

UC Irvine

UC Irvine Previously Published Works

Title

Storytelling in Community Intervention Research: Lessons Learned From the Walk Your Heart to Health Intervention

Permalink

<https://escholarship.org/uc/item/79c6x61g>

Journal

Progress in Community Health Partnerships Research Education and Action, 8(4)

ISSN

1557-0541

Authors

LeBron, Alana MW

Schulz, Amy J

Bernal, Cristina

et al.

Publication Date

2014-12-01

DOI

10.1353/cpr.2014.0066

Copyright Information

This work is made available under the terms of a Creative Commons Attribution License, available at <https://creativecommons.org/licenses/by/4.0/>

Peer reviewed



HHS Public Access

Author manuscript

Prog Community Health Partnersh. Author manuscript; available in PMC 2015 March 26.

Published in final edited form as:

Prog Community Health Partnersh. 2014 ; 8(4): 477–485. doi:10.1353/cpr.2014.0066.

Storytelling in Community Intervention Research: Lessons Learned From the Walk Your Heart to Health Intervention

Alana M. W. LeBron, MS¹, Amy J. Schulz, PhD¹, Cristina Bernal, MPH¹, Cindy Gamboa¹, Conja Wright, PhD², Sharon Sand, MPP¹, Melissa Valerio, PhD³, and Deanna Caver, MEd¹

¹Department of Health Behavior & Health Education, University of Michigan School of Public Health, Houston, San Antonio Regional Campus

²Redford Branch Library of the Detroit Public Library, Houston, San Antonio Regional Campus

³University of Texas School of Public Health, Houston, San Antonio Regional Campus

Abstract

Background—Contextually and culturally congruent interventions are urgently needed to reduce racial, ethnic, and socio economic inequities in physical activity and cardiovascular disease.

Objectives—To examine a community-based participatory research (CBPR) process that incorporated storytelling into a physical activity intervention, and consider implications for reducing health inequities.

Methods—We used a CBPR process to incorporate storytelling in an existing walking group intervention. Stories conveyed social support and problem-solving intervention themes designed to maintain increases in physical activity over time, and were adapted to the walking group context, group dynamics, challenges, and traditions.

Lessons Learned—After describing of the CBPR process used to adapt stories to walking group sites, we discuss challenges and lessons learned regarding the adaptation and implementation of stories to convey key intervention themes.

Conclusions—A CBPR approach to incorporating storytelling to convey intervention themes offers an innovative and flexible strategy to promote health toward the elimination of health inequities.

Keywords

Community-based participatory research; physical activity intervention; social support; problem-solving; storytelling

Stories are enmeshed in everything ... stories stitch together the fabric of African American life. As people begin to tell stories of their healthy selves, there is more possibility to manifest healthy behavior in their future. (Conja Wright, Storyteller)

A critical strength of CBPR partnerships is the potential to integrate evidence-based health promotion strategies with culturally and contextually relevant forms of delivery.^{1,2} We

describe herein a CBPR process used to integrate storytelling into an intervention designed to maintain behavior change. Intervention messages were adapted for particular social or cultural contexts,^{3–5} and sought to actively engage participants, toward the end of reducing racial, ethnic, and socioeconomic inequities in cardiovascular disease (CVD).^{4,6} After presenting a brief description of the CBPR process used in developing the storytelling aspect of the intervention, we discuss lessons learned and consider the potential for the use of stories within the context of partnerships working to reduce health inequities.

Storytelling may be a promising and adaptable intervention strategy. As a common way of communicating, and a key form of cultural transmission,^{2,5} storytelling can communicate themes that situate participants as active agents embedded in, and responsive to, complex social and cultural contexts.^{1,7–9} In the context of health promotion interventions, stories can engage listeners and convey information in a readily accessible manner.^{10–12}

Storytelling has been demonstrated as a useful strategy to promote walking among African-American women with hypertension.¹³ It has also been used in health promotion interventions, including colorectal cancer screening for Latinas and hypertension management among African Americans.^{4,6} Herein we examine the use of storytelling to convey intervention themes to African-American and Latino participants residing in different neighborhoods in an urban area, in communities that experience intersecting and unique barriers to walking.

