Story of Stone Soup: A Recipe to Improve Health Disparities

Bowen Chung, MD, MSHS, **Loretta Jones, MA**, **Chrystene Terry, LCSW**, **Andrea Jones**, **Nell Forge, MPH, PhD**, and **Keith C. Norris, MD**
From Department of Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine, University of California at Los Angeles and the Department of Psychiatry at Harbor-UCLA Medical Center (BC), Healthy African American Families II (LJ, AJ), and Charles Drew University of Medicine and Science (LJ, AJ, CT, NF, KN)

Abstract

Just as scientific articles are used as a way of sharing knowledge in scientific communities, stories are used as a way of transferring knowledge within African American communities. This article uses the story and metaphor of *Stone Soup* to illustrate the Healthy African American Families' (HAAF) Community Partnered Participatory Research (CPPR) method of engaging diverse partners to address health issues, such as preterm birth, depression, diabetes, and kidney disease, and to create community-wide change through education, capacity building, resource sharing, and intervention development.

Keywords

African American; Family; Community Partnered Participatory Research

Introduction

Just as presentations at scientific conferences and articles in professional journals are used to share new findings in scientific communities, storytelling is an important way for communities of color to transfer information and to share ideas with community members. In African traditions, this kind of storyteller is called a griot or griotte, a repository of oral tradition and history through mastery of words and music.[1] The story of *Stone Soup* provided a recipe for how we, Healthy African American Families, developed resources to create and disseminate potential solutions to address health and healthcare disparities in our community.

In *Stone Soup*, a fable about cooperation amid scarcity, a traveler, with only an empty pot, large stones, and water, entices townsfolk to make soup by adding small amounts of ingredients, one by one, finally producing a delicious and nourishing soup for the benefit of the entire community.[2] The key lesson of *Stone Soup* is that cooperation among an entire community amidst scarcity (eg, poor access to and quality of health services) can lead to the generation of new perspectives on reducing health disparities (nourishing soup) compared to what one person or group could do on their own.

The continuing racial/ethnic disparities in health status and health care remain a concern for underserved minority communities. This is evidenced by the high rates of unmet need for services to address chronic conditions such as diabetes, depression, substance abuse, HIV,

Address correspondence to Bowen Chung, MD, MSHS, Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine at UCLA; Harbor-UCLA Medical Center; Box 498, Building D5.5; Torrance, CA 90509. 310-222-1801. bchung@mednet.ucla.edu.

and cancer outcomes.[3–19] Although medical science has made progress towards addressing chronic illnesses, much of this knowledge has not been translated into policy and programs that can be implemented into the communities that would benefit the most from evidence-based interventions to improve health outcomes.[20–22] Nor has community knowledge been used to inform clinical practice. Participatory research approaches, like community partnered participatory research (CPPR), are currently being used to combine scientific evidence with local knowledge to address health disparities.[23–27] This research emphasizes authentic partnerships between local community members and academics with shared input into project selection, design, implementation, assessment and implementation. The hope of these efforts is that partnerships between researchers and communities will result in combining medical and community evidence bases to create new insights into how to implement more effective health promotion and disease prevention strategies in local settings.[28]

One challenge in participatory research is the engagement of a broad range of community stakeholders, each with different priorities, around the common concerns of improving health and health care.[22–24,27–36] The partnerships needed to address a specific health concern in an underserved, minority community may be as diverse and as complex as the fragmented landscape of health services.[23] Thus, successful engagement of potential partners requires that a health issue be framed in such a way as to attract the commitment of participants with divergent interests. Unlike clinical biomedical research where the goals may be focused on a discrete disease entity with a limited set of clinically focused outcomes, a CPPR project reframes clinical diseases into multilevel issues requiring broad public/civic engagement. Engaging the breadth of stakeholders needed to support a CPPR project requires developing and articulating project goals to meet the needs of the numerous potential partners: scientific (eg, academic researchers), ethical (eg, local community health advocates, community guardians), civic (eg, unaffiliated community members, local politicians), policy-related (eg, local think tanks, policymakers, foundations), and health and health care improvement (e,g, public health agencies, hospitals, community health clinics) organizations (Table 1).[23,24] For a community agency, participation may accomplish outreach and networking goals. For a local business, participation may mean enhancing visibility and networking opportunities. For an interested individual from the community, volunteering on a project may offer a sense of civic participation. A researcher may use a CPPR project to collect and analyze data, write papers, and/or develop new models of scientific activity, clinical care or public health initiatives. A government agency or a foundation may support a CPPR project because of their mission to reduce health disparities. A health advocacy agency may lend support because of their belief in supporting increased transparency and power sharing in science. This paper describes the use of the *Stone Soup* metaphor within the Healthy African American Families project to encourage diverse partners to engage with and provide unique contributions to local CPPR projects.

