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Hiring the experts: best practices for community-engaged research

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Abstract

Community-engaged approaches to research and practice continue to show success in addressing health equity and making long-term change for partnership relationships and structures of power. The usefulness of these approaches is either diminished or bolstered by community trust, which can be challenging for partnerships to achieve. In this research note we present an example process for recruiting, interviewing, and hiring community researchers as a starting place for capacity building and for laying the foundation for data collection and analysis in health-related community projects.

Keywords

community-engaged research; health equity; health partnerships; medical anthropology; qualitative research

Introduction

Community-engagement and participatory research have proven to be fertile paths toward locally-appropriate health research and practice (Baker et al., 1999; Michener et al., 2012; Minkler, 2005; Roussos and Fawcet, 2000) using approaches such as Community-based Participatory Research (CBPR) (Isreal et al., 1998; Minkler, 2010; Wallerstein and Duran,

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2010), Rapid Assessment, Response and Evaluation (RARE) and its international counterpart (IRARE) (Hardy et al., 2013; Trotter and Needle, 2000a, 2000b; Trotter et al., 2001), empowerment research (Tsey et al., 2007), and Participatory Action Research (Baum et al., 2006; Tsey et al., 2007). Each of these approaches differ in their methods, goals, and outcomes; yet the overlap of each of these approaches is in the end goal that each person involved in the effort will learn new skills by moving from the roles of insiders to outsiders and back again, and through this process, gain access to knowledge and resources, changing the way team members interact with one another and their environments in the future leading to policy change and increased health equity.

Community-based partnerships hold the potential to add layered depth to research processes, findings, and outcomes in ways that traditional deductive studies may miss, yet these are challenging to build, maintain, and navigate through time, and require trust, leadership, and capacity building to achieve goals of improved health and wellness (Christopher et al., 2008; Coe et al., 2006; Cooke, 2005; Mahmood et al., 2001; Mosavel et al., 2001). Capacity building, or empowerment research, is a prominent goal of CBPR, RARE and notably Participatory Action Research (PAR), which provides examples of how people may participate in a learning experience that expands their understanding of their own social environments, allowing them to add layered insights to action processes and implementations (Ericson-Lidman and Strandberg, 2015). These research processes challenge power structures in important and sometimes dangerous ways. It is often the unexpected and unnoticed structures of a project that may cause disruption or erode trust, as community partners may refer to individuals and organizations holding different levels of power and access in relation to anchor institutions. Community partners may include people who represent a local population or profession ranging from individuals with little access to healthcare and histories of genocide and abuse, such as indigenous partners, to physicians or other highly paid professionals. Disruptive practice details such as late payment, poor management, lack of instruction, or asking someone who may not have a credit card to travel to a conference with later reimbursement, for instance, may be invisible to people in higher positions of leadership and devastating to community partners who may not be in a position to communicate these problems.

In this research note we provide ideas for weaving strong reinforcements for community-engagement that may eliminate barriers for researchers who may or may not have formal education and training in similar work, and ideas for capacity building within the structures of health projects that benefit from the insights of researchers and partners who collaborate from different levels of power. Community partners who may have little or no formal higher education, no credit card, or no former related experience may, in fact, become the most informed and central knowledge holders within a community project. It is within the details of project planning and structure that substantial trust and empowerment/capacity building work holds the potential to bring communities closer to working relationships and leadership, or to damage trust and forward momentum. In this article we present one step in a complex process of growing trust that may help to get community-engaged projects started with the most successful groundwork for ongoing fruitful collaboration.

We used our collective past project experiences to design Health Resilience among American Indians in Arizona (*Health Resilience*), a project funded by the National Institutes of Health (NIH) under the umbrella of the Center for American Indian Resilience (CAIR), with the intent of building structures for community participation and collaboration between urban American Indians and medical providers of different ethnicities. This project structure resulted in the completion of data collection and analysis on health resilience and medical practice designed to support existing resilience practice rather than rely on a common and damaging outsider-based model of fixing an indigenous community (Tsey et al., 2007). The tools we present are only one piece of planning community-engagement, which requires community partner participation from project development. In our case, we conducted background research in partnership with local organizations to shape our research questions before we applied for funding. Steps presented here are ideally taken within a timeline of partnership activities that includes participation from different project partners.

Methods

Methods for *Health Resilience* included recruiting, hiring, and training researchers to explore questions of American Indian resilience and health care provider perceptions of patient behaviors. The roots of the project began with a prior RARE study on wellness and resilience showing differences in physician reported understandings of their patients' knowledge and actual knowledge and behavior of patients. Goals were to collaborate with community researchers on determining the most locally-appropriate methods for defining resilience and exploring how people faced with structural inequality and histories of genocide, violence, and relocation, overcame their circumstances in different ways to improve their individual and community health. We sought to explore how health care providers serving American Indian patients addressed health disparities in practice particularly in relation to indigenous patients. The project began with an intensive training for the team including interdisciplinary ethics, a toolkit of research methods, analysis, and group building. At the conclusion of training the team of researchers developed a screening matrix and began the work of developing research tools, deciding which of the available methods would be most effective, and conducting research. Weekly meetings allowed research participants to assess incoming data and correct or revise research tools to achieve project goals. Selected methods included semi-structured inductive interviews, a Wellness Mapping activity (Hardy et al., 2014), and focus groups. Once we completed research the team transcribed all data and applied codes based on emergent themes.