Communities whose members share a sense of social identity, belonging, social position, practices, or beliefs have long been posited to include many resources that may be mobilized to address health inequities.¹⁴ Using a CBPR process to develop interventions that incorporate storytelling can ensure adaptation of evidence-based messages to the social and cultural community context, and encourage active engagement of learners.^{4,5,12,15} The storytelling intervention described herein is one aspect of a multilevel intervention designed to address CVD inequities by promoting physical activity among African-American and Latino residents in low- to moderate-income communities in Detroit with excess CVD.^{1,16} We briefly describe the multilevel intervention and the CBPR process used to design it. A more complete description of the intervention can be found in Schulz and colleagues.¹⁷ Herein, our primary focus is on the CBPR process used to integrate storytelling into components of that intervention.

CBPR PROCESS FOR DEVELOPING THE CORE WALK YOUR HEART TO HEALTH INTERVENTION

The Healthy Environments Partnership (HEP), a CBPR partnership, has been working together since 2000 to understand and develop, implement, and evaluate interventions to address excess CVD in Detroit, Michigan (Figure 1). HEP's research is overseen by a steering committee (SC) that includes 11 representatives from five community-based organizations, health agencies, a community member at large, and academic researchers (see Acknowledgements).¹⁸ Community-based organization representatives are Detroit residents and organizational leaders with long-standing histories and strong reputations in the engaged communities. In 2001, the SC adopted CBPR principles emphasizing equitable,

collaborative, engagement, and the development and maintenance of mutual trust, respect, and shared commitment to HEP's mission and goals. These principles emphasize the strengths and resources that inhere in the community and SC members, and also seek explicitly to expand the capacity of all partners through all aspects of our collaborative work. The SC meets monthly, with frequent email and telephone communication between meetings, and engages in collaborative decision making that emphasizes shared power among members.¹⁹ Regular participatory and formative evaluations of the partnership process assess the extent to which HEP is reaching its group dynamics objectives.²⁰ Evaluation results regarding the HEP participatory process are discussed among the SC and actions for improvement are identified as necessary.²⁰ A more complete description of the participatory and formative evaluation process can be found in Schulz and colleagues.²⁰

Between 2005 and 2008, HEP engaged in a CBPR community planning process to identify and pilot strategies to reduce CVD inequities.¹⁸ This process culminated in the design of an intervention¹⁸ referred to here as the Core Walk Your Heart to Health. The core intervention involved a 32-week community health promoter (CHP)-facilitated walking group intervention.¹⁷ Groups met three times per week at community-based or faith-based organizations and walked in groups for 45 to 90 minutes, with the duration increasing over time. At each walking group session, a health topic was discussed, group members or CHPs identified the walking route for the day, and the walking group would warm up, walk, and cool down. Each week, participants would establish walking group goals and participants were provided with weekly reports of the number of steps they walked, based on readings from their pedometers. During the initial 8 weeks, CHPs worked to build group cohesion and leadership among group members. During the remaining 24 weeks CHPs transitioned group leadership to participants. Subsequently, HEP designed two additional intervention arms (enhanced maintenance interventions) to compare effectiveness in maintaining physical activity improvements achieved in the initial phases of the intervention. The two enhanced maintenance intervention arms included the components of the core intervention (initial 8 weeks) and also used storytelling to deliver the enhanced maintenance intervention themes during the maintenance period (weeks 9–32). One enhanced maintenance intervention arm focused on the theme of building social support for physical activity, and the second arm enhanced collaborative problem-solving skills to address barriers to physical activity. The core intervention did not include storytelling. There were a total of 36 walking groups and 868 participants in the core and enhanced maintenance Walk Your Heart to Health walking groups. Information about the walking groups was disseminated widely in the community, and those who were interested were invited to contact the study.

The SC was actively engaged in the design and implementation of the core and enhanced maintenance interventions, guided by the SC's CBPR principles. The SC engaged community members in the process of developing the core intervention, including generating and prioritizing potential intervention strategies.¹⁷ The SC used these priorities to develop and implement a pilot walking group intervention, and subsequently a larger, multilevel intervention. The CBPR process used to develop the pilot walking group intervention¹⁸ and the full multilevel intervention¹⁷ are described in detail elsewhere.

CBPR PROCESS FOR DEVELOPING THE ENHANCED MAINTENANCE INTERVENTIONS

A common challenge in physical activity interventions is maintaining improvements in physical activity.^{21,22} Whereas the Core intervention incorporated several strategies to help sustain physical activity improvements,¹⁸ Core intervention participants identified a number of important challenges (e.g., work, family responsibilities) associated with maintaining initial increases in physical activity over time.¹⁷ CHPs also observed that some participants were hesitant to ask for support from other group members to address challenges they faced in maintaining their physical activity.

