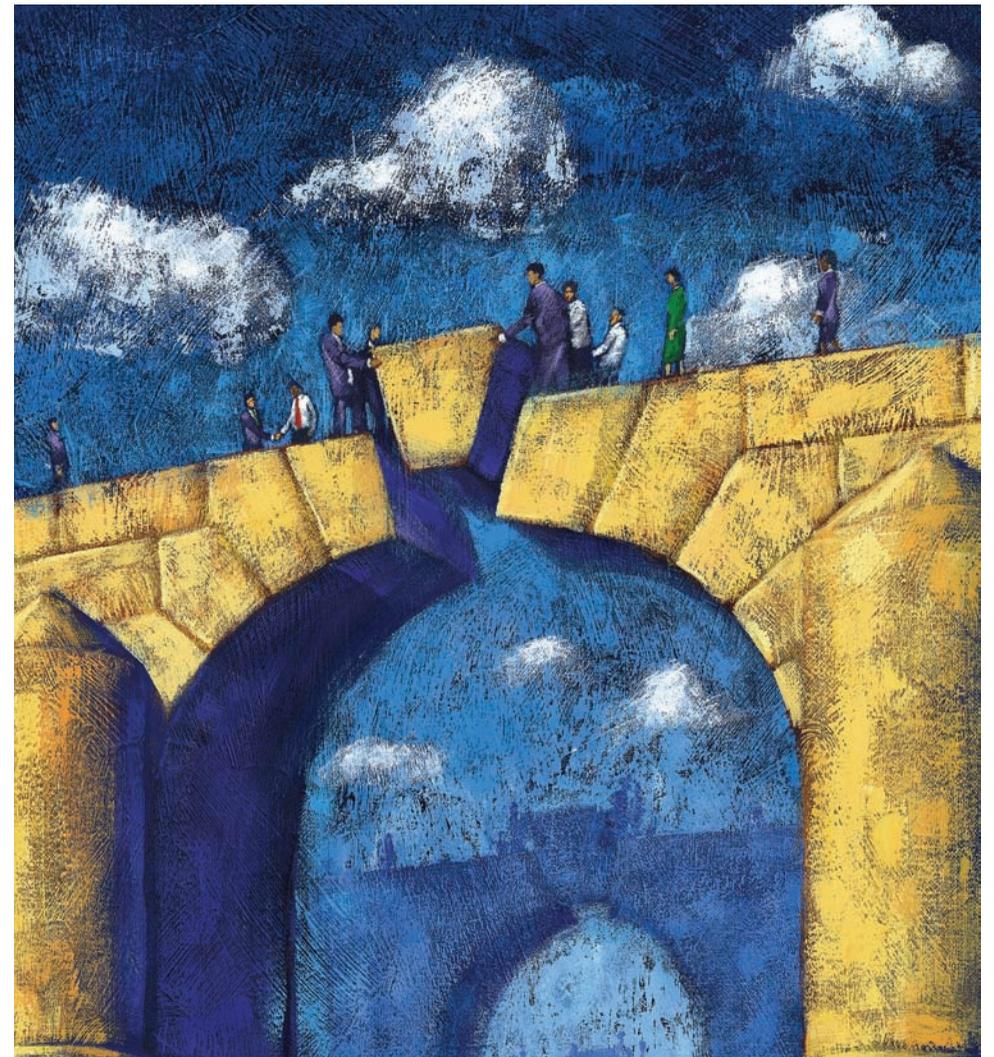


Building the Movement for Community/Academic Partnerships

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- **COMMUNITY-BASED PARTICIPATORY RESEARCH (CBPR)** in health is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities.

Definition developed and adopted by the Community Health Scholars Program based upon Israel BA, Schulz AJ, Parker E, Becker AB in "Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health," Ann. Rev. Public Health. 1998. 19:173-202.

A few years ago, we compiled a booklet telling stories of impact from the Community Health Scholars Program (CHSP). The stories demonstrated how the research projects carried out by the scholars and their community partners have made significant differences in the lives of everyone involved.*

Today, the CHSP's impact can be seen beyond the scope of the research projects themselves. At the universities where alumni have taken faculty positions, at community-based organizations, and at high levels of policy-making bodies, the idea has taken hold that the unique strengths of universities and communities can be harnessed to address public health problems. Once practiced sporadically and viewed with skepticism, community-based participatory research (CBPR) has, in the past decade or so, grown in acceptance and risen in visibility. The CHSP has been a driving force in bringing about that change.

