WELLNESS WITHIN REACH: MIND, BODY, AND SOUL: A NO-COST PHYSICAL ACTIVITY PROGRAM FOR AFRICAN AMERICANS IN PORTLAND, OREGON, TO COMBAT CARDIOVASCULAR DISEASE

Corliss McKeever, MSW; Collaine Faddis, MPH;
Nancy Koroloff, PhD; Jessica Henn, MPH

Wellness Within REACH (WWR) aims to saturate the heart of the African-American community in Portland, Oregon, with culturally appropriate physical activity opportunities. The purpose of this project is to develop and implement no-cost physical activities to increase the number of African Americans leading active lifestyles, while shifting the community norm.

Certified African-American instructors conduct exercise classes at community venues. A pre- and post-questionnaire is administered to participants attending exercise classes each quarter, to assess frequency of attendance, lifestyle changes, and attitudes over time. To date, more than 700 individuals have participated in the WWR classes. Participants (58%) in a recent sample ($N=75$) reported exercising more now than in the 6 months prior to joining the program.

Community members are bringing members of their social networks to try classes otherwise not available or affordable to them. By centering classes around the culture of this specific community, WWR has become a ''movement'' of healthy, active living. (*Ethn Dis.* 2004;14[suppl 1]:S1-95–S1-103)

Key Words: African Americans, Capacity Building, Cardiovascular Disease, Change among Change Agents, Community Collaboration, Disparity, Physical Activity, Racism's Impact on Health

From the African American Health Coalition, Inc. (CM, CF) and the Regional Research Institute for Human Services, Portland State University (NK), Portland, Oregon.

Address correspondence and reprint requests to Corliss McKeever; 2800 N. Vancouver, Suite 100; Portland, OR 97227; 503-413-1850; 503-413-1851 (fax); corlissm@aahc-portland.org

INTRODUCTION

The purpose of this project is to develop and implement no-cost, ethnic-specific physical activity classes within the African-American community of Portland, Oregon. Through sustained utilization of these opportunities, we will change community norms regarding physical activity as a means to decrease rates of cardiovascular disease (CVD).

Increased national attention has been given to the disparity between Whites and African Americans regarding rates of cardiovascular disease. Although cardiovascular disease has declined in recent years, it remains the leading cause of death among adults, particularly among African Americans, for whom mortality rates have decreased more slowly, as compared to Whites.[1] While the picture of cardiovascular health for African Americans is bleak nationwide, in Oregon, where a very small number of African Americans reside, the data are even more striking.

In Oregon, African Americans are dying at higher rates than Whites from cardiovascular disease. During the 5-year period from 1996–2001, the age-adjusted heart disease death rate among African-American Oregonians was 246, while for all Oregonians, the rate was 210, 15% lower.[2] Of more concern is the age-adjusted stroke death rate during the same 5-year period, which was 28.9% higher among African Americans living in Oregon than for all Oregonians.[2] These disproportionate outcomes are magnified when the size of Oregon's African-American population is taken into consideration, African Americans account for only 1.6% of the total population.[3] Living in Oregon imposes a dual marginalization on African Americans. Both race and population size contribute to disparate health outcomes, which what makes the contribution of the African American Health Coalition, Inc. (AAHC) so important.

In 1989, the AAHC was created as a volunteer organization to address the health disparities among African Americans, and the increasing gap between the service delivery of the healthcare system and the needs of the African-American community. The mission of the AAHC is to promote and improve wellness among African Americans living in the Portland metropolitan area, through health education, advocacy, and research. The AAHC is located in North/Northeast Portland, a set of neighborhoods where more than 80% of all African-American Oregonians reside, and which is considered to be the heart of the African-American community. The concentrated area of Oregon's African-American population makes it possible for the AAHC to reach their vision of becoming the healthiest African-American community in the nation.

As the only agency in the state of Oregon focused exclusively on African-American health issues, the AAHC provides essential resource and referral information, support, linkage, and guidance that is culturally specific and sensitive. The AAHC strives to acquire culturally derived information from all program participants, and these community members are always included in program development, from the planning stage through the analysis of the findings. Through their programs, the AAHC plays a necessary and vital role

in seeking out and addressing the root causes of the health disparities existing within Oregon's African-American community.