Methods

Healthy African American Families (HAAF) is a non-profit, health advocacy organization based in the Baldwin Hills section of south Los Angeles. HAAF's mission is to improve the health outcomes of African American and Latino communities in Los Angeles County through enhancing the quality of care provided in the community through health advocacy, education, training, and collaborative partnerships with other community agencies, academia, researchers, and government. The history and key characteristics of the HAAF project are described elsewhere in this issue.[27] Briefly, HAAF originated through a University of California – Los Angeles (UCLA) project, funded by the Centers for Disease Control and Prevention (CDC) in 1992, to describe the experience of African American women during pregnancy using community participatory research and qualitative methods,

as part of a federal initiative on preterm birth (gestational age<37 weeks).[38] A key aspect of community engagement in HAAF's early stages was the creation of a community advisory board (CAB) with representatives from a broad spectrum of agencies: the Los Angeles County Department of Public Health; a Special Supplemental Nutritional Program for Women, Infants, and Children (WIC) site; Children's Institute International (social service agency with mental health services for youth and families); Chi Etta Phi (Black student nursing sorority); the Black Nurses Association; and several health advocacy organizations (eg, Maternal Child Health Coalition, the Community Coalition, and Black Family Investment). In 1995, the HAAF partnership grew with the addition of the Clinical Research Center at Charles R. Drew University (CDU-CRC) to support the development of coordinated, collaborative community leadership to address health disparities.[28] Through these partnerships, HAAF built community-wide relationships among community members, service providers, faith-based organizations, academia and government to develop social capital and support services to aid community members.[23,28] Throughout this work, the *Stone Soup* metaphor was used for community networking, engagement, capacity building, and information and resource sharing.

Stone Soup[37]

Once upon a time, there was a great famine in which people jealously hoarded whatever food they could find, hiding it even from their friends and neighbors. One day a wandering soldier came into a village and began asking questions as if he planned to stay for the night.

"There's not a bite to eat in the whole province," he was told. "Better keep moving on."

"Oh, I have everything I need," he said. "In fact, I was thinking of making some stone soup to share with all of you." He pulled an iron cauldron from his wagon, filled it with water, and built a fire under it. Then he drew an ordinary-looking stone from a velvet bag and dropped it into the water.

Hearing the rumor of food, most of the villagers went to the square or watched from their windows. As the soldier sniffed the broth and licked his lips in anticipation, hunger began to overcome their skepticism.

"Ahh," the soldier said to himself rather loudly, "I do like a tasty stone soup. Of course, stone soup with cabbage – that's hard to beat."

Soon a villager approached hesitantly, holding a cabbage he'd retrieved from its hiding place, and added it to the pot.

"Capital!" cried the soldier. "You know, I once had stone soup with cabbage and a bit of salt beef as well, and it was fit for a king."

