthma and provide support for parents to administer regular care for asthma and respond early to symptoms. Also, CASS workers could be deployed to actively seek out and recruit nonparticipating or high-risk parents.”

Program name: The Columbus Ohio Partnership of Inner-City Asthma Education (COPICAE)

Sample/Setting
- Urban and minority children (and their parents) in predominantly ethnic minority inner-city communities
- Columbus, Ohio

Program Description
- Between September 2001 and March 2002, the Columbus Ohio Partnership for Inner-City Asthma Education (COPICAE), piloted a program to provide asthma education classes in a branch of the Columbus Metropolitan Library (CML) in four minority communities rather than at healthcare site.
- Six hours of asthma education in three 2-hours sessions were provided to children and their parents using the Open Airways for Schools curriculum developed by the ALA.
- The asthma education classes were held between 5:30 and 7:30PM. The parent-children pair received a $30 honorarium for completion of the 6 hours of asthma education.
- COPICAE schedule a follow-up visit with each participant's primary care physician within 4 to 8 weeks (or sooner if necessary) following completion of the 6 hours of asthma education. Parents were instructed to contact their physician if they had questions or needed medical advice about their asthma care after each class.
- COPICAE was staffed by a full-time medically trained project direction and four peer asthma education (not medically trained).
- COPICAE provided on-site “baby-sitters” and vouchers for public transportation or card far when requested.
- COPICAE is a partnership between the Columbus Metropolitan Library, the Columbus Children’s Hospital Primary Care Network, and the Central Ohio Chapter of the American Lung Association.

Key Findings and Lessons Learned
- Compared to pre-intervention mean scores, there were decreases in scores to all LWAS items.
- Parents reported improvements in compliance with asthma medication use and overall control of their child's asthma.
- Parents also found the information from the asthma education classes to be "beneficial." Parents found 6 hours of asthma education to be beneficial in gaining basic knowledge about asthma and improving their child's illness control and self-esteem in living with asthma.
- Total asthma-related billing claims for children who completed 6 hours of asthma education decreased 63.2%, while those for age and zip code matched controls increased 0.7%.

Program name: The Seattle-King County Healthy Homes Project

Sample/Setting
- King County, Washington
- 274 low-income, ethnically diverse urban households containing a child aged 4–12 years who had asthma

Program Description
- Participants were recruited from community and public health clinics (65%) as well as from local hospitals and emergency departments and referrals from community residents and agencies.
- Caregivers gave informed consent and received $110 for participation.
- Participants were assigned to either a high-intensity group receiving 7 visits and a full set of resources or a low-intensity group receiving a single visit and limited resources.
- A community health worker conducted a structured home environmental assessment at the first visit. Each assessment finding generated specific actions for the participant and CHW. The CHW and participant prioritized the actions to prepare an action plan.
- For the high-intensity participants, the CHW made 4–8 additional visits to encourage completion of the action plan, provide education and social support, deliver resources to reduce exposures (allergy control pillow and mattress encasements, low-emission vacuums, commercial-quality door mats, cleaning kits, referral to smoking cessation counseling, roach bait, rodent traps), offer assistance with roach and rodent eradication, and advocate for improved housing conditions. Free skin-prick allergy testing at multiple clinic sites and at special asthma fairs were also offered.
- For the low-intensity group, the CHW conducted a single visit, which consisted of the home environmental assessment, an action plan, limited education, and bedding encasements. After completing exit data collection 1 year later, low-intensity group members received the full package of resources and additional education.

Key Findings and Lessons Learned
- Primary prespecified outcomes were Pediatric Asthma Caregiver Quality of Life Scale score, asthma symptom days, and proportion with self-reported asthma-related urgent health service use during the past 2 months. Intermediate outcomes included participant self-report of behaviors related to trigger exposure and control, medication use, and school and work absences resulting from asthma. Presence of triggers in the home was assessed through interviewer observation and caregiver report.
- The high-intensity group improved significantly more than the low-intensity group in its pediatric asthma caregiver quality-of-life score ($P= .005$) and asthma-related urgent health services use ($P= .026$). Asthma symptom days declined more in the high-intensity group, although the across-group difference did not reach statistical significance ($P= .138$). Participant actions to reduce triggers generally increased in the high-intensity group.
- There were a low percentage of high participators.
According to the authors, “Several factors may have contributed to the intervention’s effectiveness. First, CHWs may be particularly successful in promoting behavior change because they share community, culture, and life experiences with their clients and are readily welcomed into the home. The CHWs developed motivating relationships with their clients, who rated them highly. Second, CHWs educated clients about asthma triggers, information frequently not imparted by health providers... Third, the intervention offered resources for trigger reduction. Fourth, a home-based intervention permitted direct assessment of the indoor environment and offered opportunities for demonstration and coaching. Fifth, the CHWs used an individualized approach to address each participant’s most pressing concerns, both asthma related and others (e.g., housing, income).”

Program name: LA CASA (Los Angeles Controlling Asthma by Stopping Allergens)

**Sample/Setting**
- Hispanic families in Los Angeles, California
- Children 6-14 years old who had at least three visits to the Breathmobile (a school-based mobile asthma clinic that visits inner-city public schools in Los Angeles) or allergy clinic, and a positive skin test to mixed cockroach allergen.
- Caretakers were largely recent immigrants from Mexico and Central America, spoke Spanish as a first language, and had limited formal education.

**Program Description**
- An educational intervention delivered by a peer health educator to the caretaker in the child's home to control cockroaches by reducing harborage and access to food and by applying boric acid, and to reduce allergen exposure by cleaning. Allergen impermeable covers were placed on the child's mattress and pillows.
- At the end of the training, the health educator and the caretaker agreed on commitments to a selected list of activities for cockroach control within the next 4 months before the second visit was to take place, e.g. house cleaning to restrict cockroach access to food, caulking, or applying boric acid.

