

**COMMUNITY-BASED  
PARTICIPATORY RESEARCH:  
WHY AND HOW**

**UNIVERSITY OF WASHINGTON**

**April 17, 2003**

**Robert M. Goodman, Ph.D, MPH, MA**

**Usdin Family Professor**

**Tulane University School of Public Health and Tropical  
Medicine**

# Overview

- **Background and Rationale for CBPR**
- **Important concepts related to CBPR**
  - ✓ **Population health (SDOH) and community health (SPF)**
  - ✓ **Community-based & community-placed research and practice**
  - ✓ **Social ecology and capacity building**
- **Examples and Directions for Community-Based Participatory Research and Practice**

# Full Disclosure



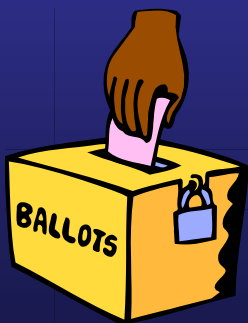
I am an applied researcher



I have the utmost regard for  
transdisciplinary approaches



I have a predilection for applying  
participatory principles to  
community-based research,  
evaluation, and practice



# Background and Rationale for CBPR

# Community-Based Participatory Research (CBPR)

**“a partnership approach to research that equitably involves community members, organizational representatives, and researchers in all aspects of the research process”**

**Israel, B. A., *et al.* (2001). “The Detroit Community-Academic Urban Research Center: Development, Implementation, and Evaluation.” *Journal of Public Health Management and Practice*, 7 (5), 1-19.**

**“an approach that entails involving all potential users of the research and other stakeholders in the formulation as well as the application of the research” (p. 1927).**

**Green, L.W., Mercer, S.L. (2001). “Can public health researchers and agencies reconcile the push from funding bodies and the pull from communities?” *American Journal of Public Health*, 91 (12), 1926-1929.**

## Maximum participation occurs when the stakeholders

- ✓ Remain active throughout the study
- ✓ Pose the research question
- ✓ Engage in the selection and application of methods
- ✓ Apply the findings

## Minimum participation requires involvement in

- ✓ Formulation of the question
- ✓ Interpretation of the data
- ✓ Application of the findings

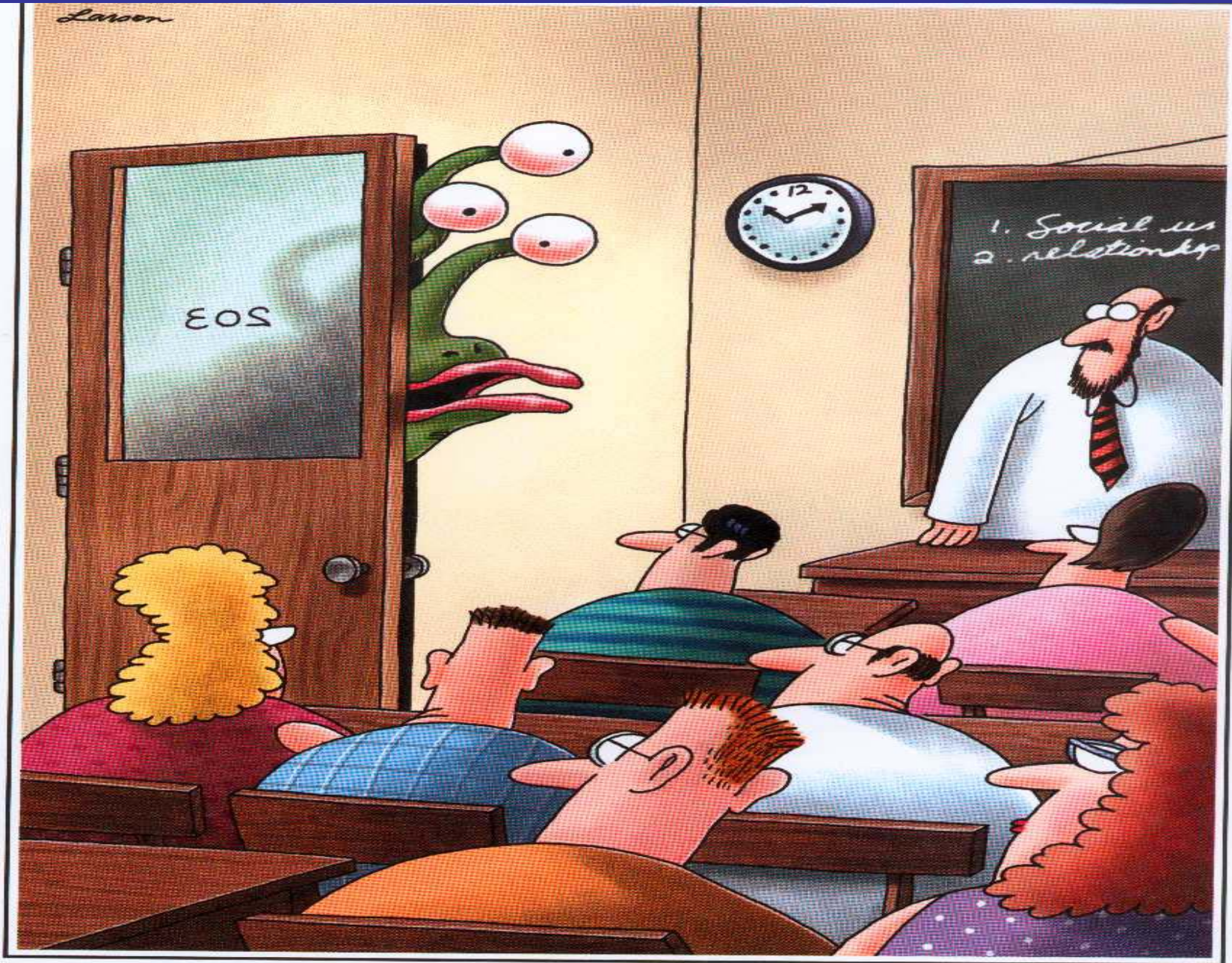
# **ATTRIBUTES OF THE CBPR APPROACH**

- ✓ the central place that communities are accorded as units of identity and as co-equals in research**
- ✓ a process that is not perceived by community constituents as university-dominated or elitist**
- ✓ the emphasis on long-term commitment by all partners**
- ✓ the emphasis on co-learning so that the process flows back and forth**

# **ATTRIBUTES OF THE CBPR APPROACH**

- ✓ the use of exercises that stimulate collective visioning among all partners**
- ✓ the incorporation of social ecology approaches as departures for research and practice**
- ✓ the use of innovative problem-solving approaches**
- ✓ the use of multiple methods of data collection to produce a rich and textured picture of partnership functioning and outcomes that result**

Larson



"Whoa! ... Wrong room."

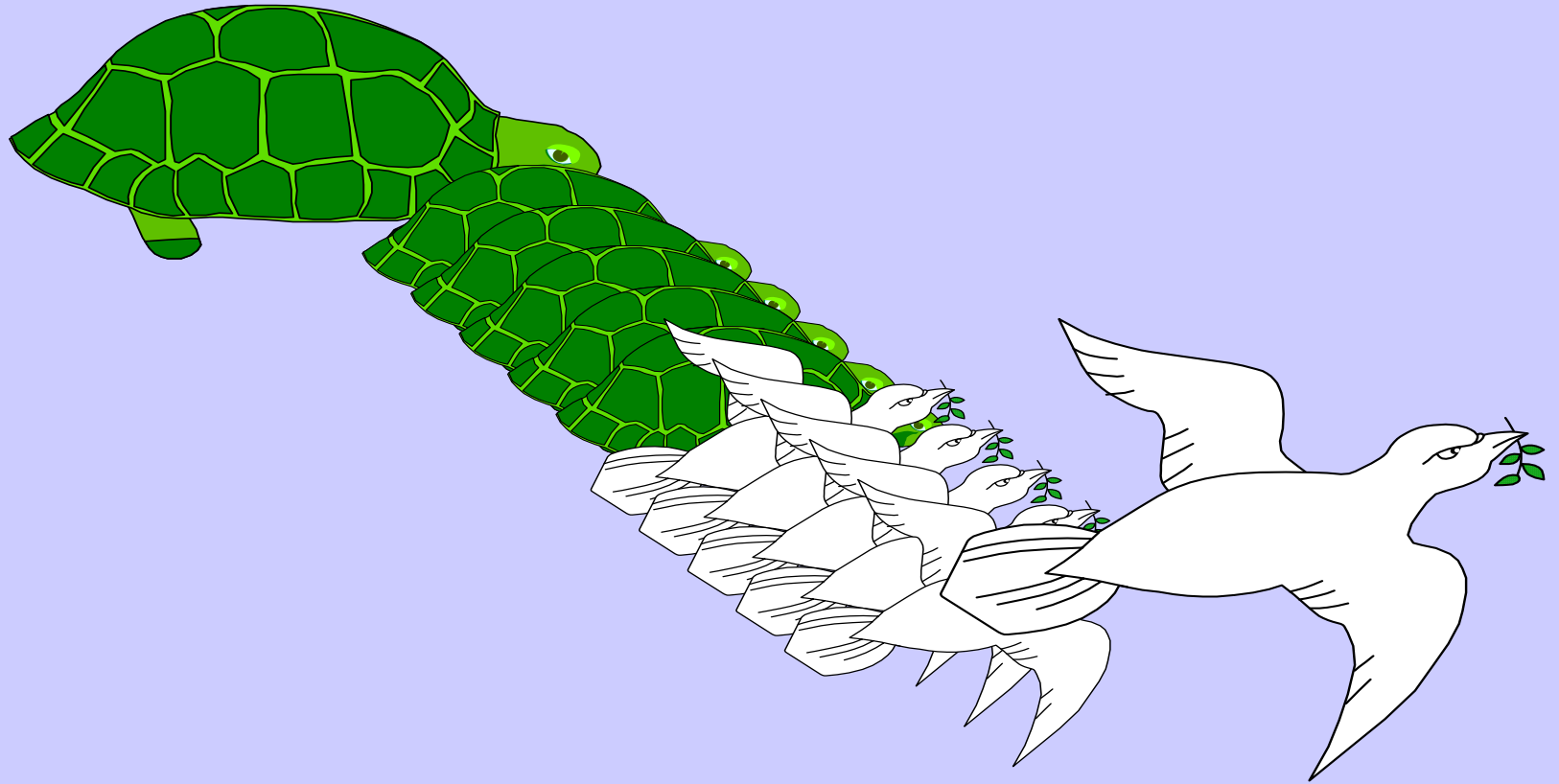
# **Institute of Medicine Report**

## **Who Will Keep the Public Healthy?: Educating Public Health Professionals for the 21st Century**

# Education in Graduate Programs and Schools of Public Health

- **Eight new content areas needed**
  - \*Informatics
  - \*Genomics
  - \*Communication
  - \*Cultural competency
  - \*Community-based participatory research (CBPR)
  - \*Global health
  - \*Policy and law
  - \*Ethics