The village butcher managed to find some salt beef and so it went, through potatoes, onions, carrots, mushrooms, and so on, until there was indeed a delicious meal for all. The moral of the story is that, by working together with everyone contributing what they can, a greater good is achieved."[2]

In the application of the *Stone Soup* model within CPPR, three aspects are critically important: reframing of issues; vision and leadership; and diverse partners, solutions and resources (Table 2). First, when an individual or a partnership initially tries to advance interest in a health problem of community concern, others may be unwilling or unable to share ideas and resources. This may happen because people might feel others could steal ideas or resources or they may be unaware of what others have and do not know what to

share. Therefore a key step is re-framing a health issue from one that is perceived to affect only a subset of community members to one, which when addressed, will benefit the whole community. Second, vision and leadership are both equally important to re-imagine the community from how it is now (the stone in water) to what it could be (stone soup full of many ingredients), thus providing a goal for change. Developing leadership around a common goal is important to persuade others that a particular problem is important. Once people begin to contribute to the process of creating and implementing solutions (adding ingredients to the soup), sustained leadership from an individual or a group of individuals is necessary to continue to sustain a vision and to continue to bring in new partners and new solutions. Third, the solutions and resources to improve health outcomes may not come from any one place, but they are likely to come from a diverse set of partners, especially in a fragmented system.

Results

For HAAF, the *Stone Soup* model of community engagement was initially used to develop knowledge and community interventions to address pregnancy health at the local level. The CAB and other project staff became "the pot" or the infrastructure by organizing the initial conference and the workgroups. The CDC became the "stone" or the initial resource. The CAB and project investigators brought people to the table by telling them that they had a federally-funded, community participatory project to address pregnancy health among black women. These new partners then began to contribute resources to the project in unexpected ways.

One key example is how the *Stone Soup* model generated, with virtually no resources, a definition of a Healthy African American Family.[27] Initially, HAAF brought in 60 concerned community members who suggested that addressing pregnancy health and preterm birth from a community perspective was not through the narrow perspective of a pregnant woman, but rather through involving the whole woman and her family, immersed in a vibrant community, throughout the lifespan (from the head to toe and from the cradle to the grave).[27] This focus on family became the focus for all of HAAF's subsequent activities. Thus, by the involvement of diverse perspectives and partnerships, the foundation for HAAF was created.

After the original qualitative data on African American pregnancy experiences were analyzed, HAAF sought to share this knowledge with the larger local community.[39] This sharing was to inform and educate the community about the issue of pregnancy health and preterm birth and their relevance locally and to initiate discussions about potential prevention or intervention strategies. A community dissemination conference was held with both community and scientific attendees to share and exchange knowledge from different perspectives.[40]

Initially, HAAF had no direct financial resources for such a conference but they did have community relationships. We also believed that pregnancy health and preterm birth were important to everyone in the community and that each community member could contribute something to addressing these problems. So HAAF staff and the CAB conducted outreach into the community and leveraged resources to conduct the conference. People contributed paper goods, such as plates and utensils, to serve food. Local restaurants donated food. Others contributed paper and supplies for printing. Volunteers contributed time to staff registration tables and to prepare conference materials. Health advocates, community agency leaders, and university researchers supplied their different knowledge bases for presentations. Meeting room space was donated. The soup grew. As a result, the first large-scale community knowledge-exchange conference, *Building Bridges to Optimal Health*, was

held.[40] After this conference, follow-up work groups with local community members, health and social service agency representatives, and academic researchers were established to develop approaches to engage others on issues of preterm birth in south Los Angeles. One intervention that resulted was *One Hundred Intentional Acts of Kindness Toward a Pregnant Woman*, which educates community members about ways to support pregnant women.[29] The intervention was created with the input of diverse community members and resources.

The *Stone Soup* CPPR approach has been used to address other local health issues such as violence, environmental health, major depression, diabetes, kidney disease, childhood asthma, and others.[23–37] HAAF and CDU-CRC continue to annually host 2–4 free, *Building Bridges* public conferences, grounded in oration, on health issues of interest to the community[27,40] Most conferences are now conducted with both monetary and in-kind services. These conferences offer underserved communities of color in Los Angeles access to the latest research on a variety of chronic health and local public health concerns.[31,40] They provide community perspectives on health issues to participating scientists. They also provide opportunities for networking. The premise of these conferences was that through mutual education and by engaging local communities we achieve a first step to improving health disparities.[24] Project staff and academic partners continue to provide the infrastructure (the pot), the funding agencies provide seed funding (the stone), and both community and academic participants provide the diversity of knowledge and perspectives (the ingredients).

