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Using Community Ties to Facilitate School-Based Prevention Research

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One of the greatest obstacles to conducting school-based HIV/STD/pregnancy prevention research with adolescents is the reluctance of administrators or site-based decision-making councils to commit their teachers and students to participation in a project designed and managed by an outside group of researchers. A major concern is that researchers may not understand or agree with community sensitivities about such personal topics. By first establishing a collaborative relationship with health district educators currently working in Appalachian schools and residing in those communities, one finds a distinct advantage in terms of gaining admittance to area schools. The presence of local health educators at formative meetings also allays many concerns of community members, as they view these local participants as monitors of outsider research efforts, thereby protecting the community culture from undue outside influence. During the course of the current study, health educators found they also learned more about their communities and about HIV prevention.

Keywords: *communities; school-based research; adolescent health; HIV prevention; pregnancy prevention*

The number and variety of school-based health promotion and prevention programs has grown exponentially in the past few decades. Research-based programs for tobacco, alcohol, drug, violence, and risky sexual behaviors are fairly abundant in the marketplace. Among others, the Centers for Disease Control and the National Institutes of Health have promoted the rigorous evaluation of these programs to

determine which can be claimed to demonstrate so-called effectiveness. However, as Hansen and Dusenbury (2001) noted, to date much of the emphasis has been on delineating the specific composition required for programs to be effective. That this is an important area of inquiry is indisputable. Another equally pressing concern is how to successfully implement and sustain these programs in the field (Hansen & Dusenbury, 2001). Although this article examines one successful approach to gaining access to a relatively large number of schools and students to conduct a large-scale intervention project, it is reasonable to propose that this strategy could also be used to facilitate long-term adoption of programs in the schools.

Barriers to School-Based Intervention Studies

What we and others have found (Blinn-Pike, Berger, & Rea-Holloway, 2000; Harrington et al., 1997) is that there is a paucity of literature delineating recruitment methods for school-based studies. It is, therefore, not surprising that published studies examining how to gain access to schools in rural areas in particular are almost nonexistent. The High 5 Alabama Project, a school-based program teaching elementary students about diet, recruited schools by seeking a district-level advocate to help facilitate the process (Harrington et al., 1997). District nutritionists helped to introduce the researchers to and facilitate relationship development in all of the schools in the three targeted school districts. Another researcher, who conducted a longitudinal pregnancy prevention study, emphasized the importance of linkages between universities and communities because they legitimize the research for the schools involved (Stevens, 1999). If the community

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advocate is viewed and treated as a research facilitator, certain procedures, such as parental consent, can be more easily instituted from his or her so-called in-the-field position. The community's cultural values are also represented through this intermediary, and she or he can ensure that the research has relevance to the community (Stevens, 1999).

► BACKGROUND

One of the most frequent concerns about doing school-based research centers on the real and perceived difficulties in gaining access to and working within public school systems. These comments in no way represent an indictment by us of public school systems and their overtaxed teaching staffs. One of the fundamental barriers to developing collaborative research relationships with schools may simply be attributed to the difference in agendas between primary and secondary school systems on one hand, and university researchers on the other. As described by Olds and Symons (1990), a primary goal of the public school system is to educate youth; their cognitive, social, and physical development is the daily concern of schoolteachers. Conversely, university professors, particularly at research-oriented institutions, are concerned with contributing to scholarship and the body of knowledge. These goals, although potentially related, require different perspectives and priorities.

While schools provide a great opportunity to reach large numbers of adolescents with prevention programs, they pose the distinct disadvantage of having a multilayered bureaucratic structure. Researchers must gain approval from a number of entities before plans can be finalized, paperwork can be processed, and participant recruitment can begin. A second, but equally problematic barrier is the mistrust many school officials have for and exhibit toward researchers. It is incumbent on researchers to consider the needs of the research project and the research participants. However, some

schoolteachers and administrators perceive that not all researchers fulfill promises or honor agreements made with individual students and teachers, the larger school community, or both (Evertson, 1977). Additional barriers include the potential for bad publicity for the school if the study is unpopular or unsuccessful, territorialism by teachers or administrators, and the pressure to make certain students perform well on statewide assessments (Sanders, 2001).