**THE EVOLUTION OF OUR  
PROFESSIONAL THINKING ABOUT  
PUBLIC HEALTH INTERVENTION  
RESEARCH IN COMMUNITY SETTINGS**



Prior to the early 1980's,  
**individual behavioral change** was  
the dominant emphasis of health  
promotion research  
and  
adherence strategies were the  
primary vehicle used to foster  
effective research outcomes

**1970's-1980's:  
Large-scale community trials**

**Stanford Five Community Project**

**Minnesota Heart Health Project**

**Pawtucket Heart Health Project**

**Stanford Five Community Project  
Minnesota Heart Health Project  
Pawtucket Heart Health Project**

**risk factor screening**

**worksite physical activity**

**school programs**

**community- wide contests**

**community task forces**

**media messages**

**grocery labeling**

**speakers bureaus**

**health practitioner programs**

**menu labeling at restaurants**

**The earliest lessons from  
these community trials  
revealed the need to alter  
research and  
implementation strategies**

**. . . community or large-scale programs . . . require a shift in perspective and the employment of the distinct set of analytic and programmatic tools from those used with patients, clients, or customers**

**Green and McAlister (1984)**

Flay (1986) writes of the **unique impediments in implementing complex community programs**, including reaching the planned targets at the correct time, with adequate intensity and desired effects

**Disaggregate program  
components to understand the  
multiple causal mechanisms  
within complex community  
interventions**

**Altman (1986)**

**BACKGROUND RATIONALE**

**Box 1**

DEVELOP AND CARRYOUT

- multi-level
- community-based

Interventions to ↓  
Improve the health-related quality of life of a community  
by ↓  
Reducing

- the burden of diabetes
- its complications in an African-American community

through

**Box 2**

A Comprehensive community-based intervention program.  
A demonstration project that is:

- multi-year
- defines the burden of diabetes

- develops innovative approaches to prevention and control of diabetes
- implement these approaches through the state-based diabetes control programs
- coordinates national, state and local resources for improved diabetes care

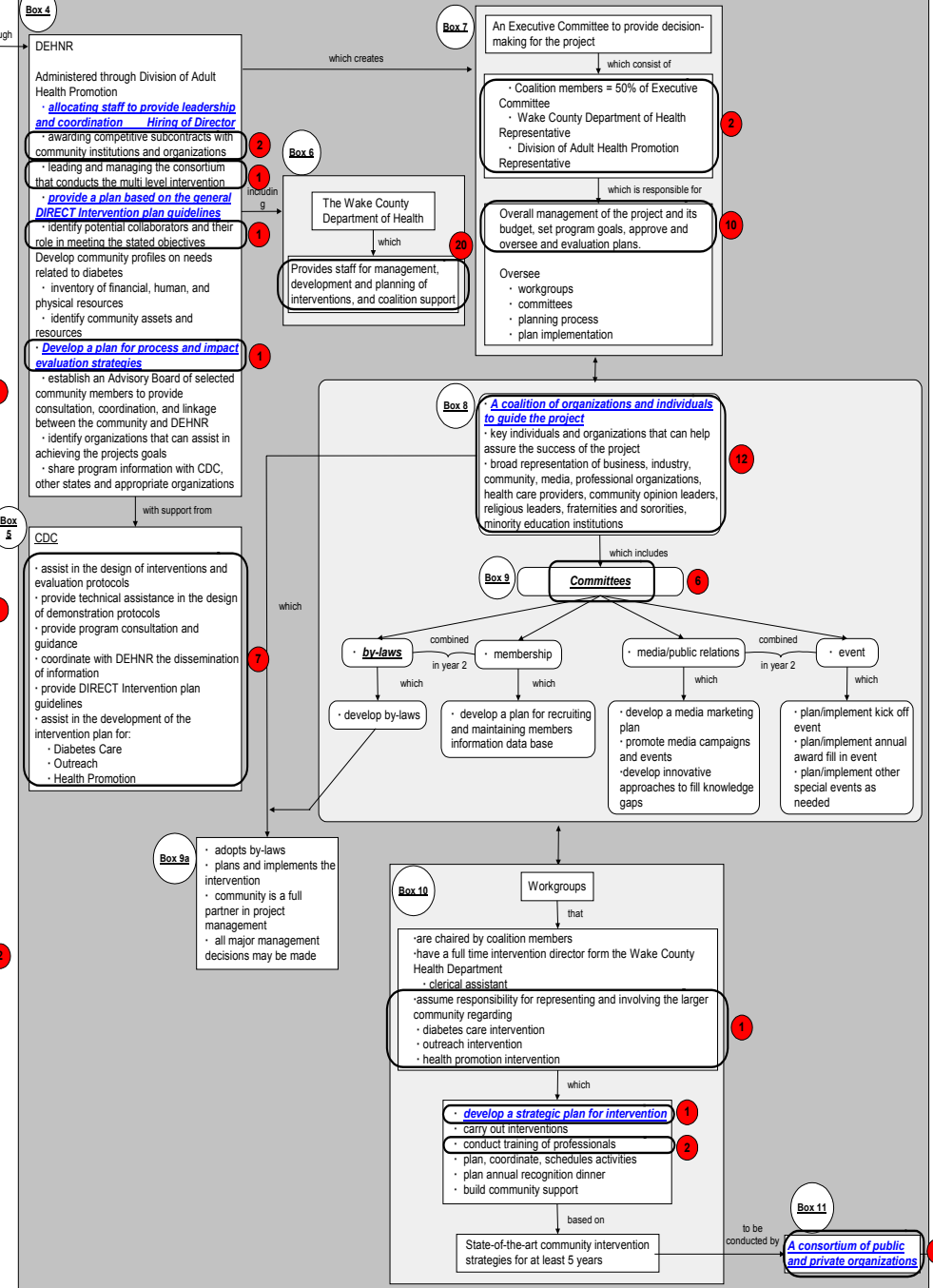
by

**Box 3**

Providing assistance only to DEHNR because:

- community organization and developmental activities already occurred in Wake County
- a community advisory board has been active for 2 years
- regular media coverage has occurred
- widespread name recognition has been achieved in the community
- randomly sampled household surveys already occurred
- extensive medical examinations were already performed on a subsample of household respondents
- a comprehensive multilevel community intervention plan has been developed
- the State HD is CDC's traditional constituency
- the agreement allows CDC to evaluate the effectiveness
- DEHNR has the expertise, administrative and technical capacity
- DEHNR has collaborated successfully with universities and research institutions
- DEHNR has an office of Minority Health that can provide policy and programmatic technical assistance

**PROGRAM STRUCTURE**



**PROGRAM INTERVENTIONS**

**Box 12**

**DIABETES CARE INTERVENTIONS**

Interventions directed at:

- persons with diabetes
- their health-care providers
- the health call system
- Increasing
  - access to care
  - quality of care
- improve self-care practices
- modify office practices to more effectively accommodate the health care needs of persons with diabetes
  - to be sensitive to the demands on providers
  - working with the existing health care system (and not providing direct services)
  - enhancing provider practices
  - developing patient empowerment programs
- identifying barriers to health-care among under served populations
- coordinating existing services better

**OUTREACH INTERVENTIONS**

Directed at:

- screening persons at high risk especially African-Americans not previously diagnosed
- ensuring persons with previously diagnosed diabetes not receiving regular care return to the health care system for monitoring
- treatment
- prevention
- improving access to diabetes care
- reducing preventable diabetes
- improved community capacity identify and treat persons with undetected diabetes

**HEALTH PROMOTION INTERVENTION**

Directed at:

- reducing risk factors associated with diabetes in the general population of African-Americans

by

- increasing physical activity
- decreasing dietary fat intake
- promoting lifestyle, environmental, and policy changes that facilitate preventing diabetes among persons with risk factors
- provide important information to the public health body of knowledge for diabetes prevention and control

**RESEARCH AND EVALUATION DESIGN**

That includes:

- a baseline population survey of a predominately urban and suburban African-American community
- follow up survey of the end of the intervention phase
- a comparison community to be surveyed at baseline and follow-up
- monitoring a longitudinal cohort of persons with diabetes
- process measures
- impact measures

**PROGRAM RESULTS**

**Box 13**

- a decrease in the mean hemoglobin A1c among persons with diagnosed diabetes in the targeted community
- an increase in the percentage of persons with diagnosed diabetes who have received an eye examination in the past 12 months in the targeted community
- an increase in the prevalence of foot exams among persons with diagnosed diabetes during regular quarterly health care examinations in the targeted community
- a decrease in the incidence of foot lesions among persons with diagnosed diabetes in the targeted community
- a decrease in the prevalence of cigarette smoking among persons with diagnosed diabetes in the targeted community
- a decrease in the prevalence of uncontrolled hypertension among persons with diagnosed diabetes in the targeted community
- a decrease in the average total cholesterol level in the targeted community, thereby increasing the percentage of persons with diabetes who have lipid levels within the acceptable range, i.e. total cholesterol and triglycerides below 200 mg/dl, LDL below 130 mg/dl and HDL above 35 mg/dl
- an increase in physical activity and good nutrition, including proper alcohol use, among persons with diabetes in the targeted community

resulting in

- a decrease in the prevalence of undiagnosed diabetes among the general population in the targeted community at high-risk for developing diabetes
- an increase in the proportion of persons with diagnosed diabetes in the targeted community who receive recommended diabetes care
- an increase in awareness of the burden of and risks

resulting in

- an increase in the percentage of persons in the targeted community participating in regular physical activity (3-4 times per week for 30 minutes or more per day)
- a reduction in the percentage of total calories from fat intake among persons in the targeted community
- an increase in the knowledge and practice of accepted nutritional guidelines, including alcohol consumption

resulting in

CDC being able to:

- translate the DIRECT experience nationally
- demonstrate a reduction in the burden of diabetes and its complications in this African-American community
- add to the understanding of the impact of diabetes mellitus in an urban African-American community

**BACKGROUND PURPOSE**

1 Establishment of a National Diabetes Prevention Center (NDPC) to serve as a focal point for:

- developing, implementing, evaluating, and disseminating culturally relevant prevention and control strategies - existing and/or new - to reduce the burden of diabetes

in Native American Communities throughout the US through activities that will involve two Indian Nations through:

- collaboration with other partners, tribes, communities, governmental and other organizations
- securing additional resources

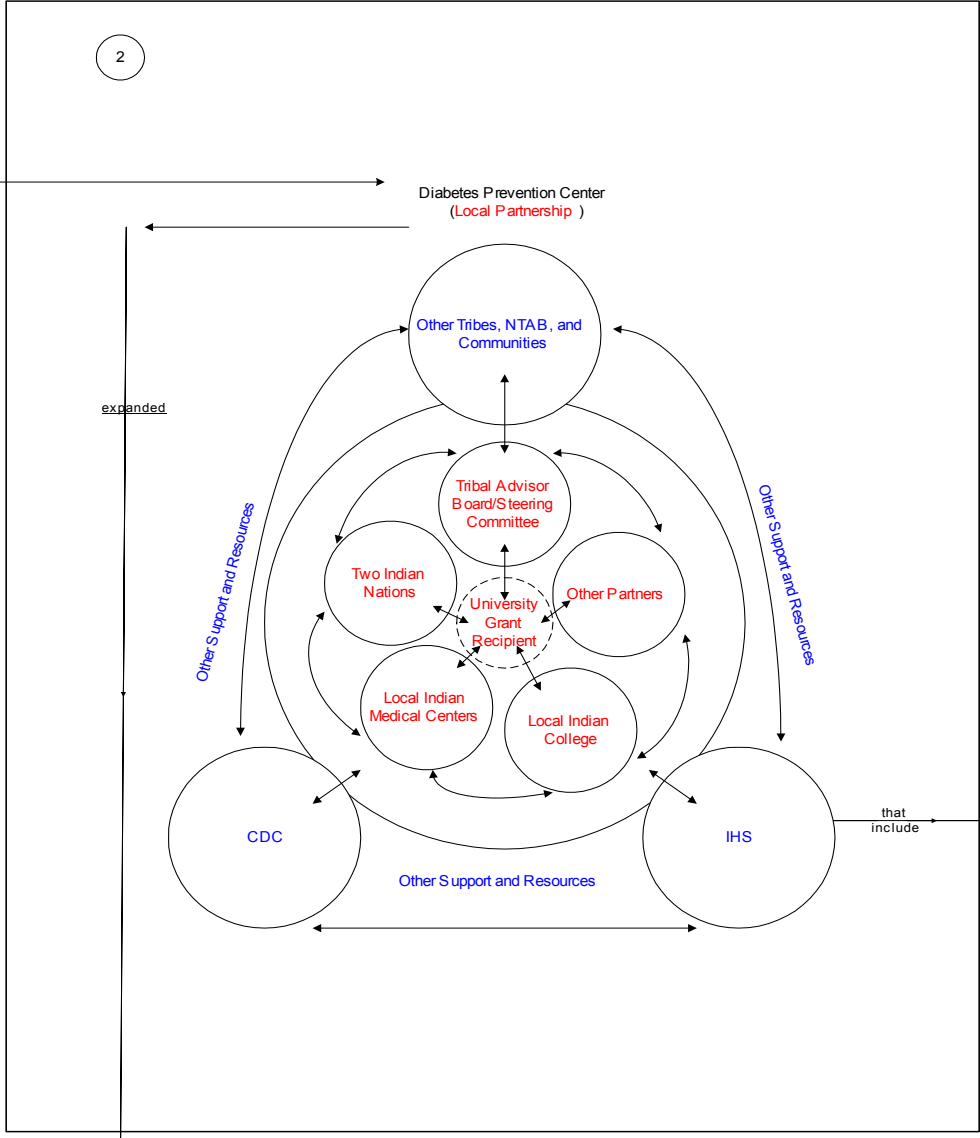
that consist of but are not limited to:

- systematic community needs assessment
- community programs that are coherent and theory based in design and holistic in approach
- implemented community interventions
- focused intervention research
- surveillance
- systematic program evaluation
  - quantitative
  - qualitative
- training
  - health professional
  - community
- tribal capacity building activities for diabetes prevention and control
- management and supervision
- meaningful and ongoing consultation and interaction with tribal leadership and community members
- cooperative partnerships

that will ultimately be applicable to:

- other high risk populations

**ORGANIZATION STRUCTURE / FUNCTION**  
(related functions on attached sheets )



**IMPLEMENTATION**

3

a) **Interventions Research Focused on Diabetes Care**

That are directed at:

- persons with diabetes
- their health care providers
- their health care systems

↓ in order to

- increase access to care
- increase quality of care

↓ by

Research products that could examine:

- methods of improving self-care practices related to diabetes management
- appropriate care for children with diabetes or at high-risk
- office practices and systems to more effectively accommodate the health care needs of those with diabetes while being sensitive to the demands on providers, office staff, etc.

resulting in

b) **Interventions Research Focused on Outreach**

That support targeted diabetes screening that:

- are directed at persons at high risk for diabetes who have not been previously diagnosed
- ensure that persons with previously diagnosed diabetes who may not be receiving regular care return to the health care system for monitoring, treatment, and prevention services

↓ by

Projects that could examine:

- screening children for type 2 diabetes
- strategies for insuring that persons return for regular preventive services, etc.

resulting in

c) **Interventions Research Focused on Health Promotion**

That are:

- directed at the general population
- seek to reduce risk factors associated with diabetes

↓ by

- increasing physical activities
- decreasing dietary fat intake

↓ through

Projects that are focused and targeted for instance

↓ for instance

Projects that examine:

- interventions focusing on promoting lifestyle for prevention of diabetes among persons and children with risk factors
- environmental and policy changes that will facilitate prevention of diabetes among persons with risk factors

↓ that are

- Prioritized and target sub-populations for which the potential for impact is greatest
- Address units of practice beyond the individual
- Address units of practice beyond clinical care and services
- Links the social, policy and ecological/environmental variables that must be changed to reduce the burden of diabetes in this population

4 Enhanced provider practices

- facilitation of appropriate diabetes practice behavior
- development of patient empowerment programs
- identification of barriers to care among underserved populations
- coordination of existing services to better serve persons with diabetes

5

- Improved, early access to diabetes care
- that results in
- reduction of preventable complications

# **RESEARCH DEVELOPMENT & ASSESSMENT OF COMMUNITY INTERVENTIONS ARE DIFFICULT BECAUSE THEY:**

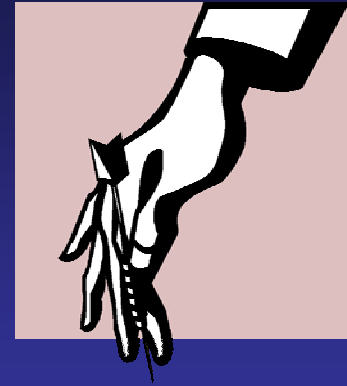
- are necessarily different in different communities**
- need to be flexible and responsive to changing local needs and conditions**
- have broad and multiple goals**
- take many years to produce MAJOR outcomes**
- require multiple data collection and analysis methods extended over long periods of time**

# **Important concepts related to CBPR**

- **Community-based & community-placed research**
- **Population health (SDOH) and community health (SPF) approaches**
- **Social ecology and capacity building as foundations**

# PUBLIC HEALTH RESEARCH

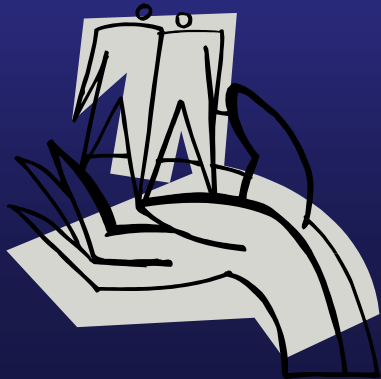
AS



**COMMUNITY-BASED**

AND

**COMMUNITY-PLACED**



Institute of Medicine. (1997). *Linking Research and Public Health Practice: A review of CDC's program of centers for research and demonstration of health promotion and disease prevention.*, Washington, DC: National Academy Press, p. 30

## Types of community-focused research

- Type 1) current proactive practice of **academically driven research** initiatives
- Type 2) a more reactive practice for designing **research in response to the needs and input of community agencies**
- Type 3) the development of **interactive practices that involve both academic researchers and the community as equal partners** in all phases of a research project

**GLOBAL**

**TYPE 1**

**Population Health**  
(informed largely by risk factors - SDOH)

***SYNERGY***

Upstream

**TYPE 2**

**Community Health**  
(informed largely by social protective factors – community capacity and competence)

**TYPE 3**

**LOCAL**



# WHAT OFTEN HAPPENS WHEN TYPE I OR TYPE II APPROACHES ARE USED?



**Goodman, R.M., LiBurd, L.C., Green-Phillips, A. (2001). “The Formation of a Complex Community Program for Diabetes Control: Lessons Learned From A Case Study of Project DIRECT,” *Journal of Public Health Management and Practice*, 7(3), 19-29.**

**BACKGROUND RATIONALE**

**Box 1**

DEVELOP AND CARRYOUT

- multi-level
- community-based

Interventions to ↓  
Improve the health-related quality of life of a community  
by ↓  
Reducing

- the burden of diabetes
- its complications in an African-American community

through

**Box 2**

A Comprehensive community-based intervention program.  
A demonstration project that is:

- multi-year
- defines the burden of diabetes

- develops innovative approaches to prevention and control of diabetes
- implement these approaches through the state-based diabetes control programs
- coordinates national, state and local resources for improved diabetes care

