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A Legacy of Science and Community Engagement via the Community Networks Program

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This special issue of *Progress in Community Health Partnerships* features lessons learned and suggestions for future research from one of the nation's most important and innovative cancer health disparities research programs, the National Cancer Institute (NCI)'s Community Networks Program (CNP) Centers. This second generation of a nationwide network of research programs across the Nation was designed by the Center to Reduce Cancer Health Disparities to support community-based participatory research (CBPR), build on educational and community outreach from the previous round of CNPs, and foster mentoring and career development of researchers and community partners in the field of cancer disparities research.

The CNP (2005–2010) was an initiative designed to address the cancer burden in racial/ethnic minorities and other underserved populations by engaging community members through CBPR efforts. The CNPs (and now the Community Network Program Centers [CNPCs]) are designed to reach communities and populations that experience a disproportionate share of the cancer burden: African Americans, American Indians/Alaska Natives, Hawaiian Natives and other Pacific Islanders, Asians, Hispanics/Latinos, and underserved rural populations. The overall goal is to significantly improve access to—and utilization of—beneficial cancer interventions and treatments in communities experiencing cancer health disparities in order to reduce these disparities. A total of 25 CNPs were funded in the first round. Currently, 23 CNPCs (including 17 of the original CNPs) continue efforts to involve these diverse communities. From the beginning, the goal has been to 1) increase access to and use of beneficial biomedical and behavioral procedures in primary and secondary cancer prevention and 2) develop a cadre of well-trained, competitive health disparity researchers.

In response to the needs expressed by affected communities, the 25 CNP awardees conducted more than 7,500 diverse educational activities (e.g., workshops, health fairs, home health parties), conducted more than 140 needs assessments to identify barriers, resources, and health priorities, and developed more than 120 new educational interventions to increase primary prevention and early detection. The 25 CNPs trained more than 330 new investigators in cancer health disparities research. Those new investigators conducted 53 small pilot research projects as part of the training activities. The CNPs further refined our understanding of the lack of access (e.g., financial and transportation barriers) to health care and other resources. Over those first 5 years, these CNP awardees obtained more than \$226 million in new funds. Overall CNP productivity and academic success are reflected in the nearly 500 peer-reviewed scientific publications the CNP awardees produced.¹ Of

considerable note, given the NCI's stated intention to translate evidence-based research into places of public health relevance and clinical need, are CNP accomplishments in the area of science-guided health policies within some states. These policies supported access to beneficial cancer interventions and expansion, and in some areas, of reimbursement for clinical costs associated with clinical trials participation.¹

CNP COMPREHENSIVE CENTERS

Guided by lessons learned from the first round of CNPs and emerging research in the field of cancer disparities, in 2010 the NCI announced the second round of awardees, which are the focus of this special issue. The goal of the CNP Centers remains to increase knowledge of, access to, and use of beneficial biomedical and behavioral methods related to cancer in areas ranging from prevention to early detection, diagnosis, treatment, and survivorship. In the CNP Centers issuance, a particular emphasis was placed on high-quality intervention research involving controlled and rigorous research studies. These trials depend heavily on partnerships established between academic institution(s) and targeted disparity community entities/community-serving health care organizations. Many of these began in the CNP. This kind of longevity and commitment underlines the importance of continuity in developing and maintaining community partnerships. In the spirit of CBPR, partnering communities contributed substantially to the design of these interventions. As Partridge and colleagues² discuss, this entailed working with the community to address challenges related to shifting from infrastructure building to address community education/outreach needs to transitioning to designing and implementing a controlled research study aimed at weight loss.

Hebert and co-workers³ call us to consider the potential role of stress in driving cancer-related health disparities, providing examples from African Americans in South Carolina, Hawaiian Natives through 'Imi Hale, and Hispanics in Washington state. Stress not only has the potential to drive many cancer-related health disparities, but it also exerts an important impact on willingness to engage in collaborative research.

Two articles in this special issue compel us to consider the larger context in which CBPR is conducted. Arroyo-Johnson and associates⁴ ask us to consider variations in the definition of CBPR that can help to support and expand further research to develop standards for CBPR evaluation. Hebert and colleagues⁵ from South Carolina, 'Imi Hale (Hawaii), Kansas, WINCART (Southern California), and Alameda County (in California's Bay Area) ask us to carefully consider expanding our conception of beneficence to include "community beneficence" to increase our ability to engage high-risk communities. These ideas and perspectives open exciting new possibilities for conducting research that might never have even been considered previously.

Clearly, an important part of NCI's mission (and that of the U.S. Public Health Service more generally) is to engage individuals from underrepresented and high-risk communities in activities ranging from cancer screening to involvement in research studies entailing collection of biospecimens. The articles by Seay and colleagues⁶ and Shirazi and colleagues⁷ address screening in groups ranging from Haitian and Cuban immigrants in Miami to breast cancer screening in Afghan women in Alameda County, California, rural

Latina and American-Indian women in Kansas, and urban African-American women in Baltimore. Meade and colleagues⁸ present an interesting description of introducing the concept of biospecimen collection in Tampa and Buffalo. Another, often overlooked aspect of health disparities problems are the limited number of well-trained, competitive researchers in biomedical and behavioral sciences from diverse populations who have appropriate cultural sensitivities and insights into sources of health disparities and solutions. In addition, few investigators are trained in research approaches that engage community members, using CBPR methods. As the article by Felder and colleagues⁹ indicates, the CNPCs fill a very important need by training a cadre of individuals from diverse communities, who have scholarly productivity comparable to other national training programs. The need for consistent use of the CBPR principles reflects the notion that the problems of the community can be solved more readily by and with the community members' participation.

SUMMARY

This special issue documents the progress of a unique group of research investigations that further legitimize the engagement of affected communities in quality cancer health disparities research and, the importance of mentoring and training of new and diverse health disparity researchers. The implications for the reduction and elimination of cancer health disparities within the United States are apparent. The diversity of populations included in these novel studies also has implications for addressing inequities in a global context.

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