It is this charge that led the AAHC to compete nationally by conducting a needs assessment in 1999, leading to the development of a Community Action Plan (CAP) in 2000. This was selected and funded by the Centers for Disease Control and Prevention (CDC) Racial and Ethnic Approaches to Community Health (REACH 2010) program. The AAHC's REACH 2010 program, "A Healthy Community Starts With You: Community Driven Strategies to Lower Risk Factors for Cardiovascular Disease," was implemented in 2001. This program exemplifies the principle of a community-based model; designed for the community, by the community.

This article focuses on a component of the AAHC REACH 2010 program, the Wellness Within REACH: Mind, Body, and Soul intervention (WWR), which promotes physical activity as a means of reducing CVD by offering physical activity opportunities at no cost throughout the African-American community of North/Northeast Portland. Numerous African-American community members have identified Portland's REACH 2010 project, and specifically the Wellness Within REACH program, as a "movement" that is shifting the community norm toward increasing regular physical activity.

CVD Mortality Statistics: Disparities Between African Americans and White Americans

Data show that the average 10-year age-adjusted stroke mortality rate for African Americans in Oregon is 59.3, a 51% greater risk compared with the rate of 29 among White Oregonians.[4] Similarly, the compressed 10-year cardiovascular health mortality rate among African Americans in Oregon is 121.8, compared to 89 among Whites. Compared to the national average, coronary heart disease (CHD) rates are somewhat lower for White Oregonians, but somewhat higher among African Americans. Consequently, the Black-White CVD mortality gap is 26% in Oregon, compared to 10% nationally.[4] Although the CHD rate in African Americans has declined in tandem with that of White Americans, the gap between the 2 races has not been narrowed.

Historical Context

Historically, African Americans in Oregon have experienced major displacements that have confirmed and enhanced their distrust of the healthcare system. This distrust has its roots deep in the past. During the early 1940s, the oldest Black neighborhood in Portland, a community named Vanport, was completely destroyed by flooding. Black families displaced by the flood moved into a second Black neighborhood, the Albina neighborhood. This neighborhood represented the hub of the African-American community in the late 1940s. Through hard work and dedication, the neighborhood developed and contained thriving and vibrant Black-owned businesses, churches, social clubs, and civic organizations.

During the 1970s, many of the homes in the flourishing and lively Albina neighborhood were purchased, then destroyed, so that a new medical center could be developed and built. Many African-American families and businesses were again displaced, and the community experienced a traumatic upheaval that still affects the neighborhood. Today, much of the property in North-Northeast Portland is undergoing gentrification, which has led to further forced displacement, a part of the marginalized history of African Americans living in Oregon.

The framework presented by Camara Phyllis Jones[5] and other investigators regarding race-associated differences in health outcomes due to the effects of racism, is a useful tool for viewing AAHC's programs and mission. Jones' framework includes 3 levels of racism that affect the health of African Americans: *institutionalized racism,* which is normative, structural, and includes access to power; *personally mediated racism,* which includes both intentional and unintentional acts of commission or omission, manifesting in societal stereotyping; and *internalized racism,* which is the acceptance of negative messages by stigmatized races, resulting in self-devaluation and hopelessness.[5] This framework is applicable to Oregon's African-American community, a small population that has been disenfranchised and demonstrates poorer health outcomes than the dominant population, due to the effects of racism. The combined effects of these 3 types of racism, which African Americans experience on a daily basis, leads to a steady dose of stress. Stress takes its toll on health,[6] even when experienced at low levels or, as often happens with racism, it is not overtly recognized due to the habitualization of racism's pervasiveness in our society. The African American Health Coalition, Inc. is taking an active role in addressing the issue of racism and its impact on health in all of its interventions.

The history and experience that the African-American community has with organizations and systems has created a deep-seated mistrust of the healthcare system, which has been passed down from generation to generation. This has affected the way in which the community views its hospitals, doctors, health systems, and research institutions. To date, predominantly White organizations and institutions provide health services in the predominantly African-American North/Northeast Portland community. No critical mass of Black health professionals exists in the state of Oregon, and the lack of a Black health infrastructure emphasizes the need for the African American Health Coalition, Inc.

METHODS

REACH 2010 Design Development

The AAHC competed nationally for the opportunity to implement the REACH 2010 program directly within the African-American community of N/NE Portland. The AAHC received an initial award from the CDC in September 2000 to develop a Community Action Plan to reduce cardiovascular disease within the African-American community.