The pages that follow reflect something of a "state of the state" of CBPR, now that the approach has reached a critical mass of evidence and institutional support. No one disputes that great strides have been made, and no one disputes that more needs to be done to keep the momentum going and achieve the full promise of community/academic partnerships. Toward that end, continuing the Community Health Scholars Program as a seedbed for future CBPR leaders is, for many, a top priority. "The more people with passion for this and who understand this," says program evaluator Norge Jerome, "the better off we are."

When CBPR practitioners talk about their work, their belief in the approach and the gratification they derive from it is striking. CBPR has clearly become part of how they think of themselves professionally. "People say, 'Public health – do you work with restaurants?'" says former scholar Stephanie Ann Farquhar, now assistant professor at Portland State University. "No, I work with community groups to study health problems and create solutions." Because they've seen results, many community-based organizations now view such collaborations as a regular part of their operations. They benefit from the resources that university partners bring and also welcome the opportunity to share their knowledge with them. "This is education all around," says Emmanuel Price, director of Community Building in Partnership, Inc., in Baltimore. "Everyone grows."

Those who were early advocates for CBPR can take satisfaction in the recognition it enjoys today, but it's no time to sit still. Rather, the moment is ripe to parlay the current enthusiasm into broad, lasting institutional support for CBPR, so that all that's been gained isn't lost.

"My hope," says Tom Bruce, one of the founders of the movement for Community/Academic partnerships, "is that the movement becomes increasingly contagious. Everybody needs to keep beating the drums and blowing the bugles to do this if we're going to make people healthier."

* To obtain a copy of "Stories of Impact," contact the Community Health Scholars Program National Office, at (734) 647-3065 or chsp@umich.edu.



In Community/Academic Partnerships, Agencies Call for the “Big P” – Participation

In 1991, the W.K. Kellogg Foundation proclaimed its support of community/academic partnerships by launching its Community-Based Public Health Initiative. In funding collaborations among community-based organizations, public health departments, and schools of public health around the country, the foundation endorsed the idea that complex health problems require the combined resources of the community and the academy.

When a major foundation moves in a certain direction, people take notice. While community-based participatory research (CBPR) certainly existed before 1991, Kellogg’s initiative helped create momentum that has grown over the years. Today, as never before, CBPR is part of the national discussion of public health. Federal agencies, such as the National Institutes of Health (NIH), the Centers for Disease Control (CDC) and the Agency for Healthcare Research and Quality (AHRQ), have put significant funding into grants that require community/academic partnerships. The American Public Health Association (APHA) now hosts a Community-Based Public Health Caucus, which has sponsored presentations to standing-room-only crowds at the association’s national conference. And Kellogg has followed up its support by funding the Community Health Scholars Program (CHSP), which enriches the field by training post-doctoral fellows in CBPR skills.

If money talks – and no one denies that it does – there’s a lot to listen to.

At the end of 2004, the NIH, CDC, and AHRQ jointly issued a call for proposals that read like a CBPR dream: “Community-partnered approaches to research promise to deepen our scientific base of knowledge in the areas of health promotion, disease prevention, and health disparities.” Proposals were required to demonstrate that community partners would be given the opportunity to be full and equal participants in the conception, design and execution of all parts of the research project – welcome words to community-based organizations. In many projects, Lucille Webb, executive director of Strengthening the Black Family Inc. in Raleigh, North Carolina, has seen ranging degrees of the P – “participatory” – of CBPR.

“Some have big P, some have little p, some have no p at all,” says Webb. “We like the big P.”

Apparently, so does the CDC. Alice Ammerman, director of a CDC Prevention Research Center in North Carolina, says that with each round of funding for her center, the agency has placed greater emphasis on CBPR and the translation and dissemination of research. In 2002, the CDC’s interest in CBPR firmly established itself with a major grant program – \$11.4 million for 25 CBPR projects. It was the first time the CDC had explicitly required community-partnered research into disease prevention and health promotion.

“There’s so much that’s been discovered and understood and described that never makes it into practical application,” says Ammerman, also assistant professor of nutrition at the University of North Carolina. “The idea is to enhance that part of things.”

