



community-based public health

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Bending The Ivory Tower: **Communities, Health Departments And Academia**

INTRODUCTION

Author Suzanne W. Morse is fond of describing two large signs that greet tourists at the airport customs area in a small Caribbean nation: *Belongers and Visitors*. As health professionals and academics interested in partnering with communities, we are indeed visitors to a new world—and our effectiveness will depend in large part on our ability to demonstrate the cultural humility, authenticity and respect for the belongers' strengths and wisdom, that are so central to effective collaboration. In this Brief, the Partnership for the Public's Health provides a thoughtful look at why partnerships between communities, academics and health departments are both promising vehicles for addressing many of today's complex health and social problems, and are often fraught with difficulties along the way. New approaches to partnership are introduced, among them community-based participatory research which "turns on its head" traditional distinctions between the researchers and the researched, makes community members equal partners in co-learning, and is committed to action as a fundamental part of the research process.

A central message of this Brief is to think broadly and creatively about partnerships, remembering that as professionals and academics, we often have access to many taken-for-granted resources that can be of tremendous help to local communities. Making such resources available, demonstrating our appreciation of the many gifts our community partners bring, including their rich knowledge of community history and dynamics, and above all, demonstrating humility in our visitor status, can go a long way toward helping such collaborative relationships achieve their full potential.

— MEREDITH MINKLER, DRPH

The potential and pitfalls of partnership

Communities have always had love-hate relationships with the colleges and universities in their midst. Public universities escape the property taxes communities impose to provide public services. High tuition at private universities often sets them beyond the means of those who live right next door. Some professional staff from local health departments may have adjunct faculty relationships, but most do not. And the world of books and ideas can seem far away when you are dealing with the immediate problems of unvaccinated children and littered alleyways.

So why should these esteemed institutions of higher education be considered potential partners in community-based public

health? This *Policy and Practice Brief* highlights several of the through-roads and detours involved in making such partnerships work.

Being able to use the knowledge gained through academic research to improve the health of their communities is one reason

This is the seventh in a series of policy briefs on the various components of Community-Based Public Health (CBPH) and associated issues. The series is being published by the Partnership for the Public's Health (PPH), a collaboration of The California Endowment and the Public Health Institute.



community groups and public health departments partner with colleges and universities. Playing a role as sites for experiential learning and student community service is another. But, like most partnerships, there are pitfalls as well as potential. Many leaders of community-based public health groups have stories of disappointment and missed opportunities, experiences that foster an unhealthy skepticism about whether academia can be a trustworthy partner in community-based health education, research, clinical care and services.

It is time for communities, health departments and academia to explore new ways of working together. Research and community-based learning are two kinds of relationship. Communities and colleges have plenty of other resources and capabilities that they can share, including training, insights into different cultures and languages, and opportunities for advocacy. This *Brief* will address all of these relationships.

Any partnership should rest on a foundation of equal rights and shared responsibilities for all parties, with the knowledge that they understand each other's expectations and capabilities. Applying these principles should help create lasting partnerships founded on trust, mutual understanding and reciprocity.

CBPR – a new orientation

Today, an approach called “community-based participatory research” (CBPR) is exciting interest among academics, government agencies, departments of public health and CBOs. CBPR is not a research technique in and of itself; rather, it is an orientation to how research is conducted.¹ While there are many definitions of CBPR, they all center on collaboration and the equitable participation of all stakehold-

ers. Other common characteristics include co-learning, empowerment for participants and a balance between research and action. (*See sidebar for more on the principles of partnership.*)

Of the billions of dollars spent on health care research in the U.S., only an estimated \$45 million is allocated to CBPR.² However, that amount is growing, as evidenced by recent funding decisions in support of CBPR made by the Centers for Disease Control and Prevention, National Institutes of Health and the WW Kellogg, Ford and Rockefeller Foundations, among others.³ The development of instruments for appraising the quality of CBPR, including the widely used guidelines framed by Lawrence Green⁴ and his colleagues for the Royal Society of Canada, also have contributed to both foundation and government interest in, and support for, this approach. Recent reports published by the Institute of Medicine recommending that all schools of public health teach CPBR are sure to increase demand.