During this pre-planning phase, the AAHC solicited community input via advertisements in local community newspapers, and postings on a variety of corporate and nonprofit listservs. These advertisements and postings posed the questions, "What should the AAHC do to reduce cardiovascular disease?" and "If money were not an issue, what would you be willing to commit to do to reduce CVD?" The feedback received from the community was invaluable in shaping the specific components of the proposed AAHC-sponsored REACH Program. In addition to community advertisements and listserv postings, the AAHC received the support of key community stakeholders and collaborators through the development of a consortium that included over 35 members, comprising individuals from state and county health departments, religious organizations, beauty and barber shops, academia, policy makers, business owners within the African-American community, consumers, and community members at-large.

The outcomes from the many focus groups, community collaborations, consortium meetings, as well as input from the community, led to the development of a Community Action Plan, and eventual submission of the grant application to the CDC for further funding. Based on the initial work and results during the pre-planning phase, in September 2001, the AAHC received a multi-year award to implement the strategies identified in order to target risk factors for CVD within the African-American community.

The REACH Program of the AAHC consists of 4 ethnic-specific interventions. Lookin' Tight, Livin' Right (LTLR) utilizes the natural networks between beauty and barber shop operators and their clients as a means of disseminating educational information regarding risk factors for CVD throughout the community. Healthy Options for Living Longer Actively (HOLLA) takes place within 2 predominately African-American high schools, and trains students to deliver messages about CVD and its risk factors to their peers and extended family members. Prevention Within REACH (PWR) reaches out to members enrolled in state-supported health insurance, CareOregon, to encourage African Americans to get screened by their physicians in order to prevent risk factors for CVD. The fourth intervention, Wellness Within Reach (WWR), promotes physical activity as a means of reducing CVD by offering physical activity opportunities at no cost throughout the African-American community of N/NE Portland.

Wellness Within Reach: Mind, Body and Soul

The link between the LTLR intervention and the WWR program is based on the Stages of Change model of behavior change. This model construes change as a process involving progression through a series of 6 stages.[7] The actual stages can be broken down and described as Precontemplation, Contemplation, Preparation, Action, and Maintenance.[7] Participants who are introduced to cardiovascular disease and its risk factors through the LTLR program are exposed to information that may start them on the path through the Stages of Change, leading to eventual enrollment in the WWR program.

Wellness Within REACH (WWR) is a consortium model that includes 35 partnerships, and was initially created as a necessary resource of the LTLR intervention. Beauty and barber shop operators speak with their clients about risk factors for CVD, and when clients are ready to be proactive in taking charge of their health, they are referred to the WWR program.

Many African-American Oregonians knew about, and were a part of, WWR at the design stage, which occurred a year before the official inception of the program. This type of open solicitation resulted in early buy-in from a large number of individuals within the African-American community of Portland. Since members from the target population knew of AAHC's intentions, and were polled during the previous year, many were beyond the pre-contemplation stage in the Stages of Change model by the time the WWR program was implemented.[8]

Wellness Within REACH Components

Capacity Building through Training the Trainers

Initially, the AAHC had to build capacity among the African-American community to facilitate the initiation of professional physical activity classes in a culturally appropriate setting. There was a dearth of certified African-American physical activity experts available to instruct the exercise classes. The AAHC overcame this barrier by identifying members of the African-American community already in the physical activity field, who had a rapport and reputation of trust within the community, but who were not certified to teach in their respective areas of expertise (ie, aerobics, strength training, yoga etc). The AAHC researched and selected a national certification program, National Endurance Sports Trainers Association (NESTA), and recruited a currently certified fitness expert to facilitate the training modules. Currently, the WWR programs include 15 instructors, and all hold a certification for their specific form of physical activity. Additionally, there are 7 indi-

viduals who are certified as Personal Trainers. Along with certifications in the specialty areas of exercise, the AAHC requires that all instructors are certified in CPR and first aid.

Another way the AAHC builds capacity in the community is through standardization of instructor training. As part of the REACH program, the AAHC and consortium members developed a culturally specific 6-week curriculum to train community educators involved in all REACH interventions on CVD and its risk factors. This ensures that the instructors have an enhanced understanding of the disparities facing African Americans, can identify signs and symptoms of CVD, and encourage participants to work toward prevention of CVD risk factors. Instructors receive this training via mandatory monthly check-in meetings, an opportunity for all instructors to come together to receive further education on health topics, to solicit technical assistance, and to share their successes and challenges.