It’s an idea that dovetails with the CHSP’s mission. As an organization and through the advocacy of its alumni, the program has been instrumental in bringing CBPR to national prominence. It played a key role in creating a Community-Based Public Health Caucus within the APHA, assuring that, as program evaluator Norge Jerome puts it, “the podium will be shared” during research presentations at the national conference. “Two voices in unison, one in academia and the other in the community,” Jerome says, “to demonstrate to whoever wants to observe and understand that this is the way you bring about change if you’re concerned about elevating the health of the public. Our alumni are the ones who are organizing these things. Planning sessions for APHA and reviewing abstracts – those ideas come from our scholars. They play a leadership role in that.”

Stephanie Ann Farquhar, a past scholar and now assistant professor of community health at Portland State University, has taken part in discussions with groups such as the Congressional Black Caucus about the benefit CBPR can have for their constituents. “The research Congress uses to make decisions about health care is driven by a medical model,” she says. “We wanted to find out how we can present community-based approaches and make them palatable to policymakers.”

Congress may seek out more community-based approaches as a natural result of a process, begun under President Clinton and recently completed, of doubling the NIH budget. “Now, Congress and the public are saying, OK, we just made this humungo investment; what are we getting?” says Sarena Seifer, executive director of the national organization Community-Campus Partnerships for Health and a research assistant professor of health services at the University of Washington. “CBPR naturally pops up in those conversations,” she adds, because of its focus on putting research results into practice in order to improve health. Seifer is a member of CHSP’s National Advisory Committee.

After completing the Community Health Scholars Program, Kaytura Felix-Aaron took a position with the AHRQ. In her years there – she now works for another federal agency – she saw “a shift in recognizing CBPR as an important approach that has value, not something you do just to be nice. It’s something that contributes to the quality of the information you get and increases the possibility that that information will be used.” Considering that AHRQ’s mission is to improve health care for all Americans and that it awards some \$150 million in grants annually, it’s a good place for the CBPR message to be spread.

“Two voices in unison, one in academia and the other in the community, to demonstrate to whoever wants to observe and understand that this is the way you bring about change if you’re concerned about elevating the health of the public.”

Certainly, Felix-Aaron herself was instrumental in raising awareness at AHRQ. She also played a crucial role in the agency's compiling of a CBPR evidence report, which grew out of a meeting convened at AHRQ in 2001. With increasing interest in and monetary support for CBPR, the group gathered at the meeting – representing several federal agencies and the Kellogg Foundation – wanted to get a better handle on it: What defines CBPR? How is it being implemented? How should CBPR grant proposals be reviewed? Have there been concrete health improvements because of CBPR? With her network of contacts, Felix-Aaron was able to pick up the phone and enlist CBPR veterans from universities, community groups and government agencies to help with the evidence report, which eventually reviewed 298 CBPR studies.

“There was nothing like that up to that point,” says Felix-Aaron, now chief of the Clinical Quality Data Branch of the Division of Clinical Quality in the Bureau of Primary Health Care. “Individual people were reporting on their work and how wonderful it was, but there was no objective overview of the whole field.”

Published in 2004, the report is an important document that reflects the state of CBPR today and, as much as any publication, indicates that CBPR has reached a critical mass from which some agreed-upon principles have emerged.¹

The report defines CBPR as a “collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change.” While these collaborations necessarily vary according to an individual project's and community's needs, the report notes, there is a consensus on two distinguishing characteristics of CBPR: “a reciprocal, co-learner relationship between the researcher and the researched”; and “the immediate and direct benefit of using new knowledge for taking collective action and effecting social change.”

Which leads to the big question: Does CBPR work?

While practitioners, both from the community and from the academy, report great satisfaction with CBPR as a process and as a vehicle for building relationships, they acknowledge that there are no studies that conclusively show that, because of CBPR, people are healthier. Those studies will need to be done, says Noreen Clark, dean of the School of Public Health at the University of Michigan.

“It's not enough to work with a community and have a good process,” she says. “If this is all going to move us forward, there have to be some specific health outcomes associated with CBPR.” Concrete results will help in championing the approach with funding agencies. “If funding agencies lose interest, it will be extraordinarily difficult to do such work.”

There's general agreement about the need to produce studies that show a direct connection between CBPR and public health, but it will take some time for those to emerge. An individual project might result in, for example, a local education effort to teach parents how to reduce the risks of asthma for their children, or the building of a community center that supplies free information on nutrition. Quantifiable health impacts from such efforts take years to determine. As Tom Bruce, a founder of the recently opened College of Public Health at the University of Arkansas, points out, “It took millions of dollars in national cooperative research efforts and decades of analysis to prove that lowering blood pressure reduced strokes.”