Beyond this generalized skepticism about research and researchers, schools in close-knit, isolated, and/or rural communities are often even more difficult to access because citizens are guarded about outsiders (Helge, 1985), particularly when these outsiders are intruding on an institution that is a major source of local control and pride (Morrisette, 2000). Some research attributes part of this suspicion to the fact that although educational, social, and economic policy decisions are made almost exclusively in urban or metropolitan areas, the impact is felt equally in rural communities (Castle, 1998). The lack of so-called voice many rural communities feel regarding these policy decisions tends to foster resentment toward those they perceive as urban decision makers, primarily because members from rural and/or small communities feel their viewpoints are not solicited or considered. This geographical isolation is complicated by cultural norms that often reify this feeling of skepticism about outsiders (Rural and Appalachian Youth and Families Consortium, 1996). In a study examining college attendance in rural communities, researchers found that rural communities may be equally or more concerned about "country values" than about academic credentials when hiring teachers (McGrath, Swisher, Elder, & Conger, 2001).

In many rural communities, and in Appalachia in particular, an important social unit is "kin." This encompasses more than the nuclear family, which is of critical importance in nearly all cultures. In this case, *kin* refers to an extended family that might include aunts, uncles, cousins, in-laws, and cousins of in-laws. Researchers have found that strong community ties and a well-developed sense of place may serve rural communities well, as they allow for creative solutions to local problems (RMC Research Corporation, 2002). However, although well-developed social networks such as these provide a strong sense of connectedness, there is sometimes an inverse relationship at work here that may have unintended consequences. As community members become more cohesive, the tendency to be suspicious of outsiders becomes greater. Thus, for outside agencies, including research groups, to work collaboratively in such an environment, it is extremely valuable to have an insider to introduce and validate the work and the workers. This endorsement of the study may come from one or more of several sources, such as key school personnel (counselors, nurses, food service workers), professional educational associations, or other influential local groups. This local connection is

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important to school administrators and decision makers (Olds & Symons, 1990). These in-house professionals also serve to validate the study for concerned parents and other community members.

In almost all circumstances, community involvement and connectedness contribute positively to the life of children (Sanders, 2001). Rural (and other politically or geographically isolated) communities may provide more social support and cohesion than urban areas; unfortunately, this does not completely insulate adolescents from rural or isolated communities from a variety of wider social concerns. Adolescents in rural communities are also at risk for becoming pregnant, getting a sexually transmitted disease (STD), and using or abusing drugs and alcohol; Helge & Paulk, 1991). A number of successful school-based intervention programs targeting such behaviors exist. However, the objection to such programs can be particularly problematic, perhaps even more so in small towns. The reality is that just one or two influential people can have an enormous impact on public opinion in small communities.

The good news is that, in general, there has been a shift in the argument, in the past decade, from whether any sexuality education should be taught in the schools to what should be the content of such school-based programs (Blinn-Pike et al., 2000). As early as 1992, the Division of Adolescent and School Health of the Centers for Disease Control and Prevention (CDC) began evaluating pregnancy and HIV/STD prevention programs to provide data for schools and other health education outlets to consider when adopting a program. Five curricula were determined to have the strongest effects on delaying sexual activity and increasing safer sex (CDC, 2000). Two of these five curricula, *Get Real About AIDS and Reducing the Risk*, are school-based programs that teach abstinence and protection. Largely because of this evaluation, the *Reducing the Risk (RTR)* curriculum was selected in 1999 (when the grant proposal was being prepared) to be the model for the researchers' modified prevention interventions designed to target adolescents who are high-sensation seekers and impulsive decision makers. Despite such high recommendations at the national level, it is nonetheless the perceptions of individuals at the local level that determine whether such programs are actually implemented in the schools.

► METHOD

Overview of the Project

The primary goals of the research project described here, *HIV Prevention for Young, Appalachian Risk-Takers* (Rick Zimmerman, P.I., MH061187), were to modify a successful HIV/pregnancy prevention program to make it more effective in reaching high-sensation seekers (HSS) and impulsive decision makers (IDM) in rural areas and to measure the impact of the

intervention on sexual attitudes, intentions, and behaviors. Based on research by Zimmerman, Donohew, and others (Donohew et al., 2000; Zimmerman et al., n.d.), HSS and/or IDM individuals are more likely to initiate sex at an earlier age, have more sexual partners, and experiment with drugs and alcohol which often lead to impaired decisions about sexual safety. In previous studies by this research group, modifications were made to RTR in an attempt to attract and hold the attention of students who are difficult to engage in traditional pedantic classroom environments. A more thorough treatment of the research perspective is available (Donohew et al., 2000).