Following a key CBPR principle of engaging community partners in intervention development, HEP partners identified and discussed potential strategies to maintain participation. A subcommittee, including three community and three academic members of the SC, formed and was supported by the health educator and project manager. The subcommittee discussed findings from a review of the evidence base to identify intervention strategies with demonstrated effectiveness in maintaining behavior change. Based on this process, the subcommittee identified more explicitly building social support and collaborative problem solving as promising, evidence-based strategies to enhance the maintenance of physical activity improvements realized in the initial 8-week intervention period. HEP received funding to add two enhanced maintenance intervention arms in 2011, allowing comparison of their relative effectiveness in maintaining walking group participation to the Core intervention (Figure 2). The University of Michigan Institutional Review Board approved the core and enhanced maintenance interventions in 2008, and 2011, respectively.

Once funded, a planning team was formed to plan, develop, and implement the enhanced maintenance intervention arms (social support and problem-solving). The planning team included community residents who were project coordinators, key staff members, and academic researchers. The team met frequently to identify intervention strategies, review the evidence base regarding behavior maintenance strategies, and develop the enhanced maintenance intervention themes and strategies.

CBPR Process for Incorporating Storytelling into the Enhanced Maintenance Interventions

The planning team explored multiple strategies for introducing the themes into the enhanced maintenance interventions in an accessible, relevant, and engaging manner. Among the strategies considered was storytelling. A form of communication commonly used within the participating communities,^{2,4,5} storytelling is an effective means of introducing key concepts while actively engaging learners.^{4,6,12} The planning team recognized the potential of stories to enhance and anchor understanding of personal experiences and challenges, as well as the potential of listening to and sharing stories to facilitate discussion, self-reflection, and the envisioning of a healthy self and health-promoting lifestyle.¹³ After substantial discussion, the planning team decided to introduce key intervention themes by incorporating two storytelling sessions in each enhanced maintenance intervention arm (Figure 2). At this point, a professional storyteller joined the planning team. She participated actively

throughout the remainder of the process and was compensated for her participation and expertise. The storyteller, who has performed in a variety of settings, has been actively involved in the community for more than 25 years as a librarian and policy advocate. She knew and had worked with several HEP SC members previously and shared a commitment to addressing health inequities in Detroit.

The planning team met regularly while developing the interventions. In these discussions, the storyteller suggested potential stories, adapted from family, community members, and children's literature, to convey the intervention themes. The planning team considered objectives in introducing each theme (e.g., build social support, enhance problem-solving skills) when selecting stories. Together, they discussed and refined potential stories to introduce the themes through narratives familiar to the engaged groups, based on conversations with the project coordinators and CHPs (residents of the engaged communities). The Team discussed themes imbedded in the stories (e.g., individual versus collective problem-solving, gendered roles), and often suggested adaptations to emphasize the intervention themes. Between planning meetings, the storyteller refined the stories, while the health educator developed training materials, with ongoing discussions via email or telephone. CHPs also contributed to finalizing the stories.

In addition to adaptations of stories to convey intervention themes, the planning team also further adapted several stories to address particular dilemmas that emerged within groups at some sites, or to enhance cultural relevance. Because each walking group was hosted by a local community-based or faith-based organization in the engaged communities, walking groups were often predominantly African American or predominantly Latino, reflecting race-based residential segregation in Detroit.¹ These communities experienced intersecting and distinct social and physical features, with racial, ethnic, and historical backgrounds varying across sites. The planning team worked with the CHPs to identify unique dynamics and challenges within walking groups, and to adapt the stories when feasible to address these dynamics. Stories were also delivered in the preferred language of participants at a given site (English or Spanish). These adaptations were informed by the planning team's intimate knowledge of the values, traditions, strengths, and challenges of the walking group members, and the community context.

