Public health problems are complex, and their solutions involve not only political and social but also biomedical dimensions. Researchers, practitioners, community members, and funders continue to recognize the importance of comprehensive and participatory approaches to research and intervention, and opportunities for such partnership approaches 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 in developing a clearer understanding of public health problems and in working collectively to address them. Like the first edition, this book is 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 inequities in particular. In the introduction to this volume, we discuss the background to and support for CBPR, principles of CBPR, core components/phases of CBPR, and the broad cultural, socioeconomic, and environmental context in which CBPR is conducted. Finally, we describe the purposes and goals of this book, and present the organization and brief descriptions of the chapters.
BACKGROUND

Over the past decade, there has continued to be increasing recognition that more comprehensive and participatory approaches to research and interventions are needed in order to address the complex set of social and environmental determinants associated with population health and those factors associated more specifically with racial and ethnic inequities in health (Commission for the Social Determinants of Health, 2008; Commission to Build a Healthier America, 2009; Israel, Schulz, Parker, & Becker, 1998; Mercer & Green, 2008; Minkler & Wallerstein, 2008; Schulz, Williams, Israel, & Lempert, 2002). Concomitantly, funding opportunities that support partnership approaches to research addressing these problems continue to grow (Catalani & Minkler, 2009; Chen, Diaz, Lucas, & Rosenthal, 2010; Cook, 2008). These include, for example, the National Institute on Minority Health and Health Disparities’ Community-Based Participatory Research Initiative (NIMHD, 2011); the Centers for Disease Control and Prevention’s Prevention Research Centers program (CDC, 2011); the National Cancer Institute’s Center to Reduce Cancer Health Disparities Community Networks Program (NCI, 2012); the National Institutes of Health’s Clinical and Translational Science Awards Program, Community Engagement Core (NIH, 2011); and the Office of Behavioral and Social Sciences Research’s opportunities for community participation in research (OBSSR, 2012).

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,” “community-involved,” “collaborative,” and “community-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” (deKoning & 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, 2006, 2008; Stringer, 2007), “participatory feminist research” (Maguire, 1987, 1996; Joyappa & Martin 1996), “action science/inquiry” (Argyris, Putnam, & Smith, 1985; Torbert & Taylor, 2008), “cooperative inquiry” (Heron & Reason, 2001; Reason, 1994), “critical action research” (Kemmis & McTaggart, 2000), “participatory
community research” (Jason, Keys, Suarez-Balcazar, Taylor, & Davis, 2004), “tribally driven participatory research” (Mariella, Brown, Carter, & Verri, 2009), “community engagement” (Clinical and Translational Science Awards Community Engagement Key Function Committee Task Force, 2011), and “community-based collaborative action research” (Pavlish & Pharris, 2012). Although there are differences among these approaches, they all involve a commitment to conducting research that to some degree 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) has been increasingly used to represent such collaborative approaches (Israel et al., 2001; Minkler & Wallerstein, 2008; Viswanathan et al., 2004), while recognizing that there are other approaches with different labels that share similar values and methods. CBPR 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, 2008). 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, 2008).

Associated with the developments described above, the Institute of Medicine Report, Who Will Keep the Public Healthy? Educating the Public Health Professionals for the 21st Century (Gebbie, Rosenstock, & Hernandez, 2003), identifies CBPR 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 then lists and discusses 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, and psychology, among others. In addition, the number of CBPR workshops and conference sessions offered in local communities as well as at regional, national and inter-
national meetings has expanded over the past decade as participants strive to enhance their knowledge and skills related to partnership approaches to research. A number of excellent books 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, 2008; Reason & Bradbury, 2006, 2008; Stringer, 2007). In 2004, the Agency for Healthcare Research and Quality commissioned a systematic, evidence-based review examining definitions of, and the evidence base regarding implementation and outcomes of CBPR approaches in population health interventions (Viswanathan et al., 2004). Over the past decade, 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), published entire issues devoted to CBPR, and special sections on CBPR appeared in such journals as the *American Journal of Public Health* (“Community-Based Participatory Research,” 2001) and *Environmental Health Perspectives* (“Community-Based Participatory Research,” 2005). In 2007, a new journal was launched dedicated entirely to CBPR, *Progress in Community Health Partnerships: Research, Education and Action*. Indicative of these activities may be the increase in the use of the term, “Community-Based Participatory Research,” in the title or abstract of PubMed cited articles from 25 in 2001 to 226 in 2011. There have also been a number of training manuals and downloadable courses developed on CBPR (Israel, Coombe, & McGranaghan, 2010; Zimmerman, Tilly, Cohen, & Love, 2009).