Capacity Building through Venue Development

Venues at which WWR exercise classes are held are strategically selected in order for African Americans to access exercise within their own community. It is critical that the sites are conveniently located in the N/NE community, have varied times available for classes, and provide ample space and appropriately safe conditions. The site must also have its own liability insurance; AAHC provides coverage but it is necessary for both partners to hold insurance. Once a venue has been identified as a potential site, a contract is negotiated between the AAHC Program Director and the venue representative. Generally a monthly fee is determined, depending on utilization rates, but some churches or other community organizations offer their space as a contribution, and many venues solicit the AAHC to launch a class within their walls.

Program Participant Recruitment/ Dissemination

In order to recruit participants into classes, the AAHC utilizes a multipronged approach. Prior to implementation of the WWR classes, the AAHC was very proactive in building community buy-in and mobilizing community members around their interests to join the program. At every outreach event and community health fair that the AAHC staff attended, WWR was discussed, interest generated, and hundreds of community members signed up to be contacted upon inception of the program. When classes were finally launched, the AAHC was able to contact these interested participants directly. An important direct linkage occurs through the LTLR program, in which the operators assess their clients' readiness to change, and refer them to classes that suit their needs. Often the operator acts as a social support, accompanying a client to a class, or at least monitors their progress by following up with them on a regular basis. Every week, the AAHC advertises the most updated class calendar in the 2 African-American newspapers in the community. Regular publication of the calendar is necessary, because the class offerings are expanded regularly. Due to the small size of the African-American community, however, the predominant method of dissemination is through word of mouth among social networks. When participants were asked in a quarterly survey how they heard about the classes, the overwhelming response was through word of mouth and family and friends (65%), and a majority of participants report exercising with family members as a support system. The AAHC continues to promote the classes at the annual Wellness Village, through the KGW media campaign which includes commercials, the AAHC website, and other local outreach events and health fairs.

Efforts toward capacity building and recruitment culminated in the launching of our First Annual Wellness Within REACH Walk, held September 2004, in the heart of the NE Portland neighborhood. More than 500 community members, from toddlers to seniors, turned out for the Walk in order to promote the WWR program, and to raise funds to sustain the program. Not only was this event successful because it raised awareness of the WWR classes, but it also shifted the cultural norm toward embracing physical activity as a lifestyle. With the participation level so high, numerous community members report that WWR has created a "movement" within the African-American community, and that people are inspired to incorporate exercise into their lives, now that structured exercise is affordable and accessible.

Evaluation Methods

As part of the REACH 2010 program, AAHC is required to conduct a rigorous evaluation of each program component. Early in the conceptualization of its REACH project, AAHC partnered with the Regional Research Institute for Human Services (RRI), a component of the Graduate School of Social Work at Portland State University. The AAHC and RRI staff worked collaboratively to craft an evaluation design and data collection protocol that would provide useful data to program designers, while imposing a minimum of data collection requirements on trainers and participants. Two major mechanisms are used to obtain data about WWR.

First, records of class attendance are obtained from each class by asking all participants to sign in. These records are transmitted to the evaluation team on a monthly basis. Two challenges are associated with this process. One is making sure that everyone signs in at each class. The second is the ability to decipher handwriting of some of the participants. To address the first challenge, trainers are responsible for making sure that everyone signs in, and for reminding the class of this requirement. To address the second challenge, the evalua-

tion team generates pre-printed class sheets that list the names of individuals who have participated in that class over the past 4 weeks. Participants can check off their names, making it easier to know who has attended. Attendance records for WWR classes from April 2003 through January 2004 are reported in this article.

Data for evaluation is also derived from a quarterly survey of class participants. During a specified period each quarter, an evaluation team member attends each class and administers a paper and pencil questionnaire to those in attendance during that session. The survey takes 15–20 minutes to complete, and asks participants about their exercise and eating habits, satisfaction with the WWR program, and assesses their level of knowledge about CVD risk factors. The first set of quarterly survey data was collected in fall 2003, and will be reported in this article. At the next quarterly data collection point, the list of those attending each class will be compared to the list from the prior quarterly survey, and non-attendees will be contacted for a telephone interview. By getting information from those not in class at the second data point, we should be able to more accurately assess the pattern of exercise activity, by determining whether the non-attending participant has stopped exercising entirely, or has switched to a different class, a different time, or different type of exercise.

RESULTS

Description of Class Offerings

By the end of its first 10 months, WWR had developed 21 different exercise classes and attendance data had been collected from 859 class sessions. Eight hundred eighty-seven unique community members had participated in at least one class, and most had participated several times a month. An initial question posed by the WWR staff focused on which classes seemed to be most attractive to community members. Table 1 displays information about the level of attendance for each class. As the second column demonstrates, classes have been active for varying lengths of time. Some are recently added (Salsa, Kickboxing) while others have been functioning for several months (Aerobics). Two classes (Chicago Step, Water Aerobics) were dropped during the existence of WWR. Chicago Step had to be discontinued when the instructor relocated outside of Portland, and Water Aerobics was terminated because the swimming pool was no longer available.

