

Finding solutions to challenges faced in community-based participatory research between academic and community organizations

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Summary

Partnerships between communities and academic institutions have been vital in addressing complex health and psychosocial issues faced by culturally diverse and hard-to-reach populations. Community-based participatory research (CBPR) has been suggested as a strategy to develop trust and build on the strengths of partners from various settings to address significant health issues, particularly those persistent health issues that reveal disparities among minority populations. There have been many challenges to developing these partnerships in the United States. The purpose of this paper is to discuss approaches and solutions used by this research team in response to the challenges they have faced in using CBPR. The team uses CBPR to understand and support the process of disclosure of intimate partner violence (IPV) within the context of the community health centers that provide services for multicultural and multi-lingual populations. While CBPR provides a route to develop trust and build on the strengths of partners from various settings, there are multiple challenges that arise when partnering organizations present with different infrastructures, missions, resources and populations served. Examples of common challenges and solutions from the literature and from the team's experience will be discussed. Implications for partners, partnerships, practice and research will be explored.

Keywords: *Community-based participatory research, domestic violence, community health centers, partnerships, multi-cultural, intimate partner violence*

Introduction

Partnerships between communities and academic institutions have been vital in addressing multiple and complex health and psychosocial issues faced by culturally diverse and hard-to-reach populations. There have been many challenges to developing these partnerships, including issues of trust/mistrust, equity/inequity of resources, who benefits, ownership of data, and much more (Matsunaga et al., 1996; Israel, Schulz, Parker & Becker, 1998). This situation has contributed to missing opportunities to explore significant health and social issues that impact the lives of vulnerable people. Community-based participatory

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research (CBPR) methods have been suggested as a strategy to develop trust and build on the strengths of partners from various settings to address significant health issues, particularly those health issues which reveal disparities among minority populations (Flaskerud, 2000; Green & Mercer, 2001; Benoit et al., 2005).

This research team was formed to respond to a challenging health issue within diverse ethnic and hard-to-reach populations. Clinical and public health scientists from four community health centers and nursing scientists from the University of Hawaii School of Nursing and Dental Hygiene (UHSONDH) in the State of Hawaii formed a community-based participatory research team to address intimate partner violence (IPV) amongst Native Hawaiians, Ilokano (Filipino), Chuukese (Micronesian), and women who work in the sex industry.

Purpose

The purpose of this paper is to discuss approaches and solutions used by this research team in response to the challenges they have faced in using community-based participatory research (CBPR) to address IPV within the context of the community health centers that provide services to multicultural and multi-lingual populations. The paper will describe team development and the significance of CBPR during this process. Common challenges for CBPR research teams, especially the challenges this team faced when clinical and public health scientists from four community health centers serving distinct, culturally diverse and hard-to-reach populations partnered with nurse scientists from an academic institution will also be shared, followed by approaches and solutions to addressing these challenges. Implications for partners, partnerships, practice and research will conclude this paper.

Community-Based Participatory Research

Previous gaps between academic researchers and community members and organizations have led to limited application of research findings to health practices and policies. Community-based participatory research (CBPR) is an approach developed to bridge the gap by bringing people from the community, agencies and universities together to make a difference regarding complex social and health issues. This is consistent with the emphasis of funding bodies and communities that are demanding that research show greater sensitivity to communities' perceptions, needs and unique circumstances (Green & Mercer, 2001).

Community-based participatory research also combines research methods and community capacity-building strategies (Green & Mercer, 2001). Participatory research has a rich and honored tradition in community development, contributing to social change and economic development. The purpose of CBPR is to increase the relevancy of studies for both researchers and community members or organizations, and it is particularly attractive for those struggling to address the persistent problems of health disparities (Viswanathan et al., 2004). Hallmarks of this method are the sharing of knowledge and valuable experience between partners that leads to the development of more effective culturally appropriate methods. The ultimate benefit is a deeper understanding of the unique circumstances and a more accurate framework for testing and adapting best practices to the community's need (Green & Mercer, 2001).