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, focus groups, ethnography, and mapping 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 to expand 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 to eliminate health inequities 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., 1998 and 2008, 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 to jointly 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 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 toward, and evaluate the extent to which they are able to adhere to those principles as one aspect of partnership capacity building (Cornwall, 1996; Green et al., 1995; Israel et al., 2008). We clearly do not think that there is one “best” set of principles, and believe that such principles can also be considered on a continuum, for example, by differing levels of community involvement. At the same time, we argue that as CBPR continues to grow in recognition and stature, care should be taken that its more widespread adoption not result in CBPR being “selectively invoked to accomplish predetermined aims or goals not collaboratively developed or locally defined” (Trickett, 2011, p. 1353). As will be evident throughout this volume, the principles described here and similar principles have been applied in numerous ways by the authors of these chapters, reflecting multiple approaches to CBPR, while at the same time having an overarching commitment to equity and power sharing in the process of research and action.

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 may be an aggregate of individuals who do not have a common identity, or it may comprise multiple overlapping communities of identity (Gaffikin & Morrissey, 2011). 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, 2008).

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, 2008; 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, 2008; Park, Brydon-Miller, Hall, & Jackson, 1993; Stringer, 2007). Researchers involved in CBPR recognize the inequalities that exist between themselves and community partners and attempt to address these inequalities by 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, 2008; Labonté, 1994; Suarez-Balcazar et al., 2004).
4. **CBPR fosters colearning and capacity building among all partners.** CBPR is a colearning 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, 2008; Stringer, 2007; 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 et al., 1993; Israel et al., 1998, 2008). 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., 2008; 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 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, 2008; 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 (Freudenberg, Klitzman, & Saegert, 2009; Israel et al., 1998, 2008; Suarez-Balcazar et al., 2004).

7. **CBPR involves systems development using a cyclical and iterative process.** CBPR addresses systems development, in which a system, such as 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 including, as appropriate, community assessment, problem definition, research design, data collection and analysis, data interpretation, dissemination, determina-
tion of intervention and policy strategies, and action taking (Altman, 1995; Israel et al., 1998, 2008; Stringer, 2007).

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 in ways that are understandable, respectful, and useful (Israel et al., 1998, 2008; 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., 2008).

9. **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, CBPR involves a long-term process and commitment to sustainability (Hatch et al., 1993; Israel et al., 2008; Mittelmark, Hunt, Heath, & Schmid, 1993). This long-term commitment frequently extends beyond a single research project or funding period. Although partners may reach a point at which they decide to discontinue the partnership, they retain a commitment to the relationships that exist and that can be called on in the future (Israel et al., 2006, 2008).

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**Core Components/Phases in Conducting CBPR**

As depicted in Figure 1.1, there are seven broad core components in conducting CBPR (Israel, Coombe, & McGranaghan, 2010). These components may be considered as phases or stages, and though there is some sequential order to conducting CBPR, the process is more circular than linear, and some elements may continue throughout an entire CBPR effort. For example, as indicated by the large circle in the center of the figure, maintaining and sustaining a partnership occurs throughout the different phases of the process, as partners work on an ongoing basis to strengthen trust, resolve conflicts, develop and share knowledge and skills, and as they work together to carry out the tasks involved in conducting the research. Similarly, evaluation of the partnership’s effectiveness needs to start at the beginning and continue throughout a CBPR project. This

1. This section is adapted from Israel, Coombe, & McGranaghan, 2010.
model provides the basis for the organization of the book, as described below, and each of these components is briefly presented here. Throughout the book, aspects of these different phases will be discussed in more depth.

The first core component is forming a CBPR partnership. This involves such processes as identifying potential partners and communities to be involved, building trust and relationships, establishing operating norms and CBPR principles to ensure equity and power sharing, and creating an infrastructure for carrying out the research process.

The second component entails assessing community strengths and dynamics. This involves asking questions, such as: What are the strengths and resources in the community? What are key cultural and historical dimensions? Which are the influential organizations? Where’s the power in the community? Who needs to be involved to ensure community voice?