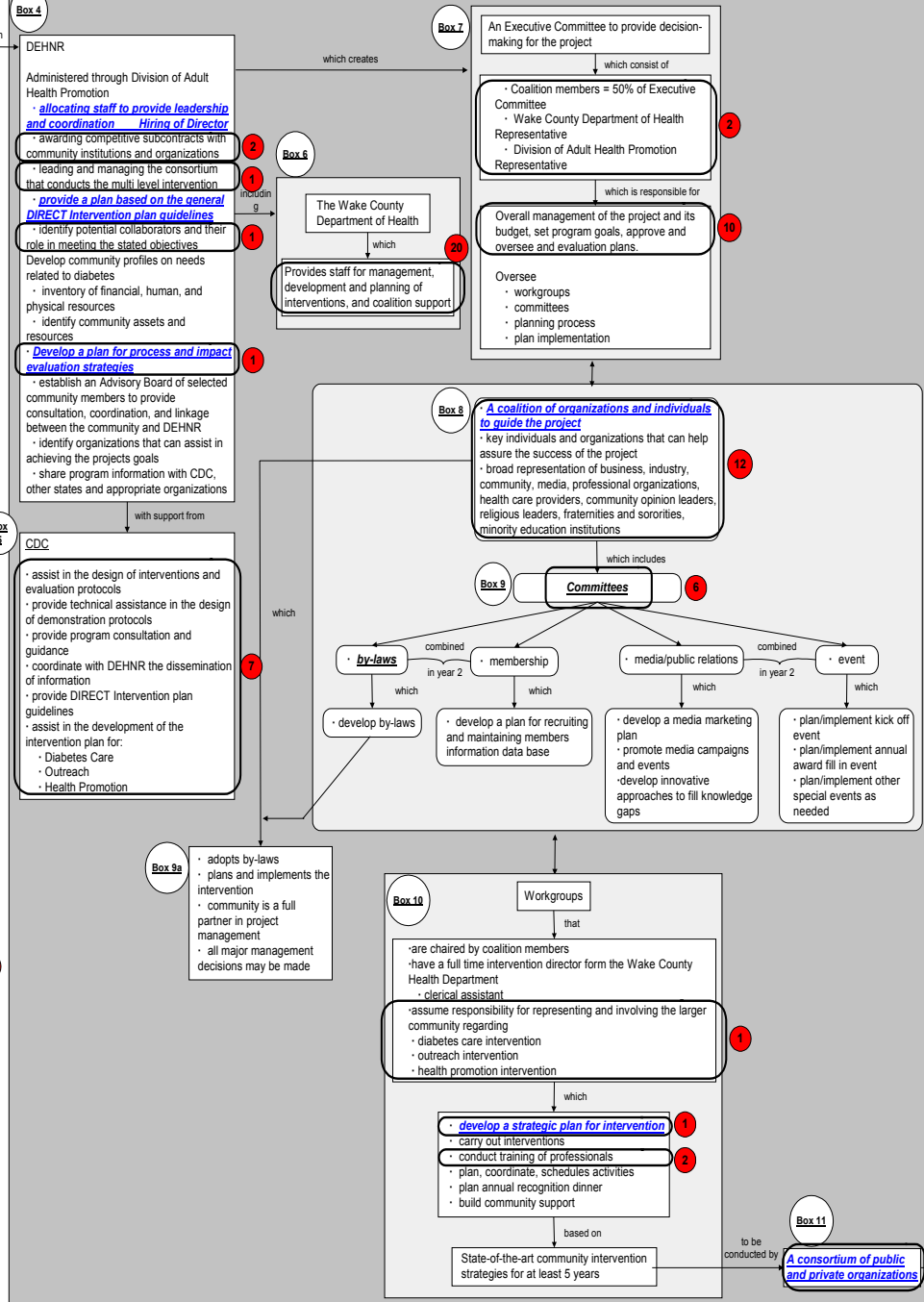
by

**Box 3**

Providing assistance only to DEHNR because:

- community organization and developmental activities already occurred in Wake County
- a community advisory board has been active for 2 years
- regular media coverage has occurred
- widespread name recognition has been achieved in the community
- randomly sampled household surveys already occurred
- extensive medical examinations were already performed on a subsample of household respondents
- a comprehensive multilevel community intervention plan has been developed
- the State HD is CDC's traditional constituency
- the agreement allows CDC to evaluate the effectiveness
- DEHNR has the expertise, administrative and technical capacity
- DEHNR has collaborated successfully with universities and research institutions
- DEHNR has an office of Minority Health that can provide policy and programmatic technical assistance

**PROGRAM STRUCTURE**



**PROGRAM INTERVENTIONS**

**Box 12**

**DIABETES CARE INTERVENTIONS**

Interventions directed at:

- persons with diabetes
- their health-care providers
- the health call system
- Increasing
  - access to care
  - quality of care
- improve self-care practices
- modify office practices to more effectively accommodate the health care needs of persons with diabetes
  - to be sensitive to the demands on providers
  - working with the existing health care system (and not providing direct services)
  - enhancing provider practices
  - developing patient empowerment programs
- identifying barriers to health-care among under served populations
- coordinating existing services better

**OUTREACH INTERVENTIONS**

Directed at:

- screening persons at high risk especially African-Americans not previously diagnosed
- ensuring persons with previously diagnosed diabetes not receiving regular care return to the health care system for monitoring
- treatment
- prevention
- improving access to diabetes care
- reducing preventable diabetes
- improved community capacity identify and treat persons with undetected diabetes

**HEALTH PROMOTION INTERVENTION**

Directed at:

- reducing risk factors associated with diabetes in the general population of African-Americans

by

- increasing physical activity
- decreasing dietary fat intake
- promoting lifestyle, environmental, and policy changes that facilitate preventing diabetes among persons with risk factors
- provide important information to the public health body of knowledge for diabetes prevention and control

**RESEARCH AND EVALUATION DESIGN**

That includes:

- a baseline population survey of a predominately urban and suburban African-American community
- follow up survey of the end of the intervention phase
- a comparison community to be surveyed at baseline and follow-up
- monitoring a longitudinal cohort of persons with diabetes
- process measures
- impact measures

**PROGRAM RESULTS**

**Box 13**

- a decrease in the mean hemoglobin A1c among persons with diagnosed diabetes in the targeted community
- an increase in the percentage of persons with diagnosed diabetes who have received an eye examination in the past 12 months in the targeted community
- an increase in the prevalence of foot exams among persons with diagnosed diabetes during regular quarterly health care examinations in the targeted community
- a decrease in the incidence of foot lesions among persons with diagnosed diabetes in the targeted community
- a decrease in the prevalence of cigarette smoking among persons with diagnosed diabetes in the targeted community
- a decrease in the prevalence of uncontrolled hypertension among persons with diagnosed diabetes in the targeted community
- a decrease in the average total cholesterol level in the targeted community, thereby increasing the percentage of persons with diabetes who have lipid levels within the acceptable range, i.e. total cholesterol and triglycerides below 200 mg/dl, LDL below 130 mg/dl and HDL above 35 mg/dl
- an increase in physical activity and good nutrition, including proper alcohol use, among persons with diabetes in the targeted community

resulting in

- a decrease in the prevalence of undiagnosed diabetes among the general population in the targeted community at high-risk for developing diabetes
- an increase in the proportion of persons with diagnosed diabetes in the targeted community who receive recommended diabetes care
- an increase in awareness of the burden of and risks

resulting in

- an increase in the percentage of persons in the targeted community participating in regular physical activity (3-4 times per week for 30 minutes or more per day)
- a reduction in the percentage of total calories from fat intake among persons in the targeted community
- an increase in the knowledge and practice of accepted nutritional guidelines, including alcohol consumption

resulting in

CDC being able to:

- translate the DIRECT experience nationally
- demonstrate a reduction in the burden of diabetes and its complications in this African-American community
- add to the understanding of the impact of diabetes mellitus in an urban African-American community

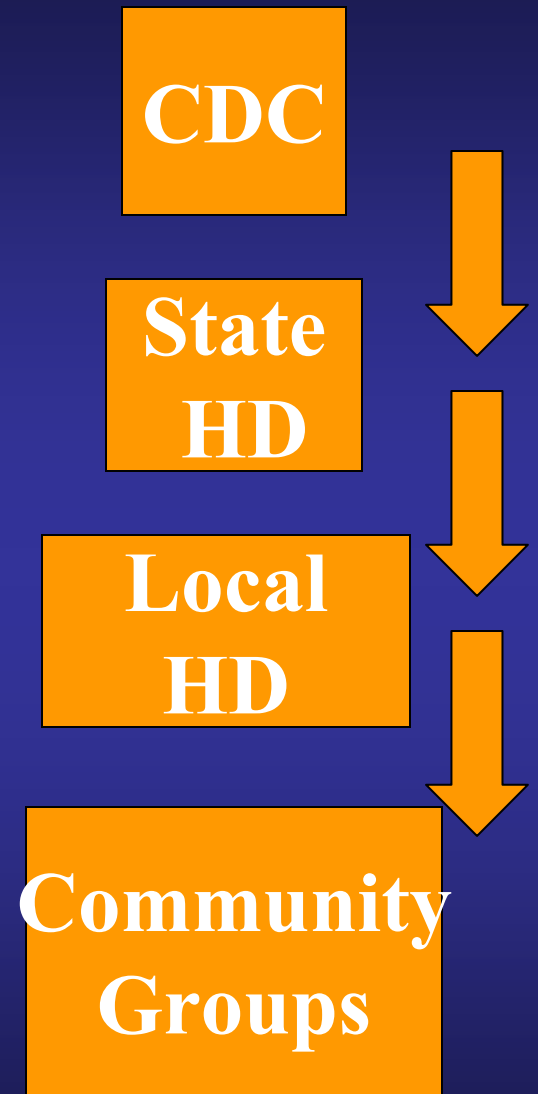
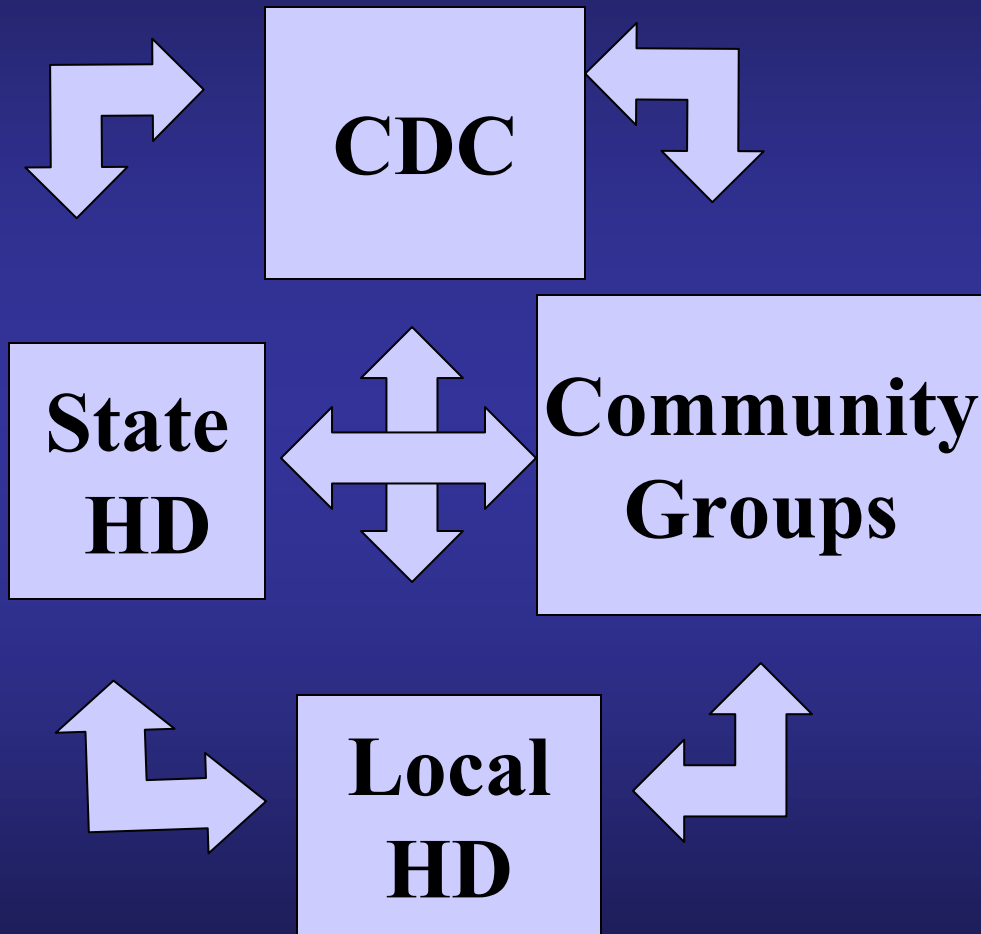
# Characterizations of each group by other groups

