Striving to Reduce Youth Violence Everywhere (STRYVE)
Final Evaluation Report

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Executive Summary

Background

From September 2011 through August 2016, the Community Capacitation Center of the Multnomah County Health Department was funded by the Center for Disease Control and Prevention to implement a youth violence prevention project. This project, which went by the acronym STRYVE (Striving to Reduce Youth Violence Everywhere) aimed to bring a public health, preventive approach to work on youth violence. A major, innovative component of the program at MCHD was the integration of Community Health Workers (CHWs) as the primary agents of change in the program. CHWs are trusted community members who participate in training so they can promote health in their own communities.

Purpose of the Evaluation

The purpose of the evaluation component of the STRYVE project was to understand the impact of the project on several groups involved in the project. A second, equally important purpose, was to understand the processes that brought about change, so that we can continually improve our youth violence prevention efforts.

Methods

During the course of the 5-year project, we used word-based and number-based methods to asses both what the program was doing and the results of that action. Methods included focus groups, pre-post surveys, tracking of program actions and adaptations, collection and analysis of existing population-level data, and collection of stories shared in newspapers and social media.

Key Findings

- Participants in the program experienced an increase in factors that help people and communities to avoid violence, and a decrease in factors that make it more likely people and communities will experience violence.
- Our program increased the awareness of those involved about the fact that violence is a public health issue, and their ability to use a public health approach to address violence.
- The integration of Community Health Workers (CHWs) into youth violence prevention work was very successful. This was probably the most important aspect of STRYVE in Multnomah County.

Next Steps

- We will **use this report** to advance violence as a public health issue. The report will provide further evidence of the important role of public health professionals, including CHWs, in youth violence prevention efforts. Specifically, this report will inform planning for our new teen dating violence/youth violence prevention project.
- We will **share our evaluation findings** through newsletters, presentations to County decision-makers, local community-based organization networks, conference presentations and possibly, journal articles.
- In our new project, we will **continue to employ both word-based and number-based methods** to explore the action and results of the project. Lessons learned about appropriate secondary measures of risk and protective factors will inform that effort.

Introduction

Violence is a pressing public health issue that disparately affects young people of color and young people living in poverty. Because of the importance of youth violence as a health inequity, in 2011 the Centers for Disease Control and Prevention (CDC) funded four jurisdictions around the country to plan and implement comprehensive solutions to the problem of violence affecting youth. These demonstration projects were collectively titled, "Striving to Reduce Youth Violence Everywhere," and go by the acronym STRYVE. The Multnomah County Health Department (MCHD) Community Capacitation Center was funded to implement STRYVE in North and Northeast Portland, though the boundaries were eventually extended to include East Multnomah County. Years 1 and 2 were dedicated to developing a comprehensive youth violence prevention plan. Years 3-5 were dedicated to implementation.

The purpose of the evaluation component of the STRYVE project was to understand the impact of the project on several groups of stakeholders: people living in four neighborhoods of focus (including youth), staff at partner organizations, STRYVE Coalition members, and key staff at organizations represented on the Local Public Safety Coordinating Council (LPSCC). (Changes in Health Department staff were measured separately using CDC assessment tools). A second, equally important purpose, was to understand the processes that brought about change, so that we can continually improve our youth violence prevention efforts. A final purpose was to contribute to the sustainability of our violence prevention efforts. Thus, the primary intended audience of this report includes program staff and funders at the CDC. Findings will be shared with Health Department leaders and program participants in more concise and user-friendly formats (including the Executive Summary that precedes this report).

Specifically, our evaluation sought to answer the following questions:

1. *Was the project associated with change in four risk and protective factors (community disorder, exposure to violence, collective efficacy, and commitment to school) in the project neighborhoods?*
2. *Was the project associated with an increase in awareness that violence is a public health issue and increased capacity to address violence as a health issue among project partners?*
3. *What was the role of Community Health Workers (CHWs) in bringing about changes in risk and protective factors and awareness of violence as a public health issue?*

Methods included document analysis, secondary data analysis, surveys, and focus groups. The findings from this evaluation are being disseminated to a broad range of community members, public health practitioners and academics through community presentations, articles in peer-reviewed journals, presentations at conferences, and workshops. Findings will have their most direct benefit for Portland communities disparately affected by violence, but will potentially also benefit communities throughout the country.

A major innovation, not fully anticipated when this evaluation was designed, was the development of a Community Health Worker (CHW) model focused on youth violence prevention. This development, which is probably the single most significant contribution of the Multnomah County program to the field of youth violence prevention, will be discussed in detail later in this report. The plan for this evaluation was reviewed and approved by the Institutional Review Board at Portland State University, where the Principal Investigator is an adjunct faculty member. This does not include the data from the YES Survey, which is reported here but will not be included in peer-reviewed articles.

Background

Youth violence as a public health issue

Violence involving youth has been identified as a significant contributor to the global crisis of premature death, injury and disability (Kruger et al., 2002). The persistent and concentrated presence of violence (including youth violence) has been associated with geographically intensified forms of social and structural maldevelopment (Kruger et al., 2002; *Preventing Multiple Forms of Violence,* 2016). Within the last 30 years, public health strategies to prevent youth violence in the US have exhibited steady progress (Dalhberg & Mercy, 2009) yet the field has struggled with achieving momentum towards widespread adoption (Dodge, 2008). Although various studies have established the efficacy of health-centered prevention (Dahlberg & Mercy, 2009) the lack of appropriate framing, messaging and funding has hindered its visibility (Dodge, 2008). A national campaign has been established that stresses the importance of concentrating collective efforts on identifying and strengthening shared protective factors, while simultaneously working to eliminate and reduce shared elements of risk associated with multiple forms of violence (*Preventing Multiple Forms of Violence*, 2016). With this critical paradigm shift, public heath leaders have identified the need for more collaborative, multi-disciplinary, cost efficient, and comprehensive approaches to youth violence prevention (*Preventing Multiple Forms of Violence,* 2016).

Youth violence in North and Northeast Multnomah County

The STRYVE Program at MCHD set out to contribute to preventing and reducing inequitable levels of violence affecting youth of color in 23 census tracts in North/Northeast Portland; as mentioned above, the program was later expanded to address rising levels of youth violence in East Multnomah County. Given the scope of the program, we did not expect to impact population level data during the course of STRYVE; however, we were asked by the CDC to track it.

Baseline data for youth violence showed that in N/NE Portland, the arrest rate for 10 to 24 year olds for violent crime, homicide, aggravated assault, and simple assault was 2,398 per 100,000 people in 2008, which was 1.7 times the countywide rate of 1,446/100,000. A closer look at the census tract level data within N/NE Portland showed just how elevated arrest rates were: 21 of N/NE's 23 census tracts experienced rates above the countywide average; 7 had rates over 2.5 times the countywide average (3,615/100,000); and 2 had rates over 5 times the countywide rate (7,230/100,000). Gang activity, incarceration, and homicides were also elevated within N/NE, which was at that time home to 12% of the county's 10 to 24 year olds: from 2005-10, 36% (521) of all documented arrests of 10 to 24 year olds for gang activity in Portland took place in N/NE; in 2010, 20% of all 10 to 24 year olds residing in juvenile corrections/detention facilities were residents of N/NE Portland; and from 2003-07, 18% of homicides with a victim 10 to 24 years of age were in N/NE Portland.[1]

Baseline data on risk factors for youth violence (poverty, low school achievement, low school engagement) demonstrated that poverty was prominent in N/NE Portland: 13.8% of families lived below 100% of the federal poverty level (compared to the countywide average of 8.9%); and 70% of students in N/NE were eligible for free/reduced lunch (nearly 20% higher than the countywide average of 53%). Rates of school achievement and engagement were also low for

[1] Portland Police Arrest Data, 2008; Gresham Police Arrest Data, 2008; Department of Community Justice Incarceration Data, 2010; OR DHS, Center for Health Stats; and Portland State Uni. Population Estimates, 2008.

N/NE's youth. In 2009, the graduation rate for Jefferson High School was 52%, which is 14% below the Oregon average of 66%; and the drop-out rate at Jefferson was 7.5%, over twice the statewide average of 3.6% in 2009.[2]

Baseline data for protective factors for youth violence (academic achievement) showed that students attending Jefferson High School also had drastically lower academic achievement when compared to students statewide and nationally: in 2009, only 25% of Jefferson students took the SAT, compared to 54% of Oregon students and 47% of students nationwide. Jefferson students who did take the SAT performed very poorly: they scored, on average, 154 points lower in reading, 174 points lower in math, and 136 points lower in writing than Oregon students.[3]

Community health workers and youth violence prevention

Community Health Workers (CHWs) are trusted community members who participate in training so that they can promote health in their own communities (Farquhar, Michael and Wiggins, 2005). The CHW model grew out of natural helping and healing mechanisms that have existed in all human communities. These mechanisms were formalized in communities that lacked access to health care and the conditions necessary for health. CHWs have played important roles in the US health system since at least the 1960s (Wiggins, Kaan, et al., 2013). Persistent work by CHWs, allies, and researchers over the last 30 years led, in 2010, to major recognition of the actual and potential role of CHWs in the Patient Protection and Affordable Care Act (2010). The ACA added motivation to an existing movement to credential CHWs and better integrate them into the health and health care system. Staff at the Community Capacitation Center (CCC) have been involved in this movement for more than 25 years, and brought substantial capacity to the project of pioneering a CHW model focused on violence prevention.

For the purpose of CHW programs, "community" can be defined in a variety of ways: by race/ethnicity, age, gender, sexual orientation, immigrant status, disability status, geography, other factors, or a combination of factor. For the purpose of this project, "community" was defined as the community of people with a lived experience of youth violence and its effects.

CHWs were integrated into the MCHD STRYVE Program in multiple ways. First and foremost, starting in Year 1, CHWs were hired as core staff. All project CHWs participated in the CCC's approved 90-hour curriculum which qualifies participants to become certified CHWs with the State of Oregon. In Year 4, STRYVE staff partnered with staff at the CCC to develop and conduct a special CHW certification training with a violence prevention focus. This training was offered free of charge to community members already working in violence prevention. It used the CCC's approved curriculum as a basis; however, the training was substantially adapted to center it in the lived experience of people who have experienced violence. In addition, this cohort also participated in a newly-developed seven-hour training titled, "Understanding Violence," and an existing 14-hour training on "Children's Exposure to Violence." The goals of the CHW trainings were to enhance CHWs' understanding of violence as a public health issue and of the protective and risk factors for youth violence and to provide the CHWs with tools/strategies needed to reach out to their communities and protect their youth. After meeting for several weeks, in the tradition of previous cohorts, this cohort chose a name. They chose "the CORE 27."

[2] 2000 Census; Oregon Department of Education, 2010.

[3] Oregon Department of Education, 2010.