Recent community conferences include the *Witness for Wellness* (W4W) and *Diabetes Through the Lifespan* conferences.[40] The W4W conference originated as a partnership between CDU-CRC, HAAF, UCLA, and the RAND Corporation to provide critical information about depression to both community and scientific audiences.[35] Post-conference working groups include: Talking Wellness (to develop community-generated arts, such as spoken word, as modes of communicating with others about depression); Building Wellness (to create high quality services in the community); and Supporting Wellness (to advocate for depression services in the community).[33–36] In particular, Talking Wellness developed and evaluated strategies that combined scientific rigor with community-friendly approaches like poetry and film to engage the community around depression care as an important health priority.[26,33] The innovative use of the arts and measurement approaches used to evaluate these models would have not been possible without the infrastructure (the pot) and the diverse partners (the soup ingredients) already existing within HAAF.

The Clinical Research Center at CDU and HAAF continue to reach out to foster new partnerships by developing new community conferences and post-conference working groups to build solutions to address ongoing health disparities affecting the Los Angeles community.[40] Thus through use of the *Stone Soup* model, the *Building Bridges to Optimum Health* conferences have become an ongoing longitudinal CPPR project model that continues to build bridges with community partners, values their expertise, and brings together community, academia, and service providers. [24]

Discussion

The story of *Stone Soup* communicates both a model of action and a vision of how solutions to address health disparities in underserved communities may emerge from the unique contributions of everyone in the community. The *Stone Soup* model of development has as its underlying principle that all should have a win-win and that everyone can make a positive contribution to a problem of common concern. All can contribute to make the broth thicker and all can receive nourishment from a more robust product. Thus, the *Stone Soup* model

provides a way to specifically address the three key elements of community engagement: reframing of issues for mutual benefit, vision and leadership, and diversity of partners.

The CPPR approach offers a new method to addressing public health needs. Unlike a traditional public health research project that focuses on utilizing problem-focused, research-driven assessment approaches (needs assessments, surveys, focus groups, semi-structured interviews) to describe a problem and then to develop solutions, CPPR's approach to reducing health disparities in low income, culturally diverse populations is to develop community wide social change through a process of partnering scientific evidence with the perspectives of the local community-level evidence under conditions of equal partnership.[24,26,31] The challenge of CPPR is that it relies on developing new relationships and resources. The *Stone Soup* model can meet this challenge.

Although the *Stone Soup* model has been used extensively as an approach to community organizing and program development, no randomized trials of CPPR have been conducted on assessing the effectiveness of CPPR in improving the relevance of scientific research in low income communities of color, in improving health outcomes in these communities, or enhancing rates of minority participation in research. Future work on assessing the effectiveness of the *Stone Soup* model or the CPPR model may rely on research designs that include randomization of workgroups or the use of instrumental variables to that evaluate CPPR effectiveness as an approach to engaging and disseminating evidence-based practices around health in low-income minority communities.[41]

The story of *Stone Soup* shows that the ingredients for developing and sustaining partnered initiatives to address common problems are inherent within the community. However, as one community member noted, "It takes a little imagination, a vision, and communicating that vision so that others will want to be part of it and find a win-win in the situation."

Acknowledgments

References

1. Hale, TA. Griots & Griottes: Masters of Words & Music. Bloomington, Indiana: University Press; 1998.

2. Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press; 2003.

3. Wang PS, Lane M, Olfson M, et al. Twelvemonth use of mental health services in the United States: results from the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005; 62(6):629–640. [PubMed: 15939840]

4. U.S. Department of Health and Human Services. Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001.

5. U.S. Department of Health and Human Services. The President's New Freedom Commission on Mental Health Achieving the Promise: Transforming mental health care in America. Rockville, MD; Department of Health and Human Services: 2003. SMA-03-3832

6. Williams DR, Gonzalez HM, Neighbors H, et al. Prevalence and distribution of major depressive disorder in African Americans, Carribean Blacks, and non-Hispanic Whites: results from the National Survey of American Life. Arch Gen Psychiatry. 2006; 64:305–314. [PubMed: 17339519]

7. Meara ER, Richards S, Cutler DM. The gap gets bigger: changes in mortality and life expectancy by education, 1981–2000. Health Affairs. 2008; 27(2):350–360. [PubMed: 18332489]

8. Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press; 2001.

