



**Community-Campus  
Partnerships for Health**  
A POLICY AGENDA FOR HEALTH  
IN THE 21ST CENTURY



## TRACK 6

### ***Community-Based Participatory Research: Engaging Communities as Partners in Health Research***

written by

Barbara Israel, University of Michigan School of Public Health,  
Ann Arbor, MI

Amy J. Schulz, University of Michigan School of Public Health,  
Ann Arbor, MI

Edith A. Parker, University of Michigan School of Public Health,  
Ann Arbor, MI

Adam B. Becker, Tulane University Medical Center,  
New Orleans, LA

Prepared for Discussion at Community-Campus Partnerships  
for Health's 4th Annual Conference  
April 29th ~ May 2, 2000 Washington, DC

*Please do not cite or reproduce without permission from:*

Community-Campus Partnerships for Health  
3333 California Street, Suite 410  
San Francisco, CA 94118

PH: 415-476-7081 FAX: 415-476-4113 E-MAIL: [ccph@itsa.ucsf.edu](mailto:ccph@itsa.ucsf.edu)  
<http://futurehealth.ucsf.edu/ccph.html>

This preparation of this paper was made possible, in part, by support from  
the W.K. Kellogg Foundation and the Corporation for National Service

## ABSTRACT

Community-based participatory research in public health focuses on social, structural, and physical environmental inequities through active involvement of community members, organizational representatives, and researchers in all aspects of the research process. Partners contribute their expertise to enhance understanding of a given phenomenon and integrate the knowledge gained with action to benefit the community involved. This paper provides a synthesis of key principles of community-based participatory research, discusses the rationale for its use, identifies major challenges and facilitating factors in conducting effective community-based participatory research, and provides a number of policy recommendations at the organizational, community and national levels aimed at advancing the application of CBPR, especially the engagement of communities as equal partners in the process.

## INTRODUCTION<sup>1</sup>

Historically, the field of public health has examined environmental and social determinants of health status (Frenk 1993; Krieger 1994; Pearce 1996; Steuart 1969; Susser & Susser 1996a; Terris 1987; Trostle 1986; Wall 1995) and involved the public itself in identifying and addressing public health problems (Kark & Steuart 1962; Nyswander 1955; Steuart 1969). Over time, greater emphasis has been placed on research aimed at creating knowledge about determinants of health that has tended to stress individual rather than social or environmental risk factors, and to separate researchers and public health practitioners from the public at-large as the health “experts” (Freudenberg 1978; Israel et al. 1995; Krieger 1994; McKinlay 1993; Pearce 1996; Susser 1995; Susser & Susser 1996a). The emphasis on individual level risk factors tends to obscure the contributions of social and environmental conditions to health and disease, most visible in the growing gap between the health status of rich and poor, white and non-white, urban and non-urban (Bullard 1994; Krieger 1994; Krieger et al. 1993; Williams & Collins 1995).

More recently, researchers have called for a renewed focus on an ecological approach that recognizes that individuals are embedded within social, political and economic systems that shape behaviors and access to resources necessary to maintain health (Brown 1991; Gottlieb & McLeroy 1994; Krieger 1994; Krieger et al. 1993; Lalonde 1974; McKinlay 1993; Stokols 1992; 1996; Susser & Susser 1996a; 1996b; Williams & Collins 1995; WHO 1986). Such an approach corresponds with increased interest in understanding the complex issues that compromise the health of people living in marginalized communities (Bullard 1994; James 1994; Williams & Collins 1995). Emphasis has also been placed on the need for expanded use of both qualitative and quantitative research methods (Israel et al. 1995; Pearce 1996; Steckler et al. 1992; Susser 1995); greater focus on health and quality of life (Antonovsky 1985; Davies and Kelly, 1993); and more translation and integration of basic, intervention, and applied research (Clark and McLeroy 1995; Remington et al. 1988). Greater community involvement in processes that shape research and intervention approaches, e.g., through partnerships between academic, health

---

<sup>1</sup> This section has been adapted from an article by Israel, Schulz, Parker and Becker, 1998.

services and community-based organizations (Fisher 1995; Green et al. 1995; Israel et al. 1994; Israel et al. 1998; James 1993; Minkler and Wallerstein 1997; Novotny and Heaton 1995) is one means towards these ends, and also increases sensitivity to and competence in working within diverse cultures (Bishop 1994; Marin et al. 1995; Singer 1994; Vega 1992).

These calls for a more comprehensive and participatory approach to research and practice in public health have been voiced in major national reports (e.g., *The Future of Public Health, Healthy People 2000*, and *Health Professions Education for the Future: Schools in Service to the Nation*). They have also been translated into funding initiatives by a number of private foundations and federal and international organizations.<sup>2</sup>

This combination of critical reflection within public health and new opportunities for funding has given rise to a number of partnership approaches to research and practice, variously called “community-based/involved /collaborative/centered-research” (Barnett 1993; Buchanan 1996; COMMIT 1995a; 1995b; Davies & Kelly 1993; Dressler 1993; Durie 1996; Eng & Parker 1994; Farquhar et al. 1990; Israel et al. 1992a; 1998; Minkler & Wallerstein 1997; Novotny & Heaton 1995; Schulz et al. 1998a; 1998b). At the same time, a large literature spanning the social sciences has examined approaches to research in which participants are actively involved in all aspects of the research process. Examples include “participatory research” (deKoning & Martin 1996a; Green et al. 1995; Hall 1981; Maguire 1987; Park et al. 1993; Stoecker & Bonacich 1992; 1993; Tandon 1981), “participatory action research” (Fals-Borda & Rahman 1991; Whyte 1991) “action research” (Brown & Tandon 1983; Cunningham 1976; Israel et al. 1989; Lewin 1946; Peters & Robinson 1984; Stringer 1996), “action science/inquiry”

---

<sup>2</sup> Examples include: the W.K. Kellogg Foundation’s “Community-Based Public Health Initiative” (1992); the Robert Wood Johnson Foundation’s “America’s Promise”; the Pew Charitable Trusts’ support of “Community-Campus Partnerships for Health” (Connors & Seifer 1997); the Centers for Disease Control and Prevention’s “Urban Center(s) for Applied Research in Public Health Initiative” (1994); the National Institute of Environmental Health Sciences’ “Community-Based Prevention Intervention Research” (1999); the National Cancer Institute’s “Plan for Cancer Prevention and Control Research among American Indians and Alaska Natives” (1994); the U.S. Office of Disease Prevention and Health Promotion’s “Healthy Communities Initiative” (Flynn 1993); and the World Health Organization’s “Healthy Cities Initiative” (Davies & Kelly 1993; Yeich & Levine 1992).

(Argyris et al. 1985), “cooperative inquiry” (Reason 1988; 1994a), “feminist research” (Maguire 1987; Mies 1993), “participatory evaluation” (Weiss & Greene 1992), and “empowerment evaluation” (Fetterman et al. 1996). Despite differences among these approaches (e.g., Reason 1988; Stoecker & Bonacich 1992, 1993), each is explicitly committed to conducting research that will benefit the participants either through direct intervention or by using the results to inform action for change.

The purpose of this paper is to examine the lessons to be learned from the interdisciplinary pool of knowledge about conducting collaborative or participatory forms of research, and from the experience of public health researchers, practitioners, and community members working in what is referred to here as community-based participatory research in (CBPR) public health. Rather than attempt an exhaustive review of the literature mentioned above (e.g., Gaventa 1993; Green et al. 1995; Maguire 1987; Reason & Rowan 1981; Reason 1994b; Yeich & Levine 1992), this paper draws on the literature on community-based and related forms of research, the authors’ experiences with community-based participatory research, and related literature on community-based interventions, coalitions, and community organizing (e.g., Davies & Kelly 1993; Goodman et al. 1993; Minkler & Wallerstein 1997; Stokols et al. 1996; Wallerstein & Bernstein 1994a; 1994b). This paper provides a synthesis of key principles or characteristics of community-based participatory research; discusses rationales for its use; identifies major challenges and facilitating factors in conducting effective community-based participatory research, and provides a number of policy recommendations at the organizational, community and national levels aimed at advancing the use of CBPR, especially the engagement of communities as equal partners in the process.

## COMMUNITY- BASED PARTICIPATORY RESEARCH: OVERVIEW<sup>3</sup>

The label “community-based participatory research” (CBPR) is being used here to acknowledge the fundamental characteristic that emphasizes the participation, influence and control of non-academic researchers in the process of creating knowledge and change. This approach is also often referred to as “community-based research”. However, the use here of CBPR represents a critical distinction from what is a somewhat different use of the term “community-based research”, that emphasizes conducting research in a community as a place or setting, in which community members have only limited involvement, if any, in what is primarily a researcher-driven enterprise. By comparison, community-based participatory research involves conducting research which recognizes the community as a social and cultural entity with the active engagement and influence of community members in all aspects of the research process (Hatch et al. 1993; Schulz et al. 1998a). Furthermore, the inclusion of the term “participatory” more clearly aligns CBPR with its roots in participatory research approaches (Hall 1981; Maguire 1987; Stoecker and Bonacich 1992; Tandon 1981).

Community-based participatory research in public health is a collaborative approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process. The partners contribute their expertise and share responsibilities and ownership to enhance understanding of a given phenomenon, and integrate the knowledge gained with action to improve the health and well-being of community members (Dressler 1993; Eng & Blanchard 1990-1; Hatch et al. 1993; Israel et al. 1998; Schulz et al. 1998a).

---

<sup>3</sup> This section has been adapted from Israel et al. 1998.