The third component is identifying priority local health concerns and research questions. Key questions here include: What are the major health problems that
have an impact on the community that a partnership might address? How are these problems identified and prioritized? What are the factors (for example, social, economic) that contribute to these health concerns? What are the key research questions that this study is intended to answer?

The fourth component involves designing and conducting etiologic, intervention, and/or policy research. This involves, for example, deciding which research design and data collection methods to use, and, as appropriate, what the most appropriate intervention strategy is, as well as determining how to implement the design and the strategies selected.

The fifth component is feeding back and interpreting the findings within the partnership. This involves sharing the findings from the research, such as the results of the analysis of survey or in-depth interview data, and engaging all partners in making sense of what was found.

The sixth component is disseminating and translating research findings. Critical questions here include: What is most important from the findings to share with the community? What are the most appropriate ways to disseminate results to the community? What is the role of community partners in publishing the results? How can the results be translated and disseminated into more broadscale interventions and policy change?

The last core component is maintaining, sustaining, and evaluating the partnership—which, as depicted in Figure 1.1, is an ongoing process that is at the center of all these phases and occurring throughout them. Relevant questions to address include: How well is the partnership working? How can the partnership process be improved? What aspects of the partnership need to be considered regarding sustainability, for example, enhanced relationships and capacity?

As we hope is apparent from this discussion and will be elaborated below, CBPR is an approach to research and not a specific method. Indeed, similar phases apply to the application of any approach to research. What is unique to CBPR is its emphasis on the diverse partners involved, and on striving for equal participation and ownership, reciprocity, colearning, and change.

**CBPR AND HEALTH INEQUITIES: CULTURAL, SOCIAL, ECONOMIC, AND ENVIRONMENTAL CONTEXT**

Although CBPR is appropriate for addressing many health problems in different 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 and low-income communities disproportionately experience the burden of higher rates of morbidity and mortality (Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010; Commission for the Social Determinants of Health, 2008; Commission to Build a Healthier America, 2009; House & Williams, 2000; Schulz et al., 2002). These health inequities are associated with numerous socio-structural 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 (Braveman et al., 2010; Commission for the Social Determinants of Health, 2008; Commission to Build a Healthier America, 2009; Marmot, 2007; Schulz et al., 2002; Schulz & Northridge, 2004; Wilkinson & Pickett, 2009). Thus, it is critical that CBPR efforts strive to understand the historical and contemporary social, economic, and environmental contexts that have a significant impact on the communities involved, and work to improve the conditions that foster these health inequities. In addition, as elaborated here, it is essential that the cultural context of communities be understood and respected, explicitly informing partnership approaches to research.

CBPR is intended to bring together researchers and communities to establish trust, share power, foster colearning, 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, 2008; Minkler, 2004; Nyden & Wiewel, 1992; Ross, 2010). These differences require researchers to gain the self-awareness, knowledge, and skills to work in multicultural contexts.

Two concepts are particularly germane to our focus on CBPR and to efforts to work effectively in cultures different from the researcher’s own. First, 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). Second, the concept of cultural humility has its roots in medical education in the United States (Chávez et al., 2008; Juarez et al., 2006; Ross, 2010; Tervalon & Murray-García, 1998). We provide brief descriptions of the ways in which each concept provides a framework for considering the many methods and issues addressed in this volume.

Cultural safety was first defined in New Zealand during the processes of (1) examining how relationships and power imbalances affect, and are affected by, racism, and (2) investigating the health inequities that exist between Maori (the colonized indigenous peoples of New Zealand) and non-Maori (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 inequities, can contribute to communities’ distrust of, and feeling unsafe 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, as culturally safe (Crampton et al., 2003; Ramsden, 1997).

As articulated by Tervalon and Murray-García (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-García 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). Cultural humility has three areas of focus that researchers and practitioners need to address: (1) knowledge—such as understanding the social determinants of health and health inequities (Ross, 2010; Smith, et al. 2007); (2) attitudes—which includes conscious and subconscious stereotyping and bias, and the recognition of power and privilege (Ross, 2010; Tervalon & Murray-García, 1998); and (3) skills—such as, nonhierarchical communication, and the ability to identify power imbalances and share decision making and power (Ross, 2010; Smith et al., 2007; Tervalon & Murray-García, 1998). Achieving cultural humility is reflected in the principles of CBPR, given its emphasis on colearning, 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. The concepts of cultural humility and cultural safety are integral to the purpose and goals of this book.

