J Ambulatory Care Manage
Vol. 38, No. 4, pp. 297–308
Copyright © 2015 Wolters Kluwer Health, Inc. All rights reserved.

"It's In My Veins"

Exploring the Role of an Afrocentric, Popular Education-Based Training Program in the Empowerment of African American and African Community Health Workers in Oregon

Arika Bridgeman-Bunyoli, MPH, BA; S. Renee Mitchell, MBA; Abdul'Hafeedh M. bin Abdullah, BA, CHW; Ty Schwoeffermann, BA; Toliver Phoenix, CHW, AA; Cat Goughnour, MSc, BA, CHW; Richard Hines-Norwood, BS, CHW, PWS; Noelle Wiggins, EdD, MSPH

Abstract: The role racism and other social determinants of health play in the creation of health inequities in African American communities in the United States is increasingly understood. In this article, we explore the effectiveness of an Afrocentric, popular education–based community health worker (CHW) training program in creating positive change among CHW participants and their communities in Portland, Oregon. Findings suggest that CHW participants experienced 4 types of awakening, in addition to changes in their interaction with their family members and increased community involvement. The CHWs identified group bond, Afrocentrism, public health knowledge, popular education, facilitators, and time management as important elements of an effective training program for this community. Psychological empowerment, self-reported health status, and health behavior among participants generally increased over time, but changes were not statistically significant. **Key words:** *Afrocentric, CBPR, community health workers, culturally specific, popular education*

Author Affiliation: *Multnomah County Health Department, Portland, Oregon.*

The opinions expressed in this article are those of the authors and do not necessarily represent the opinions of the Multnomah County Health Department.

The authors thank all the CHWs, who participated in both WAHM cohorts, the interns, who helped make the research possible, and to J. Jordan-Green, who cofacilitated the focus group.

The authors have disclosed that they have no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.ambulatorycaremanagement.com).

Correspondence: *Arika Bridgeman-Bunyoli, MPH, BA, Multnomah County Health Department, 10317 E Burnside, 2nd floor, Portland, OR 97216 (arika.bridgeman-bunyoli@multco.us).*

DOI: 10.1097/JAC.0000000000000112

AFRICAN AMERICANS are disproportionately impacted by many chronic conditions such as premature birth, diabetes, and asthma (Centers for Disease Control and Prevention, 2011; Jasienska, 2009; Smith et al., 2005). Institutional racism and structural violence are examples of social determinants that

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

have been shown to have permanent negative impacts on health in African American communities (Collins et al., 2004).

Community health workers (CHWs) have successfully addressed health inequities in a variety of communities, including the African American community (Hill-Briggs et al., 2007). Previous studies suggest that the type of training in which CHWs engage has an impact on their ability to be successful in their work (Wiggins et al., 2013).

The We Are Health Movement (WAHM) CHW training and follow-up were designed using an Afrocentric and popular education (PE)–based approach to support African and African American CHWs in Portland, Oregon, to increase their health knowledge, psychological empowerment, self-reported health status, self-reported health behavior, community-connectedness, professional development, and employment status. The CHWs participated in 90 hours of training and then were connected to the larger CHW movement in Oregon. Using mixed-methods and a community-based participatory research (CBPR) approach, we measured changes among the CHWs and assessed their perceptions of the training program and how it could be improved. Specific research questions addressed are found in Table 1.

In this article, we first provide background about the intervention before going on to describe the study design, paradigms, and methods. We conclude by sharing the quantitative and qualitative results of the study and reflecting on their implications for future research.

BACKGROUND

Health inequities among Africans and African Americans in Oregon

WAHM CHW trainings and associated support were initiated in direct response to increasing concern regarding health outcomes for Africans and African Americans in Oregon. Specifically, a series of disturbing reports published between the years 2009 and 2014 provoked nonprofit and public health leaders to develop strategies designed to reduce the prevalence of health inequities among African and African American populations in Portland, Oregon. In 2011, the Multnomah County Health Department published its *Report Card on Racial and Ethnic Disparities*, which noted that African Americans experienced the largest number of health disparities among ethnic groups within Multnomah County. The data collected about African Americans identified significant disparities within 10 of the 18 health indicators measured.

