



# Creating neighborhood recreational space for youth and children in the urban environment: Play(ing in the) Streets in San Francisco

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## ABSTRACT

In 2013, San Francisco was one of eight sites funded by Partnership for a Healthier America to implement Play Streets, a smaller-scale Open Streets-type initiative, aimed at increasing physical activity (PA) among children and youth by closing neighborhood streets for recreational activities. This paper evaluates the pilot Play Streets events held in summer of 2013 in San Francisco with a focus on examining the characteristics of users of such events, the impact on youth and children's physical activities, use of open space and level of community engagement. The study uses survey data, observational data, existing secondary data as well as GIS mapping to measure the space created by Play Streets. Demographic characteristics, levels/types of PA and level of community engagement for a sample of 1364 participants were examined. Engagement in vigorous PA increased three-fold (11.5% to 35%) during PS and 93.3% of participants agreed that "PS strengthens our community." Open space for PA and recreation added through Play Streets ranged from 47%–100% of available space depending on the site. Play Streets offers a significant opportunity for neighborhoods and small communities to implement a health-benefiting recreational event for its youth and families. However, specific programming is an important key to the success of Play Streets implementation and for attracting the targeted participants.

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## 1. Introduction

Physical activity (PA) has been identified as a significant determinant of physical, mental and emotional health across the lifespan (USDHHS, 2008). Insufficient PA is associated with higher prevalence of overweight and obesity as well as increased risk for diabetes and other chronic diseases (Ogden, Lamb, Carroll, & Flegal, 2010). Despite the benefits of PA, many adults and children—particularly ethnic minority and low-income populations—do not meet the minimum national recommendations (Troiano et al., 2008; CDC, 2012). In urban areas particularly, space limitations, inadequate financial resources and low prioritizing of health-benefiting recreation, have diminished the opportunities for increasing PA among the broader population (Van Cauwenberg et al., 2015).

Park use has been associated with PA among children and youth and later PA among adults (Jongeneel-Grimen et al., 2014), though access and proximity to parks (Brodersen, Steptoe, Williamson, & Wardle, 2005; Timperio et al., 2006), as well as playgrounds and open space (Kaczynski, Potwarka, & Saelens, 2013; Vaughan et al., 2013; Oreskovic et al., 2015), impacts usage among children and adults.

Among children, distances greater than one-half mile negatively impact PA (Cohen et al., 2006); for youth and adults, proximity combined with park quality increases likelihood of PA recommendations being met (Van Cauwenberg et al., 2015). Where parks and playgrounds are available in low-income areas, they tend to have fewer, and lower quality, amenities (Coughenour, Coker, & Bungum, 2014). Renovating school playgrounds increases PA among elementary students and reduces sedentary behavior (Brink et al., 2010).

Elements of the social environment such as organized activities (Bailey, Hillman, Arent, & Petitpas, 2012) and connecting with friends and family (Baskin, Dulin-Keita, Thind, & Godsey, 2015) also influence PA. Parental co-activity, in addition to parental support and encouragement, increases PA, especially among younger children (Rhodes et al., 2015). Such evidence suggests that there are ways to improve PA behavior using existing urban infrastructure.

Even where there is political will (Goins et al., 2013), the limited space of many urban areas can be a barrier to the development of parks and open spaces, and many communities are searching for innovative strategies to use existing space and resources. Joint-use agreements are one effective strategy increasingly being used by communities to support PA by encouraging shared facility use between schools and local organizations or by opening school resources to the local community (Slater, Chriqui, Chaloupka, & Johnston, 2014). Open Streets initiatives, in which miles of streets are closed to vehicle traffic,

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are another promising mechanism for increasing PA and offering broad-range community health benefits (Sarmiento et al., 2010).

>80 U.S. cities have implemented Open Streets to provide low-served communities with temporary parks (Alliance for Walking and Biking). Sunday Streets San Francisco, an Open Streets initiative in place since 2008, has demonstrated health benefits such as increased PA levels among residents of low-income areas (Zieff, Kim, Wilson, & Tierney, 2014). The success of Open Streets led the national organization, Partnership for a Healthier America (PHA), to fund a pilot program—Play Streets—with the goal of temporarily closing urban streets to vehicular traffic to provide open space for children and youth to play. The first Play Streets in the US was held in New York City in 2012, where 64% of participants aged 10 years and older reported that without Play Streets they would have been engaged in sedentary activities and >80% felt that Play Streets increased neighborhood safety and friendliness (So Godzeno, Lopez, Owens, Freij, & Holisko, n.d.). Play Streets type events have already proven successful in various international settings. In Belgium, elementary schoolchildren in neighborhoods with Play Streets decreased the amount of time spent in sedentary activities in comparison to children in non-Play Streets neighborhoods (D'Haese, Van Dyck, De Bourdeaudhuij, Deforche, & Cardon, 2015). Community-based PA mega-events in Brazil have also been successful in fostering both improvements in PA behavior and the use of existing infrastructure to expand available recreational resources (Matsudo et al., 2003). In addition, evidence from a range of international settings suggests that initiatives to promote PA are more effective when conducted as partnerships between organizations such as schools and government agencies, when specific communities and neighborhoods are targeted, and through street-scale land use, among other recommendations (Heath et al., 2012).