PURPOSE AND GOALS OF THIS BOOK

As in the first edition, 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 (CBPR) 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 non-experimental 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 exposure assessment instruments) and qualitative (for example, in-depth interview and participant observation), as well as mixed-methods 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 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. There are six new chapters in
this second edition and all remaining chapters have been revised and updated. 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 to describe and provide examples of how to conduct research across a variety of methods in ways that involve all partners and that attend to issues of equity, power sharing, cultural differences, dissemination, and mutual benefits to all partners. Thus, our goal is not to provide detailed explanations of how to administer data collection methods per se, for example, survey questionnaires and in-depth interviews; numerous excellent books provide such guidance (for example, Denzin & Lincoln, 2011; Fowler, 2009; Nardi, 2006; Patton, 2002), and they are referred to throughout this volume. Rather, the chapters discuss different processes for engaging community partners in research, providing 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 2008 excellent second edition of their volume *Community-Based Participatory Research for Health*, which provides an in-depth discussion of: what CBPR is, its history, and its theoretical roots (Wallerstein & Duran, 2008); issues related to power and trust (Chávez et al., 2008); and case examples of CBPR efforts that examine topics such as ethical considerations (Farquhar & Wing, 2008) and conducting CBPR with and by diverse populations (Cheatham-Rojas & Shen, 2008). *Community-Based Participatory Research for Health* is an outstanding 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 et al., 1993; Reason & Bradbury, 2006, 2008; Smith, 1999; 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 importance of attending to the context within which CBPR is conducted (Minkler & Wallerstein, 2008). 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. The first introductory part provides an overview of CBPR and the entire book. The remaining five parts combine to correspond with the core components or phases in conducting CBPR presented in Figure 1.1, collapsing those seven components into the five parts of the book. The parts of the book are listed below.

1. An introduction to methods in CBPR and to the seven specific phases of the CBPR approach that are discussed in the subsequent parts.

2. Partnership formation and maintenance (phases 1 and 7 described above in Figure 1.1).

3. Community assessment and diagnosis (phase 2).

4. Definition of the issue, design and conduct of the research (phases 3 and 4).

5. Documentation and evaluation of the partnership process (phase 7, occurs throughout the process).

6. Feedback, interpretation, dissemination, and application/translation of results (phases 5 and 6).

Although these phases are presented in the book as distinct entities, as depicted in Figure 1.1, CBPR is an iterative process in which a partnership will cycle through different 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 CBPR; an analysis of the challenges and limitations of the method within the context of CBPR; an examination of the lessons learned, implications, and recommendations for using the data collection method in CBPR projects more broadly; and a list of discussion questions to stimulate the readers’ reflection and understanding of the topics covered.
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 given that their application differs depending on the phase of CBPR in which they are used.

Part Two (Chapters Two, Three, and Four) 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? How will equitable participation and influence be achieved across all partners? To address these and more questions and the issue of developing and maintaining effective partnerships, Chapters Two, Three, and Four examine *process methods* that can be used. Although this phase is presented as the start of a CBPR effort, as presented in Figure 1.1, it is essential to recognize that while the initial formation of a partnership happens only once (at the beginning), continued attention needs to be paid to these partnership process methods throughout all phases of a CBPR endeavor in order to maintain the partnership.

In Chapter Two, Duran, Wallerstein, Avila, Belone, Minkler, and Foley share their experiences in building and maintaining university-community research partnerships working with tribes and rural and urban community-based organizations 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, Gustat, Reyes, 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 which they have been involved in Michigan and Louisiana, as well as several other locations. This chapter is organized around 12 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.

In Chapter Four, one of the new chapters in the second edition, Yonas, Aronson, Coad, Eng, Petteway, Schaal, and Webb discuss structures and mechanisms that can be used by CBPR partnerships to create an infrastructure for equitable participation in decision making that anticipates and manages conflict, and is transparent and accountable to all partners. The six structures and mechanisms examined are: (1) *Undoing Racism Training* for developing a common language and framework on health equity to address power differences and historical challenges; (2) *Full Value Contract* for identifying the specific set of values, affirmed by each member of the partnership; (3) *Research Ethics Training and Certification* for community partners; (4) *Partnership Bylaws* for explicitly stating long-term principles and procedures for the partnership; (5) *CBPR Conflict Management Procedures*; and (6) *Publications and Dissemination Guidelines* for ensuring co-ownership and control of dissemination. The authors draw on the experiences of the North Carolina Community-Based Public Health Initiative Consortium and the Greensboro Health Disparities Collaborative to highlight the impetus, process, and application of these six structures and mechanisms.