**Key Findings and Lessons Learned**
- There was improvement in knowledge and in observed and reported behavior hypothesized to be associated with cockroach control.
- The geometric mean cockroach number in the intervention homes at the follow-up visit was 60% lower than in the non-intervention homes (95% confidence interval (CI) 14%, 81%). Geometric mean total cockroach allergen collected from the child's bedding was 64% lower in the intervention group (95% CI 12%, 85%).
- In homes with heavier initial cockroach infestation, there was a larger reduction in total kitchen dust allergen and concentration associated with the intervention than in homes with fewer initial cockroaches.
- The authors note that the “educational approach might make this intervention more sustainable over a prolonged period than professional cockroach extermination and cleaning. Nevertheless, allergen concentration in kitchen dust in our study remained high in the intervention group.”
- Further, “it is possible that because of language and cultural barriers, many LA CASA study participants had limited understanding of the relationship between allergen exposure and asthma at study entry or of methods for allergen control. Some had little prior positive experience with social service agencies. Thus, we speculate that the participant population and a favorable experience with the peer health educators may have enhanced the effect of the intervention relative to the comparison group.”
- Although cockroaches were eradicated in a majority of homes, the authors highlighted that this approach was expensive.
Program name: Harlem Children’s Zone Asthma Initiative (HCZAI)

Sample/Setting
- Central Harlem, New York City, New York
- Children <12 years with asthma or asthma-like signs or physical findings consistent with asthma

Program Description
- A pediatric asthma team (including four community workers, a social worker, a nurse, and three physicians) offers medical, educational, environmental, social, and legal services to families of enrolled children.

Key Findings and Lessons Learned
- School absences reported by the parents/guardians of enrollees declined during the preceding 14 days, both for any reason (from 34.4% to 16.0% in 18 months) and because of asthma (from 23.3% to 8.0% in 18 months).
- Emergency department and unscheduled physician office visits for treatment of asthma decreased from 35.0% to 8.0% in 18 months.
- Reported use of asthma management strategies (e.g., using a spacer device and having an asthma action plan) by parents/guardians of enrolled children increased substantially over time.
- According to authors, “monitoring effectiveness proved burdensome for some staff and clients and failed to capture the full extent of client needs and service provision.” Thus, additional activities in the future include “1) building closer working alliances with other community organizations and agencies...; 2) developing protocols for situations in which family and mental health problems preclude participation in HCZAI; and 3) expanding community education regarding asthma to enhance health literacy through existing Harlem Children’s Zone, Inc. programs.”


Program name: Clean Air for Kids (CAFK)

Sample/Setting
- Convenience sample consisted of 60 caregivers. Between 2001 and 2003, 197 families received program services.
- Tacoma-Pierce County, Washington

Program Description
- The CAFK partnership in Tacoma-Pierce County, Washington, implemented a community-based asthma outreach worker (AOW) program
- The AOW was trained in conducting home visits, home environmental assessments, and providing asthma education about asthma management and methods to minimize home environmental asthma triggers. Free supplies to better manage asthma and reduce exacerbating factors, such as allergen proof pillow and mattress covers, doormats, spacers with facemasks, and peak flow meters, were provided by AOWs. Home visits were then completed with the option of further contact via telephone or e-mail.
- Partners of the Clean Air for Kids (CAFK) included the local and state health departments, the American Lung Association of Washington, health care agencies, the tribal health authority, the school district, and the local university.

Key Findings and Lessons Learned
- Caregivers reported significantly higher quality of life at follow-up than at baseline.
- At follow-up, 93% of the children had asthma management plans as compared with 31% at baseline. Self-reported hospitalizations were significantly reduced. All of the families made changes to minimize household asthma triggers. Caregivers reported high satisfaction with the AOW and 90% of them felt that the home environmental assessment conducted by the AOW helped improve their child’s asthma.
- Authors noted, “The AOW’s personality and competence, as reported by the caregivers, may have influenced their perception of effectiveness. Results may differ if multiple outreach workers were employed.”

Program name:  Healthy Public Housing Initiative

Sample/Setting

- Fifty asthmatic children aged 4-17 from three public housing developments in Boston, Massachusetts

Program Description

- The Healthy Public Housing Initiative (HPHI) was a community-based participatory research project involving Boston city agencies, or housing and health, three universities, several public housing community groups and expert consultants.
- Environmental interventions primarily consisted of integrated pest management and related cleaning and educational efforts and resources (e.g. replacement of mattresses in the asthmatic child’s room with new mattresses with microfiber technology), but also included limited case management and support from trained community health advocates -who were residents of the developments or surrounding neighborhood who received training about asthma and interviewing techniques.
- Additionally, a community health nurse worked with caregivers on asthma action plans and provided peak flow meters as well as facilitating a linkage with healthcare providers for children with acute distress.

Key Findings and Lessons Learned

- Significant reductions in a 2-week recall respiratory symptom score (from 2.6 to 1.5 on an 8-point scale) and in the frequency of wheeze/cough, slowing down or stopping play, and waking at night.
- Authors noted that, "in spite of the work of our Community Health Nurse and CHAs, many children still relied on the emergency room rather than primary care physician, there were no gains in the prevalence of asthma action plans, and many children remained incorrectly medicated with their caregivers perceiving otherwise".
- Longitudinal analyses of asthma-related quality of life similarly document significant improvements, with a suggestion of some improvements prior to environmental interventions with an increased rate of improvement subsequent to pest management activities.
- Further, authors noted a benefit of the CBPR approach in this study is that "it effectively engaged the city and helped with plans to expand IPM [integrated pest management] in Boston public housing").

Program name: The YES We Can Urban Asthma Partnership

Sample/Setting
- Children (aged 0 to 12+) and were mainly Latino and African American; 65 Yes We Can patients.

Program Description
- The Yes We Can Urban Asthma Partnership is a collaboration with 17 local medical, governmental, and social service organizations. Yes We Can is a medical/social care model for clinic-based, community focused, team-oriented pediatric asthma management. Developed using the Chronic Care Model.
- The three Yes We Can components include: 1) medical evaluations (consultation by clinic physicians and nurse practitioners; e.g. medical assessment, allergy skin testing), 2) social interventions (conducted by community health workers during clinic visits and at separate home visits; e.g. discussion of environmental triggers and appropriate medication use); and 3) integrated efforts (performed by clinicians and community health workers; e.g. patient education, social support and community outreach).