No. of characteristics pertaining to  
intergroup cooperation

	<u>Positive</u>	<u>Neg.</u>	<u>Neutral</u>
<b>Consultants</b>	<b>21</b>	<b>6</b>	<b>7</b>
<b>CDC</b>	<b>8</b>	<b>10</b>	<b>4</b>
<b>State administration or state project personnel</b>	<b>2</b>	<b>24</b>	<b>2</b>
<b>Executive committee members</b>	<b>9</b>	<b>15</b>	<b>5</b>
<b>Local county representatives</b>	<b>5</b>	<b>12</b>	<b>0</b>
<b>Work group leaders</b>	<b>18</b>	<b>10</b>	<b>3</b>

# PARTNERSHIP

# CHAIN OF COMMAND



# A Partnership or a Chain of Command?

We have CDC funding for the project. The grant is to the state health agency, and then we have the state health agency contracting the grant to the County Department of Health. So you have all of these controlling factors.

-Local community representative

## **Green and Mercer (2001)**

➤ **Communities often find that they participate in research that has limited applicability and is insensitive to the community in the process**

➤ **Lack of access to and cooperation from community groups are common ramifications of poor relationships with communities**

➤ **The breach in research/community relationships is frequently reflected in IOM reports:**

- *The Future of Public Health (1988)*

- *Linkages Between Research and Practice (1997)*

- *We The People (2002)*

**Institute of Medicine (1988). *The Future of Public Health*.  
National Academy Press.**

In a free and diverse society, effective public health action for many problems requires **organizing the interest groups, not just** assessing a problem and determining a line of **action based on top-down authority**. (p. 122)

# HOW COMMUNITIES MAY JOIN IN THE RESEARCH?

# Community capacity

- the characteristics of communities that affect their **ability to identify, mobilize, and address social and public health problems**
- **cultivation and use of transferable knowledge, skills, systems and resources that affect the community's ability to work effectively in achieving its vision**

# **Developing Measures of Community Capacity and Other Social Protective Community Factors**

A Three-Year Study Funded by the Centers for  
Disease Control and Prevention (FY 2000-02)

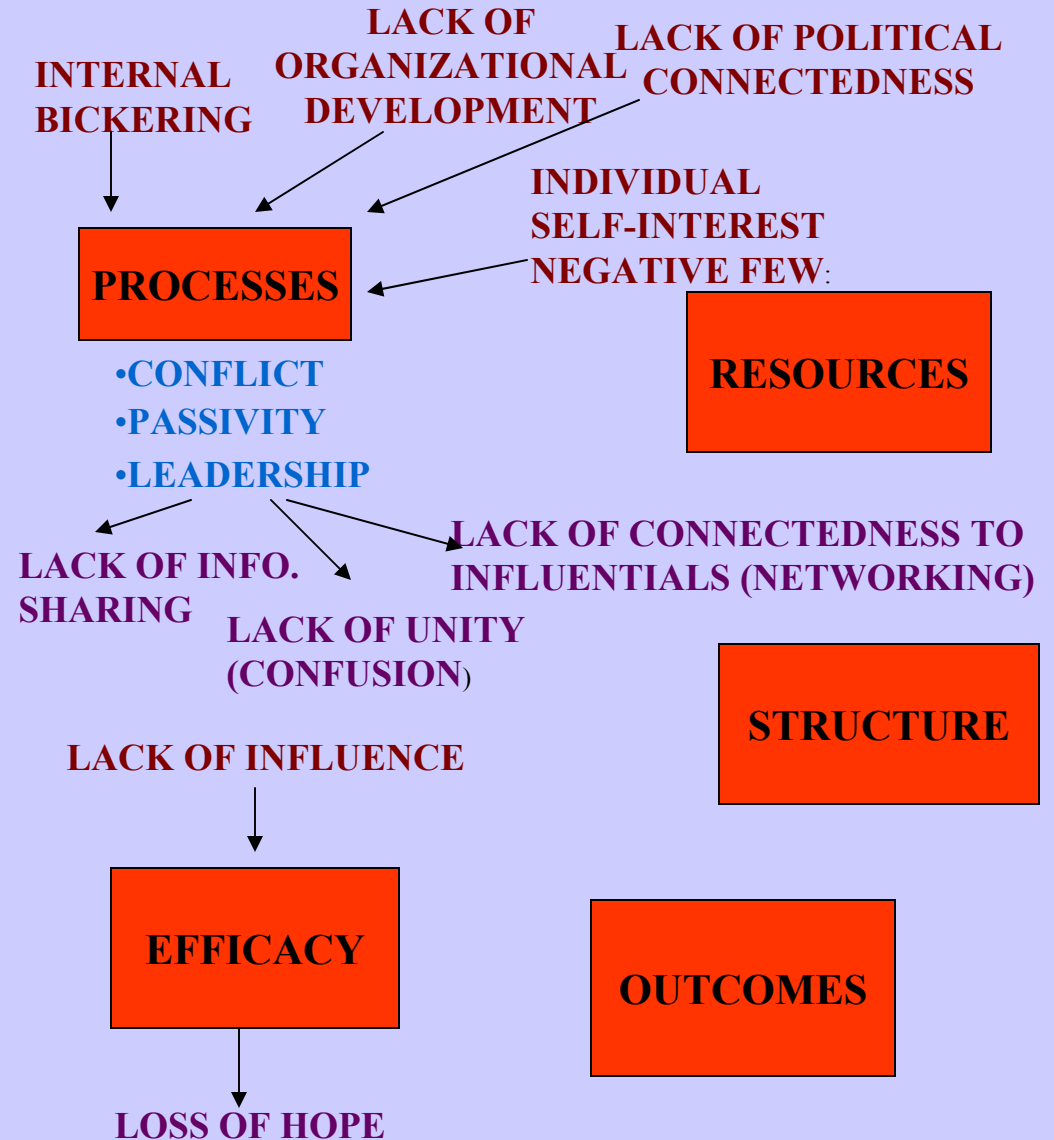
Robert M. Goodman, Ph.D. - Principal Investigator

**Tulane Prevention Research  
Center is the Lead center (LC)  
among four participating  
Prevention Research Centers  
(PPRCs)**

- **St. Louis University**
- **University of Illinois – Chicago**
- **University of New Mexico**

