



PART ONE



INTRODUCTION TO METHODS
IN COMMUNITY-BASED
PARTICIPATORY RESEARCH
FOR HEALTH

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Introduction to Methods in Community-Based Participatory Research for Health

Barbara A. Israel, Eugenia Eng,
Amy J. Schulz, and Edith A. Parker

Public health problems are complex, and their solutions involve political and social, as well as biomedical, dimensions. Researchers, practitioners, community members, and funders have increasingly recognized the importance of comprehensive and participatory approaches to research and intervention, and opportunities for such partnership approaches to research and intervention continue to emerge. As they do, so does the demand for concrete skills and knowledge about how to conduct community-based or other participatory approaches to research. Both new and established partnerships continue to search for information about strategies, skills, methods, and approaches that support the equitable participation and influence of diverse partners, toward the end of developing a clearer understanding of public health problems and working collectively to address them. This book is intended to be a resource for students, practitioners, researchers, and community members seeking to use community-based participatory research (CBPR) approaches to improve the health and well-being of communities in general and to eliminate health disparities in particular. In the introduction to this volume, we discuss the background to and growing support for CBPR, the principles of CBPR, the broad cultural and socioeconomic environmental context in which CBPR is conducted, and the purposes and goals of this book, and we present the organization and brief descriptions of the chapters.

BACKGROUND

There is increasing recognition that more comprehensive and participatory approaches to research and interventions are needed in order to address the complex set of determinants associated with public health problems that affect populations generally and those factors associated more specifically with racial and ethnic disparities in health (Butterfoss, Goodman, & Wandersman, 1993; Green & Mercer, 2001; Israel, Schulz, Parker, & Becker, 1998; Minkler & Wallerstein 2003; Schulz, Williams, Israel, & Lempert, 2002; Williams & Collins, 1995). Concomitantly, the number of funding opportunities that support partnership approaches to research that addresses these problems has grown. These include, for example, the Centers for Disease Control and Prevention's (CDC's) Urban Research Centers program, initiated by then CDC Director David Satcher (Higgins, Maciak, & Metzler, 2001; CDC, 1994), Racial and Ethnic Approaches to Health initiative—REACH 2010 (CDC, 1999), and community-based participatory prevention research projects from the Prevention Research Initiative (Green, 2003); the National Institute of Environmental Health Sciences' Environmental Justice Initiative and Children's Health Initiative (NIEHS, 1997; O'Fallon & Dearry, 2002); and the W. K. Kellogg Foundation's Community-Based Public Health Initiative (Bruce & Uranga-McKane, 2000), Turning Point Initiative (Sabol, 2002), and Community Health Scholars Program (2004). In addition, the emergence of the National Institutes of Health Interagency Workgroup on Community-Based Participatory Research, which aims to further advance the use of partnership approaches for examining and addressing these complex health problems, illustrates the growth of interest in and support for the CBPR approach.

Partnership approaches to research exist in many different academic disciplines and fields. In the field of public health, partnership approaches to research have been called, variously, "community-based participatory," "involved," "collaborative," and "centered-research" (see Israel et al., 1998, for a review of this literature). In addition, a large social science literature has examined research approaches in which participants are actively involved in the process. Examples include discussions of "participatory research" (deKonig & Martin, 1996; Green et al., 1995; Hall, 1992; Kemmis & McTaggart, 2000; Park, 1993; Tandon, 1996), "participatory action research" (Whyte, 1991), "action research" (Peters & Robinson, 1984; Reason & Bradbury, 2001; Stringer, 1996), "participatory feminist research" (Maguire, 1987), "action science/inquiry" (Argyris, Putnam, & Smith, 1985; Torbert, 2001), "cooperative inquiry" (Heron & Reason, 2001; Reason, 1994), "critical action research" (Kemmis & McTaggart, 2000), "empowerment evaluation" (Fetterman, Kaftarian, & Wandersman, 1996), and "participatory community research" (Jason, Keys, Suarez-Balcazar, Taylor, & Davis, 2004). Although there are differences among these approaches, they all involve a commitment to conducting research that shares power with and

engages community partners in the research process and that benefits the communities involved, either through direct intervention or by translating research findings into interventions and policy change.

In public health, nursing, social work, and related fields, the term *community-based participatory research* (CBPR) is increasingly used to represent such collaborative approaches (Israel et al., 2001; Minkler & Wallerstein, 2003), while recognizing that there are other approaches with different labels that share similar values and methods. Community-based participatory research in public health is a partnership approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process and in which all partners contribute expertise and share decision making and ownership (Israel et al., 1998, 2003). The aim of CBPR is to increase knowledge and understanding of a given phenomenon and integrate the knowledge gained with interventions and policy and social change to improve the health and quality of life of community members (Israel et al., 1998, 2003).