9. Institute of Medicine. Improving the Quality of Health Care for Mental and Substance Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press; 2006.

10. King WD, Minor P, Ramirez Kitchen C, et al. Racial, gender and geographic disparities of antiretroviral treatment among US Medicaid enrollees in 1998. J Epidemiol Community Health. 2008; 62(9):798–803. [PubMed: 18701730]

11. Kraut-Becher J, Eisenberg M, Voytek C, et al. Examining racial disparities in HIV: lessons from sexually transmitted infections research. J Acquir Immune Defic Syndr. 2008; 47(1):S20–S27. [PubMed: 18301130]

12. Levine RS, Briggs NC, Kilbourne BS, et al. Black-White mortality from HIV in the United States before and after introduction of highly active antiretroviral therapy in 1996. Am J Public Health. 2007; 97(10):1884–1892. [PubMed: 17761583]

13. Tammemagi CM, Nerenz D, Neslund-Dudas C, et al. Comorbidity and survival disparities among black and white patients with breast cancer. JAMA. 2005; 294(14):1765–1772. [PubMed: 16219879]

14. Bach PB, Schrag D, Brawley OW, et al. Survival of blacks and whites after a cancer diagnosis. JAMA. 2002; 287(16):2106–2113. [PubMed: 11966385]

15. Asch SM, Kerr EA, Keesey J, et al. Who is at greatest risk for receiving poor-quality health care? N Engl J Med. 2006; 354(11):1147–1156. [PubMed: 16540615]

16. Trivedi AN, Zaslavsky AM, Schneider EC, et al. Trends in the quality of care and racial disparities in Medicare managed care. N Engl J Med. 2005; 353(7):692–700. [PubMed: 16107622]

17. Sequist TD, Fitzmaurice GM, Marshall R, et al. Physician performance and racial disparities in diabetes mellitus care. Arch Intern Med. 2008; 168(11):1145–1151. [PubMed: 18541821]

18. Signorello LB, Schlundt DG, Cohen SS, et al. Comparing diabetes prevalence between African Americans and Whites of similar socioeconomic status. Am J Public Health. 2007; 97(12):2260–2267. [PubMed: 17971557]

19. Wells K, Miranda J, Bruce ML, Alegria M, Wallerstein N. Bridging community intervention and mental health services research. Am J Psychiatry. 2004; 161(6):955–963. [PubMed: 15169681]

20. Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: assessing partnership approaches to improve public health. Annu Rev Public Health. 1998; 19:173–202. [PubMed: 9611617]

21. Israel, BA.; Eng, E.; Schulz, AJ.; Parker, EA. Methods in Community-Based Participatory Research for Health. San Francisco, CA: Jossey-Bass Publishers; 2005.

22. Wells KB, Staunton AA, Norris K, et al. Building an academic-community partnered network for clinical services research: the Community Health Improvement Collaborative (CHIC). Ethn Dis. 2006; 16(1 Suppl 1):S3–S17. [PubMed: 16681125]

23. Jones L, Wells K. Strategies for academic and clinician engagement in community-participatory partnered research. JAMA. 2007; 297(4):407–410. [PubMed: 17244838]

24. Wallerstein N. Commentary: Challenges for the field in overcoming disparities through a CBPR approach: A commentary. Ethn Dis. 2006; 16(1 Suppl 1):S146–S148. [PubMed: 16681137]

25. Chung B, Jones L, Jones A. Using community arts to enhance collective efficacy and community engagement as a means of addressing depression in an African American Community. Am J Public Health. 2009; 99(2):237–44. [PubMed: 19059844]

26. Ferre C, Jones L, Norris K, Rowley D. The Healthy African American Families (HAAF) project: from community-based participatory research to community-partnered participatory research. Ethn Dis. 2010; 20(1, Suppl 2):S2-1–S2-8.