The lack of a definitive study, however, doesn't prevent CBPR practitioners from seeing the health improvements taking place right in front of them. On Detroit's southwest side, a project involving a current CHSP scholar and Detroit's Community Health and Social Services Center (CHASS) has involved adults in exercise classes, walking clubs, dance clubs and other efforts to promote exercise and better nutrition. Since the project began, the levels of diabetes hemoglobin among the target population (150 adults) are down, says Ricardo Guzman, CHASS executive director.

Substantive changes in health behavior don't happen overnight, says Meredith Minkler, professor in the School of Public Health at the University of California, Berkeley. But she's confident that policy changes being brought about now because of CBPR will eventually produce measurable health improvements.

“A CBPR project that gets a moratorium on industrialized hog factories, which are known to cause respiratory problems in a community, that change will show a health impact,” Minkler says, referring to a project in North Carolina in which CHSP scholars have participated. Another CBPR project in southern California resulted in a 75 percent reduction in the level of allowable toxic emissions. Healthier policy, which opens the door to healthier behavior.

“...two distinguishing characteristics of CBPR: a reciprocal, co-learner relationship between the researcher and the researched and the immediate and direct benefit of using new knowledge for taking collective action and affecting social change.”

¹ Viswanathan M, Ammerman A, Eng E, et al. *Community-Based Participatory Research: Assessing the Evidence. Summary.* Summary. Evidence Report/Technology Assessment: Number 99. AHRQ Publication Number 04-E022-1. August 2004. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/epcsums/cbprsum.htm>

Collaborating with Universities, Community-Based Organizations Elevate Their Vision

Most community-based organizations, says Alex Allen, start out with what he calls a “neighborhood-focused” approach: They zero in on one or two health problems and work to improve them. Allen – formerly executive director of the Butzel Family Center in Detroit and now vice president of community planning and research at Isles, Inc., a community development and environmental organization in Trenton, N.J. – used to operate that way himself. But over time, he came to see that while a local success is important, it’s “a small dent in the greater scheme of things.” To truly improve the quality of life in a community – what any community-based organization wants most – local groups, Allen says, need to understand and influence policy.

His view expanded, he says, as a result of partnering with university researchers.

“Working with university researchers opens your eyes to things like social determinants of health and how social factors affect a community,” Allen says. “It broadens your perspective on what you can or can’t do.”

At one time, partnering with university researchers was about the last thing Allen, and many other CBO leaders, wanted to do. Mistrust of academia ran deep after too many projects in which communities served as research subjects but never benefited from the results. Community-based participatory research (CBPR), particularly as espoused by the W.K. Kellogg Foundation and the Community Health Scholars Program (CHSP), has significantly reversed that situation. Working in full collaboration with their partners from the academic world, CBOs are involved in all stages of CBPR, from shaping the questions to translating the findings into practical use.

In the seven years since the CHSP began, relationships between the three schools of public health – from the University of Michigan, Johns Hopkins University, and the University of North Carolina – and their partnering organizations have considerably matured. CBOs report greater satisfaction with the research experience and hope to see the program enlarged, so that more faculty members and policymakers with a CBPR outlook will populate the land. Long past their previous misgivings, CBOs have grown in the way Allen describes – they’ve become more effective and savvy in bringing about change in the populations they serve, and they’ve also become instrumental in promoting CBPR at a national level. And while it’s still too early to determine that efforts resulting from CBPR projects have made long-lasting changes in health, many CBO leaders have seen enough progress on the ground to affirm their confidence in the approach.

“Organizations that develop a good partnership with a university, over time, get better at understanding how to do research, how to frame what the questions are, so researchers can help their organizations,” Allen says. And the teaching goes both ways; researchers learn from CBOs the crucial skill of engaging community members, and gain insight on handling CBPR-related administration challenges.

If partnering with universities has changed the way his organizations operate, Allen says, it’s because those partnerships have changed him. Not only did Allen’s former organization host CHSP scholars, but he has served on the CHSP’s National Advisory Committee since its inception. He’s become much more aware of and interested in the impact of social policy on local issues. Currently, one of his main responsibilities is organizing groups in central New Jersey around issues of tax policy and housing equity. CBPR is usually his preferred method of working, but CBPR “is just one kind of research,” he says. “I’m even open to non-CBPR research methods, as long as they’re ethical, if that’s a better fit” for remedying a particular issue.