Table 1. Attendance by classes

Class	Meeting Times per Week	Number of Classes	Total Attendance	Average Attendance
Chicago Step	1	9	89	9.9
African dance	1	31	184	5.6
Salsa	1	6	10	1.7
Water aerobics	2	61	5	5.0
Senior exercise	2	47	385	8.2
Tai Chi	1	14	40	2.9
Yoga	2	51	356	7.0
Walking group	3	89	519	5.8
Low impact aerobics	2	31	118	3.8
Aerobics 1	3	111	1320	11.9
Aerobics 2	3	110	546	5.4
Aerobics 3	2	45	411	9.1
Aerobics 4	3	92	2216	24.1
Kickboxing	1	5	14	2.8
Body conditioning	1	29	260	9.0
Walk to run	2	19	53	2.8
Strength training 1	2	23	130	5.7
Strength training 2	2	32	49	1.5
Strength training 3	3	59	608	10.3
Weight management	2	64	227	3.5

As Table 1 suggests, certain classes seem to consistently attract larger groups of participants. One of the aerobics classes averaged 11.9 attendees per class over 111 class sessions. A second aerobics class averaged 24 people per class over 92 classes. The WWR staff reviewed both the timing and the instructors for these classes to see if this success could be replicated. Individual community members have differing needs, and while some may particularly enjoy a large class with many friends and family members for support, others may prefer smaller, more intimate, groups. The array of classes reported here allows community members to choose where, when, and with whom to exercise.

Table 1 also demonstrates the wide variety of physical exercise options that have been made available to the community during this time period. Even if a participant chooses to attend a particular class only once or twice, he or she will have been introduced to another form of activity. In addition, the offerings span a range of physical abilities, from Senior Exercise to Kickboxing. This range helps community members remember that individuals at all levels of functioning can be physically active.

Quarterly Survey of Class Participants

In early fall 2003, an evaluation team member attended one session of each of 9 classes active at that time, and administered a paper-and-pencil survey to those in attendance. Seventy-five in-

dividuals completed the survey, with 32 of the respondents being from one aerobics class. The respondents were mostly female (96%), and reported an average age of 47 years, with participants ranging from 25 years to 81 years old. Ninety-one percent reported that their health was *good, very good, or excellent.* Ten percent said that their health was *fair,* and no one reported that their health was *poor.*

On average, this group of participants was 5′5″ tall, and weighed 176 pounds. When asked how they described their weight, 53% (*N*=40) said they were *slightly overweight* and 12% (*N*=9) said they were *very overweight.* Seventy-eight percent (*N*=57) said they were currently trying to lose weight. When BMI was calculated using the CDC's formula, 46% (*N*=30) were classified as overweight, and 38% (*N*=25) were classified as obese. Forty-one percent (*N*=28) reported that someone had told them they were overweight or obese. Twenty-six percent (*N*=19) had been told that they had high blood pressure, and 19% (*N*=13) had been categorized as having high cholesterol.

Given that they were attending an exercise class, it is not surprising that these participants were taking steps to improve their health. Very few of the participants were currently smoking; only 4 of the 75 reported smoking most days of the prior month. Participants were asked about their exercise and eating patterns over the past 7 days. Although a week is a fairly short time period, these data give some indication of the efforts being made. Table 2 provides the detailed responses to the questions about health behaviors.

Taken at face value, these data suggest that participants are exercising at least 2 days a week, and that slightly more than half are exercising 5 or more days a week, which means that more than half of the participants are exercising more than they were 6 months ago. Most surprisingly, 82% of participants reported exercising for 30 minutes or longer at each session, and 18% reported exercising for an hour or more. This may reflect the length of the classes that they attend, rather than the amount of aerobic exercise. Whether these data are affected by under- or over-reporting is unknown.