Meredith Minkler and Nina Wallerstein, co-editors of the new book *Community Based Participatory Research for Health*, cite the call to eliminate racial and ethnic health disparities by the year 2010⁵ as one of the key drivers for CBPR. “There is ample evidence of profound differences in health and life chances along racial, ethnic and socio-economic lines,” they write. “These have been associated with socio-structural factors such as poverty, racism, minimal public infrastructure, lack of employment opportunities and environmental factors, such as air quality and the prevalence of mite allergens, mold and the like in low-income homes. Such realities underscore the importance of creative, new approaches that can address health disparities.”⁶

Principles of Partnership

Founded in 1996, Community-Campus Partnerships for Health is a national network of more than 1,000 communities and campuses that are collaborating to promote health through service learning, community-based research, coalitions and other partnership strategies. Through ongoing dialogue with its members, CCPH has identified nine principles to facilitate and strengthen these partnerships.

1. Partners have an agreed upon mission, values, goals and measurable outcomes for the partnership.
2. The relationship between partners is characterized by mutual trust, respect, genuineness and commitment.
3. The partnership builds upon identified strengths and assets, but also addresses areas that need improvement.
4. The partnership balances the power among partners and enables resources among partners to be shared.

5. There is clear, open and accessible communication between partners, making it an ongoing priority to listen to each need, develop a common language and validate/clarify the meaning of terms.
6. Roles, norms and processes for the partnership are established with the input and agreement of all partners.
7. There is feedback to, among and from all stakeholders in the partnership, with the goal of continuously improving the partnership and its outcomes.
8. Partners share the credit for the partnership's accomplishments.
9. Partnerships take time to develop and evolve over time.

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Articles on each principle are available at www.ccpH.info*





Why academia needs communities

Colleges and universities have several reasons for becoming involved at the community level, including an increased focus on population health and the need to maintain good reputations in the community.⁷ Increasingly, funders require letters of support or commitment from community agencies and other intended research partners as part of an application for funding on projects that will require participation. Calls for more education “experiences where students learn to see their roles more broadly and can facilitate sustainable relationships with others in the community”⁸ are another incentive.

As a result, schools of nursing, public health, dentistry and pharmacy compete with medical schools for access to community sites for training and research activities.⁹ Sarena Seifer, MD, executive director of Community-Campus Partnerships for Health (CCPH) and research assistant professor in the Department of Health Services, University of Washington School of Public Health and Community Medicine, suggests CBOs can take advantage of this shift in emphasis and the strong desire for community involvement by asserting their own desires. “The university is intent on its mission. CBOs need to be equally intent on theirs,” she says. “CBOs must be careful not to get sucked into the university’s agenda. Think carefully about your agenda and use that to drive the conversation with potential academic partners.”

Infrastructure needs for CBPR

In February 2003, CCPH presented findings from a paper commissioned by the National Institutes for Health on the infrastructure needed to conduct and sustain community-university research partnerships.¹⁰ The paper, which drew upon findings from a literature review and telephone interviews with both academic researchers and CBO leaders, looked specifically at issues related to relationships, policies and procedures, financial and human resources and “hard” infrastructure such as computer resources. Many of the findings validate the CBPR principles already recommended by CCPH and other leading CBPR advocates. (See sidebar, page 2.) But the study delved further into the issues that both help and hinder CBPR.

Academic skepticism of CBPR as “soft science,” along with

considerations of tenure, job evaluation, publication and the use of grant money are among the barriers to CBPR from the academic perspective. Among CBOs, mistrust, cultural conflicts, funding pressures and conflicting priorities make CBPR relationships difficult.

Among the things that promote positive CBPR experiences are true power sharing (e.g., co-principal investigators), a project liaison based primarily in the community and shared financial resources, including those for indirect expenses.