Associated with the developments just described, the recent Institute of Medicine Report *Who Will Keep the Public Healthy? Educating the Public Health Professionals for the 21st Century* (Gebbie, Rosenstock, & Hernandez, 2003) identifies community-based participatory research as one of the eight areas in which all public health professionals need to be trained. As stated in the report, “the committee believes that public health professionals will be better prepared to address the major health problems and challenges facing society if they achieve competency in the following eight content areas,” and the text goes on to list and discuss CBPR as one of “these eight areas of critical importance to public health education in the 21st century” (p. 62).

Further recognition of the relevance of CBPR for professionals can be found in the increasing number of participatory research courses being taught in schools and departments of public health, nursing, sociology, social work, psychology, and the like. In addition the number of CBPR workshops and conference sessions offered in local communities as well as at regional and national meetings has expanded over the past decade as participants strive to enhance their knowledge and skills related to partnership approaches to research. There are now a number of excellent books that examine the theoretical underpinnings of participatory approaches and provide case studies that illustrate implementation issues (see, for example, deKoning & Martin, 1996; Jason et al., 2004; Minkler & Wallerstein, 2003; Reason & Bradbury, 2001; Stringer, 1996). Several journals, such as the *Journal of General Internal Medicine* (“Community-Based Participatory Research,” 2003) and *Health Education & Behavior* (“Community-Based Participatory Research—Addressing Social Determinants of Health: Lessons from the Urban Research Center,” 2002), have recently published entire issues

devoted to CBPR. Special sections on CBPR have appeared in such journals as the *American Journal of Public Health* (“Community-Based Participatory Research,” 2001) and *Environmental Health Perspectives* (“Community-Based Participatory Research,” in press). Finally, the Agency for Healthcare Research and Quality commissioned a systematic, evidence-based review that consolidates and analyzes the body of literature produced to date on (1) what defines CBPR, (2) how CBPR has been implemented with regard to the quality of research methodology and community involvement, (3) the evidence that CBPR efforts have resulted in the intended outcomes, and (4) criteria and processes that should be used for review of CBPR in grant proposals (Viswanathan et al., 2004).

As opportunities for conducting and learning about CBPR expand, so does the demand for knowledge and skills in this area. Practitioners and scholars ask for information about specific participation structures and procedures needed to establish and maintain equitable partnerships among individuals and groups from diverse cultures. They ask how specific data collection methods, such as survey questionnaires, in-depth interviews, and focus groups, can be designed and implemented to follow participatory principles, and how to engage all CBPR partners in disseminating research findings and translating results into action and policy change. This book is designed as a resource for students, practitioners, community members, and researchers in public health and related disciplines, with the aim of expanding their repertoire of skills and methods for supporting partnership approaches to research intended to improve the health and well-being of communities in general and eliminate health disparities in particular.

PRINCIPLES OF CBPR

Based on an extensive review of the literature, the following discussion briefly presents nine guiding principles of CBPR (see Israel et al., 2003, for a more detailed examination). These principles are offered with the caution that no one set of principles is applicable to all partnerships. Rather, the members of each research partnership need jointly to decide on the core values and guiding principles that reflect their collective vision and basis for decision making. However, as partnerships go about the process of making these decisions, they may be informed by the considerable experience and many lessons learned over the past several decades of participatory forms of research as well as by the literature on partnerships and group functioning. Developing or existing partnerships may choose to draw on the principles presented here, as appropriate, as well as to develop additional or alternative principles that facilitate equitable participation and influence in each partnership’s particular context. We suggest that

partnerships consider the principles they adopt as ideals or goals to strive for, and evaluate the extent to which they are able to do so as one aspect of partnership capacity building (Cornwall, 1996; Green et al., 1995; Israel et al., 2003). As will be evident throughout this volume, these and similar principles have been applied in numerous ways by the authors of these chapters, reflecting multiple approaches to CBPR.

1. *CBPR acknowledges community as a unit of identity.* Units of identity refer to entities in which people have membership, for example, a family, social network, or geographical neighborhood; they are socially created dimensions of identity, created and re-created through social interactions (Hatch, Moss, Saran, Presley-Cantrell, & Mallory, 1993; Steuart, 1993). Community as a unit of identity is defined by a sense of identification with and emotional connection to others through common symbol systems, values, and norms; shared interests; and commitments to meeting mutual needs. Communities of identity may be geographically bounded (people in a particular physical neighborhood may form such a community, for example) or geographically dispersed but sharing a common identity or sense of common interests (as members of an ethnic group or gay men may do, for example). A city, town, or geographical area may represent a community of identity, or then again it may be an aggregate of individuals who do not have a common identity or it may comprise multiple overlapping communities of identity. CBPR partnerships seek to identify and work with existing communities of identity, extending beyond them as necessary, to improve public health (Israel et al., 1998, 2003).
2. *CBPR builds on strengths and resources within the community.* CBPR recognizes and builds on the strengths, resources, and assets that exist within communities of identity, such as individual skills, social networks, and organizations, in order to address identified concerns (Balcazar et al., 2004; Israel et al., 1998, 2003; McKnight, 1994; Steuart, 1993).
3. *CBPR facilitates a collaborative, equitable partnership in all phases of research, involving an empowering and power-sharing process that attends to social inequalities.* To the extent possible, all partners participate in and share decision making and control over all stages of the research process, such as defining the problem, collecting and interpreting data, disseminating findings, and applying the results to address community issues (Balcazar et al., 2004; deKoning & Martin, 1996; Green et al., 1995; Israel et al., 1998, 2003; Park, Brydon-Miller, Hall, & Jackson, 1993; Stringer, 1996). Researchers involved in CBPR recognize the inequalities that exist between themselves and community partners