Since its inception, Community Building in Partnership, Inc. (CBP) in the Sandtown/Winchester neighborhood of Baltimore, has worked with the Bloomberg School of Public Health at Johns Hopkins, a relationship that has improved since the advent of the CHSP, says Director Emmanuel Price, also a member of CHSP’s National Advisory Committee. “We deal with each other more intimately now,” Price says. Their CHSP projects have studied, among other topics, rheumatism, mental health and, most recently, the influence of media images on adolescent girls. Getting the community to agree to the first study, on rheumatism, wasn’t easy. “The people of Sandtown have felt over the past ten years that they’ve been poked and prodded,” Price says. Securing the community’s cooperation has gotten easier with each project, as a track record of trust has been built with the scholars.

Interactions with scholars have had benefits beyond the objectives of any single project. The scholars are “young professional people of all races,” Price says. “They often work with our youth and young adults, who see them and say, ‘Hey, they’re just like me.’ That increases exposure to professions that our youth know about and could aspire to. Sometimes I think that personal interaction is, for our young people, the most important thing that comes out of our partnership.”

A key for his organization, Price says, is spacing out research. Too many consecutive studies “make people feel manipulated and used,” he says. He advises academic researchers: “Stay engaged in the community, but don’t always be doing studies.”

Between studies, Hopkins has helped CBP apply for grants or attract guest speakers, and interns have assisted at its after-school program. “They help us all across the board,” Price says. That help has been particularly welcome in the wake of budget cuts in recent years. “What the relationship gives us is resources, information, assistance and sometimes personnel that we wouldn’t have access to in any other way. They help us fill in the gap.”

“The practice (of community/academic partnering) should expand not because an academic partner is helpful to a particular CBO, but because communities and universities, marshalling their resources toward a common purpose, can impact the health of the nation. ... We’re past the show-me stage. It works.”

SOLO BUILDINGS

Please check and see that I got these revisions in first paragraph correct??

Thank you

“It’s not just signing on the dotted line and saying we’re partners, but really partnering, with all the give-and-take of a relationship.”

Lucille Webb, executive director of Strengthening the Black Family, Inc., a CBO based in Raleigh, North Carolina, and another member of CHSP’s National Advisory Committee, has seen how her organization has been elevated by its relationship with the University of North Carolina. Strengthening the Black Family recently landed a half-million-dollar grant from a local public hospital to study how often the hospital is used for primary health care. “Ours was one of the few applications that had a university public health department as a partner,” she says. “And the hospital was willing to do this project with us because we had contacts with the university.”

Recently, Webb served as an investigator for the federal report, *Community-Based Participatory Research: Assessing the Evidence*. Funded by the Agency for Healthcare Research and Quality and published in 2004, the report was the first comprehensive evidence review of CBPR. “It was something the field needed,” Webb says. She then took part in presenting the report at the annual American Public Health Association conference. “We had people all out in the halls. They couldn’t get in that room.”

Webb believes that the CBPR projects her organization has partnered on have raised awareness of health issues in her city. “Ten years ago, you would have not heard persons in southeast Raleigh acknowledging diabetes,” Webb says. “They would have said, ‘I have a little sugar. I’m on the borderline.’ Or they would not say anything at all about having it. The burden was just too great.” Now, menus in churches have changed and kitchen staffs at local organizations have been trained to prepare healthier food. “I think we’ve had an impact,” Webb says. “What the quantitative data will show may be something else, but from my standpoint, my own personal experience, it’s certainly had an impact on making us aware and changing our behavior.”

Participatory research “pushes the envelope” of academic/community partnerships, says Ella Greene-Moton, assistant director of the Flint Odyssey House Inc. Health Awareness Center in Flint, Michigan. Both sides must candidly discuss issues of trust and respect if the project is to succeed, she says. “It’s not just signing on the dotted line and saying we’re partners, but really partnering, with all the give-and-take of a relationship,” she says. “Early on, we had to admit that everyone has an agenda. The university has one, the CBO has one. We each have goals, and sometimes those goals are not the same. We must listen to each other and know what we need to have and what we need to compromise on.” For example, she says, they love their current CHSP scholar so much that it was tempting to ask him to do more and more. But as his community advisor, one of her responsibilities was to keep their expectations realistic in order for him to succeed.