Key Findings and Lessons Learned
- Program evaluation demonstrated increases in prescribing controller medications, use of action plans, and the use of mattress covers; and decrease in asthma symptoms.
- Additional changes occurred within the local system of asthma care to support ongoing efforts to improve asthma management.
- The authors highlighted the importance of community health workers in achieving and effective intervention.
- Authors noted that despite the value of the intervention, there was some reluctance among some families to accept home visits as a component of asthma care. This reluctance could come from such issues as immigration status and stability of housing which may have led to home visit refusal.

Program name: Community Asthma Prevention Program

Sample/Setting
- Philadelphia, Pennsylvania
- 281 asthmatic children (between 2-16 years old). Almost exclusively African American.

Program Description
- In-home education visits covered asthma physiology, asthma trigger avoidance and asthma management (e.g. development of a medication action plan). Environmental remediation was conducted together with the caregiver.
- Participants were randomized to receive home visits only or home visits with environmental remediation.
- Incentives were given to both groups at the end of each home visit, and included coupons, gift certificates, etc worth up to $10 cash value.

Key Findings and Lessons Learned
- Both intervention groups experienced reduction of hospitalizations, emergency room visits, sick visits and asthma symptoms. Both groups showed outcomes significantly superior to the matched control group. Intervention effectively reduced the presence of rodents and carpet in home and increased the use of mattress and pillow covers.
- The authors discussed the importance of the community health worker model for health promotion in general and asthma management.
Programmatic Findings on Mental Health and Youth Empowerment


Sample/Setting
- 181 ethnically diverse children ages 6-12 and their mothers exposed to intimate partner violence
- Midwest, United States

Program Description
- 10-week community-based intervention program with group therapists that were paired with community providers, such as therapists at local mental health clinics.
- Mothers were recruited for participation in the study through flyers and newspaper advertisements, at social service agencies, and through shelters for battered women in five urban locations in Michigan.
- The intervention programs were conducted in settings available in each community, such as existing mental health clinics, education centers, and shelter outreach programs.
- Child-only intervention (CO): Targeted children's knowledge about family violence, their attitudes and beliefs about families and family violence, their emotional adjustment, and their social behavior in the small group. Groups were age graded (6–8 years, 9–12 years) and gender mixed. Each intervention group had 5-7 children and two therapists trained to provide support and to serve as models for managing emotions and interpersonal conflict that the child's family may not have provided.
- Child-plus-mother intervention (CM): Designed to support mothers by empowering them to discuss the impact of the violence on their child's development; to build parenting competence; to provide a safe place to discuss parenting fears and worries; and to build connections for the mother in the context of a supportive group.
- Mothers received $20 and children were given a gift ($5 value) at each interview.

Key Findings and Lessons Learned
- A sequential assignment procedure allocated participants to 3 conditions: child-only intervention, child-plus-mother intervention, and a wait-list comparison. A 2-level hierarchical linear model consisting of repeated observations within individuals and individuals assigned to conditions was used to evaluate the effects of time from baseline to post-intervention comparing the 3 conditions and from post-intervention to 8-month follow-up for both intervention conditions. Outcomes were individual children’s externalizing and internalizing behavior problems and attitudes about violence.
- Of the 3 conditions, CM children showed the greatest improvement over time in externalizing problems and attitudes about violence. There were 79% fewer children with clinical range externalizing scores and 77% fewer children with clinical range internalizing scores from baseline to follow-up for CM children.

Program name: The Parenting-Toddler Project

Sample/Setting
- Families with at least one young child (2-3 years old); approximately 91% of the participating parents were mothers and most were from racial/ethnic minority groups (African American and Latino).
- 11 day care centers in low-income neighborhoods in Chicago, Illinois.

Program Description
- 12-week group-based cognitive behavioral parent training program: Parents meet in groups of approximately 12 parents led by two trained group leaders once a week for 12 weeks at their children's day care center.
- During the group sessions, parents watched and discussed videotaped vignettes of parent and child models engaged in a variety of situations typically faced at home by many families. Additionally, parents received weekly 'homework assignments' that help them to generalize the program concepts to their home.
- Group leaders were all registered nurses.

Key Findings and Lessons Learned
- Parents who participated in the program used less coercive discipline strategies, gave fewer critical comments to their children during play, were less directive with their children during free play, and praised their children more frequently than parents in the comparison group.
- Children’s aversive behaviors across multiple contexts were significantly reduced following the intervention as assessed by teachers and observers blind to the study group assignment.
- The program was generally well received by participants. For example, the vast majority parents reported that they would “highly recommend” or “recommend” the program to a friend of relative.
- The authors noted that most parents found it “difficult to complete a 12-week program”.
Program name: Children’s Medication Algorithm Project (CMAP)

Sample/Setting
- 90 ethnically diverse children between the ages of 6 and 17 years with ADHD or a depressive disorder
- Texas.

Program Description
- A psychoeducational program into the medication algorithm created to improve treatment of children with ADHD and/or depression in four Texas community mental health centers.
- CMAP is a collaborative venture of the Texas agency charged with mental health treatment, several Texas universities and medical schools, parent and family representatives, and representatives from various mental health advocacy groups.
- CMAP included four major programmatic components: 1) evidence-based, consensus-driven medication treatment algorithms, 2) clinical and technical support for treating physicians including clinical assessments to help the physician implement the program; 3) a patient and family psychoeducation program (e.g. where program materials were available for different participants in the child’s care – family, teacher, primary care physician); 4) uniform documentation of treatment decisions and patient outcomes.

Key Findings and Lessons Learned
- Overall, the caregivers and children were satisfied with the program and thought it was helpful. For example, of the caregivers that completed the surveys, 63% indicated that they received the right amount of education information; 60% of children/adolescents reported that they receive the right amount of education.
- Authors noted that a large proportion of individuals did not complete the program. They hypothesize that the “reductions in barriers to group attendance, such as providing transportation and offering groups in the evening, may not be enough to facilitate this intervention without the formal support of the clinic system.”