and attempt to address these inequalities through developing relationships based on trust and mutual respect and by creating an empowering process that involves open communication and sharing information, decision-making power, and resources (Blankenship & Schulz, 1996; Israel et al., 1998, 2003; Labonte, 1994; Suarez-Balcazar et al., 2004).

4. *CBPR fosters co-learning and capacity building among all partners.* CBPR is a co-learning process that fosters the reciprocal exchange of skills, knowledge, and capacity among all partners involved, recognizing that all parties bring diverse skills and expertise and different perspectives and experiences to the partnership process (deKoning & Martin, 1996; Freire, 1973; Israel et al., 1998, 2003; Stringer, 1996; Suarez-Balcazar et al., 2004).
5. *CBPR integrates and achieves a balance between knowledge generation and intervention for the mutual benefit of all partners.* CBPR aims to contribute to science while also integrating and balancing the knowledge gained with interventions and policies that address the concerns of the communities involved (Green et al., 1995; Park, Brydon-Miller, Hall, & Jackson, 1993; Israel et al., 1998, 2003). Although a given CBPR project may not include a direct intervention component, it will have a commitment to the translation of research findings into action strategies that will benefit the community (deKoning & Martin, 1996; Green et al., 1995; Israel et al., 2003; Schulz, Israel, Selig, Bayer, & Griffin, 1998).
6. *CBPR focuses on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinants of health.* CBPR addresses public health concerns that are of local relevance to the communities involved, and it emphasizes an ecological approach to health that pays attention to individuals, their immediate context (for example, the family or social network), and the larger contexts in which these families and networks exist (for example, the community and society) (Bronfenbrenner, 1990; Israel et al., 1998, 2003; Stokols, 1996). Thus CBPR efforts consider the multiple determinants of health and disease, including biomedical, social, economic, cultural, and physical environmental factors, and necessitate an interdisciplinary team of researchers and community partners (Israel et al. 1998, 2003; Suarez-Balcazar et al., 2004).
7. *CBPR involves systems development using a cyclical and iterative process.* CBPR addresses systems development, in which a system, for example, a partnership, draws on the competencies of each partner to engage in a cyclical, iterative process that includes all the stages of the research process, such as community assessment, problem definition,

research design, data collection and analysis, data interpretation, dissemination, determination of intervention and policy strategies, and action taking, as appropriate (Altman, 1995; Israel et al., 1998, 2003; Stringer, 1996).

8. *CBPR disseminates results to all partners and involves them in the wider dissemination of results.* CBPR emphasizes the dissemination of research findings to all partners and communities involved and in ways that are understandable, respectful, and useful (Israel et al., 1998, 2003; Schulz et al., 1998). This dissemination principle also emphasizes that all partners engage in the broader dissemination of results, for example as coauthors of publications and copresenters at meetings and conferences (Israel et al., 2003).
9. *CBPR involves a long-term process and commitment to sustainability.* CBPR involves a long-term process and commitment to sustainability in order to establish and maintain the trust necessary to successfully carry out CBPR endeavors, and to achieve the aims of addressing multiple determinants of health (Hatch et al., 1993; Israel et al., 2003; Mittelmark, Hunt, Heath, & Schmid, 1993). This long-term commitment frequently extends beyond a single research project or funding period, and although partners may reach a point at which they decide to no longer continue as a partnership, they retain a commitment to the relationships that exist and that can be called on in the future to the extent that partners feel is needed and desired (Israel et al., 2003).

