Community Health

The Effect of Neighborhood-Based Community Organizing: Results from the Seattle Minority Youth Health Project

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Objective. To evaluate the effect of a community mobilization and youth development strategy to prevent drug abuse, violence, and risky sexual activity.

Data Sources/Study Setting. Primary surveys of youth, parents, and key neighborhood leaders were carried out at baseline (1994) and at the end of the intervention period (1997). The study took place in four intervention and six control neighborhoods in Seattle.

Study Design. The study was designed as a randomized controlled trial with neighborhood as the unit of randomization. The intervention consisted of a paid community organizer in each neighborhood who recruited a group of residents to serve as a community action board. Key variables included perceptions of neighborhood mobilization by youth, parents, and key neighborhood leaders.

Data Collection/Extraction Methods. Youth surveys were self-administered during school hours. Parent and neighborhood leader surveys were conducted over the phone by trained interviewers.

Principal Findings. Survey results showed that mobilization increased to the same degree in both intervention and control neighborhoods with no evidence of an overall intervention effect. There did appear to be a relative increase in mobilization in the neighborhood with the highest level of intervention activity.

Conclusion. This randomized study failed to demonstrate a measurable effect for a community mobilization intervention. It is uncertain whether the negative finding was because of a lack of strength of the interventions or problems detecting intervention effects using individual-level closed-end surveys.

Key Words. Community activation, community-based program evaluation, community mobilization, youth programs

Health-promotion strategies are shifting increasingly from targeting individuals to intervening in entire communities (COMMIT Research Group 1995a, 1995b; Farquhar, Fortmann, Flora, et al. 1990; Farquhar, Wood, Breitrose, et al. 1977; Glasgow, Terborg, Hollis, et al. 1995; Kornitzer et al. 1980; Lando, Pechacek, Pirie, et al. 1995; Luepker, Murray, Jacobs, et al. 1994; MacCoby et al. 1977; Mittelmark, Luepker, Jacobs, et al. 1986; Potter, Graves, Finnegan, et al. 1990; Shea and Basch 1990; Wagner, Koepsell, Anderman, et al. 1991; Harachi, Ayers, Hawkins, et al. 1996); as they do so, some form of "community mobilization" or "community activation" is often incorporated as part of the overall strategy. The community transformations required to have an effect on the most pressing current public health problems—violence, drug use, teen pregnancy, cancer, and cardiovascular disease—can only be achieved by bringing together or mobilizing a broad cross section of community organizations and individual community members (Wallack and Wallerstein 1986). A sizeable literature describes examples of community mobilization projects, many of which have been documented as successful in achieving their aims (Boyte 1980; Brown 1984; Chiu et al. 1997; Eisen 1992; Eng and Parker 1994; Fawcett, Lewis, Paine-Andrews, et al. 1997; Flick, Reese, Rogers, et al. 1994; Freudenberg and Trinidad 1992; Hanson 1988; Kronus 1977; Lorig and Walters 1980; Prestby and Wandersman 1985; Shea et al. 1996; Sutton and Baker 1990; Minkler 1992).

Most of the interventions to date with a major community mobilization component have been implemented in a single community with either an uncontrolled or quasiexperimental evaluation design. To the authors' knowledge only one other study explicitly included quantitative measures of community

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mobilization in a randomized design (Wickizer, Wagner, Cheadle, et al. 1998). This article describes results from a 5.5-year project designed as a randomized controlled trial of a community mobilization strategy. The Minority Youth Health Project (MY Health) combined youth projects with a community empowerment approach to neighborhood mobilization to prevent violence, teen pregnancy, sexually transmitted diseases, and drug use among youth of color in four Seattle neighborhoods. This article presents final evaluation results for the measures of community mobilization; results for the youth health risk behaviors will be published separately.