Program name: Family Preservation Program and 5-day Residential Program

Sample/Setting

- 82 predominantly low-income, White youth with emotional and behavioral disorders

Program Description

- The program involved short-term treatment (3 months of intensive treatment) and a longer-term treatment (1 year postdischarge intervention): Treatment outcome goals were: 1) reduce the prevalence of externalizing disorders, 2) increase normative functioning; and 3) increase prosocial behavior.
- For the family preservation program, in-home service was the core program component, which provided up to 12 hrs a week. After the completion of the intensive phase, ongoing support was available in the form of parent support groups offered either at an agency or through a community-based program (i.e. Boys & Girls Club). Focus on cognitive behavioral methods as strategies to enact change.
- The 5-day residential program, was housed in a residential treatment unit, licensed for nine beds to meet the needs of children and youth with emotional and behavioral disorders. Programs were highly individualized and flexible. Services were solution focused and based on the brief therapy model of treatment.
- Upon completion of surveys, parents were given monetary incentives

Key Findings and Lessons Learned

- Results confirmed high rates of comorbidity in this population for externalizing and internalizing disorders. A significant Treatment x Program interaction was evident for internalizing disorders.
- At 1-year follow-up, significantly higher percentages of youth from the FP Program revealed a reduction of clinical symptoms for ADHD, as well as, general anxiety and depression, whereas significant proportion of youth from the 5DR Program demonstrated clinical deterioration and increased symptoms of anxiety and depression
- Authors discuss the important role of cognitive and behavioral methods in the treatment of ADHD and the reduction of anxiety.

Sample/Setting
- New York City, New York

Program Description
- To promote collective recovery, New York City RECOVERS (NYCR)--a network of organizations formed to promote trauma recovery post 9/11--in conjunction with the New York University’s International Trauma Studies Program, persuaded the New York City Department of Health and Mental Health and the FEMA-funded Project Liberty to sponsor a conference (Together We Heal) on collective recovery, with a focus on the first anniversary of the tragedy.
- Other campaign elements were: youth outreach and decorating the city. For youth outreach, the Columbia Center for Youth Violence Prevention (CCYVP) joined NYCR to tailor Take a Deep Breath/September Wellness Month to the needs of youth. Tip sheets were created and posted on the web and distributed through schools, boards of education, and other educational and family-centered organizations. One set of tip sheets offered options of healing activities. Decorate the City was an initiative that took inspiration from the many kinds of visuals that were posted around the city after 9/11, most especially the missing persons posters, and some city organizations held Decorate the City events.

Key Findings and Lessons Learned
- No youth mental health outcomes were reported, but the authors wrote, “The concepts and materials created for the Healing Anniversary of 9/11 found their way into many hands. One NYCR staff person found a tip sheet posted in a taxi because the driver wanted to help riders manage the anniversary. A number of NYCR partners were in the spotlight on radio and television for their special efforts around the anniversary. ... By the time of the anniversary, however, peace and healing were being pushed off the dominant agenda by war in Afghanistan and the growing hostility toward Iraq. NYCR did not succeed in achieving the broad mass mobilization needed for full social and emotional recovery. NYCR did, however, help the researchers gain an insight into how to engage organizations in community mobilization efforts.”
- The authors state, “The most practical lesson learned through this process was that asking stakeholders what to do produced powerful and unexpected answers. The actual actions of organizations tended to follow the actions of other organizations, rather than more theoretical ideas proposed by the conveners. Thus, the observation that people-follow-other-people offered an important path for continuing efforts to reknit urban fractures and decrease youth violence.”
- The importance of community and academic partnerships were also discussed.

**Sample/Setting**
- Youth in Flint, Michigan; hosted by teen centers and local churches

**Program Description**
- Photovoice is a grassroots method in which participants are provided cameras to document the features of their environment that are most salient and to communicate issues to policymakers and community leaders, media, and community members.
- Youth were provided with cameras to document the causes and prevention of youth violence, and photographs were used to promote group discussions about community issues and assets. The discussions and Photovoice activity apply a consciousness-raising, feminist theory framework.
- Youth displayed their photographs and narratives in public spaces throughout the city. In addition, youth shared their narratives with city leaders.

**Key Findings**
- Photovoice helped community leaders to understand issues underlying neighborhood safety and youth violence. Testimonies and photographs taken by youth and presented to city leaders resulted in reinstating funding for programs.
- This method of community assessment may provide a rich opportunity to engage in dialogue and awareness-raising with policymakers, media, and community organizations.
Programmatic Findings on Injury and Violence Prevention


Program name: Love Our Kids, Lock Your Guns

Sample/Setting
- 112 adult gun owners recruited through a mass media advertising campaign
- 62% White; 38% Black
- Urban county in central North Carolina

Program Description
- Community-based tailored firearm safety counseling, gun safety information, and gun lock distribution program with a demonstration of proper use.
- Participants also received a T-shirt with the Love Our Kids, Lock Your Guns logo.
- Campaign spearheaded jointly by a law enforcement officer and a pediatrician; the program received official, financial, and in-kind support from the law enforcement agency, the mayor, the city council, the county baseball team, the North Carolinians Against Gun Violence, the local Wal-Mart, the Injury Prevention Research Center, and University of North Carolina at Chapel Hill.
- Program participants were recruited through a multimedia campaign, which included press conferences, newspaper and television advertisements, and radio public service announcements. Churches, community organizations, neighborhoods, and clinics were also sent letters and flyers about the event.
- Participants were also given gun locks—free of charge—to eliminate a financial barrier that may not be accomplished by discount coupons for safety devices used in other programs.