CBPR AND HEALTH DISPARITIES: CULTURAL, SOCIAL, ECONOMIC, AND ENVIRONMENTAL CONTEXT

Although CBPR is appropriate for addressing many health problems in community contexts, in the United States such partnership efforts have been carried out primarily in predominantly low-income communities, often communities of color (Minkler, 2004). African American, Latino, Native American, and other ethnic communities have historically been economically and politically marginalized and have compelling reasons to distrust research and researchers (Gamble, 1997; Minkler, 2004; Ribisl & Humphreys, 1998; Sloane et al., 2003). Furthermore, communities of color disproportionately experience the burden of higher rates of morbidity and mortality accompanied by lower socioeconomic position (Cooper et al., 2000; House & Williams, 2000; Krieger, Rowley, Herman, Avery, & Phillips, 1993; Schulz, Williams, et al., 2002). These health disparities are associated with sociostructural and physical environmental determinants of

health status, such as poverty, inadequate housing, racism, lack of access to community services and employment opportunities, air pollution, and exposure to toxic substances (Collins & Williams, 1999; Krieger et al., 1993; Schulz, Williams, et al., 2002; Schulz & Northridge, 2004). Thus it is critical that CBPR efforts strive to understand and address the social, economic, and environmental contexts that have an impact on the communities involved. In addition, as elaborated upon here, it is essential that the cultural context of communities be understood and respected and that this context inform partnership approaches to research.

CBPR is intended to bring together researchers and communities to establish trust, share power, foster co-learning, enhance strengths and resources, build capacity, and examine and address community-identified needs and health problems. Given that academically based researchers involved in CBPR are often from “outside” the community in which the research is taking place and are often different from community partners in terms of, for example, class, ethnicity, and culture, a number of power issues and tensions may arise and need to be addressed (Chávez, Duran, Baker, Avila, & Wallerstein, 2003; Minkler, 2004; Nyden & Wiewel, 1992; Wallerstein, 1999). These differences require researchers to gain the self-awareness, knowledge, and skills to work in multi-cultural contexts.

Two concepts are particularly germane to our focus on CBPR and to efforts to work effectively in cultures different from one’s own. First, the concept of *cultural humility* has its roots in medical education in the United States (Tervalon & Murray-Garcia, 1998). Second, the concept of *cultural safety* originated in nursing education and has been applied to medical education in New Zealand (Crampton, Dowell, Parkin, & Thompson, 2003; Ramsden, 1997). Here are brief descriptions of the ways in which each concept provides a framework for considering the many methods and issues addressed in this volume.

As articulated by Tervalon and Murray-Garcia (1998), cultural humility rather than *cultural competence* is the goal for professionals to strive to achieve, because achieving a “static notion of competence” (p. 120) is not possible. That is, professionals cannot fully master another’s culture. Tervalon and Murray-Garcia recommend a process that requires humility and commitment to ongoing self-reflection and self-critique, including identifying and examining one’s own patterns of unintentional and intentional racism and classism, addressing existing power imbalances, and establishing and maintaining “mutually beneficial and non-paternalistic partnerships with communities” (p. 123). Achieving cultural humility is reflected in the principles of CBPR, given its emphasis on co-learning, which requires relinquishing one’s role as the “expert” in order to recognize the role of community members as full partners in the learning process.

Also reflected in CBPR principles is the concept of cultural safety, which was first defined in New Zealand during the processes of examining how relationships and power imbalances affect and are affected by racism and of investigating the health disparities that exist between Māori (the colonized indigenous peoples of New Zealand) and non-Māori (Crampton et al., 2003; Ramsden, 1997). A policy of cultural safety gives the power to community members to say whether or not they feel safe, and professionals need to enable the community members to express the extent to which they feel risk or safety, resulting in changes in the behaviors of health professionals as appropriate. The concept of cultural safety purports that cultural factors, such as differences in worldview and language, have a major influence on current relationships between professionals and communities. Hence professionals need to acknowledge and understand that these cultural factors, as well as the social, economic, political, and historical determinants of health disparities, can contribute to communities' distrust of and not feeling safe about collaboration (Ramsden, 1997). To achieve cultural safety within a CBPR partnership, it is essential to establish deliberation and decision-making structures and procedures whereby all partners are required to express and critically examine their own realities and the attitudes they bring to the issue at hand, be open-minded toward others whose views are different from their own, consider the influences of social and historical processes on their present situation, and work toward becoming members of a partnership that anticipates differences and conflict by addressing them through processes that have been defined by all partners, and particularly by community partners, to be culturally safe (Crampton et al., 2003; Ramsden, 1997). The concepts of cultural humility and cultural safety are integral to the purpose and goals of this book.

PURPOSES AND GOALS OF THIS BOOK

The overall purpose of this book is to provide students, practitioners, researchers, and community members with the knowledge and skills necessary to conduct research that is guided by community-based participatory research principles. CBPR is *not* a particular research design or method. Rather, it is a collaborative approach to research that may draw on the full range of research designs (from case study, etiological, and other nonexperimental designs to randomized control trial, longitudinal, and other experimental or quasi-experimental designs). CBPR data collection and analysis methods may involve both quantitative (for example, psychometric scaling and survey questionnaire) and qualitative (for example, in-depth interview and participant observation) approaches. What distinguishes CBPR from other approaches to research is the

integral link between the researcher and the researched whereby the concepts of cultural humility and cultural safety are combined with process methods and procedures (such as group facilitation) to establish and maintain the research partnership.