# COMMUNITY SCENARIO A - CHALLENGES

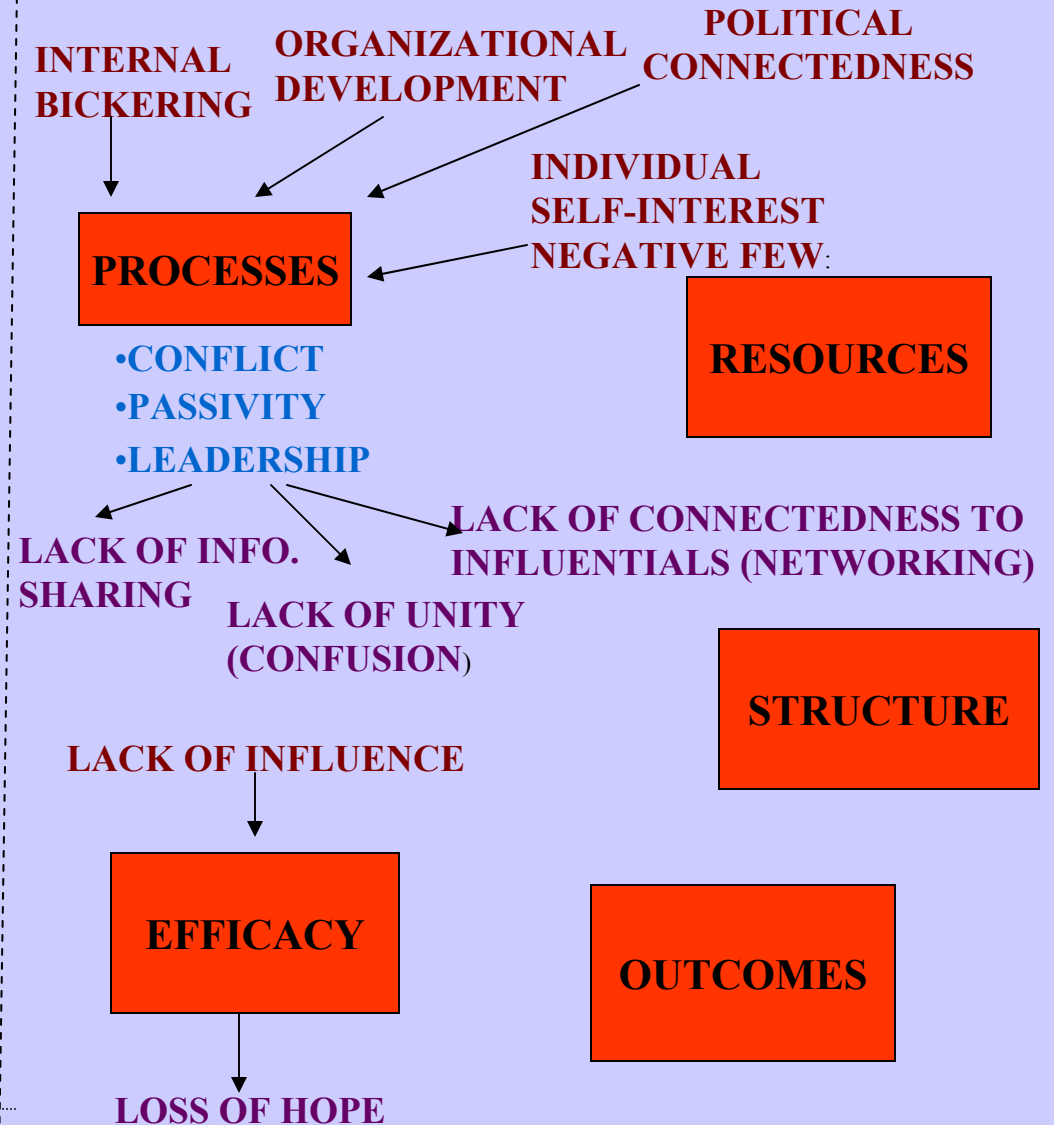
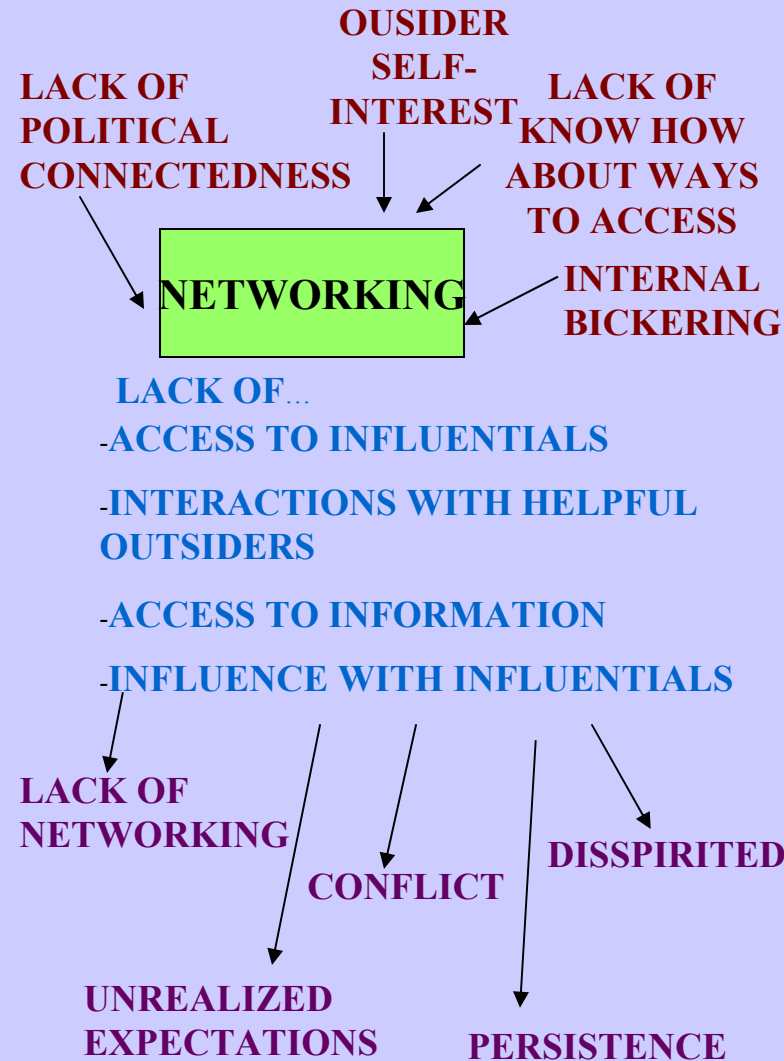
## INTERNAL CONDITIONS



# COMMUNITY A - CHALLENGES

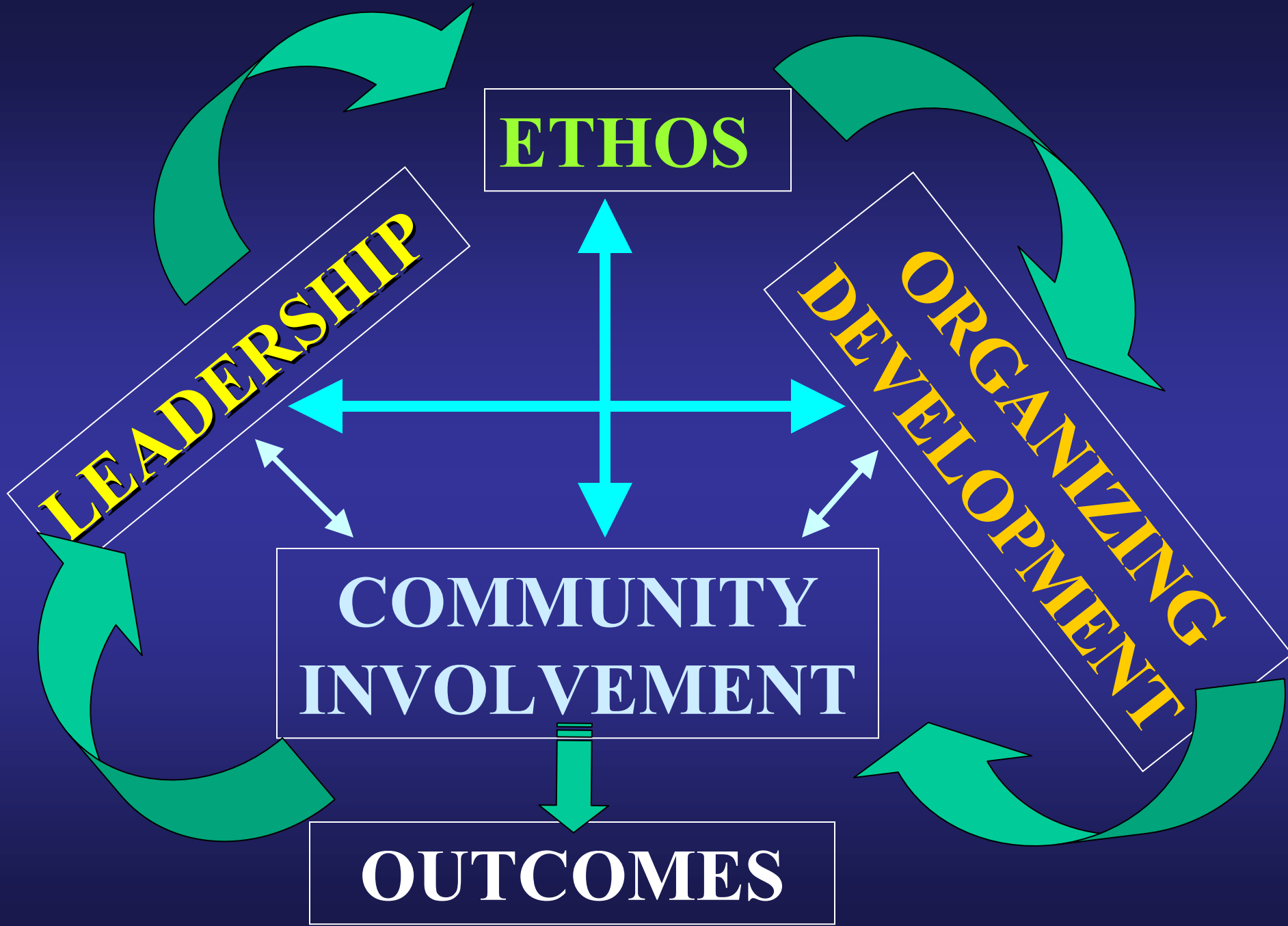
## EXTERNAL ENVIRONMENT

## INTERNAL CONDITIONS



# COMMUNITY SENARIO B - CAPACITY

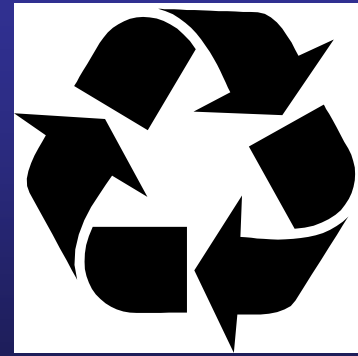




# COMMUNITY CAPACITY



&



SOCIAL ECOLOGY

**According to Social Ecology**  
**Principles, complex health issues like**  
**substance abuse, teen pregnancy,**  
**violence, or chronic disease should**  
**be viewed as interwoven into the**  
**social fabric**

**Stokols, Allen & Bellingham. (1996). Translating social ecology theory into guidelines for community health promotion. *American Journal of Health Promotion, 10*, 282-298.**

**A shift to comprehensive ecological formulations is a needed transformation because pockets of prevalence for ill health remain fixed in communities when interventions are limited in scope. Such limited programs are the cause of high relapse and attrition rates.**

# Ecological View of Health

- **multiple determinants of health**
- **linkages and relationships among determinants are emphasized**
- **An approach in which multiple strategies are developed to impact determinants of health relevant to the desired health outcomes**