Thus, the function of the intervention, including the core intervention, enhanced maintenance intervention themes, and process of conveying these themes through stories were standardized across study arms. However, the form of the intervention, the specific stories (e.g., story setting, characters) within which these themes were delivered, was designed to vary across walking group sites to enhance relevance and resonance for groups with different characteristics and dynamics. This is consistent with a complex systems framework of adapting interventions to suit the local context.²³ Examples of how stories were adapted to convey key themes are provided in Table 1. For more information about the use of these stories, see Video 1 <http://youtu.be/9zs4VLk8CqM>

INTERVENTION IMPLEMENTATION

The storyteller, who identified as African American, introduced stories at walking group sites with predominantly English-speaking participants. At sites with predominantly Spanish-speaking participants, a bilingual staff member (a community resident) delivered the stories, after coaching from the storyteller. Stories were introduced at the beginning of sessions, as participants began stretching, but before walking, to initiate dialogue about the intervention theme among participants. The storyteller and CHPs engaged participants in the storytelling process by inviting participants, for example, to participate in the story (e.g., call and response), discuss questions, or engage in activities that reinforced key themes. CHPs encouraged participants to continue discussing themes while walking, and to consider how these themes relate to their own efforts to maintain the improvements they had realized in physical activity and health through walking group participation. CHPs continued to reinforce themes highlighted by the stories in later sessions.

EVALUATION

Project staff observed the storytelling sessions, recording field notes regarding the delivery of the intervention themes through stories and participants' engagement with the storytelling process. The health educator discussed with CHPs the extent to which participants engaged with the themes during the storytelling sessions and in subsequent sessions. These discussions helped to adapt subsequent intervention activities to reinforce those themes. In addition, CHPs completed summary sheets for each session, describing topics discussed, the level of participant engagement with the themes, and any challenges that arose.

LESSONS LEARNED

At the outset, the planning team envisioned developing a single story that would be used across all sites in a given intervention arm. However, planning team members who were residents of the engaged communities felt that, although some stories would resonate for some groups or communities, they would be less relevant for others. As a result, in some instances different stories were used to convey the key themes in different communities. We learned that stories can be uniquely adaptive and flexible tools for conveying core content (themes) even while the form (the story itself) may vary.

Although the stories were told in the manner conceptualized by the planning team, the stories lasted longer than planned. To maximize walking time in the groups, the stories were designed to take 3 to 4 minutes, followed by brief discussion that would continue as participants walked. However, based on observations conducted as part of the evaluation, storytellers and participants became engaged in the stories, with elaboration and interchange between the storyteller and participants, and storytelling took more time than initially anticipated. These group responses highlight the dynamic and engaging nature of storytelling and suggest the importance of balancing time to introduce intervention themes with other activities (in this case, walking). One strategy for addressing this challenge is to encourage storytellers to convey the stories as concisely as possible.

Another challenge involved variation in participants' engagement with the storytelling process and ensuing discussions. Staff observed that some walking groups discussed the themes at length, posing a challenge for CHPs as they sought to transition participants to walking. In other groups, discussion after stories was more limited and the extent to which group members considered or engaged with the key themes was unclear. Finally, in some groups, discussions elicited strong emotions among group members as they considered the themes and their implications or applications in their own lives. In all of these instances, the CHP's skill in facilitating discussions and supporting participants was critical to the success of the activities and support of group members. Enhanced training of CHPs to facilitate group discussions is an important component of this process.

Although the evaluation of the use of storytelling in the enhanced maintenance intervention in the walking group intervention is currently underway, in our experience, storytelling offered an innovative and flexible means to introduce evidence-based intervention themes to promote health in populations that experience disproportionate risk. Thus, storytelling deserves attention as a strategy in efforts to eliminate health inequities.^{8,24} The CBPR process used to refine and incorporate stories in this intervention was instrumental in identifying and addressing differences across groups, and effectively engaging participants with various histories, racial and ethnic identities, language, and contexts. Furthermore, this CBPR process recognized and mobilized community strengths and resources to address barriers to continued walking, building social support, and enhancing problem-solving skills.

This process catalyzed other creative uses of storytelling within HEP. Walk Your Heart to Health participants have offered testimonials about the benefits of the walking groups for their physical activity and health, and the partnership has subsequently developed short films to convey efforts to promote health equity. Such opportunities illustrate the potential of partnership approaches to develop contextually and culturally appropriate interventions that build on, and extend, the evidence base to promote health equity. This experience illustrates synergies that emerge as community and academic partners work together to develop and implement evidence-based interventions to promote health equity.^{1,2}

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

The HEP is a community-based participatory research partnership affiliated with the Detroit Community-Academic Urban Research Center. We thank the members of the HEP Steering Committee for their contributions to the work presented here, including representatives from Brightmoor Community Center, Detroit Department of Health and Wellness Promotion, Institute for Population Health, Detroit Hispanic Development Corporation, Friends of Parkside, Henry Ford Health System, Detroit Neighborhood Partnership East/Warren-Conner Development Coalition, and University of Michigan School of Public Health. We also acknowledge the contribution of the Community Health Promoters, Jewel Everette, Roxanne Thompson, and Adriana Castillo. The views presented here are those of the authors, and not necessarily those of the National Institutes of Health. For more information about the Healthy Environments Partnership, please visit the website: <http://www.hepdetroit.org/>.