## KEY PRINCIPLES OF COMMUNITY-BASED PARTICIPATORY RESEARCH<sup>4</sup>

The following presents a set of principles or characteristics that seek to capture the key elements of this approach based on the present state of knowledge in the field. These principles will continue to evolve as further CBPR is conducted and evaluated. They are presented with the recognition that the extent to which any research endeavor can achieve any one or a combination of these principles will vary depending on the context, purpose, and participants involved in the process. Each principle may be located on a continuum, with the principle as described here representing a goal to strive to achieve, for example, equitable participation and shared control over all phases of the research process (Cornwall 1996; Dockery 1996; Green et al. 1995).<sup>5</sup> While presented here as distinct items, community-based participatory research is an integration of these elements.<sup>6</sup>

*Recognizes community as an unit of identity.* The concept of community as an aspect of collective and individual identity is *central* to community-based participatory research. Units of identity, for example, membership in a family, friendship network, or geographic neighborhood, are all socially constructed dimensions of identity, created and recreated through social interactions (Hatch et al. 1993; Steckler et al. 1993; Steuart 1993). Community is characterized by a sense of identification and emotional connection to other members, common symbol systems, shared values and norms, mutual - although not necessarily equal - influence, common interests, and commitment to meeting shared needs (Israel et al. 1994; Klein 1968; Sarason 1984; Steuart 1993). Communities of identity may be centered on a defined geographic neighborhood or a geographically dispersed ethnic group with a sense of common identity and shared fate. A city or other

---

<sup>4</sup> This section has been adapted from Israel et al. 1998.

<sup>5</sup> See the guidelines for participatory research in health promotion by Green and his colleagues (1995) which are intended to be used to assess the extent to which proposed projects meet participatory research criteria.

<sup>6</sup> In addition to these key principles, the reader is referred to Appendix 1 for a listing of the CBPR Principles adopted by the Detroit Community-Academic Urban Research Center (URC). The URC partnerships is comprised of representatives from academia, community-based organizations, public health and health care organizations, and is in its fifth year, with funding through a cooperative agreement from the Centers for Disease Control and Prevention. The overall goal of the URC is to conduct CBPR that improves the health of families and communities on the southwest and east sides of Detroit..

geographic area may not be a community in this sense of the term, but rather an aggregate of people who do not share a common identity, or may contain several different and overlapping communities of identity within its boundaries. CBPR endeavors attempt to identify and to work with existing communities of identity, and/or to strengthen a sense of community through collective engagement (Israel et al. 1994; Stringer 1996).

*Builds on strengths and resources within the community.* Community-based participatory research seeks to identify and build on strengths, resources, and relationships that exist within communities of identity to address their communal health concerns (McKnight 1987; 1994; Minkler 1989; Steuart 1993). These may include skills and assets of individuals (McKnight 1994), networks of relationships characterized by trust, cooperation and mutual commitment (Israel & Schurman 1990), and mediating structures within the community such as churches and other organizations where community members come together (Berger & Neuhaus 1977) - resources that have recently sometimes been referred to as social capital (Putnam 1993; James, Schulz and vanOlphen 1999). Community-based participatory research explicitly recognizes and seeks to support or expand social structures and social processes that contribute to the ability of community members to work together to improve health.

*Facilitates collaborative, equitable involvement of all partners in all phases of the research.* Community-based participatory research involves a collaborative partnership in which all parties *participate* as equal members and share control over all phases of the research process, e.g., problem definition, data collection, interpretation of results, and application of the results to address community concerns (Bishop 1994; deKoning & Martin 1996b; Durie 1996; Green et al. 1995; Hatch et al. 1993; Israel et al. 1992a; 1992b; Levine et al. 1992; Lillie-Blanton & Hoffman 1995; Maguire 1996; Mittelmark et al. 1993; Nyden & Wiewel 1992; Park et al. 1993; Schulz et al. 1998a; Singer 1993; Stringer 1996). Communities of identity contain many individual and organizational resources, but may also benefit from skills and resources available from outside of the immediate community of identity. Thus, CBPR efforts may involve individuals and groups who are not members of the

community of identity. Such partnerships may include representatives from health and human service organizations, academia, community-based organizations, and the community-at-large. These partnerships focus on issues and concerns identified by community members (Bishop 1996; deKoning & Martin 1996b; Gaventa 1993; Green et al. 1995; Hatch et al. 1993; Lillie-Blanton & Hoffman 1995; Petras & Porpora 1993; Singer 1993; Stringer 1996), and create processes that enable all parties to participate and share influence in the research and associated change efforts.

*Integrates knowledge and action for mutual benefit of all partners.*

Community-based participatory research seeks to build a broad body of knowledge related to health and well-being while also integrating that knowledge with community and social change efforts that address the concerns of the communities involved (Green et al. 1995; Israel et al. 1994; Lincoln & Reason 1996; Maguire 1987; Park et al. 1993; Reason 1988; Schulz et al. 1998a; Singer 1993; Stringer 1996). Information is gathered to inform action, and new understandings emerge as participants reflect on actions taken. CBPR may not always incorporate a direct action component, but there is a commitment to the translation and integration of research results with community change efforts (Schulz et al. 1998a) with the intention that all involved partners will benefit (deKoning & Martin 1996b; Green et al. 1995; Lather 1986; Petras & Porpora 1993; Reason 1988; Schulz et al. 1998a).

*Promotes a co-learning and empowering process that attends to social inequalities.* Community-based participatory research is a co-learning and empowering process that facilitates the reciprocal transfer of knowledge, skills, capacity, and power (Bishop 1994; 1996; deKoning & Martin 1996b; Eng & Parker 1994; Freire 1987; Israel et al. 1994; Labonte 1994; Lillie-Blanton & Hoffman 1995; Nyden & Wiewel 1992; Robertson & Minkler 1994; Schulz et al. 1998a; Singer 1993; Stringer 1996). For example, researchers learn from the knowledge and “local theories” (Elden & Levin 1991) of community members, and community members acquire further skills in how to conduct research. Furthermore, recognizing that socially and economically marginalized communities often have not had the power to name or define their own experience, researchers involved with CBPR

acknowledge the inequalities between themselves and community participants, and the ways that inequalities among community members may shape their participation and influence in collective research and action (Blankenship & Schulz 1996; Maguire 1987; Wallerstein 1999; Yeich & Levine 1992). Attempts to address these inequalities involve explicit attention to the knowledge of community members, and an emphasis on sharing information, decision-making power, resources, and support among members of the partnership (Bishop 1994; Israel et al. 1994; Labonte 1994; Martin 1996; Robertson & Minkler 1994; Yeich & Levine 1992).

*Involves a cyclical and iterative process.* Community-based participatory research involves a cyclical, iterative *process* that includes partnership development and maintenance, community assessment, problem definition, development of research methodology, data collection and analysis, interpretation of data, determination of action and policy implications, dissemination of results, action taking (as appropriate), specification of learnings, and establishment of mechanisms for sustainability (Altman 1995; Fawcett et al. 1996; Hatch et al. 1993; Israel et al. 1994; Levine et al. 1992; Reason 1994b; Smithies & Adams 1993; Stringer 1996; Tandon 1981).

*Addresses health from both positive and ecological perspectives.* Community-based participatory research addresses the concept of health from a positive model (Antonovsky 1985; Hancock 1993; Kelly et al. 1993) that emphasizes physical, mental, and social well-being (WHO 1946). It also emphasizes an ecological model of health (Brown 1991; Durie 1996; Gottlieb & McLeroy 1994; Green, Richard & Potvin 1996; Hancock 1993; Israel et al. 1994; Krieger 1994; McKinlay 1993; Schulz et al. 1998a; Stokols 1992; 1996) that encompasses biomedical, social, economic, cultural, historical, and political factors as determinants of health and disease.

*Disseminates findings and knowledge gained to all partners.* Community-based participatory research seeks to *disseminate* findings and knowledge gained to all partners involved, in language that is understandable and respectful, and “where ownership of knowledge is acknowledged” (Bishop 1996; p. 186; Dressler 1993; Gaventa 1993; Hall 1992; Lillie-Blanton & Hoffman 1995; Maguire 1987; Schulz et

al. 1998a; Singer 1994; Whitehead 1993). The ongoing feedback of data and use of results to inform action are integral to this approach (Fawcett et al. 1996; Francisco et al. 1993; Israel et al. 1992b). This dissemination principle also includes researchers consulting with participants prior to submission of any materials for publication, acknowledging the contributions of participants and, as appropriate, developing co-authored publications (Schulz et al. 1998a).

*Involves a long-term commitment by all partners.* Given the emphasis in community-based participatory research on an ecological approach to health, and the focus on developing and maintaining partnerships that foster empowering processes and integrate research and action, CBPR requires a long-term commitment by all the partners involved (CDC/ATSDR 1997; Hatch et al. 1993; Israel et al. 1992b; Mittelmark et al. 1993; Schulz et al. 1998a; 1998b). Establishing trust and the skills and infrastructure needed for conducting research and creating comprehensive approaches to community change necessitates a long time frame (CDC/ATSDR 1997; Israel et al. 1992b). Furthermore, communities need to be assured that outside researchers are committed to the community for the long haul, after initial funding is over.

In summary, community-based participatory research involves a collaborative partnership in a cyclical, iterative process in which communities of identity play a lead role in: identifying community strengths and resources; selecting priority issues to address; collecting, interpreting, and translating research findings in ways that will benefit the community; and emphasizing the reciprocal transfer of knowledge, skills, capacity and power. As appropriate, such partnerships may involve individuals and groups who are not members of the community of identity, for example, representatives from health and human service agencies, academia. However, the focus of the partnership is driven by the issues and concerns identified by members of the community of identity.

It is valuable to distinguish between CBPR efforts as "partnerships" and other types of interagency collaborations such as those referred to as "coalitions". While there are some similarities between CBPR partnerships and coalitions (e.g., diverse organizations working together to achieve a common goal), and there are different

types of coalitions (e.g., grassroots, professional, and a combination of the two) (Butterfoss et al. 1993), there are several critical differences. Coalitions, for example, are frequently initiated to address an issue or problem identified by professionally-based organizations, in which more often than not groups are invited to participate representing a broad geographic area (e.g., city, county, region), in which the diverse perspective of different communities of identity are usually not emphasized, and in which issues of equity and power are not necessarily in the forefront of the coalition's goals. What is important here is to recognize that both coalitions and CBPR partnerships have viable roles to play in improving the health and well-being of the public's health, and that they do so from a somewhat different perspective and approach to research and change.

#### RATIONALE FOR COMMUNITY-BASED PARTICIPATORY RESEARCH

Some key rationales and advantages of community-based participatory research as discussed in the literature are presented in Table 1.

