PARTICIPATION IN ACTION: THE HEALTHY AFRICAN AMERICAN FAMILIES COMMUNITY CONFERENCE MODEL

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The Healthy African American Families project (HAAF) in Los Angeles developed ''community conferences'' as a method of engaging local community members in mutually beneficial participatory collaborations with academic and clinical researchers. In these conferences, community voices and concerns about a health issue are translated into the language of scientific inquiry. Scientific information and process are translated into forms that can be understood and utilized by the lay community. Equally important, the conference process enables community members to provide input into scientific projects and to take ownership of subsequent interventions resulting from the research conducted in its community. The HAAF conference model is participation in action. It may be useful for other communities engaging in community participatory prevention research. (*Ethn Dis*. 2010;20[Suppl 2]:S2-15–S2-20)

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INTRODUCTION

Since the early 1990s, community participatory research, especially directed at reducing health disparities in disadvantaged communities, has been resurrected in the United States.[1] A key question is how to conduct participatory research with disadvantaged, disenfranchised communities when previous research has been hierarchical, exploitative, and of little direct benefit to the participating communities.

There are also other concerns such as authentic community representation, engagement of community members with diverse backgrounds and expertise in meaningful ways throughout the project, and development of community ownership of health problems and potential solutions. This article presents an overview of the community engagement conference model developed by the Healthy African American Families (HAAF) project in Los Angeles to foster participatory research, information dissemination, and public health action. This model evolved as a way to: decrease distrust between researchers and community members; increase opportunities to voice community concerns about research and about what is needed to improve health outcomes at the community level; increase use of community resources and networks to promote community resilience; and increase community ownership of health problems and intervention strategies.

Healthy African American Families (HAAF)

HAAF is a community-partnered, community-driven agency which addresses the health concerns of the African American community in Los Angeles County. The history and functions of HAAF are described elsewhere.[2–4] Briefly, HAAF is a nonprofit agency and works in partnership with universities, other community-based organizations (CBOs), government, and other entities. HAAF's mission is to improve the health outcomes of the local community by: enhancing the quality of medical services; advancing social progress through education, training, and collaborative partnering; and providing forums to enable the disenfranchised community to take a leadership role in its health. HAAF conducts community-partnered participatory research (CPPR).[2,5] In CPPR, the community participates and is a valued member from a project's conception through its completion. Listening to community voices and giving back to the community occur throughout the process. HAAF is a living network of community relationships that evolve with each new activity and project. It is this pre-existing, yet expanding, partnership network that distinguishes the HAAF CPPR model from a time-limited, funding-responsive, community-based participatory research project.

For HAAF, the African American community definition combines both geographic and social dimensions.[6] Although primarily centered in central and south-central Los Angeles, HAAF serves the entire county. The Los Angeles African American community is diverse and includes members from different socioeconomic classes and professions. In this article, the ''community'' refers to those members who are the subjects of research and service delivery programs and who usually have little voice in the construction and delivery of these programs.

When HAAF began in the early 1990s, academia, public health researchers, and medical professionals were

viewed as threats, not resources, to the local community. Since its beginning, HAAF has worked constantly to acknowledge this distrust and to engage in open, honest, and inclusive processes. In this, there is healthy vigilance against exploitation and hidden agendas.

Given this distrust, it was imperative to have multiple mechanisms for community involvement and participation throughout the research process - from project conceptualization to presentation of results, and to subsequent action. Understanding the need for expression and acknowledgement of community voices, the HAAF community conference process became one mechanism to address this need.

THE HAAF CONFERENCE MODEL

The HAAF community conference model initially began as a community meeting of local community members in 1993 to present concepts for participatory ethnographic research on women's experiences during pregnancy; meeting organizers sought community feedback, suggestions, and participation in the project.[2] Regular community meetings continued as a mechanism to present project updates and results and to openly receive community feedback, insight, and concerns. In response to requests from community members and healthcare providers, other issues related to research ethics and to community and healthcare provider education began to be presented at these meetings. For example, community members wanted information on the human subjects review process and protection of rights in research. Healthcare providers wanted more information on the physiology of stress during pregnancy.

Over the ensuing years, these community meetings, initially lasting a few hours, evolved into a one- or two-day community ''conferences'' with two goals: 1) dissemination of information (knowledge transfer) and results; and 2) identification of research needs. Other meeting structures, such as lunch-box symposia and workshops, also emerged. These conferences provided community members with the aspects of professional scientific/academic conferences, including research and knowledge presentations, networking, planning, and discussion of policy. The HAAF conference model is a primary way to allow community voices to be heard, for the research process to be visible and open within the community, and for research results to be given back to the community. This was crucial for developing and maintaining trust.