Methods

Participant Recruitment and Data Collection

Below we describe the tools used to collect data, how participants were recruited and consented (when applicable), and how data was collected. All data collection tools are included in the Appendix.

Secondary Data

Data on arrest rates for simple and aggravated assault for youth 18-24 were obtained from the Multnomah County Sherriff's Office. Data on detentions of juveniles in Multnomah County were obtained from the Multnomah County Department of Community Justice.

Data on homicides in the census tracts of focus were obtained from vital statistics records available from the Oregon Health Authority, Public Health Division, Center for Public Health Practice, Center for Health Statistics. Data on homicides in the County as a whole were obtained from the Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Data on risk and protective factors were obtained from the US Census, American Community Survey, 5 year estimates available at the Census Tract level.

In addition, we consulted reports on gang-related violence ad homicide from local news media. Secondary data is relevant for answering Evaluation Question 1 (and to a limited extent, Questions 2 and 3).

Surveys

YES pre-post survey

A convenience sample of youth who participated in the Youth Empowerment Solutions (YES) program in Year 5 were asked to fill out a questionnaire at baseline and after the completion of the curriculum. The questionnaire used was a modification of the YES survey designed by the University of Michigan School of Public Health. The pre-post questionnaire was analyzed only for those youth who had completed both questionnaires (n=14). The data collected were relevant to Evaluation Questions 1 and 2. Youth were not consented for this process and this data will not be included in any peer-reviewed publications.

Partner survey

STRYVE staff and evaluators developed a 28-item survey for key organizational stakeholders. The convenience sample consisted of key staff at partner organizations in the five STRYVE sites, STRYVE volunteers and Coalition members, Community Health Workers, and staff at organizations involved in the Local Public Safety Coordinating Committee (LPSCC) and its Youth and Gang Violence Steering Committee (YGVSC). The project-developed survey incorporated some questions from CDC capacity surveys as well as other questions derived from other instruments. The survey was primarily used to answer Evaluation Question 2.

Participants were recruited via an online invitation to participate. Participants were fully informed of any risks and benefits of participation and of their right to participate or not as they

choose. Agreement to complete the survey constituted passive consent. The survey was conducted during the summer of 2016 (end of Year 5).

CHW cohort pre-post survey

Participants in the CHW training completed a 43-item survey at the beginning and end of the 90-hour basic certification curriculum. This survey was based on a survey developed by Wiggins and colleagues (Wiggins, Hughes, Rodriguez, Potter, & Rios-Campos, 2014). It measured changes in four constructs: health knowledge, psychological empowerment, health behavior and self-reported health status. The questionnaire also collected demographic information including age, gender, level of formal education, birthplace, average annual household income, household size, marital status, primary language, and number of years the respondent had been in the United States. In addition, participants completed an 11-item pre-post survey for the Understanding Violence curriculum that was newly created for this project. Participants reviewed an informed consent protocol; agreement to participate constituted consent.

CHW cohort participant satisfaction survey

After each half-day module in the training, participants also completed the standard 20-item participant satisfaction survey conducted with all participants in training at the CCC. This survey includes 17 Likert-scale items and three open-ended questions, as follows: 1) What did you like about the training? 2) What would you like to change about the training? 3) What else would you like to tell us?

Focus groups

Latinx community focus group

In order to get targeted input from Spanish-speaking parents from the Wood Village community, a total of 11 individuals age 18 or above were recruited to participate in a focus group that took place on October 4, 2016. Participants were recruited through personal invitations from project staff either in person or by phone. Participants reviewed an informed consent protocol; agreement to participate in the focus group constituted passive consent. The focus group was conducted in Spanish by the Principal Investigator (PI), who is fluent in the language and has conducted previous research and evaluation in Spanish. Translations from the Spanish in the results are by the PI. Data from the community focus group are relevant for answering Questions 1 and 2.

Focus group with CHW training participants

Various data collection methods were used with participants in the training (see above, pre-post survey, participant satisfaction survey). In order to gather reactions from a purposive sample of participants several months after the training, we conducted a focus group (n=6). Participants were recruited through an email and personal invitations from project staff. They reviewed an informed consent protocol; agreement to participate in the focus group constituted passive consent. Data from the CHW focus group are relevant for answering Questions 1, 2, and 3.

Data Analysis and Interpretation

Quantitative Data

Secondary Data

Homicides among the 10 to 24-year-old age group were geocoded using decedent residential address at the time of death. The homicide rate for the STRYVE census tracts was calculated using the aggregated number of homicides in the 23 tracts as the numerator and the estimated aggregated population of 10-24 year olds living in those tracts, and reflects the rate per 100,000.

Violence data viewed as simple and aggravated assault originated as x/y coordinate pairs for the address locations of the persons committing an offense. The data was filtered to show groupings by year 2010 to 2015 based on report date, as well as date of birth ranges to satisfy the 10-24 age requirement for each year. Finally, the point locations were aggregated to Census Tract geography using a Spatial Join with ArcGIS software tools; this geographically matches the point address locations to Census Tracts. To normalize values from different years, the year with the largest range was used as the template range for other smaller range years, to achieve a common class range and color symbol scheme through the 6-year period. Percentages for ages 10-24 were calculated based on the American Community Survey Census Tract population estimates of ages 10-24 years for each year.

Juvenile detention data for ages <25 years originated as counts per zip code in a table and ArcGIS software was used to join the table to zip code geography. Census tracts of the area of interest were overlaid to show the relationship to the zip code data. Zip code data were displayed using a slight modification of the Natural Breaks (Jenks) method, where nearest whole numbers were used as the class break points to ease map literacy.

Poverty data were displayed using a slight modification of the Natural Breaks (Jenks) method, where nearest whole numbers were used as the class break points to ease map literacy; for instance, 9.2 is shifted to 10 as the break point. To normalize values from different years, the year with the largest range was used as the template range for other smaller range years, to achieve a common class range and color symbol scheme through the 6-year period.

Primary Data (surveys)

Data from pre-post questionnaires were entered into Excel. In Excel, we constructed demographic profiles and calculated the percentage of participants whose scores improved from baseline to follow-up. For the STRYVE CHW pre-post survey, data were then transferred into SPSS, where we used paired t-tests to calculate whether changes were statistically significant. Given small sample sizes, we were not able to assure that all the assumptions of homogeneity and normality of variance were met, so these data need to be interpreted with caution. All scales included in the pre-post questionnaires have been previously used and have demonstrated acceptable levels of reliability (Wiggins et al., 2014).

Data from participant satisfaction surveys were entered into an Excel spreadsheet. They were then transferred into STATA Version 13. Denominators, numerators, means and percentages of those who responded *strongly agree* or *agree* were calculated for each question by session producing statistics for detailed session evaluations, and also by all sessions (GroupXSeries) using listwise deletion (i.e. if a person did not answer the question it was excluded from the computation of the new variables [numerators and denominators] and in analyses [means, %].)

Qualitative Data

Focus group data were collected using semi-structured guides, which allow facilitators to probe for deeper understanding, and transcribed by a professional transcriptionist. The first author did the initial analysis of the qualitative data. She used a form of grounded theory technique (Strauss and Corbin, 1990), modified by the fact that focus group and open-ended survey questions provided a pre-existing codebook for the data (Miles and Huberman, 1994). Specifically, in the open coding phase, she conducted a line-by-line analysis of each transcript, giving rise to concepts and initial categories that were then written up as code notes. As analysis proceeded, the first author alternated between open and axial coding, relating subcategories to categories and verifying categories by comparing them back to the data. Finally, in the selective coding phase, central phenomena were identified (Wiggins et al., 2009). A draft report was prepared and reviewed by the fourth author, who is a CHW and was a member of the STRYVE team. A similar process was used to analyze qualitative data from the participant satisfaction surveys.

Results

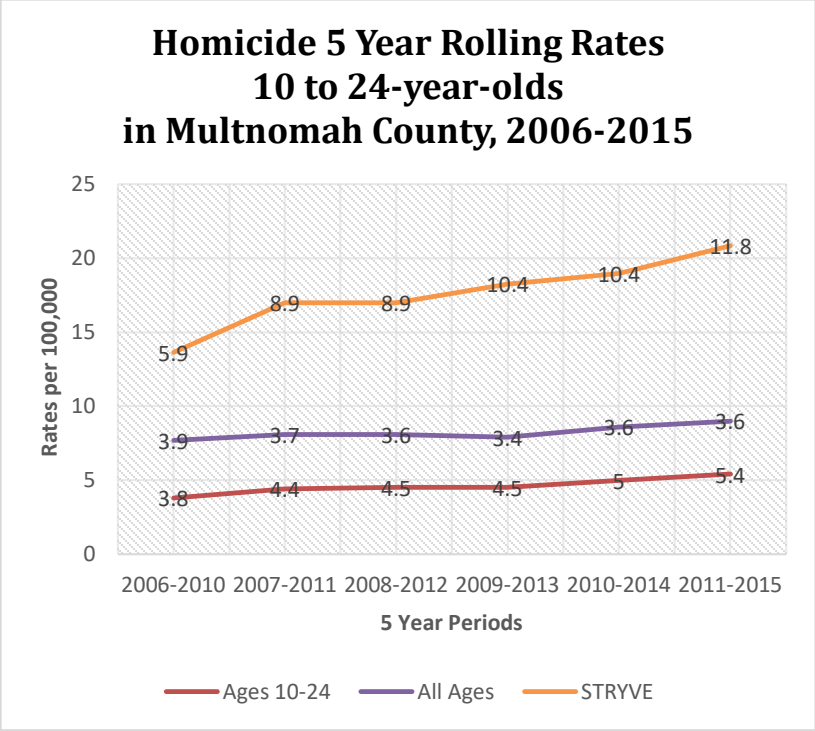
Secondary Data

Youth and gang-related violence

Maps 1-6 (Youth Violence: Simple and Aggravated Assault for Ages 10-24) in the Appendix show the percent of the population of youth ages 10-24 who were arrested for simple and aggravated assault from 2010-2015. The 23 census tracts of interest for the STRYVE Project are outlined in red. The maps suggest that, between 2010 and 2015, the percentage of youth from the STRYVE census tracts who were arrested for simple and aggravated assault declined. In 2010, 12 of the 23 census tracts were included among those with the second highest percentages of youth arrested for violence crimes, whereas by 2015, the number was only 6 of 23. However, the percent arrested in the census tracts of focus still remains much higher than the percentage for the County as a whole.

As regards youth 10-17 in correctional facilities (Map 7, Youth 10to17, in Correction Facilities by Zip Code) in the Appendix), as of 2017, we can see a clear pattern. By far the majority of youth in detention facilities have home addresses in the far northwestern and far eastern sector of the County. Between 21-28 youth currently in detention facilities reside in those areas. Four of the STRYVE census tracts are in the affected area in the far northwestern corner of the County. Most of the remainder of the STRYVE census tracts lie in areas where between 11 and 20 youth currently reside in detention facilities.