Table 1<sup>7</sup>

Summary of Rationales/Advantages of Community-Based Participatory Research

Rationale/Advantage	References
Enhances the relevance and use of the research data by all partners involved	Brown 1995; Cousins & Earl 1995; Schensul, Denelli-Hess, Borreo, & Bhavati 1987; Schulz et al. 1998b
Joins partners with diverse skills, knowledge, expertise, and sensitivities to address complex problems	Butterfoss, Goodman, & Wandersman 1993; Hall 1992; Himmelman 1992; Israel, Schurman, & House 1989; Schensul et al. 1987
Improves quality and validity of research by engaging local knowledge and local theory based on the experience of people involved	Altman 1995; Bishop 1996; deKoning & Martin 1996b; Dressler 1993; Elden & Levin 1991; Gaventa 1993; Hall 1992; Maguire 1987; Schensul et al. 1987; Vega 1992
Acknowledges that "knowledge is power", thus knowledge gained can be used by all partners involved to direct resources and influence policies that will benefit the community	deKoning & Martin 1996b; Dressler 1993; Hall 1992; Himmelman 1992; Maguire 1987; Tandon 1981
Strengthens research and program-development capacity of partners	Altman 1995; Green et al. 1995; Schensul et al. 1987; Schulz et al. 1998a; Singer 1993, 1994
Increases possibility of overcoming understandable distrust of research on part of communities that have historically been "subjects" of such research	Hatch et al. 1993; Schulz et al. 1998b
Has potential to "bridge the cultural gaps that may exist" (Brown 1995; p. 211) between partners involved	Bishop 1994, 1996; Hatch et al. 1993; Schulz et al. 1998b; Vega 1992
Overcomes fragmentation and separation of individual from culture and context that are often evident in more narrowly defined, categorical approaches	Green et al. 1995; Israel et al. 1994; Reason 1994b; Stokols 1996
Provides additional funds and possible employment opportunities for community partners	Altman 1995; Nyden & Wiewel 1992; Schulz et al. 1998b
Aims to improve health and well-being of communities involved, both directly through examining and addressing identified needs and indirectly through increasing power and control over research process	Durie 1994; Green et al. 1995; Hatch et al. 1993; Schulz et al. 1998a, deKoning & Martin 1996b; Israel & Schurman 1990; Israel et al. 1994; Wallerstein 1992
Involves communities that have been marginalized on basis of, for example, race, ethnicity, class, gender, and sexual orientation in examining impact of marginalization and attempting to reduce and eliminate it	deKoning & Martin 1996b; Gaventa 1993; Hatch et al. 1993; Krieger 1994; Maguire 1987; Vega 1992; Williams & Collins 1995

<sup>7</sup> Adapted from Israel et al. 1998.

## CHALLENGES AND FACILITATING FACTORS IN CONDUCTING COMMUNITY-BASED PARTICIPATORY RESEARCH

There are numerous challenges, *and* barriers, as well as facilitating factors in conducting community-based participatory research (Israel et al. 1998). It is beyond the scope of this paper to provide an in-depth discussion, rather a few of the key issues will be highlighted in conjunction with the major policy implications that will be addressed in the remainder of this paper. (See Appendix 2 for a complete listing of these challenges and facilitating factors as discussed in Israel et al. 1998).

## POLICY RECOMMENDATIONS FOR INCREASING COMMUNITY-BASED PARTICIPATORY RESEARCH

As indicated by the challenges and facilitating factors in conducting community-based participatory research presented in Appendix 2, there are numerous issues that need to be addressed and policies that need to be changed in order to increase the use of CBPR (with specific emphasis on enhancing the engagement of community partners in this process). Towards achieving this goal, there are number of potential policy recommendations that we considered, and different ways to organize how they could be presented. Based upon our experience and conversations with members of the Detroit Community-Academic Urban Research Center Board (a CBPR partnership in which we have all been actively involved), the following discussion will focus on three key interrelated areas for policy change: (1) funding research partnerships, (2) capacity building and training for CBPR partners, and (3) benefits and reward structures for CBPR partners. Policy recommendations are provided that address changes needed at the organizational, community and national levels.

### Funding Research Partnerships

In order to increase the use of CBPR, additional resources are needed to fund this approach to research. As indicated earlier, there are a growing number of such funding opportunities, and several organizations have recently organized meetings with representatives from Federal funding agencies and Foundations to specifically discuss this issue (Loka Institute, January, 2000; the National Institute of

Environmental Health Sciences, March, 2000). In support of these initiatives and the expanded use of CBPR, we provide policy recommendations that relate specifically to the following topics: planning grants; long-range funding; initial and ongoing funding for infrastructure; funding directly to community-based organizations as well as universities; funding for process as well as outcome evaluation; funding for comprehensive approaches that extend beyond categorical perspectives and traditional research designs; and grant application and review process.

Planning grants. One of the major challenges in conducting community-based participatory research is the understandable lack of trust that often exists between community members and researchers, based on the long history of research that has had no direct benefit (and sometimes actual harm) and no feedback of the results to the participants involved (Dockery 1996; Hatch et al. 1993; Levine et al. 1992; Lillie-Blanton & Hoffman 1995; Martin 1996; Remington et al. 1988; Schulz et al. 1998a). A related challenge is the amount of time required to develop and maintain such trusting relationships (Hatch et al. 1993; Israel et al. 1992b; Maguire 1987; Mittelmark et al. 1993; Schulz et al. 1998a; Weiss & Greene 1992). In addition, most funding sources have grant application deadlines that do not allow for the time needed to establish trusting working relationships and collaborative proposal submissions (Himmelman 1992; Israel et al. 1992a).

In order to address these challenges, it is recommended that funding initiatives make greater use of one-year planning grants that focus on creating the relationships and infrastructure necessary for developing and maintaining long-term CBPR partnerships. Emphasis needs to be placed on using these funds to enable the partners to jointly: establish their trustworthiness; develop agreed upon operating norms and CBPR principles for how they will work together as a group (see Appendix 1 and 3 for examples); identify common goals and issues that they want to address; set priorities for CBPR projects; and develop plans for maintaining and evaluating the partnership, as well as plans for implementing and evaluating CBPR projects. Thus, the focus of such planning grants is to provide the resources

needed to create a CBPR partnership that can effectively compete for and carry out community-based participatory research endeavors.

A critical component of such planning grants is that they need to be part of a longer term funding initiative, that would follow the initial planning year with up to five years of funding for particular CBPR projects. An important aspect of such initiatives is that resources need to be available from the beginning that would assure that all partnerships that successfully complete the criteria laid out in the planning grants would receive subsequent funding. While it is certainly appropriate that there be no guarantee that a recipient of a planning grant would automatically receive subsequent project-related funding, such planning grants should be conceptualized and have adequate resources behind them to guarantee that all partnerships that meet the agreed upon objectives of the planning grant would indeed receive further funding. One of the major shortcomings of previous programs that have provided planning grants is that they were established to fund twice as many initial one to two year grants than there were funds available for actual CBPR projects. This resulted in the establishment of some partnerships that were not able to sustain themselves when subsequent funding was not received. The trust that had been established between the partners involved was not only jeopardized, but it became even more difficult in the future to establish credibility and create trusting relationships.

There are several possibilities for overcoming this potential limitation of planning grants. First, as described above, is for funding agencies to guarantee subsequent funds for all partnerships that successfully carry out the requirements of the planning grant. Second, if a partnership is not able to meet all of the requirements during the planning grant period, some mechanism and limited resources could be provided to assist the partnership in becoming more effective in competing for subsequent funds. Third, longer-term program initiatives, involving at least five years worth of funding, could build in a one-year planning period (for the purposes described above), that would be embedded within the actual proposed CBPR project. This latter recommendation would require that funders and reviewers be prepared to support projects that do not fully specify up front all aspects of the

community-based research endeavor, given that all partners would not yet have been able to equally contribute to the writing of the initial grant proposal.

Long-range funding. As presented earlier, two of the key principles of community-based participatory research are the integration of knowledge and action for mutual benefit of all partners, and addressing health from both positive and ecological perspectives (Israel et al. 1998). Long-range funding opportunities are needed for CBPR projects that focus on physical, mental and social well-being, as well as on enhancing understanding of and addressing the biomedical, social, economic, cultural, behavioral, historical, and political determinants of health and disease. While there have been an increasing number of five-year funding initiatives, there is a need to think in terms of at least ten-year efforts in order to effect changes in these broad scale determinants of health, especially to reduce the health disparities that exist between rich and poor, and white and non-white (Collins & Williams 1999; Krieger 1994; Krieger et al. 1993; Williams & Collins 1995).

Initial and ongoing funding for infrastructure. Related to the above is the need for initial and continued funding to support the infrastructure necessary for developing and maintaining CBPR partnerships. Most funding opportunities are for project specific funds that often place greater emphasis on the particular research and/or intervention, and fewer resources are available for partnership development and maintenance. Funds are needed, for example, to hire project support staff whose responsibility it is to keep the partnership together (e.g., through communicating between meetings, providing minutes of meetings, gaining input on agenda items, establishing computer linkages, distributing grant-related and other materials, briefing participants who are unable to attend meetings, orienting new members to the partnership) (Barnett 1993; Cosier & Glennie 1994; Fawcett et al. 1996; Israel et al. 1998; Whitmore 1994). Funds are also needed to support community partner organizations' involvement in the CBPR partnership. Such funds recognize the organizational time and commitment that are provided as part of the infrastructure, and go to the partner organizations rather than to particular individuals. In addition, when the funding period is over, it is extremely difficult to obtain ongoing funds for the infrastructure itself, that is not necessarily project

related. These funds are critical for keeping partnerships together while they apply for additional project-related funds. They also provide continued funds for support staff who can provide a bridge in working on newly funded projects until new staff have been hired.

Funding directly to community-based organizations as well as universities.