The chapters in this volume provide a wide range of concrete examples of CBPR study designs, specific data collection and analysis methods, and innovative partnership structures and process methods. Each chapter addresses one or more methods for data collection and analysis and presents a detailed case example of CBPR from the authors' experience to examine challenges, lessons learned, and implications that can be applied to other contexts. The purpose is not to provide detailed explanations of how to administer such data collection methods as survey questionnaires and in-depth interviews—there are numerous excellent books that do that (for example, Nardi, 2002; Patton, 2002), and they are referred to throughout this volume. Rather, the focus is on how to conduct these methods in ways that involve all partners and that attend to issues of equity, power sharing, cultural differences, and research dissemination and benefits. The chapters that discuss different process methods also provide numerous examples from the authors' experiences in multiple settings. In keeping with the principles of CBPR, all chapters have community partners as coauthors, ensuring that community partners' voices are reflected in the descriptions and recommendations provided.

Our work has been greatly enhanced by Minkler and Wallerstein's excellent volume *Community-Based Participatory Research for Health* (2003), which provides an in-depth discussion of what CBPR is, its history, and its theoretical roots (Wallerstein & Duran, 2003); issues related to power and trust (Chávez et al., 2003); and case examples of CBPR efforts that examine topics such as ethical considerations (Farquhar & Wing, 2003) and conducting CBPR with and by diverse populations (Cheatham & Shen, 2003). *Community-Based Participatory Research for Health* is an outstanding precursor to and companion volume for this one.

We also acknowledge the international body of work in participatory research that has laid the foundation for CBPR (for examples of work in Australia and Canada and in Asia, Latin America, and Africa, see deKoning & Martin, 1996; Fals-Borda & Rahman, 1991; Park, Brydon-Miller, Hall, & Jackson, 1993; Reason & Bradbury, 2001; Stringer & Genat, 2004). While recognizing and drawing upon this important work, we have chosen to focus this CBPR methods book on case examples from the United States, given the necessity to attend to the context within which CBPR is conducted (Minkler & Wallerstein, 2003). Our intent is that readers will embrace the lessons learned by the authors of the chapters in this book and gain the skills needed to apply them throughout the United States and to adapt them as appropriate to the particular context of other countries as well.

ORGANIZATION OF THIS BOOK

The chapters in this book are organized into six parts:

1. An introduction to methods in CBPR and to the five specific phases of the CBPR approach that are discussed in the subsequent parts
2. Partnership formation and maintenance
3. Community assessment and diagnosis
4. Definition of the issue
5. Documentation and evaluation of the partnership process
6. Feedback, interpretation, dissemination, and application of results

Although these phases are presented in the book as distinct entities, we understand that CBPR is an iterative process in which a partnership will cycle through earlier phases at various points in time.

Each chapter examines one or more methods organized around a case study and includes an overview of each method, background on the CBPR partnership and project to be discussed, a description of how the method was designed and implemented within a particular phase of the CBPR process, an analysis of the challenges and limitations of the method within the context of CBPR, and an examination of the lessons learned, the implications, and recommendations for using the data collection method in CBPR projects more broadly. When a method examined in relation to a particular phase of CBPR is also applicable to another phase, readers are referred to relevant chapters elsewhere in the book. In addition, a few methods are covered in more than one part of the book because their application differs depending on the phase of CBPR in which they are used.

Part Two (Chapters Two and Three) focuses on one of the most critical aspects of CBPR, partnership formation and maintenance. In any CBPR project, regardless of the specific focus of the project and the data collection methods used, a number of important questions need to be addressed regarding the creation of a partnership. Such questions include the following: How is the community defined? Who will be involved, and who decides on that involvement? Are community members involved as individuals or representatives of organizations? To what extent do members of the partnership represent the community in terms of class (income and education level), gender, race, or ethnicity, and language(s) spoken? How will partners be involved? How will trust and open communication be established and maintained? How will issues of power and conflict be addressed? And how will equitable participation and influence be achieved across all partners? To address these questions and the issue of developing and maintaining effective partnerships, Chapters Two and Three

examine *process methods* that can be used. Although this phase is presented as the beginning of a CBPR effort, it is essential to give continued attention to these partnership formation methods throughout all phases of a CBPR endeavor in order to maintain the partnership.

In Chapter Two, Wallerstein, Duran, Minkler, and Foley share their experiences in building and maintaining university-community research partnerships in New Mexico and California. They describe the how-to methods and challenges of partnership development and maintenance, framed specifically for academic and other outside research partners. However, all readers, including community partners and those new to CBPR, will benefit from the self-reflection and dialogue methods provided. They examine different starting points and strategies for establishing partnerships, process methods for creating and incorporating collaborative principles to foster effective partnerships, the dilemmas and challenges of collaboration between outside researchers and communities that are built into the various contexts represented and strategies for addressing these challenges (such as ways to achieve cultural humility), and process methods for maintaining partnerships over the long haul.