From 2011-2015, the homicide rate for youth ages 10-24 in the 23 census tracts of focus for the STRYVE program was 10.4 homicides per 100,000. This compares to a rate of 5.4/100,000 for youth ages 10-24 in the County as a whole, and 3.6/100,000 for people of all ages in the County. It is important to note that the rate in the 23 census tracts is artificially inflated due to the fact that 4 of 7 total homicides of 10-24 year olds occurred in one census tract within the STRYVE boundaries, and this census tract averaged only about 400 total youth ages 10-24 per year during the reporting period. Of the 7 homicides during this period, 6 were of people of color or biracial people while one was White. Most homicides in the 10-24-year-old age group were to residents of East County, the area of focus for our new TDV-YV grant.



A more complete picture of trends in homicides of 10 to 24-year-olds in the census tracts of focus can be obtained by looking at rolling rates within these census tracts, as compared to rolling rates within the County as a whole. The chart at left summarizes these rates. As the chart shows, rates in the census tracts of focus remain higher and have continued to rise more sharply than rates for youth ages 10-24 in the County as a whole, and more sharply than rates for all ages in the County as a whole.

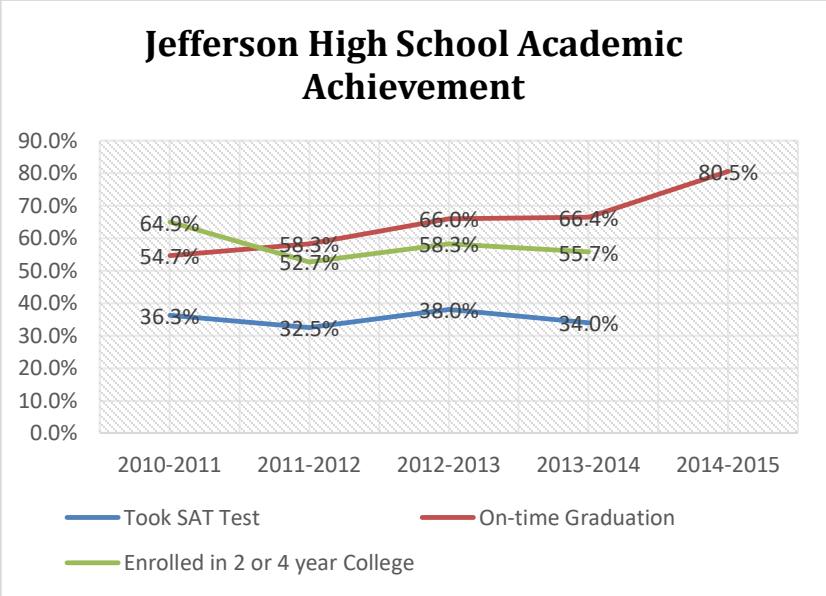
Reports in local news media suggested that gang-related violence, including homicides, went down in 2016 after a high in 2015. (Veteran gang enforcement officers hypothesize that the rates were actually higher in the 1990s, when separate records were not kept [Redden, 2017].) On Dec. 31, 2016, *The Oregonian* reported that only one homicide (out of a total of 20) in 2016 was gang-related, and the homicide was not the result of a gang rivalry, but rather, of a personal dispute (Bernstein, 2016). Overall, homicide was down compared to the two previous years. In March of 2017, *The Portland Tribune* reported that a decrease in incidents of violence investigated by the Portland Police Bureau's Gang Enforcement Team which began in 2016 was continuing into 2017. Nine incidents of gang-related violence were investigated in January and February of 2017, the lowest for that time period since 2013 (Redden, 2017). There was some controversy in local media about whether violent crime was increasing in the East County area that is the focus of our new TDV-YV grant from the CDC. While Part 1 person crimes reached a 5-year low (letter from Gresham Police Chief Robin Sells, 2017), the number of homicides (8) was the highest in 22 years (Smith, 2016) and a majority of those were concentrated in the Rockwood area. It is important to note that that statistics from East County concern violence generally, not youth and/or gang-related violence.

Risk and protective factors

Maps 8-13 (Percent of Population Below Poverty Level) in the Appendix reveal trends from 2010 to 2015 in the percent of the population living below the poverty level, both within the STRYVE census tracts of focus and across the entire County. Whereas in 2010 three of the STRYVE census tracts were among those with the highest percentages of people living in poverty, by 2015 this was true for only two STRYVE census tracts (and one of those is a tract in the far northern part of the County with very low population, thus inflated rates). Falling percentages of people living in poverty in inner NE Portland reflect the gentrification occurring in that area, whereas the intensification of poverty in the eastern part of the county reflects the movement of people living in poverty into that region. The increase in poverty in East Multnomah County, combined with an

increase in other risk factors and increasing rates of youth violence, was a major driver of our decision to focus our current teen dating violence/youth violence project in that region.

A similar trend is visible in Maps 14-19 (Populations of Color in Poverty, 2010-2015) in the Appendix. These maps show the percentage of people of color living in poverty in the census tracts of focus and across the County. In the STYRVE census tracts, from 2010 to 2015 we see decreasing percentages of people of color living in poverty, while those percentages are increasing in East Multnomah County.



Oregon Department of Education data show that from 2010-2015, the percentage of students at Jefferson High School who graduated on time climbed markedly, from below 60% to 80%. The percentage of students taking the SAT test stayed flat, while the percentage enrolling in a 2 or 4-year college actually declined.

Overall, these data suggest that while risk factors for youth violence and rates of youth violence remain higher in the STRYVE census tracts than in the County as a whole, over time risk and violence have become concentrated in the far eastern sections of the County, driven to a great degree by gentrification in inner North and Northeast Portland.

Surveys

YES Pre-Post Survey

Participant profile

Of the 14 participants, 5 (37.5%) identified as Hispanic, 3 (21.4%) identified as African, 2 (14.3%) identified as white, 1 identified as Asian, 1 as Black or African American, 1 as Pacific Islander and the other 1 youth identified as belonging to two or more racial/ethnic groups.

Results

The results from the questionnaire are summarized in Tables 1, 1.1, and 1.2 in the Appendix. Almost half the youth (42.9%) demonstrated increases in three of the attitudinal variables: leading and organizing peers (Q.1-2) and expectation of being in college or getting a college degree (Q.12). The same percentage demonstrated a decrease in their belief that violence is the only way to stop harassment (Q.23). In addition, 35.7% of youth demonstrated increases in a number of other positive attitudes (Q.15, 16), protective factors (Q. 20, 21 & 22), and self-reported health status (Q. 25). There was a limited increase in the following attitudinal variables:

setting a good example for younger children (Q. 9) and self-efficacy to graduate high school (Q. 11). For these two questions, 100% of respondents reported either agreeing or strongly agreeing on both the pre and post-survey.

In addition to the Likert scale items, the youth were also asked to respond to the questions, "What are the causes of violence in your community?" and "What are the solutions to end or prevent violence in your community?" Qualitative responses to these questions are summarized in Tables 2 and 2.1.

To better understand responses to the survey, we asked STRYVE staff for their interpretations. Program CHWs noted that Q.1 and Q.2 ask about leading peers, and those questions showed a significant increase, while Q.3 involves leading in the community. Staff suggested that Latin@ and African American youth may be more comfortable working within their families and peer groups and may not feel safe working with larger groups. The program manager suggested the word "advocate" in Q.3 is very formal and believed the response would have been different if the survey used the term "I am feeling confident to speak up." Staff also noted that causes and solutions to violence reported on the post-survey were related to themes emphasized in the curriculum.

In addition to the small size of the convenience sample, another limitation of this data is that the sample was drawn from only two STRYVE sites.

Partner survey

Participant profile

The survey was sent to 41 individuals and a response was received from 19 individuals (a response rate of 46.3%). Of these, 10 (52.6%) identified themselves as an administrator at a partner organization, eight (42.1%) identified as a member of the YGVSC, eight (42.1%) identified as a STRYVE coalition member, six (31.6%) identified themselves as a LPSCC member, two respondents identified as Community Health Workers (CHWs), and one identified as a STRYVE volunteer.

Results

The survey questions and the participants' response frequencies are summarized in Tables 3 and 3.1 in the Appendix. Analysis of the responses indicate the STRYVE partners showed a remarkable increase in knowledge about violence (Q.1 – 9) and ability to address violence as a public health issue (Q.10-11) after having been involved with STRYVE. On six of nine questions dealing with awareness, participants registered 100% awareness. Additionally, respondents indicated strong interest in additional training (Q.12) and a high degree of involvement in various STRYVE activities (Q.13-14).

Findings suggest this group of respondents is now more aware that violence is a public health issue, and they are more able to address that violence following their involvement with STRYVE. It is quite likely that those who chose to respond to the survey felt more favorably towards the program than those who did not. Therefore, these responses cannot be considered representative of all STRYVE project partners.

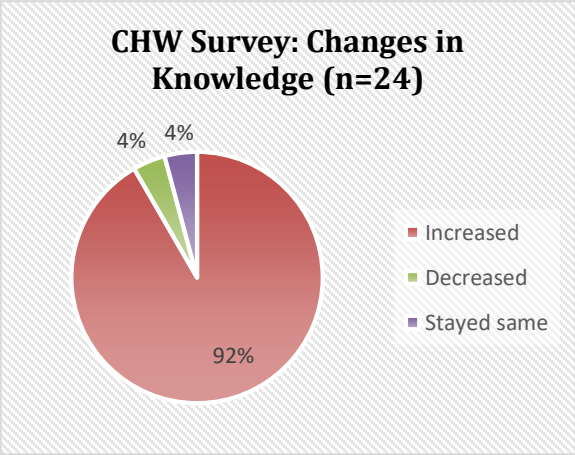
In addition to the Likert scale items, the participants were also asked to respond to the questions, "Please tell us 3 things that you learned about youth violence prevention" and "Please tell us 3 things that could be done to improve the effectiveness of the STRYVE program." Qualitative responses to these questions are summarized in Table 3.2 along with their frequencies. Sample quotations and examples are provided in the right-hand column. The

qualitative responses underscore the quantitative responses, indicating that partners learned new approaches and strategies for violence prevention and increased their appreciation for the importance of involving youth and addressing upstream factors.

CHW Pre-Post Survey (pre-post n = 24; demographic n=27)

Participant profile

Of the 27 members of the CHW cohort, 16 (59%) were female while 11 (41%) were male. The majority identified as African American (15 or 55%), but the group was diverse, with 6 identifying as Latinx, 2 as Asian, 2 as Native American, 1 as white; 1 participant chose not to identify a race/ethnicity. Three identified as LGBTQ, and 10 had a high school education or less. The majority (14) identified their type of work as gang prevention intervention.