Two related challenges in conducting community-based participatory research are the inequitable distribution of power and control among the partners, and conflicts over funding (Israel et al. 1998). Given the history and presence of power differentials among researchers, human service providers, and community-based organizations, the latter are legitimately skeptical about becoming “equal partners” with true shared ownership and control of the process (Altman 1995; Barnett 1993; Buchanan 1996; Cosier & Glennie 1994; Dockery 1996; Israel et al. 1992b; 1998; Martin 1996; Plough & Olafson 1994). Related to this are issues concerning equal access to resources, including determining the fiduciary of funds, how funds are distributed, the amount of funds provided to different partners, and how budget-related decisions are made (Buchanan 1996; Israel et al. 1998; Plough & Olafson 1994).

One mechanism for addressing these challenges is to increase funding initiatives that not only allow for but also require, as appropriate, that community-based partners be the direct recipient and fiduciary of CBPR grant awards. While it is certainly recognized that these community-based organizations (CBOs), just as universities, need to be accountable for funds received, funders need to be careful not to assume that CBOs lack the capacity to be the fiduciary, and thereby create different measures of proof and oversight mechanisms for them to account for their capabilities. For example, we are aware of one instance in which a funding agency sent an independent auditor to review the financial records of a large, well-established community-based organization prior to awarding them a grant in which they served as fiduciary for a CBPR partnership. Such an approach can further reinforce the concerns about lack of trust and equity that community partners may have. At the same time, in some CBPR partnerships there may not initially be CBOs that have the necessary track record to handle large budgets. In these

instances, resources are needed to provide training and technical assistance to the CBOs involved to enhance their capacity in fiscal management (see next section on “Capacity Building and Training of CBPR Partners”).

Funding for process as well as outcome evaluation. Given the principles of CBPR, and the emphasis placed on the partnership itself for conducting effective research and interventions, it is essential that resources be provided that support the evaluation of the process of developing and maintaining the partnership, as well as the evaluation of the outcomes of a particular project. While there is a growing body of literature concerning the factors associated with CBPR partnership functioning (Israel et al. 1998), there is a need to better understand the conditions necessary for developing and maintaining successful partnerships. Grant funds need to be earmarked and review criteria established that provide resources to conduct such process evaluations and the dissemination of findings in ways that will be useful and accessible to others interested in creating CBPR partnerships.

Funding for comprehensive approaches that extend beyond categorical perspectives and traditional research designs. As discussed above, given the emphasis within CBPR on a broad-based definition of health and the multiple determinants across multiple units of analysis, not only do funding opportunities need to be long term, but they need to support comprehensive and innovative approaches to research and intervention. Many granting institutions that fund public health research have determined priorities for investigations that examine categorically defined physical health problems, involving individual behavior change interventions (if at all), emphasizing outcomes on morbidity, mortality, and risk factors, using traditional research designs in which the expert researcher defines the problem and the methods used, in which the randomized control trial is considered the “gold standard” (Israel et al. 1999; Mittelmark et al. 1993; Whitehead 1993). Funding institutions need to extend beyond categorical perspectives and support initiatives that provide the resources necessary to address the complexity of public health problems, using appropriate research methods, that often include non-randomized, non-control group designs, and the use of qualitative and quantitative methods (deKoning & Martin 1996b; Dressler 1993; Green et al. 1995; Hatch et al.

1993; Israel et al. 1998; Susser and Susser 1996a). As mentioned earlier, there are a number of funding institutions that have begun to adopt such an approach (e.g., National Institute of Environmental Health Sciences' "Community-Based Prevention Intervention Research Initiative"; Centers for Disease Control and Prevention's "Urban Research Centers Initiative"). In addition, within categorical funding opportunities, resources can be designated for research that adopts an ecological perspective, examining multiple determinants of a given disease across multiple levels of analysis, using innovative research designs.

Grant application and review process. In order to support increased use of CBPR, not only are changes needed in the types of research funded, and who receives the funds, but there is also a need to create changes in the grant application and review process. Two critical challenges for community-based participatory research are the questions raised concerning scientific quality and the ability to prove intervention success (Israel et al. 1998). As discussed elsewhere, methodological flexibility is essential, that is, the use of research methods that are tailored to the purpose of the research and the context and interests of the community involved (Israel et al. 1998). Grant application and review processes need to recognize the importance of diverse methodologies and the validity of multiple approaches to research.

At perhaps the most basic level, calls for grant proposals need to incorporate the principles of CBPR in content, as well as the grant application submission and review processes themselves. For example, the U. S. Federal Government's Public Health Service Grant Application #398 Form needs to be revised to more flexibly accommodate the principles of CBPR. This would include: how "Key Personnel" are defined and the role for community partners in this definition; the description of the "Research Plan" and all that entails; and the language used throughout that may not be easily understood by community partners. Technical assistance and pre-application consultation needs to be readily available that focuses on assisting organizations that have little experience completing these application forms.

In addition, the review criteria for judging applications for CBPR projects and the persons involved in the review process need to be consistent with the principles

themselves. For example, as mentioned earlier, Green and his colleagues (1995) have developed guidelines for participatory research in health promotion that are intended to be used to assess the extent to which proposed projects meet participatory research criteria, that are very similar to the CBPR principles presented here. Furthermore, who is involved in the review process needs to include not only academicians with expertise in the particular content area being addressed, but also academicians with expertise in CBPR, and community members who have been involved in CBPR endeavors. In the instance of including community members in the review process, it is essential that the necessary steps be taken to ensure that the input of the community participants be heard and incorporated into the final decision-making processes. For example, community members need to be oriented to how the review process is conducted, their roles need to be clearly defined upfront, and how their input is going to be “weighted” needs to be clarified. Thus, community members’ perspectives and expertise might best be applied to assess specific partnership-related criteria across all applications, rather than taking a lead review role on the entirety of a few applications.

#### Capacity Building and Training for CBPR Partners

There are a number of policy recommendations related to the need for training and capacity building to support CBPR within the community and the academy. Importantly, these relate to the capacity building needs of all the partners involved. The topic areas that will be addressed here are: pre and post doctoral training; training programs for community members; institutional support for continuing education and community service; and educational opportunities for members of traditionally marginalized communities. While these are related to the funding issues discussed above, and the benefit and reward structures discussed below, they will be presented here separately.

Pre and post doctoral training. As discussed elsewhere, an important facilitating factor in the successful conduct of CBPR is the presence of researchers who have the requisite skills to follow the principles of CBPR (Israel et al. 1998). In addition to competencies in the areas of research design and methods, researchers need skills in, for example, group process, communication (e.g., the use of language

that is understandable and respectful), conflict resolution, participating in multicultural contexts, ability to be self-reflective and admit mistakes, capacity to work within different power structures, and humility (Israel et al. 1998). There is the need for doctoral and post doctoral programs that emphasize preparing researchers to be able to conduct CBPR. Emphasis should be placed on recruiting students who come from the same marginalized communities that are frequently the very partners involved in CBPR projects. Doctoral training is particularly important in that it is easier for researchers to learn this approach initially rather than having to “unlearn” another perspective. In addition to the regular doctoral program content and format, courses are needed that specifically address the principles of CBPR and the concomitant researcher skills and competencies. Many of these competencies are best learned through a process of field-based learning in which students work with and are mentored by both faculty and community partners involved in CBPR projects. The value of community partners in this teaching and learning process needs to be recognized and compensated. In order for such an approach to be adopted, policy changes are needed within the curriculum at the university level, as well as for funding institutions to devote resources to support these training programs.

Training programs for community members. In order for community members to participate as equal partners and share power and control over the research process, there is a need to enhance their knowledge and skills in areas in which they identify. For example, in our work with the Detroit Community-Academic Urban Research Center, the community partners have specifically identified the importance of capacity building in the areas of evaluation, grant writing, research design, survey administration, and fiscal management. In all instances, the content and the approaches used (e.g., training short courses, technical assistance) need to be tailored to the organizations involved. Funding for such training programs could come from grants specifically focused on continuing education (e.g., expanding the target audience of more traditional training grants to include not only members of the public health workforce but also members of community-based organizations); and/or be built into project specific CBPR efforts. Upon requests by community

partners, universities also need to consider making existing courses available to them in non-degree granting programs, with recognition provided for successful completion of the courses involved.

Institutional support for continuing education and community service. In order for faculty members to be able to provide the requisite time required to provide training and technical assistance to community partners, universities need to recognize the value of faculty members' contributions in this arena. For example, release time could be provided from campus-based courses in exchange for training for community members. Similarly, participation in training activities should be recognized in tenure and promotion processes. While such policy changes are most likely to occur at the institutional level, policy recommendations from, for example, the Association of Schools of Public Health, in conjunction with the accreditation review process, could foster more widespread change in this area.

Educational opportunities for members of traditionally marginalized communities. While doctoral and post doctoral training programs in CBPR are necessary, it is critical that similar educational initiatives also be put into place that target high school and undergraduate students from traditionally marginalized communities. Examples of university programs and policies that would foster this include: summer institutes that prepare high school students for college level work; the recruitment and retention of faculty and staff from communities of color; development of programs for "returning students" that allows them to continue full-time jobs and receive recognition and credit for relevant work experience.

#### Benefits and Reward Structures for CBPR Partners

There are a number of policy issues concerning benefits and reward structures for partners involved in CBPR efforts. It is beyond the scope of this paper to discuss these in depth, and some of them are addressed in detail in other papers developed for this conference. However, given their importance to the present discussion, the following topics will be briefly described: tenure and promotion process; and roles, responsibilities and recognition of community partners involved in community-based participatory research.

Tenure and promotion process. As discussed elsewhere, one of the most frequently mentioned institutional barriers to conducting CBPR are the risks associated with trying to achieve tenure and promotion (Israel et al. 1998). While excellence in scholarship and having a national reputation are major criteria for tenure and promotion at many universities, it is important that there be multiple means of providing evidence of having obtained such recognition. Thus, for example, given the emphasis on publication in peer-reviewed journals, it is necessary that highly regarded journals acknowledge the methodological issues associated with conducting CBPR, and review and publish articles accordingly. Furthermore, universities need to expand their assessment of reputable journals in which CBPR efforts can be credibly published. In addition, in keeping with the principles of CBPR and upon request of community partners, faculty members are often involved in and take a major role in writing grant proposals that are submitted through community-based partner organizations as the fiduciary, rather than through the university. Policies and mechanisms need to be established in universities to ensure that faculty members receive credit for the role that they play in these grant submissions. Furthermore, as discussed above, faculty involvement in providing training and technical assistance to community partners needs to be recognized in the tenure and promotion process.