One major way the relationship with U-M has benefited Odyssey House as an organization, says Greene-Moton, is improving the way it handles evaluations, a crucial component of any project but, involving much tedious paperwork, one that was all too easy to neglect. Working with academic researchers drove home the importance of evaluations, not only to ensure the quality of the research but because many of the grants they applied for required a clear-cut evaluation piece. “I remember ‘evaluation’ used to be a dirty word,” says Greene-Moton. “Now, it’s part of the process from day one. You think about it; you talk about it. It has made a huge difference in the way we approach projects. Even if we’re not at the point where we’re documenting as well as we could, we’re better than we were.”

This was the first year Greene-Moton has served as a mentor to a CHSP scholar. “It was kind of unnerving at first to think in terms of mentoring a person who has his doctorate,” she says, “but then I realized that he’d gone through the schooling and still needed to learn different aspects of working with the community, that hands-on piece. I was honored to be able to fill that role.”

She’d like to see more communication between a scholar’s community and academic mentors who, she says, have worked in a “vacuum” in the past.

When Ricardo Guzman, executive director of the Community Health and Social Services Center in Detroit, first discussed CBPR a dozen or so years ago, “there weren’t many listeners,” he remembers. “The issue of whether the work that was valid or rigorous enough always raised heads. That’s not to say that it still doesn’t, but what you now see, as opposed to being an anomaly, CBPR comes up more consistently in (requests for grant proposals), and community-based issues are becoming part of the core curriculum within the schools. Once that happens, it legitimizes the process.”

The only shortcoming of the Community Health Scholars Program, in Guzman’s view, is that it’s too small – a few scholars a year at three universities. “Man,” he says, “we need more than that.” Webb and Allen also believe that community involvement should spread to other schools and departments on campus. “It can’t just be the ten or twelve people at the School of Public Health,” Webb says. “It has to be the whole university.”

The practice should expand not because an academic partner is helpful to a particular CBO but because communities and universities, marshalling their resources toward a common purpose, “can impact the health of the nation,” says Guzman. “We’re past the show-me stage. It works.”



No Longer An Academic Anomaly, CBPR Gaining Ground on Faculties

A few years ago, Craig Lehmann had barely heard of community-based participatory research, but he was about to discover that CBPR was exactly what he needed.

Lehmann, dean of the School of Health Technology and Management at Stony Brook University in New York, tracks the impact of a technology called TeleHealth – a laptop computer that screens blood pressure, heart rate and other vital signs. The information is monitored by off-site health professionals who can order treatment if they detect health problems. Riverhead, a low-income community near Stony Brook with a large uninsured population, particularly stood to benefit from TeleHealth’s mobility and early-diagnosis potential. The question, Lehmann says, was how to bring the technology where it was needed.

A colleague suggested going out to local churches and meeting with reverends, who knew Riverhead’s health needs better than anyone. It was a new approach for Lehmann, a clinical biochemist by trade, but he agreed. The meetings were so productive that the research took a much stronger community focus, especially once Lisa Benz Scott, an assistant professor who had been a post-doctoral fellow in the Community Health Scholars Program (CHSP), came on board. “She was a lot more well-versed in this than any of us,” Lehmann says. Benz Scott organized a meeting of academic researchers and community leaders “and really pulled this whole thing together.”

With a grant from the W.K. Kellogg Foundation, they created Project CARE, a partnership among the School of Health Technology and Management, the First Baptist Church of Riverhead, United Comprehensive Care clinic, and Central Suffolk Hospital. Project CARE aims to link underserved residents to existing medical and social services by installing TeleHealth systems in community settings. To date, fourteen systems have been set up, available any time to anyone.

The experience has galvanized Lehmann into a champion of community/academic partnerships. “I’m a clinical chemist,” he says. “I would have never known how to get to the community; I never even would have thought about the church. But you can do so much more when you approach it from this angle. I found out some of their problems and their strengths that I never would have uncovered.”

Once espoused by just a scattering of people and given little credence within academia, CBPR today enjoys greater acceptance than some of its early practitioners could have ever imagined: Faculty members with community-building skills are increasingly sought after. CBPR papers are being regularly published in journals and presented at the annual meeting of the American Public Health Association, demonstrating a growing

recognition of the scholarly rigor of community-based participatory research. More funding agencies are supporting CBPR and even requiring a community partnership component in proposals. A textbook published in 2003, *Community-Based Participatory Research for Health*¹, compiles knowledge on theory, practice and skills, and gives teachers of CBPR a long-awaited tool in the classroom. There’s even a new college of public health – at the University of Arkansas – founded entirely on community-based principles.