The first cohort of students was recruited in ninth-grade health class either in fall 2000, or spring 2001. Baseline survey administration occurred about 1 month prior to the implementation of the main intervention in ninth grade. Students in the treatment condition received one of the two 3-week, skills-based HIV and pregnancy prevention curricula, while students in the comparison condition continued to receive the school's predominantly knowledge-based instruction about HIV and pregnancy. Follow-up data collections occurred at the end of 10th and 11th grades. Students in the comparison condition completed surveys at the same time in the school year as those in an intervention condition; matching of survey administrations across experimental and comparison conditions was done to standardize ages and developmental stages of students, rather than proximity to interventions as most comparison schools did not have well-defined HIV and pregnancy prevention units. A second cohort was recruited 2 years after the first one and followed the same schedule as described above.

As mentioned, schools were recruited in spring 2000 to be in one of two treatment conditions (RTR or Modified RTR) or in a comparison condition. Because health district educators often teach in multiple schools, the educator (classroom teacher or health department educator) was the unit of randomization so that each educator was only exposed to one condition, acting to reduce confusion and minimize contamination between conditions. Schools were also stratified by size and a number of other variables (e.g., poverty, racial composition) prior to randomization in an attempt to yield comparable samples in the two intervention groups. Schools were then assigned to either the Modified RTR curriculum or the original RTR curriculum.

Recruiting comparison schools for the current study required a different method. Because no health educators were offering RTR in these schools, health department representatives usually did not have solid preexisting relationships with these administrators or teachers. Therefore, health educators were not used to recruit comparison schools because eligibility to be a comparison school was based on the fact that the school was not currently teaching RTR. School principals were contacted about the current study, and proposals were made to several school systems that were similar demo-

graphically to the intervention schools and that did not teach RTR or a similar curriculum. However, without the advantage of having an inside health educator promoting the project, the schools were less open to collaborating on the project. The agreement process, consequently, was much more lengthy and tedious. Although only three comparison schools had agreed to participate in the project at the beginning of the first cohort, three more were added by the end of that school year.

Health Department Educators as Collaborators

Through the collaborative efforts of the health departments and members of the research team, 28 schools in four different rural health districts were recruited to participate in the current study. This feat would probably not have been possible without assistance from representatives of the various health departments. In addition to this approach being of great benefit to the research group, health district educators also reported participation in this project to be a positive experience.

The initial decision to approach health districts to collaborate was somewhat serendipitous for both parties. As stated earlier, the intent of the project was to build on previous research conducted in urban high schools using the RTR program. For the past few years, the Kentucky Health Department has offered training to health educators throughout the state to prepare them to teach sex education using RTR in the high schools. Because the research designed featured RTR as the intervention in one treatment condition and as the basis for the modified intervention in the other treatment condition, it was deemed to be most suitable to propose a collaborative arrangement to those agencies already familiar with, supportive of, and in some cases already teaching the program.

School Recruitment

Approximately 6 months prior to submitting the current project proposal for review, meetings between health district administrators and/or educators and the research team were conducted to enlist their support. The health district administrators came to the meeting willing to listen but skeptical about the benefits to their organizations. They posed many questions, mainly centering on staff time commitment, and determined that they needed to discuss the project with others at the district level. While a couple of the districts seemed especially enthusiastic at the initial meeting, none of them committed at that time. Mirroring previous experiences with a variety of school systems, the research team found they first had to gain the trust of the health department by responding to each concern about the processes, goals, and commitments relating to the project. As these local health department educators were already familiar with RTR from teaching it in the

schools, the questions were usually about administrative details or what the research process would add to their workload. They requested a detailed project description and timetable delineating their roles and the accompanying incentives. The amount each district would be compensated was based on the number of schools, teachers, classes, and students participating in the current study within the health district. Incentives would be paid quarterly for the duration of the project, including during the initial year of formative research.