Roles, responsibilities and recognition of community partners involved in CBPR. Another major challenge to conducting CBPR is the multiple and competing demands on the time and resources across partner organizations that make it difficult for participants to devote the time needed for a particular CBPR endeavor (Israel et al. 1998). This is especially problematic for individuals who get involved in CBPR projects but are not relieved of other responsibilities (Himmelman 1992). Policies within community-based organizations and other partner organizations need to be established that recognize the contributions that participants from their organization make to the partnership (e.g., release time from other activities, pay raises). Given that it is the university partners that are often requesting the time and participation of community partners, there is a need for institutional policies that compensate community partners for their contributions (e.g., payments made to

organizations that have participants involved, publicity/publications that highlight organizational involvement).

### CONCLUDING REMARKS

The purpose of this paper was to provide a synthesis of the key principles of community-based participatory research, to examine the rationale for its use, to identify major challenges and facilitating factors in conducting effective CBPR, and to provide relevant policy recommendations at the organizational, community and national levels aimed at advancing the application of CBPR, especially the engagement of communities as equal partners in the process. As indicated throughout, there are an increasing number of examples of CBPR initiatives, which speaks even more to the need for the policies suggested here. If CBPR is to become a valued approach within public health, the resources necessary to sustain its use into the future must be developed. (See Appendix 4 for a list of resources for additional information regarding CBPR.)

While the focus here has been on policies for enhancing the CBPR approach, it is important to not lose sight that the aim of CBPR is to benefit the communities involved, and that there are policy implications that result from the findings of particular CBPR endeavors. Given the emphasis on working within marginalized communities, and on examining and addressing social and structural determinants of health and disease, the potential for translating research findings into policy is especially critical. In adhering to the principles presented here, the results of CBPR will be grounded in the experiences of the communities involved, and reflect a comprehensive understanding of the complex issues under investigation and addressed through action. Thus, the translation of such findings into policy would have the potential to have a broad impact on communities in multiple arenas, without increasing the burden of change on specific subgroups. Therefore, in order to effect such policy changes, it is within the realm of CBPR that participants may, for example, testify at public hearings to share the results of the research, seek appointments on local and state policy making boards, serve internships on Capitol Hill, and prepare documents that inform policy makers of key findings that support policy decisions.

If we are to have a major impact on the public's health, it is not enough that we advocate for a community-based participatory research approach, but we also need to engage CBPR partnerships in applying what we learn to effect large scale policy changes. Given that many of the challenges to community members' participation in CBPR, as discussed throughout this paper, are similar to the underlying issues that contribute to health differentials, the establishment of broad policies that enhance equity would both serve to reduce health disparities and increase the engagement of communities as partners in health research.

## *Bibliography*

Altman, D.G. (1995). Sustaining interventions in community systems: On the relationship between researchers and communities. Health Psychology, 14, 526-536.

Antonovsky, A. (1985). Health, stress and coping. San Francisco: Jossey Bass.

Argyris, C., Putnam, R., & Smith, D.M. (1985). Action Science: Concepts, Methods and Skills for Research and Intervention. San Francisco: Jossey Bass.

Barnett, K. (1993). Collaboration for community empowerment: Re-defining the role of academic institutions. Center for Community Health, School of Public Health, University of California, Berkeley, CA.

Berger, P.L & Neuhaus, R.J. (1977). To empower people: The role of mediating structures in public policy. Washington, DC: American Enterprise Institute for Public Policy Research.

Bishop, R. (1994). Initiating empowering research? New Zealand Journal of Educational Studies, 29, 175-188.

Bishop, R. (1996). Addressing issues of self-determination and legitimation in Kaupapa Maori research. In B. Webber (Ed.) Research perspectives in Maori education (pp. 143-160). Wellington: New Zealand: Council for Educational Research.

Blankenship, K.M. & Schulz, A.J. (1996, August). Approaches and dilemmas in community-based research and action. Presented at Annual Meeting of the Society for the Study of Social Problems, New York: NY.

Brown, E.R. (1991). Community action for health promotion: a strategy to empower individuals and communities. International Journal of Health Services, 21, 441-456.

Brown, P. (1995). The role of the evaluator in comprehensive community initiatives. In J.P. Connell, A.C. Kubisch, L.B. Schorr, and C.H. Weiss (Eds.) New approaches to evaluating community initiatives (pp. 201-225). Washington D C: Aspen.

Brown, L.D. & Tandon, R. (1983). Ideology and political economy in inquiry: Action research and participatory research. Journal of Applied Behavioral Science, 19, 277-294.

Buchanan, D.R. (1996). Building academic-community linkages for health promotion: a case study in Massachusetts. American Journal of Health Promotion, 10, 262-269.

Bullard, R. (Ed.) (1994). Unequal protection: Environmental justice and communities of color. San Francisco: Sierra Club Books.

Butterfoss, F.D., Goodman, R.M., & Wandersman, A. (1993). Community coalitions for prevention and health promotion. Health Education Research, 8, 315-330.

Centers for Disease Control and Prevention. (1994). "Cooperative Agreement Program for Urban Center(s) for Applied Research in Public Health," Program Announcement #515, US Department of Health and Human Services.

Centers for Disease Control and Prevention & Agency for Toxic Substances and Disease Registry. (1997). Principles of community engagement. Atlanta: CDC Public Health Practice Program Office.

Clark, N.M. & McLeroy, K.R. (1995). Creating capacity through health education: what we know and what we don't. Health Education Quarterly, 22, 273-289.

Collins, C. & Williams, D. (1999). Segregation and mortality: The deadly effects of racism. Sociological Forum, 14(3), 495-523.

COMMIT Research Group. (1995a). Community intervention trial for smoking cessation-I. American Journal of Public Health, 85, 183-192.

COMMIT Research Group. (1995b). Community intervention trial for smoking cessation-II: changes in adult cigarette smoking prevalence. American Journal of Public Health, 85, 193-200.

Connors, K., & Seifer, S.D. (1997). Overcoming a century of town-gown relations: Redefining relationships between communities and academic health centers. Expanding boundaries: Building civic responsibility within higher education. Washington DC: Corporation for National Service.

Cornwall, A. (1996). Towards participatory practice: participatory rural appraisal (PRA) and the participatory process. In K. deKoning and M. Martin (Eds.) Participatory research in health: Issues and experiences (pp. 94-107). London: Zed Books Ltd.

Cosier, J., & Glennie, S. (1994). Supervising the child protection process: a multidisciplinary inquiry. In P. Reason (Ed.), Participation in human inquiry (pp. 99-119). London: Sage.

Cousins, J.B. & Earl, L.M. (Eds.) (1995). Participatory evaluation: Studies in evaluation use and organizational learning. London: Falmer.

Cunningham, B. (1976). Action research: Toward a procedural model. Human Relations, 29, 215-238.

Davies, J.K. & Kelly, M.P. (Eds.) (1993). Healthy cities: Research and practice. New York: Routledge. 188 pp.

deKoning, K. & Martin, M. (1996a). Participatory research in health: Issues and experiences. London: Zed Books Ltd.

deKoning, K. & Martin, M. (1996b). Participatory research in health: Setting the context. In K. deKoning and M. Martin (Eds.) Participatory research in health: Issues and experiences (pp. 1-18). London: Zed Books Ltd.

Dockery, G. (1996). Rhetoric or reality? Participatory research in the National Health Service, UK. In K. deKoning and M. Martin (Eds.) Participatory research in health: Issues and experiences (pp. 164-176). London: Zed Books Ltd.

Dressler, W.W. (1993). Commentary on "Community research: Partnership in Black communities". American Journal of Preventive Medicine, 9(supp), 32-34.

Durie, M.H. (1994). Whaiora: Maori health development. Auckland: Oxford University.

Durie, M.H. (1996, September). Characteristics of Maori health research. Presented at Hui Whakapiripiri: A Hui to Discuss Strategic Directions for Maori Health Research, Eru Pomare Maori Health Research Centre, Wellington School of Medicine, University of Otago, Wellington, N.Z.

Elden, M. & Levin, M. (1991). Cogenerative learning. In W.F. Whyte (Ed.) Participatory action research (pp. 127-142). Newbury Park, CA: Sage.

Eng, E. & Blanchard, L. (1990-1). Action-oriented community diagnosis: A health education tool. International Quarterly of Community Health Education, 11(2), 93-110.

Eng, E. & Parker, E.A. (1994). Measuring community competence in the Mississippi Delta: The interface between program evaluation and empowerment. Health Education Quarterly, 21, 199-220.

Fals-Borda, O. & Rahman, M.A. (1991). Action and knowledge: Breaking the monopoly with participatory action research. New York: Intermediate Technology Pubs/Apex.

Farquhar, J.W., Fortmann, S.P., Flora, J.A., Taylor, C.B., Haskell, W.L., et al. (1990). Effects of community-wide education on cardiovascular disease risk factors. JAMA, 264, 359-365.

Fawcett, S.B., Paine-Andrews, A., Francisco, V.T., Schultz, J.A., Richter, K.P., et al. (1996). Empowering community health initiatives through evaluation. In D. Fetterman, S. Kaftarian and A. Wandersman (Eds.), Empowerment evaluation: Knowledge and tools of self-assessment and accountability (pp. 161-187). Thousand Oaks: Sage.

Fetterman, D.M., Kaftarian, S.J. & Wandersman, A. (Eds.) (1996). Empowerment evaluation: Knowledge and tools for self-assessment and accountability. Thousand Oaks, CA: Sage.

Fisher, Jr. E.B. (1995). The results of the COMMIT trial. American Journal of Public Health, 85, 159-160.

Flynn, B.C. (1993). Healthy cities within the American context. In J.K. Davies and M.P. Kelly (Eds.) Healthy cities: Research and practice (pp. 112-126). New York: Routledge.