“While CBPR partnerships can be challenging,” Seifer says, “we see a number of supportive changes in the environment. For example, federal and private funding agencies are increasingly acknowledging CBPR’s contribution to understanding and solving important public health problems, and consequently investing in such research. Many of the people we interviewed have success stories to tell, which we hope to follow up on in more detailed case studies.”

Challenges and benefits of partnership

Barbara Israel, DrPH, MPH, professor in the Department of Health Behavior and Health Education, School of Public Health, University of Michigan, has practical experience with both the benefits and challenges of CBPR through her involvement with the Detroit Community-Academic Urban Research Center, a partnership involving the University of Michigan Schools of Nursing and Public Health, the Detroit Public Health Department, Henry Ford Health System, and eight CBOs.¹¹

The amount of funding for CBPR is growing.

She uses the example of a survey done with the East Village Healthworker Partnership in Detroit to illustrate how partnering with a community organization can provide academics with a deeper and more authentic understanding of the community. “We wanted to identify sources of stress women were experiencing in their lives. Community members were invaluable in pointing out a number of stressors they experience. We customized the survey instrument and obtained much better results than we would have using only a standard instrument that didn’t include these stressors,” Israel recalls.

Benefits can be both immediate and long-term. In another Detroit CBPR project, poor nutrition and lack of access to affordable food were identified among the factors associated with risk for diabetes and diabetes management. The CBPR partnership, Healthy Eating and Exercising to Reduce Diabetes, obtained funding to establish mini-markets in the neighborhood, where residents could buy fresh fruit and vegetables. These markets filled an immediate need, and the data collected from this and several related CBPR projects was used to make their case for additional



funds to extend these mini-markets, and should have positive long-term public health effects, according to Israel.

Special research programs at the University of California

California has a number of organized academic research programs that encourage and sustain partnerships with CBOs. One example is the Special Research Programs (SRP), Office of Health Affairs, within the Office of the President of the University of California. Headed by Charles L. Gruder, PhD, the SRP comprises three State-funded research programs targeting HIV/AIDS, breast cancer and tobacco-related disease. SRP has funded research in a range of disciplines, including public health and public policy, clinical and behavioral medicine and epidemiology. Administered by UC, grants have been awarded to California's public and private universities, not-for-profit research institutes, for-profit companies and CBOs.

In reaching out to CBOs, Dr. Gruder says “we use a very open definition of community. It may be geographic, as in our Marin County breast cancer studies. It also could be based on ethnicity, race, age or faith. In one of our AIDS studies, the community is inmates of San Quentin. Whatever the community, we want to make sure that we have a sincere partnership, based on mutual respect and responsibilities.”

For example, the San Francisco Department of Public Health



Division of STD Prevention and Control partnered with researchers at UC San Francisco to develop YUTHE (Youth United Through Health Education), a community-based, peer-led HIV/STD prevention program

to increase detection and treatment of sexually transmitted diseases. YUTHE recruits young outreach workers from the community to conduct venue- and street-based outreach. The risk assessment tool and the screening and prevention messages they deliver were developed with the participation of focus groups also recruited from the targeted community. The program is collecting valuable data and “may provide support for future community-based efforts that integrate brief risk assessments with STD screening and prevention messages through peer outreach.”¹²

Finding partners

Finding partners can be a challenge, especially in communities far removed from urban or academic centers. Partnerships don't have to be with schools of public health or medical schools.

Departments of nursing, business, education and urban planning all offer curricula and resources that support public health goals. In the California State University system, each campus has a Service Learning Coordinator, charged with facilitating volunteer and community-based learning opportunities for students. Campus financial aid offices are another resource, since at least seven percent of federal work-study dollars must be used for students who are providing community service. (*See resource list for contact information.*)

For their part, Israel suggests that colleges and universities should look for CBOs that are “well-respected and have an established history in the community. And of course, it always helps if there is some prior history of positive working relationships,” she says.