San Francisco was one of eight pilot sites funded by PHA in June–August 2013 to develop and implement Play Streets programming nationwide to increase youth activity time on weekends (Rodriguez et al., 2012). The popularity of Sunday Streets in San Francisco and high demand by neighborhoods to host Sunday Streets influenced the decision to implement Play Streets (King, 2016a). Play Streets was to be implemented on a smaller-scale (1–2 car-free city blocks) with lower staff requirements and was designed to provide flexibility for each neighborhood in determining their unique needs, cultural preferences and utilization of resources. The simplified structure of Play Streets with its possibility of more frequent events adds significantly to the amount of open space available for recreational and social activities (King, 2016a) for the city's youth and children.

The city sponsors of the Play Streets events identified four neighborhoods to pilot Play Streets (King, 2016a) based on the following criteria:

low-income (e.g., minimum 16% below poverty line); higher rates than the city average of chronic diseases including childhood obesity; and areas low-served for recreational resources (e.g., less than one acre of open space per 1000 residents, toxic land). Communities were encouraged to offer spontaneous and unofficial activities along the route in addition to the organized ones provided by the SF Recreation and Parks Department.

Once the neighborhoods of Western Addition, Excelsior, Bayview and Tenderloin were selected, additional criteria were developed that: excluded streets with public transportation to minimize disruption to service; gave preference to residential streets; and considered features such as steep slopes and availability of facilities (King, 2016b). Although the Bayview Play Streets occurred on a street with a slight slope, the site was considered favorable because of its proximity to a small plaza earmarked for revitalization, a recreation center with restrooms and the sponsoring organization - a local opera house. Connection with other neighborhood resources (e.g., community centers) was also a determining factor (King, 2016a). The Excelsior event was situated alongside an elementary school and was organized with the school's Parent-Teacher Association (PTA). The Tenderloin event was located in front of a community center with an adjacent playground, and the Bayview event was placed in front of a recreation center. Although the intended population of Play Streets according to PHA was pre-teen youth, SS organizers used the term "Play Streets for All" to indicate the lifespan approach and family-friendliness of the local version of the initiative (King, 2016a). Play Streets in San Francisco was organized and implemented through a partnership between non-profit organizations (i.e. Livable City, the umbrella organization of Sunday Streets and San Francisco Beautiful, a local advocacy organization) and the fiscal sponsorship of the San Francisco Municipal Transportation Agency (SFMTA).

The purpose of this paper is to evaluate the pilot Play Streets events held in summer of 2013 in San Francisco with a focus on examining the characteristics of users of such events, the impact on youth and children's physical activities, use of open space and level of community engagement.

## 2. Methods

There are two parts to the evaluation conducted in this study. First, a process evaluation of Play Streets was conducted to understand the design and operations of this pilot program. The goal was to identify strengths, weaknesses, program reach and sustainability of this youth-centric program. This was done using a multi-method evaluation design that had four components. First, data was collected using a survey

**Table 1**  
Demographics by neighborhood (SOPARC).

		Excelsior		Bayview		Tenderloin		Overall	
		Comparison n = 37	Treatment n = 313	Comparison n = 83	Treatment n = 267	Comparison n = 128	Treatment n = 536	Comparison n = 248	Treatment n = 1116
Gender*									
	Male	60%	49.45%	61.5%	80%	80%	66.8%	69.7%	62.7%
	Female	40%	50.55%	38.5%	20%	20%	33.2%	30.3%	37.3%
Age									
	Child								
	M	2.7%	26.8%	2.4%	22.5%	4.1%	20.7%	4.9%	38.4%
	F	0	24.6%	2.4%	12%	1.6%	11.9%		
	Teen								
	M	5.4%	1.9%	7.2%	4.5%	5.7%	4.5%	8.6%	7.1%
	F	5.4%	4.8%	3.6%	6.7%	0.01%	0.6%		
	Adults	86.5%	41.9%	84.3%	54.3%	90.2%	61.9%	87.7%	54.5%
Ethnicity									
	White	24.3%	36.1%	3.6%	15.2%	13%	20.3%	11.5%	23.5%
	Black	2.7%	2.6%	71%	58.1%	64.2%	28.5%	57.2%	28.1%
	Latino	37.8%	44.7%	20%	17.5%	6.5%	28.4%	16.0%	30.3%
	Others	35.1%	16.6%	4.8%	9.1%	14.3%	22.8%	12.3%	18.0%

Note: \* Does not include adults.

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