The study and analysis were supported by the National Institute of Minority Health & Health Disparities (R24 MD001619), an ARRA Supplement to P60-MD-002249, and the Promoting Ethnic Diversity in Public Health Research Education project (5-R25-GM-058641-11).

References

1. Schulz AJ, Kannan S, Dvonch JT, Israel BA, A A III, James SA, et al. Social and physical environments and disparities in risk for cardiovascular disease: The Healthy Environments Partnership Conceptual Model. *Environ Health Perspect.* 2005; 113(12):1817–25. [PubMed: 16330371]
2. Banks-Wallace J. Womanist ways of knowing: Theoretical considerations for research with African American women. *Adv Nurs Sci.* 2000; 22(3):33–45.
3. Hartling L, Scott S, Pandya R, Johnson D, Bishop T, Klassen T. Storytelling as a communication tool for health consumers: Development of an intervention for parents of children with croup. Stories to communicate health information. *BMC Pediatr.* 2010; 10(64):1–10. [PubMed: 20078871]
4. Larkey L, Lopez A, Minnal A, Gonzalez J. Storytelling for promoting colorectal cancer screening among underserved Latina women: A randomized pilot study. *Cancer Control.* 2009; 16(1):79–87. [PubMed: 19078934]
5. Banks-Wallace J. Talk that talk: Storytelling and analysis rooted in African American oral tradition. *Qual Health Res.* 2002; 12:410–26. [PubMed: 11918105]
6. Houston T, Allison J, Sussman M, Horn W, Holt C, Trobaugh J, et al. Culturally appropriate storytelling to improve blood pressure. *Ann Intern Med.* 2011; (154):77–84. [PubMed: 21242364]
7. Trickett E. Community psychology: Individuals and interventions in community context. *Annu Rev Psychol.* 2009; 60:395–419. [PubMed: 19035828]
8. Hawe P, Shiell A, Riley T. Theorising interventions as events in systems. *Am J Community Psychol.* 2009; 43:267–276. [PubMed: 19390961]
9. Hecht, ML.; Warren, JR.; Jung, E.; Krieger, JL. The communication theory of identity: Development, theoretical perspective, and future directions. In: Gudykunst, WB., editor. *Theorizing about intercultural communication.* Thousand Oaks (CA): Sage; 2005. p. 257-78.
10. Bergman P. Storytelling as a teaching tool. *Clin Excell Nurse Pract.* 1999; 14(6):154–7. [PubMed: 10646409]
11. Hodge F, Pasqua A, Marquez C, Geishirt-Cantrell B. Utilizing traditional storytelling to promote wellness in American Indian communities. *J Transcult Nurs.* 2002; 13(6):6–11. [PubMed: 11776018]
12. Hinyard LJ, Kreuter MW. Using narrative communication as a tool for health behavior change: A conceptual, theoretical and empirical overview. *Health Educ Behav.* 2007; 34(5):777–92. [PubMed: 17200094]
13. Banks-Wallace J, Barnes A, Swanegan D, Lewis S. Listen, just listen: Professional storytelling and interactive learning as strategies for prompting reflection on the importance of taking time for self. *Storytelling, Self, Society.* 2007; 3(3):161–82.
14. Steuart G. Social and cultural perspectives: Community intervention and mental health. *Health Educ Q.* 1993; S1:S99–S111. [PubMed: 8354654]
15. Trickett E, Beehler S, Deutsch C, Green L, Hawe P, McLeroy K, et al. Advancing the science of community-level interventions. *Am J Public Health.* 2011; 101(8):1410–9. [PubMed: 21680923]
16. Schulz AJ, House JS, Israel BA, Mentz G, Dvonch JT, Miranda PY, et al. Relational pathways between socioeconomic position and cardiovascular risk in a multiethnic urban sample: Complexities and their implications for improving health in economically disadvantaged populations. *J Epidemiol Community Health.* 2008; 62:638–646. [PubMed: 18559448]
17. Schulz A, Israel B, Bernal C, Caver D, DeMajo R, Gamboa C, et al. Findings from the Walk Your Heart to Health Intervention: Promoting physical activity and cardiovascular health in predominantly non-Hispanic Black and Hispanic neighborhoods in Detroit. *Forthcoming.*
18. Schulz A, Israel B, Coombe C, Gaines C, Reyes A, Rowe Z, et al. A community-based participatory planning process and multilevel intervention design: Toward eliminating cardiovascular health inequities. *Health Promot Pract.* 2011; 12:900–11. [PubMed: 21873580]
19. Becker, AB.; Israel, BA.; Gustat, J.; Reyes, AG.; Allen, AJ. Strategies and techniques for effective group process in CBPR partnerships. In: Israel, BA.; Schulz, AJ.; Parker, EA., editors. *Methods for community-based participatory research for health.* 2. San Francisco: Jossey-Bass; 2013. p. 69-96.