The HAAF community conference model has become institutionalized and sustained. It is now used to generate new projects and subsequent conferences. Topics or results are presented in a community conference and then multidisciplinary, academic-provider-community workgroups are formed for subsequent activities, such as qualitative research, grant writing, intervention development, etc. Workgroup results are then presented at future conferences. Each conference has produced community-researcher collaborations that are still functioning.

To achieve the conference's objective of community engagement, HAAF, as broker, extends its network of collaborators into the community. Current collaborators are encouraged, in a snowball-type technique, to bring other potential collaborators or participants into the conference process. Building on its core of staff, funding agencies, and researcher partners, HAAF thus extends its network and resources. This process of community engagement moves research and health promotion into extended community networks.

Knowledge transfer is the two-way exchange of information and perspectives between community and science. Knowledge transfer fosters the utilization of relevant research and knowledge by both community members and scientific researchers. The conferences confront community beliefs that ''researchers have nothing of value to us,'' and researcher beliefs that ''communities do not have insight into their own problems.''

HAAF conferences also confront academic research norms that a research project is finished when published in a scientific journal. A key principle of participatory action research is that the research results must be applied in the community from which data were collected and must lead to subsequent action. In the HAAF conference model, this new knowledge is marketed and transmitted to community members. To the extent in which the goal of converting knowledge into action is met, a conference is a nurturing interaction.

The work and activities around each of the HAAF conferences are in various stages of development. Each activity builds on prior experience and relationships although specific health topics may vary. Each new HAAF project and conference builds on an established CPPR foundation and not from a new beginning.

KEY COMPONENTS OF THE CONFERENCE MODEL

Topic Selection

Initially, conference topics were related to the original HAAF ethnographic project or to the need to educate both community members about the research process and researchers about working with communities. Subsequent new topics are primarily identified from community need and request, many times as they arise during presentations at current conferences. Selected topics addressed in HAAF conferences are listed in Table 1. Passion, or enthusiasm for a specific topic, is a much-utilized resource in conference planning. Participants self-select into planning or subgroups based on this perso-

Table 1. Selected community conference topics, Healthy African American Families Project, Los Angeles, 1995–2009

Year	Topic
1995	Building Healthy Communities
	What is an IRB?
1996	What is a Healthy African American Family?
	The Voice of African American Women
1997	The Knowledge Transfer
	Stresses that Affect African-American Women
	How Participatory Research is Conducted in Los Angeles African American Communities
1998	The State of African American Youth and Children In America: What Is Their Health Status?
	Community-Based Organizations HIV/AIDS Information Transfer
	Information on Participating in Research
	The Impact of Alcohol in Sexual Assaults
1999	Working in Urban Communities
	Research Concerns in Los Angeles
	What is Informed Consent?
	Ethnographic Methods of Research in Community
2000	Clinical Research and Research Ethics in Multicultural Communities
2001	Mental Health of the Disadvantaged
	Addressing Violence in the Community
2002	Mold and Pregnancy
	Impact of the Environment on Health
2003	Women's Health Issues in Preterm Birth
	Loving Myself – The CDC VERB project
	Violence Impact on Women and Families
	Witness for Wellness Identifying Depression and its Impact on Lives: How Can We Make a Difference?
2004	Building Bridges to Optimum Health: Stress and Pregnancy
	Supporting Wellness: Media Relations Training
2005	Witness for Wellness: The Impact of Stress and Clinical Depression on Communities
	Bacterial Vaginosis
	Building Bridges to Optimum Health: Diabetes through the Lifespan
2006	Pesticides
	Witness for Wellness Report Back
2007	Community-Partnered Restoration Center
	Community Report Back on Diabetes
	Building Bridges to Optimum Health: Preventing Low Birth Weight Babies
2008	Kidney Disease
	State of Emergency: Access to Care in Los Angeles County
2009	Women in Pain

nal interest. Topics, such as depression and diabetes, were chosen based on community interest.[7–9] Generally topics need to be of community interest, or shown how it relates to community health, to be suitable and relevant for a HAAF conference.

Lunch-box symposia, or workshops, have more focused topics. They generally occur every two months and have one speaker. The target audience comprises representatives from other CBOs who then take the information learned to their own constituents. Lunch-box symposia focus on providing specific how-to resources and information. Topics have included asthma, lead poisoning, and bioterrorism.

Planning

After topic identification, a planning group and timeline are created. The planning group always includes community members working alongside academic, clinical, or government members on the same aspects of the planning process. Lay community members have an equal voice in the planning process. The planning group size has varied according to specific conference needs and time. For example, the Witness for Wellness depression conference had eight members at the initial planning meeting. Those members were encouraged to ''to bring more people to the table'' and the number of members doubled within a month. Over the year of planning for this conference, 64 different people attended at least one meeting.