In addition to the aims of obtaining salient data to guide future resilience and medical practice training, the project also sought to build capacity. Planned processes included hiring people who may or may not have opportunities to work in such project settings, providing training in new methods and theoretical foundations, and assisting with ongoing support through opportunities to present, personalized letters of recommendation, and other means for assisting in the leadership of those people who became researchers in the project. Recruitment and hiring of the original team was the first step in setting up the ability of the project to work with community experts.

Hiring the experts: recruitment and interviews

Project design and implementation drew on professional experiences and resources suggesting policy recommendations for the support of community-engagement beyond the participation of community partners as recruiters or resources (AAPCHO, 2013; Brown, 2013; CCPH, 2012; Mosavel et al., 2001). We wrote and strategically disseminated a job description, selected and interviewed candidates, and hired future researchers. Our ability to develop a strong team created the necessary building blocks for collaboration on data collection and analysis, thereby increasing the value of data and ability to use the insights of research participants and team members in ways that could potentially improve wellness opportunities among American Indians in Arizona. Necessary skills for researcher positions included an ability to view one's own community with insight and non-judgmental thinking, understand how individual stories and life experiences create context, a propensity to listen and understand how others make sense of the world, and a willingness to learn new frameworks and methods.

A hiring process in the United States often begins with the circulation of online job postings requesting applicants to submit an electronic résumé documenting their education and work experiences. While this might be the most effective practice for hiring clinic personnel or others, in this case it serves as a qualification checklist to begin screening out ideal applicants who may not meet minimum qualifications. We have each witnessed projects where employers chose community researchers based on prioritization of graduate education or work experience over other forms of local knowledge. In those cases the selection resulted in resentment among local communities who were forced to work with a new hire who won the job over other local applicants as well as the placement of a qualified person in a job position which was not well-matched with his or her ability to become an intuitive and successful member of a community-engaged research team. We have also witnessed projects where recruitment originated through only one organization without interview processes, resulting in a similar pool of researchers who, in some cases, lacked enthusiasm and participated out of obligation, often leaving the project before they made meaningful contributions to the work. We do not intend to imply here that there is only one way to embark on this process, rather that we developed a strategy that looked differently than those we have used or witnessed in the past, and it provided a strong collaborative effort with a wonderful team of dedicated researchers.

In our experience, the most successful candidates for community research positions may have an abundance of local knowledge, community ties, or the ability to inspire participation and engagement from their fellow community members; skills that may not be apparent on a résumé. Several qualified applicants stated the absence of Internet or computer access (as is the case in parts of the Navajo reservation near our project location). Instead of removing these applicants from our pool of candidates, we used informal and formal networks to recruit applicants by circulating a plain language job description in public spaces and through multiple local networks including a community outreach office, health clinics, university centers, and local churches. A recruitment flyer described the project as a 'study on wellness and healthy lifestyles: how we achieve it, how we stay on track, and how we can inspire others to do so'. Applicants completed a short questionnaire either online or in

person about his or her interest in the project and job description, scheduling considerations, and contact information. Once we recruited applicants for researcher positions we developed an interview process that was designed to train and hire those applicants who would be most successful in this role.

The interview: listening to stories

During the interview process we asked candidates to listen to a three-minute story told in first person by project investigators. Interviewers wrote a semi-autobiographical story including questionable decisions and legal action, which we wrote down in order to maintain consistency. Interviewer[s] read the story aloud to each candidate and provided time for candidate questions. Interviewers then asked applicants a series of specific content-driven questions eliciting information on which details the candidate retained, such as the age of the narrator and the location of the events, and any identifiable themes. This approach allowed interviewers to determine which candidates had skills that would be useful for conducting qualitative data collection and analysis, and screen for those who may not excel at these tasks. Several candidates asked insightful questions demonstrating their ability to inquisitively synthesize someone else's experience and ask probing questions. Candidates who showed immediate judgment about the story that obscured their listening skills on the context of the narrator's experience were less likely to hear details about the story and more likely to ask questions that were unrelated to content. Those candidates who set aside biases and carefully focused on someone else's story showed a propensity to learn semi-structured interviewing and data analysis techniques, and become excellent researchers. These were also the researchers who asked the questions that identified their ability to see social context, such as the reasons for the narrator's choices, and where and how the story took place. Selected community researchers were thoughtful listeners, capable of encouraging community participation and involvement. By avoiding the tendency to examine whether candidates met a list of criteria, the interviewers were able to hire from a broader talent base and thus developed a well-balanced team. Once the research team (including academic and community researchers) was formulated, the group collaborated on developing research questions, participated in ethics and methods training, and selected a toolkit of strategies to analyze results and disseminate research findings.