Results: The CHW pre-post survey measured change in four constructs: health knowledge, psychological empowerment, health behavior, and self-reported health status. A pie chart for health knowledge showing percent increased, percent decreased and percent staying the same is at left, and reveals that fully 92% of participants increased their health knowledge from baseline to follow-up. A summary of changes in the other three constructs is provided in Table 4 in the Appendix. It reveals substantial increases in confidence in ability to promote health and share health information (Q.1-2).

Both of these changes were significant at the <.05 level or below. (See Table 5 in the Appendix.) Even larger increases occurred in participants' understanding of and ability to explain how personal and community problems are connected to bigger problems at the state, national and global level (Q. 9-10) and understanding of how historical factors affect life today (Q.11). All these changes were significant at <.01 level (see Table 5).

Questions 9-11 comprise the "critical consciousness" sub-scale within the larger empowerment scale; critical consciousness is an important component of empowerment, which independently predicts better self-reported health status and reduced depressive symptomatology (Wallerstein, 2006). Empowerment is closely related to (though broader than) self-efficacy, which is a protective factor for youth violence. The change in critical consciousness noted in participants in the CHW training can reasonably be attributed to the use of popular education (PE) in the training, since PE puts a large emphasis on developing critical consciousness.

CHW Participant Satisfaction Survey (n=27)

Participant profile

The participant profile is the same as for the CHW Pre-Post Survey.

Results

Quantitative results from the Satisfaction Survey are summarized in Table 6 in the Appendix. Qualitative responses along with their frequencies are summarized in Table 7 in the Appendix. The quantitative data reveal that large majorities of participants (above 80% in all cases) appreciated the content and methodology of the courses and felt the courses had improved their ability to promote health in the community. Participants gave particularly high marks to the new, "Understanding Violence" course.

According to the qualitative data, aspects of the course that were most appreciated by the participants included the teaching/facilitation style, the information provided, the group participation and interaction, and the personal check-ins and "journeys." (In all culturally specific CHW training courses at the CCC, both participants and facilitators are invited to share the life paths that brought them to the CHW training. This practice is often mentioned as one of the most meaningful aspects of the course for participants and facilitators.) Suggested ways to improve the course included better facilitation, especially when dealing with challenging participants; more time for discussion; a larger space and better food; and more respect for others, especially on behalf of one participant.

Focus groups

Latinx Community Focus Group

Results of the focus group conducted with Latinx parents in the Wood Village community (see Table 8 in the Appendix) revealed a variety of aspects of the program that parents liked, including the information that was shared and how it was shared. Suggestions for improvement included finding more funding, especially for Summerworks jobs, so that more youth could participate.

Parents identified a number of changes associated with the program, including a decrease in risk factors (exposure to violence and community disorder) and an increase in protective factors, including one that was targeted by the program (commitment to school) and two that were not (connection to a caring adult and connection to pro-social peers). As one parent commented, "There are many young people I know who were not doing well in school and this program has helped them to finish high school."

Parents mentioned a variety of factors that contributed to program success, including the personnel, the variety of activities, the location, and the year-round nature of the program. Commenting on this later aspect, a parent stated, "Just because STRYVE ended, the youth didn't end. They still come to play soccer with [facilitator], and they still have plans, they get together, they call them, they don't leave them [alone]."

Parents in the focus group evidenced awareness about and ability to address violence as a public health issue. Rather than defining violence prevention as a criminal justice activity best conducted by law enforcement, parents in the group defined violence prevention as an activity they could do by keeping their kids involved in positive activities in a healthy and safe community. They stressed the need for parents to be involved, while acknowledging this can be challenging because of the pressures of work. They expressed a need for more training, for law enforcement officials who will come out to the community, for fundraising skills, and for year-round programs. While we did not specifically inquire whether their knowledge came from the STRYVE Program, we can infer that at least some of their knowledge was a result of their involvement.

CHW Focus Group

The CHW focus group allowed us to gather valuable information such as feedback on the training, the effects of the training on the CHWs and their communities, and participants' ability to address violence as a public health issue. Themes and sample quotes are summarized in Table 9 in the Appendix.

Since the focus group was conducted a few months after the completion of the training, the participants had had the opportunity and time to process their thoughts about the training and to use the tools they learned from the training, before evaluating the training once again. This and the nature of the focus group, which allows more detailed conversations, gave us the opportunity to gather better and more in-depth data, when compared to the participant satisfaction survey (see Tables 5 and 6 in the appendix) administered at the end of each training session.

The participants' feedback on the training stayed consistent between the two evaluations (participant satisfactory survey and the focus group) but the focus group gave us the opportunity to explore the effect of the training on the participants and their community, and the ability of the participants to address violence as a public health issue. The participants reported that the connections they developed amongst their fellow Core 27 CHWs and the tools they gained from the training have empowered them and have made them better at serving and responding to the needs of their community. Participants also reported increased understanding and capacity to practice self-care; in the words of one participant "We are like our own Dr. Phil." From the in-depth conversations, it was also evident that the participants have developed a deeper understanding of violence as a public health issue and they were also able to articulate the harmful health effects of violence.

Limitations of the Evaluation

This evaluation had many limitations. Principle among them was the fact that funding for the evaluation was not prioritized in the Request for Proposals. While MCHD did write evaluation functions into the job description of the Assistant Coordinator included in the original project budget, we made a decision during Year 1 to shift funds away from evaluation and toward the CHW component. While we do not regret this decision, it limited our ability to conduct evaluation throughout the project. Many activities had to be carried out in Year 5, when the CDC approved a no-cost extension to allow us to complete evaluation activities.

Another limitation of the evaluation results from reduced access to secondary crime data. In 2014, the Portland Police Bureau and the Gresham Police Department (the two biggest law enforcement agencies in Multnomah County), changed IT platforms. The previous platform was connected to the Multnomah County Decision Support System Justice (DSSJ), allowing Local Public Safety Coordinating Committee (LPSCC) staff to access arrest data. Since then, law enforcement agencies have focused on implementation and improving operational use of the new platform and do not have capacity yet to connect it to DSSJ. This change limited our ability to track secondary data.

Regarding primary data, all surveys and focus groups depended, to one degree or another, on convenience samples. Selection bias was no doubt an issue, since those who chose to respond likely felt more favorably towards STRYVE than those who did not. Finally, the fact that STRYVE staff were busy with project activities meant that data collection methods that depended on STRYVE staff were less effective than those that depended on CCC evaluation staff.

Summary of Findings

Incidence of Youth Violence

While the CDC did not expect that we would be able to show a decrease in rates of youth violence during the course of the STRYVE Program (and this was not one of our evaluation questions), the CDC did ask that we track secondary data and report trends in youth violence over the course of the project. Our analysis suggested that while risk factors for youth violence and rates of youth violence remain higher in the STRYVE census tracts than in the County as a whole, over time risk and violence have become concentrated in the far eastern sections of the County, driven to a great degree by gentrification in inner North and Northeast Portland.

Risk and Protective Factors

Our first evaluation question concerned change in four risk and protective factors: community disorder, exposure to violence, collective efficacy, and commitment to school. The YES pre-post survey, the CHW focus group, and particularly the Latinx community focus group, suggested that participation in STYRVE was associated with an increase in protective factors (cultural pride, self-efficacy, commitment to school, connection to a caring adult, health knowledge, cognitive development, and connection to pro-social peers) and a decrease in risk factors (exposure to violence, community disorder) among both youth and adults involved in the program.

Awareness about and Ability to Address Violence as a Health Issue

Our third evaluation question asked whether the project was associated with an increase in awareness that violence is a public health issue and increased capacity to address violence as a health issue among project partners. We found evidence for this increase in the YES pre-post survey, the CHW pre-post survey, both focus groups, and most markedly, the Partner Survey, where awareness on most variables increased to 100%. While not a comparative measure, multiple articles about the project in local news media (attached as appendices) undoubtedly contributed to increased awareness of violence as a health issue.

The Role of Community Health Workers

Our third evaluation question inquired about the role of Community Health Workers (CHWs) and popular education in bringing about changes in risk and protective factors and awareness of violence as a public health issue. While we failed to ask question specifically about the role of the two CHWs employed in the project, the CHW training was quite successful, and one graduate was subsequently hired into the program. In addition, we can anecdotally report that the project CHWs contributed in multiple ways to the success of STRYVE. Contributions included CHW involvement in: the published report on adaptations of the YES curriculum in partnership with the CDC (2015); countywide strategic planning (comprehensive gang assessment) and policy review and policy modification (Portland Police Department Gang List); and LPSCC Youth and Gang Violence Sub-Committee and the City of Portland's Office of Equity and Human Rights Black Male Achievement Steering Committee. CHWs were also the primary staff in the partnership with the Defending Childhood Initiative, developing and facilitating with teachers and staff at a community partner organization a year-long training on "Building resiliency through relationships in an educational setting."

Next Steps

We will **use this report** to advance violence as a public health issue. The report will provide further evidence of the important role of public health professionals, including CHWs, in youth violence prevention efforts. Specifically, this report will inform planning for our new teen dating violence/youth violence prevention project.

We will **share our evaluation findings** through newsletters, presentations to County decision-makers, local community-based organization networks, conference presentations and possibly, journal articles.

In our new project, we will **continue to employ both word-based and number-based methods** to explore the action and results of the project. Lessons learned about appropriate secondary measures of risk and protective factors will inform that effort.