In Chapter Three, Becker, Israel, and Allen describe group process methods and facilitation strategies to establish and maintain effective partnerships. Based on concepts and findings from the field of group dynamics, they present specific techniques and activities for facilitating CBPR groups, drawing from a number of CBPR efforts in Michigan and Louisiana in which they have been involved. This chapter is organized around twelve elements of group dynamics (including equitable participation and open communication, developing trust, addressing power and influence, conflict resolution, and working in culturally diverse groups) relevant to CBPR partnerships. For each element the authors provide useful strategies and techniques for improving the partnership process with the aim of achieving the ultimate outcomes of a given CBPR effort.

Part Three (Chapter Four) examines the important phase of community assessment and diagnosis. Unlike a needs assessment that focuses on identifying health needs and problems often out of context, this phase focuses on gaining a better understanding of what it is like to live in a given community. Such understanding includes, for example, the strengths and resources that exist within the community; the history and involvement of its members and organizations; community values, language, communication, and helping patterns; and community needs and concerns (Eng & Blanchard, 1991–1992; Kretzmann & McKnight, 1993; Steuart, 1993). Eng, Moore, Rhodes, Griffith, Allison, Shirah, and Mebane, the authors of Chapter Four, refer to this phase as *action-oriented community diagnosis* (AOCD). As in the phase of partnership formation (although it is necessary for AOCD to occur early in a CBPR partnership), gaining entry to a community and establishing relationships is a long-term, ongoing process for outsiders.

Eng and colleagues examine several different methods for collecting and interpreting data (participant observation, key informant in-depth interviews, key informant focus group interviews, and community forums) as part of an AOCD community assessment procedure. They provide a case example of their experience with conducting an AOCD in Efland-Cheeks, North Carolina, describing in detail the CBPR approach they have used to engage community members and outsider researchers throughout the process, including formulating the AOCD case study research design, selecting and using multiple data collection methods, analyzing data using the technique of constant comparison to identify differences and similarities, and interpreting the findings and determining next action steps to address them. They highlight the challenges and limitations and the lessons learned and implications of using this multimethod community assessment approach within the context of CBPR.

As discussed in Part Four (Chapters Five through Eleven), whether a CBPR project is examining a basic research question, an intervention evaluation question, or both, a major phase is defining the issue or health problem that will be the focus of the project. As in all phases of CBPR, a key aspect is obtaining the active involvement of all partners in the process, ideally from the very beginning. These chapters examine various data collection methods (survey questionnaires, focus group interviews, neighborhood observational checklists, social mapping, ethnography, and exposure assessments) used to identify the issue(s) that a research partnership will investigate and address. Although the methods examined in each chapter are quite different, the lessons learned with regard to their application as part of a CBPR effort are similar. For example, lessons are offered on the role of community partners in developing measurement instruments, in tailoring language and data collection procedures to the local culture of the community, and in training and involving community members as data collectors.

In Chapter Five, Schulz, Zenk, Kannan, Israel, Koch, and Stokes draw on their experience with the Healthy Environments Partnership in Detroit, Michigan. Their case example illustrates collaboration among community members and the partners in jointly developing and implementing a population-based survey administered to a stratified random sample of community residents. They give particular attention to processes through which representatives from diverse groups were actively engaged and the contributions of these various forms of engagement to such aspects of the survey as conceptualization, identification of specific topics and items, selection of language and wording, and administration. The authors discuss challenges, lessons learned, and implications for CBPR partnerships seeking to jointly develop and implement community surveys.

In Chapter Six, Christopher, Burhansstipanov, and Knows His Gun McCormick discuss the CBPR process they used to modify interviewer training protocols developed originally for use with non-Native groups, in order to

increase the cultural acceptability and accuracy of the survey data gathered by and from women on the Apsáalooke Reservation in Montana. They describe a history of inequality, manifested in the community's past disrespectful interactions with researchers and the community's inability to access, influence, or make use of information generated through research to improve the health of community members. The authors discuss how this history has shaped the community's current perspectives and responses to research, and the implications for training survey interviewers. Some of the training implications they address relate to issues of recruitment and enrollment of interviewees, the manner of interviewers, beginning the interview, language use, and dissemination of findings. The authors provide a summary of the lessons learned in this process and the implications for public health research and interventions.

In Chapter Seven, Kieffer, Salabarría-Peña, Odoms-Young, Willis, Baber, and Guzman describe how they have used focus group interviews in several CBPR projects in Detroit. They provide an in-depth examination of one partnership, Promoting Healthy Lifestyles Among Women, emphasizing the role and contributions of community partners throughout the focus group interview process. The process includes developing focus group guides, recruiting and training focus group moderators and note takers, recruiting participants, collecting and analyzing data, reporting the findings to the community, and engaging community members in the interpretation of results. The authors discuss challenges and limitations, lessons learned, and the implications for using a participatory approach in conducting focus group interviews.