The best partnerships are forged over time, not under the pressure of meeting an RFP (request for proposals) due date. “When the partnership develops as a result of genuine

needs, and not just because of a grant, the likelihood of sustaining the relationship over the long term is so much greater,” says Seifer. “It's much better to solidify the relationship and define your own mission first, rather than let the funding drive what you're doing.”

There are different levels of involvement. Gruder suggests there may be opportunities for CBOs to get a place at the table by becoming members of program advisory committees. Citing SRP's breast cancer and tobacco initiatives as examples, he notes that the governing legislation stipulates participation by both scientists and community advocates. This means the researchers must partner with community organizations in order to participate.

Partnerships to build capacity

PPH grantees from Long Beach strengthened their own research skills thanks to a partnership with the Health Data Program, part of the Center for Health Policy Research in UCLA's School of Public Health. Bryce Lowery, formerly assistant director of the Health Data program, delivered workshops on community assessment and basic data analysis to the group.

“They were focusing a lot on environmental health issues at the time – pollution, garbage collection and cleaning up the community,” he recalls. “I presented a bilingual workshop, simultaneously interpreted into Spanish, that helped community advocates, program directors and members of the county public health department better understand how they could use research to demonstrate need and tailor their programs to meet those needs.”

Learning to gather, analyze and present data is vital, Lowery says, because decision-makers and funding agencies are

The best partnerships are forged over time.



requiring more data to verify their support and continued funding for community programs. The community assessment workshop emphasizes simple, easy-to-use data collection techniques, such as community forums and focus groups. Despite our fascination with numbers, Lowery urges groups not to discount qualitative and anecdotal evidence. That, he says, is what “adds color to the picture. Something as simple as making a note that Mrs. Lopez was late to her appointment because she and her children had to transfer buses twice to reach the clinic, could be used to establish the need for a location closer to public transit or funding reduced rate bus tokens for clients.”

Once a community's needs are identified and quantified, CBOs need the skills to convince authorities and politicians to address them. A separate Health Data workshop addresses how to use research to advocate policy positions. Lowery says that government actions limiting smoking in public places can, in part, be attributed to advocacy by local and special interest groups, including the parents of asthmatic children. Another example of this kind of “trickle-up policymaking” can be seen in the 2002 U.S. Supreme Court decision barring the execution of mentally retarded persons. In his opinion, Justice Stevens gave considerable weight to shifts in public opinion on the issue, writing “it is fair to say that a national consensus has developed against it.”¹³



Other kinds of partnership

There are many ways for colleges, universities and CBOs to partner.¹⁴ They include sharing human and other resources, and the sharing goes in both directions. For example, colleges and universities can offer:

- **HUMAN RESOURCES:** faculty and staff can serve as consultants, facilitators and board members, or provide technical skills.
- **FACILITIES:** conference rooms or meeting space, dormitories or recreation centers can be opened to CBOs.
- **EQUIPMENT OR TECHNOLOGY:** donations of used equipment, assistance with technical support or Internet access.
- **POLICY AND ADVOCACY:** academic institutions and the “evidence” they can create through their research, or assemble and analyze through literature reviews, can lend credibility and provide connections to policymakers and funders.

Conversely, communities can bring to universities and colleges access to these types of resources:

- **Research Review Sections:** Community advocates can serve as valuable members of study sections reviewing research proposals, especially those concerning applied research and translational research (projects moving therapies from the laboratory to the bedside).

- **Facilities:** Community groups often have access to local meeting places that are familiar to residents and so more likely to attract participation in important meetings.



- **Publicity:** Community groups often know the best places to distribute flyers, post signs and otherwise get the word out about meetings or research efforts. They also

can mobilize numbers to get the attention of local elected representatives in ways that academic partners can't.