Key Findings and Lessons Learned
- At follow-up, of the 82 participants, 63 (77%) (up from 39 [48%]) reported storing their gun(s) in a locked compartment
- 59 (72%) (up from 0) reported using gun locks
- 61 (74%) (up from 57 [69%]) reported storing their ammunition locked in a separate location
- 59 (72%) (up from 52 [63%]) reported storing their gun(s) unloaded
- 6 (7%) (down from 15 [18%]) reported storing firearms unlocked and loaded
- Participants with children were more likely at baseline to store weapons unlocked and loaded (38 [59%] vs. 19 [41%]) but were more likely after counseling to lock their weapons (29 [58%] vs. 14 [44%]) and remove guns from the home (5 [10%] vs. 0 [0%]).
- Authors noted that program success was likely because of the following: (1) it took place in a community setting; (2) unlike in a primary care setting, where generally women take children to appointments, we were able to attract men, the actual gun owners; (3) we provided "tailored" counseling; (4) we did not have time limitations for participant counseling; and (5) it was preceded by a multimedia campaign using high-profile community professionals.

Program name: Youth Injury Prevention Initiative (YIPI)

Sample/Setting

- Cincinnati, Ohio
- 14 predominantly African American churches (7 intervention churches and 7 control churches). The congregation sizes ranged from 67-3,000 total members

Program Description

- Community participatory faith-based culturally sensitive youth injury prevention program, targeting motor vehicle restraint use.
- Selected program elements include: youth injury prevention education, ministers incorporating messages in sermons, family safety fair, and safety device distribution.
- Program developed by advisory committee and was based on social learning theory and health behavior model.
- Control group received a nutrition education program.

Key Findings and Lessons Learned

- Program received excellent recognition and participation.
- Significant improvements were observed in restraint use compared to control churches following program implementation. There was a 72% reduction in unrestrained children, a 25% increase in children being secured in the rear-seat position and a nearly 20% increase in driver restraint use.
- The program designers underscored the importance of partnering with the community in all phases of the program. For example, "CBPR helps to address the gaps related to sociodemographic and economic characteristics between the public and 'experts.' Including community members as equal partners, as done in our program, has the potential of bridging the cultural gaps that exist between involved partners. This approach is particularly useful for addressing the persistent problems of health disparities" (P. 1340). However, the program designers also noted that “building relationships with the church and all the partners required extensive time and coordination".

Program name: The Injury Free Coalition for Kids of Greater Cincinnati

**Sample/Setting**
- Children from birth through 18 years of age
- Low income, predominantly African American communities
- Cincinnati, Ohio

**Program Description**
- The Injury Free Coalition for Kids of Greater Cincinnati (IFCK-C) is a multi-faceted injury prevention program in one Cincinnati community based on the Harlem Hospital IFCK model.
- IFCK-C is a multi-disciplinary group composed of hospital personnel (physicians, nurses, paramedics, etc at Cincinnati Children's Hospital Medical Center) and community leaders, with representation from organizations such as the poison control center, the Cincinnati Recreation Commission, the community council, and business owners.
- IFCK-C’s approach to preventing injuries combines hospital expertise of knowing injury data with community recommendations and input for addressing concerns and developing interventions.
- Educational endeavors to promote safety were provided for families at school and community fairs with prevention messages geared toward the population present.
- To promote change within the community youth were provided with safe play places (e.g. building playgrounds, building a football stadium adjacent to one of the community’s elementary schools and spearheading construction of speed bumps strategically placed in high pedestrian-injury areas) and were provided with supervised, coordinated activities during high injury times.
- Products such as booster seats and home safety kits, with instructions on their use, were also given away free, when available, to promote safer behaviors.

**Key Findings and Lessons Learned**
- During the study period, 5065 intervention community youth sustained 3796 injuries, while 9297 youth from the control settings sustained 5445 injuries. Injury rate in the intervention community decreased 42% from 1999 to 2004, 17551.83 to 10187.56 injuries/100,000 children/year, respectively, compared with the mean rate among the three control sites, which decreased 25.7%, 12950.41 to 9626.76 injuries/100,000 children/year.
- The authors highlighted the importance of a community-based approach: “building a collation with both community members and hospital personnel is essential”.

Sample/Setting
- Low income Latino (primarily Mexican) families, with low education and acculturation levels.
- Chicago, Illinois

Program Description
- Education intervention, provided by Latino Spanish speaking community health workers -- from a Latino community center -- trained as child passenger safety technicians. They used videos and an office demonstrator.
- Community center provided child safety seats priced on a sliding scale. Available to families who participate in an hour long training session held in their office.
- Additional education and training could be requested by program participants.
- Along with academic researchers, representatives from the community were actively involved in all phases of the study, including program design and implementation.
- Intervention and comparison group participants were told they must come to a child safety seat check event with their child safety seats installed, children present, and that they would receive a $10 gift certificate for their participation

Key Findings and Lessons Learned
- Families exposed to the intervention were more likely to have their child’s seat within the manufacturer’s recommended weight/height range, their child facing the correct direction, the harness straps positioned properly, to have not been in a crash, the harness straps snug, the harness retainer clip used correctly, the seat belt routed correctly, and the seat belt locked.
- The intervention overcame language, cultural, and socioeconomic barriers. The program designed particularly called attention to the intervention addressing the Latino community cultural nuances.
- Authors noted that, involving these communities in the prevention effort, not just as recipients of services and education, but also as planners and implementers of safety programs, can reduce barriers to proper child safety seat usage.

Sample Setting
- Hispanic preschool-aged children
- Dallas, Texas

Program Description
- Program components included establishing a child safety seat loaner program, educating parents in small classes, identifying mothers as authority figures to help communicate the message, addressing the issue of fatalism or destiny, and using videos that graphically showed what happens to a child held on an adult's lap in a car crash.
- The program was conducted by bilingual staff, most of whom were also residents of the target area.
- The intervention was tailored as it incorporated various aspects of the Hispanic culture. For example, local priests were asked to bless the child safety seats in a ceremony before they were distributed; pamphlets about the program were distributed through local botanicas (stores that sell traditional Hispanic remedies and often employ a folk healer), churches, and community centers; and educational materials about child safety seats were presented on local Spanish-language radio and television shows. Used the Safe Communities model to develop the intervention.
- Activities were carried out at neighborhood block parties, local festivals and in a local community health center, local day care centers, churches, community centers, and botanicas

Key Findings and Lessons Learned
- The program was successful in increasing child restraint use in the community. Restraint use among Hispanic preschool-aged children attending the clinic (72%) had surpassed use in a comparison population of preschool-aged children in the rest of Dallas (69%). The program was most successful in the youngest age group (children younger than 2 years). Use of child safety seats and restraints was closely linked to drivers’ use of seat belts.
- The authors attributed the program’s success to incorporating religion, cultural beliefs, and community into the interventions, and because it was ongoing and multifaceted.