Depending on need, planning meetings occurred monthly, bi-weekly, or weekly. During planning meetings, conference goals, memorandums of understanding and planning structure were developed. Subgroups were created for different conference tasks and functions. Subgroup members did not have to be members of the overall planning group.

This planning structure operationalizes several principles of the HAAF CPPR model.[2,5] Inclusivity is essential. Anyone who wants to participate is included. Different perspectives and skills are necessary to the conference success. Members do not have to commit to being involved in the entire conference process. Since the planning process is very time-intensive, many community members are continuously involved throughout the planning phase but others have joined, left, and rejoined later.

Resources

HAAF conferences are not solely dependent on monetary support. While HAAF has used financial support from federal, state, business, and private organizations to support the community conferences, no HAAF conference or workshop has been entirely supported from monetary funds. In fact, the success of HAAF community conferences resulted because many community resources are utilized along with dollars. HAAF received in-kind resources because community members believe in HAAF's goals and share in its responsibility and resources. Table 2 shows the range of in-kind support and resources HAAF received.

An example of HAAF's creativity in the use of community resources in no-

Table 2. In-kind support for local community conferences, Healthy African American Families, Los Angeles

Printing
Copying
Binding
Site (free or reduced cost)
Parking (free or reduced cost)
Presenters
Audio and video equipment
Audience participation monitoring equipment
Language translation equipment
Translators
Conference Bags
Give-aways and door prizes
Sanitation and other janitorial services
Food and beverages
Food service workers (kitchen staff and servers)
Utensils and dishes
Volunteers, including work study students
Note takers
Publicity
Continuing education credits
Press and media services
Security

cost, mutually rewarding ways occurred in a pregnancy health-related conference. This conference was held over the dinner hour so that community members could attend after work. HAAF wanted to provide dinner to conference attendees as compensation. A community member donated funds to provide the food. For wait staff and kitchen help, HAAF called two local agencies – one which provided training in hotel services and the other providing training opportunities for recovering drug users. Both agencies sent trainees to do the food service and kitchen functions for this conference. A mutually beneficial situation occurred where local trainees received valuable work experience and HAAF received the help it needed – all free of charge.

Participants/Attendees

HAAF reaches broadly into the community through networking for a diversity of participants in its conferences. Categories of attendees include men, women, African American, Hispanic, Asian, Caucasian, health care providers, CBOs, social services, psychologists, professors, students (both high school and college), state and local health departments, state and local government representatives, and media.

Location

To enhance community participation, conferences are held in non-university sites. This reduces unconscious or conscious negative associations about meeting on university campuses. HAAF has had conferences in meeting rooms in malls, churches, public utility buildings, museums, CBOs, and county government facilities. HAAF conferences have no registration fees and only an occasional parking fee (depending on location).

Agenda

The conference planning committee, which includes both professional and nonprofessional community members, develops the agenda in response to community needs. Conferences have generally been one or occasionally two days. A conference includes presentations from both scientific and community perspectives. The oral presentations target both healthcare providers and community members. Community voices and concerns about a health issue are translated into the language of scientific inquiry. Scientific information and process are translated into forms that can be understood and utilized by the lay community.

A conference goal is to present information in user-friendly, entertaining ways which fit with African American cultural traditions of information sharing and in formats appropriate for a heterogeneous group of community participants. Multiple presentation techniques are used. Information is conveyed both orally and visually and not solely in written form. Besides Powerpoint presentations (more often used for the scientific talks), conferences have also included film, story-telling, and dialogs. A common agenda structure is to have a whole group presentation and then whole-floor or break-out group discussions with note-takers. An electronic ''voting'' system has been used to assess participants' knowledge and opinions about a topic in real time.

Materials and Other Benefits

As with other professional conferences, educational materials and other items are given to each participant. These include syllabi with slide handouts, contact lists, sponsor information, and evaluation forms. Some conferences have been audio-recorded. Spanish translation services were provided at both the depression and diabetes conferences. Food and beverages were provided. Food is an important aspect of HAAF conferences. Besides reciprocation, the implications of food as ''breaking bread together'' or ''sharing a meal'' are important elements of relationship facilitation and development, reducing boundaries between people with different backgrounds.

HAAF conferences provide continuing education credits to encourage attendance by social and healthcare providers, to provide additional benefit to those providers, and to encourage evaluative feedback. Certificates of participation, which satisfy documentation required by county government agencies and CBOs for training activities, are awarded to other conference attendees.

Publicity

Conferences are widely promoted throughout the CBO networks and individuals already at the table. HAAF maintains computerized databases of community organizations and contacts. These databases are used to send mailings of upcoming conferences by electronic and postal mail. Free publicity has also been provided by local media who are HAAF partners.