Francisco, V.T., Paine, A.L. & Fawcett, S.B. (1993). A methodology for monitoring and evaluating community health coalitions. Health Education Research, 8, 403-416.

Freire, P. (1987). Education for critical consciousness. New York: Continuum.

Frenk, J. (1993). The new public health. Annual Review of Public Health, 14, 469-490.

Freudenberg, N. (1978). Shaping the future of health education: From behavior change to social change. Health Education Monographs, 6, 372-377.

Gaventa, J. (1993). The powerful, the powerless, and the experts: Knowledge struggles in an information age. In P. Park, M. Brydon-Miller, B. Hall, and T. Jackson (Eds.) Voices of change: Participatory research in the United States and Canada (pp. 21-40). Westport, Connecticut: Bergin & Garvey.

Goodman, R.M., Burdine, J.N., Meehan, E., & McLeroy, K.R. (Eds.) (1993). Community coalitions for health promotion. Health Education Research, 8, 305-453.

Gottlieb, N.H. & McLeroy, K.R. (1994). Social health. In M.P. O'Donnell and J.S. Harris (Eds.) Health promotion in the workplace (pp. 459-493). Albany, NY: Delmar, 2nd ed.

Green, L.W., George, M.A., Daniel, M., Frankish, C.J., Herbert, C.J., et al. (1995). Study of participatory research in health promotion. University of British Columbia, Vancouver: The Royal Society of Canada.

Green, L.W., Richard, L., & Potvin, L. 1996. Ecological foundations of health promotion. American Journal of Health Promotion, 10(4), 270-281.

Hall, B. (1981). Participatory research, popular knowledge and power: A personal reflection. Convergence, 14(3), 6-17.

Hall, B.L. (1992). From margins to center? The development and purpose of participatory research. American Sociologist, 23, 15-28.

Hancock, T. (1993). The Healthy City from concept to application: Implications for research. In J.K. Davies and M.P. Kelly (Eds.) Healthy cities: Research and practice (pp. 14-24). New York: Routledge.

Hatch, J., Moss, N., Saran, A., Presley-Cantrell, L. & Mallory, C. (1993). Community research: Partnership in Black communities. American Journal of Preventive Medicine, 9(supp), 27-31.

Himmelman, A.T. (1992). Communities working collaboratively for a change. Humphrey Institute of Public Affairs. University of Minnesota, Minneapolis, MN.

Israel, B.A., Schurman, S.J. & House, J.S. (1989). Action research on occupational stress: Involving workers as researchers. International Journal of Health Services, 19(1), 135-155.

Israel, B.A. & Schurman, S.J. 1990. Social support, control and the stress process. In K. Glanz, F.M. Lewis and B.K. Rimer (Eds.) Health behavior and health education: Theory, research and practice (pp. 179-205). San Francisco, CA: Jossey-Bass.

Israel, B.A, Schurman, S.J, Hugentobler, M.K, & House, J.S. (1992a). A participatory action research approach to reducing occupational stress in the United States. In V. DiMartino (Ed.) Preventing stress at work: Conditions of work digest, Vol. II (pp. 152-163). Geneva, Switzerland: International Labor Office.

Israel, B.A, Schurman, S.J. & Hugentobler, M.K. (1992b). Conducting action research: relationships between organization members and researchers. Journal of Applied Behavioral Science, 28, 74-101.

Israel, B.A, Checkoway, B., Schulz, A.J. & Zimmerman, M.A. (1994). Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational, and community control. Health Education Quarterly, 21, 149-170.

Israel, B.A, Cummings, K.M, Dignan, M.B, Heaney, C.A, Perales, D.P., et al. (1995). Evaluation of health education programs: current assessment and future directions. Health Education Quarterly, 22, 364-389.

Israel, B.A., Schulz, A.J., Parker, E.A., & Becker, A.B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. Annual Review of Public Health, 19, 173-202.

James, S.A. (1993). Racial and ethnic differences in infant mortality and low birth weight: a psychosocial critique. Annals of Epidemiology, 3, 130-136.

James, S.A. (1994). Addressing the public health needs of a diverse America. Presented at the 8<sup>th</sup> Annual Minority Health Conference, School of Public Health, University of Michigan, Ann Arbor, MI.

James, S.A., Schulz, A.J. & vanOlphen, J. (1999, March). Social capital, poverty and community health: An exploration of linkages. Paper presented at the Conference on Social Capital, Ford Foundation, New York, NY.

Kark, S.L. & Steuart, G.W. (Eds.) (1962). A practice of social medicine: A South African team's experiences in different African communities. Edinburgh: E & S Livingstone.

Kelly, M.P., Davies, J.K. & Charlton, B.G. (1993). A modern problem or a post-modern solution? In J.K. Davies and M.P. Kelly (Eds.) Healthy cities: Research and practice (pp. 159-167). New York: Routledge.

Klein, D.C. (1968). Community dynamics and mental health. New York: Wiley.

Krieger, N. (1994). Epidemiology and the web of causation: has anyone seen the spider. Social Science & Medicine, 39, 887-903.

Krieger, N., Rowley, D.L, Herman, A.A., Avery, B. & Phillips, M.T. (1993). Racism, sexism and social class: Implications for studies of health, disease and well-being. American Journal of Preventive Medicine, 9(supp), 82-122.

Labonte, R. (1994). Health promotion and empowerment: Reflections on professional practice. Health Education Quarterly, 21, 253-268.

Lalonde, M. (1974). A new perspective on the health of Canadians. Ottawa, ON: Ministry of Supply and Services.

Lather, P. (1986). Research as praxis. Harvard Educational Review, 56, 259-277.

Levine, D.M., Becker, D.M., Bone, L.R., Stillman, F.A., Tuggle, M.B. II, et al. (1992). A partnership with minority populations: a community model of effectiveness research. Ethnicity & Disease, 2, 296-305.

- Levine, D.M., Becker, D.M., Bone, L.R., Hill, M.N., Tuggle, M.B. II, et al. (1994). Community-academic health center partnerships for underserved minority populations. JAMA, 272, 309-311.
- Lewin, K. (1946). Action research and minority problems. Journal of Social Issues, 2(4), 34-46.
- Lillie-Blanton, M. & Hoffman, S.C. (1995). Conducting an assessment of health needs and resources in a racial/ethnic minority community. Health Services Research, 30, 225-236.
- Lincoln, Y.S. & Reason, P. (1996). Editor's introduction. Qualitative Inquiry, 2, 5-11.
- Maguire, P. (1987). Doing participatory research: A feminist approach. School of Education, Amherst, MA :The University of Massachusetts.
- Maguire, P. (1996). Considering more feminist participatory research: what's congruency got to do with it? Qualitative Inquiry, 2, 106-118.
- Marin, G., Burhansstipanov, L., Connell, C.M., Gielen, A.C., Helitzer-Allen, D., et al. (1995). A research agenda for health education among underserved populations. Health Education Quarterly, 22, 346-363.
- Martin, M. (1996). Issues of power in the participatory research process. In K. deKoning and M. Martin (Eds.) Participatory research in health: Issues and experiences (pp. 82-93). London: Zed Books Ltd.
- McKinlay, J.B. (1993). The promotion of health through planned sociopolitical change: Challenges for research and policy. Social Science & Medicine, 36, 109-117.
- McKnight, J.L. (1987). Regenerating community. Social Policy, 17, 54-58.
- McKnight, J.L. (1994). Politicizing health care. In P. Conrad and R. Kern (Eds.) The sociology of health and illness: Critical perspectives (pp. 437-441). New York, NY: St. Martin's. 4th ed.
- Mies, M. (1993). Feminist research: science, violence and responsibility. In M. Mies and V. Shiva (Eds.) Ecofeminism (pp. 36-54). London: Zed Books.
- Minkler, M. (1989). Health education, health promotion and the open society: An historical perspective. Health Education Quarterly, 16, 17-30.
- Minkler, M. & Wallerstein, N. (1997). Improving health through community organization and community building. In K. Glanz, F.M. Lewis, and B.K. Rimer (Eds.)

Health behavior and health education: Theory, research and practice (2<sup>nd</sup> ed.) (pp. 241-269). San Fransisco: Jossey-Bass.

Mittelmark, M.B., Hunt, M.K., Heath, G.W., & Schmid, T.L. (1993). Realistic outcomes: Lessons from community-based research and demonstration programs for the prevention of cardiovascular diseases. Journal of Public Health Policy, 14, 437-462.

National Institute of Environmental Health Sciences. (1999). RFA # ES-00-004 "Health Disparities: Linking Biological and Behavioral Mechanisms".

Network for Cancer Control Research Among American Indian and Alaska Native Populations. (1994). Cancer prevention and control research among American Indians and Alaska Natives: A strategic plan for state public health agencies. Washington, DC: National Cancer Institute.

Novotny, T.E. & Heaton, C.G. (Eds.) (1995). Research linkages between academia and public health practice. American Journal of Preventive Medicine 11(supp): 1-61.

Nyden, P.W. & Wiewel, W. (1992). Collaborative research: harnessing the tensions between researcher and practitioner. American Sociologist, 24, 43-55.

Nyswander, D.B. (1955/1982). The dynamics of planning in health education. California's Health 13(7). Reprinted in The collected works of Dorothy B Nyswander (1982) (pp. 55-63). School of Public Health, University of Hawaii, Manoa.

Park, P., Brydon-Miller, M., Hall, B. & Jackson, T. (Eds.) (1993). Voices of change : Participatory research in the United States and Canada. Westport, Connecticut: Bergin & Garvey.

Pearce, N. (1996). Traditional epidemiology, modern epidemiology and public health. American Journal of Public Health, 86, 678-683.

Peters, M. & Robinson, V. (1984). The origins and status of action research. Journal of Applied Behavioral Science, 29(2), 113-124.

Petras, E.M. & Porpora, D.V. (1993). Participatory research: Three models and an analysis. American Sociologist, 24, 107-126.

Pew Health Professions Commission. (1993). Health professions education for the future: Schools in service to the nation. San Francisco: UCSF Center for the Health Professions.

