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Community Building Community: The Distinct Benefits of Community Partners Building Other Communities' Capacity to Conduct Health Research

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Abstract

Background: Academic partners typically build community capacity for research, but few examples exist whereby community partners build community research capacity. This paper describes the benefits of communities sharing their “best practices” with each other for the purpose of building health research capacity.

Methods: In the context of a grant designed to engage African American communities to address health disparities (Faith Academic Initiatives Transforming Health [FAITH] in the Delta), leaders of two counties exchanged their “best practices” of creating faith-based networks and community health assessment tools to conduct a collective health assessment.

Lessons Learned: There were numerous strengths in engaging communities to build each other's capacity to conduct research. Communities identified with each other, perceived genuineness, conveyed legitimacy, and provided insider knowledge.

Conclusions: Engaging communities to build each other's research capacity is a potentially valuable strategy.

Keywords

Community-based participatory research, community health partnerships, health disparities, process issues, North America, United States

Building community research capacity is crucial to the participatory process and has been nationally recognized as an important component of health promotion (e.g., National Institutes of Health's Clinical and Translational Science Awards¹). There are numerous definitions and conceptualizations of community capacity^{2,3} and many include the characteristics, infrastructure, ability, and skills of a community to address public health problems.⁴⁻⁷

In community-based participatory research (CBPR) projects, academic partners build community research capacity and community partners build the capacity of academics in working effectively with community.^{4,8} However, to the authors' knowledge there are no participatory research proj-

ects where distinct community partner groups have built each other's capacity in different domains to conduct health disparities research. Engaging community partners in this way may be a unique strategy to build community research capacity that complements academic partners' capacity building efforts. From January to July 2013, an academic-community partnership fielded a project in which two distinct community groups trained each other in different skills and the academic group facilitated this community building community process. The purpose of this paper is to describe 1) how the partnership facilitated ‘community building community’ within the context of an National Institutes of Health-funded partnership building grant (FAITH in the Delta), 2) the ben-

efits of “community building community” research capacity, and 3) identified community characteristics that facilitated a successful community building community effort.

APPROACH

Setting

The partnership’s work took place in the predominately rural region of the Arkansas Lower Mississippi River Delta.⁹ In this region, 16% to 22% of households have incomes below the federal poverty level.¹⁰ Primarily consisting of African American and White residents,⁹ the Delta has marked racial health disparities.

Partnership

FAITH in the Delta capitalized on existing relationships to share skills and capacity developed in previous partnered work. The partnership consisted of collaborations between academic partners at University of Arkansas for Medical Sciences (UAMS) and community partners representing two distinct community networks: The Faith Task Force and the TriCounty Rural Health Network. Members of the team have been partnering in health disparities research for more than 10 years.^{11–16}

Previous work between these three partners has resulted in “best practices” for health research—methodologies that seem to have been highly effective. (The authors acknowledge that the methodologies reported have not been studied in randomized, clinical trials.) These best practices were the result of years of work by both community and academic experts. Community members (led by the first author) and UAMS partners developed a successful Faith Task Force in Phillips County as a mechanism for engaging churches across the county. The 11-member Phillips County Faith Task Force, comprising clergy, parishioners, and community leaders, has engaged more than 30 churches and nonprofit organizations to partner with UAMS on National Institutes of Health-funded projects. Recent projects include a randomized, controlled weight loss maintenance trial in 450 participants¹³ and a feasibility intervention pilot to increase minority participation in breast cancer research.¹² The partnership viewed the Phillips County Faith Task Force’s approach of engaging the faith community in research as a “best practice” for activation of churches around health in the Delta.

The second author, TRCHN, and UAMS thoughtfully developed a survey to assess health needs and an inventory of community resources to engage communities in minority health research. Over a 17-month period, community partners surveyed 2,665 Black and 913 White Jefferson County residents, assessing their health concerns, connecting them to resources, and identifying those willing to be recontacted about research opportunities of potential interest (i.e., 85% of Blacks and 88% of Whites).¹⁷ The partnership considered their survey as a “best practice” from Jefferson County to assess community assets and issues.

Project

FAITH in the Delta aimed to address health disparities in the Arkansas Delta by engaging rural African American churches, one of our most trusted institutions.¹⁸ Churches have served as community “portals” through which advances in health care have been translated into real-world settings.¹⁹ Given the importance of the church, the reported weekly church attendance of approximately 85% of rural African Americans,¹⁸ and concern for community well-being, churches were viewed as ideal partners.