Program name: Kids in the Back/Niños Atrás

Sample/Setting
- Predominantly low-income Hispanic community
- Holyoke, Massachusetts

Program Description
- The intervention was led by a community coordinator, who was a bilingual Holyoke resident who received training to become a certified child passenger safety technician.
- A community task force was established and met monthly to identify community needs and to guide the development of materials and activities.
- A primary intervention strategy community-based effort was to change social norms through implementation of an incentive program (e.g., travel mugs, candy, raffle tickets for larger prizes) that rewarded families when children were observed rear-seated in a motor vehicle. Trained volunteers distributed incentives at locations chosen on the basis of high traffic volume and safe stopping points (e.g. schools, child care facilities, summer camps) and provided verbal and written information on the importance of child rear seating for families in motor vehicles where children were not rear-seated.
- Community education and awareness strategies supplemented the incentive program. Culturally appropriate, bilingual (Spanish and English) educational materials focused on child rear seating were developed, including educational brochures for parents and activity books for children. Educational materials were distributed through the incentive program, schools, community agencies, health care providers, and community events. The project hosted an information table at community events. Posters were also displayed throughout the community, and some tail signs were placed on city buses.
- A local media agency (voluntarily) developed a public service announcement for the program and donated airtime on 3 radio stations. Additional publicity for the program and its messages was gained through local media, including English- and Spanish language newspapers, English- and Spanish-language radio stations, and local television news.

Key Findings and Lessons Learned
- Child seating patterns were observed pre- and post-intervention at intersections in 3 Massachusetts cities: Holyoke (intervention city), Lawrence, and Brockton (control cities).
- Child rear seating increased from 33% to 49% in the intervention city, which represented a greater increase than that in the control cities. The greatest improvement was observed in relatively higher-income areas. Rear seating was significantly correlated with reported program exposure.
- Incentives and exposure to the program across multiple channels seemed to have a substantial effect on motorist seating their children in the rear.

Sample/Setting
- First- and second-year pediatric residents and their patient-parent dyads.
- A hospital-based pediatric resident community clinic in a large, urban teaching hospital that serves families living in low-income, inner-city neighborhoods

Program Description
- This intervention trial aimed to enhance parents’ home-safety practices. The safety topics and practices covered in this trial were fall prevention (use of safety gates), poison prevention (use of ipecac syrup and safe storage of poisons), and fire and burn prevention (use of smoke alarms and safe hot-water temperatures).
- Parents in the standard-intervention group received pediatric safety counseling (including American Academy of Pediatrics Injury Prevention Program materials, EAG training program, and incorporated role-playing to learn the SAFE Communication Framework (Solicit Information, Advise, Focus on Risks and Barriers, Encourage Compliance) and referral to the on-site children's safety center (CSC) from their pediatrician where parents receive personalized education and can purchase reduced-cost products (e.g. ipecac syrup, cabinet latches, safety gates, smoke alarms, batteries, and hot-water thermometers).
- Families in the enhanced-intervention group received the same services as the standard-intervention group plus the offer of a home-safety visit by a community health worker. The community health workers assessed injury hazards for falls, burns, and poisonings with the parent; made recommendations about the appropriate safety products and practices; and referred families to the CSC. The home-safety visit occurred between the patient's 6- and 9-month well-infant visits

Key Findings and Lessons Learned
- Randomized, controlled trial. Pediatricians were randomized to a standard- or an enhanced-intervention group. Parents (or guardians) of infants no older than 6 months who agreed to be in the study were assigned to the same study group as their pediatrician. Audiotapes of scheduled clinic visits were obtained throughout the study to measure exposure to the pediatric counseling. Intake surveys completed by parents at each visit asked whether the parent had been to the CSC since their previous visit. A follow-up interview was completed at the child's 12-month visit (or the 15- or 18-month visit if the 12-month visit was missed), and the home observation to assess safety practices was scheduled for a convenient time within 2 weeks. Home observers assessed the following safety practices: reduction of hot-water temperature, poison storage, and presence of smoke alarms, safety gates for stairs, and ipecac syrup.
- Families received $10 for each completed interview and for the home observation.
- No significant differences in safety practices were found between study groups. However, families who visited the children’s safety center compared with those who did not had higher rates for all safety practices (except for smoke alarms) and had a significantly greater number of safety practices (34% vs. 17% had >3).

**Sample/Setting**
- Children <13 years old in Georgia

**Program Description**
- One small Georgia community passed an ordinance instructing police officers to impound the bicycle of any unhelmeted child under 13 years old.
- The program included active police enforcement of this ordinance, combined with a helmet giveaway and education program (including and 2 bicycle rodeos). Helmets were distributed at the only local elementary school to all children in kindergarten through fifth grade (5-10 years).
- To deliver the safety message to parents and to remind them of the penalty, an information pamphlet was sent home from school with each child and 2 articles were printed in the local newspaper.
- Of note, when police impounded the bicycle, a parent was required to retrieve it at the police station, where the safety message was reinforced to the parent and child and helmet ownership was verified or a helmet was provided.