CBPR’s appeal is expanding due to “a recognition by more and more people that the way the system currently works isn’t working,” says Sarena Seifer, executive director of the national organization Community-Campus Partnerships for Health and a research assistant professor of health services at the University of Washington. “Research isn’t being translated into practice. Knowledge in academic journals doesn’t reach that many people.” Randomized clinical trials, she adds, often fail to reach communities of color, because patients who mistrust researchers don’t want to sign up for the studies. Further, the questions asked and the methods used often don’t reflect community priorities. “So we need to rethink how we engage with communities in this work.” CHSP alumni, she notes, are well-positioned to lead academic institutions in this transformation.

Many reports over the past decade or so, Seifer says, urge health professionals – whether in public health, medicine, nursing, pharmacy, dentistry, or allied health – to learn and serve in communities as part of their training. As just one example, a 2002 report by the Institute of Medicine² recommends that all schools of public health actively engage with communities, and that federal agencies fund CBPR. The opportunity for community engagement also appeals to students who prefer to learn from experience in addition to PowerPoint presentations in the classroom.

“We’re at a time where all the different evidence and experience is coming together,” Seifer says, “and it’s pointing in one direction: community/academic partnerships are central to what needs to be done.”

Despite these encouraging signs, challenges remain. With a few notable exceptions, most universities don’t consider community-based work when granting tenure or promotions, forcing CBPR-minded faculty members, in the interest of professional vitality, to balance their community work with more traditional research.

A few years ago, the University of North Carolina added public health practice, in addition to teaching and research, as an important criteria for tenure. “That was a pretty major institutional change,” says Alice Ammerman, associate professor of nutrition at UNC. “But it’s still a challenge. It takes a lot of time and energy to do the community-based work and do it right.

“We’re at a time where all the different evidence and experience is coming together, and it’s pointing in one direction: community/academic partnerships are central to what needs to be done.”

¹ Minkler M, Wallerstein N, eds., *Community Based Participatory Research for Health* (Jossey-Bass, 2003)

² Institute of Medicine, *Who Will Keep the Public Healthy?* (National Academies Press, 2003)

recognition

You need thoughtful planning about how you enter your career so you do the necessary steps to get tenure without giving up a CBPR focus.” She commends the CHSP, the pre-eminent training ground for scholars going into this kind of work, for taking into account the necessity for such a balance.

Meredith Minkler, a professor in the School of Public Health at the University of California, Berkeley – who, with Nina Wallerstein, edited the recently published CBPR textbook – calls the greater acceptance of community/academic partnerships a “lovely surprise,” something she couldn’t have predicted when she began doing CBPR about 15 years ago. At Berkeley, however, CBPR remains “the weak orphan” in terms of prestige, she says, and she doesn’t see this changing soon. “On the tenure committees, you tend to get people doing traditional research making the decisions about what kind of research counts,” Minkler says. For that reason, and because of the time involved in CBPR, she advises untenured faculty members to combine their participatory research with other, more widely accepted forms of research.

While tenure remains a frustration, most CHSP alumni are not hindered in finding a job or incorporating their interests into their lives as faculty members. Lehmann, for one, has seen the difference even a single person with CBPR skills can have on his entire school, where most of the faculty members are scientists who approach issues from the angle of their own discipline. “As dean, I’ve been trying to bring them together as a whole, and it’s very difficult,” Lehmann says. “People like Lisa can bring them together more easily by saying, ‘Take everything you have and look at it as what you will bring to the community.’ It’s an ability to think differently than many of us here can. When she talks to you and you hear about community and empowering the community and how that improves your outcomes, it’s amazing. If I had three more people like that, we could really do some great research projects that would yield important knowledge while benefiting communities.”

Katherine Alaimo has found a very live-and-let-live attitude at Michigan State University, where she’s an assistant professor of food sciences and human nutrition. While many faculty members aren’t familiar with the type of research she does, “I haven’t had a hard time at all with people being accepting of what I do.” In fact, students have sought her out to ask about CBPR, and she recently gave a seminar to her entire department about a community gardening project she worked on as a CHSP fellow. Her seminar involved an explanation of CBPR.

“In a school of public health, there’s this medical model that people traditionally follow, so you can feel like you’re going against the grain if you do community work,” Alaimo says. “I’ve found that at a land-grant university, with a history of the extension system, they are very open to community work, even if they are not familiar with CBPR.” While interviewing for her position, she says, CBPR didn’t really come up. However, she says she wouldn’t have accepted a job at a place that discouraged it.

“It isn’t enough for a project to simply be located in a community; the community has to help shape the research questions from the beginning.”

Stephanie Ann Farquhar, another program alumna, says that when she was interviewing for academic positions, “I was very vocal that this was work I had to do.” She landed in a hospitable place: Portland State University, where she’s now an assistant professor in the School of Community Health. A sign at the entrance to the Portland State campus reads, “Let Knowledge Serve The City,” reflecting the university’s focus on interaction with its urban home. The school periodically brings in civic and business leaders to campus for “umbrella tours.” On one such tour, Farquhar was one of the featured speakers, chosen precisely because of her community work.

She’s not the only one to discover that CBPR can create good buzz for universities – especially publicly funded ones – seeking to shed their ivory-tower image. When the chancellor of the University of North Carolina caught wind of a project involving cancer education efforts taking place in African-American hair salons, he excitedly offered himself – bald pate and all – for a photo op to demonstrate the school’s involvement with the community. A sign of the broader awareness of CBPR is the degree to which the word “community” has seeped into the academic lexicon. Veteran CBPR practitioners report of hearing colleagues describe their own community projects – although often without the “participatory” part, which most would say is what makes CBPR CBPR.

“I was at a dinner party, and a physician sitting across from me said he was doing CBPR on obesity in the community,” says Norge Jerome, the CHSP’s external evaluator. “I asked him how he was doing it, and, of course, he wasn’t doing it.” Why? He was using a top-down approach that did not include the community as partner or involve members in defining obesity as a problem. It isn’t enough for a project to simply be located in a community; the community has to help shape the research questions from the beginning. “We can’t say, ‘Obesity is a problem,’ and go into a community and do work,” Jerome says. “They’re the ones who have to say, ‘Obesity is a problem here, and we want you to work with us to improve that.’”

As the practice of CBPR matures, more communities are initiating projects in just that way. Having done several CBPR projects in Michigan, Alaimo’s name is well-known enough among community groups that she can wait for them to contact her. And while she thinks of CBPR as “the democratization of research” and talks about it every chance she gets, she’s also come to understand that community partners don’t need to be involved in every last detail of a project. “Often, community partners are not interested in the details or don’t have the time,” she says. “They may not want to help with the analysis, or they may not care about participating in every aspect of your research design – they just want results. So I’m being more relaxed about that. I think I was overzealous at first.” Farquhar agrees that no single CBPR approach applies in all instances; the model has to be determined by what’s best for a particular partnership.

While happy to see CHSP alumni move into faculty positions at what she calls “enlightened health sciences departments,” Jerome can’t help but note their conspicuous absence at many of the top-rated, long-established schools of public health. It’s an area where she’d like to see improvement. “When they hire them as an assistant professor on a tenure track, I will say, mmhmm, they understand and value CBPR for its added value to public health. They’re going to wake up one day, I believe, when they see the kind of work that our highly talented alumni do.”

That kind of work is exactly what the new college of public health at the University of Arkansas has been set up to encourage. Opened in 2000, the college was part of a package of initiatives funded by the state’s tobacco settlement money. Community work and participatory partnerships are embedded into every aspect of the school, says Tom Bruce, who served as inaugural dean. The college has established ongoing partnerships with three communities – one in the Mississippi Delta, one a rural African-American population, and one an urban Latino population – and tenure and promotion guidelines, he says, are built around the need to show scholarship in community-based approaches.

Bruce, who also served as dean of the University of Arkansas School of Medicine, was working at the Kellogg Foundation when the idea of the Community Health Scholars Program first surfaced. He’d been talking with other deans about why their schools couldn’t do more community work. The deans said they lacked people with the skills; any faculty members who knew how to do CBPR got weeded out in the tenure process. The Community Health Scholars Program was launched to fill that void.

Now, Bruce says, “very few schools wouldn’t love to have a graduate of this program.” To him, it’s not especially surprising that alumni have found jobs in places other than schools of public health. “Sometimes, in established schools, there’s no good place to put people with this experience. It really is kind of a cross-cutting arena. So they usually land where some of the more adventurous faculty leaders want to move this idea to the fore.”

What comes up time and again in discussions of the Community Health Scholars Program is how important the program has been in – true to its name – creating a community of scholars across the country, connected by their dedication to CBPR. The very existence of a post-doctoral training program testifies to CBPR as a legitimate research approach, says Seifer. “It’s telling the rest of the field that there’s rigor to this and there are competencies to be acquired. It’s not something to be done on the fly. This program is developing a pipeline of leaders who have these skills.”

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