Table 2. Health behaviors reported by participant (*N*=75)

Risk/Reduction Behavior	Frequency	Percent
Exercise to lose weight*	62	86%
Eat less, reduce fat*	49	68%
Smoke cigarettes* (no)	69	94%
Exercise for at least 20 minutes†		
0–1 days	3	4%
2–4 days	33	45%
5–7 days	37	51%
Amount compared to 6 months ago		
More	40	58%
Same	19	28%
Less	10	14%
Total time spent in exercise session‡		
<10 to 20 minutes	7	9%
21–30 minutes	6	8%
31–40 minutes	13	18%
41–50 minutes	4	6%
51–60 minutes	29	40%
>61 minutes	13	18%

* During the past 30 days did you . . . .
† On how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes?
‡ On days when you exercised at least 20 minutes at a time, how much total time?

Although health behaviors other than exercise are not an explicit focus of the WWR program, we asked participants to respond to a standard set of questions about these behaviors as part of the survey. This standard set of questions, as well as several about exercise, are asked of all participants in all REACH programs in Oregon, and will eventually help us determine changes occurring across the population. Table 3 displays these results.

Many WWR participants practice some healthy eating behaviors. For example, most of the survey participants eat red meat less than 3 times a week, and frequently eat chicken and fish. Two eating behaviors stand out for targeted change. Many of the participants are still consuming fast food on a regular basis, although the majority of responses were in the "1–3 times a week or less" category. The low consumption of fruits and vegetables is most striking, with 58% reporting that they eat fruits and vegetables less than once a day. Only 19% reported eating fruits and vegetables 3 times a day or more. There is a large gap between the participants' reported consumption, and the REACH goal of "5 a day."

DISCUSSION

The AAHC has successfully filled a need in the community, which is demonstrated by the number of participants and comprehensive community buy-in. Wellness Within REACH (WWR) has completed many milestones in a short period of time; including a very fast start up during the 10 months discussed in this article, an increasingly expansive class schedule with a variety of venues and classes to choose from, an ever-

Table 3. Eating behaviors (*N*=75)

Behavior	Frequency	Percent
Eat fruits and vegetables*		
None	3	4%
1–3 times in week	20	27%
4–6 times in week	20	27%
1–2 per day	16	21%
3 per day or more	14	19%
Eat red meat*		
None	15	21%
1–3 times in week	41	56%
4–6 times in week	10	14%
1 or more times per day	7	9%
Eat chicken and fish*		
None	1	1%
1–3 times in week	36	48%
4–6 times in week	23	31%
1 or more times per day	12	16%
Eat fast foods*		
None	26	35%
1–3 times in week	41	55%
4–6 times in week	2	3%
1–2 per day	5	7%
Drink water*		
None	3	4%
Less than 1 per day	10	13%
1–2 per day	17	23%
3 per day	14	19%
4 or more per day	30	41%

* During the past 7 days, how many times did you . . . .

growing number of participants enrolling in the program, and an essential capacity building skill of African-American physical activity specialists. The AAHC has learned a lot during this process, leading to standardization of the program through documented protocols and procedures, as well as continual process evaluation and program refinement. The collaboration efforts with broad-based key community partners have been essential in securing partnerships and community wide buy-in for the program.

Personal anecdotes from participants and instructors reaffirm that the program is shifting the community norm toward embracing physical activity and healthier lifestyle choices. Self-reports from numerous individuals illustrate that with the free access to, and availability of, the classes they have been able to overcome obstacles in their lives. For example, several community members declared that they have used the opportunity to exercise to combat stress and depression due to unemployment, that they have persuaded family and friends to join them, and that they are dedicated to this "movement" that is spreading throughout the African-American community. The AAHC has seen individuals of all ages participating in the classes, from 21 years old to 87 years old, and often hear that individuals feel accountable to show up to classes regularly, due to their relationships with their instructors, and the opportunity to engage in their social support networks. The success of the REACH Walk for Wellness, with over 500 community members turning out for the First Annual Event, was a clear signal that people are supporting this program, and that the AAHC and WWR have become household names.

A point of interest is that the survey data demonstrate that smoking is not an issue for this population, perhaps because this cohort is already seeking healthier lifestyle choices by exercising. This also may be attributed to the fact that many of the participants are being referred from African-American beauty and barbershops, where some clients are being educated and coached on quitting smoking through the operators' application of the Stages of Change.[7,8] This will be further explored following the next quarterly survey and the data analyses of the LTLR intervention.

While smoking may not be a primary concern for this group, the data point out that education efforts are needed in promoting the consumption of fruits and vegetables (5 per day is the target amount) and cutting down on the consumption of fast food. In addition to more nutrition education, the next quarterly survey will be evaluated to determine whether further knowledge is needed in the area of cardiovascular disease. There is opportunity to incorporate an education component into the exercise classes in order to realize a holistic approach to lifestyle choice, thus living up to the program's name, "Wellness Within REACH: Mind, Body and Soul."