**Key Findings and Lessons Learned**
- None of 97 observed riders wore a helmet before the program began. During the next 5 months, helmet use among 358 observed children averaged 45% (range: 30%-71%), a significant increase in all race and gender groups. Adult use, in contrast, did not change significantly. Police impounded 167 bicycles during the study, an average of 1 per day. 21 of 39 child riders (54%) were observed wearing a helmet two years after program initiation.
- This program did not require financial resources or even much additional time by local police. The helmets were donated, and police officers, community volunteers, and Department of Health workers conducted the distribution component. The principal responsibility for enforcement was assigned to 1 officer each day, to be performed during routine patrol. The perception of enforcement, perhaps augmented by local conversation and media attention, might have been more important than the actual enforcement itself. If so, personnel requirements for such a program may not be prohibitive for larger communities.

Program name: Vehicle Injury Prevention (VIP) Program

**Sample/Setting**
- Low income neighborhoods
- Houston, Texas

**Program Description**
- The purpose of this program was to improve restraint use and modeled after North Carolina’s Click It or Ticket program.
- Used a multifaceted approached, combining a number of community intervention strategies. The program established partnerships between six segments of the community: 1) Healthcare (e.g. Harris County Hospital District employees integrated VIP material into the patients’ usual health care visits, particularly in the newborn, prenatal, and parenting clinics); 2) Education (e.g. elementary school principals identified school nurses and social workers to become trained to incorporate this program into existing safety educational/awareness programs); 3) Law enforcement (e.g. the Houston Police Department provided four officers to survey the target areas for two weight hour shifts a week. When an officer saw a motorist properly restrained, the driver was given a small prize/incentive package; however, the driver received a traffic citation when a motorist was caught improperly restrained); 4) Private industry (Corporate underwriting from 14 companies provided educational materials, incentives etc); 5) Government (e.g. government officials lead the effort); and 6) Media (e.g. print, radio, and television medical informed the public about the program).
- The intervention included safety education in three elementary schools and two community health centers.

**Key Findings and Lessons Learned**
- The program was evaluated by observation of proper restraint use before and nine months after implementation. Observers were masked as to which schools were in the target area and which was comparison. Trained, independent observers made observations of occupants in the target area and at two comparison sites. Pre-post differences in restraint compliance were calculated by a binomial proportion test
- Motorists in target area one significantly improved their restraint use by 15%, whereas use in the comparison neighborhoods remained unchanged
- The program designers/evaluators suggest that the program was effective because it address the community’s needs, social norms, and characteristics.

Program name: The Oklahoma City Smoke Alarm Project

**Sample/Setting**
- A community in Oklahoma City within an area with high rate of these residential fire related injuries

**Program Description**
- Community-based residential fire injury prevention program.
- The two major components of this community-based project were: 1) the distribution and testing of smoke alarms in residential dwellings and 2) written educational material provided to each individual participant and selected populations (schools, churches, media, and so on). This material addressed prevention of the major causes of residential fires resulting in injury in the target area, including children playing with fire, smoking, and flammable liquids.
- The material also covered 911 emergency calls, escaping fires, and installing and maintaining smoke alarms

**Key Findings and Lessons Learned**
- The outcome evaluation focused on the program’s primary goal: to decrease hospitalized and fatal burn and smoke inhalation injuries associated with residential fires by 50% in the targeted population. This component of the evaluation relied on injury surveillance data. The rest of Oklahoma City (outside the target area) was used as a comparison population. The effectiveness of methods of distributing alarms and soliciting household participation in the program was measured in the process evaluation. The subsequent and appropriate use and function of the smoke alarms distributed was measured in the impact evaluation (and was measured by off-duty uniformed firefighters). Finally, educational material provided to participants in conjunction with the smoke alarm distribution was refined during the formative evaluation.
- A few months after the program had begun, 80% of the homes in need and approximately 25% of total homes in the target area received an alarm. Nearly two-thirds of the alarms were installed and functioning within three months of implementing the program.
- During the six years following the project, the residential fire-related injury rate decreased 81% in the target population but only 7% in the rest of Oklahoma City.
- Among children less than five years, only 2 were injured in the target area during the six years after intervention, and at least 60 estimated injuries and death were prevented in the Oklahoma City high-risk area during the six years following the program implementation.
- Of the various distribution methods, the program evaluators note that canvassing allowed the volunteers to distribute more alarms per hour.

Program name: Urban Improv

Sample/Setting
- Urban elementary-school students from 8 fourth-grade classrooms in Boston, MA for whom English was a first language
- Schools were selected based upon risk profile (i.e., urban, high crime neighborhood)

Program Description
- Urban Improv (UI), a theater-based youth violence prevention program for inner-city youth, provides opportunities for students to practice and enhance learned information and skills pertaining to violence prevention and conflict resolution. UI provides a space for students to examine and discuss the consequences of personal actions and conflict resolution strategies.
- UI includes three nine-week developmentally appropriate units, with classes meeting once a week for 75-minute sessions in a theater space.
- Sessions begin with a song pertaining to the session theme; a prepared scene (involving 4 actors) is presented and students are invited to participate in the role-play to influence the outcome of the scene. In groups, students then perform their own scene. The session ends with a group discussion about the decisions and consequences.
- The objectives of UI include: improve decision-making, problem-solving, leadership skills, cooperation, assertiveness, impulse control, and values clarification
- Essential components include: group format, behavioral rehearsal, adult involvement, mentoring and feedback, use of humor, facilitating self-regulation skills

Key Findings and Lessons Learned
- Quasi-experimental, matched control evaluation
- Behavioral and psychological outcomes include: reduction in aggression, violence, and crime; improved prosocial behaviors; and enhanced scholastic attention and engagement.
- 77 elementary school students (8-11 years old) in classes that received the intervention (UI), compared to 63 students in matched control classrooms. Control classrooms were primarily drawn from same schools
- Students who received the intervention had better behavioral and psychosocial outcomes. Findings revealed increased teacher-reported prosocial behavior (p=0.021), prevention of the onset of aggressive behavior (p=0.022), decreased hyperactivity (p=0.033), and internalizing (p=0.01) among students who received the intervention.
- Elementary school age may be a sensitive time in which to focus on the development of conflict-resolution skills, as problem-solving skills are still being developed. Furthermore, the elementary school age is a period preceding the developmental stage in which peers exert a larger influence on behavior.