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TABLE 1. Quantitative results of YES pre-post survey

Attitudinal Variables (n=14)	% reporting increase	% reporting decrease	% remaining the same
1. I am often a leader in my peer group	42.9%	7.1%	50.0%
2. I can usually organize my peer to get things done	42.9%	21.4%	35.7%
3. I am willing to advocate for causes I think are important	14.3%	21.4%	64.3%
4. I know what things are needed to do a community project.	28.6%	7.1%	64.3%
5. Youth and adults can work together in equal partnership.	21.4%	14.3%	64.3%
6. I do volunteer activities to help my neighborhood.	28.6%	14.3%	57.1%
7. I encourage others to do things to help improve my neighborhood.	21.4%	7.1%	64.3%
8. I am helpful if someone is hurt, upset, or feeling ill.	14.3%	28.6%	57.1%
9. I set a good example for younger children.	14.3%	7.1%	78.6%
10. I can make my community a better place.	21.4%	14.3%	64.3%
11. I will graduate from high school.	14.3%	7.1%	78.6%
12. Ten years from now, it is very likely I will be in college or have a college degree.	42.9%	7.1%	50.0%
13. I feel prepared to get a job.	21.4%	7.1%	71.4%
14. I actively participate in my school's activities.	21.4%	21.4%	57.1%
15. I encourage others to do things to help improve my school.	35.7%	28.6%	35.7%
16. I think it is important to try to do a good job.	35.7%	7.1%	57.1%
17. I know how to plan things so I get my work done.	21.4%	14.3%	64.3%
18. I work hard at my school work.	21.4%	14.3%	64.3%
19. I participate/take part in my classes.	28.6%	21.4%	50.0%

Table 1.1

Protective Factors Variables	% reporting increase	% reporting decrease	% remaining the same
20. I have an adult in my life that listens to me when I need to talk about things that are important.	35.7%	7.1%	57.1%
21. I feel like I am part of my community.	35.7%	21.4%	42.9%
22. There are adults in this neighborhood that children or youth can look up to.	35.7%	14.3%	50.0%
23. If someone picks on me, the only way I can get him/her to stop is if I hit him/her.	14.3%	42.9%	42.9%
24. I know ways to avoid a fight.	21.4%	28.6%	50.0%

Table 1.2

Self-reported Health Status	% reporting increase	% reporting decrease	% remaining the same
25. How would you rate your overall health?	35.7%	7.1%	57.1%

Table 2

What are the causes of violence in your community? - Baseline	
Gangs/guns	n=12
Inter-personal relationship issues like betrayal/hate/love/argument	n=9
Drugs	n=6
Race	n=4
Miscommunication/ misunderstanding	n=2
Free time	n=1

Table 2.1

What are the causes of violence in your community? – Follow-up	
Drugs	n=9
Gangs/guns	n=8
Poverty	n=6
Inter-personal relationship issues like betrayal/hate/love/argument	n=5
Miscommunication/ misunderstanding	n=3
Race	n=1

Table 3. Partner Survey: Awareness about and ability to address violence as a public health issue

SURVEY QUESTIONS	Before STRYVE			After STRYVE		
	YES	NO	UNSURE	YES	NO	UNSURE
1. I am aware that violence is a public health issue.	68.4%	31.6%	0%	100%	0%	0%
2. I can explain what the phrase "risk factor for youth" violence means.	63.2%	26.3%	10.5%	100%	0%	0%
3. I can give examples of risk factors for youth violence.	68.4%	21.1%	10.5%	100%	0%	0%
4. I can explain what the phrase "protective factors against youth violence" means.	47.4%	36.8%	15.8%	100%	0%	0%
5. I can give examples of protective factors against youth violence.	47.4%	36.8%	15.8%	94.7%	0%	5.3%
6. I can explain what the phrase "social determinants of health" means.	52.6%	36.8%	10.5%	94.7%	5.3%	0%
7. I can give examples of social determinants of health.	52.6%	31.6%	15.8%	94.7%	5.3%	0%
8. I believe violence is a health inequity.	63.2%	15.8%	21.1%	100%	0%	0%
9. I believe violence can be prevented.	100%	0%	0%	100%	0%	0%
10. The organization I work for is committed to preventing youth violence.	84.2%	10.5%	5.3%	89.5%	5.3%	5.3%
11. The organization I work for is able to address violence as a public health issue.	21.1%	47.4%	31.6%	63.2%	5.3%	31.6%

Table 3.1 Partner Survey: Participation in STRYVE and interest in youth violence prevention

	YES	NO
12. I would like to receive additional training in youth violence prevention.	84.2%	15.8%
13. I have visited a STRYVE site.	84.2%	15.8%
14. I have participated in a STRYVE event.	79.0%	21.1%

Table 3.2 Partner Survey: Responses to open-ended questions

Learnings about youth	Violence prevention approaches/strategies	n=7	"Connect mentors at younger age, wrap around services for family can break intergenerational cycle, accountability a must."
	Importance of youth engagement	n=6	Engage young people themselves in coming up with solutions to address youth violence.

violence prevention	Address upstream problems	n=5	To be effective, we need to address problem at its roots (e.g. Address poverty, education, etc.)
	Work to build youth skill and help them understand self-value	n=2	Engage youth with opportunities to work together and with positive adult mentors to build their skills and help them see their value.
	Vulnerable population/ Risk factors	n=2	Gained knowledge such as "Your Wealth determines Health." And "Poor neighborhoods are risk factors."
	Needed/available resources	n=2	"The community needs to become involved with govt. and CBO's."
	Ultimate goal	n=1	"The ultimate goal is to stop violence before it starts."
Ways to improve the STRYVE program	Personal development opportunities for youth/CHWs	n=5	Help youth come up with solid projects.
	Need more resources	n=5	We need more resources to reach other areas and to hire more CHWs. Also, "More resources around housing and employment."
	Growing partnership	n=4	"Continue to expand partners so that youth have access to many different parts of the community."
	Year-round program	n=4	"Giving groups of youth longer to plan their projects and learn about violence in Portland."
	More trainings/meetings	n=4	"Have more training and all coordinator meetings to help facilitate cohesion between the admin."
	More outreach	n=2	"Reach more kids."
	Start early	n=2	Involve youth at a younger age.
	Increase public awareness	n=2	"Address violence in the media, television, and video games" to show how it is normalized/ affects people.

Table 4. CHW Training Pre-Post Survey

Psychological Empowerment	% reporting increase	% reporting decrease	% remaining the same
1. I feel quite confident about my ability to share health information.	41.7%	4.2%	54.2%
2. I feel quite confident about my ability to promote health.	37.5%	8.3%	54.2%
3. I have control over the decisions that affect my life.	29.2%	12.5%	58.3%
4. I am satisfied with the amount of control I have over decisions that affect my life.	29.2%	20.8%	50.0%
5. I am often a leader in groups.	20.8%	16.7%	62.5%
6. I find it very easy to talk in front of a group.	29.2%	8.3%	62.5%
7. I can usually organize people to get things done.	20.8%	16.%	62.5%
8. I am a person who believes in myself. I can make it in this world.	33.3%	12.5%	54.2%
9. I understand quite well how my individual problems are connected to bigger problems at the state, national and global level.	45.8%	4.2%	50.0%
10. I can explain to others in my community how our problems as a community are connected to bigger problems at the state, national, and global level.	50.0%	4.2%	45.8%
11. I understand quite well how historical factors affect my life today.	45.8%	8.3%	45.8%
12. **Self-reported health status**	29.2%	16.7%	54.2%
Health Behavior			
13. I get 30 minutes or more of physical activity at least five times a week.	29.2%	20.8%	50.0%
14. I eat 5 or more servings of fruits and vegetables per day.	37.5%	16.7%	45.8%
15. I make an effort to manage my weight in a healthy manner.	45.8%	12.5%	41.7%
16. I find healthy ways to respond to stress.	33.3%	16.7%	50.0%

Table 6.

Results of Paired T Tests for CHW Training Cohort

Item	t	df	Sig.
1. Confidence about ability to share health information	3.19	23	.004**
2. Confidence about ability to promote health	2.29	23	.032*
3. Feeling of control over decisions that affect my life	1.28	23	.213
4. Satisfaction with control over decisions that affect my life	.90	22	.377
5. Often a leader in groups	.33	23	.747
6. Find it very easy to talk in front of a group	2.31	22	.030*
7. Can usually organize people to get things done	.33	23	.747
8. Believe in myself – can make it in this world	1.55	23	.135
9. Understand how individual problems are connected to problems at state and national level	3.41	23	.002**
10. Can explain to others in community how community problems are connected to problems at state and national level	3.68	23	.001**
11. Understand how historical factors affect my life today	2.85	23	.009**
12. Self-reported health status	1.55	22	.137
13. Get 30 min. or more of physical activity at least 5x per week	.000	21	1.00
14. Eat 5 or more servings of fruits and vegetables per day	-1.45	22	.162
15. Make an effort to manage my weight in a healthy way	-1.91	21	.069
16. Find healthy ways to respond to stress	-.90	22	.377

Note. *$p \leq .05$, **$p \leq .01$ (2-tailed); last 4 items are scaled in opposite direction, thus negative t statistics.

Table 7. Summary of Qualitative Responses to CHW Participant Satisfaction Survey

Strengths of the Course		
Teaching style/ facilitation	n= 277	"I liked how the info being presented stayed true to people's education by taking advantage of the wisdom in the room."
Information	n= 198	"It was very informative and had tools to help us in the work we do and also to talk to people."
Group participation/ interaction/ engagement	n= 59	"The group tried to support each other and to problem solve."
Dinámica	n=43	"Excellent movement building activities that fit in well with the discussion that followed."
Personal check-ins/journeys	n= 30	"Journey-brought healing."
Conducive environment	n= 13	"Open and fluid-conscious effort to create a comfort zone for each respective individual."
Art session	n= 5	"It was nice to spend time doing art."
Ways to Improve the Course		
Better facilitation	n=72	"Calling people out who have not been mindful of step up step back in the moment." "Better time management." Facilitators need to model popular education."
More time/discussion	n=65	"More time in group to work through exercise."
Having more videos/ variety of materials	n=56	"Having a video of families to have open discussion."
Logistics/food/ water	n=41	"Larger space, better food, having water."
Allow space/respect for others	n=25	"I couldn't help but wonder how we politely ask someone to step out the space when they are no longer making the space "safe". This content was very intense, tension was felt, and it got real. "
Dinámicas	n=6	
Other Themes		
Great job	n=78	"Loved the training!!!"
Tension between facilitators and/or group	n=11	"Facilitators need to model the topics that are being taught."
Need more energy	n=5	Some parts of the training felt dry and lacked energy.
Need validation on opinions	n=4	"Would appreciate if facilitators would reflect and validate contribution of classmates."