In Chapter Eight, Zenk, Schulz, House, Benjamin, and Kannan begin by reviewing the ways in which direct neighborhood observation has been used in research, including CBPR, and then they describe how community and academic partners of the Healthy Environments Partnership in Detroit worked together to design and conduct an assessment using an observational tool, the Neighborhood Observational Checklist (NOC). The authors highlight how they obtained input from and engaged other community residents in this process. They emphasize the role of community partners and other residents in content discussions regarding the NOC (clarifying the purpose of the NOC, probing the meaning and examining the appropriateness of items, and adding items to better reflect community strengths and assets, for example) and in discussions on pilot testing and implementing the NOC. The authors examine challenges and lessons learned in applying a CBPR approach to the design of a neighborhood observational tool, with specific attention to implications for the use of neighborhood observation in future CBPR endeavors.

In Chapter Nine, Ayala, Maty, Cravey, and Webb examine the concept of mapping social and environmental influences using a CBPR approach. They consider not only the question of why one should use mapping techniques but also the important question of how one can engage a community in a mapping

activity. They describe the methods used in two CBPR projects in North Carolina, one in Raleigh, Wake County, and the other in Burlington, Alamance County. The authors specifically address the role of community and academic partners in the development of the mapping protocol, selection and recruitment of participants, data collection and analysis, and data feedback, interpretation and discussion. They present challenges and limitations of social-mapping techniques and lessons learned and implications for the use of these techniques in CBPR partnerships.

In Chapter Ten, McQuiston, Parrado, Olmos, and Bustillo demonstrate how to conduct ethnography as CBPR. Community-based ethnographic participatory research (CBEPR) focuses on culture and cultural interpretation and uses a participatory process. These authors discuss the example of a case in Durham, North Carolina, involving Latinos who have recently immigrated to the area. They examine the roles of community and academic partner organizations and community members in proposal development, ethnographic survey development and administration, training community members as ethnographers and participant observers, and analysis and interpretation of findings. The authors also reflect on the capacity building of the partners involved and discuss challenges and limitations, lessons learned, and implications for practice.

In Chapter Eleven, Krieger, Allen, Roberts, Ross, and Takaro describe how to conduct exposure assessments of harmful substances in the environment associated with adverse health effects. Drawing from their experience with the Healthy Homes Project in Seattle, Washington, they examine the role of community partners and other community members trained as community health workers in the development and implementation of exposure data collection instruments and protocols (such as dust sampling and measuring surface moisture). These authors discuss the benefits of and lessons learned from involving community partners, community staff, and participants in this process.

As discussed in Part Five (Chapter Twelve), it is essential that CBPR partnerships continually document and evaluate their progress toward achieving an effective collaborative process (Israel et al., 2003; Lasker, Weiss, & Miller, 2001; Parker et al., 2003; Schulz, Israel, & Lantz, 2003; Sofaer, 2000; Wallerstein, Polacsek, & Maltrud, 2002; Weiss, Anderson, & Lasker, 2002). Such an evaluation involves focusing on the partnership's adherence to its CBPR principles, such as those described earlier (determining, for example, whether the partnership fosters co-learning and capacity building; involves equitable participation, influence, and power sharing; and achieves balance between knowledge generation and action). The rationale is that it is essential to determine whether and how well a research partnership is achieving, as intermediate outcomes, principles that it must use to refine and improve its methods to accomplish its long-term outcomes (Lantz, Viruell-Fuentes, Israel, Softley, & Guzman, 2001; Rossi, Freeman & Lipsey, 1999; Schulz et al., 2003; Weiss et al., 2002).

In Chapter Twelve, Israel, Lantz, McGranaghan, Kerr, and Guzman describe the use of two data collection methods, in-depth, semi-structured interviews and closed-ended survey questionnaires, for assessing the process and impact of the collaborative dimensions of CBPR partnerships (for example, participatory decision making, two-way open communication, and constructive conflict resolution). They also present a conceptual framework for assessing CBPR partnerships and the use of this framework in guiding the Detroit Community-Academic Urban Research Center's application of the two data collection methods. The authors emphasize the role of academic and community partners in the participatory process used in designing, conducting, feeding back, and interpreting the results of these two data collection methods for evaluating this CBPR partnership. They examine the challenges and limitations, lessons learned, and implications for the use of these methods.

Part Six (Chapters Thirteen through Seventeen) focus on the CBPR phase of ensuring active engagement of all partners in the feedback, interpretation, dissemination, and application of results. There are process methods that can be used to foster the steps in this phase, such as the collaborative development of dissemination guidelines (as discussed in Chapter Thirteen). In addition, four of the chapters in Part Six include case examples of using group dialogue, photovoice, document review, survey questionnaire, focus group interview, and secondary data analysis methods of data collection.