Table 1. Sources of Data for Research Questions in the We Are Health Movement Study

Question	Data Source(s)
1. Is participation in an Afrocentric, popular education–based CHW training course associated with positive changes in health knowledge, psychological empowerment, self-reported health status, self-reported health behavior, community-connectedness, professional development, and employment status among participants?	Primary: CHW Questionnaire Secondary: CHW interviews and focus group
2. What changes, if any, do the CHWs perceive in themselves, their families, and their communities as a result of their participation in the training course?	CHW interviews and focus group
3. From the perspective of the participants, which specific aspects of this Afrocentric training program are most successful and how can the training program be improved?	CHW interviews and focus group

Abbreviation: CHW, community health worker.

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

In addition, 2 community-driven reports—the *State of Black Oregon* (Urban League of Portland [ULP], 2009) and *The African Immigrant and Refugee Community in Multnomah County: An Unsettling Profile* (Curry-Stevens & Coalition of Communities of Color, 2013)—provided context that eventually shaped the training and the study. The *State of Black Oregon* revealed health inequities among African Americans in Oregon such as an African American infant mortality rate that was 50% higher than the white infant mortality rate. The 2013 *Unsettling Profile* report also noted that 12.8% of African immigrants and refugee communities were without health insurance in Portland (Curry-Stevens & Coalition of Communities of Color, 2013).

The role of CHWs in addressing health inequities

More than 30 years of research has credited CHWs with achieving a wide range of outcomes, from successfully connecting individuals to existing services to addressing the social determinants of health to eliminate inequities (Brownstein et al., 2011; Ingram et al., 2014). As partners in research, CHWs offer valuable insights into the lives of community members, including impediments they face to accessing care and services (Andrews et al., 2004; Hill-Briggs et al., 2007; Peacock et al., 2011). Partly as a result of these demonstrated outcomes, the Patient Protection and Affordable Care Act (2010) highlighted the actual and potential role of CHWs and encouraged their further integration into health care teams. *Oregon House Bill 3650* (2011) further stimulated an increased focus and commitment to the professional development of a CHW workforce.

An Afrocentric, PE-based CHW training program was identified by staff at the ULP as a critical next step to addressing health inequities on this political landscape. They subsequently approached staff at the Community Capacitation Center of the Multnomah County Health Department, who linked them to an African American–serving primary care clinic, and the WAHM was born.

A PE-based Afrocentric approach to CHW training

The use of PE philosophy and methodology to improve health outcomes has been explored in the public health literature as early as the 1980s. Recently, efforts have been made to systematically review and document the model and its successes within the public health context (Wiggins, 2012) and specifically as the methodology and philosophy for CHW training (Wiggins et al., 2014). However, the study of PE as a method to train CHWs with an Afrocentric lens is virtually nonexistent within the public health literature. Core principles within PE emphasize lived experience and commitment to cultivating environments of collective and shared learning, allowing for a type of flexibility that is needed when engaging diverse and culturally complex populations.

In addition to being influenced by PE, the WAHM training was intentionally Afrocentric. Various scholars have contributed to a rich body of literature defining Afrocentric paradigms. Some emphasize ways of viewing phenomena that ultimately facilitate a process of self-affirmation, reawakening, and a rebirth of beliefs and behavior (Asante, 2009; Robinson & Howard-Hamilton, 1994). Others highlight the existence of principles inherent in Afrocentricity that connect the individual perception of self to a collective perception of reality (Coppock & Coppock, 1990).

Building on previous definitions, for the purpose of the WAHM training and this study, "Afrocentric" was broadly defined as:

> Affirming the strengths and rich history of the Black Diaspora; meaning that it will not only highlight the injustices of health disparities as a result of the social determinants of health, but also highlight the strength and creativity of the Diaspora in overcoming injustice and social determinants. (Bridgeman-Bunyoli, 2013)

On the basis of our working definition of Afrocentricism, several Afrocentric elements were integrated into the intervention. These elements are described in depth in Figure (see Supplemental Digital Content 1, available at: http://links.lww.com/JACM/A51).

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

METHODS

Training design and curriculum adaptation

WAHM training design and implementation began with the first cohort, known as the Queens and Kings of Community Health (QKCH), who participated in training in the summer of 2013. Our study, however, focuses on the second WAHM cohort, known as the Divine 25 (D25), who participated in training in January and February 2014.

The CHW training curriculum of the Community Capacitation Center (CCC) of the Multnomah County Health Department was approved by the Oregon Health Authority prior to the beginning of training for the QKCH. The original curriculum was culturally adapted for the QKCH by staff from the CCC and the ULP. Subsequently, it was further modified with the participation of CHWs from the QKCH. Eleven CHWs from the QKCH were cofacilitators in the second training to ensure the Afrocentricity of the curriculum and to increase the professional development of CHWs from the QKCH.