Table 8. Results of Latinx Community Focus Group

Feedback on the Program	
Things parents liked: Parents reported liking the information that was shared, how it was shared, and that fact that children who were too young to participate in the YES program could still benefit from the food and the sports programming.	"I think that the information that they gave them or the form in which they trained them to do the program was interesting."
Ways to improve the program: Parents wished there were more Summerworks funds to pay young people, and that more younger youth could participate.	"I think there is a lack of funding, because there are many young people who would like to be included, but there isn't enough funding to pay them or help them."
Changes Associated with the Program	
Decrease in risk factors: Parents reported that the program had helped to reduce exposure to violence (specifically bullying) and community disorder (as evidenced by an increase in participation from parents and youth living in a nearby mobile home park).	"My son had suffered from bullying, so he didn't have many friends, much social interaction, and then he found this program, he had the opportunity to participate, and now he is a different person. He likes it, he has friends."
Increase in protective factors: Parents reported an increase in protective factors including connection to caring adult (the pastor at the church where the program was conducted, and STRYVE staff), connection to pro-social peers, and commitment to school. They provided some evidence for an increase in efficacy at the personal level. In addition, they reported that their children were more sociable and more motivated to help one another. Finally, two parents reported that their children had found jobs as a result of the program.	My son "had some friends who were not very appropriate, they were not desirable, and now he has learned to choose good friends." "There are many young people I know who were not doing well in school and this program has helped them to finish high school." "My son is working a lot harder in school. His grades are low [but] they are getting better."
Contributors to Program Success	
The personnel: Parents gave much of the credit for the success of the program to the staff, including the pastor at the church where the program was held and the two STRYVE/CCC staff.	I attribute the success of the program "to Sister Tere and Pam, because they have given [the young people] cause to trust them, and they have helped them a lot, not only [the young people], but also each of us who are here. In addition, they have given their time, they listen and all that."
The variety of activities: Parents felt the program worked for their children because it included field trips, meetings, work	My daughter "was one of the youth who went to represent the young people in Atlanta, and

experience, and for some, a trip to Atlanta to visit the CDC!	well it has really been good for her and she has learned a lot."
The location: Parents appreciated that the program was held in a trusted location, in this case, a church.	"I think that also the location [helped] … because it's a place that the youth know, where they also have the trust to come and feel safe here."
Year-round nature of the program: Parents were very appreciative of the fact that, even though the YES program had ended, activities continued.	"Just because STRYVE ended, the youth didn't end. They still come to play soccer with Jairo, and they still have plans, they get together, they call them, they don't leave them [alone]."
Awareness about and ability to address violence as a health issue	
Definition of violence prevention: Rather than defining violence prevention as a criminal justice issue best solved by law enforcement, parents in the group defined violence prevention as an activity they could do by keeping their kids involved in positive activities in a healthy and safe community.	"Well for me, preventing violence means keeping my children in a healthier place, in a place where there aren't drugs, where there aren't problems, where there is not delinquency. And teaching them to live for a healthy community, to fight for a healthy community, and to do that we all have to be united, parents and children and neighbors."
Ways to prevent violence: Parents in the group believe violence can be prevented by creating activities for youth and with youth, in which older children can be mentors and role models for younger children. Parents also need to be involved, motivating and supporting young people who are new to the group. Parents acknowledged that sometimes it can be hard to give their children the attention they need, because they can be very focused on working.	"As a community we can come together to create activities for youth, or come together with the youth to create activities and young people can be mentors to the children who are younger than them."
What do parents need to prevent violence? Parents expressed a need for more training and contact with law enforcement, for law enforcement officers who are willing to come out to the community, fund-raising skills, and year-round programs.	"What has worked for me is … about three or four years ago we had a training with the sherriff's deputies, and it was once a month, and personally … I learned a lot, and always, each month it was a different training for parents … for example, about how to know what's happening with our kids. It was a good year and I learned a lot."

Table 9. Results of CHW Focus Group

Positive Aspects of the Training	
Meeting people and learning about them: Meeting people, listening to their heart-touching "journeys" (personal stories of what had brought them to the training), and learning about their organizations, their ambitions and goals, provided the space to connect with each other.	"Without having [the journeys] aspect there, it wouldn't have been the space to become as connected as we had the opportunity to be, because we got to listen to people's background … It made me feel a lot more connected with each individual that was in there." "I enjoyed meeting different community workers in the community and learning the different organizations that everyone was employed with and learning about their ambitions and goals and what to do next in the community."
Methodology: The use of popular education (including dinámicas, social learning games used to build trust) created a safe space for cultural practices, physical movements and an atmosphere for conversation, sharing ideas, new discoveries and critical thinking.	"[[I appreciated] an atmosphere where we were having conversations and it wasn't just somebody was there and was talking at us." "To be able to get up and to stretch, and have that be incorporated into the lesson, that was huge for me. I enjoyed that a lot."
Facilitation style and variety: CHWs appreciated the well- prepared and engaging facilitators. Having different facilitators for different sessions exposed the participants to a variety of teaching styles and energy levels.	"We even ran out of time because it was so intense and people were so engaged. And, that's always a good thing to leave people wanting more." "I liked the different teachers, not having to listen to one single person everyday all day. That made it way more interesting."
Ways to improve the training	
Choose facilitators with lived experience: Most facilitators did have lived experience with their topic. They were strongly preferred to those who did not.	"I think I was more interested in … the more life-skilled people that had already lived a life. And, hearing them talk – seemed like they grabbed my attention way more than just somebody coming in and – not lived the life."
Make sure facilitators respect participants' lived experience: In one session, a facilitator appeared to discount the experience of one participant. Other participants felt this was not respectful.	"Even with the domestic violence … working in this field, people – you know, it's always been one-sided, and they don't understand, as societies change, domestic violence changes."
Make sure facilitators are prepared to facilitate the topics they are facilitating: In another session,	"So, I think if you make more of a conscious decision with who would be facilitating certain things, knowing that they can lead into other things, it would be best

participants felt the facilitator was not adequately prepared to deal with the topic.	to be real conscious about who was presenting that information, and wouldn't just break down if it just doesn't go a certain way for them, so."
Logistics: CHWs would have preferred a space that was quieter, more comfortable and confidential, and with better bathrooms. Different scheduling for the training might help to accommodate work and childcare responsibilities.	"It was kind of hard to regulate the temperature for everybody, and the whole bathroom facility, you know?" "There can be sound barriers so that people in the hall way talking, you can't hear them." "I'm thinking about that Monday. If it's not on a Monday, [it would be better] so you have the first day of the week to go to your office and you can organize the rest of your week."
Effects of the Training on the Participants and Community	
Increased self-confidence and cultural pride: The CHWs felt empowered and enhanced a sense of pride about their and others' cultures, through the learning and resources they gained from the training.	"Going through that training, learning what I learned, and taking pride in it – like, I can put CHW behind my name now." "I have more of a sense of pride about culture, and the cultures that were represented in the room. And, I tried to impart that on the people I work with, you know? That our history is very important, and the way we do things is very important. So, I'm very cognizant of that now, that we have something to offer society."
Better prepared to serve the community: The content of the training, the deep discussions, the information provided in the notebook handed out during the training and most importantly, the strong connection/network developed by the CHWs amongst each other during the training, has provided them all the tools and resources to better address the needs of their community.	"I feel like there wasn't anything I couldn't really solve." "We are like our own Dr. Phil." "When a client comes and I'm assessing what their needs are - and it may not be my organization, or my team that can best serve them, and having gone through Core 27, it's just an enormous resource. I feel like my team got larger." "Understanding that this person has a story also. I'm not supposed to just be listening to this person, waiting for my turn to talk, you know? I'm supposed to be listening to that person, and seeing where I can fit to assist that person."
Ability to Address Violence as a Public Health Issue	
Better understanding and ability to respond: The CHWs reported that the training helped them to form	"The training formed my opinion about violence as a public health issue. Because, before the training, that's all I've been doing, is living a violent lifestyle. That's

their opinion about violence as a public health issue. Before the training, due to their life experiences, they thought that a violent lifestyle was acceptable. But after the training, they reported they always analyze the situation before responding to it. The CHWs further documented their increased knowledge about violence as a public health issue by saying that violence perpetuates and affects everyone and all systems like schools, healthcare, etc.	where I come from, you know, just all the way through there's been violence. So, I felt it was acceptable." "[Violence] affects all of our systems. When people are injured, there's the hospital system, there's the family, there's social services, there's child welfare, there's the education system." "When one person gets injured in a family, that impacts a whole community."
Other Themes	
Facilitation interest among participants: The participants expressed their interest in facilitating future CHW trainings. With their various life experiences, the participants felt that they would have something to offer, when given the opportunity to facilitate.	"I appreciate the opportunity of being able to facilitate a group… I think that there are people from the Core 27, I think you can grow some facilitators. And, they bring that life experience, and they bring the benefit of having gone through the training too, as a participant."
Corrective action on participants who fail to practice step-back: After giving a few opportunities for behavior change the participants requested some sort of corrective action for participants who exhibit negative behavior. The participants reported feeling anxious and overwhelmed just thinking about the negative energy and behavior of one particular participant.	"It was just such a negative energy. And, I don't know what his experience is, I don't know what he's been through, but sometimes it was just overwhelming to me."

Striving to Reduce Youth Violence Everywhere (STRYVE)
Consent Form for Community Focus Group

This form contains important information about the study in which you are being invited to participate. Please read the form carefully and ask questions of the investigators.

Who is the principal investigator?
Noelle Wiggins, EdD, MSPH, 503-988-6250 x 26646

What is the purpose of this study?
The purpose of the research component of the STYVE project is to understand the impact of the project on several groups of stakeholders: people living in 4 neighborhoods of focus, staff at partner organizations, STRYVE Coalition members, key staff at organizations represented on the Local Public Safety Coordinating Council (LPSCC), and Health Department staff.

Why was I selected to participate?
You were selected as a possible participant because you live/work in the area, have knowledge about the neighborhood and/or have interest in violence prevention and have been involved with STRYVE over the course of the program.

What can I expect as a study participant?
If you decide to participate, you will be asked to participate in a focus group lasting approximately 1.5-2 hours. Transcripts and notes will be analyzed and data may be used in articles or presentations in the future.

What are the possible risks of participating in this study?
Participating in the focus groups could make you feel embarrassed or uncomfortable. You might also experience some negative feelings as a result of thinking about violence that you or others in the community may have experienced. Although we will make every effort to protect your identity, there is a minimal risk of loss of confidentiality.

How will my privacy be protected?
We will protect your privacy in the following ways:

1. Your name will not be used. We will not identify individual comments.
2. Only the study team will be able to access your information.

What are the possible benefits of participating in the study?
As a result of participating in this study, you may not receive any personal benefit. However, you may gain satisfaction from contributing to the overall reduction of violence in your community and increased community cohesion.

What are my rights as a participant?
Most important, you can stop participating at any time and if you need to talk to someone about feelings that come up for you, a staff member is here to talk with you.

If you have any questions or concerns regarding your rights as a research subject, you may contact the Human Subjects Research Review Committee, Office of Research and Strategic Partnerships, Portland State University, (503) 725-2227 or hsrrc@pdx.edu

You do not have to join this or any research study. If you do join, and later change your mind, you may quit at any time. If you refuse to join or withdraw early from the study, there will be no penalty or loss of any benefits to which you are otherwise entitled.

If the researchers publish the results of this research, they will do so in a way that does not identify you unless you allow this in writing.

You may request a written copy of this form.

What should I do if I have questions about the study?
If you have questions about the study or this group, you can call Noelle Wiggins. Her number is provided above.

Do you feel as if:

- You understand what was reviewed?
- You will allow your answers on the survey and the map to be used in research?
- You know that you do not have to participate in this study. Even if you agree, you can change your mind and stop at any time; and
- You may get a copy of this form to keep for yourself.

If your answer is "yes" and you are willing to participate, please proceed to participate in the focus group.

Striving to Reduce Youth Violence Everywhere (STRYVE)
Consent Form for Partner Survey

This form contains important information about the study in which you are being invited to participate. Please read the form carefully and ask questions of the investigators.

Who is the principal investigator?
Noelle Wiggins, EdD, MSPH, 503-988-6250 x 26646

What is the purpose of this study?
The purpose of the research component of the STYVE project is to understand the impact of the project on several groups of stakeholders: people living in 4 neighborhoods of focus, staff at partner organizations, STRYVE Coalition members, key staff at organizations represented on the Local Public Safety Coordinating Council (LPSCC), and Health Department staff.