The first and second authors served as Community Principal Investigators (PIs) for Phillips and Jefferson Counties, respectively. FAITH in the Delta supported dissemination of the “best practices” resulting from our partnership across two counties, whereby Pastor Turner (Phillips County) assisted Pastor Smith (Jefferson County) in forming a Faith Task Force in Jefferson County, and Pastor Smith assisted Pastor Turner in administering the health survey. Once the Community PIs exchanged their “best practices,” they engaged their Faith Task Force networks in administering the survey across both counties. Additional information about the survey and its results are published elsewhere.²⁰

In the context of the FAITH in the Delta project, the partnership discovered unique benefits of engaging communities to build each other’s research capacity and factors that facilitated capacity building in an interaction involving two separate communities. Typically, academic partners alone build community research capacity through formal training sessions and collaborative research partnerships.^{4,8} The Community PIs shared their perspectives with the academic partners about the process of engaging their respective communities with each

other for the benefit of health disparities research, with an emphasis on the specific benefits and challenges of utilizing a community building community approach. The last author generated themes regarding the specific strengths of the process and community characteristics that facilitated a community building community approach. The themes were then shared with the entire community-academic team and fine tuned.

STRENGTHS OF COMMUNITY BUILDING COMMUNITY

The partnership discovered that a “community building community” approach facilitated by academic partners yielded distinct advantages compared with direct academic efforts to build community research capacity. The partnership observed four distinct advantages: community identification, expressed genuineness, conveyed legitimacy, and provision of insider knowledge. These advantages are consistent with general advantages of CBPR reported in the literature: CBPR recognizes the community as the unit of identity, facilitating a community-level understanding and community identification.⁵ Collaborative research is not possible without expressed genuineness of all partners involved and the acknowledged legitimacy of all partners to contribute to the research process.⁵ The co-learning process of CBPR involves the academic learning of community insider knowledge.⁵ Finally, trust is needed for community identification, conveyed legitimacy, and the provision of receipt of insider knowledge to occur.^{5,21,22}

Community Identification

As African American men and community members, Pastors Turner and Smith share a common experiential understanding of the challenges that their communities face, and the historical and social factors that contribute to racial/ethnic health inequities. Although initially only acquaintances, the strength of their partnership developed quickly because of their identification with one another. Both of them intimately understood the “plight of their people.” Both Pastors Turner and Smith had served rural African American communities for decades as religious leaders and community activists. Both grew up and resided in the communities they served and witness first-hand the strengths and challenges of their communities. Oftentimes, academic partners can only *associate* with their collaborating communities because they are

not community residents interacting in the wider society. In contrast, community partners serving similar populations can truly *identify* with other communities because of their mutual community experience and in the broader culture. Academic partners have an invaluable role in building community research capacity, yet they often lack this distinct advantage community partners have. Community partners’ unique benefit of identification with similar communities may serve as a concurrent strategy to supplement traditional capacity building approaches.

Perceived Genuineness

Academics, regardless of their best intentions, are commonly viewed as prioritizing research over community.^{23,24} Although many communities understand the grant-driven incentives of academia, the researcher’s transient presence in the community can convey a lack of commitment and genuineness.²⁵ Their emphasis on prioritizing research, although not negative, may serve as a barrier in building community-academic collaborations.²⁵ Community partners are perceived by other communities as having a level of genuineness that academic partners may be hard pressed to achieve.

In contrast with many academic partners, community partners remain in the community when the research is over. Pastors Turner and Smith trusted that neither would introduce something into their communities that would not be in the community’s best interests. They also recognized that their priority was community and that their commitment to community was not limited to research, which made them more receptive to each others’ capacity-building efforts. Pastor Smith was receptive to engaging his faith networks to participate in research because he observed that Pastor Turner and his community had benefited from research participation. He trusted Pastor Turner’s intentions because he knew that Pastor Turner was not like other researchers, who had come and gone in the past after collecting data. Pastor Turner was like himself, who prioritized the community first. Likewise, Pastor Turner was receptive to learning about the health assessment that Pastor Smith and his networks had implemented because he saw how the health assessment data had been used for the community’s benefit, and trusted that the health assessment would likewise benefit the community he served.

Conveyed Legitimacy

Communities are not expected to talk about health research, so when they do, communities listen. Pastor Smith was eager to build a county-wide network to engage the faith community in research because Pastor Turner had built the network in his county and testified to its positive impact in his community. Pastor Turner met with Pastor Smith regularly over the course of several months to establish the network in a step-by-step fashion, where Pastor Turner explained to Pastor Smith his strategy in engaging faith communities and then worked with Pastor Smith to outreach to community organizations to participate in the faith–research network. Likewise, Pastor Smith’s positive experience administering the health assessment in his community helped Pastor Turner and his community partners readily receive the health assessment implementation training. A community partner that the actively worked with Pastor Smith delivered several structured trainings in survey administration using the Audience Response System.

Provision of Insider Knowledge

Typically in CBPR, community partners provide insider knowledge and facilitate development of academic–community relationships. The partnership discovered that having community partners build each other’s capacity in conjunction with academic partners was more efficient than academics alone building community capacity. As community leaders, Pastors Turner and Smith had a similar understanding of how to work in community and could readily translate “community speak.” Although there were differences between their communities that needed to be understood during capacity building, this process was expedited because they saw their communities as similar, that is, “they are like us.” For example, they knew that garnering the pastor’s support first was necessary before attempting to engage an entire church; otherwise, efforts to involve a church would be unsuccessful. Pastors Turner and Smith did not need to explain this to each other and were automatically able to engage the churches together.