- **Cultural and Linguistic Competency:** Communities can provide indigenous interpreters, tips on appropriate wording of illustrative examples, whom to approach first in a community, so that social traditions may be respected and so on.
- **Membership on Academic Advisory Boards and Committees:** Community representatives can serve on various boards, especially those that develop guidelines for the academic institution's relationship with its neighbors. Community representatives can provide invaluable assistance when serving on scholarship and awards committees.
- **Experience and perspective:** Community residents contribute perspectives based on experience that can complement academic research and deepen the understanding of the health consequences of community life.

Public health departments can play a role by providing internships and facilities for meetings. Staff members can lend real-life experience by serving as adjunct faculty or guest lecturers. They can make valuable contributions as members of advisory committees and as grant proposal reviewers.

A partnership for youth

The Anderson Partnership for Healthy Children (APHC), a PPH grantee in Shasta County, is an example of a community-college partnership. This small, nine-year-old organization started with a focus on young children. As its gaze shifted to teens, APHC found a willing partner in Shasta College's GEAR UP program (Gaining Early Awareness and Readiness for Undergraduate Programs). “We wanted to hear from teens what they needed and GEAR UP was instrumental in referring teens to us for our strategy and planning sessions,” says Michele Erickson, APHC's executive director. Two years later, the relationship is going strong.

“It's a two-way street,” Erickson says. “GEAR UP students satisfy their community service and tutoring requirements by



volunteering at our Teen Center and we've been able to include them in the leadership training we offer to our members."

APHC also has paired with Anderson Middle School to promote "youth asset development" training. By focusing on participants' positive attributes, this training helps teens understand their strengths and what they need to do to succeed in life. After APHC trained its own community members and several educators, Erickson worked with Eleanor Hysell, GEAR UP coordinator at Anderson Middle School to sell local school administrators on the idea of using the technique in schools. "Getting people from the school on board was crucial," she says. "Eleanor played a key role in obtaining commitments from the Anderson Unified High School District and the Cascade Unified Elementary School District for district-wide training. I believe this will really make a difference in the lives of young people here in Shasta County."

Conclusion

While it is often difficult to match academic calendars and traditional research time frames with community needs, and to accommodate policymakers and public health officials who have to respond to emergencies, the mutual benefits that accrue from bringing academics into the community and the community onto the campus are worth the effort. Similarly, strengthening the relationships between academia and practice, by creating and reinforcing ties between faculty and health department staff can be mutually advantageous—as well as supportive of the partnerships between local health departments and their communities, and between communities and campuses. From distance learning, to continuing education for the public health workforce, to assistance in community asset mapping, to summer programs for high-school science students, colleges and universities are key players in addressing the broader determinants of health necessary to improving community health status.

For More Information

1. California State University, Service Learning Coordinators: www.castate.edu.csl.csuservice
2. Campus Compact: www.compact.org
3. Community-Campus Partnership for Health: <http://future-health.ucsf.edu.ccp>
4. Council on Linkages Between Academia and Public Health Practice: <http://www.phf.org/Link.htm>
5. Detroit Community-Academic Urban Research Center: <http://www.sph.umich.edu/urc>
6. Loka Institute: <http://www.loka.org>
7. Practice coordinators from the Association of Schools of Public Health: www.asph.org

8. Health Data Program: www.healthdata.ucla.edu or e-mail hdp@ucla.edu
9. UC Special Research Programs: www.ucop.edu/srphome
10. YUTHE Program, contact John Sieverding, siever@itsa.ucsf.edu

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- 2 Ibid., p. 12.
- 3 Ibid., p. 12 and Seifer presentation at UCSF, January 7, 2003.
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- 13 Atkins v. Virginia, 536 U.S. ____ (2002).
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About this Series

The policy brief series is part of PPH's commitment to its grantee partners; The California Endowment (that supports PPH); and the larger public health world. Each brief will define terms, identify challenges, share success stories and best practices, indicate issues for policy and systems change, and point towards key sources of further information. We encourage feedback and suggestions from our readers (please e-mail Adele Amodeo at aamodeo@partnershipPH.org).

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