Part Three (Chapters Five and Six) 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, culture, language, communication, and helping patterns; and community needs and concerns (Eng & Blanchard, 1991; Kretzmann & McKnight, 1993; Minkler & Hancock, 2008; Steuart, 1993).

In Chapter Five, Eng, Strazza, Rhodes, Griffith, Shirah, and Mebane 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 this systematic and in-depth community assessment process. 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, lessons learned and implications of using this multi-method community assessment approach within the context of CBPR.

In Chapter Six, a new chapter in the second edition, Schensul, Berg, and Nair describe ways in which ethnography can be used to assess communities in the context of CBPR in health and other sectors. Ethnographic methods provide accessible ways for academically trained researchers and community researchers to partner to gather information about community life, processes, organizational structures, cultural factors, beliefs, and norms that can be used to help in planning interventions. In this chapter, the authors define ethnography, describe why it is a useful participatory community assessment approach, and how it can be used to conduct a community assessment. They present an overview of ethnographic methods including mapping, surveys, photography, GIS, semi-structured and in-depth interviews with community residents, and consensus modeling. The chapter illustrates with an example from the Institute for Community Research in Hartford, Connecticut, involving their youth action research work in which a group of youth identified hustling as a major issue. The ethnographic
participatory assessment process they describe provides an in-depth and rigorous analysis of the multiple factors that contribute to underlying health inequities and the resources available to solve them.

As discussed in Part Four (Chapters Seven through Twelve), whether a CBPR project is examining a basic research question, an intervention evaluation question, or both, two major phases that go hand in hand are defining the issue or health problem that will be the focus of the project, and the design and conduct of the research. 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, including quantitative (for example, survey questionnaires, systematic observations) and qualitative (for example, focus group interviews, ethnography) used to identify the issues that a research partnership will investigate and address, and provide examples of different research designs and implementation processes. Although the methods examined in each chapter are quite different, there are some similar lessons learned with regard to their application as part of a CBPR effort. 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 Seven, Schulz, Zenk, Kannan, Israel, and Stokes draw on their experience with the Healthy Environments Partnership in Detroit, Michigan. Their case example illustrates collaboration among community and academic partners in jointly developing and implementing a population-based survey administered to a stratified random sample of community residents. The survey was conducted to provide the communities involved with data that documented community concerns as well as strengths. This information helped to establish connections between those phenomena and the health of community residents, and provided information to inform specific community level interventions and policy change efforts. The authors 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’ discussion of challenges, recommendations, and lessons learned for addressing these challenges, and impli-
cations for CBPR partnerships seeking to jointly develop and implement community surveys is particularly valuable.

In Chapter Eight, Christopher, Burhansstipanov, Knows His Gun McCormick, and Watts-Simonds 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, manifest 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 and the implications for research and interventions. Their description of the CBPR process used offers a model for partnerships seeking to improve the cultural acceptability of interview protocols, as well as the reliability of survey data gathered.

In Chapter Nine, Guzman, Kieffer, Odoms-Young, Palmisano, Salabarria-Peña, and Willis describe a multistage process that engaged community residents and policymakers in focus groups to define and develop concrete strategies to address challenges faced by women as they sought to maintain healthy diets and physical activity levels during and following pregnancy. They draw upon their experiences with several CBPR projects in Detroit, 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. This is an important chapter offering concrete strategies for identifying community factors that contribute to health problems while engaging community women, local organizations, and state decision makers in a problem-solving discussion of future potential action strategies.
In Chapter Ten, another new chapter in this second edition, Zenk, Schulz, Izumi, Sand, Lockett, and Odoms-Young describe a series of participatory approaches used in the design and implementation of systematic observational instruments for documenting food availability, quality and costs, store characteristics, and linking the information gathered through these observational data collection instruments to dietary-related health outcomes in Detroit. The authors describe how partners based in community-based organizations, health service providers, and academic institutions worked together to design the Healthy Environments Partnership’s food store audit instrument, Food Environment Audit for Diverse Neighborhoods. The authors provide direct and concrete examples of specific contributions made by community and academic partners through this participatory process to the development of this observational tool. They offer a cogent discussion of challenges faced as well as lessons learned in the process of applying a CBPR approach to the design of this food environment observational tool. This is an insightful and instructive chapter for CBPR efforts seeking to apply systematic observation to establish links between community contexts and health outcomes.