In November 2013, a WAHM CBPR Steering Team was formed to inform the study design and participate in data analysis and dissemination of results. The 12-member team was composed of 3 CHWs from the QKCH, who were later joined by 4 CHWs from D25, as well as 2 staff members from the ULP, and 3 staff members from the CCC.

Study design and framework

The approach for the study was CBPR (Israel et al., 2013). In accordance with CBPR principles, every effort was made to build on the strengths and interests of the participants in both the QKCH and D25 and provide opportunities for professional development. Supplemental Digital Content 2 (Table 3, available at: http://links.lww.com/JACM/A52) details the specific actions taken in accordance with each CBPR principle.

Quantitative data collection and analysis

The principal quantitative data collection tool used in the WAHM study was a 38-item, written, self-assessment tool adapted from a survey developed by Wiggins et al. (2014). Items used to assess health knowledge were specific to the WAHM curriculum. Items assessing psychological empowerment were drawn from Romero et al. (2006). We used the SF-36 (MOS 36-item Short-Form Health Survey) "general health status" question to assess self-reported health status (Ware & Sherbourne, 1992). Health behavior was assessed using 4 questions that were used in a previous study sponsored by the Oregon chapter of the American Heart Association. The questionnaire also collected demographic information. Cronbach α scores calculated for the source survey showed that scales and subscales had acceptable levels of reliability (Wiggins et al., 2014).

After review of a standard passive consent protocol, the survey was completed by all willing D25 participants at 3 points: before training, immediately after training, and approximately 6 months after training. The surveys collected at the 6-month point were gathered at 2 events coordinated by CHWs in June and August 2014. The first event was an evening meeting at the Urban League. The remaining surveys were collected in August at a barbeque dinner that took place prior to a family movie showing in a local park in what was once a historically black neighborhood. This event, which was envisioned and organized by the seventh author (a member of the D25), not only provided an opportunity to collect data but also served as a reunion of D25 members and an opportunity to continue building relationships. Twenty of the D25 CHWs completed the presurvey; 18 completed the postsurvey; and 15 completed the survey 6 months after training, for a total loss to follow-up of 25%.

Survey data were entered into an Access database and then transferred to SPSS version 22.0 for analysis. To develop demographic profiles of participants, descriptive statistics were calculated. Next, scales were created for psychological empowerment and self-reported health behavior. Repeated measures analysis of variance was used to assess changes within the group from time 1 to time 2 to time 3.

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

Qualitative data collection and analysis

The primary qualitative research methods were semistructured individual interviews (N = 4) and 1 focus group (N = 4). The interviews were conducted by staff from the CCC (the first and last authors), whereas the focus group was conducted by 2 members of the QKCH cohort (including the sixth author). Participants from the D25 cohort were selected using purposive sampling and were invited to participate in either the focus group or an interview. The focus group was held 8 months after the completion of training and the interviews took place 10 months after the completion of training.

Once the data had been collected, it was coded collaboratively using a modified form of grounded theory (Strauss & Corbin, 1990). The deidentified transcripts were given to 4 members of the WAHM CBPR Steering Team (the first, second, fourth, and fifth authors), who conducted open coding. This subcommittee met and members jointly identified 11 axial codes. Then, the larger Steering Team met and, using PE methods, grouped quotes from the interviews and focus groups into the axial codes. The lead author then analyzed the quotes in each category in light of the research questions and identified preliminary findings, which were revised through an iterative process with the authors of this article. The guiding principle behind this iterative process was that the entire research process should be informed by Afrocentricism, PE, and CBPR principles, just as the intervention had been.

RESULTS

Participants

Demographic information collected at baseline (N = 20) revealed a group that was predominantly female (70%), born in the United States (80%), and whose first language was English (90%). Marital status varied, with a fully 50% identifying as single and 30% as married. All participants had at least 12 years of formal schooling; 15% had 17 years or more of formal schooling. The number of children varied from 0 to 6. Annual household income varied widely, with 20% of participants reporting less than \$2000 a year and 20% reporting more than \$50 000. Consistent with the culturally centered nature of the curriculum, all but one participant identified as black or multiracial. Two identified as African. The mean age of the group (n = 19) was 46 years, and ranged from 31 to 66 years.