**Stanford Five Community Project  
Minnesota Heart Health Project  
Pawtucket Heart Health Project**

**risk factor screening**

**worksite physical activity**

**school programs**

**community-wide contests**

**community task forces**

**media messages**

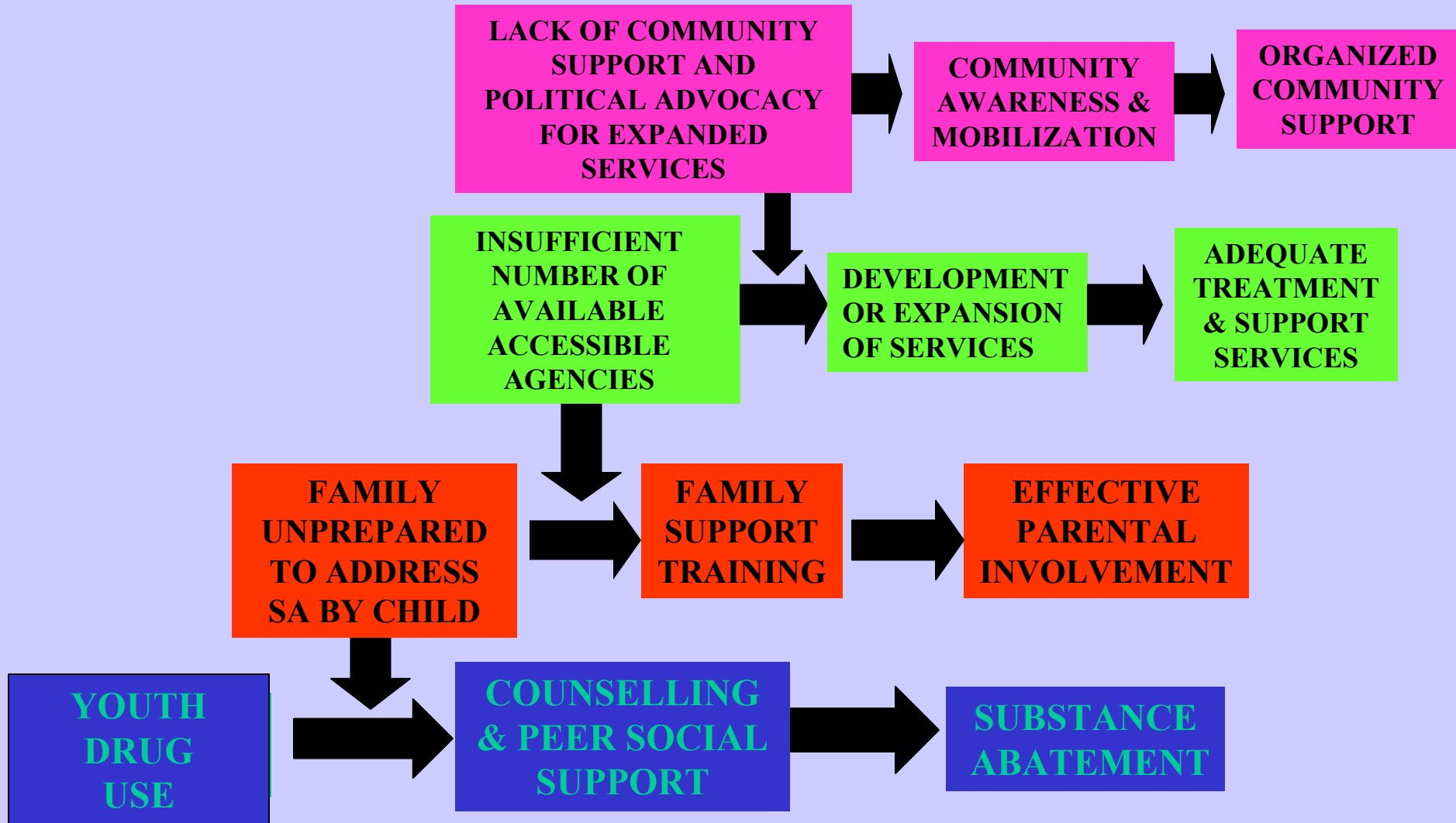
**grocery labeling**

**speakers bureaus**

**health practitioner programs**

**menu labeling at restaurants**

# ECOLOGICAL MODEL FOR DESIGNING PROGRAM INTERVENTIONS IN THE 1990'S (& BEYOND???)



# SYNERGISTIC EFFECT IN PUBLIC HEALTH RISK

**SMOKING**



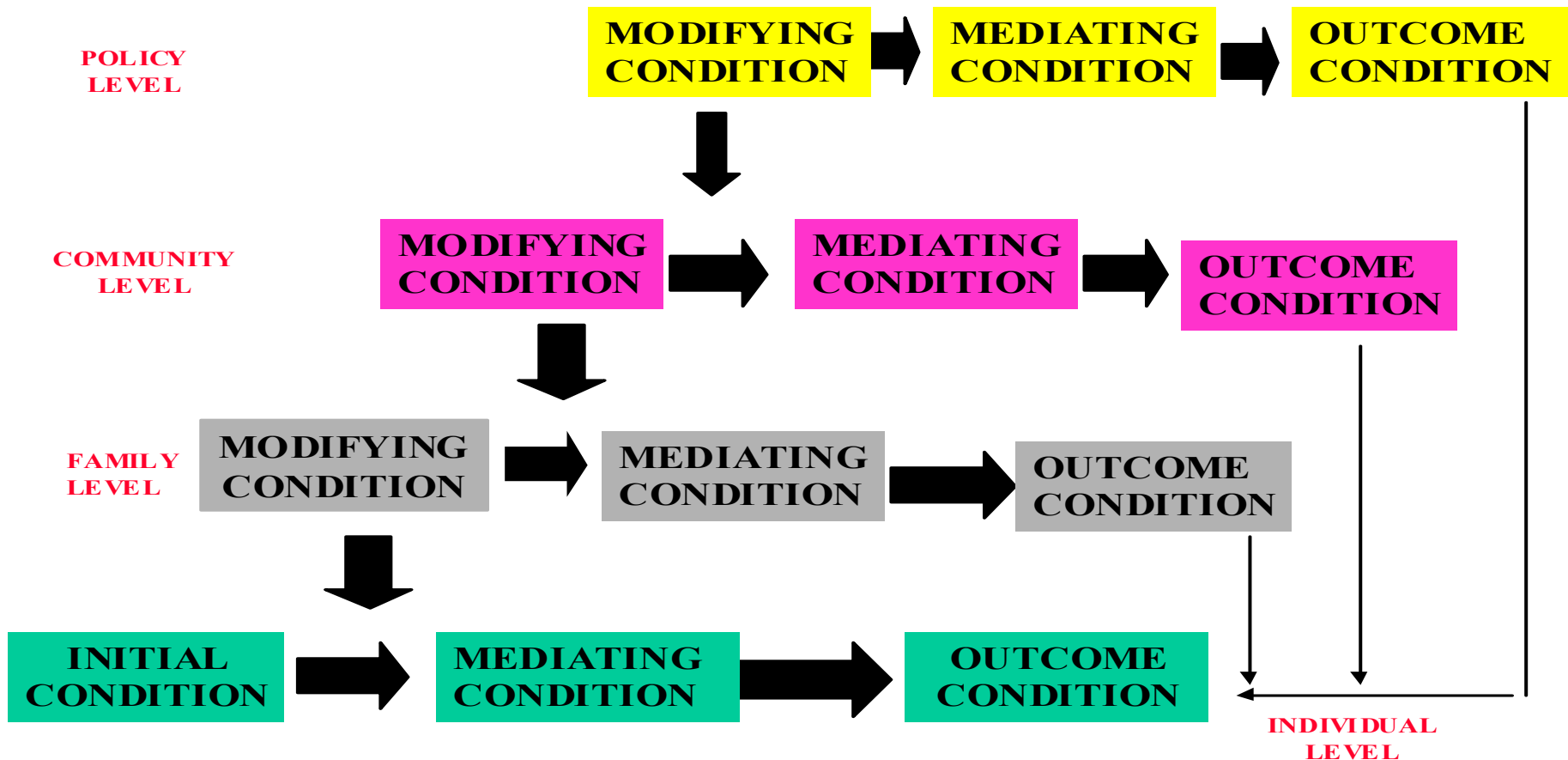
**1 CANCER DEATH**

**ASBESTOS  
INHALATION**



**1 CANCER DEATH**

# SYNERGISTIC EFFECT IN SOCIAL ECOLOGY INTERVENTIONS ADDRESSING PUBLIC HEALTH RISK



**Types of Programs/  
Interventions**

**Levels of  
Influence**

**Targets of  
change**

**Short-term  
Outcomes**

**Intermediate  
Outcomes**

**Long-term  
Outcomes**

Moral/Ethical  
Educational  
Motivational  
Affective  
Skill building  
Resource development  
Economic  
Sociocultural  
Ecological  
Regulatory