In Chapter Eleven, Berry, McQuiston, Parrado, and Olmos describe a CBPR approach to gathering ethnographic data, with the aim of understanding the social context of health and illness in a population of recent immigrants. Community-based ethnographic participatory research (CBEPR) focuses on culture and cultural interpretation and uses a participatory process. The authors discuss a case example from their experiences 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 process of cultural interpretation that they describe provides a model for conducting collaborative research that is critical and self-reflective. The authors also reflect on the capacity building of the partners involved and provide a cogent discussion of challenges and limitations, lessons learned, and implications for practice.

In Chapter Twelve, Krieger, Allen, and Takaro describe their efforts using a community-based participatory process to apply exposure assessments within two community-level interventions developed and implemented as part of the Seattle-King County Asthma Program aimed at reducing household asthma triggers in
Seattle, Washington. Their discussion of the application of different methods (for example, GIS mapping, home environmental checklists, surveys, dust samplings) using a CBPR approach to collect information on exposure to indoor environmental asthma triggers is an important one in illuminating both challenges and contributions made by joining together epidemiologists, toxicologists, community residents and community health workers. The collaborative efforts of the partners as they worked together to address challenges illustrate the emergence of trust and trustworthiness on the part of both the academic and community partners as they learned to understand and value the contributions that each made to the success of the project. The discussion of lessons learned offers insights for researchers as well as community members who are seeking to adapt complex and sophisticated technologies to address public health concerns.

As discussed in Part Five (Chapter Thirteen), it is essential that CBPR partnerships continually document and evaluate their progress toward achieving an effective collaborative process (Brooks, 2010; Butterfoss, 2009; Cheadle, Hsu, Schwartz, Pearson, Greenwald, Beery, et al., 2008; Israel et al., 2008; Lasker, Weiss, & Miller, 2001; Schulz, Israel, & Lantz, 2003; Sofaer, 2000; Tolma, Cheney, Troup, & Hann, 2009; Wallerstein et al., 2008). 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 colearning and capacity building; involves equitable participation, influence, and power sharing; and achieves balance between knowledge generation and action). A determination of whether and how effectively a partnership is collaborative and participatory (for example, in its project implementation process), and whether and how effectively it achieves its intermediate or impact objectives (for example, those considered essential to attaining ultimate health outcomes), can occur long before it is possible to assess the partnership’s impact on health (Butterfoss, 2009; Cheadle et al., 2008; King et al., 2009; Rossi, Lipsey, & Freeman 2004; Schulz, Israel, & Lantz, 2003; Wallerstein et al., 2008). Such documentation and evaluation of the partnership process can be used by the partnership to improve its actions and in turn the achievement of its ultimate goals (Butterfoss, 2009; Brooks, 2010; Lantz, Viruell-Fuentes, Israel, Softley, & Guzman, 2001; Schulz, Israel, & Lantz, 2003; Wallerstein et al., 2008).

In Chapter Thirteen, Israel, Lantz, McGranaghan, Guzman, Lichtenstein, and Rowe 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 how it has been used to guide the Detroit Community-Academic Urban Research Center’s application of these 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. Their discussion of the strengths and weaknesses of using multiple methods is particularly informative. They provide a thorough examination of the challenges and limitations, lessons learned, and implications for the use of these methods in other CBPR contexts.

Part Six (Chapters Fourteen through Nineteen) focuses on the CBPR phases of ensuring active engagement of all partners in the feedback, interpretation, dissemination, and application/translation of results. Feedback and interpretation of findings involves all partners in reviewing results from data analysis for the purpose of sharing reactions and interpretations of what the findings mean in the context of their community. Of equal importance to the CBPR process is dissemination of findings to all partners and community members more broadly through multiple venues and in ways that are understandable, respectful and useful. Lastly, the translation and application of research findings for broadscale intervention development and policy formation is a critical link to CBPR’s commitment to action and social change. The chapters in Part Six show how various data collection methods used (for example, photovoice, economic assessment, secondary data analysis) within the context of CBPR relate to these four elements of data feedback, interpretation, dissemination, and application/translation of research findings.