The AAHC is already strategically planning as to how to sustain this program after federal funding has ended. With the launch of the first annual REACH Walk, the AAHC was able to raise some funds toward this effort, and are confident that each year this fundraising event will grow in size and donations. The community partnerships play a pivotal role in the program's sustainability because of the win-win situation created for all parties. The AAHC is currently building its strategic development plan to secure a broader donor base, including individual giving, cor-

porate and foundation giving, as well as an advocacy campaign, locally and nationwide. It is certain that with advocacy at the regional, local, and national levels, and with the demonstration of positive health outcomes, there will be interest in changing policy and systems to support the continuation of this critical program.

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REFERENCES

1. Alderman MH, Cohen HW, Madhaven S. Myocardial infarction in treated hypertensive patients; the paradox of lower incidence by high mortality in young Blacks compared with Whites. *Circulation.* 2000;101(10): 1109–1114.
2. Ngo DL, Wheel CE, Bye K, Moore JM. *Keeping Oregonians Healthy: Preventing Chronic Disease by Reducing Tobacco Use, Improving Diet, and Promoting Physical Activity and Preventive Screenings.* Portland, Ore: DHS, Oregon Public Health Services, Health Promotion and Chronic Disease Prevention Program; 2003:72.
3. Oregon Census Data, 2002. Available at: http://quickfacts.census.gov/gfd/states/41000.html. Accessed January 7, 2003.
4. Foster WR, Burton BT, eds. National Institutes of Health Consensus Development Panel on health implications of obesity. *Ann Intern Med.* 1985;103(suppl 6):1073–1077.
5. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health.* 2000;90:1212–1215.
6. Bezruchka S. Societal hierarchy and the health Olympics. *CMAJ.* 2001;164(12): 1701–1703.
7. Glanz K, Rimer BK, Lewis FM, et al. Health behavior and health education. In: *The Transtheoretical Model and Stages of Change Core Constructs.* 3rd ed. San Francisco, Calif: John Wiley & Sons, Inc; 2002:100.
8. Karanja N. Steps to Soulful Living (Steps): a weight loss program for African-American women. *Ethn Dis.* 2002;12:363–368.