The attitudes of the health department representatives toward the proposed research were not uniform; some expressed willingness to participate in a research project, while others expressed skepticism. One ultimately chose not to commit because of logistical problems. A legitimate concern expressed by the health district was the potential disruption of introducing a new project and a group of outsiders into established routines with the schools; the fear was that this might affect carefully developed relationships. Another valid concern was how researchers' expectations might influence their staff (perhaps staff would not meet expectations, increased workload would result in upheaval, or other tasks would be neglected). In addition, the health department directors and educators demonstrated protectiveness about their schools and students and wanted to ensure that any promises made regarding procedures or incentives would be honored. Finally, health department directors and educators were concerned about the reaction of the school administrators and site-based council members to the content of the confidential surveys. The research team allowed them to review a draft survey and express concerns about the content. Subsequently, items that were not critical to the success of the project were eliminated. In addition, senior project scientists offered to meet with any school official who had additional concerns about specific questions. School administrators were also given the data collection protocol, which explained that active parental consent would be required, that several different versions of surveys would be used (to increase privacy during survey administration), and that no link to students' names would be visible on the survey, thus offering a very high degree of confidentiality.

After weeks of perseverance, the concerns of the health districts were allayed. By the time the grant proposal was submitted, four health districts, representing a potential of 30+ intervention sites and 7,000 students, had agreed to participate in the current study.

When the project was funded, another series of meetings began, involving health educators, school officials, teachers, and research team members. After the health districts committed to participating in the current study, a project representative talked briefly with the schools about the project and then set up a meeting to introduce the researchers to school personnel (usually the principal or vice principal) to discuss the logistics and requirements of the research to them. Despite using

these community advocates to help present the research, three of the schools decided not to participate in the project. Generally, the major concern cited with the three that decided not to participate was potential reprisal from parents and other members of the community because of the sensitive nature of the current study (adolescent sexual behavior); the other concern was related to the time and effort it would require of school staff.

Project Implementation

Further planning, role definition, and task assignment ensued, with some variations accepted at the district level. For instance, three of the four health departments elected to use health department educators to teach the curriculum, while one district decided they would support the classroom teachers in teaching RTR but would not provide the principal instructors. The health educators also agreed to serve as the principal liaison between the schools and the research team and to play a major role in distributing and collecting consent forms and scheduling focus groups, pilot trainings, data collection, teacher trainings, intervention implementation, and classroom observations.

Training of the health department educators and health teachers began with a mandatory 16-hour training session approximately 1 month prior to the distribution of consent forms and baseline data collection. During this 2-day retreat, the research team taught the RTR and Modified RTR curricula to small groups of educators, with each educator being exposed to only one version of the curricula. In addition, the research team trained the health departments on the appropriate procedures for distributing and collecting consent forms, keeping records, and facilitating classroom observations.

Neither health department educators nor classroom teachers were actively involved in data collection. When present, the health educators and teachers were asked to maintain a low profile and were instructed not to answer students' questions or look at the students' surveys. Maintaining confidentiality, and the appearance of confidentiality, is extremely important to the research team to not only encourage honest responses from students but also to uphold promises made to the schools and health districts.

To date, health department educators and the research team have met formally twice per year to voice opinions, ideas, and concerns; share experiences related to teaching the curriculum; and work through problems by talking about them collectively. These meetings have offered an opportunity for dialogue between those implementing the intervention and those who created and oversaw the intervention, thereby enhancing communication and relationships.

► RESULTS

Discussion of the Benefits and Limitations of This Recruitment Method

The research group's perspective. Gaining entry to and acceptance within schools in rural communities is often a great challenge for school-based prevention research. The previously described strategy of involving health departments allowed this research group to enter these communities and conduct research concerning sensitive topics. The collaborative partnerships between the health department educator and project staff have proven essential in the furthering of this school-based research. Following is a summary of the benefits garnered as a result of this methodology.

First and foremost, establishing a collaborative partnership with the health department educator afforded the project access, credibility, and reputability within the rural communities. On seeing respected health educators willing and eager to work with an outside research group, other members of the community were more willing to join the partnership. This resulted in 28 schools agreeing to participate in the first cohort of the current study and 32 in the second cohort. Equally important, when the administrators signed on to the project, teachers responded enthusiastically during the participant recruitment phase of the current study. The overall consent rate was about 73%, netting 5,679 study participants. Once again, this level of success was largely attributable to the positive influence of the health educators with classroom teachers.

As part of the collaborative partnership, the health educators attended initial meetings between superintendents, principals, site-based councils, and the research team. With the support of a local health department educator at these first meetings, the responses of school personnel were more likely to be positive about the project. The function of the health educator in these meetings was twofold: first, he or she facilitated introductions and offered a thumbnail sketch of the research project; second, he or she could serve as a buffer or negotiator if the need arose. This was particularly useful when the research team was not attuned to cultural or community values.

During the life of the project, this collaboration also provided researchers easier access to the teachers and students at the schools. The health district educators, being members of the community and local service providers, worked continually with the school systems via a variety of preexisting programs, maintaining a visible presence in the school systems. This ongoing relationship refined two-way communication between researchers and teachers; health educators helped to make certain that teachers received important information and routine messages about the project. Installing a

toll-free line in the project office has also helped to encourage greater communication between researchers, classroom teachers, and health educators.

Health district educators also served as important field representatives that helped monitor and maintain strict adherence to fidelity to the delivery of the curriculum in the schools. Although teachers and health educators were trained in the research methodology, it would be an exaggeration to presume absolute fidelity to the curriculum or study design. The researchers believe, and site visits confirm, that in most cases data collection and intervention implementation followed established protocol. In fact, although relationships between the researchers and the classroom teachers and health educators were collegial, local collaborators were quick to draw attention to any real or perceived deviations from said protocol.

Finally, without health district educators, the project staff would have been unable to maintain the everyday operations of a project that involved as many as 28 schools, spanning 5,000 square miles, and reaching up to 3,000 students per year. Health educators were available to assist in consent form distribution and collection, processing evaluations, scheduling, and other needed communication with the schools. Using health educators to perform these tasks afforded greater efficiency, eliminating the need for near-constant travel by a research team that could have easily become overextended. Overall, the health educators played many roles in the implementation of the project and were vital to the daily functioning and overall success of the project.

The perspective of the health districts and health educators. In an attempt to identify the benefits and drawbacks for the health districts, qualitative interviews were conducted with the health education directors. These midlevel managers were the individuals most directly involved with the project in each district. The health education director generally reports to the overall director of the health district and supervises from one to four health education specialists. To differing degrees, these individuals perform administrative and health education outreach duties. In the current study, three of the four health education directors actually were involved in participant recruitment, teacher training, and/or intervention delivery.

For this article, each director was interviewed individually and asked several open-ended questions about the project. While three of the four health education directors answered the questions in quite a similar fashion, one director provided not only positive feedback but also constructive criticism. Following is a summary of benefits and drawbacks of the research method from the perspective of the health education director. The health education directors were asked to discuss the positive aspects of being involved in the project. First of all, they acknowledged the benefits received by the health department. Instead of jeopardizing their rela-

tionships with the schools, as was the original concern, working with the project resulted in improved collaborative relationships among the health departments, school administrators, and classroom health teachers. In addition, health district staff reported that this collaboration resulted in them having greater credibility and prestige because of an association with a project from a regionally prominent university. An increased willingness to work in tandem to better provide education and resources to high school students now exists. Through day-to-day activities associated with the research project, schoolteachers and health educators came to better understand one another's needs, goals, and responsibilities, thus forming a unique support system. However, the health education directors did acknowledge that the effort required to maintain teacher–health educator partnerships has added to the workloads of the health educators and their support staff.

The directors also stated that being a part of the project has increased their network of resources. The health departments were not only connected to new resources in their community but also realized additional resources at the university through the project. The directors expressed that they could now call the university to gain access to current statistics and to have their questions answered. Before the project began, they had to rely on local sources that were not always accurate or timely. One director claimed that she could ask a question, and if the researchers did not know the answer, then she would be referred to someone who could answer the question. She appreciated the effort made by the project staff in responding to these requests.

In response to a question about how this project enhanced the work of the health district, they responded that district-level staff gained added exposure to and information about the systematic, scientific evaluation of HIV/STD and pregnancy prevention programs. This is consistent with other research, such as the study (Smith, Blake, Olson, & Tessaro, 2002) in West Virginia looking at cultural interpretations of diabetes and available treatments. Community organizations felt they were better able to plan for diabetes management as a result of this collaboration. As suggested in one of the interviews in the current study, the project also served as a form of continuing education in research methods. The exposure to new strategies in school-based prevention research was definitely a benefit for the health educators.

When asked to discuss some of their frustrations in working with the project, health educators and teachers expressed concern about the balance between their involvement in the day-to-day details of the project and their awareness of and involvement in the overall project goals and outcomes. While health department colleagues reported that communication about schedules and activities was satisfactory in most cases, they expressed a desire for project staff to improve ongoing

feedback about the overall status of the project. A monthly e-mail newsletter has been suggested as a method of improving overall communication.

When asked about the monetary benefits to the district, all of the directors readily acknowledged that the cash stipend awarded to the health district was the best incentive and the most attractive aspect of the current study. For larger health districts, the quarterly compensation paid the majority of an entry-level professional staff member's salary. The smaller health districts found that the stipend was useful in expanding their own services. The monetary compensation seemed to increase staff morale and cooperation within the districts and served to justify the additional work created by collaborating with the research project.

When asked how they personally benefited from the current study, the directors also acknowledged that they did, indeed, gain from their association with the project. First cited was the enjoyment derived from being a part of a research project. The directors found that the project directly related to the concerns and goals of health educators and that participating in a research project could be an exciting and rejuvenating experience. Because the materials used in conjunction with the project were preprepared for the directors, the majority of the directors agreed that the amount of so-called busy work required to prepare for a class had decreased, leaving them with more time to read and study relevant materials and current literature. However, some of this extra time was needed to manage the process of distributing and collecting parental consent forms for the students. Despite support from the project staff, this proved to be a labor-intensive task. Overall, the directors were enthusiastic and expressed positive comments about working on the project and would enthusiastically recommend a similar arrangement to other health districts.

► DISCUSSION

The success achieved to date in forming and maintaining collaborative partnerships with the health departments in rural Kentucky has exceeded initial expectations. However, on interviewing the health district directors, the research team now has a clearer understanding of how to make the relationship even stronger. In the near future, it is clear that health educators should be provided additional training on research design, specifically as it relates to research projects in which they are involved.

Next, health educators need continuous communication with the research team to ensure the smooth progress of the project. This includes open and frequent communication among the research team, health educators, and the schools. The tendency is to initiate direct communication about specific project events and needs, while failing to provide adequate project updates and positive feedback. Both types of communication are

necessary to sustain a cooperative working arrangement.

It is also important that the research team specify early in any collaborative agreements that part of the incentive funds provided to the district be used specifically for health education programs, training, and materials. To date, money provided to the district from the grant has been used to defray the costs at the district office, such as salaries and benefits. However, what the health educators suggested is that these salary savings are not necessarily used to improve health education programs. Although not clearly unethical or improper, this practice does little to improve the working situation of collaborators.

Another key consideration is that the success of research projects, especially those investigating sensitive topics such as drug use and sexual behavior, is predicated on the level of trust between the researchers and the community (Thomas, Eng, Earp, & Ellis, 2001). Perhaps the most significant contributions of community collaborators include vouching for the integrity of the research team and sharing their perceptions about community norms with the researchers. It then becomes incumbent on researchers to deal with this information responsibly so no harm is done to relationships that colleagues living in the community have built.

Finally, it is important to realize that health districts also have their own cultures. In an attempt to standardize everything related to the project, the research team tried to insist that all health districts behave identically. This could have proved disastrous if not for the fact that the researchers were too busy to enforce these rigid expectations. Health districts in Kentucky are significant medical service providers and sources of employment in many towns. These organizations have their own cultures and political structures. To work collaboratively, one must accept that each district operates differently and that it is essential to cultivate individual relationships, expectations, and systems with each district.

Several important implications for future work in rural schools can be gleaned from the current study. First, more frank discussion and specific detail about the process of recruiting schools for school-based studies is definitely needed in the literature. While little attention is paid to this critical process in the method sections of most publications, there is much to learn about developing relationships that can truly be characterized as collaborative.

Second, developing symbiotic relationships in the community is critical. If the researchers or the research are never truly accorded access to the community, the quality of the research will suffer. Taking time early on in the research project to cultivate healthy, respectful relationships is a good investment.

It is also critical to communicate about the potential and realized advantages available to collaborators in the research process. While the health district educators

provide a critical service to the project, they also realize benefits as a result of their collaboration. That this can be a positive arrangement for everyone involved is something worthy of sharing. Good research programs not only use participants and collaborators for their own purposes but also give back to the community information, resources, and support for programs.

Finally, for those of us involved in applied research, long-term sustainability of effective programs is an important goal. By developing open, collaborative relationships with community members during the research process, local enthusiasm about and ownership of the program can be cultivated. This is potentially an important first step in achieving program sustainability.

In scientific inquiry, the principal consideration is the results of a study. However, using this article as but one example, it is also important that we continue to share information about processes for study design and implementation to consistently improve.

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