They were able to communicate with each other about the challenges in the research process that they may have been uncomfortable conveying to academic partners. For example, at one point the payment of the community subcontract was delayed by several months. Because of the insider trust

between Pastors Turner and Smith, Pastor Smith felt comfortable expressing his concerns regarding the project’s finances to Pastor Turner. Pastor Turner addressed his concerns and encouraged him to dialogue with the academic team members about the subcontract’s status. This not only alleviated Pastor Smith’s concerns, but also strengthened our entire partnership.

CHARACTERISTICS OF SUCCESSFUL COMMUNITY

Building Community Efforts

The partnership also noted several community characteristics that facilitated the capacity building process, including a willingness to give and to receive. These community characteristics were also consistent with the CBPR literature. A willingness to give and receive needs to be grounded in trust between partners; trust precludes the willingness to participate in the research process.^{5,21,22}

A Willingness to Give. Communities that are building other communities’ capacity need to have something to offer and be willing to share what they know. In sharing their strengths, “giving” communities need to make an effort to cater to the needs of the “receiving” community. When Pastor Turner taught Pastor Smith how to build a research network in his county, he met him at times and locations that were convenient for Pastor Smith. Pastor Turner realized that he was going to teach Pastor Smith to do something new and wanted to make the process as easy for him as possible by working with his schedule and going to where he was. When the giving community gives, it must be done in a way that is as comfortable as possible for the receiving community to receive. In addition, the giving community needs to be willing to be available to the receiving community through spending time in the receiving community, preferably in person. Pastor Turner spent time with Pastor Smith in Jefferson County often without being asked. Thus, giving communities need to be invested in the receiving community beyond providing a specific set of skills.

A Willingness to Receive. Likewise, communities that are receiving assistance from other communities need to be willing to value the input given. For the community to receive, they need to have trust in the giving community. As Community PIs, Pastors Turner and Smith led the exchange of community best practices and already knew each other. A close relationship between community leaders is not necessary—Pastors

Turner and Smith were only acquaintances before they worked together—but a familiarity in at least knowing about each other in name and reputation can help in the community's receipt of capacity-building efforts. Their shared experience as Baptist pastors and African American men also facilitated a strong working relationship. Race and occupational concordance between communities and community leaders are not necessarily needed for a successful partnership, but can expedite the process of the give-and-take-relationship needed when communities build each other's capacity.

DISCUSSION

In this case study, community partners leading the engagement between two distinct community partners to build each other's capacity in different domains with the facilitation of academic partners was an effective strategy to galvanize health research across two underserved counties. The partnership believes that this approach can be used by other partnerships concurrently with other research capacity building activities. Although the narrative is focused on two key players—the Community PIs—each of the PIs worked in context with their own respective community advisory boards that represented larger communities. Typically in CBPR work, key community leaders are part of the research team to represent and galvanize the larger community, whether through community organizations, government agencies, or other local institutions. Likewise, academic partners are part of the research team and represent and galvanize the larger academic institution. In any CBPR partnership that represents more than one community, specific persons can be identified from each community to lead cross-community capacity building efforts and organize community-wide change.

To replicate and utilize our community-building-community approach, the following strategies are recommended. 1) In community-academic partnerships for participatory research, consider including multiple community partners representing distinct organizations. To engage communities to build each others' capacity, more than one community needs to be involved in community-engaged work. 2) When selecting which communities to engage in a project, consider the strengths and

weaknesses of each community and purposively select communities that have complementary strengths and weaknesses. A survey or inventory of skills may be administered to community leaders to specifically identify organizational strengths and weaknesses. 3) When choosing which communities might undergo a community building community approach, make sure that the communities are willing to work together. Understanding the history of community organizations in the area and asking community leaders to identify which areas they would like to see their community or organization develop are ways to facilitate efficient working relationships between communities. 4) Consider the demographic characteristics of communities before deciding which communities would benefit from engaging in a community building community process. The community building community process described in this paper may have been facilitated by the two communities sharing similar demographic and ideological characteristics. Working with communities who are dissimilar to each other may experience challenges not reported in this manuscript and thus may involve a longer process. 5) Both of the communities described in this manuscript had some foundation in health research, having previously worked with academic partners before initiating a community building community relationship. Thus, in selecting communities for engagement, it would be beneficial if communities have at least some familiarity with research and engage in community building community activities complement academic activities to build community capacity.

In closing, the authors of this manuscript emphasize that this paper does not advocate for a decrease in the role of academics in building community research capacity, but rather for community to also be considered as a viable resource for sharing best practices with other distinct communities. The community building community process proposed in this manuscript is not only consistent with CBPR principles, but invites an extension of those principles in community-engaged work.

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