

COMMENTARY: CHALLENGES FOR THE FIELD IN OVERCOMING DISPARITIES THROUGH A CBPR APPROACH

Nina Wallerstein, DrPH

Within the last decade, community-based participatory research (CBPR) has gained momentum with the recognition that community engagement is necessary for community interventions to effectively address seemingly intractable social problems and health disparities.¹⁻³ Philanthropic foundations, in response to increasing community demands, have led the way in supporting health disparities research that is collaborative and community “based,” rather than community “placed” or community “targeted.”⁴

Academia has responded with new academic-community centers and re-examination of tenure and promotion criteria⁵; with participatory research tools for judging the extent of collaboration^{6,7}; with CBPR as a new recommended competency for education⁸; and with special theme issues of medical and public health journals, such as the *American Journal of Public Health*, *Environmental Health Perspectives*, *Health Education and Behavior*, and the *Journal of General Internal Medicine*, among others. The Campus Community Partnerships for Health has created a CBPR listserv for university and community partners nationwide (mailman1.u.washington.edu).⁹

The Centers for Disease Control and Prevention (CDC) has led CBPR-oriented governmental funding with their Urban Research Centers,¹⁰ their CBPR emphasis in the Prevention Research Centers, and recent investigator-driven CBPR initiatives, with the National Institutes of Health (NIH) responding more slowly. The National Institute of Environmental Health Sciences took an early lead with its environmental justice funding; yet increasingly other NIH institutes are releasing individual CBPR-based requests for applications (RFAs), and last year, two major RFAs were released with multiple institutes.

Despite this apparent and increasing support for CBPR, the field is still learning how best to implement authentic

participatory research partnerships; how best to address the scientific questions that arise through using participatory processes; and how best to reduce the predominant skepticism within the academy in adopting CBPR, as opposed to more traditional research.

This issue of *Ethnicity & Disease* goes a long way to providing grounded examples of an evolving, multicenter university-community partnership and to exploring the science of the added value of community participation to improving clinical and community practice and health outcomes. The Los Angeles Community Health Improvement Collaborative (CHIC) has taken the idea of partnerships to a new level by bringing together multiple academic centers (rather than creating a single new center) to collectively work on distinct diseases and to identify and share resources for priority domains for action. The CHIC started with both a short-term practical approach, to identify potential practice sites for pilot projects, and a long-term vision, to build community research capacity, to sustain the academic-community partnerships, and to improve community health status over time, across the life span, and across health conditions.

The articles in this special issue provide a window into several core issues that need to be addressed to create a stronger science of CBPR. The two that I want to focus on are, first, the meaning and reality of “partnership,” with our social context of institutional and structural racism; the inherent dilemma of partners who have different expertise and self-perceptions of the value of their knowledge (ie, the academy versus the community); and the concern of representation, who represents the community or the academy, and which voices are being heard and which are still silenced. Second, we need to better understand how to adapt intervention research designs in the context of fluid and dynamic participation both in the intervention and in the research process. We must develop strategies to test the hypothesis, or at least to better understand, how participation in community intervention research may promote greater effects on health status and health disparities.

While partnership and collaboration are guiding values of CBPR, the work of creating partnership remains challenging. Most collaboratives start with principles drafted by the partners¹¹; yet partnerships range across a continuum, from those driven by communities to those controlled by universities. These dynamics are not static but unfold and change over time.

From the Masters in Public Health Program, Department of Family and Community Medicine, University of New Mexico, Albuquerque, New Mexico.

Address correspondence and reprint requests to Nina Wallerstein, DrPH; Professor and Director, Masters in Public Health Program; Department of Family and Community Medicine; MSC 09_5060; 1 University of New Mexico; Albuquerque, NM 87131; 505-272-4173; nwallerstein@salud.unm.edu

Four strategies are helpful for university- or other institution-based researchers as they seek partnerships with communities:¹² 1) to engage in self-reflection on our capacities, resources, and liabilities as academics and health professionals and on these qualities in our institutions, which includes understanding the effect of predominately White academics seeking to be allies with communities of color; the history of institutional relationships between universities and communities; and the effect this history has had on use and translation of previous and current research; 2) to seek appropriate community networks to identify community partners; 3) to negotiate the health issue(s) for research and being open to renegotiation as the partnership grows, which involves recognizing the mutual contribution between academic knowledge and the empirically supported science of what works with community knowledge and the culturally supported science of what works¹³; and 4) to create nurturing structures to sustain partnerships through constituency building and organizational development. These strategies are not sequential and may take place simultaneously, yet all require continual attention for trust building and sustainability over time.

The CHIC leadership council, formed in April 2003, has attempted to engage each of these strategies. The principal investigators (PIs) of each of the contributing NIH centers recognized in the formation of their collaborative that their earlier research had not directly promoted community participation in the research and, in fact, their medical environment favored research using carefully controlled experimental designs or clinical epidemiology studies rather than the more dynamic processes that result from a CBPR model. As a tribute to their commitment to the new CBPR effort, the CHIC coined their own term, community-partnered participatory research (CPPR) to promote full and equitable participation of partners. Their strongest example is the Witness for Wellness project, which has impressive participation not just of the leadership of Healthy African-American Families but also of community members in public events and in planning efforts.

Second, while partnerships have been more explored in the literature, there remains the largely untapped question of the role of participatory processes in improving health status. This issue breaks down into two questions: the role of participation in the research (ie, the extent to which community leaders and members are involved in all stages of research: identifying the questions, overall design, data collection, analysis, use of results, and dissemination) and the role of community participation in developing and implementing the interventions. Participatory evaluation links these issues, as community members identify indicators of success and targets of change and as data are returned to the program staff for continuous quality improvement and refinement of the intervention.

The most important step to answering these questions is to directly incorporate an assessment of participation and the potential impact of participatory processes on the intervention and on the research itself. While a few comparative research trials have assessed the effect of participatory processes on health outcomes, (ie, Eng et al, 1990¹⁴), for most communities and contexts, processes are inherently dynamic, comprehensive, and messy, and traditional evaluation designs are less appropriate.¹⁵ Alternative research strategies are called for that involve integration and triangulation of multiple methods, ie, quasi-experimental designs, longitudinal and comparative case studies, and qualitative and quantitative data collection of changes at multiple levels: individuals, families, program and institutional practices and policies, community and cultural norms, governmental policies, and socio-economic or environmental conditions.

Research on the effectiveness of participatory empowerment strategies has identified two pathways: the processes by which empowerment or capacity outcomes are generated and the effects of empowerment outcomes in improving health status.¹⁶ Empowerment is recognized both as an outcome by itself and as an intermediate step to long-term health and disparities outcomes.

Within the first pathway, solid evidence of empowerment outcomes exists on multiple levels: psychological, organizational, and community; and within households/families; programs and services; and economic, political and legal spheres. In what holds specific promise for CHIC, greater community participation has been clearly linked to project effectiveness through improved efficiency, transparency, and more equitable distribution of services¹⁷⁻¹⁹ as well as to enhanced effect size in child maltreatment prevention programs.²⁰

As stated, linking these empowerment outcomes to health-status changes is more challenging, yet here as well, solid evidence is increasing, especially from the literature on interventions with specific marginalized populations: women, youth, people at risk for HIV/AIDS, and the poor.¹⁶ The success in identifying health outcomes from participatory empowerment interventions, despite the challenges of attribution of causality, lends support to CBPR as a viable public health strategy. This special issue highlights the current status of CHIC achievements and offers a future promise for systematic inquiry into the role of participatory processes for improving health status and reducing disparities in Los Angeles County.

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