METHODS

Project Description

The Seattle-based MY Health was part of a larger seven-city cooperative agreement funded by the National Institutes of Child Health and Human Development and the Office of Minority Programs to design and test programs to reduce the prevalence of four key health problems—violence, teen pregnancy, sexually transmitted diseases, and substance abuse—among youth of color. MY Health was a collaborative effort among the University of Washington Social Development Research Group and School of Public Health, the Seattle Minority Health Coalition, Seattle/King County Department of Public Health, Group Health Cooperative of Puget Sound, and Harborview Medical Center. The Social Development Research Group affiliated with the School of Social Work at the University of Washington had overall responsibility for project management.

The goals of the MY Health community mobilization effort were to increase the degree to which individuals and groups in the neighborhood worked together to solve problems, particularly problems related to the targeted youth health behaviors, and to increase the level of pride and identification with the neighborhood. The approach to community mobilization was based on principles of "community empowerment" (Israel et al. 1994); specifically, neighborhood residents were given wide latitude to devise their own strategy for achieving the mobilization goals. In practice an empowerment approach meant that activities undertaken by residents were often only indirectly related to the youth health behaviors because the residents believed that other underlying factors were the source of the youth problems.

The decision-making power in each neighborhood was vested in a community action board (CAB). A community organizer (community liaison)

who recruited a group of neighborhood residents to serve on the CAB and provided staff support for their activities was hired for each neighborhood. The initial plan for recruiting CAB members was to seek nominations from established civic leaders, with the intent of identifying people already active in neighborhood groups. Initial attempts at soliciting nominations identified people active in citywide organizations and campaigns but not enough who identified primarily with a single neighborhood. As a result, this approach was abandoned in favor of recruiting neighborhood residents who for the most part had not been previously involved in organized neighborhood groups.

CAB members were paid small stipends to participate, and each board was given a budget of $8,000 per year to be spent on neighborhood projects of their choosing. The projects were designed to bring the neighborhood together, recruit youth and other community members into the other MY Health interventions, and raise awareness of the targeted health issues. The boards were intended to last beyond the life of the project, providing a resource for future neighborhood organizing activity.

Table 1 shows neighborhood characteristics, gives an abbreviated chronology of the CABs, and lists projects undertaken by the CABs. Most of the CABs were dominated by a single ethnic group: two were largely African American (neighborhoods A and C), one was Vietnamese (neighborhood B), and one was Latino (neighborhood D). In all four neighborhoods there was an initial short-lived group in 1994 that was either replaced by or evolved into another CAB that lasted through the duration of the project. During this second phase (from 1995 to 1997) all CABs were made up largely of residents who had not been previously active in other organized neighborhood groups.

The CAB neighborhood projects included several health fairs and community festivals, workshops, and training and education programs. In all, close to 2,000 youth and adults participated in the projects across the four neighborhoods. (This figure may include people who came to more than one event.) The greatest number of activities were carried out in neighborhood D (approximately 1,150 participants), which was also the neighborhood with the fewest number of existing community groups and community-based programs. For this reason we hypothesized that if any intervention effects were found, they would be strongest in neighborhood D.

Evaluation Design

The MY Health Project was designed using the neighborhood as the unit of analysis, with power sufficient to detect 10-percent reductions in key health

Table 1: MY Health Project-Intervention Neighborhood Characteristics, Community Action Board Composition, and Projects Undertaken

Neighborhood	*Demographics*	*Community Board (Dominant Ethnic Group)*	*Projects (No. of Participants)*
A	Population 28,000 47% African American 40% Caucasian	1994: parent group (African American) 1995–97: neighborhood group (African American)	•1994: community health fair and picnic (300) •1995: learn to earn–youth activities, prevention education, mentoring (32)
B	Population 4,700 50% Caucasian 26% African American 21% Asian/Pacific Islander	1994: neighborhood group (Vietnamese, African American) 1995–97: partnership with existing Vietnamese community-based organization	•1995: workshop on employee rights, job search skills (30) •1997: three 10-week ESL classes (180) •1997: neighborhood event surrounding Tet festival (50)
C	Population 6,600 40% African American 33% Caucasian 25% Asian/Pacific Islander	1994: existing neighborhood group (African American) 1995–97:neighborhood group (African American)	•1995: community resource fair (200) •1996–97: Providing Resources in Math Education (PRIME)–youth tutoring, employment skills (20)
D	Population 2,800 67% Caucasian 15% Hispanic 13% Asian/Pacific Islander	1994: youth board 1995–97: neighborhood group (Latino)	•1994: community forum ("A United Community Is a Healthy Community") •1994: community get-together and dance (50) •1995: ten-week ESL class (138) •1994–96: Feast of the Dead festival (350–500) •1996: celebration of the Day of the Child (community festival) (600) •1997: youth peer education training program (13)

risk behaviors using statistical methods developed for other community-level trials (Koepsell, Martin, Diehr, et al. 1991). Twelve neighborhoods were initially identified as possible program sites based on a minimum size criteria (at least 200 youth of color in the target age range of 11 to 14 years). These 12 neighborhoods were split into four clusters of three based on geographic proximity, and then one in each cluster was randomly selected as the intervention neighborhood. One of the intervention neighborhoods was subsequently recognized to be two distinct communities, bringing the total number of neighborhoods in the study to 13 (five intervention and eight control). Three of the neighborhoods were relatively small, resulting in too little data to analyze productively. These included one intervention neighborhood (one of the two resulting from the split noted above) and two control neighborhoods. Thus, the final sample used in all analyses presented here includes ten neighborhoods (four intervention and six control).

The key outcome measures were obtained using school-based surveys of youth, a survey of the parents of youth participating in the school survey, and a community mobilization survey of key neighborhood leaders and activists. The youth and parent surveys included a core set of questions developed for all seven sites in the cooperative national program plus additional questions specific to Seattle. The community mobilization survey was developed only for Seattle.

Data

The sampling frame for the community mobilization survey consisted of neighborhood leaders and activists selected to provide a variety of perspectives on neighborhood organizing and mobilization around youth health issues. The sample included school personnel (principals, counselors), recreation center staff, community police team members, members of other community-based organizations doing youth-related work, and neighborhood councils. Snowball sampling techniques were used to construct a sampling frame of knowledgeable key informants: an initial group of contacts identified by their organizational affiliation (e.g., neighborhood councils, recreation center staff) were asked to provide names of others who were knowledgeable about neighborhood activities.

The target sample size for the community mobilization survey was ten informants per neighborhood, with an attempt to balance the mix of informants across neighborhoods, that is, to try to get the same proportion of school personnel, neighborhood council representatives, and community-

based organization staff in each neighborhood. The survey instrument included both closed- and open-end questions and took from half an hour to an hour to complete. The baseline sample of informants was treated as a cohort, and all baseline respondents were contacted for a follow-up interview. When respondents were unavailable at follow-up an attempt was made to locate a person in a similar position in the neighborhood as a replacement (e.g., a school counselor who left would be replaced by their successor at the same school).

The primary purpose of the youth and parent surveys was to measure program outcomes at the individual or family level: changes in risky health behaviors among youth (violence, sexual activity, drug use) and changes in parenting practices among parents (rule setting, family management, parent-child communication). However, several questions asking about the neighborhood as a whole were included in each instrument: activities taking place around youth health problems, whether people worked together, and how much they liked their neighborhood.

The youth survey was conducted among sixth-, seventh-, and eighth-grade students in four middle schools in the targeted communities in the spring of 1994 and again in the spring of 1997. Passive consent for participation in the survey was obtained via letters to parents that described the project and requested that parents who did not want their child to participate in the survey contact the school to decline participation. The survey was self-administered and took about 45 minutes to complete.

Parents of youth of color who completed the youth survey were identified via tear sheets that were attached to the youth survey. Information collected on the tear sheet included the youth's address and zip code, age, ethnicity, and the primary language spoken in the home. Only tear sheets for youth of color were included in the parent survey sampling frame. Telephone surveys of these parents were conducted from June to November in 1994 and again in 1997. In addition to English the survey was translated into the three most other languages most common in the project neighborhoods: Spanish, Vietnamese, and Cambodian. Bilingual survey interviewers reviewed the translated surveys and cross translated surveys back into English to ensure parallel meaning.

Additional information used in assessing the community mobilization effort came from semistructured interviews with participants in MY Health community mobilization activities including CAB members, community liaisons, and other project staff. These interviews were conducted after the end of the intervention period in late 1997.

Statistical Analysis

As described above, the MY Health evaluation had three major sources of information available for quantitatively assessing changes in community mobilization: youth surveys, parent surveys, and community mobilization surveys. Questionnaire items were analyzed individually and by creating summary scales from clusters of similar questions. In creating the scales, individual items were standardized to have an overall mean of 50 and standard deviation of 25 at the individual respondent level across both baseline and follow-up samples. A mean score was computed for each respondent by averaging these standardized variables across all items in a particular construct; for example, the "working together" score for the community mobilization survey was calculated as the mean of six individual items related to neighborhood cooperation/working together. These individual-level scores were then averaged across all respondents in a neighborhood to obtain the neighborhood-level scale score. The standard error of the neighborhood-level scores was a function of the number of items in the scale and the number of respondents in a neighborhood; larger number of items in the scale and more respondents resulted in smaller standard errors.

Two methods were used to test for intervention effects. In the primary analysis mean neighborhood-level scores were first calculated for each survey occasion. Difference scores were then computed by subtracting the baseline score for each neighborhood from its follow-up score. Independent sample *t*-tests were used to test whether the average change scores in the intervention neighborhoods were significantly different from those in the control neighborhoods.

A second analysis was performed using individual-level analyses that adjusted appropriately for neighborhood-level clustering by treating neighborhood as a random effect using SAS PROC MIXED software (SAS Institute 1992). This analysis adjusted for the fact that the design was unbalanced; the number of surveys conducted varied considerably across neighborhoods. The results from the neighborhood-level and individual-level analyses were very similar, and only the neighborhood-level results are reported here.

RESULTS

Response Rates/Sample Sizes

The response rate for the baseline community mobilization survey was 80.5 percent, with 108 respondents interviewed across all 13 neighborhoods. At

follow-up 76 of the original 108 (70.3 percent) were successfully located and reinterviewed. An additional 17 replacement respondents (i.e., people in a similar position in the neighborhood) were found, bringing the total number of respondents in the cohort (i.e., original respondents plus replacements) to 93 across all 13 neighborhoods. As noted earlier, two of the control neighborhoods and one intervention neighborhood were relatively small, and we were only able to locate and interview two respondents per neighborhood. These neighborhoods were not included in the final analysis, thus the final sample size was 87 respondents (range per community six to 13). (Results including the three small neighborhoods were nearly identical to the results reported here.)

The response rate for the youth survey was just over 80 percent on both occasions. (81.5 percent at baseline and 83 percent at follow-up). Overall 2,233 youth of color took part in the survey: 1,148 at baseline, 1,085 at follow-up. The number surveyed per community (excluding the three small neighborhoods) ranged from 18 to 178. The response rate for the parent survey was just over 70 percent on both occasions. Overall 1,249 parents were interviewed: 654 at baseline, 595 at follow-up. The number interviewed per community (again excluding the three small neighborhoods) ranged from eight to 99.

Questionnaire Items/Descriptive Statistics

The questionnaire items from the community mobilization survey are shown in Table 2 along with the means for the individual items at both baseline and follow-up. The figures in Tables 2 and 3 were calculated by first computing the neighborhood-level means for each item and then averaging across all intervention and control neighborhoods ($n = 10$). Three constructs were measured using the community mobilization survey: cooperation/working together (six items), neighborhood pride (three items), and the effectiveness of community-based programs serving the neighborhood (four items). Scale score means, Cronbach's alpha, and the range across neighborhoods are shown for each of the three scales.

Approximately half of the respondents felt that there was effective leadership in the neighborhood, that there was a lot of cooperation among groups, and that the level of cooperation/working together had increased in the past year. Three-quarters felt that it was easy to volunteer to solve neighborhood problems, and roughly two-thirds felt that people worked together to solve problems in the neighborhood. For five of six items there was an increase in cooperation/working together between baseline and follow-up

Table 2: Descriptive Statistics for MY Health Community Mobilization Survey*

Survey Variable	Survey Occasion	
	Baseline	*Follow-up*
Sample size (No. of neighborhoods)	10	10
Cooperation/Working Together		
People work together to solve problems in the neighborhood	59.2	69.0
There is effective leadership at the neighborhood level	49.2	55.1
Easy to volunteer to help solve neighborhood problems	72.1	79.9
There is a lot of cooperation between groups in the neighborhood	45.4	68.8
The level of cooperation has increased in the past year	47.8	49.3
The degree to which people work together has increased in the past year	48.7	37.7
Neighborhood cooperation scale† (alpha = .69‡)	47.9	51.4
Range of scale scores§	35.8–59.1	44.8–61.3
Neighborhood Pride		
There is a lot of pride in the neighborhood among adults	42.7	51.5
There is a lot of pride in the neighborhood among youth	19.4	29.8
The level of pride in the neighborhood has increased in the past year	35.4	48.2
Neighborhood pride scale (alpha = .69‡)	46.5	54.6
Range of scale scores§	32.4–53.5	48.7–60.3
Community-Based Programs		
There are effective programs for youth in the neighborhood	50.4	70.2
Programs are available for the kids who really need them	48.0	72.0
Parents have good opportunities to learn parenting skills	47.0	68.4
The number of programs has increased in the past year	34.0	34.2
Community program scale (alpha = .53‡)	46.3	54.6
Range of scale scores§	32.3–57.7	44.4–62.2

*Except for scales, figures show percent of respondents agreeing with the statement across all neighborhoods (intervention and control) at baseline and follow-up. Means calculated by first computing neighborhood-level means and then averaging them across the ten neighborhoods.

†Scales computed by normalizing each survey variable (Likert scales ranging from one to five or one to three) to have mean = 50 and standard deviation = 25 and then averaging them across all variables in that construct.

‡Cronbach's alpha measuring scale internal consistency.

§Range of scale scores across neighborhoods showing the highest and lowest score at both baseline and follow-up.

Table 3: Descriptive Statistics for MY Health Youth and Parent Surveys*

Survey Variable	*Survey Occasion*	
	Baseline	*Follow-up*
Sample size (No. of neighborhoods)	10	10
Youth Survey		
People help each other out (some or a lot)	47.9	49.1
People work together to make neighborhood safe (some or a lot)	44.6	45.4
Neighborhood becoming a better place to live	62.8	75.0
I like my neighborhood (somewhat or a lot)	89.0	92.3
Youth survey mobilization scale† (alpha = .69‡)	48.9	52.2
Range of scale scores§	45.4–53.3	47.4–58.9
Parent Survey		
Worked with others to solve neighborhood problem	42.3	58.4
Asked by a neighborhood organization to participate	36.9	65.0
Participating in block safety program	51.4	45.6
I like the neighborhood I live in (very true)	51.4	54.9
I know many people by name (very true)	31.8	27.2
Parent survey mobilization scale† (alpha = .69‡)	47.0	51.8
Range of scale scores§	44.4–49.8	46.3–55.0

*Except for scales, figures show percent of respondents agreeing with the statement across all neighborhoods (intervention and control) at baseline and follow-up. Means calculated by first computing neighborhood-level means and then averaging them across the ten neighborhoods.

†Scales computed by normalizing each survey variable (Likert scales ranging from one to five or one to three) to have mean = 50 and standard deviation = 25 and then averaging them across all variables in that construct.

‡Cronbach's alpha measuring scale internal consistency.

§Range of scale scores across neighborhoods showing the highest and lowest score at both baseline and follow-up.

surveys. This increase is reflected in the summary scale score, which increased from 47.9 at baseline to 51.4 at follow-up. (The units of the scale score are arbitrary, with a mean of 50 across both survey occasions at the individual respondent level.)

The results for neighborhood pride show that between 40 and 50 percent of respondents felt that there was a lot of pride in the neighborhood among adults, whereas only 20 to 30 percent saw a lot of pride among youth. The level of pride was seen to increase substantially between baseline and

follow-up. At baseline approximately half of the respondents felt that there were effective programs, that they were available for the kids who really needed them, and that parents had good opportunities to learn parenting skills. Agreement increased for all three items to roughly 70 percent at follow-up. The community program scale score increased correspondingly, from 46.3 at baseline to 54.6 at follow-up.

Table 3 gives corresponding figures for the community mobilization items in the youth and parent surveys. The pattern of responses was similar to that found in the community mobilization survey; roughly half of the respondents to both surveys agreed that people helped each other, worked together to solve neighborhood problems, and participated in a block watch program. The percent agreement increased from baseline to follow-up although the increase was less pronounced than for the community mobilization survey. Both youth and parents liked the neighborhoods they lived in: 90 percent of youth liked their neighborhood somewhat or a lot, and more than 50 percent of parents responded "very true" to the statement "I like the neighborhood I live in."

Table 4 examines the central study question of whether MY Health efforts led to increased mobilization in the intervention neighborhoods relative to the controls. That is, were the overall increases in mobilization noted in Tables 2 and 3 concentrated to a greater degree in the intervention neighborhoods or were they simply reflecting a larger phenomenon taking place in all areas of the city/county? For this analysis only the scale scores were used–five scales in all, three from the community mobilization survey and one each from the youth and parent surveys.

There was no evidence of greater increase in mobilization in the intervention neighborhoods. There was an increase in all five mobilization scales in both intervention and control neighborhoods. For four of the five scales the (positive) changes were greater in the intervention neighborhoods; however, in no case did the differences approach statistical significance.

Table 5 shows change scores comparing each intervention neighborhood with its controls. The p-values were computed by testing for the difference in change scores using the individual as the unit of analysis. Only one of the differences was statistically significant (favoring the intervention for the youth survey scale in neighborhood A), about what would be expected due to chance alone. The only systematic result was a greater change in mobilization in neighborhood D relative to its controls for the community mobilization survey. The increases in mobilization were two to three times greater in neighborhood D and approached statistical significance ($p = .10$). However,

Table 4: Measuring MY Health Intervention Effects: Comparing Community Mobilization Scale Change Scores—Intervention Versus Control Neighborhoods*

	Intervention (n = 4)			*Control (n = 6)*			
Survey Variable	*Baseline*	*Follow-up*	*Change*	*Baseline*	*Follow-up*	*Change*	p-*Value*†
Community Mobilization Survey							
Neighborhood cooperation scale	45.6	49.6	4.0	49.3	52.5	3.2	0.91
Neighborhood pride scale	47.0	55.3	8.3	46.2	54.2	8.0	0.94
Community program scale	45.9	55.4	9.5	46.5	54.0	7.5	0.69
Youth Survey							
Youth survey mobilization scale	48.5	51.4	2.9	49.1	52.7	3.6	0.71
Parent Survey							
Parent survey mobilization scale	47.1	52.7	5.6	46.9	51.1	4.2	0.41

*Scales computed by normalizing each survey variable (Likert scales ranging from one to five or one to three) to have mean = 50 and standard deviation = 25 and then averaging them across all variables in that construct.

†*p*-Value for *t*-test (neighborhood-level, $n = 10$) comparing intervention and control change scores.

Table 5: Measuring MY Health Intervention Effects: Neighborhood-Level Change Scores—Intervention Versus Control Neighborhoods*

	Neighborhood A		*Neighborhood B*		*Neighborhood C*		*Neighborhood D*	
Survey Variable	*Intervention*	*Control (n = 2)*	*Intervention*	*Control (n = 1)*	*Intervention*	*Control (n = 2)*	*Intervention*	*Control (n = 1)*
Community Mobilization Survey								
Neighborhood cooperation scale	.2	−10.5	0.6	18.9	−1.7	8.4	16.9	4.5
Neighborhood pride scale	5.7	6.4	10.2	−.8	6.9	15.0	10.3	6.2
Community program scale	−.3	0.3	9.8	13.6	12.1	13.1	16.5	4.6
Youth Survey								
Youth survey mobilization scale	7.6	2.6†	2.7	4.1	3.1	4.9	−2.0	2.8
Parent Survey								
Parent survey mobilization scale	1.3	1.9	5.4	5.9	8.6	5.5	7.1	4.5

*Scales computed by normalizing each survey variable (Likert scales ranging from one to five or one to three) to have mean = 50 and standard deviation = 25 and then averaging them across all variables in that construct.

†$p < .05$, individual-level analysis comparing individual intervention neighborhoods with their controls.

the parent and youth survey results for neighborhood D were mixed and did not approach significance.

DISCUSSION

Surveys of youth, parents, and key neighborhood leaders were used to evaluate the effectiveness of the community mobilization campaign carried out as part of the Seattle MY Health Project. Results showed that mobilization increased to the same degree in both intervention and control neighborhoods with no evidence of an overall intervention effect. The only positive result was a greater relative increase in mobilization in the neighborhood that also had the highest number of intervention activities and was hypothesized a priori to have the greatest chance of showing an effect (neighborhood D).

There are at least two possible explanations for the lack of a positive finding. First, community mobilization activities may not have been strong enough relative to the size of the neighborhoods to produce visible, population-level changes. The mobilization campaign took longer than expected to implement, partly because of a change in strategy from using existing neighborhood leaders to a more grass roots approach. In addition, because they were new to serving on organized community boards, the CAB members may have taken longer to become organized and choose projects to implement. In only one neighborhood–neighborhood D–was the MY Health board mentioned in response to an open-end question asking community mobilization survey respondents to list effective neighborhood organizations.

However, a second possible explanation for the negative finding is that there were intervention effects resulting from CAB projects but these changes could not be detected using the population-based surveys and closed-end questions used in the evaluation. The difficulties of measuring something as nebulous as community mobilization using quantitative measures have been noted elsewhere (Wickizer, Von Korff, Cheadle, et al. 1993; Cheadle, Wagner, Anderman, et al. 1998). In a previous article we examined the reliability and validity of the MY Health community mobilization survey and found wide variation among respondents both in how they defined the boundaries of their community and in what activities constituted mobilization (Cheadle, Wagner, Anderman, et al. 1998). The result was relatively low inter-rater reliability for all of the closed-end survey items used in this evaluation. The low levels of reliability may have resulted in measurement error that made it difficult to detect what may have been modest program-induced changes.

The negative findings reported here are consistent with the only other randomized trial of community mobilization of which the authors are aware, which also found no significant effects for the quantitative measures of mobilization (Wickizer, Wagner, Cheadle, et al. 1998). More generally the findings are consistent with the results from other community-based health-promotion trials that found no measurable intervention effects despite the implementation of broad-based and intensive activities in relatively small communities (COMMIT Research Group 1995a, 1995b; Farquhar, Fortmann, Flora, et al. 1990; Mittelmark et al. 1993). This study shared the limitations of those other community-based studies, namely small numbers of experimental units and a short time frame for measurement when the problems addressed are acknowledged to require much longer to change. The difficulty of using a relatively short-term, randomized approach to evaluate the effect of community-based programs has led some to call for a greater emphasis on process evaluation and single-community designs (Mittelmark et al. 1993).

The MY Health Project did not produce a measurable effect on community mobilization in the four neighborhoods where intervention activities were carried out. It is uncertain whether this was because of a lack of strength of the interventions or problems detecting intervention effects using the surveys available. The uncertainty underlying these results provides further support for the argument that large-scale randomized trials may not be the best way of evaluating community-based health interventions.

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