Plough, A. & Olafson, F. (1994). Implementing the Boston healthy start initiative: A case study of community empowerment and public health. Health Education Quarterly, 21, 222-234.

Putnam, R.D. (1993). Making democracy work: Civic traditions in modern Italy. Princeton: Princeton University.

Reason, P. & Rowan, J. (Eds.) (1981). Human inquiry: A sourcebook of new paradigm research. Chichester: Wiley.

Reason, P. (Ed.) (1988). Human inquiry in action: Developments in new paradigm research. London: Sage.

Reason, P. (1994a). Human inquiry as discipline and practice. In N.K. Denzin and Y.S. Lincoln (Eds.) Handbook of qualitative research (pp. 40-56). Thousand Oaks, CA: Sage.

Reason, P. (1994b). Three approaches to participative inquiry. In N.K. Denzin and Y.S. Lincoln (Eds.) Handbook of qualitative research (pp. 324-339). Thousand Oaks, CA: Sage.

Remington, R.D., Axelrod, D., Bingham, E., Boyle, J., Breslow, L. et al. (1988). The future of public health. Institute of Medicine Publication, Washington DC: National Academy Press.

Robertson, A. & Minkler, M. (1994). New health promotion movement: A critical examination. Health Education Quarterly 21, 295-312.

Sarason, S.B. (1984). The psychological sense of community: Prospects for a community psychology. San Francisco, CA: Jossey-Bass.

Schensul, J.J., Denelli-Hess, D., Borreo, M.G., Bhavati, M.P. (1987). Urban comadronas: Maternal and child health research and policy formulation in a Puerto Rican community. In D.D. Stull and J.J. Schensul (Eds.) Collaborative research and social change: Applied anthropology in action (pp. 9-32). Boulder CO: Westview.

Schulz, A.J, Israel, B.A, Selig, S.M., Bayer, I.S. & Griffin, C.B, (1998a). Development and implementation of principles for community-based research in public health. In R.H. MacNair (Ed.) Research strategies for community practice (pp. 83-110). New York: Haworth Press.

Schulz, A.J., Parker, E.A., Israel, B.A., Becker, A.B., Maciak, B. et al. (1998b). Conducting a participatory community-based survey: Collecting and interpreting data for a community health intervention on Detroit's east side. Journal of Public Health Management and Practice ,4(2),10-24.

Singer, M. (1993). Knowledge for use: Anthropology and community-centered substance abuse research. Social Science & Medicine, 37(1), 15-25.

- Singer, M. (1994). Community-centered praxis: Toward an alternative non-dominative applied anthropology. Human Organization, 53, 336-344.
- Smithies, J. & Adams, L. (1993). Walking the tightrope. In J.K. Davies and M.P. Kelly (Eds.) Healthy cities: Research and practice (pp. 55-70). New York: Routledge.
- Steckler, A.B., McLeroy, K.R., Goodman, R.M., Bird, S.T. & McCormick, L. (Eds.) (1992). Integrating qualitative and quantitative methods. Health Education Quarterly 19(1) special issue.
- Steckler, A.B., Dawson, L., Israel, B.A. & Eng, E. (1993). Community health development: An overview of the works of Guy W Steuart. Health Education Quarterly, Supp 1, S3-S20.
- Steuart, G.W. (1969). Scientist and professional: The relations between research and action. Health Education Monographs, 29, 1-10.
- Steuart, G.W. (1993). Social and cultural perspectives: community intervention and mental health. Health Education Quarterly, Supp.1, S99-S111.
- Stoecker, R. & Bonacich, E. (Eds.) (1992). Participatory research, part I. American Sociologist, 23, 3-115.
- Stoecker, R. & Bonacich, E. (Eds.) (1993). Participatory research, part II. American Sociologist 24, 3-126.
- Stokols, D. (1992). Establishing and maintaining healthy environments: toward a social ecology of health promotion. American Psychologist, 47, 6-22.
- Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. American Journal of Health Promotion, 10, 282-298.
- Stokols, D., Allen, J. & Bellingham, R.L (Eds.) (1996). Social ecology. American Journal of Health Promotion, 10(4), 244-328. Special issue.
- Stringer, E.T. 1996. Action research: A handbook for practitioners. Thousand Oaks: Sage.
- Susser, M. (1995). The tribulations of trials-intervention in communities. American Journal of Public Health, 85, 156-158.
- Susser, M. & Susser, E. (1996a). Choosing a future for epidemiology: Eras and paradigms. American Journal of Public Health, 86, 668-673.
- Susser, M. & Susser, E. (1996b). From black box to Chinese boxes and eco-epidemiology. American Journal of Public Health, 86, 674-677.

Tandon, R. (1981). Participatory evaluation and research: Main concepts and issues. In W. Fernandes and R. Tandon (Eds.) Participatory research and evaluation (pp. 15-34). New Delhi: Indian Social Institute.

Terris, M. (1987). Epidemiology and the public health movement. Journal of Public Health Policy, 7, 315-329.

Trostle, J. (1986). Anthropology and epidemiology in the twentieth century: a selective history of collaborative projects and theoretical affinities, 1920-1970. In C.R. Janes, R. Stall and S.M. Gifford (Eds.) Anthropology and epidemiology (pp. 59-94). Norwell, MA: D. Reidel.

U.S, Department of Health and Human Services. (1990) Healthy People 2000. (DHHS Publication No. PHS 91-50212). Washington, DC: Government Printing Office.

Vega, W.A. (1992). Theoretical and pragmatic implications of cultural diversity for community research. American Journal of Community Psychology, 20, 375-391.

Wall, S. (1995). Epidemiology for prevention. International Journal of Epidemiology, 24, 655-664.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: implications for health promotion programs. American Journal of Health Promotion, 6, 197-205.

Wallerstein, N.M. & Bernstein, E. (Eds.) (1994a). Community empowerment, participatory education and health-part I. Health Education Quarterly, 21, 141-268.

Wallerstein, N.M. & Bernstein, E. (Eds.) (1994b). Community empowerment, participatory education and health-part II. Health Education Quarterly, 21, 279-419.

Wallerstein, N.M. (1999). Power between evaluator and community: Research relationships within New Mexico's Healthier Communities. Social Science & Medicine, 49(1), 39-53.

Weiss, H.B. & Greene, J.C. (1992). An empowerment partnership for family support and education programs and evaluations. Family Science Review, 5, 131-149.

Whitehead, M. (1993). The ownership of research. In J.K. Davies and M.P. Kelly (Eds.) Healthy cities: Research and practice (pp. 83-89). New York: Routledge.

Whitmore, E. (1994). To tell the truth: working with oppressed groups in participatory approaches to inquiry. In P. Reason (Ed.) Participation in human inquiry (pp. 82-98). London: Sage.

Whyte, W.F. (1991). Participatory action research. Newbury Park, CA: Sage

WK Kellogg Foundation. (1992). Community-based public health initiative. Battle Creek, Michigan

Williams, D.R. & Collins, C. (1995). US socioeconomic and racial differences in health: patterns and explanations. Annual Review of Sociology, 21, 349-386.

World Health Organization. (1946). Constitution. New York: World Health Organization.

World Health Organization. (1986). Ottawa Charter for Health Promotion. Copenhagen, WHO.

Yeich, S. & Levine, R. (1992). Participatory research's contribution to a conceptualization of empowerment. Journal of Applied Social Psychology, 22, 1894-1908.

## APPENDIX 1

### **DETROIT COMMUNITY-ACADEMIC URBAN RESEARCH CENTER**

#### **Community-Based Public Health Research Principles\***

**Adopted July 24, 1996**

1. Community-based research projects need to be consistent with the overall objectives of the Detroit Community-Academic Urban Research Center (URC.) These objectives include an emphasis on the local relevance of public health problems and an examination of the social, economic, and cultural conditions that influence health status and the ways in which these affect life-style, behavior, and community decision-making.
2. The purpose of community-based research projects is to enhance our understanding of issues affecting the community and to develop, implement and evaluate, as appropriate, plans of action that will address those issues in ways that benefit the community.
3. Community-based research projects are designed in ways which enhance the capacity of the community-based participants in the process.
4. Representatives of community-based organizations, public health agencies, health care organizations, and educational institutions are involved as appropriate in all major phases of the research process, e.g., defining the problem, developing the data collection plan, gathering data, using the results, interpreting, sharing and disseminating the results, and developing, implementing and evaluating plans of action to address the issues identified by the research.
5. Community-based research is conducted in a way that strengthens collaboration among community-based organizations, public health agencies, health care organizations, and educational institutions.
6. Community-based research projects produce, interpret and disseminate the findings to community members in clear language respectful to the community and in ways which will be useful for developing plans that will benefit the community.
7. Community-based research projects are conducted according to the norms of partnership: mutual respect; recognition of the knowledge, expertise, and resource capacities of the participants in the process; and open communication.
8. Community-based research projects follow the policies set forth by the sponsoring organization regarding ownership of the data and output of the research (policies to be shared with participants in advance). Any publications resulting from the research will acknowledge the contribution of participants, who will be consulted with prior to submission of materials and, as appropriate, will be invited to collaborate as co-authors. In addition, following the rules of confidentiality of data and the procedures referred to below (Item #9), participants will jointly agree on who has access to the research data and where the data will be physically located.
9. Community-based research projects adhere to the human subjects review process standards and procedures as set forth by the sponsoring organization; for example, for the University of Michigan these procedures are found in the Report of the national commission for the Protection of Human Subjects of Biomedical and Behavioral Research, entitled "Ethical Principles and Guidelines for the Protection of Human Subjects of Research" (the "Belmont Report").

\*Adapted from Schulz, A.J, Israel, B.A, Selig, S, and Bayer, I. (1998a).

