



A Split Second of Celebration

Foster PP*

Community and Rural Medicine and Institute for Rural Health Research, The University of Alabama, USA

*Corresponding author: Pamela Payne Foster, MD, MPH, Community and Rural Medicine and Institute for Rural Health Research, The University of Alabama, 107B, Medical School, Tuscaloosa, AL 35487, USA, Tel: 205-348-5148, E-mail: pfoster@ua.edu

Received date: Mar 15, 2016; Accepted date: Mar 25, 2016; Published date: Mar 30, 2016

Copyright: © 2016 Foster PP. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Commentary

Recently I was sitting in a brainstorming session in Alabama coming up with ideas for future community based participatory research (CBPR) and heard a comment that made my heart and soul leap for joy! The session was not a typical one where a bunch of academic types with terminal degrees like PhDs, MDs, or JDs sit around the table and review the literature on issues of interest, then strategize and plan out ideas and write a research proposal for future funding. Usually the person leading the efforts is thinking about how this grant will fit into their own academic career goals. Or sometimes, administrators at the university will see a grant proposal which can enhance funding for departments and individuals within the University. So a Dean or a Chair or Division head may send the proposal to certain faculty member to pursue. Even if it is a grant where community partners are required, the community may not initiate the plan; they are usually pulled in after discussions have gone on at the academic level with a variety of players.

But this particular brainstorming session was different. In this meeting, the session was being led by a community member: a rural hospital administrator of a small hospital in Alabama with 33 beds. In addition to this hospital administrator, there were two other colleagues: one in Nursing, one from Psychology, along with me in Medicine. And the academic team wasn't traditional academicians: we all had varying experiences in CBPR (community based participatory research). So, we all professed to being at the table not with our professional motives (publications and grants in order to maintain or gain tenure and promotions) but with the motive of seeing real impact and sustainability for health promotion and disease prevention to decrease health disparities in the rural Deep South. I believe we took this charge seriously.

So when we began to brainstorm on potential settings for our work, someone mentioned the "Black Church." Because I have spent an incredible amount of time conducting HIV prevention in Black rural churches, I got excited! We talked about potential structures within the Black Church in our targeted rural community. I thought about some of the churches I had been working in throughout Alabama: some had parish nurses, some health ministries, but most did not. But I did remember that many also had nurse's guilds: these were women in white uniforms, some nurses in their profession, some not, but were women who were responsible for assisting those people who may have been "slain in the spirit and passed out." Often the nurse's guild would offer tissues if people were crying or place a blanket over persons who were lying on the floor. Those in the nurse's guild were natural helpers and a structure within the church to assist in organizing around health promotion and disease prevention. But before I could get an affirmation of this suggestion, the community person on the team, quickly shot it down and said none of the churches in her rural community had nurses guilds. In other words, despite my community

experience, "she was the community expert" and she did not agree with my assumption. In that split second, I said, "You know, you are probably right; I think I better listen to the expert." Although it is never easy to be corrected, I was happy for two reasons. First, her response is why we were meeting in the first place.

Barbara Israel and her colleagues in Michigan, who gained early experience in community-based participatory research, have identified nine key principles of community-based participatory research that support successful research partnerships and are widely cited [1]. They include:

- Recognizes community as a unit of identity
- Builds on strengths and resources within the community
- Facilitates collaborative, equitable involvement of all partners in all phases of the research
- Integrates knowledge and intervention for mutual benefit of all partners
- Promotes a co-learning and empowering process that attends to social inequalities
- Involves a cyclical and iterative process
- Addresses health from both positive and ecologic perspectives
- Disseminates findings and knowledge gained to all partners
- Involves long-term commitment by all partners

The hospital administrator embodied most of the principles identified in the nine key principles. She represented the "C" in CBPR. None of us in academia are the "C". We might be able to approximate the C with our experiences but no matter how hard we may try, we can never replace those who live the experiences. In CBPR, the "true representation of the community" is the goal because it (facilitates, enables or secures – pick one) the people we are trying to impact. If it is rural African Americans living in the Deep South, we need those individuals as a part of our team. If not, we will miss the opportunity to have the real life translational outcomes that we so desperately need to address, and eventually eliminate health disparities.

The split second encounter also took me back to a recent video that I had just shown to community members describing CBPR. The video described a CBPR project in Detroit called the Urban Research Center Project [2]. In the video, Dr. Barbara Israel, who is the Principal Investigator and Professor in the University of Michigan School of Public Health said, "As academicians we are trained in a particular culture which is counter to the CBPR culture. We have to learn to un-learn our academic culture." I believe she was saying that "we who are in academia are always right; we are always the experts; we always have the answers". In CBPR, we have to acknowledge that we need help with the answers, we need help with the solutions, we may need to rely on community members who have more expertise than us on matters of their communities. In fact, I have learned that the persons from the

academy or other partner non-community institutions (health departments, hospitals, clinics, etc.) who master CBPR the best are those who do very little talking and a lot of listening. This is counter to a culture especially in academia where we do all the talking and very little listening. In that split second, I celebrated that this community leader felt empowered enough to use her expertise to correct us and guide us on the right path.

Secondly, I also was happy because this was happening in the rural Deep South, where community members are very polite and don't want to seem to contradict those in authority. It is the Southern tradition. Most of my experiences with CBPR have not been in the rural South; they have been in the urban Northeast and South where community leaders feel a little more empowered to "speak their minds." In the same video where the Detroit URC was highlighted, a community partner said, "I come to the CBPR table to be antagonistic. I am distrustful." I understood his comments not to be rude, but to establish respect from other partners who historically have not shown underserved communities respect as an equal partner in research. For example, our research team resided in the same state where the *USPHS Experiment for Untreated Syphilis better known as the Tuskegee Syphilis Study* occurred. The same state where the effects of the study still ring true for many rural African Americans [3,4]. So the need for community voices and opinions to be heard and seriously considered is great.

And even in the literature, the terminology is changing to reflect this change. For example, a recent article by Claudia Baquet, Associate Dean for Policy and Planning and Professor of Medicine at the

University of Maryland School of Medicine, describes a model of community academic engagement or CAE in partnered research and programs which addresses health disparities, tobacco related diseases and increasing public trust in research using a bi-directional model between academia and communities in order to build academic environment and community capacity [5]. This newer model moves academic institutions and communities closer to the goal of producing more and more good CBPR research projects.

So in that split second, I knew that the "C" was evolving even where I was and for that I have a reason to celebrate.

References

1. Israel B, Schulz A, Parker E, Becker A (1998) Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health* 19: 173-222.
2. (2016) Detroit Urban Research Center Project Video.
3. Katz R, Green L, Kressin NR, Keegles SS, Wang MQ, et al. (2008) The Legacy of the Tuskegee Syphilis Study: Assessing its Impact on Willingness to Participate in Biomedical Studies. *Journal of Health Care for the Poor and Underserved* 19: 1168-1180.
4. Brandon DT, Issac LA, LaVeist TA (2005) The legacy of Tuskegee and trust in medical care: is Tuskegee responsible for race differences in mistrust of medical care? *Journal of the National Medical Association* 97: 951-956.
5. Baquet C (2012) A Model for Bi-Directional Community-Academic Engagement (CAE): Overview of Partnered Research, Capacity Enhancement, Systems Transformation, and Public Trust in Research. *Journal of Health Care for the Poor and Underserved* 23: 1806-1824.