20. Schulz AJ, Israel BA, Lantz P. Instrument for evaluating dimensions of group dynamics within community-based participatory research partnerships. *Eval Prog Plann.* 2003; 26:249–62.
21. Banks-Wallace J, Conn V. Interventions to promote physical activity among African American women. *Public Health Nurs.* 2002; 19(5):321–35. [PubMed: 12182692]
22. Marcus BH, Williams DM, Dubbert PM, Sallis JF, King AC, Yancey AK, et al. Physical activity intervention studies: What we know and what we need to know: A scientific statement from the American Heart Association Council on Nutrition, Physical Activity and Metabolism; Council on Cardiovascular Disease in the Young; and the Interdisciplinary Working Group on Quality of Care and Outcomes Research. *Circulation.* 2006; 114:2739–52. [PubMed: 17145995]
23. Hawe P, Shiell A, Riley T. Complex interventions: How “out of control” can a randomised controlled trial be? *BMJ.* 2004; 328:1561–3. [PubMed: 15217878]
24. Diez-Roux AV. Conceptual approaches to the study of health disparities. *Annu Rev Public Health.* 2012; 33:41–58. [PubMed: 22224879]
25. Bjaras G, Harberg L, Sydhoff J, Ostenson C. Walking campaign: A model for developing participation in physical activity? Experiences from three campaign periods of the Stockholm Diabetes Prevention Program. *Patient Educ Counsel.* 2001; 42:9–14.
26. Kahn EB, Ramsey LT, Brownson RC, Heath GW, Howze EH, Powell KE, et al. The effectiveness of interventions to increase physical activity: A systematic review. *Am J Prev Med.* 2002; 22(4S): 73–107. [PubMed: 11985936]
27. Uchino BN. Social support and health: A review of physiological processes and potentially underlying links to disease outcomes. *J Behav Med.* 2006; 29(4):377–87. [PubMed: 16758315]
28. Sahler O, Varni J, Fairclough D, Butler R, Noll R, Dolgin M, et al. Problem-solving skills training for mothers of children newly diagnosed with cancer: A randomized trial. *Dev Behav Pediatr.* 2002; 23(2):77–86.
29. Perri M, Nezu A, McKelvey W, Shermer R, Renjilian D, Viegner B. Relapse prevention training and problem-solving therapy in the long-term management of obesity. *J Consult Clin Psychol.* 2001; 69(4):722–6. [PubMed: 11550740]
30. Umberson D, Montez J. Social relationships and health: A flash-point for health policy. *J Health Soc Behav.* 2010; 51(S):S54–S66. [PubMed: 20943583]
31. Brown, M. *Stone soup: An old tale.* New York: Aladdin Paperbacks; 1947.