## APPENDIX 2\*

### **Challenges and Facilitating Factors in Conducting Community-Based Participatory Research**

#### PARTNERSHIP RELATED ISSUES

##### Challenges/Barriers

*Lack of trust and respect*  
*Inequitable distribution of power and control*  
*Conflicts associated with differences in perspective, priorities, assumptions, values, beliefs and language*  
*Conflicts over funding*  
*Conflicts associated with different emphases on task and process*  
*Time consuming process*  
*Who represents “community” and how is community defined*

##### Facilitating Factors

*Jointly developed operating norms*  
*Identification of common goals and objectives*  
*Democratic leadership*  
*Presence of community organizer*  
*Involvement of support staff/team*  
*Researcher role, skills and competencies*  
*Prior history of positive working relationships*  
*Identification of key community members*

#### METHODOLOGICAL ISSUES

##### Challenges/Barriers

*Questions of scientific quality of the research*  
*Proving intervention success*  
*Inability to fully specify all aspects of research up-front*  
*Seeking balance between research and action*  
*Time demands*  
*Interpreting and integrating data from multiple sources*

##### Facilitating Factors

*Methodological flexibility and different criteria for judging quality*  
*Involvement of community members in research activities*  
*Conduct community assessment/diagnosis*  
*Development of jointly agreed upon research principles*  
*Conduct educational forums and training opportunities*  
*Involve partners in the publishing process*  
*Create interdisciplinary research teams*

\*See Israel et al. 1998 for a discussion of these issues.

APPENDIX 2, continued

## BROADER SOCIAL, POLITICAL, ECONOMIC, INSTITUTIONAL AND CULTURAL ISSUES

### Challenges/Barriers

*Competing institutional demands*

*Risks associated with achieving tenure and promotion within academia*

*Expectations/demands of funding institutions*

*Political and social dynamics within the community*

*Deterrents to institutional, community and social change*

### Facilitating Factors

*Broad-based support: top down and bottom up*

*Provision of financial and other incentives*

*Actions promoting policy changes*

## APPENDIX 3

### **Detroit Community-Academic Urban Research Center**

#### **MISSION STATEMENT /OPERATING PRINCIPLES** **ADOPTED JANUARY 26, 1996**

The Detroit Community-Academic Urban Research Center (URC) seeks to establish an effective partnership among the Detroit Health Department, Community-Based Organizations (Friends of Parkside, Warren/Conner Development Coalition, Butzel Family Center, Kettering/Butzel Health Initiative, Community Health And Social Services (CHASS), Latino Family Services, and future CBOs as appropriate), Henry Ford Health System, Centers for Disease Control and Prevention (CDC), and the University of Michigan School of Public Health to jointly identify problems affecting the health of residents on the east and southwest sides of the city and to implement and evaluate solutions to these health problems which recognize, build upon, and enhance the resources and strengths in the communities involved. All activities of the URC will be in the interest of improving the health and well-being of community residents through an approach that emphasizes the prevention of health problems. While the initial emphasis will focus on child and family health issues, it is understood that the URC aims to address overall health issues of residents in these communities.

In order to realize these operating principles, we will uphold the following values:

- equal participation by all partners in all aspects of the Center's activities;
- recognition that all partners have expertise that they bring to the URC;
- recognition that community-based prevention research is a collaborative process that is mutually beneficial to all partners involved; and
- recognition that health is more than the absence of disease -- and that to ensure good health we must address the individual, political, economic, and environmental risk factors in the community.

## APPENDIX 4

### **Resources for Community-Based Participatory Research**

Center for the Advancement of Community-Based Public Health (CACBPH)  
5102 Chapel Hill Blvd.  
Durham, NC 27707-3311  
(919) 403-2124  
email: center@cbph.org

The Center for Community Partnerships  
Office of the President  
University of Pennsylvania  
Mellon Bank Building, Fifth Floor  
133 South 36<sup>th</sup> St.  
Philadelphia, PA 19104  
(215) 898-5351

Center of Excellence for Sustainable Development  
<http://www.sustainable.doe.gov>

Center for Policy Alternatives  
<http://www.cfpa.org>

Center for Research on Women  
The University of Memphis  
339 Clement Hall  
Memphis, TN 33152  
(901) 678-2770  
<http://www/cas.memphis.edu>

College of Public and Community Service  
University of Massachusetts Boston  
100 Morrissey Blvd.  
P.O. Box 413  
Boston, MA 02125  
(617) 287-7262  
<http://www.umb.edu>

Comm-org: Online Conference of Community Organizing and Development  
University of Toledo  
<http://comm-org.utoledo.edu/>

APPENDIX 4, continued

Community-Campus Partnerships for Health  
3333 California Street, Suite 410  
San Francisco, CA 94118  
(415) 476-7081  
<http://futurehealth.ucsf.edu/ccph.html>

Community Health Resource and Development Center  
<http://www.chrhc.org>

Community Health Scholars Program  
<http://www.sph.umich.edu/chsp/>

Community Partnership Center  
University of Tennessee  
410 Aconda Court  
Knoxville, TN 37996-0645  
cpc@utk.edu  
<http://www.ra.utk.edu/cpc/>

Community Scholars Program  
Department of Urban Planning  
School of Public Policy and Social Research  
University of California at Los Angeles  
Los Angeles, CA 90024  
(310) 206-7150  
[www.spssr.ucla.edu/dup](http://www.spssr.ucla.edu/dup) (look under "academic programs")

Community Toolbox  
University of Kansas  
<http://ctb.lsi.ukans.edu/>

Cornell University Participatory Research Network  
214 Warren Hall  
Ithaca, NY 14853  
(607) 255-1967  
<http://munex.ame.cornell.edu/-parnet/home.htm>

APPENDIX 4, continued

Detroit Community-Academic Urban Research Center  
University of Michigan School of Public Health  
Department of Health Behavior/Health Education  
1420 Washington Heights  
Ann Arbor, MI 48109-2029  
(734) 764-5171  
<http://www.sph.umich.edu/urc>

East St. Louis Action Research Project  
Department of Urban and Regional Planning  
University of Illinois at Urbana-Champaign  
611 E. Taft Dr.  
Champaign, IL 61820  
(217) 244-5384  
<http://imlab9.landarch.uiuc.edu/~eslarp>

Environmental Justice Resource Center  
Clark Atlanta University  
James P. Brawley Dr. at Fair St., SW  
Atlanta, GA 30314  
(404) 880-6911  
[www.cau.edu](http://www.cau.edu)

Great Cities Initiative  
University of Illinois at Chicago  
601 South Morgan  
Chicago, IL 60607  
(312) 413-3375  
<http://www.uic.edu/cuppa/greatcities/>

Institute for Development Studies  
University of Sussex  
Brighton, BN19RE  
England, UK  
(44) 1273-606261  
<http://www.ids.ac.uk/eldis/pr/pr.htm>

Loka Institute and the Community Research Network (CRN) Project  
email: [Loka@amherst.edu](mailto:Loka@amherst.edu)  
<http://www.loak.org/>  
<http://www.loka.org/crn/index.htm>

APPENDIX 4, continued

National Association for Community Leadership  
<http://www.communityleadership.org>

National Civics League  
Alliance for National Renewal  
<http://www.ncl.org>

National Coalition of Hispanic Health and Human Services Organizations  
<http://www.cossmho.org>

National Community Building Network  
<http://www.ncbn.org>

National Council of La Raza  
1111 19<sup>th</sup> Street, NW, Suite 1000  
Washington, DC 20036  
(202) 785-1670

New York Urban Research Center  
Center of Urban Epidemiologic Studies  
New York Academy of Medicine  
1216 Fifth Avenue  
New York, NY 10029-5293  
(212) 822-7382

The Policy Research Action Group  
Center for Urban Research and Learning  
Loyola University of Chicago  
Department of Sociology  
6525 N. Sheridan Rd.  
Chicago, IL 60626  
(312) 508-3650  
<http://www.luc.edu/depts/prag>  
<http://www.luc.edu/depts/curl>

Seattle Partners for Healthy Communities  
Seattle-King County Department of Public Health  
999 3<sup>rd</sup> Avenue, 12<sup>th</sup> Floor  
Seattle, WA 98104  
(206) 296-6817

APPENDIX 4, continued

Sustainable Urban Neighborhoods  
University of Louisville  
<http://www.louisville.edu/org/sun/>

Urban Institute  
Public Affairs  
The Urban Institute  
2100 M. Street, NW  
Washington, DC 20037  
(202) 261-5709  
[paffairs@ui.urban.org](mailto:paffairs@ui.urban.org)  
<http://www.urban.org>

Women's Research Centre  
#103-1718 Commercial Drive  
Vancouver, B.C. V5N 4A3  
Canada  
(606) 734-0485  
<http://www.wrc.bc.ca>  
email: [info@wrc.bc.ca](mailto:info@wrc.bc.ca)

COMMUNITY-BASED PARTICIPATORY RESEARCH:  
ENGAGING COMMUNITIES AS PARTNERS IN HEALTH RESEARCH

Paper prepared for the Community-Campus Partnerships for Health's 4<sup>th</sup> Annual Conference, "From Community-Campus Partnerships to Capitol Hill", April 29-May 2, 2000, Washington, D.C.

*Barbara A. Israel, Dr. P.H.*  
Health Behavior and Health Education  
University of Michigan School of Public Health  
1420 Washington Heights  
Ann Arbor, MI 48109-2029  
samanj@umich.edu

*Amy J. Schulz, Ph.D.*  
Health Behavior and Health Education  
University of Michigan School of Public Health  
1420 Washington Heights  
Ann Arbor, MI 48109-2029  
ajschulz@umich.edu

*Edith A. Parker, Dr. P.H.*  
Health Behavior and Health Education  
University of Michigan School of Public Health  
1420 Washington Heights  
Ann Arbor, MI 48109-2029  
edithp@umich.edu

*Adam B. Becker, Ph.D.*  
School of Public Health and Tropical Medicine  
Tulane University Medical Center  
1440 Canal Street  
New Orleans, LA 70112  
abecker@mailhost.tcs.tulane.edu

We greatly appreciate the contributions of our partners from numerous projects who have helped develop our understanding of community-based participatory research. We are particularly indebted to our partners in the Detroit Community-Academic Urban Research Center, representatives from community-based organizations, academic, public health, and health care organizations who continue to teach us how to "walk the talk". (See Appendix 1 for jointly developed Principles of Community-Based Research.) We thank Sue Andersen for her assistance in preparing the manuscript.