Sample/Setting
• Youth in an inner-city, predominantly African American neighborhood in Kansas City Missouri, who are predominantly 12-15 years of age.

Program Description
• The Ivanhoe Neighborhood Council Youth Project (INCYP) is a community mobilization initiative that was created in response to gang violence and drug activity in an inner-city, predominantly African American neighborhood in Kansas-City, Missouri. The INCYP organized around the goal of creating an environment that fosters positive youth development by addressing the distal causes of youth violence. Community members identified the goal of eliminating criminal activity in the neighborhood and increasing youth programs and services.
• The Ivanhoe Youth Council, which was supported by the INCYP, was developed shortly after assessing community issues and establishing strategic goals. Youth 12-18 years old were recruited for the council. However, it was difficult to engage youth 15 years and older.
• Sixteen neighborhood youth and community partners collaborated to develop a youth-initiated strategic plan whereby youth defined community issues and identified objectives (i.e., increase number of youth activities), strategies (i.e., create after-school program for youth leaders), and action steps (i.e., survey youth regarding desired skills development and activities of interest).
• Residents, both youth and adult, were trained for leadership positions on INCYP committees and to serve as block-level contacts.
• The INCYP created community partnerships to train and support youth to work with police to plan the first National Night Out Against Crime, organize other youth volunteers, and canvass neighborhoods.

Key Findings
• Council members identified desired outcomes as (1) decreased youth violence and (2) youth engagement in the INC through youth-led development of the youth council and building capacity among youth as block organizers. The latter outcome was identified as a protective behavior and intermediate outcome to achieve the impact goal of preventing youth violence.
• The authors cite early and consistent engagement of youth as necessary in community mobilization initiatives.

Program name: Turning Point

Sample/Setting
- Juveniles and their parents/guardians who were first-time offenders of a violent offense including robbery, assault, battery, arson, and weapons offenses; male offenders age 13-18; participants screened for “psychological appropriateness” of the program; reside within the Jacksonville, FL area

Program Description
- **Turning Point**, a tertiary intervention, is a six-week court-ordered program for juveniles and their parents/guardians. This program seeks to deter future violence among first-time offenders by including core components: exposure to the real-life consequences of violence, improving communication, and remediation.
- Juveniles and their parents attend one “Trauma Experience” session which exposes participants to the consequences of violence by touring the trauma center at a local medical center; visiting a morgue; and speaking with a trauma psychologist about the emotional impact of death on the victim’s friends and family. The objective of this session is to expose participants to the consequences of violence from the perspective of the victim and their family/friends.
- The teens also attend 5 group therapy sessions to build anger management, conflict resolution, and reality-based communication skills. Sessions include video presentations, role plays, and peer evaluations.
- One of the 5 sessions, the “Victim Impact Panel“, introduces participants, both juveniles and their parents/guardians, to the victim-side of violent experiences. This session includes a panel discussion regarding the consequences of violence on family and friends of victims. This session is modeled after the Mothers Against Drunk Driving (MADD) victim impact panels.
- The final session, participants “graduate” from the program and families receive a mental health referral and community networking information.

Key Findings and Lessons Learned
- An evaluation was comprised of a randomized control trial: Thirty-eight juvenile offenders were randomly assigned to the *Turning Point: Rethinking Violence* intervention, which was mandated by the courts. The control (n=38) received standard sentencing options (usually 100 hours of community service for first-time violent offense).
- To measure the impact of the intervention on violence recidivism, the authors reviewed each juvenile's legal records for juvenile violent crime involvement within the year after the first violent conviction and completion of court-ordered sentence.
- The recidivism rate was significantly lower for the intervention group (0.05) than the control group (0.33, p<0.05). It is notable that the intervention group had a shorter “dosage” of the sentencing program (14 hours), as compared to the control, where were sentenced to complete 100 hours of community service.
- The evaluation does not identify the essential elements of the program (i.e., determine which components are linked/more strongly linked to the outcomes).
• Evaluations completed by juveniles and their parents noted that the victim impact panel was provocative and emotional, morgue visit was anxiety-provoking, and the role-play was honest and reality-based
• The authors discuss that the development of relationships among program participants and facilitators contributed to program success
• The authors also believe that success was partially attributed to mandating parental involvement whereby parents take partial ownership for their child’s behavior. In addition, the program facilitated provocative communication between the child and parent, as youth were able to develop communication skills during the sessions.

Program name: GREAT student intervention

Sample/Setting
- Six grade students in 37 schools from four communities: Chicago, IL, Durham, NC, Northeastern GA, and Richmond, VA.
- Most students (42%-95% across sites) were from low-income families

Program Description
- The intervention included a student curriculum of 20 sessions which provided instruction and practice on topics such as avoiding dangerous situations, ignoring teasing, asking for help, defusing situations, and being helpful to peers.
- The program also included a teacher component which involved 12 hours of a workshop and 10 consultation/support group meetings that focused on increasing teacher awareness of different forms of aggression and associated risk factors.
- A family intervention was also implemented with a sub-set of sixth graders at 19 schools. The family intervention involved groups of 4-8 high-risk students and a parent/guardian and last 15 weeks.
- A primary focus of the intervention was on decreasing normative beliefs about the legitimacy of using violence and promoting beliefs supporting non-violent strategies for dealing with problem situations.

Key Findings and Lessons Learned
- Evaluation findings showed that high-risk students benefited the most from the intervention, in terms of decreasing their beliefs and attitudes that supported aggression and increasing their self-efficacy, beliefs, and attitudes supporting non-violence behavior.
- Surprisingly, among students who were considered low-risk at the beginning of the program, their scores were in the opposite direction.
- While the benefit of these types of interventions may be minimal for students already at low-risk for aggressive behaviors, intense violence prevention programs appear to benefit middle school youth with strong beliefs and attitudes towards aggression.
- However, because risk and protective factors play different roles at different developmental stages, it is likely that comprehensive efforts that go beyond those that focus on individual youth by incorporating interventions at multiple levels across different stages of development will be required to address this problem.
Appendix I. Endnotes

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