Community Based Participatory Research (CBPR) 101

PURPOSE/INTENDED AUDIENCE
Through the broad research and community engagement efforts of the resource group members (see below), whose research and community work spans decades, we recognize that UW research investigators are in various stages of their research careers and research implementations.

Many investigators, new and seasoned, are being encouraged to conduct research in off-campus settings and to examine how their research findings translate into different community settings. There is growing interest in and a need for a brief, yet comprehensive introduction about how to successfully engage and conduct research with community partners in different settings, including medically underserved communities. There is also a complementary need for an introduction into the basic tenets of Community Based Participatory Research (CBPR).

The following information is intended to introduce what CBPR is generally and introduce broad themes to consider when contemplating the development and implementation of a CBPR project. References and resources are provided throughout to encourage deeper exploration of issues introduced here, and to point to more developed sources of information about CBPR. Resource group members can also direct you toward useful sources of information about communities of interest in Wisconsin.

KEY TERMS

Culture
The term culture had been used to denote the totality of the humanly created world, from material culture and cultivated landscapes, via social institutions (political, religious, economic etc.), to knowledge and meaning and has also been defined as the symbolic, linguistic and meaningful aspects of human collectivities. A widely cited definition follows: Culture, or civilization, taken in its broad, ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society." (Edward B. Tyler, 1871)

Cultural Competence
In many health care settings, cultural competence is defined as the ability of systems and individuals to provide care to patients with diverse values, beliefs and behaviors, including tailoring care delivery to meet patients’ social, cultural and linguistic needs (Betancourt, Green & Carrillo, 2002).

Culturally competent organizations and individuals:

• have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally;
• have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of
difference, (4) acquire and utilize cultural knowledge and (5) adapt to diversity and the cultural
contexts of the communities they serve;

• incorporate the above in all aspects of policy making, administration, practice, service delivery and
involve systematically consumers, key stakeholders and communities. (Cross et al., 1989)

It is generally recognized that cultural competence is not a skill that is mastered once, but rather assumes
an ongoing commitment to a process where individuals conduct “self evaluation and self critique, to
redressing power imbalances...and to developing mutually beneficial and non paternalistic partnerships
with communities on behalf of individuals and defined populations.” (Tervalon et al.,1998)

In a research context, culturally competent research is sensitive of and responsive to the ways in which
cultural factors and differences (among researchers and research participants) influence what we
investigate, how we investigate, and how we interpret and disseminate findings. Culturally competent
research approaches are critically important when striving to address disparities in the health status of
people of diverse racial, ethnic and cultural backgrounds including sovereign nations.

Community
We use the term ‘community ‘to refer to target populations that may be defined by: geography; culture;
race; ethnicity; gender; sexual orientation; disability; illness or other health condition; or to groups that
have a common interest or cause, such as health or service agencies and organizations, health care of
public health practitioners or providers, policy makers, or lay public groups with public health concerns.
[Modified from the definition given in NIH Program Announcement # PA-08-077]

The CCHE is particularly interested in serving as a resource to community-engaged research endeavors
with underserved communities or communities who have traditionally been excluded from research
including tribal, refugee, and racial/ethnic minority groups.

Community Based Organizations
Community based organization refer to organizations that may be involved in the research process as
representatives of the community. Possible community partners include, but are not limited to, Tribal
governments and colleges, state or local governments, independent living centers, other educational
institutions such as junior colleges, technical colleges, advocacy organizations, health delivery
organizations (e.g. clinics, hospitals, and networks), health professional associations, and non-
governmental organizations. [Modified from the definition given in NIH Program Announcement # PA-08-
077]

Community Based Organizations can also include: neighborhood advocacy groups, community
based health care providers (doctors, dentists, veterinarians etc.) and clinics, community coalitions
and philanthropic groups (e.g. Lions Club, Rotary etc).
COMMUNITY PLACED RESEARCH/RESEARCH IN COMMUNITIES
Many research projects that are relevant to communities and take place in community settings differ fundamentally from CBPR projects. Community placed research “focuses on conducting research in a community as a place or setting and allows community members limited, if any, involvement in what is primarily a researcher-driven endeavor.” (Israel et al, 2001)

Research that is placed in communities and draws participants from the community is appropriate for some research, but we felt it was important to make the distinction to highlight the differences between CBPR and other research.