Why was I selected to participate?
You were selected as a possible participant because you live in the area, have knowledge about the neighborhood, work in the principal agency or a partner agency, and/or have interest in violence prevention.

What can I expect as a study participant?
If you decide to participate, you will be asked to complete an anonymous survey.

What are the possible risks of participating in this study?
Completing the survey could make you feel embarrassed or uncomfortable due to the nature of some of the questions.

How will my privacy be protected?
The survey is anonymous.

What are the possible benefits of participating in the study?
As a result of participating in this study, you may not receive any personal benefit. However, you may gain satisfaction from contributing to an overall reduction of violence and increased community cohesion in Portland communities.

What are my rights as a participant?
If you have any questions or concerns regarding your rights as a research subject, you may contact the Human Subjects Research Review Committee, Office of Research and Strategic Partnerships, Portland State University, (503) 725-2227 or hsrrc@pdx.edu

You do not have to join this or any research study. If you do join, and later change your mind, you may quit at any time. If you refuse to join or withdraw early from the study, there will be no penalty or loss of any benefits to which you are otherwise entitled.

If the researchers publish the results of this research, they will do so in a way that does not identify you unless you allow this in writing.

You may request a written copy of this form.

What should I do if I have questions about the study?

If you have questions about the study or this group, you can call Noelle Wiggins. Her number is provided above.

Do you feel as if:

- You understand what was reviewed?
- You will allow your answers on the survey and the map to be used in research?
- You know that you do not have to participate in this study. Even if you agree, you can change your mind and stop at any time; and
- You may get a copy of this form to keep for yourself.

If your answer is "yes" and you are willing to participate, please proceed to participate in the survey.

Striving to Reduce Youth Violence Everywhere (STRYVE)
Community Focus Group Guide

Set-up

Before participants arrive:

- Arrange chairs in a circle.
- Make sign-in sheet accessible
- Place food, cups, napkins, etc. on a table.
- Place the tape recorder in such a way that it will capture participants' voices, and test it.

As participants arrive, invite them to help themselves to food.

Introduction

Good Morning/Good Afternoon! Thank you for agreeing to participate in this focus group. My name is [.....] and I will be facilitating the group today. Please help yourself to food and drinks as you choose. Also, the bathroom is located [.....] if you may need to use it. I anticipate this group will last approximately 1.5 to 2 hours.

The purpose of this focus group is to understand the impact of the STRYVE project in the community. Specifically, we are interested in your perspective on the STRYVE project, any changes that happened in the community because of the project, and violence prevention in general. Your insights and opinions are very important, so please share what is on your mind. There are no wrong answers.

Before we go any further, I'd like to review an informed consent form. If you are comfortable with it, I will ask for a verbal agreement to proceed. [Review informed consent for focus group.]

As we mentioned, we would like to tape record this focus group. That way, we will have a record of exactly what you all said. One of us or a transcriptionist will type up the focus group. If someone else does it, they are covered by the same confidentiality requirements that we talked about. Is it okay if I turn on the tape recorder? [If yes, turn on tape recorder.]

One last request: Please identify yourself when you speak, so that we can keep track of who said what. When we or some else transcribes the tape, we will give each person a pseudonym so your name will not go into the transcript.

I just want to remind you one last time that you can stop at any time or step out of the room if you need to. One of my co-workers is here to talk with you if you need to talk to anyone one-on-one during the course of the focus group.

Your experience of STRYVE

(NOTE: Some questions may change based on experience in the project.)

STRYVE staff and process

1. What did you think about the STRYVE meetings? [Probe: Did the style of the meetings help you learn, feel closer to others in the meeting(s), develop trust, etc.?]

2. What did you think about how popular education was used in the meetings? [Probe: What is popular education to you?]

3. Did you feel supported during this process? Give some examples.

Changes in the community

4. Have you noticed any changes in the community following the implementation of STRYVE? If yes, what kind of changes? [Probe: How often do you and people in your neighborhood have get-togethers? Are there any differences in violence or crime? Do people in your community feel more capable of solving community problems? Are youth more likely to stay in school?]

Violence prevention

5. What is violence prevention? [Probe: Who or what is involved? How have you been involved and what skills have you used?]

6. How can members of the community prevent violence and crime in their own neighborhoods?

7. Do you feel that your community has the tools to address violence in the neighborhood? If not, what else is needed?

8. Do you feel that YOU have the tools to address violence in the neighborhood? What else might you need?

Anything else you want to say

Before we end, we'd like to ask you one last, very important question.

9. Is there anything else about the STRYVE that you would like to share with us?

Conclusion

We have asked you a lot of questions. Do you have any questions for us, about STRYVE, this study or anything else?

Thank you very much for sharing your time and your opinions with us. We want to remind you again that we will do all we can to protect your confidentiality and your individual answers will not be shared. Your answers will be very important for us and others as we try to determine the affects of STRYVE in the four designated areas of Multnomah County. Please feel free to call us if you think of anything else you want to say or have any other questions.

Striving to Reduce Youth Violence Everywhere (STRYVE)
CORE 27 CHW Training Focus Group Guide

Set-up:
Before participants arrive:
• Arrange chairs in a comfortable position in a circle.
• Place food, cups, napkins, etc. on a table.
• Place the tape recorder in such a way that it will capture the participants' voices, and test it.

As participants arrive, invite them to help themselves to food.

Introduction:
Good Morning/Good Afternoon! Thank you for agreeing to participate in this focus group. My name is [.....] and I will be facilitating today along with my co-worker […]. Please help yourself to food and drinks as you choose. If you may need it, the bathroom is located [.....]. I expect that this focus group will last about one hour.

The purpose of this focus group is to understand more about your experience with the STRYVE CORE 27 CHW Training. Your insights and opinions are very important, so please share what is on your mind. There are no wrong answers.

Before we go any further, I'd like to review an informed consent form. If you are comfortable with it, I will ask for a verbal agreement to proceed. [Review informed consent for in-depth focus group.] Due to the fact that focus groups involve other people, everyone in the group will know what the others have said. Therefore, we can only be responsible for the confidentiality of the data we collect. Please do not talk about what is shared in the group outside of the group.

As I mentioned, we would like to tape record this focus group. That way, we will have a record of exactly what you said. Myself or a transcriptionist will type up the focus group. If someone else does it, they are covered by the same confidentiality requirements that we talked about. Is it okay if I turn on the tape recorder? [If yes, turn on tape recorder.]

One last request: Please identify yourself when you speak, so that we can keep track of who said what. When we transcribe the tape, we will give each person a pseudonym so your name will not go into the transcript.

I just want to remind you one last time that you can stop at any time or step out of the room if you need to.

Okay let's get started:

<u>Feedback on the Training</u>
1. First, I'd like to hear about what you liked about the training. [Probe: What worked for you, increased your learning, or made you feel happy or satisfied?]

2. We are constantly making changes to the training to make it better. How can we improve the training, based on your experience?

Effects of the Training on the Participants and Communities

3. Are you aware of any changes in yourself as a result of the CORE 27 CHW training? If yes, what are they? [Probe for any of the following: increased knowledge, empathy, problem solving skills, understanding of the need for community health workers in violence prevention, ability to advocate, new job, position, professional development, etc.]

4. Did your participation in the training affect your ability to serve your community? If so, how? [Probe: Do you feel more empowered to address violence? Are you more aware that violence is a public health issue?]

5. Have you been able to use what you learned in your work in the community, and if so, how? [Probe: What was most useful/least useful?]

6. Have you encountered obstacles to using what you learned and if so, what are they? [Probe: Lack of time, capacity, resources]

7. If you are employed as a CHW or in violence prevention, to what degree does your supervisor support you to use the new skills and knowledge you learned at the CHW training?

8. Are you aware of any changes in your community as a result of the Core 27 training? If yes, what are they? You can define "community" in whatever way makes the most sense to you.

9. What type of contact (if any) have you maintained with other members of your cohort?

Addressing Violence as a Public Health Issue

10. What does it mean to say that violence is a "public health issue"?

11. Did the training change your opinion about violence as a public health issue? If yes, how?
    - Ex: violence affects brain development, has risk and protective factors, is preventable, and has lifetime health implications.

12. Can you tell us about any tools or strategies that you use to address violence in your community? If not, what else do you need?

Conclusion

We have asked you a lot of questions. Do you have any questions for us, about STRYVE, this study or anything else?

Thank you very much for sharing your time and your opinions with us. We want to remind you again that we will do all we can to protect your confidentiality and your individual answers will not be shared. Your answers will be very important for us and others as we work to evaluate the CHW training and the program in general. Please feel free to call us if you think of anything else you want to say or have any other questions.

Understanding Violence
Community Health Worker Capacitation Questionnaire

Please review each of the statements below. According to definitions used in this training, circle T if the statement is true, F if the statement is false and U if you are uncertain at this time.

1. The four main categories of public health activities are: health promotion, harm reduction, health literacy and curative care. T F U

2. Divorce, sexual abuse, neglect and addiction are all examples of adverse childhood experiences. T F U

3. Structural violence include both police profiling and brutality, and normalization of violence in the media. T F U

4. Community violence does not include violence associated with human trafficking. T F U

5. A car accident and death of a spouse are examples of chronic trauma. T F U

6. People that work with clients that have survived traumatic life events may experience vicarious trauma (also called secondary trauma). T F U

7. When the environment "flips a genetic switch on or off," that process is called epigenetics. T F U

8. Social conditions, individual determinants, and epigenetics/biological factors are the three types of root causes of violence. T F U

Please complete the statements below by selecting the correct answer.

9. The six key principles of trauma-informed approach include: 1) trustworthiness and transparency, 2) collaboration and mutuality, 3) empowerment, voice and choice, AND

A) 4) protective factors, 5) hyper vigilance, and 6) self-esteem
B) 4) safety, 5) peer support, and 6) equity
C) 4) humility, 5) self regulation, and 6) resilience

10. Family violence and intimate partner violence includes:

A) Both sexual abuse and financial abuse
B) Both gang violence and police violence
C) Both coerced sterilization of women of color and racism

11. One definition of Allostatic Load is:

A) Sum total of what happens to our body as a result of unrelenting stress
B) A single event accompanied by feelings of intense fear, anger or helplessness
C) Multigenerational trauma experienced by a specific cultural group.