BACKGROUND REFERENCES

9. American Heart Association. *2000 Heart and Stroke Statistical Update.* Dallas, Tex: American Heart Association; 1999:30.
10. Assaf AR, Coccio E, Gans K, Lasater TM. Community-based approaches with implications for hypertension control in Blacks. *Ethn Dis.* 2002;1(suppl 1):S27–S33.
11. Barrett-Connor E, Orghard T. Diabetes and heart disease. In: Harris MI, Hamman RF, eds. *Diabetes in America.* Washington, DC: US Dept of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Arthritis, Diabetes, Digestive, and Kidney Diseases; August 1985. NIH Publication No. 85-1468.
12. Brownell KD. Public health approaches to obesity and its management. *Annu Rev Public Health.* 1986;7:521.
13. Burt VL, Culter JA, Higgins M, et al. Trends in the prevalence, awareness, treatment, and control of hypertension in the adult US population: data from the Health Examination Surveys, 1960 to 1991. *Hypertension.* 1995; 26:60–69.
14. CDC. *Physical Activity and Health: A Report of the Surgeon General.* Atlanta, Ga: US Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, President's Council on Physical Fitness and Sports; 1996.
15. CDC resource page. Center for Disease Control and Prevention web site. Available at: http://wonder.cdc.gov.morj.shtml. Accessed January 7, 2003.
16. Cooper RS. Health and the social status of Blacks in the United States. *Ann Epidemiol.* 1993;3:137–144.
17. Cooper SE. Cardiovascular disease and stroke in African Americans and other racial minorities in the United States. *Circulation.* 1991; 31:1463–1479.
18. Criqui MH, Barrett-Connor E, Holdbrook MJ, Austin M, Turner JD. Clustering of cardiovascular disease risk factors. *Prev Med.* 1980;9:525–533.
19. Friedewald WT. Physical activity research and coronary heart disease. *Public Health Rep.* 1985;100:115–117.
20. Gillum RF. Epidemiology of hypertension in African-American women. *Am J Med.* 1999; 107(2A):22S–24S.
21. Gotto AM Jr. Interactions of the major risk factors for coronary heart disease. *Am J Med.* 1986;80(suppl A):48–55.
22. Grundy SM, Balady GJ, Criqui MH, et al. Guide to primary prevention of cardiovascular diseases. *Circulation.* 1997;95:2329–2331.
23. Hahn RA, Heath GW, Chang M-H. Cardiovascular disease risk factors and preventive practices among adults—United States, 1994: a behavioral risk factor atlas. *MMWR.* 1998; 47(SS-5):35–48.
24. Hubert HB. The importance of obesity in the development of coronary risk fact and disease: the epidemiological evidence. *Annu Rev Public Health.* 1986;7:493–502.
25. Hughes D, DuMont K. Using focus groups to facilitate culturally anchored research. *Am J Community Psychol.* 1993;21(6):775–806.
26. Jeffery RW. Community programs for obesity prevention: The Minnesota Heart Health Program. *Obes Res.* 1995;3(suppl): 283s–288s.
27. Kuczmarksi RJ, Flegal KM, Campbell SM, Johnson CL. Increasing prevalence of overweight among US adults: the National Health and Nutrition Examination Surveys, 1960 to 1991. *JAMA.* 1994;272:205–211.
28. May GS, Eberlin KA, Furbert CD, Passamani ER, DeMets DL. Secondary prevention after myocardial infarction: a review of long term trial. *Prog Cardiovasc Dis.* 1982;24:331.
29. Morbidity and Mortality: 1998 NHBLI Chartbook on Cardiovascular, Lung, and Blood Disease. October 1998. National Heart, Lung and Blood Institute. Available at: http://www.nhlbi.nih.gov/nhlbi/sciing/other/cht-book.htm.
30. Mulchahy R. Influence of cigarette smoking on morbidity and mortality after myocardial infarction. *Br Heart J.* 1983;49:410–415.
31. Nichter M, Ritenbaugh C, Nichter M, Vukovic N, Aickin M. Dieting and "watching" behaviors among adolescent females: report of a multi-method study. *J Adolesc Health.* 1995; 17(3):153–162.
32. O'Connor GT, Buring JE, Yusaf S, et al. An overview of randomized trials of rehabilitation with exercise after myocardial infarction. *Circulation.* 1989;80:234–244.
33. Paffenbarger RS Jr, Wing AL, Hyde RT. Physical activity as an index of heart attack risk in college alumni. *Am J Epidemiol.* 1978; 108:161.
34. Pathobiological Determinants of Atherosclerosis in Youth (PDAY) Research Group. Relationship of atherosclerosis in young men to serum lipoprotein cholesterol concentration and smoking. *JAMA.* 1990;264:3018–3024.
35. Pooling Project Research Group. Relationship of blood pressure, serum cholesterol, smoking habit, relative weight, and ECG abnormalities to incidence of major coronary events: final report of the Pooling Project. *J Chronic Dis.* 1978;31:202–306.
36. Powell KE, Thompson PD, Caspersen CJ, et al. Physical activity and the incidence of coronary heart disease. *Annu Rev Public Health.* 1987;8:253.
37. *Reducing the Health Consequences of Smoking: 25 years of Progress—A Report of the Surgeon General.* Rockville, Md: US Dept of Health and Human Services, Public Health Service, CDC, Center for Disease Prevention and Health Promotion; 1989. DHHS Publication No. (CDC) 889-8411.
38. Stern M. Epidemiology of obesity and its link to heart disease. *Metabolism.* 1995;44(9[suppl 3]):P1–P3.
39. The sixth report of the Joint National Committee on Prevention, Detection, Evaluation,

and Treatment of High Blood Pressure. *Arch Intern Med.* 1997;157:2413–2446.
40. Tull ES, Roseman JM. Diabetes in African Americans. In: Harris MI, Cowie CC, Stern MP, Boyko EJ, Reiber GE, Bennett PH, eds. *Diabetes in America.* 2nd ed. Bethesda, Md: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 1995. NIH Publication No. 95-1468.
41. US Bureau of Census resource page. US Bureau of Census web site. Available at: http://www.census.gov/population/www/estimatesco_casrh.html. Accessed January 7, 2003.
42. Williamson DR, Kahn HS, Byers T. The 10 year incidence of obesity and major weight gain in Black and White women aged 30–55 years. *Am J Clin Nutr.* 1991;53:1515–1518.
43. Morse JM. Designing funded qualitative research. In: Denzin NK, Lincoln YS, eds. *Handbook of Qualitative Research.* Thousand Oaks, Calif: Sage Publications; 1994.