Results

Here we discuss the results of only one aspect of the project: capacity building. Other findings included an in-depth analysis of why and how urban American Indians become and stay healthy, and barriers of health and patterns in lack of understanding of medical providers in their ability to recognize the resilient practices of their patients, are included elsewhere. In the meeting of the goals of our capacity building aim we intended to support community-engagement beyond partnerships that require (often unremunerated) commitment and time of community researchers by providing training and experience. We structured our project to avoid the pitfalls of previous studies where communities with measurable health disparities may have encountered requests for partnership with little return (Parker et al., 2012). We streamlined our training to a three-day workshop and held analysis meetings at a mutually agreed upon time. The training began with participant

activities whereby each team member reflected on his or her own life to define resilience and wellness through word association activities, stories of how people are able to overcome adversity, and how environmental and cultural factors impact human health. We then presented a collaborative approach to training in several ethnographic research methods including semi-structured interviewing, focus group moderation, and a Wellness Mapping Toolkit (Hardy et al., 2014) using tools from RARE. The research team discussed advantages and challenges associated with each research method. We provided community researchers with detailed instruction on participant recruitment, field notes, observation, and participation in research events.

To foster capacity building on an individual level we focused on providing training and opportunities for each person's résumé, recognizing investment within institutions and making new connections for community researchers to pursue in future work (academic programs, medical institutions, and others) depending on their interests. Several project researchers currently hold positions where they apply the tools they learned through RARE training. In one case, tribal government employers recruited one of the community researchers to conduct home assessments and surveys based on the knowledge of the training and experience in social research methods obtained through the project. Additionally, the academic researchers provided personally crafted letters of recommendation outlining the strengths of each community researcher and volunteered to serve as references for future employment opportunities.

Capacity building and support included a constant effort to ensure community researcher ongoing daily support. We created a project management structure that allowed for the scheduling and tracking of potential interview and focus group participants, allowing for constant communication between researchers with multiple jobs and family responsibilities and the inclusion of research participants who were only available in off-hours. Researchers recruited interviewees and focus group participants from within their own social networks and scheduled them on the calendar using codes to protect privacy. Team discussions took place in weekly analysis meetings including a 'housekeeping' portion dedicated to issues on recruitment and scheduling, note taking, and updates on interview methods and outcomes. Our experience suggests a collaborative approach is ideally part of the project management, and not limited to data collection and analysis.

Conclusion

To increase the value of research partnerships and the inclusion of community researchers it is essential to create a community-engaged structure. In doing so partners must be imminently aware of existing power inequalities and historical violence and trauma that have often befallen the histories of global indigenous people and others who have endured forced relocation, death or separation of immediate family members through violent policies, and lack of resources. The development of community empowerment and engaged partnerships must not begin with an erasure of these inequalities or a lack of recognition of how the re-creation of inequality within a project structure may continue to cause mistrust and false data collection. While these barriers may not be visible to all involved project partners, they may be insurmountable to some. The inclusion of project partners in research and project

design from the outset may shift institutional policies and practice toward partnerships that move beyond the present realities to foster stronger communities. Our use of a hiring process designed to sidestep a reliance on previous access to formal education and jobs is one that may contribute to details of research progress that will begin to recognize the knowledge and wisdom of people who are often the subjects and not the researchers of understanding important aspects of the world. Scientific inquiry based on community engagement must include knowledge and training of leaders from within communities for those projects to reach depths of understanding and knowledge through collaboration. The importance of community partnerships for research cannot be underestimated in both obtaining accurate assessment data that represent people's needs and developing projects to address health disparities. We believe that processes within projects designed to eliminate disparities among researchers are crucial for sustained participation and support from the communities involved in research.

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Biography

Lisa J Hardy, PhD is a medical anthropologist with over 10 years' experience working in broad-based wellness and health-related research. Her current projects focus on health equity through community-engagement, ethics, and resilience.

Amy Hughes, MLS, MS is an academic librarian at Northern Arizona University's Cline Library in Flagstaff, Arizona. She currently works with the College of Social and Behavioral Sciences. Her interests include information and resource management and services to rural populations.

Elizabeth Hulen, MA is a research specialist in the Department of Anthropology at Northern Arizona University. Her professional and academic experiences have been in the areas of applied medical anthropology, qualitative research methods, and human development.

Alejandra Figueroa, MA (Anthropology) has several years of experience in research coordination and data analysis positions. Her interests include community engagement, education, and evaluation to support efficient programs. She has worked in the US and overseas with diverse populations, creating and implementing community-based programs in several industries.

Coral Evans, MBA, was elected as Vice-mayor for her second four-year term in May 2012. In addition to serving on council she is the Executive Director of a nonprofit organization

(the Sunnyside Neighborhood Association of Flagstaff, Inc.) and is pursuing a PhD in Sustainability Education; she holds a Master's degree in Business Administration and a bachelor's degree in Business Management.

R. Cruz Begay, MPH, DrPH is an associate professor in the Health Sciences Department at Northern Arizona University. She is a member of the Tohono Oodham Nation in Arizona and has completed MPH and DrPH degrees from the University of California, Berkeley. Her research interests are focused on mitigating health disparities in American Indian populations by examining the socio-cultural and environmental factors influencing health.

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