Community Health Worker Certification Training Questionnaire

SECTION ONE

The questions in Section 1 have to do with your knowledge about health and health care. Check true or false for the following statements:

1. Beans and nuts are part of the protein food group that helps build healthy bones and strong muscles.
   True _____ False _____

2. Community Health Workers' only role is to connect individuals to existing services.
   True _____ False _____

3. Anxiety is a persistent or severe fear or worry in situations where most people wouldn't feel threatened.
   True _____ False _____

4. The only goal of an assessment is to identify problems or needs.
   True _____ False _____

5. Income level is considered a "social determinant of health."
   True _____ False _____

6. Your culture is completely defined by your race/ethnicity.
   True _____ False _____

7. Fatty foods are now the biggest single source of calories in the American diet.
   True _____ False _____

8. Since 1984, more women than men have died each year from heart disease.
   True _____ False _____

9. Organizing a health fair is an example of community organizing.
   True _____ False _____

10. According to the World Health Organization, "health promotion" means promoting individual behavioral changes.
    True _____ False _____

Check the <u>one</u> correct answer to the questions below:

11. ONE of the lists below includes four steps in the community organizing process. Choose the correct list:
    ___ Advocating, educating, promoting lifestyle changes, getting out the vote
    ___ Grassroots leadership development, choosing an issue, cutting the issue, choosing a target
    ___ Providing direct service, organizing a health fair, cutting the issue, choosing a target
    ___ Picketing, boycotting, rallies, marches

12. ONE of the lists below includes four steps in the Stages of Change Model. Choose the correct list:
    ___ Considering, deciding, doing, defending
    ___ Action, maintenance, follow-through, recovery
    ___ Denial, anger, bargaining, acceptance
    ___ Pre-contemplation, contemplation, action, maintenance

13. Which of the following is NOT an occurrence which might cause historical trauma?
    ___ Holocaust
    ___ Slavery
    ___ Genocide
    ___ Three generations of child abuse

14. Which of the following IS an essential element of popular education?
    ___ Using lots of dinámicas when teaching a class
    ___ Using pictures of people of color on outreach materials
    ___ Working towards a more just and equitable society
    ___ Paraphrasing people's opinions

15. The Triple Aim of health care reform does NOT include:
    ___ Reducing the cost of care
    ___ Increasing the quality of care
    ___ Improving population health
    ___ Health insurance for all

16. The following are signs and symptoms of using drugs referred to as "downers":
    ___ Slurred speech, shallow breathing, sluggishness
    ___ Dilated pupils, memory impairment, fatigue
    ___ Paranoia, irritability, thoughts of suicide
    ___ All of the above

17. According to Tervalon and Murray-Garcia, three components of cultural humility are:
    ___ Critical self-reflection, addressing power imbalances, institutional accountability
    ___ Using the correct language, knowing all about people's beliefs, understanding culture
    ___ Conducting home visits, accepting food when offered, advocating for people
    ___ Knowing everything there is to know about people's culture, beliefs, and practices

SECTION TWO

The questions in Section 2 have to do with your feelings about yourself and your ability to promote health.

Check to indicate how much you agree or disagree with the following statements.

18. I feel quite confident about my ability to share health information.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

19. I feel quite confident about my ability to promote health.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

20. I have control over the decisions that affect my life.
    Agree strongly ____ Agree_____ Disagree_____ Disagree strongly____

21. I am satisfied with the amount of control I have over decisions that affect my life.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

22. I am often a leader in groups.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

23. I find it very easy to talk in front of a group.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

24. I can usually organize people to get things done.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

25. I am a person who believes in myself. I can make it in this world.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

26. I understand quite well how my individual problems are connected to bigger problems at the state, national and global level.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

27. I can explain to others in my community how our problems as a community are connected to bigger problems at the state, national, and global level.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

28. I understand quite well how historical factors affect my life today.
    Agree strongly ___ Agree_____ Disagree_____ Disagree strongly____

SECTION THREE

The questions in Section 3 have to do with your health and your health habits.

29. In general, would you say that your health is: (check only one)
    Excellent ___ Very Good ___ Good ___ Fair ___ Poor __

How often do you take the following actions?

30. I get 30 minutes or more of physical activity at least five times a week.
    Never _____ Sometimes _____ Usually _____ Always _____

31. I eat 5 or more servings of fruits and vegetables per day.
    Never _____ Sometimes _____ Usually _____ Always _____

32. I make an effort to manage my weight in a healthy manner.
    Never _____ Sometimes _____ Usually _____ Always _____

33. I find healthy ways to respond to stress.
    Never _____ Sometimes _____ Usually _____ Always _____

The following questions help us understand your particular situation. Remember, your answers will be kept confidential.

34. How old are you?_____

35. How do you identify your gender? _____

36. Were you born outside the United States? Yes_____ No_____

37. Is English your first language? Yes_____ No_____

38. Are you (mark only one):

Single, never married _____ Married _____ Widowed _____
Partnered _____ Divorced _____ Other (specify): _____

39. How do you identify your race/ethnicity?

Mark all that apply.

Hispanic or Latino Mexican, Central American or South American _____
Indigenous Mexican, Central American or South American _____
American Indian/Native American _____
Alaskan Native _____
African _____
African American _____
White _____
South Asian _____
Southeast Asian _____
East Asian _____
Pacific Islander _____
Slavic _____
Other (specify): _____
I choose not to answer: _____

40. Please circle the highest grade of school or year of college you completed:

GRADE OF SCHOOL													COLLEGE				
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17+

41. How many children do you have? _____

42. Please check the box next to the amount that comes closest to your total family income last year, before you paid taxes. Be sure to count monies of all family members living at home. Count social security, disability or unemployment benefits, help from relatives – all the ways you can get money.

□ Under $2000 (1)
□ $2000-$4999 (2)
□ $5000-$9999 (3)
□ $10000-$14999 (4)
□ $15000-$19999 (5)
□ $20000-$24999 (6)
□ $25000-$29999 (7)
□ $30000-$39999 (8)
□ $40000-$49999 (9)
□ $50000 or more (10)

43. Do you identify as a person with a disability? ____ Yes _____ No

This is the end of the questionnaire.
Thank you very much for your time!

Multnomah County Health Dept. Community Capacitation Center
Participant Evaluation of Session

Name of Group: _____

Name of Session: _____

Name of Facilitator: _____ **Date:** _____

Please answer the following questions as completely as possible. Your answers will help us improve the quality of this capacitation series and future series.

1. What did you like about this session?

2. What could be changed about this session to make it better?

3. What else would you like to tell us about this session?

Please answer questions on the other side.

Please tell us how much you agree or disagree with the following statements:

Number 1 = strongly agree Number 2 = agree Number 3 = disagree Number 4 = strongly disagree

	Strongly Agree	Agree	Disagree	Strongly Disagree
4. The facilitator for this session valued what I already knew and built on it.	1	2	3	4
5. I felt involved and included in this session.	1	2	3	4
6. Most participants were actively involved in this session.	1	2	3	4
7. As a result of this session, I feel more able to promote health in the community.	1	2	3	4
8. The facilitator knows a lot about the topic of this session.	1	2	3	4
9. The facilitator used a variety of teaching methods.	1	2	3	4
10. The facilitator included information about diverse cultures in this session.	1	2	3	4
11. The facilitator enhanced my understanding of the relationship between inequality and health.	1	2	3	4
12. This facilitator appreciates the role of Community Health Workers.	1	2	3	4
13. The facilitator provided enough time for breaks.	1	2	3	4
14. These physical factors made it easy for me to learn in this session:				
a) Temperature	1	2	3	4
b) Food	1	2	3	4
c) Seating arrangement	1	2	3	4

STRYVE Partner Survey

The purpose of this survey is to find out whether the STRYVE Program has helped to make people, especially project partners, more aware that violence is a public health issue and more able to address violence as a health issue. For the purposes of this survey, project partners are defined as key staff at partner organizations in the STRYVE sites and staff at organizations involved in the Local Public Safety Coordinating Committee.

Please respond "yes" or "no" to the following statements, first thinking about your knowledge BEFORE your involvement with STRYVE, and then thinking about your knowledge AFTER your involvement with STRYVE.

	Yes	No	Unsure
1. Before my involvement with STRYVE, I was aware that violence is a public health issue	☐	☐	☐
2. After my involvement with STRYVE, I am aware that violence is a public health issue	☐	☐	☐
3. Before my involvement with STRYVE, I could explain what the phrase "risk factor for youth violence" means.	☐	☐	☐
4. After my involvement with STRYVE, I can explain what the phrase "risk factor for youth violence" means.	☐	☐	☐
5. Before my involvement with STRYVE, I could give examples of risk factors for youth violence.	☐	☐	☐
6. After my involvement with STRYVE, I can give examples of risk factors for youth violence.	☐	☐	☐
7. Before my involvement with STRYVE, I could explain what the phrase "protective factors against youth violence" means.	☐	☐	☐
8. After my involvement with STRYVE, I can explain what the phrase "protective factors against youth violence" means.	☐	☐	☐
9. Before my involvement with STRYVE, I could give examples of protective factors against youth violence.	☐	☐	☐

10. After my involvement with STRYVE, I can give examples of protective factors against youth violence. ☐ ☐ ☐
11. Before my involvement with STRYVE, I could explain what the phrase “social determinants of health” means. ☐ ☐ ☐
12. After my involvement with STRYVE, I can explain what the phrase “social determinants of health” means. ☐ ☐ ☐
13. Before my involvement with STRYVE, I could give examples of social determinants of health. ☐ ☐ ☐
14. After my involvement with STRYVE, I can give examples of social determinants of health. ☐ ☐ ☐
15. Before my involvement with STRYVE, I believed that violence is a health inequity. ☐ ☐ ☐
16. After my involvement with STRYVE, I believe that violence is a health inequity. ☐ ☐ ☐
17. Before my involvement with STRYVE, I believed that violence can be prevented. ☐ ☐ ☐
18. After my involvement with STRYVE, I believe that violence can be prevented. ☐ ☐ ☐
19. Before my involvement with STRYVE, the organization I work for was committed to preventing youth violence. ☐ ☐ ☐
20. After my involvement with STRYVE, the organization I work for is committed to preventing youth violence. ☐ ☐ ☐
21. Before my involvement with STRYVE, the organization I work for was able to address violence as a public health issue. ☐ ☐ ☐
22. After my involvement with STRYVE, the organization I work for is able to address violence as a public health issue. ☐ ☐ ☐

Please respond "yes" or "no" to these questions:

23. I would like to receive additional training in youth violence prevention. YES_____ NO_____

24. I have visited a STRYVE site. YES_____ NO_____

25. I have participated in a STRYVE event. YES_____ NO_____

26. Please tell us 3 things that you have learned about youth violence prevention.

a. _____

b. _____

c. _____

27. Please tell us 3 things that could be done to improve the effectiveness of the STRYVE program.

a. _____

b. _____

c. _____

28. Please identify your relationship to the STRYVE program. (check all that apply)

- ☐ LPSCC member
- ☐ YGVSC member
- ☐ Administrator at a partner organization (ex. POIC)
- ☐ STRYVE volunteer
- ☐ STRYVE coalition member
- ☐ Other (please specify)