Individuals  
Families  
Groups  
Organizations  
Communities  
Societies

Lifestyles

Social norms

Environments

Policies

Resources

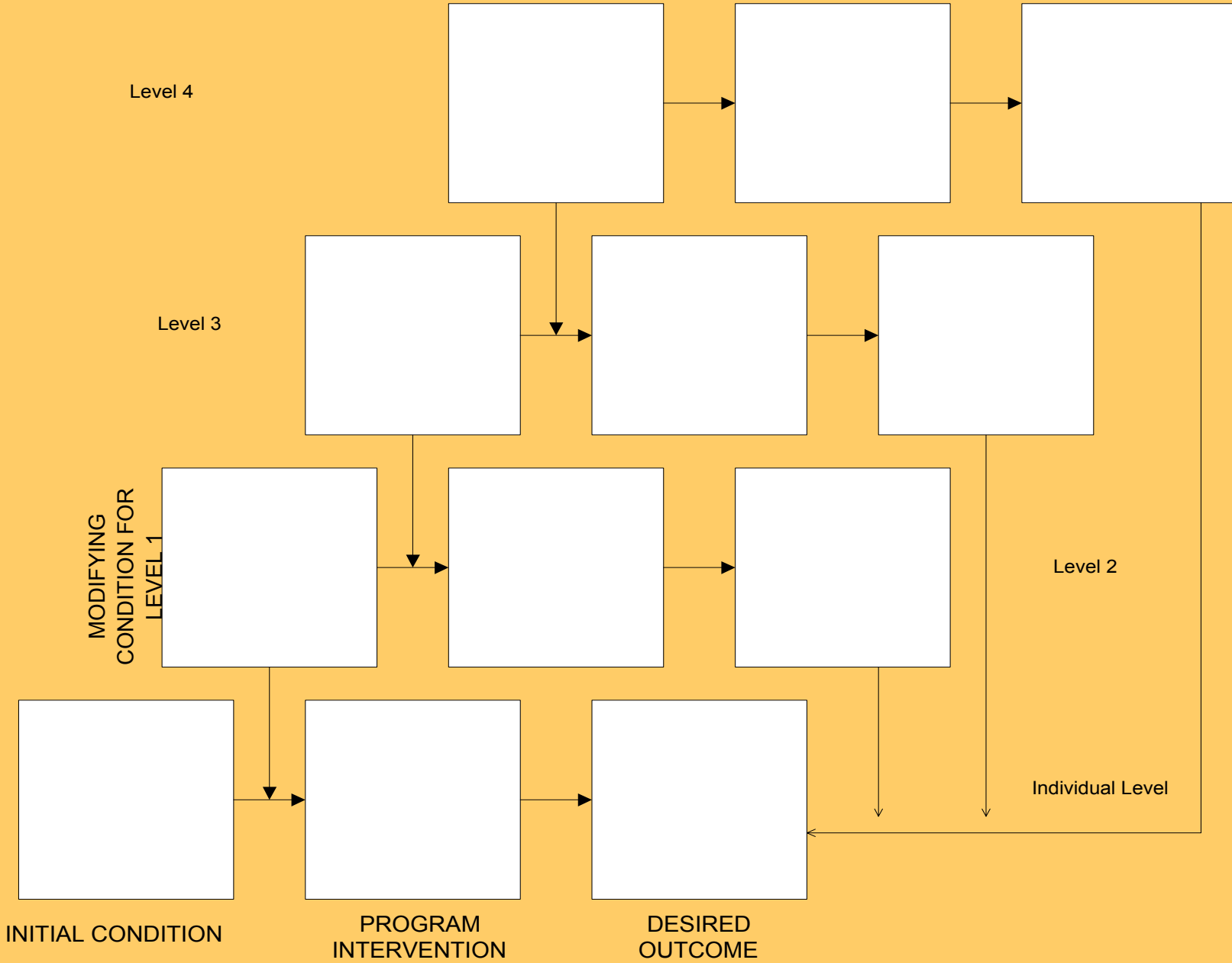
Altered norms  
Increased knowledge  
Altered attitudes and beliefs  
Restructured priorities  
Modified behaviors  
Supportive policies  
Increased access to resources

Empowerment  
Reduced risk factors  
Optimized well-being  
Appropriate use of health care and resources  
Increased life satisfaction  
Increased productivity  
Enhanced images for organizations  
Increased sense of community

Improved quality of life  
Extended productive longevity  
Reduced illness and injury  
Enhanced organizational competence  
Increased community competence  
Expanded health consciousness in society

**The approximate relationships among objects of interest to health and other sectors cooperating in health promotion are shown as causes and effects.**

# An Ecological Model For Designing Program Interventions



# **Examples and Directions for Research and Practice**

**Yoo, S.Y., Weed, N.E., Lempa, M.L.,  
Mbondo, M. Shada, R., Goodman, R.M.  
“Collaborative Community  
Empowerment: An Illustration of a Six-  
Step Process,” *Health Promotion  
Practice*, (in press).**

# SIX STEP STRATEGY

- **Entrée into the community**
- **Issue identification**
- **Issue prioritization**
- **Strategy development**
- **Implementation**
- **Transition**

# ENTRÉE INTO THE COMMUNITY

- **Initial Contact**
- **Facilitator training**
- **Introduction to the community**
- **Mission**

# ISSUE IDENTIFICATION

- Brainstorming
- Free listing
- Identification of community leaders

# ISSUE PRIORITIZATION

- **Voting**
- **Selecting top priority**

# IDENTIFIED COMMUNITY ISSUES

- Group #1: Quality Education
- Group #2: Drugs & Housing
- Group #3: Damaged Homes
- Group #4: Blighted Properties

# STRATEGY DEVELOPMENT

- **Elaboration of the top priority issue**
- **Introduction of a social ecological model**
- **Community planning meetings**

# STRATEGIC PLAN

## Policy Level

Time limitations on filing claims

Present problem at city council meetings  
Get legal representation  
Vote for public official who support community efforts  
Media Advocacy

Extended Time limitations on filing claims

## Organizational Level

S&WB Policies not clear to community

Education on S&WB policy  
Inspections to ascertain damage

S&WB Policies clarified for the community

## Community Level

Community not working together to support those with damaged homes

Community Mobilization  
Group meetings  
Group letter – homes identified  
Calls to city council representatives  
Collaboration with other groups

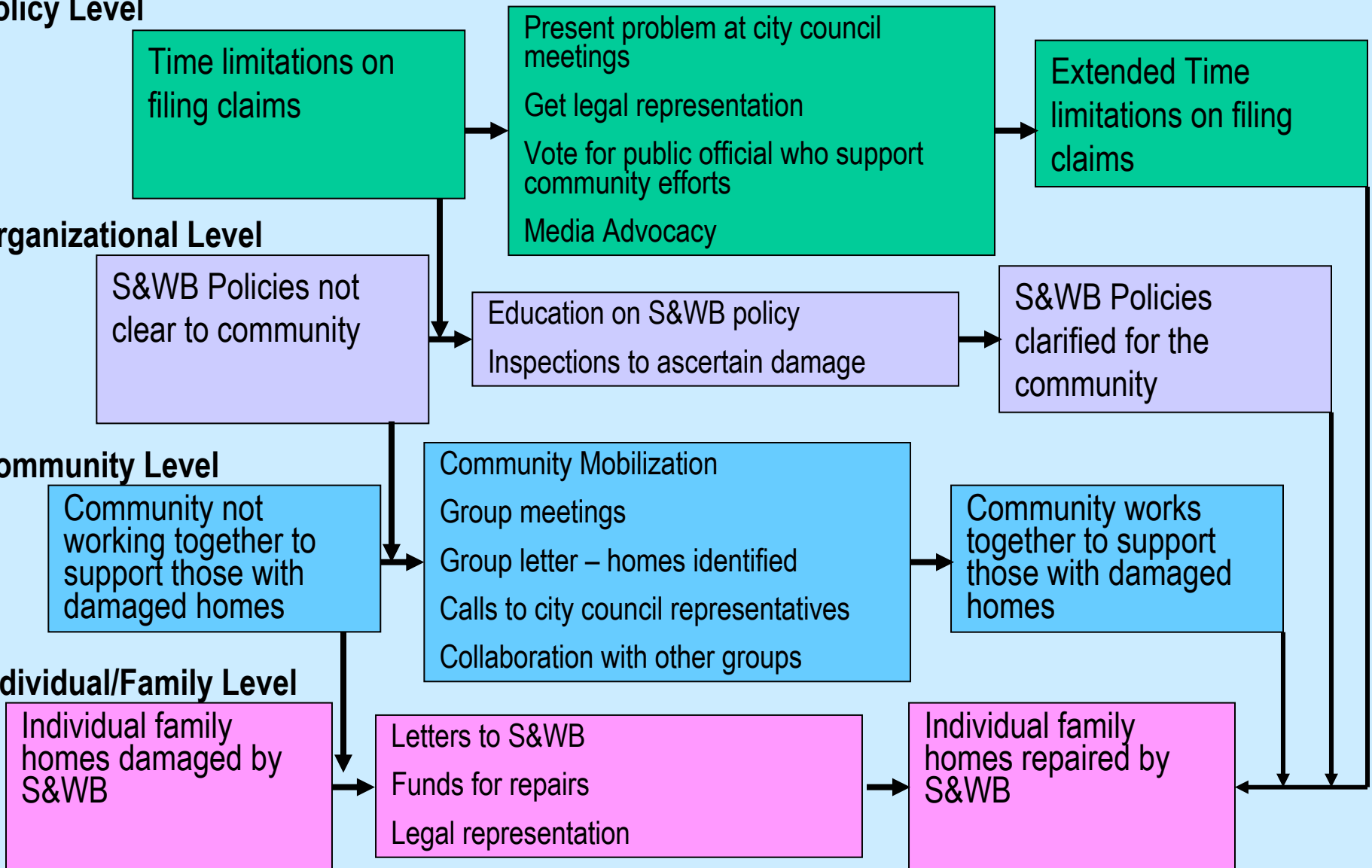
Community works together to support those with damaged homes

## Individual/Family Level

Individual family homes damaged by S&WB

Letters to S&WB  
Funds for repairs  
Legal representation

Individual family homes repaired by S&WB



# IMPLEMENTATION

- **Establish action plans**
- **Task assignment among the community members**
- **Timeline for the action plan**
- **Resource utilization**
- **Step by step execution of the action plan**
- **Monitoring of the status**
- **Debriefing**

# TRANSITION

- **Discussion of the of the first action**
- **Decision making for the next action steps**
- **Transitioning of facilitation responsibility**

# Near-term Results

**Policy Change**

**Responsiveness**

# IMPLICATIONS

- **A better relationship between the academic institution and the community results**
- **Community members learn about the research process through participation**
- **Community develops ownership of the process**
- **CBPR can be informed by the six-step strategy**
- **Community outcomes can result where high levels of capacity are present**

# **FOR CBPR TO BE EMBRACED**

- ✓ OUTCOMES MUST BE DEFINITIVE**
- ✓ ADDITIONAL FOCUS ON OUTCOMES ARE NECESSARY AT THIS JUCTURE**

# CHALLENGES OF THE CBPR APPROACH

- **CBPR is difficult to do**
- **the time and effort required to build trust and true partnering**
- **the difficulties in developing a common purpose**
- **the challenges of working with partners from diverse backgrounds and experiences**

# CHALLENGES OF THE CBPR APPROACH

- the practical constraints that compromise CBPR principles in practice
- the difficulties in reaching balance and equity in the distribution of resources and other benefits
- the career challenges faced by academics

## Required skills for PBCR:

- the ability to **communicate with diverse audiences and to understand their perspectives and needs**
- the ability to **sense and deal with important changes in the community** that are the context for public health programs
- the ability to **find common pathways for action.**
- appropriate training in these leadership skills** needs to be a part of the educational preparation of public health leaders. (p. 122)

In doing community-based participatory research, the practitioner requires training in:

- **providing continuous feedback** during each stage of a community program's development
- becoming a program **stakeholder, collaborator, and builder of capacity** for the community initiative
- ability to **gain entrée, cooperation and trust** among various community groups
- competencies in **team building, group process, negotiation, teaching, and interpersonal communication; and the acquisition of political acumen**

**THE ROLE OF SCHOOLS OF  
PUBLIC HEALTH IN TRAINING  
FOR COMMUNITY-BASED  
RESEARCH AND PRACTICE**



**THANK YOU**