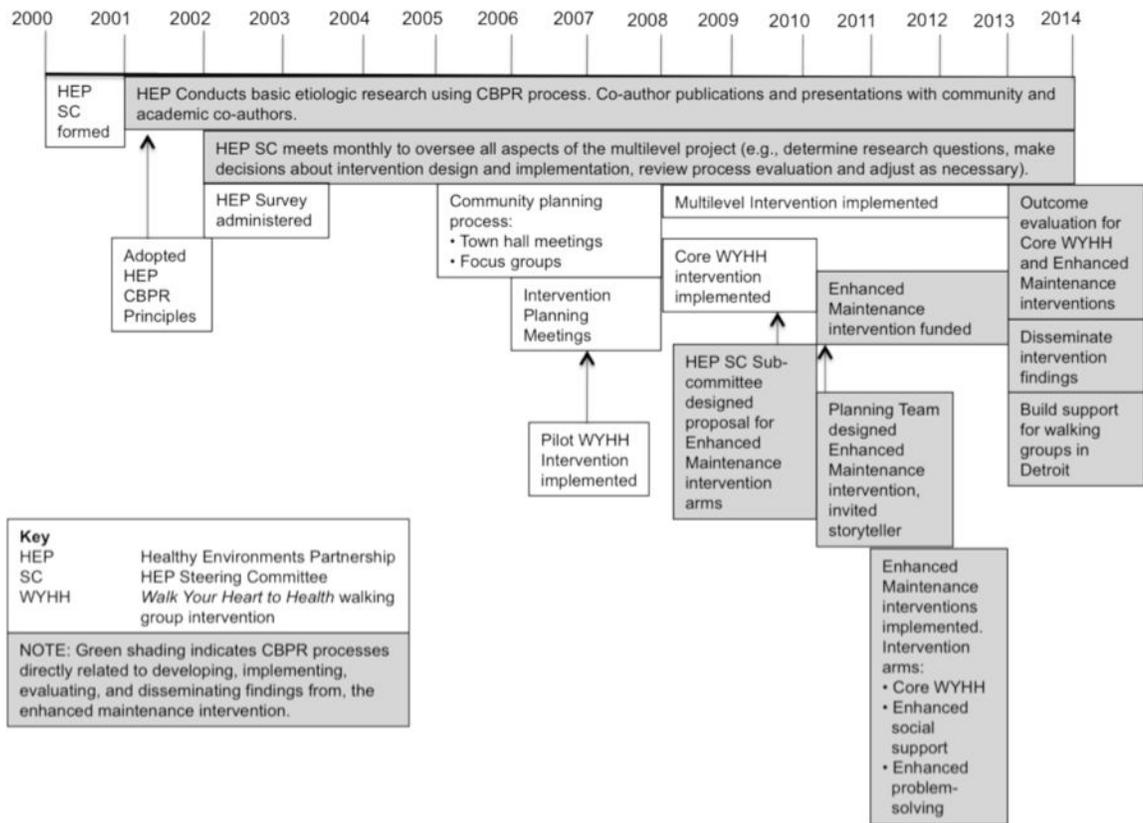


Figure 1. Timeline of the HEP Steering Committee’s Community-Based Participatory Research (CBPR) Process of Identifying Strategies to Address Cardiovascular Disease (CVD) Inequities