The research team described in this paper adopted the definition of CBPR by Israel and colleagues that defines CBPR as:

[a] collaborative approach to research that equitably involves, for example community members, organizational representatives, and researchers in all aspects of the

research process. The partners contribute unique strengths and share responsibilities to enhance understanding of a given phenomenon and the social and cultural dynamics of the community and integrate the knowledge gained with action to improve the health and well-being of community members (Israel, Schulz, Parker & Becker, 1998, p.177).

Since the 1960s many participatory research studies have taken place in social, educational, and health services. Nursing has led the way with collaborative studies between faculty and nursing administrators and staff aimed at improving roles and difficult working environments (Green & Mercer, 2001). While CBPR provides a route to develop trust and build on the strengths of partners from various settings, there are multiple challenges that arise when partnering organizations present with different populations served, infrastructure, mission, and resources.

Background

In the State of Hawaii there has been a history of unsatisfactory relationships between researchers and community members and organizations. Conventional research efforts, in which the principal planners and decision-makers were university-based researchers, left many in the community feeling exploited (DeCambra, Enos, Matsunaga & Hammond, 1992). Often studies did not deal with priority health issues of the populations served by the centers; academic researchers expected that the health centers provide staff, space, and right of entry to the vulnerable populations; analysis was done entirely without input from staff of the community health centers or members of the community; and researchers often broke contact at the end of the research study. Given these past circumstances, clinicians and administrators from community health centers, and residents of many communities are skeptical of academic researchers (Matsunaga et al., 1996). Consequently many studies designed by investigators from universities have been turned down by clinicians and administrators of community health centers (CHCs).

Two researchers from the University of Hawaii School of Nursing and Dental Hygiene (UHSONDH) were interested in knowing more about a significant health issue, intimate partner violence, and in working with investigators from community health centers. The university researchers were aware of the well-founded concerns regarding traditional research approaches that have been proposed to communities in the past. With this in mind, the researchers from the UHSONDH contacted four community health centers to determine their willingness to work together on the issue of disclosure of intimate partner violence at their respective health centers.

One or two representatives from each partner site, interested in making a difference, became a member of this research team. Personnel varied at each site, but most had responsibility for management of maternal child programs within the CHCs. The participants at each site included: an epidemiologist with a PhD; a masters level maternal child public health practitioner; a doctorally-prepared nurse; and two nurses with baccalaureate degrees. Two other members of this team are faculty members from UHSONDH, a research-intensive institution providing baccalaureate, masters and doctoral nursing programs within urban Honolulu. These faculty members have clinical and administrative backgrounds that include women's health and community health. Both faculty members have conducted other studies of IPV within the multicultural communities of Hawaii (Taylor, Magnussen & Amundson, 2001; Shoultz, Phillion, Noone & Tanner, 2002; Magnussen, Smith & Amundson, 2005).

Description of the Community Health Centers

The CHCs participating in this CBPR partnership were all developed in the 1970s and are nonprofit organizations. Each site has been designated as a Federally Qualified Health Center (FQHC) from the Bureau of Primary Health Care. The CHCs provide a wide range of services to vulnerable populations who might not otherwise have access to health care. Significant social factors (economics, transportation, language) affect the multicultural populations served by the CHCs. These broader social issues influence the health of the populations served and add to the complexity of the provision of appropriate health services. Three of these health centers are located in urban Honolulu and one is located in a rural community on the island of Oahu. A description of each community health center is included to provide the context for this community-based research team.

Kalihi Palama Health Center (KPHC). The KPHC primary health care clinic was started in 1975 by concerned citizens who recognized the urgent need for medical services for low income Native Hawaiians and immigrants who faced cultural and economic barriers to healthcare. Eighty-five per cent (85%) of patients are Asian and Pacific Islanders (APIs) with about one third non-English speaking, and over 13% are homeless. The KPHC offers comprehensive, integrated, preventive and primary health and social services that are accessible, cost-effective, and culturally appropriate. The service delivery model is a combination of both freestanding and “mobile” services.

Kokua Kalihi Valley Comprehensive Family Services (KKV). This was formed in 1972 by community leaders in response to the absence of accessible and appropriate health and human services in Kalihi Valley, with the mission to be an agent of health and reconciliation for the community. The health center has grown to now include a hundred staff, fluent in 17 languages including Samoan, Tagalog, Ilocano, Chuukese, Chinese and Vietnamese, and working out of five main locations, including two public housing projects. The health center currently serves over 6,000 Kalihi Valley residents per year with a broad array of holistic health and human services covering all stages of the lifecycle. The main ethnicities served by KKV are Samoan (28%), Filipino (31%), and Micronesian (numbers currently unknown but rapidly increasing). In October 2002, Kokua Kalihi Valley Health Center (KKV) was officially designated as one of 12 National Community Centers of Excellence (CCOE) in Women’s Health by the US Department of Health and Human Services, Office of Women’s Health to integrate clinical, preventative care, education and outreach for women across their lifespan.

Waianae Coast Comprehensive Health Center (WCCHC). This center has served the Wai’anae community by responding to community needs for 33 years. From its start as a one-physician office, the WCCHC is a community owned and operated, non-profit health center which serves the Leeward Coast through a main clinic and four satellite clinics, offering a range of services. The majority of patients are Native Hawaiian (52%) followed by Asians (23%) and Caucasians (18%). In 2004, the Health Center served 24,048 patients through 127,227 encounters; 68% of the Health Center users are 100% and below poverty level, 17% are uninsured.

Waikiki Health Center (WHC). This center has provided accessible healthcare for the residents of O’ahu for over 30 years. The original clinic was founded in 1967 by the Waikiki Ministry and known as the Waikiki Drug Clinic. The WHC is dedicated to providing quality

medical services on a sliding fee scale, and is the only service provider in the area that does not refuse service because of an inability to pay. The mission of the WHC is to provide quality accessible and affordable medical care, health education, and community services that are responsive to the changing needs of individuals and to the community statewide. The services are provided at a primary care clinic, two satellite clinics, and a mobile van. At the primary medical care clinic the population served is approximately 53.2% Caucasian, 35.78% Hawaiian/Asian/Pacific Islander, 3.96% African American, 2.86% Latino; and 39.61% are uninsured. The population served with the HIV/STD services includes 55% Caucasian, 13% Asian/Pacific Islander, 7% African-American, 12% Latino, 13% other minorities; 95% male, 5% female. On the North Shore of O'ahu the population served includes 47% Hawaiian, 17% Caucasian, 7.6% Tongan, 5% Samoan, 6% Filipino, and other API minorities.

Background on IPV

Intimate partner violence (IPV) is a complex health issue impacting on the lives of women in the community and providers who care for them. The primary concern of health care providers is the safety of the women and their children, however, the complexity regarding IPV is related not only to fear of the effect of disclosure and stigma on the individual, their partner and the relationship between the couple, but also to the impact on their family members including children. The complexity is also related to other cultural and social aspects of family life such as housing, legal mandates and economic resources (Campbell & Humphrey, 1993). Perspectives about IPV vary from one cultural group to another and may lead to barriers that prevent women from receiving effective care (Campbell & Humphreys, 1993). Campbell and Campbell (1996) suggested that interventions for abused women be based on principles that include cultural competence and empowerment.

Culturally relevant care is sensitive to cultural traditions and differences such as languages, communication styles, decision-making within the cultural group and must emerge from understanding IPV within the broader cultural and social context (Campbell & Campbell, 1996). Thus this area of research lends itself well to the use of the CBPR approach because it involves people from the community and from different cultures. The research team works together in the development of culturally appropriate interventions to encourage women to disclose IPV to health care providers based in the local community health center. Community-based participatory research can facilitate greater knowledge of intimate partner violence within the context of the culture and the specific community. The ultimate benefit to emerge from such collaborations is a deeper understanding of a community's unique circumstances, and a more accurate framework for testing and adapting best practices to the community's needs (Viswanathan et al., 2004).

First study of IPV by this CBPR team

This CBPR team initially conducted a retrospective study of documentation of disclosure of IPV at the four community health centers. Each team member participated in designing the study, developing the questions on the chart review tool, and conducting the chart review. Initially the chart review was to be done by a graduate assistant, but with the implementation of the Health Insurance Portability and Accountability Act (HIPPA), the sites decided that use of their own personnel would more easily address this new law. Consequently a graduate assistant entered the data after it had been cleaned of all identifiers. As additional research

has been undertaken by the team, further challenges and solutions pertaining to this area have been developed and will be discussed later in the paper.

To make sure that each site conducted the chart review consistently, the exact procedures of the chart review were identified and one researcher from the University of Hawaii worked with staff at each site to make sure that the chart review was conducted identically at each site. Initially each member of the research team evaluated the findings from their health center so that they could understand the statistical data from their site. A statistician was available to answer questions and provide additional data if requested. All team members then agreed to integrate the results from all sites, and to participate in writing a manuscript for publication.

Findings have been published (Magnussen et al., 2004) and the CHCs have been able to use the findings to assist in service planning and provision. Based on these preliminary results, a larger proposal for an additional study has been submitted by this CBPR team to a federal agency. This evolving collaboration has presented multiple benefits and challenges.

CBPR challenges and solutions

Even with the use of CBPR, challenges during the research process have been identified. Benoit et al. (2005) and Israel and colleagues (1998) identified multiple challenges and facilitating factors inherent to working on CBPR teams. The challenges were clustered by Israel into three broad categories: partnership-related issues; methodological issues; and broader social, political, economic, institutional and cultural issues. Examples of common challenges and solutions from the literature and from the team's experience are integrated in this section of the paper.

A partnership-related challenge basic to the development of the CBPR is the stability of the research team. Matsunaga et al. (1996) point out that the continuity of both scientific staff and community membership was a critical factor in their success. MaCaulay et al. (1998) make this same point, framing it as one of the obligations of members of a CBPR team. In addition to having a stable research team, Banner et al. (1995) point out the need to build trust. They note that acceptance is a critical factor in conducting community participatory action research. An important aspect of building trust is the establishment of defined roles for each member of the team as well as specific rules of operation. These rules should include developing policies for the research project as well as providing guidance for interventions and evaluations (MaCaulay et al. 1998).

Matsunaga et al. (1996) make explicit the real test of the relationship issues facing these teams by describing conflicts between and among scientific and community investigators in a study they undertook. These conflicts were based on differing perspectives and priorities. They were labeled "inevitable". It is because of these differences that the development of trust is so crucial.

Trust on this CBPR team evolved through various shared activities between CHCs and between the CHCs and the University. Shared activities between the CHCs included common grant meetings, shared project funding sources, and participation on the advisory committee for the UHSONDH Center for Health Disparities. This evolving relationship helped this CBPR team face other challenges. Finding a common time to meet and work on tasks was one such challenge. This required members to be willing to take risks in the group and to have courage enough to say they could not be present. This has been more difficult at certain crucial times such as when deadlines were close for either the group work or for work that involved only one health center. The site for meeting has generally been off campus at the most central community health center that has the most convenient parking. Meetings

are usually for specific tasks, an agenda is developed ahead of the meeting, work assignments from the previous meeting are reported on, and future agenda items and timelines are proposed. Email communication is extremely helpful to this team. Documents are circulated ahead of time and updates sent out regarding decisions made by the group for members that could not be present on a given day.

During the development phase of establishing the CBPR team one of the social workers from Kokua Kalihi Valley Health Center received a stipend to serve as the liaison for all group activities. She arranged meeting rooms, parking for meetings, and kept the email listserv up to date. Since the first research study has been completed the pattern of managing the contacts has become less formal. While university researchers circulate items for the agenda prior to the meeting, each person adds items or revises the agenda and may change the sequence of the agenda, the team has evolved such that CHC researchers are comfortable in voicing their opinions, changing the agenda, or boldly suggesting a different direction altogether. Team members are acutely aware of the work that needs to be accomplished and understand that workload demand, at times, may be highly related to the CHCs degree of resources/infrastructure available, diversity of population, degree of community development/capacity, and health issue priority in CHCs.

Leadership for the team is shared based upon the particular stage of the research and is consistent with a description by Becker et al. (2005). For this specific CBPR team, the entire team works together on the research design; however, the literature review is carried out primarily by the academic investigators. When the data collection is underway the clinical investigators assume leadership for the research logistics at each site, while the academic members monitor methodological issues. Data analysis and oral dissemination are done jointly by the research team, while the leadership for written dissemination is often taken by the academic investigators.

The second category of challenges identified by Israel and colleagues focused on methodological issues. These challenges include issues such as data obtained from a study using the CBPR approach may have limited application to other populations because the study has been tailored to the needs, resources and priorities of the partnership. Consequently the conduct of CBPR varies from site to site during implementation of the research plan (Frasier et al., 2004). Hohmann and Shear (2002) point out that there is "noise" introduced by a community setting that may affect the consistency of the research planned in different community sites (p. 202). Although this issue is presented as a caution in setting up clinical trials, it provides valuable advice for CBPR as well. To address consistency across sites the research team has found that during the research design process it is useful if the procedures are thoroughly discussed to highlight issues that may emerge during the study. Research team members have met with others at the sites who work directly with the population to determine their perspective on the design and operational aspects of the study. Consequently the research procedures have been developed specifically for the populations to be included in the study and described in detail in the proposed research document. As the study is undertaken, the research team will meet on a regular basis to discuss procedures and methods.

Examples of variables tailored to the needs, resources and priorities of the partnership include geography, length of residency, and ethnicity. These are not clearly defined in communities; therefore, it becomes incumbent upon the community partners to define the sample population from these perspectives. For example, this research team has had to identify the geographic boundaries for the proposed study, which usually falls within the CHC defined service area. Length of residency is a significant issue due to the high immigrant population served by two CHCs. Therefore, issues of immigration (time point of

immigration to Hawaii) and family generation of participants (first, second, or third generation) are vitally important to the research proposed. Finally, ethnicity is, and always will be, one of the most important issues when defining a sample population in Hawaii. There are two primary principles that this team has advocated for based on the services provided in CHCs. The first principle has to do with identifying a sample population. The principle is to ensure that ethnicity is dis-aggregated - identifying the specific ethnic group and language, if necessary. Identifying the sample population by race (Asian or Pacific Islander) is of no value to the CHCs on this team as this term is too broad to describe the many unique differences between people described as Asian or Pacific Islander. Asians in Hawaii may include people who are Japanese, Korean, Chinese, Taiwanese, Thai, etc. Pacific Islander may include people who are Hawaiian, Samoan, Tongan, etc. The second principle related to identifying a sample population is selecting the ethnic group that presents the most challenges, regardless of the number of individuals available. This CBPR research team has had lengthy discussions about ethnic groups that require more resources, or for whom the CHCs lack resources, or that present a high incidence of IPV (the topic of interest). Ethnic groups that meet these criteria are of the most importance to the CHCs, and CBPR is seen as a strategy for developing the knowledge base and interventions necessary to serve this population.

To address the HIPPA and other human subjects' issues of collaborative research, including confidentiality and informed consent, the investigators have collaborated with the Chair of the Human Subjects Committee at the university to design training activities for all members of the CBPR team and others from the specific CHC. The Chair of the Human Subjects Committee recognized this training as an opportunity to include others from additional health centers; consequently, the training will be offered to members of the primary care association, an organization that includes all of the community health centers on Oahu.

Broader social, political, economic, institutional and cultural challenges are the third category of challenges. This category includes conflicts associated with differences in perspectives, priorities, assumptions, values and beliefs as identified by Israel et al. This CBPR research team has identified core values that are shared by members of the team. These included recognizing strengths of CBPR and each partner, a desire to make a difference for underserved populations and a commitment to work on the issue of intimate partner violence. The team desires to participate together in CBPR and has made a long-term commitment to the team. However the research team, formed by a partnership with the UHSONDH and CHCs in Hawaii, also recognized the differences in mission between the community health centers and the University. The CHCs have a focus on providing service to hard to reach, clinically complex populations and the University has a focus on research. To clarify the mission of the research team, a mission statement was developed that set out common goals and principles and defined the group expectations. The development of the following common mission statement has been a facilitating factor in furthering the development of the CBPR team:

To move community needs and concerns forward with participation, action, and research through a trusting and respectful long-term commitment between the University of Hawaii School of Nursing and Dental Hygiene and the community health center partners of Kalihi Palama Health Center, Kokua Kalihi Valley comprehensive Family Services, Waianae Coast Comprehensive Health Center, and Waikiki Health Center.

The long-term goal of this CBPR team is to inform the development of services at the community health centers in ways that would make women from many cultural groups comfortable and safe enough to disclose IPV and to receive services to address this important

health issue. Omenn (1999) points out that one of the struggles of CBPR is to maintain the momentum of the team. He notes that after getting a group together to develop a project and making the necessary adjustments to meet the demands of the participants, the group may lose momentum when funding is not obtained. A solution to this challenge that the team in Hawaii has found helpful is to continue to meet and communicate on the development of additional manuscripts, further submission of proposals and contact with consultants as funding notification for the first proposal was pending. As soon as notification regarding the proposal was received, the comments from the reviewers were sent to the entire team so that they could begin the process of revision on the proposal. Engaging in these activities has been a solution to sustaining a long-term commitment as a team during challenging times. As economic support for a larger study is being sought, opportunities to seek pilot funding for research with only one of the populations has been secured. The entire research team of four health centers agreed that it was acceptable for the team to seek pilot funding for only one population at one health center.

DeFrancesco et al. (2002) point out that the academic environment presents challenges to the formation of a CBPR team. They describe career development demands that focus on the achievements of the individual rather than the collective. In addition to that problem, the administrative tasks that are necessary (such as maintaining the electronic distribution list, scheduling meetings, organizing responses to opportunities) to allow for full functioning of the team require an infrastructure that often is not available.

A significant challenge this team has faced has to do with inflexible institutional rules that make it difficult to use methods that promote equity and redirect power to all partners. Examples of this have to do with who is allowed to be the principal or co-investigators. Suggestions from the literature include the need for co-investigators from each organization (Matsunaga et al., 1996). However institutional policies may prohibit equitable recognition of co-investigators or appropriate fiscal arrangements. Revision of policies and education of administrative personnel who are responsible for deciding on monetary policies needs to be undertaken to facilitate equitable processes and decision-making about resources.

In this CBPR team an agreement was made that the three nurse researchers on the team with doctoral degrees (two from the University and one from Waianae Coast Comprehensive Health Center) would serve as co-Principal Investigator's (PI) for the newly submitted National Institutes of Health proposal. Since the proposal was submitted through the University, the group understood that only one of the co-PI's could be the "official" PI. However, within the group it was understood that the credit and the responsibilities of PI are shared. Release time from teaching for the research activities was requested for the University researchers. All of the CHC members of the CBPR team will be paid for their research efforts via contracts for service at an hourly rate. Since these arrangements were discussed and agreed to prior to the submission of the grant proposal all team members expressed satisfaction with their fairness. It is also understood within the group that all publications from the group will be co-authored with first authorship (and the responsibilities that go with this designation) being rotated.

Israel and colleagues (1998) recommend developing broad-based support for participatory research. The successful conduct of CBPR is facilitated when both staff representatives and the senior leadership/management of the organizations involved are supportive of the endeavor and make sure the policies and personnel to carry out the effort are in place. With several partners, the dynamics and extreme differences of policies, indirect costs, staff time and limited resources become even more complex.

In the past, funding bodies were hesitant to support research that used CBPR methods. Now that funding is becoming available, organizations must develop the capacity to work in

ways that are consistent with the philosophy underlying CBPR. Faculty and staff development in the use of participatory methods are crucial to facilitating solutions to this very real challenge.

Workshops on CBPR such as the Summer Institute conducted by the Center for Vulnerable Populations Research at the School of Nursing at UCLA can provide tremendous support for the development of a cadre of researchers familiar with the benefits of CBPR and strategies to deal with the real life challenges of carrying out research using equitable and participatory approaches. Having fiscal and administrative personnel attend these workshops may provide hope for the faculty and community members that processes will be in place to support this evolving approach to research.

Another categorical challenge this research team had to consider was the multicultural and multi-lingual populations served by the CHCs. The clinical scientists were able to identify the priority groups for the study, many who speak a language other than English. The majority of research funds were committed to the translation of research questions and conducting focus groups in multiple languages. Translation and transcription cost are not only expensive, but challenging in other ways also. Identification of appropriate research assistants who can translate and transcribe the exact languages of the group and have the time and interest to conduct the groups are time-consuming activities when resources are limited. The clinical scientists and faculty at other universities who were familiar with translation and transcription have been helpful in reducing the cost and recommended reliable processes and people. In the future, preparing research assistants to meet the ethical and procedural requirements of the University for staff involved in the research study will also be a challenge. Again, colleagues within the local university and others familiar with these issues can be helpful to the research team.

A final broader social, political, economic, and institutional challenge that impacts the climate of CHCs is receiving mandates from current funding sources to implement procedures that have not been developed for specific populations and may be culturally inappropriate. The timing of these mandates is not always in the best interest of communities. For example CHCs on this CBPR team have been required by funding sources to screen for IPV in particular populations; however, resources are scarce to appropriately identify screening questions, processes, and interventions for the various multicultural and multilingual groups in which services are provided. The CHCs are expected to work out these processes on their own. The use of CBPR provides an excellent resource and network to assist CHCs in answering questions that could lead to culturally appropriate and effective services for distinct populations.

Implications for partners, partnerships, practice and research

Interaction of the CBPR team has led to shared information, knowledge, and efforts among the CHCs. The clinical and public health scientists from the CHCs have frequently commented on the usefulness of meeting regarding the topic of intimate partner violence and the use of participatory research methods. One of the benefits has been time to reflect on current practices at the health centers and potential collaboration in the future.

Using the common goals and principles agreed to by this research team, one of the health centers approached the SONDH about the development of a Memorandum of Understanding (MOU) based on these principles. This long-term strategy has been agreed to by both the CHC and the school and will benefit both parties by having these expectations explicitly stated. All interested faculty members have met with administrators and clinicians

at the health center to discuss potential collaboration on other research studies. An additional benefit is that students interested in working with vulnerable populations will be included in research activities. The inclusion of the students will help to develop a cadre of nurses with doctoral degrees who have the appropriate attitudes, knowledge and skills to conduct research on relevant health issues in culturally appropriate ways using community based participatory approaches.

Flaskerud (2000) points out the important interaction between practice, education and research. As new challenges are faced or information gained in one aspect such as practice, changes must occur in education so that practitioners are prepared to face these challenges. Both clinical and academic partners in this CBPR team have learned from discussions focused on improving practices to encourage women to disclose intimate partner violence in community health centers. Scholarly excellence develops in an academic setting when there is a synergy between research, education, practice and community involvement (Goldstein, Robson, & Botnick, 1998). This CBPR team works within that rich environment characterized as one that develops scholarly excellence. Excellence can become evident in all dimensions of scholarship including practice, education, research and community health outcomes.

Another implication for partners, particularly CHCs, is being able to use the evidence derived from research to not only improve practice, but to apply for funding to sustain specific services or programs. Historically, past research efforts have left communities with no evidence, outcomes or legacy. Community-based participatory research provides an opportunity to hold all members of the research team accountable for leaving a meaningful legacy in communities and for CHCs. Working as a research team presents occasions for CHCs to consider partnering with each other on large service grant proposals to sustain or develop interventions based on research evidence.

Conclusions

The CBPR team has continued to develop, adapt and find solutions to multiple challenges as they work together seeking to use CBPR methods. The team continues to address the challenges by finding solutions from a variety of sources: from within the team, from others who use participatory research processes in other settings, and from the literature. Implications go far beyond the team members and include the potential for improved services at the community health centers, more collaboration between the community organizations and academic institutions, changes in the operation of both community and academic institutions, additional opportunities for students and improved service for community members who are vulnerable to intimate partner violence.

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