In Chapter Thirteen, Parker, Robins, Israel, Brakefield-Caldwell, Edgren, and Wilkins describe how they established and implemented dissemination guidelines in a CBPR project in order to ensure widespread dissemination of results and participation of all partners in the process. The case example draws on their experience with Community Action Against Asthma, a CBPR effort of the Michigan Center for the Environment and Children's Health. The authors examine the role of community and academic partners in deciding how to address issues in the dissemination guidelines. These issues included developing a process for selecting members to participate in presentations, establishing ground rules for collaborative authorship, drafting a list of proposed core articles and presentations, and providing feedback of results to participants and the wider community. The authors discuss the challenges and the lessons learned in creating and applying dissemination guidelines.

In Chapter Fourteen, Baker and Motton focus on the data collection method of in-depth group interviews, examining the stages involved in collecting data and using data to develop action within a CBPR project. The case example concerns a partnership in rural southeast Missouri involving a series of group interviews conducted with the Bootheel Heart Health Coalitions over an eleven-month period. The authors consider the role of community and academic partners in development of the interview guide, recruitment and data collection, data analysis, data feedback and member checking, and interpretation of the

results. They discuss the challenges and limitations of the method and the lessons learned and implications for its application within CBPR efforts.

In Chapter Fifteen, López, Eng, Robinson, and Wang discuss the use of photovoice in the context of a CBPR approach. Photovoice is a participatory method in which community members use cameras to take pictures that represent their experiences and communicate those experiences to others (Wang & Burris, 1994). Following a brief review of the origins, diverse applications, and theoretical underpinnings of photovoice, the authors present a case example of the Inspirational Images Project that was conducted in three counties in rural, eastern North Carolina using photovoice as the primary data collection method. They examine the role of academic and community partner organizations and individual breast cancer survivors, who were coinvestigators in this effort, in deciding on the design of the study and research protocol, the selection and recruitment of participants, photovoice training, data collection and theoretical sampling, data management and grounded theory analysis, data feedback and interpretation, and the engagement of local policymakers in discussing the findings. The authors share lessons learned, and draw from feedback provided by photovoice participants to describe implications of the method for CBPR.

In Chapter Sixteen, Freudenberg, Rogers, Ritas, and Nerney describe participatory policy research (PPR), an approach to CBPR designed to analyze the impact of policies on public health and to use these analyses to mobilize action to change harmful policies. They illustrate the multiple methods used in PPR through their experiences in a multipronged partnership process in New York City. They examine the role of different stakeholders in applying diverse methods to understand issues and change policies, methods such as review of public data, review of relevant legislation and agency regulations, surveys, focus group interviews, literature reviews, opinion polls, and meeting with legislators, staff, and executive branch officials. The authors discuss limitations and challenges, the lessons learned, and the implications of using such a multimethod approach.

In Chapter Seventeen, Morello-Frosch, Pastor, Sadd, Porras, and Prichard demonstrate how the Southern California Environmental Justice Collaborative has applied a CBPR approach to conducting research in the region using secondary data sources. They discuss the rationale for the use of secondary data analysis and focus on how the collaborative has collectively developed research projects, interpreted data, disseminated study findings, and leveraged the results of secondary data to promote policy change and bolster organizing. The authors explore how their research approach has sought to transform traditional scientific approaches to studying community environmental health. They conclude with a discussion of some of the challenges they have faced and the lessons learned from their work.

This book ends with sixteen appendixes that give the readers examples of the process methods tools, procedural documents, and data collection instruments discussed by some of the chapter authors. The intent of these appendixes is to provide further detail on methods for conducting CBPR and the instruments developed as a result of the process. Among the process methods and procedural documents included are an informed consent form, guidelines for establishing research priorities, and dissemination guidelines. The data collection instruments include a key informant in-depth interview protocol, the Neighborhood Observational Checklist, open-ended and closed-ended questionnaires for evaluating partnership functioning, and a group dialogue interview protocol. The appendixes are intended to further assist researchers, practitioners, and community partners in developing and implementing strategies and methods that strengthen the use of community-based participatory research.

CONCLUSION

As is evident throughout this volume, there is no one approach to community-based participatory research, and there are no process methods or data collection methods that are applicable to all CBPR efforts. Rather, community-based participatory research is a fluid, iterative approach to research, interventions, and policy change that draws from a wide range of research designs and methods and pays particular attention to issues of trust, power, cultural diversity, and equity. Furthermore, CBPR is one of many different approaches to research and action. The case examples throughout this book illustrate methods used by various CBPR partnerships whose goal has been to move the public health field forward by generating new knowledge (such as better information on the ways social and physical environmental factors influence health), identifying the factors associated with intervention success, and determining actions (based on partnership findings and co-learning) that will effect social and behavioral change in order to eliminate health disparities.

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