WHAT IS COMMUNITY BASED PARTICIPATORY RESEARCH (CBPR)?
CBPR is a mutually respectful research partnership between the University and a community that combines the wisdom and experience of both to address health, social and economic challenges. In CBPR projects:

- research is initiated in partnership with a community;
- the community has a voice in the design of the research, its implementation in the community and the dissemination of the results;
- clear roles and expectations are defined;
- the research values and engages the knowledge, experiences, strengths and resources within the community;
- the research develops and relies upon partnerships that balance power, responsibilities and share resources equitably among all partners;
- both community and academic partners gain valuable and transferable benefits (e.g. knowledge, new skill sets, resources/technologies that can be used in the community, economic development/jobs, etc.); and
- action is taken based on the results obtained from the research.

WHY CBPR?
There is a growing recognition that some traditional research approaches have neglected to recognize and incorporate community health knowledge and practices. As a result, these approaches can fail to adequately address complex health and social issues and can unintentionally harm or burden community members and/or resources. Therefore, sustainable change can be difficult to maintain.

Many community partners are demanding research initiatives that address locally identified priorities rather than research that relies on community participation as research subjects only.

CBPR approaches require equitable partnerships, promotes self determination and builds efficacy for all involved. CBPR can enhance the relevance and usefulness of research data for all partners and can be conducted in a culturally competent manner.
TOP 10 CBPR “DO’s”

1. Do establish trusting relationships in order build a successful research partnership.
2. Do be prepared to listen and learn from the community. The community has expertise to contribute.
3. Do plan on longer time frames to meet with the community, develop the research question, identify funding, conduct the research and disseminate results.
4. Do remain flexible and open to new ideas and approaches. There will be tension between scientific rigor and community acceptability/feasibility.
5. Be visible. Communicate regularly – by phone, mail, email and in person.
6. Do learn to deal with different and sometimes competing priorities.
7. Do implement a clear and mutually agreed upon process for shared decision making.
8. Do be prepared to return results to the community and collaboratively interpret data.
9. Do share the benefits of the partnership’s accomplishments.
10. Do be prepared for some partnerships to dissolve and prepare an “exit strategy”.

TOP 10 CBPR “DON’Ts”

1. Don’t assume the community speaks with one voice or that there is only one community leader.
2. Don’t go to a community with a defined research question and expect automatic collaboration or participation.
3. Don’t assume that CBPR is always the best option to use (it may not be a good fit for every community nor every research question).
4. Don’t use “research language” when meeting with community partners.
5. Don’t overestimate or over promote what one project can accomplish.
6. Don’t underestimate the impact of past research experiences on potential future projects (by you or others).
7. Don’t ignore community dynamics and different spheres of power/decision making.
8. Don’t make decisions “behind closed doors”, but do respect information shared in confidence.
9. Don’t make hollow promises.
10. Don’t fail to communicate about issues that can affect project timelines (e.g. IRB approval process/timeline, community approval processes, dates of funds being released etc.)
RESOURCES/REFERENCES:

Adams AK. “Community Based Participatory Research in Public Health”, course #PH650, University of Wisconsin Department Family Medicine March 2008.


Community-Campus Partnerships for Health (CCPH) [http://www.ccph.info/](http://www.ccph.info/)


National Center for Cultural Competence [http://www11.georgetown.edu/research/gucchd/nccc/](http://www11.georgetown.edu/research/gucchd/nccc/)
NIH Program Announcement # PA-08-077  http://grants.nih.gov/grants/guide/pa-files/PA-08-077.html


Responsible Research with Communities: Participatory Research in Primary Care - A Policy Statement Contributors: Macaulay AC (Chair), Commanda LE, Freeman WL, Gibson N (Editor), McCabe ML, Robbins CM, Twohig PL.  http://www.napcrg.org/resources-responsible.cfm


CBPR RESOURCE GROUP MEMBERS

Alexandra Adams, MD, PhD
Dr. Adams has been on the faculty in the Department of Family Medicine for the past nine years, and is recognized both nationally and throughout Wisconsin for her pioneering work in CBPR with American Indian communities. She is also an affiliate faculty member in the SMPH Department of Population Health Sciences and the UW Interdisciplinary Graduate Program in Nutrition Sciences.

Dr. Adams is in the ninth year of a research partnership with the Great Lakes Inter-Tribal Council (GLITC), a consortium of federally recognized Indian tribes in Wisconsin and Upper Michigan, and several individual Wisconsin tribes.

Dr. Adams and her research team work in collaboration with tribal leaders, educators, and health care providers on the development and implementation of interventions designed to prevent obesity, cardiovascular disease, and diabetes in high-risk American Indian children and their families. Her work has been funded by several NIH grants, including the Native American Research Centers (NARCH) for Health grant to GLITC, and most recently a five-year NIH-U-01 award. Currently, she devotes most of her participatory research efforts to a family-based intervention project called Healthy Children, Strong Families and Supportive Communities (HCSF-SC).

Kate Cronin, MPH
Ms. Cronin is a program coordinator for Healthy Children Strong Families and Supportive Communities (HCSF-SC), a childhood obesity and diabetes prevention research intervention working with four American Indian tribes in Wisconsin. HCSF-SC is an academic-community partnership between the University of Wisconsin Department of Family Medicine and Great Lakes Inter-Tribal Council. HCSF-SC was developed using CBPR methods and continues to be a fertile learning environment for all parties.

Ms. Cronin has published a model for culturally competent design and conduct of clinical research and has been an invited speaker on recruiting and retaining racial and ethnic minority research participants.

Sarah Esmond, MS
As the Administrative Director for the CCHE, Ms. Esmond provides administrative oversight and project management to multiple community-academic partnerships, collaborations and initiatives. She brings significant background in qualitative research methodologies and urban community-academic partnership building in particular.

Jamie Scott, MS
Ms. Scott coordinates the environmental change arm of Healthy Children, Strong Families-Supportive Communities (HCSF-SC) intervention. Using Community Based Participatory Research partnership techniques, she conducts community outreach and facilitates Community Advisory Board (CAB)
meetings on the reservations, where the focus is on identifying environmental barriers and supports that affect healthy lifestyle choices and developing viable options for intervention and change.

Ms. Scott has taught health education to urban and rural K-8 populations for 24 years and also worked as a health educator with the Wisconsin Department of Health and Family Services in the Division of Public Health. Ms. Scott has worked in rural Alaska villages with Native Eskimos, Athabascan Indian, and Aleut populations.

**Rick Strickland, MA**
Since December 2000, Rick has served as Project Director for Spirit of EAGLES: American Indian/Alaska Native Leadership Initiative on Cancer (SOE) in the North Central region (IA, MN, ND, SD, WI). SOE is a national initiative to improve cancer outcomes among American Indians and Alaska Natives under the leadership of Dr. Judith Kaur, Mayo Clinic. In 2006, Rick was named Co-Director of the Cancer Health Disparities Initiative (CHDI) at the Carbone Cancer Center. CHDI’s goal is to reduce cancer disparities by building the capacity of Center faculty members and scientists to conduct disparities related research.

Rick brings to his present position experience as a community organizer, and over 25 years of working in outreach, community development and health promotion with minority and under-served populations in the non-profit sector. A graduate of the national Healthy Communities Fellowship program, Rick has particular interests in asset-based community development and participatory research.

**Lisa Tiger, MA, PhD (c)**
Ms. Tiger is an enrolled member of the Muscogee Nation of Oklahoma and is a research Ambassador with the CCHE. She serves as point of contact for researchers who are interested in accessing research resources to support community-academic research partnerships focusing on health disparity/health equity. Ms. Tiger is trained as a medical anthropologist and also has experience working with tribes engaged in academic, government and community partnerships.