Evaluation

Along with continuing education evaluations, pre- and post-test evaluations are routinely conducted at every

HAAF conference. Approval from an institutional review board from a partnering academic institution is obtained if necessary, depending on the research and evaluation goals. Evaluations assess prior knowledge and what was learned at the conference, presentations; and conference structure and content. Evaluations also solicit potential topics for future conferences. Perhaps the best measures of success of the conference model are that community members: regularly ask for a topic-specific conference; take time to attend HAAF conferences; and attend a conference no matter what the topic is.

Follow-up Activities

Recent conferences, such as the depression, diabetes and preterm birth conferences, developed working groups to pursue scientific and community issues raised at the conference and to develop new intervention strategies. HAAF then conducted ''feedback'' conferences where these workgroup results were presented. This process provided consistent and regular feedback to the community and keeps the working groups connected to HAAF's network of relationships.

DISCUSSION

The HAAF community conference and subsequent working groups are manifestations of community participation in action in Los Angeles; through careful work, the conference participants reduce tensions between community research and action and, between community members and academics. A HAAF community conference sets a tone of egalitarian collaboration across a heterogeneous set of partners by valuing and listening to the different voices and perspectives in the process. The broader community collaborates on a conference and this then becomes a way in which community unites for health promotion and begins to define solutions utilizing community resources. Conferences help to direct and focus prevention efforts at the local level.

The conference process enables community members to provide input into scientific projects and to take ownership of subsequent interventions resulting from the research conducted in its community. Issues for disadvantaged communities, such as racism, are explicitly and openly discussed. HAAF community conferences also directly confront and address two stereotypes which partially underlie the distrust between community members and researchers. The first is community beliefs that researchers are exploitative, elitist, racist, ignorant, disrespectful of community strengths, and culturally incompetent. The second is the researcher beliefs that the community is deficit ridden, disabled, uninformed, without its own expertise and skills, and needs to be taken care of and treated. The experiences of both parties in the conference process may confirm, disconfirm, or modify these beliefs. During a conference, scientific researchers and lay community members see each other as real people and working relationships are formed.

Through this process, beneficial situations are achieved for both academic/clinical professionals and community members. The success of HAAF conferences is indicated by the increased understandings of research by the community and of community perspectives by researchers. Success is also indicated by the ongoing level of commitment that both local scientists and community members have for this process.

The HAAF community conference model is readily transferable to other communities. Replicating this model will require time, effort, resources, and many partners and networks. This work has not been easy. In the conduct of a community conference and resulting workgroups, HAAF has to balance personalities, shadow agendas, differing visions, ongoing local controversies, and resource needs. However, these are issues in any participatory research project.

The HAAF community conference model is one example of community mobilization and self-help for health promotion and research. It will not by itself lead to reduced disparities in health outcomes in a disadvantaged community but it can be a way to develop necessary interventions at a local level.

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REFERENCES

1. Minkler M, Wallerstein N. *Community-based Participatory Research for Health: From Process to Outcome*. Second ed. San Francisco, CA: John Wiley & Sons; 2008.
2. Ferre CD, Jones L, Norris K, Rowley DL. The Healthy African American Families (HAAF) project: from community-based participatory research to community-partnered participatory research. *Ethn Dis*. 2010;20(1, Suppl 2):S2-1–S2-8.
3. Chung B, Jones L, Norris K, Terry C, Forge N, Jones A. Story of stone soup: a recipe to improve health disparities. *Ethn Dis*. 2010;20(1, Suppl 2):S2-9–S2-14.
4. Jones L, Lu MC, Lucas-Wright A, et al. One hundred intentional acts of kindness toward a pregnant woman: building reproductive social

capital in Los Angeles. *Ethn Dis*. 2010;20(1, Suppl 2):S2-36–S2-40.
5. Jones L, Wells K. Strategies for academic and clinician engagement in community-participatory partnered research. *JAMA*. 2007;297(4):407–410.
6. Hatch J, Moss N, Saran A, Presley-Cantrell L, Mallory C. Community research: partnership in black communities. *Am J Prev Med*. 1993; 9(6):27–31.
7. Chung B, Corbett CE, Boulet B, et al. Talking Wellness: a description of a community-academic partnered project to engage an African-American community around depression through the use of poetry, film, and photography. *Ethn Dis*. 2006;16(1)Suppl 1:S67–S78.
8. Bluthenthal RN, Jones L, Fackler-Lowrie N, et al. Witness for Wellness: preliminary findings from a community-academic participatory research mental health initiative. *Ethn Dis*. 2006;16(1) Suppl 1:S18–S34.
9. Stockdale S, Patel K, Gray R, Hill DA, Franklin C, Madyun N. Supporting wellness through policy and advocacy: a case history of a working group in a community partnership initiative to address depression. *Ethn Dis*. 2006;16(1) Suppl 1:S43–S53.