Quantitative results

A repeated-measures analysis of variance was conducted in SPSS to determine whether there were significant changes over time (as measured at 3 time points) in the mean scores for psychological empowerment, self-reported health status, and health behavior. Mean scores for psychological empowerment (measured on a Likert scale, where 1 is high and 4 is low) indicated that psychological empowerment improved from time 1 to time 2 but worsened from time 2 to time 3 (MT_1 = 1.76, SD = 0.39; MT_2 = 1.58, SD = 0.30; MT_3 = 1.60, SD = 0.36). However, the effect of time was nonsignificant for all multivariate tests (F = 2.46, error df = 13, P = .12). Health behavior (measured on a Likert scale, where 1 was low and 4 was high) improved over time (MT_1 = 2.35, SD = 0.53; MT_2 = 2.52, SD = 0.59; MT_3 = 2.68, SD = 0.55), but again the change was nonsignificant (F = 1.83, error df = 13, P = .19). Self-reported health status (a 1-item measure, where 1 is excellent and 5 is poor) remained unchanged from time 1 to time 2 and improved slightly at time 3 (MT_1 = 2.8, SD = 0.1.01; MT_2 = 2.8, SD = 1.01; MT_3 = 2.73, SD = 0.88); again, changes were nonsignificant (F = 0.8, error df = 13, P = .92).

Many factors could account for marginal changes over time, including maturation, history effects, and testing. Actual effects could also have been obscured by the small sample size. While the directional nature on all 3 variables is hopeful, it cannot be interpreted more conclusively than that.

Qualitative results

The key findings for the first research question (see Table 1) were measured primarily in the quantitative analysis. However, changes

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

in professional development and employment status were examined in the qualitative analysis. Generally, participants said they gained technical skills, increased access to networking opportunities, and became more active in their community. Specific outcomes that were reported by participants are given in Table 2.

The key findings for research questions 2 and 3 are addressed in this section. First, we describe results of research question 2, which concerned changes in the CHWs, their families, and their communities. Then we move on to discuss results from research question 3, which inquired into the aspects of training that were successful and how it could be improved.

Changes in CHWs

The primary change that CHWs described in themselves was their process of awakening or conscientization. "Conscientization" is a translation of the term "concientizacao" coined by Freire (2012) to describe "the deepening of the attitude of awareness characteristic of all emergence" (p. 109) Freire explained that "reflection upon situationality is reflection about the very condition of existence: critical thinking by means of which people discover each other to be 'in a

Table 2. Professional Development Outcomes and Opportunities for D25 Participants

Outcome	Further Information
Field organizer	1 CHW became employed as a "field organizer" or community organizer with the Urban League of Portland.
CHW positions	2 CHWs from the D25 became employed as CHWs for the Urban League of Portland.
Research internship with ORCHWA	1 D25 interview participant reported receiving a research internship with the Oregon CHW Association.
Leadership board	1 participant reported being nominated for a leadership board.
ORCHWA conference attendance	2 individual interview participants and 1 focus group participant reported having attended the ORCHWA conference; 1 reported that she provided child care so that other participants could attend.
Volunteering with Youth Violence Program	1 participant reported having shadowed CHWs from the QKCH cohort who were working on a Youth Violence Program as a professional development opportunity.
WAHM Urban League	1 focus group participant stated that she or he had been involved with the WAHM Hub that convened professional development meetings of CHWs from both cohorts.
Additional trainings	Participants mentioned attending the following conferences and trainings: Western Migrant and Community Health Forum, the CCC's Children's Exposure to Violence Training Series, North by Northeast Health Center's Clinical Topics Training Series, and an "additional diabetes training" program.

Abbreviations: CCC, Community Capacitation Center; CHW, community health worker; D25, Divine 25; QKCH, Queens and Kings of Community Health; WAHM, We Are Health Movement.

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

situation'" (p. 109). It is this process of emergence that leads participants to move toward the action of changing their own lives and the communities around them. Oxforddictionaries.com (2015) defines "awakening" as "an act or moment of suddenly becoming aware of something." Seventeen quotations from participants were interpreted as indicating awakening by the WAHM team. CHWs describe moments of awakening in 4 distinct areas: awakening to their own woundedness, awakening to changes needed in their own lives, professional awakening, and cross-cultural awakening. They also describe their participation in the training as a process of conscientization in and of itself. The 4 types of awakening are not mutually exclusive. A participant could have experienced one or all of these types, although the first 2 types appear to be linked.

Awakening to their own woundedness

This type of awakening emerges as a result of increased awareness of the health effects of racism discussed extensively in the training. It was the impact of this awareness that was the reason that the cohort responded so much to an old African American spiritual "It's in My Veins" (Turner, 2011) sung by one of the participants, who learned it from her grandmother. It was a reflection of cultural resilience in the midst of intergenerational systemic oppression.

The following quote is a clear description of one participant's process of conscientization to his own woundedness:

> And there's historical trauma and how things have been a toxin from our generations to generations. So personally [the training] gave me the space, the liberty to begin to heal and go back to areas that I had suppressed and did not want to go back to . . . . Now to have a spiritual emotional journey with men and women that embrace me, that are my peers, [helped me] personally.

Associated with learning about historical trauma and its effects on health, participants experienced awakening to their own woundedness.

Awakening to changes that are needed within their own lives

This type of awakening builds sequentially on the first type. In this category, the CHWs describe needing to make changes in 3 main areas: self-care, diet, and communication with family members (nuclear and extended). One interview participant expressed a new awareness of the need for self-care to maintain the CHW's commitment to the work:

> . . . once again we learned that in community health working [if] we give so much to others that we don't take care of our self, then the job is not really getting done. So for me it was even for me to get more focused on my health.

Participants in both the interviews and focus groups mentioned attempting to make changes in their families' diets as a result of the training. For example, one participant stated: " . . . I tried different foods with [my son], more vegetables in our lifestyle, getting rid of the, you know, grease and margarine. Trying to get more olive oil with our eating habits."

Another participant reflected on the impact that the training had on family communication: "[The training] also allowed me to forgive other people for what they had done and begin to repair those relationships and open up communications and give things a name." Associated with the training, participants became aware of and began to initiate changes in their own lives.

Professional awakening

Several CHWs in both the interviews and the focus group mentioned becoming aware that their current work was part of a larger profession. For some, learning about the CHW model helped validate that the work that they were already doing was on the right path, whereas for others it provided a new direction. A focus group participant realized that she had already been doing CHW work professionally for a long time, and doing it well, although CHW was not title of her position: "It validated what I'm doing in my career, professionally. That I was on the right track. That I handled things appropriately."

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

One interview participant mentioned that she did not really know much about the CHW profession, before being given the opportunity to attend the training by the organization that sponsored her: "I don't think that was a direction that I even thought [about] going professionally until I took the training, and then it was like 'Wow, you know I think that I would really enjoy doing something like that.'"

For this participant, like others, the training helped her or him identify a new and exciting career path.

Cross-cultural awakening

Despite the critique that there was not enough African representation in the training, African American participants did discuss experiencing a cross-cultural awakening in respect to African immigrants. For example, one participant commented:

> Something that I learned that was very valuable in the training, was learning from a different culture what they are taught when they come to the United State. And I shared that information just the other day, but what it has done for me professionally is to reach out, communicate, and have conversations with people from African immigrant cultures to learn even more than what I learned in the training.

In relation to their participation in the training, CHWs reported experiencing 4 types of awakening that propelled them forward into the next stage of their lives.

Changes in families and the community

In response to questions about changes in their families associated with the training, CHWs reported sharing their new health information widely with family members, but with mixed results. In many cases, family members saw the transformation in the CHW, listened deeply to the new information they were providing, and treated them with increased respect, but in other cases, family members resisted because, in their opinion, the CHWs wanted to make changes too quickly. One CHW commented about her or his experience sharing information with the family:

> So I come home with all this material, and all this information, and I'm jazzed up and I'm like, "Let's try this, let's try this, let's try this" and my family was like, "Hold up! You're taking this class, not us."

CHWs experienced varied results when they attempted to share information gained in the training with their families.

When asked what changes they perceived in the community as a result of the training, participants generally turned the question back to themselves and talked about how they have become more active in the community. This may be a reflection that they felt that not enough time had passed to see the impact on the community, or a reflection of the depth of the CHWs' perception of themselves as an integral part of the larger community. As one CHW stated:

> I am trying to bring healing to the community as a whole; going back to the community feeds the individual, not the individual feeding the community. So just interacting, just outreaching more, just being more social about the problems that we're having and why we're having it, and the infant mortality rates and just things like that, just being out there more.

CHWs did report changes in their families and communities, although these were understandably more muted and partial than changes in themselves.

Reflections on the Afrocentric training program

Six themes emerged from participants' observations about the Afrocentric training program: group bond, Afrocentrism, PE, facilitators, curriculum, and time management.

Group bond

Participants described the group bond among the cohort members as an essential element of the training that contributed to the process of each individual's conscientization and fostered networking and increased community connectedness after the training was complete. One interview participant spoke about how seeing others grapple with the trauma of their shared experience made this participant stronger:

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

> There is pain everywhere but you see how the system is still pushing and still killing us . . . . But to see my brothers and sisters experience, to hear it, that is something that really touched me. I liked it. It made me stronger. And to see people come up at the end, as someone said, the group was one.

While one participant reported holding back some opinions regarding sexuality to avoid hurting feelings, most participants reported that an atmosphere of trust was created during the process of the training, that there was a sense of family, and that they have been able to connect with cohort members since the training. When asked what specific elements helped create an atmosphere of trust, participants consistently named the sharing of personal stories through the "journeys" activity (see Supplemental Digital Content 1, Figure, available at: http://links.lww.com/JACM/A51).

Afrocentrism

This theme, which was composed of 9 quotes, pertained to the degree to which the training was culturally centered. (Specific Afrocentric elements of the curriculum are present in Supplemental Digital Content 1, Figure, available at: http://links.lwww.com/JACM/A51.) Participants said they appreciated that the training was Afrocentric, but there were some limitations. For example, one participant felt that culturally specific trainings should continue to be offered:

> I think that the course should continue to be the way it is with the African and African-American cohort and then once we do the other ones have us all blend together, because . . . we are the ones in just so much . . . depression, oppression, just problems, so . . . the more we keep doing this class the more it's going to be more of us to be able to make the change.

Most of the participants in the training were sponsored by organizations primarily serving African Americans or African immigrant populations. One of the organizational representatives chosen to engage in the D25 training was white. This issue was brought up in the focus group as a factor that diminished the Afrocentricity of the training: "I was a little thrown back when we, as a culturally specific group, had a guest among our group, a white girl. We had a guest. It was Afrocentric, but we had a guest."

The focus group members were uncertain if the training qualified as truly Afrocentric if one of the participants was white, and this issue was left unresolved.

Another concern was that the training did not include enough African participants or African content. Although 4 African immigrants and refugees (2 African women and 2 African men) signed up for the training, only 2 African men were able to participate. One participant from the focus group commented on the lack of content about African history:

> I would say that was one of the elements missing, we kind of know the history of slavery and post-traumatic slave syndrome and all that. But if you want the history of Africa, I would say there wasn't [any] and that's a very vital element.

When asked whether the training met its goal of being Afrocentric, one participant responded, "Yeah, almost too much," and went on to cite a concern that if trainings focus only on the issues affecting black communities, participants may not gain the information that they need to serve other cultural communities. She or he also felt this might hamper her or his ability to work in Oregon where the black population is very small because she or he would not have enough knowledge of other cultures that may constitute the majority of people seeking services.

Public health knowledge

Eight quotations about the training were categorized into the theme of "public health knowledge." Participants reported being deeply affected by this new knowledge, which was an integral part of the training curriculum. This theme is related to the theme of awakening mentioned earlier in that the public health knowledge gained by participants helped them make the changes needed within their own lives. Participants reported a variety of changes associated with their new public health knowledge, including learning to manage their own diabetes, deciding to spread

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

the word about diabetes in the community, understanding how to support loved ones with various disorders, making changes in their diet or diet of a family member, drinking more water, and paying more positive attention to pregnant women.

Popular education

Participants identified the following aspects of PE as effective in increasing their learning: the setup of the chairs and the classroom, the interactive nature of the classes, community building, classroom equality, food, tackling difficult topics, popular methodology as a core part of the curriculum, and movement-building activities. These elements and corresponding quotes are listed in further detail in Supplemental Digital Content 3 (Table 4, available at: http://links.lww.com/JACM/A53).

Facilitators

Participants identified qualities of instructors that made them more or less effective in the creation of a safe, Afrocentric environment. Effective qualities or behaviors of facilitators that participants appreciated included being self-revealing and willing to share their story with the participants, acknowledging privilege (white facilitators specifically), having good information, being concerned about the community and the lives of the participants, and having consistent facilitators throughout the training in addition to guest trainers. One of the participants stated: "I loved [that] the trainers really had the information that we needed . . . . They had the knowledge, and I felt that they were really concerned about changing my community, my people."

Ineffective qualities and behaviors in facilitators included talking too much, having a perceived antimale bias, rushing through the material too fast, and not having enough mental health resources available if a participant was triggered by the information in the session.

Time management

Participants mentioned time management frequently, often in the context of their own experience of conscientization. Some of the participants felt that the training moved too quickly and hampered their ability to process the feelings that emerged. Other participants felt that too much time was spent processing feelings and that it used time that could have been spent covering more of the content of the training.

Taken together, the qualitative and quantitative results of our study suggest that an Afrocentric CHW training program based on PE can contribute to positive changes among the participants, including various types of awakening. Positive changes in families and communities are suggested but will need more time to develop. The results further reveal specific aspects of the training program that can make it more or less successful.

DISCUSSION

The findings of this study are consistent with existing literature about Afrocentricism and its potential effects on African American empowerment (Asante, 2009; Karenga, 1980; Robinson & Howard-Hamilton, 1994). The underlying impetus for CHWs moving from the first type of awakening (awakening to woundedness) to the second (lifestyle change) was the idea of resistance, of being able to take back control of their own lives, health, and community well-being from the forces that were systemically oppressing them. One participant put it this way: "I made a thing of 'they're not going to kill me, not this easy.' I can fight my own stuff, but I'm not going to fight to stay alive with their crazy stuff."

This attitude of resistance is consistent with the principles of many Afrocentric philosophies, including our definition that includes the African/African American history of overcoming adversity. It reflects the second principle of *Kwanzaa* of self-determination (Karenga, 1980). Resistance is also consistent with PE and the CHW model. It is a reflection of the idea in PE that change is possible and that we must tie the experiences of the community with larger societal dynamics so that the community can work toward creating change.

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

There were many limitations to this study, some of them due to financial constraints. As a single-group case study, our study lacked a comparison group of African and African American CHWs who went through a 90-hour training program that was not Afrocentric but did use a PE-based curriculum. We had only 2 African immigrant participants in the second cohort, and less demographic diversity overall in the D25 than there had been in the QKCH, so the study was based on a more narrow representation of black communities in Portland than it would have if it had been inclusive of both cohorts. (Timing prevented us from obtaining institutional board review approval to collect data from the first cohort.) In addition, we had a regrettable loss to follow-up in the survey collection. Also, a small sample size may have contributed to the fact that our quantitative analysis was only able to show directionality but not significant change. To have an effective training program, cohorts are usually limited to 25 participants. This means that any loss to follow-up will have an impact on our ability to measure significance.

The findings in this study reflect the thoughts of the participants of the D25, a group of African and African Americans living in Portland, Oregon, the whitest major city in the United States. During informal participant observation, participants from both cohorts mentioned that it was impactful for them to be given the opportunity to spend significant amounts of time in environments with other African Americans and Africans. More study is needed to know if the process of conscientization would be similar in a geographic community that was predominately African American. In addition, we did not fully integrate African history or African immigrant and refugee participants into the trainings. In future studies, it would beneficial to ensure that at least half of training participants are African immigrants and refugees or to conduct an Afrocentric training program specifically for African immigrants and refugees.

CONCLUSION

Generally, culturally centered solutions have been shown to be effective tools for addressing health inequities. Our study supports the idea that this principle also applies to trainings for CHWs. Once CHWs have been empowered through cultural culturally centered means, they can go on to create a more powerful multicultural movement.

REFERENCES

Andrews, J., Felton, G., Wewers, M., & Heath, J. (2004). Use of community health workers in research with ethnic minority women. *Journal of Nursing Scholarship*, *36*(4), 358–365.

Asante, M. (2009). *Afrocentricity*. Retrieved April 19, 2015, from http://www.asante.net/articles/1/afrocentricity

Bridgeman-Bunyoli, A. (2013). *Philosophy statement for the creation of Afro-centric CHW curricula*. Unpublished document. Portland, OR: Multnomah County Health Department Community Capacitation Center.

Brownstein, J. N., Hirsch, G. R., Rosenthal, E. L., & Rush, C. H. (2011). Community health workers "101" for primary care providers and other stakeholders in health care systems. *The Journal of Ambulatory Care Management*, *34*, 210–220.

Centers for Disease Control and Prevention. (2011). *Age-adjusted rates per 100 of civilian, noninstutionalized population with diagnosed diabetes by race and sex, United States, 1980-2011*. Retrieved from http://www.cdc.gov/diabetes/statistics/prev/national/figraceethsex.htm

Collins, J., David, R., Handler, A., Wall, S., & Andes, S. (2004). Very low birth weight in African-American infants: The role of maternal exposure to interpersonal racial discrimination. *American Journal of Public Health*, *94*, 2132–2138.

Coppock, N., & Coppock, B. (1990). *Afrocentric theory and applications* (Vol. *1*). Washington, DC: Baobab Associates.

Curry-Stevens, A. Coalition of Communities of Color. (2013). *The African immigrant and refugee community in Multnomah County: An unsettling profile*. Portland, OR: Portland State University.

Freire, P. (2012). *Pedagogy of the oppressed*. New York, NY: Continuum.

Hill-Briggs, F., Batts-Turner, M., Gary, T., Brancati, F., Hill, M., Levine, D., . . . Bone, L. (2007). Training

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

community health workers as diabetes educators for urban African-Americans: Value added using participatory methods. *Progress in Community Health Partnerships: Research, Education, and Action*, *1*(2), 185–194. Retrieved May 31, 2015, from https://muse.jhu.edu/login?auth=0&type=summary&url=/journals/progress_in_community_health_partnerships_research_education_and_action/v001/1.2hill-briggs.pdf

Ingram, M., Schachter, K. S., Sabo, S. J., Reinschmidt, K. M., Gomez, S., Guernsey De Zapien, J., . . . Carvajal, S. C. (2014). A community health worker intervention to address the social determinants of health through policy change. *The Journal of Primary Prevention*, *35*, 119–123. doi:10.1007/s10935-013-0335-y

Israel, B., Eng, E., Schulz, A., & Parker, E. (2013). Introduction. In B., Israel, E., Eng, A., Schulz, & E., Parker (Eds.), *Methods for community-based participatory research for health* (2nd ed., pp. 4–37). San Francisco, CA: Jossey-Bass.

Jasienska, G. (2009). Low birth weight of contemporary African Americans: An intergenerational effect of slavery? *American Journal of Biology*, *21*, 16–24.

Karenga, M. (1980). *Kawaida theory*. Los Angeles, CA: Kawaida Publications.

Multnomah County Health Department. (2011). *Report card on racial and ethnic disparities*. Portland, OR: Author. Retrieved from https://multco.us/file/19350/download

Oregon House Bill 3650, 76th Oregon Legislative Assembly (2011).

Oxforddictionaries.com. *Awakening*. Retrieved April 20, 2015, from http://www.oxforddictionaries.com/us/definition/american_english/awakening

Patient Protection and Affordable Care Act of 2010s, 42 U.S.C. § 18001 *et seq*. (2010).

Peacock, N., Issel, L. M., Townsell, S. J., Chapple-McGruder, T., & Handler, A. (2011). An innovative method to involve community health workers as partners in evaluation research. *American Journal of Public Health*, *101*(12), 2275–2280.

Robinson, T. L., & Howard-Hamilton, M. (1994). An Afrocentric paradigm: Foundation for a healthy self image and healthy interpersonal relationships. *Journal of Mental Health Counseling*, *16*(3), 327–337.

Romero, L., Wallerstein, N., Lucero, J., Fredine, H. G., Keefe, J., & O'Connell, J. (2006). Woman to woman: Coming together for positive change—Using empowerment and popular education to prevent HIV in women. *AIDS Education and Prevention*, *18*, 390–405.

Smith, L., Hatcher-Ross, J., Wertheimer, R., & Kahn, R. (2005). Rethinking race/ethnicity, income, and childhood asthma: Racial/ethnic disparities concentrated among the very poor. *Public Health Reports*, *120*, 109–120.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Turner, C. (2011). *In My Veins. On Live Collection*. New York, NY: Chris Turner Music.

Urban League of Portland. (2009). *State of Black Oregon report*. Retrieved from https://ulpdx.org

Ware, J., & Sherbourne, C. D. (1992). The MOS 36-Item Short-Form Health Survey (SF-36): Part I. Conceptual framework and item selection. *Medical Care*, *30*, 473–483.

Wiggins, N. (2012). Popular education for health promotion and community empowerment: A review of the literature. *Health Promotion International*, *27*, 356–371. doi:10.1093/heapro/dar046

Wiggins, N., Hughes, A., Rios-Campos, T., Rodriguez, A., & Potter, C. (2014). *La Palabra es Salud* (The Word is Health): Combining mixed methods and CBPR to understand the comparative effectiveness of popular and conventional education. *Journal of Mixed Methods Research*, *8*, 278–298. doi:10.1177/1558689813510785

Wiggins, N., Kaan, S., Rios-Campos, T., Gaonkar, R., Rees Morgan, & Robinson, J. (2013). Preparing community health workers for their role as agents of social change: Experience of the Community Capacitation Center. *Journal of Community Practice*, *21*, 186–202.

Copyright © 2015 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.