In Chapter Fourteen, Parker, Robins, Israel, Brakefield-Caldwell, Edgren, O’Toole, Wilkins, Batterman, and Lewis describe how they established and implemented dissemination guidelines in a CBPR partnership 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 affiliated with the Detroit Community-Academic Urban Research Center. 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, and provide a thoughtful discussion of implications for practice.

In Chapter Fifteen, a new chapter in this edition, Baker, Motton, Barnidge, and Rose argue for the use of multiple data collection methods to provide different types of data and answers to different types of questions, which together enhance understanding of the complex set of factors that contribute to health disparities, and are essential for the development of viable and effective interventions. The authors describe the use of multiple methods in their Men on the Move CBPR project to assess individual, environmental, and social determinants of cardiovascular disease in a rural community in Southeast Missouri. The methods presented include community forums, economic assessment, and photelicitation focus groups. The authors also discuss the impact of collaboration on the development of tools, data collection, and interpretation. They provide a cogent and compelling description of how the use of multiple methods and the active engagement of community and academic partners enabled them to identify mechanisms through which individual, environmental, and social determinants influence health outcomes, and to develop interventions that address these multiple determinants.

In Chapter Sixteen, another new chapter in this volume, Corburn, Lee, Imara, and Swanston describe how map making is an essential aspect of CBPR and offer two case studies—one from East Oakland, California, and a second from Brooklyn, New York—to show how community groups use map making to highlight health equity issues in their neighborhoods. In this chapter, the authors emphasize that there are multiple approaches and technologies that can be used for the purposes of mapping, for example, hand-drawn maps, Geographic Information Systems, web-based mapping tools, and Global Positioning Systems. The two case examples of collaborative mapping processes provide compelling examples of the challenges and opportunities for community members, scientists and decision makers interested in generating visual representations of community and professional knowledge, and how that knowledge can be used to inform action.

In Chapter Seventeen, López, Robinson, and Eng 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 provide a thorough examination of 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 in providing thoughtful implications of the method for CBPR efforts more broadly.

In Chapter Eighteen, also a new chapter in this edition, Tsui, Cho, and Freudenberg define community-based participatory policy work (CBPPW), an approach to policy activism that combines CBPR and community-based policy advocacy. The authors focus on the methods that CBPPW practitioners use to collect, interpret, and apply the data that guide their activities. To illustrate the methods used in CBPPW, they draw from the experiences of three collaborative efforts to change food-related policies in New York City. The methods described in the chapter (for example, literature reviews, surveys, elicitation dialogues, participatory mapping) can help CBPPW practitioners interested in food policy work to explore multiple topics, including eliciting data on experiences of current policies, collecting and/or analyzing data on food environments, policy scanning and analysis, and eliciting views on policy opportunities. Based on the case examples, the authors note several limitations and challenges, followed by several lessons learned about conducting research to support CBPPW.

In Chapter Nineteen, Morello-Frosch, Pastor, Sadd, Prichard, and Matsuoka discuss how the Los Angeles Collaborative for Environmental Health and Justice has applied a CBPR approach to conduct research 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. The authors provide a compelling argument that the work of the Collaborative shows that CBPR projects that emphasize secondary data analysis can be powerful agents for policy change without compromising scientific rigor.

This book ends with 13 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 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, open-ended and closed-ended questionnaires for evaluating partnership functioning, and focus group interview guidelines. 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. To expand upon these resources, a new aspect of the second edition of the book is the inclusion of downloadable supplements for each chapter which are available on the publisher’s Web site. These supplements are organized to include the following categories of materials, as appropriate for each chapter: toolkits, measurement instruments, experiential learning activities/small group exercises, guideline/procedures, and PowerPoint presentations. Every item listed includes a reference, brief description of the item, and a link to a Web site, where appropriate. The inclusion of these downloadable supplements greatly expands the resources available to the reader for enhancing the use of community-based participatory research.

**SUMMARY**

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 provided 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 colearning) that will effect social and behavioral change in order to eliminate health inequities.

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