27. Lu MC, Jones L, Bond MJ, et al. Where is the F in MCH? Father involvement in African American Families. Ethn Dis. 2010; 20(1, Suppl 2):S2-49–S2-61.

28. Jones L, Lu MC, Lucas-Wright A, et al. One hundred acts of kindness toward a pregnant woman: Building reproductive social capital in Los Angeles. Ethn Dis. 2010; 20(1, Suppl 2):S2-36, S2-40.

29. Fleming ES, Perkins J, Easa D, et al. The role of translational research in addressing health disparities: a conceptual framework. Ethn Dis. 2008; 18(2 Suppl 2):S2-155, S2-160.

30. Norris KC, Brusuelas R, Jones L. Partnering with community-based organizations: an academic institution's evolving perspective. Ethn Dis. 2007; 17(1 Suppl 1):S27–S32. [PubMed: 17598314]

31. Vargas RB, Jones L, Terry C, et al. Community-partnered approaches to enhance chronic kidney disease awareness, prevention, and early intervention. Adv Chronic Kidney Dis. 2008; 15(2):153–161. [PubMed: 18334240]

32. Chung B, Corbett CE, Boulet B, et al. Talking Wellness: a description of a community-academic partnered project to engage an African-American community around depression through the use of poetry, film, and photography. Ethn Dis. 2006; 16(1 Suppl 1):S67–S78. [PubMed: 16681130]

33. Jones D, Franklin C, Butler BT, et al. The Building Wellness project: a case history of partnership, power sharing, and compromise. Ethn Dis. 2006; 16(1 Suppl 1):S54–S66. [PubMed: 16681129]

34. Bluthenthal R, Jones L, Fackler-Lowrie N, et al. Witness for Wellness: preliminary findings from a community-academic participatory research mental health initiative. Ethn Dis. 2006; 16(1 Suppl 1):S18–S34. [PubMed: 16681126]

35. Stockdale S, Patel K, Gray R, et al. Supporting wellness through policy and advocacy: a case history of a working group in a community partnership initiative to address depression. Ethn Dis. 2006; 16(1 Suppl 1):S43–S53. [PubMed: 16681128]

36. Jones, L. Successful Models of Community-Based Participatory Research: Final Report from a Meeting, March 2000. National Institute for Environmental Health Sciences; 2000. Partnership Building.

37. [Last accessed on March 25, 2009] The Brothers Grimm. The Story of Stone Soup. Available at: http://en.wikipedia.org/wiki/Stone_soup

38. Rowley DL, Hogue CJ, Blackmore CA, et al. Preterm delivery among African-American women: a research strategy. Am J Prev Med. 1993; 9(6 suppl):1–6. [PubMed: 8123282]

39. DeFreitas P, et al. The experience of pregnancy among African American women in Los Angeles: findings from the Healthy African American Families project. Final Report Healthy African American Families. 1999

40. Jones L, Collins B. Participation in action: the Healthy African American Families community conference model. Ethn Dis. 2010; 20(1, Suppl 2):S2-15, S2-16.

41. Viswanathan, M.; Ammerman, A.; Eng, E., et al. Community-Based Participatory Research: Assessing the Evidence. Rockville, Md: Agency for Healthcare Research and Quality; Jul. 2004 Publication 04-E022-2

Table 1

Examples of partners and outcomes needed in a community partnered participatory research project

Partner	Outcome
University partner	scientific
Centers for Disease Control and Prevention	
National Institutes of Health	
Community health advocates	ethical/social justice
Community guardians	
Unaffiliated community members	civic
Local politicians	
Think tank	policy change
Foundations	
Health and health care improvement	local public health agency community clinics

Table 2

Important ingredients for community engagement

1	Re-framing potential benefits to make the outcomes meet the needs of the entire community
2	Vision and leadership
3	Diversity of partners