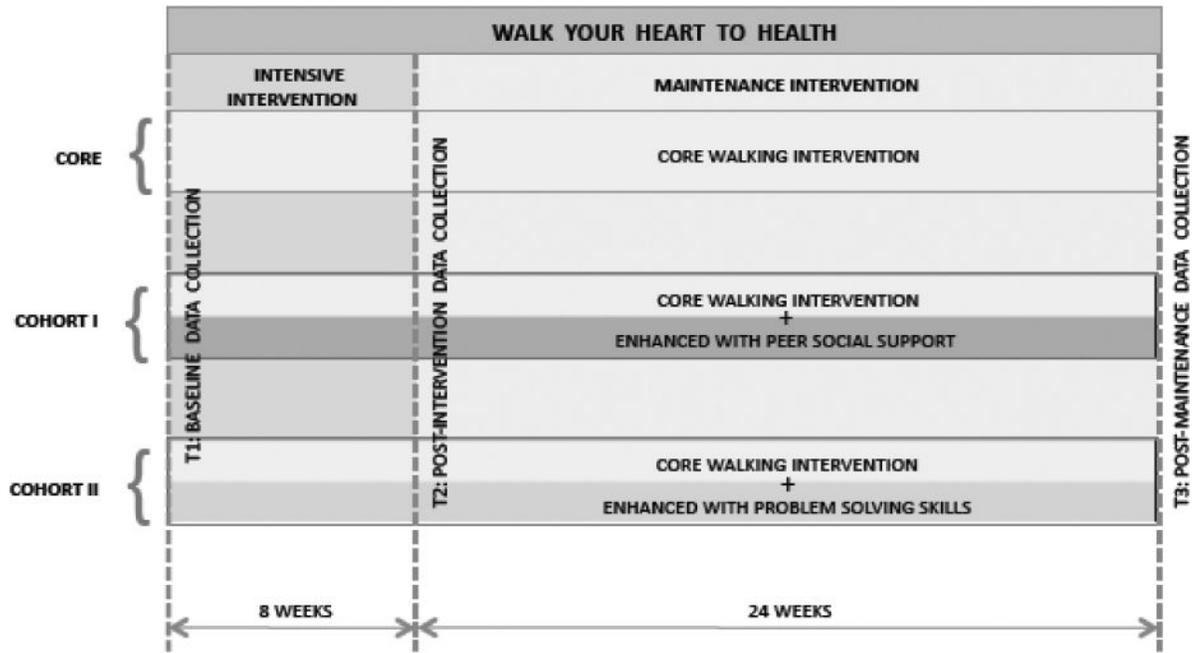


Figure 2. Walk Your Heart to Health core and enhanced maintenance interventions.

Table 1

Walk Your Heart to Health Intervention Structure, by Intervention Arm

Intervention Arm	Core Intervention	Enhanced Maintenance Intervention: Enhanced Peer Social Support	Enhanced Maintenance Intervention: Problem Solving
Facilitator	CHP	CHP	CHP
Intervention Period	8 weeks: CHP worked to build group cohesion and develop leadership among participants.	8 weeks: CHP worked to build group cohesion and develop leadership among participants.	8 weeks: CHP worked to build group cohesion and develop leadership among participants.
Maintenance Intervention Period	24 weeks: CHP transitioned leadership to participants.	24 weeks: CHP transitioned leadership to participants.	24 weeks: CHP transitioned leadership to participants.
Components	Warm up.	Warm up.	Warm up.
	Walk 30–50 minutes.	Walk 30–50 minutes.	Walk 30–50 minutes.
	Cool down.	Cool down.	Cool down.
Enhanced Maintenance Arm (Storytelling Component)		Two sessions (after week 8) focused on developing skills in building and maintaining social support among walkers and networks of family and friends. Focused on finding balance between providing and receiving social support. ^{25–27} Key intervention themes were conveyed using stories and the storytelling process.	Two sessions (after week 8) focused on strengthening problem-solving skills, ^{28,29} particularly engaging others in problem-solving to address challenges that arise in continuing walking in walking groups using the IDEAS framework. Key intervention themes were conveyed using stories and the storytelling process.
Key Themes		Reach out. Give back. Find balance for lifelong health. ³⁰	Work it out, walk it out together. Identify the problem. Determine options. Evaluate options. Act on selected option. See if it work and reevaluate options as necessary. ²⁸
Example Original Story		Marcia Brown's Stone Soup ³¹ A young, hungry boy with only stones in his pocket travels to a town. Hungry, he convinces one resident in the town to let him cook stone soup in her kitchen. Community members gather around as he prepares the soup, and community members begin to come together to help prepare the soup, each contributing different ingredients.	Aesop's Fable: A Raven in the Woods The thirsty raven spotted a source of water, but was unable to reach the water at the bottom of a container (identify the problem). The raven looked around (determine options) and noticed many small pebbles on the ground (evaluate options). She picked up many small pebbles and dropped them into the container to raise the water level (act), enabling the bird to drink from the container (see if it worked).
Adaptation of Story to Address Themes		Enhanced emphasis on working together to address challenges.	A group of thirsty ravens worked together to drop pebbles into the container, so that all could drink.
Adaptation of Story to Address Cultural Context		Stories were told in preferred language of walking group participants (i.e., English or Spanish), depending on walking group site. Soup ingredients were modified to reflect ingredients commonly known among members at one walking group site.	Stories were told in preferred language of walking group participants (i.e., English or Spanish), depending on walking group site. Story was situated in Mexico when told to one walking group site.
Activities to Reinforce Themes		Social network mapping exercise	Discussed application of the IDEAS framework to the story and how the

Intervention Arm	Core Intervention	Enhanced Maintenance Intervention: Enhanced Peer Social Support	Enhanced Maintenance Intervention: Problem Solving
		Participants were encouraged to identify one member of their social network with whom they will work to develop a plan to support sustained physical activity. Peer support members (one form of instrumental support) would receive a pedometer.	IDEAS framework can be applied when encountering challenges to continued walking.

CHP, community health promoter; IDEAS.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript