Research Articles

A Door-to-Door Needs Assessment to Guide a Community-Campus Health Partnership and Contribute to Community Empowerment

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ABSTRACT

A community-campus health partnership was formed in 1999. To determine health partnership priorities, it was collaboratively decided that an assessment of the community's health needs and interests was necessary. This article describes a community-based participatory research project: namely, a door-to-door survey to assess community health needs and interests. The survey was developed and approved by the health partnership's board of directors, consisting of a majority of community residents, and university personnel. The survey was based on the National Health and Nutrition Examination Survey, allowing comparison between community residents (97 percent of who were African American) and a national sample of African Americans. Resident interviewers were trained to administer the survey. Data were collected from 301 residents (195 adults and 106 children) from 124 households. A test of binomial proportions was used to compare the study population with a national sample of African Americans. Similarities and differences from that national sample were observed. The data will be used to prioritize health promotion programming, to validate health needs in funding proposals, and to track community health over time. The study's protocol is offered as a community-based participatory research model for communities seeking to acquire health data specific to their jurisdictions.

INTRODUCTION

This article describes a community-based participatory research study to determine health needs of residents of a city in a community-campus partnership. In the past decade, community-campus partnerships have developed in various locations in the United States.[1–3] There were two main motivations of these partnerships and they relate to each of the partners. A major motivation was to better understand and contribute to the health of communities in which these colleges are located. That is the right thing to do. As the economy changed and funding for colleges and universities became more of a challenge, another motivation was demonstrating the university's centrality to the public welfare. And, of course, there was concern for enhancing student learning through a service-learning modality[4–7] or student research that could take the form of community-based participatory research.

BACKGROUND

Recognizing the benefits of community-campus partnerships, faculty of the Department of Public and Community Health at the University of Maryland and Seat Pleasant formed the *Seat Pleasant/University of Maryland Health Partnership*. The partnership has two main goals. One goal is to provide health promotion services to the residents of Seat Pleasant that they either cannot afford or do not have the appropriate expertise to provide. The second goal is to provide a community site for student and faculty practice. This occurs through service-learning projects, class assignments, faculty research, MPH internships and capstone projects, and theses and dissertations. The modality to achieve these goals

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is community-based participatory research.

The City of Seat Pleasant

Seat Pleasant is an incorporated city located in Prince George's County, Maryland. Seat Pleasant is comprised of 4,885 residents, of which 97 percent are African-American. At the time of this study, there was no health data repository specific to Seat Pleasant. Health status, therefore, had to be extrapolated from health statistics maintained by Prince George's County, Maryland.

The Seat Pleasant/University of Maryland Health Partnership

The *Seat Pleasant/University of Maryland Health Partnership* is described in detail elsewhere.[8] In terms of this article, though, it should be noted the partnership is governed by a board of directors, made up of a majority of city residents. As such, the city's residents, through their representatives on the board of directors, were empowered to sanction or not sanction activities under the aegis of the health partnership. In this respect, and others described later, the city and its residents were a vital part of this community-based participatory research. Readers interested in learning more about the *Seat Pleasant/University of Maryland Health Partnership* are referred to other publications.[9–11]

The Need

The projects conducted by the Health Partnership were deemed necessary by the members of the board of directors, with input from the community and the city administration; in particular, the mayor and city administrator. However, it soon became apparent that a more objective determination of community needs was necessary. As a result, a search was conducted of available health data specific to Seat Pleasant. It was soon concluded that no such data existed. Data were available at the county level, but not specific to jurisdictions within the county. Furthermore, given that Seat Pleasant shares a ZIP code with neighboring jurisdictions, data were not available by ZIP code.

Several attempts at determining health-related needs specific to Seat Pleasant were undertaken.[12] Approximately every month, the city mails a newsletter to each resident. As such, there is a listing of each household in the city. Several community-appointed board members suggested that a mailed survey, with a self-addressed and stamped envelope for return, would elicit the community's health needs and interests. Since it was assumed these community-appointed board members knew the community better than university-appointed board members, a survey was developed and mailed to city residences chosen at random from the city's listing of households. Approximately a thousand surveys were mailed out of almost 1,400 households in the city. To increase the understanding that this was not merely a university research study, surveys were mailed on Health Partnership stationary and the return address was the Seat Pleasant City Hall. Unfortunately, too few surveys (approximately 15) were returned to be useful. It was suspected that residents either do not read mail carefully from sources with whom they are unfamiliar, or were preoccupied with managing their daily lives such that they decided not to take the time to complete and return the surveys.

Given the low response rate to the mailed survey, focus groups were suggested by university-appointed board members to determine the community's health needs and interests. These board members had conducted such groups in other studies. Focus group participants were recruited through several churches and apartment complexes in the city. Although commitments for attendance at the prearranged times for the focus groups were obtained, too few residents attended to provide useful data on needs and interests. Again, it was believed that residents in this community were struggling to manage their daily lives and, as such, were unwilling to reassign time to participate in a focus group.

A discussion of these previously failed attempts was conducted by the Health Partnership's board of directors, and with the mayor and several city council members. It was collaboratively decided that a door-to-door survey, conducted by Seat Pleasant resident interviewers, was the best means of determining these needs and interests. Feedback from the community suggested that residents would be more likely to open their doors and provide survey responses to neighbors than to strangers—in particular, strangers from the university.

METHODS

Conducting community-based participatory research often involves methodological compromises. This study is no exception. Among the limitations of this study, discussed in more detail at the conclusion of this article, are lack of information about respondents who chose not to participate in the study, residents collecting data regarding their neighbors and the question of validity that procedure in raises, and a potential bias in selection of respondents. Consequently, the results of this study should be interpreted in view of these limitations. Still, the process of conducting community-based participatory research as applied in this study is instructive.

The Door-to-Door Survey

A grant application was written, submitted, and awarded by the Community Health Foundation of Washington, D.C. to conduct the door-to-door survey.

Study Purposes: There were several purposes of this study. The overall purpose was to acquire health data specific to the City of Seat Pleasant. Underlying purposes included: 1) identifying community health needs to serve as a guide for prioritizing Health Partnership health promotion interventions and programs; 2) to be able to demonstrate health-related needs when applying for grant and contracts; 3) to track changes in health status over time; and 4) to serve as a model for other jurisdictions who also want to acquire health data specific to their jurisdictions.

Community-based Participation: The community was integrally involved in the development and administration of the survey, and analysis of survey results. The community was represented through the Health Partnership's board of directors. The board is comprised of representatives of various

sub-populations in the city. Over the years, the board has included clergy, youth, elders, apartment complex managers, business people, school principals, and others. It was the board that commissioned the survey of health needs and interests, and that charged a university faculty member to develop a draft of that survey. That draft was based on items in the NHANES survey. When submitted to the board, it was suggested that some items were too sensitive for city residents to ask other residents (for example, items concerning sexually transmitted infections and HIV/AIDS). As a result, those items were omitted from the final survey. The survey was then pilot tested for comprehension and time for completion with residents of several apartment complexes in the city and the results of that pilot testing reported back to the board of directors. As a result of the pilot test, the survey was made shorter in order to be able to be completed in 30 minutes. Comprehension was deemed to be appropriate. The board then approved the final version of the survey.

The data collection protocol was also suggested by the city members of the board of directors. Having previously sanctioned failed attempts at acquiring these data, the board felt strongly that the best way to obtain residents' cooperation was to have them surveyed by their neighbors. Consequently, resident interviewers were trained and used to collect data (see below). Given that it was decided neighbors could best obtain data from neighbors, a random selection of respondents was deemed unfeasible. As a result, a convenience sample was used in this study.

Once survey results were available, a presentation was made to the board, the mayor of the city, and the city council at a meeting open to the public—approximately 20 members of the public attended this meeting. These groups and individuals suggested uses of survey data that included health promotion programming, health screenings, and collaborations with health care providers. As noted below, these community priorities were, or are being, implemented.

Development of the Survey: In addition, there needed to be a way to analyze those data to determine the areas in which Seat Pleasant was different from similar communities in the United States. After meetings with staff at the Center for Disease Control and Prevention's National Center for Health Statistics, it was decided to use questions from the *National Health and Nutrition Examination* Survey (NHANES)[13] in developing the door-to-door survey. In this way, results obtained in Seat Pleasant could be compared to results obtained nationally. Further, since 97 percent of residents of Seat Pleasant are African American, data obtained in Seat Pleasant could be compared to a national sample of African Americans.[14] By these comparisons, it could be determined which health areas in particular need attention in Seat Pleasant, and which health areas should hold a lower priority. Another advantage of using survey items from NHANES is that survey had already been validated and successfully used nationally to obtain health data. It was, therefore, decided that no independent determination of validity of the survey was necessary. It should be recognized that this is a potential limitation of this study but, given compromises required in doing community-based participatory research and NCHS having previously validated NHANES nationally, one we believed we could accept.

Surveys were confidential; that is, no names appeared on the surveys although, obviously, interviewers knew who completed the surveys. Limitations based on the study protocol are discussed below. Several items included in NHANES were omitted in the door-to-door survey. This was for several reasons: 1) concern about the time required to administer the survey, 2) the discomfort respondents might feel in disclosing sensitive information to resident interviewers, and 3) the irrelevancy of certain item to the interests of the Health Partnership. As a result, the door-to-door survey consisted of 36 items that collected data relative to: demographics; health, dental, and prescription drug insurance status; hospital utilization and access to care; medical conditions; health screening history such as blood pressure, blood cholesterol, prostate specific antigen (PSA), digital rectal exams, stool tests, breast self-examination and mammogram; vaccination history such as influenza and pneumonia; social support; tobacco use; alcohol use; physical activity; nutrition and weight; vision; oral health; and physical functioning and activities of daily living. Surveys took approximately 30 minutes to complete.

Resident Interviewers: Key community stakeholders—city councilpersons, mayor, after-school program administrator, city employees, long-term city residents—were asked to help recruit residents of Seat Pleasant to be door-to-door survey interviewers. Ten resident interviewers were recruited as a result of this process. Resident interviewers were paid $20 for each completed survey submitted. Given previous failed attempts to collect health data specific to Seat Pleasant through mailed surveys and focus groups, it was decided that the protocol most likely to be successful was one in which neighbors collected data from neighbors. It should be recognized, though, that this protocol was fraught with limitations. For example, residents without telephones were not contacted to make appointments to complete the survey. These limitations are discussed below. Still, data collected in this manner were deemed to be better than no data that resulted from previous attempts.

Workshops were conducted for three hours on two Saturday mornings to train interviewers. At the workshops, the study protocol was described, informed consent forms to be completed by respondents were distributed, grocery gift cards worth $10 each to be given to respondents as an incentive to participate in the study were distributed, and copies of a letter signed by the mayor and president of the city council requesting that residents participate in the study were given to interviewers. The door-to-door survey was then reviewed with each question being discussed. The need for interviewers to maintain confidentiality of the data collected was emphasized. They were instructed not to share any of the data with anyone else. After allotting time for ques-

tions about the protocol and/or the survey, interviewers formed pairs and administered the survey to each other. Clarification was offered on the survey as questions arose. Surveys completed by pairs of interviewers were collected by the researcher and reviewed to determine that Resident interviewers were able to administer the surveys reliably.

Collection of Data: Interviewers were asked to telephone neighbors, explain the purpose of the health survey, and arrange a time to conduct the door-to-door survey. As an incentive for participating in the study, respondents received a $10 grocery store gift certificate.

Once in respondents' residences, interviewers were instructed to have respondents complete an informed consent form, and to state that no names would appear on the surveys. The consent forms were kept separate from the completed surveys and submitted in a batch such that no respondent could be associated with his or her completed survey. Respondents were then given a letter from the mayor and city council president describing the importance of the survey and requesting resident participation. Next, interviewers were instructed to read each question on the survey, recording residents' responses. After the surveys were completed, interviewers dropped them off, with signed informed consent forms, at a predetermined location in the Seat Pleasant city hall from which the researcher collected them for analysis.

RESULTS AND DISCUSSION

The study sample, comparisons of respondents' health with a national sample of African Americans, findings specific to the study population, and limitations of the study are described below.

The Sample: Resident interviewers were able to obtain data on 124 households. Data were collected on 301 respondents, 195 of which were adults and 106 children 19 years of age and younger (see Table 1). The average household size of the sample is 2.43. This compares to Census Bureau data citing the average household size in Seat Pleasant is 2.86. All respondents were African American. Children were included in the sample in order to provide as much data about the community as could be acquired and that could govern future partnership activities. If children's health needs were determined by the community to be of priority once they were identified, the partnership would be guided by this community perspective. Of the adult respondents for whom data were available (N = 183), the mean age was 53. Adult respondents consisted of 73 males with a mean age of 55, which comprised 40 percent of adult respondents. This compares to Census Bureau data citing 45 percent of the city population is male. There were 110 female respondents with a mean age of 52, which comprised 60 percent of adult respondents. This compares to Census Bureau data citing 55 percent of the city population is female. Thirty-five percent of the study respondents were youth and 65 percent were adults. This compares to Census Bureau data citing 33 percent of the city population are youth and 67 percent are adults. Given these demographic comparisons between the sample and Census Bureau data pertaining to city residents, researchers were more confident the data were representative of the city population.

Comparison to National Data from NHANES: One goal of this study was to determine whether health status and health-related variables of Seat Pleasant residents differed from a national sample of African Americans responding to the *National Health and Nutrition Examination Survey*. African American respondents to NHANES were somewhat younger than Seat Pleasant respondents, 49 years of age for the national sample compared to 53 years of age for the Seat Pleasant sample. However, the age of children respondents was comparable. Division by gender was also comparable, 40 percent male and 60 percent female for the Seat Pleasant sample compared to 45 percent male and 55 percent female for the national sample. In addition, Seat Pleasant respondents were somewhat more highly educated than the national sample, as 59 percent reported some education after high school compared to 35 percentage of the national sample.

Since the number of Seat Pleasant respondents was far fewer than the national sample of African Americans, a *Test of Binomial Proportions* was employed to determine significant differences between these two samples. Table 2 presents those medical conditions for which Seat Pleasant respondents reported statistically higher or lower incidences than the national sample of African Americans. Note that 40 percent of Seat Pleasant respondents reported trying to lose weight in the past year compared to 26 percent of the national African American population ($p = .05$).

Community Involvement in Analysis and Interpretation of Data: As stated above, the community drew on the expertise of the researcher to statistically analyze the data. However, a presentation of the findings were made at several community meetings and community residents' interpretation and significance of the results sought at those meetings. These meetings included a presentation of findings at a board of directors meeting, and at a meeting of the city council at which the mayor and approximately 20 members of the public were present. At these meetings, members of the community expressed agreement with the results, indicating they had a good handle on community health issues and lending validity to the findings. Priorities which the Health Partnership ought to address were also suggested by community members attending these meetings. Those priorities are discussed below.

Findings of Particular Interest to the *Seat Pleasant/University of Maryland Health Partnership*: As shown in Table 3, Seat Pleasant respondents generally reported healthier behaviors than did the national sample of African Americans.

However, although the comparison between the Seat Pleasant sample and the national sample of African Americans was of interest to give the data perspective, the actual status of Seat Pleasant residents was of prime importance. It was interesting, therefore, that upon closer inspection of the data,

although Seat Pleasant respondents report healthier behaviors, the levels of some of these behaviors were wanting. With these local data, the Health Partnership could plan future interventions and health promotion activities, and provide evidence to funding agencies of health-related needs. These data are presented in Table 4.

These findings will inform Health Partnership activities. For example, in cooperation with the county health department, we have conducted educational sessions regarding free and low cost health insurance. We are also developing a program to financially supplement prescription medication fees for those without health insurance. In addition, in collaboration with local and regional medical care providers, we have explored the purchase of a dental van to serve the oral health needs of Seat Pleasant and neighboring community residents. Many other activities have been instigated by the results of the door-to-door survey, activities which may not have been perceived as needs without these data.

Limitations: The study protocol recognized several compromises that were deemed necessary but, nonetheless, resulted in several limitations. For example, although it was judged to be necessary to use residents as interviewers, especially after other attempts to obtain community-wide health data failed, this might have resulted in respondents withholding certain information they did not want their neighbors to know. Still, the results are not inconsistent with the national sample of African American respondents to the NHANES study thereby lending some credence to the results reported herein.

Another limitation pertained to the convenience sample used in this study. Resident interviewers chose households of neighbors in which they thought they could gain entry, rather than employ a stratified random sampling technique. This protocol was based on feedback from the board of directors having been informed by previously failed attempts at acquiring these data. As such, there was no guarantee that respondents would adequately represent various factions of city residents; for example, the elderly, children, males, and females. Some of this concern was alleviated when the data was inspected and there appeared to be sufficient numbers of respondents by age, gender, education level, and size of household. Yet, given the sampling method, these data should be considered in

Table 1. Door-To-Door Survey Respondents

	Number	Percentage
Households	124	
Number in Household		
1	40	32%
2	40	32%
3	15	12%
4	17	14%
5	7	6%
6	4	3%
7	1	1%
Subjects	301	
Adults	195	65%
Children	106	35%
Adult Age (Mean = 52.7)		
Younger Than 50	84	44%
50–64	35	19%
65 or Older	70	37%
Adult Gender		
Male	73	40%
Female	110	60%
Children's Education		
Less Than 8th Grade	67	70%
9–12 Grade	26	27%
Voc. Tr., GED, or Some College	3	3%
Adult Education		
Less Than 9th Grade	7	4%
High School Degree	69	37%
Voc. Tr., GED, or Some College	81	43%
College Degree or Higher	30	16%
Adult Occupation		
Working	82	43%
Looking for Work	24	13%
Stay at Home or Retired	83	44%
Youth Occupation		
Working	3	3%
Looking for Work	8	8%
Student	70	66%
Stay at Home	25	24%

Table 2. Statistically Significant Higher Incidence of Medical Conditions and Variables of Seat Pleasant Respondents When Compared to a National Sample of African American Respondents Using a Test of Binomial Proportions

Medical Condition/Variable	Z Value	P Value
Higher Incidence:		
Anemia	4.59	.001
Trouble Seeing With Glasses/ Contact Lenses	5.10	.001
Arthritis	2.38	.05
Coronary Heart Disease	1.78	.05
Chronic Bronchitis	2.80	.01
Hypertension	5.10	.001
Tried to Lose Weight in Past Year	4.78	.05
Lower Incidence:		
Learning Disability	4.12	.01
Stomach/Duodenal/Peptic Ulcer	2.48	.01
Engaging in Strength Training Activity	1.83	.01

Table 3. Healthier Behaviors Reported by Seat Pleasant Respondents When Compared to a National Sample of African American Respondents Using a Test of Binomial Proportions

Health Behavior	Z Value	P Value
Ever Having Had Blood Cholesterol Checked	5.96	.001
Blood Cholesterol Checked Within the Past Year (Adults)	2.66	.01
Blood Pressure Screening in the Last Six Months (Men)	2.07	.05
PSA Screening for Prostate Cancer	3.92	.001
Ever Had a Digital Rectal Examination	2.01	.05
Ever Had a Pneumonia Vaccination	7.64	.001
Do Not Add Salt to Food	2.06	.05
Do Not Smoke Cigarettes	1.81	.05
Regular Visits to a Dentist	2.54	.05

terms of this limitation.

Lastly, the survey questions were taken from the NHANES questionnaire and may not have been applicable to the local setting in which they were employed. Perhaps Seat Pleasant residents experience a different set of health-related issues, needs, and interests than the national African American respondents to NHANES. If that is the case, then the survey questions may have been interpreted differently than the national sample. Yet, the demographical nature of the Seat Pleasant sample differed little from the national sample and issues for African Americans in general—hypertension, lack of physical activity, low percent age of health screenings—were also issues for Seat Pleasant respondents.

LESSONS LEARNED: COMMUNITY-BASED PARTICIPATORY RESEARCH FOR COMMUNITY-CAMPUS HEALTH PARTNERSHIPS

More community-campus partnerships have been formed in the past 10 years. Along with this development has come the recognition of the value of community-based participatory research to accomplish the goals of these partnerships.[15–17] This study employed community-based participatory research to identify community health needs. Blumenthal and DiClemente[18] present principles that should guide community-based participatory research. These principles are briefly presented here, and how they were articulated in this study, to assist readers in conducting community-based participatory research.

• *Builds on the community as a unit of identity*. The community in this study was identified as an incorporated city, with geographical boundaries, a small enough population with which to work, and represented by a mayor and city council. The Health Partnership further enhanced community unity.

• *Builds on strengths and resources within the community*. The Health Partnership relied on volunteers from the community with an understanding of the community's values and styles of interacting. This was important to inform study procedures and interpretation of study results.

• *Facilitates collaborative partnerships in all phases of the research*. Representatives of the city were involved in the establishment of the objective to acquire health data regarding city residents, planning and approval of the survey, interpretation of study results, and establishing Health Partnership priorities based on the study's findings.

• *Integrates knowledge and action for mutual benefit of all partners*. The community benefited from this study in that findings allowed for the planning of health-related activities to improve residents' health. University researchers benefited by having guidance for follow-up program activity that would serve city residents, as well as provide a study population for subsequent research and allow students to apply what they learn during their professional preparation to a real community.

• *Promotes co-learning and empowering process that attends to social inequities*. This study involved collaboration between the community and university researchers. As a result, researchers learned about commu-

nity health needs and were then better able to organize meaningful follow-up activities (interventions and research) for an underserved population. Community members gained a better insight regarding how to use university resources to better meet their health-related needs, about which they previously felt powerless.

• *Involves a cyclical and iterative process.* This research can be perceived to have started with the establishment of the Health Partnership in 1999 and the resulting issue of identifying community health needs. Now that these needs have been determined, the next step is to develop health promotion interventions to respond to these needs and conduct subsequent research to determine the effectiveness of those efforts.

• *Addresses health from both positive and ecological perspectives.* Conducting health promotion programming is one way to respond to community health needs. However, these needs do not exist in a vacuum. They are impacted by ecological issues. By way of example, one of the follow-up activities that evolved from this study is the development of a pharmacy assistance program for families who do not have sufficient health and drug insurance coverage to pay for prescribed medications.

• *Disseminates findings and knowledge gained to all partners.* Findings of this study were disseminated at several meetings in the community, several of which were open to the public. Interpretation of these results were conducted at these meetings and follow-up activities prioritized. The result was knowledge gained regarding community health needs and planning for responding to those needs.

In conducting this study, several lessons were learned that other community-campus partnerships should consider when organizing to achieve their objectives. These lessons are described below.

• The community should be well represented in all phases of the research. This includes the planning, implementation, and analysis phases. Without this level of participation, there will be no community ownership of the research or of activities to respond to research findings. Still, this is often easier said than done. Residents of underserved communities, in particular, have more pressing needs than participating in research, even if that research has the potential of enhancing their health. One way to have the

Table 4. Findings Specific to Seat Pleasant Respondents

Variable	Percentage
Total Sample	
Lacking Health Insurance	16%
Lacking Dental Insurance	37%
Lacking Prescription Drug Insurance	30%
Occasionally or *Very Often* Adds Salt to Foods	55%
Do Not Have the Right Kinds of Foods to Eat	20%
Do Not Have Enough Food to Eat (60% Due to Cost)	6%
Adult Men	
Overweight	49%
Hypertension	37%
Vision Problems	31%
Arthritis	23%
Never Had PSA Screening	40%
Never Had Digital Rectal Exam	26%
Never Had Stool Test	32%
Never Had Influenza Vaccination	50%
65+ Who Never Had Pneumonia Vaccination	50%
Do Not Engage in Strength Training Activities	81%
Fair or *Poor* Dental Health	39%
Last Visited a Dentist Over a Year Ago	37%
Adult Women	
Anemia	20%
Overweight	64%
Hypertension	50%
Vision Problems	37%
Arthritis	42%
Never Had Performed Breast Self-Exam	21%
Never Had a Mammogram	34%
Never Had a Stool Test	39%
Never Had Influenza Vaccination	49%
65+ Who Never Had Pneumonia Vaccination	47%
Do Not Engage in Strength Training Activities	72%
Fair or *Poor* Dental Health	34%
Last Visited a Dentist Over a Year Ago	44%
Children	
Asthma	27%
Vision Problems	19%
Never Screened for Hypertension	28%
Never Screened for Blood Cholesterol	42%
Never Had Influenza Vaccination	74%
Do Not Engage in Strength Training Activities	87%
Overweight	11%
Fair or *Poor* Dental Health	18%
Last Visited a Dentist Over a Year Ago	34%

community represented is by forming a board of directors of the partnership consisting of segments of the community. In that way, these community sub-populations with have a voice in community-based participatory research activities.

• Community-based participatory research requires living with various study limitations. For example, often compromises need be made in data collection procedures in order to obtain respondents' cooperation. Even study purposes need to be subject to community priorities, rather than researchers' perceptions of community needs.

• University personnel are often seen as separate from the community. Their research studies only serve to reinforce this perception. One way to counter this concern is to develop a history of successful projects in the community prior to engaging in community-based participatory research. The *Seat Pleasant/University of Maryland Health Partnership* had been in existence for five years prior to this study and had conducted numerous projects in the city. This history helped when recruiting resident interviewers and survey respondents.

• Community-campus partnerships interested in community health assessment should recognize that more than merely identifying community health needs and interests is required. Assets also need to be recognized. As such, the *Seat Pleasant/University of Maryland Health Partnership* has conducted several ethnographic studies of the community relative to churches, education, recreation, and crime. These studies have included drive-throughs, walk-throughs, interviews, and asset mapping. Along with the results of the door-to-door survey, these studies provide us with a more complete picture of our target population and setting.

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