Realizing the Promise of Community-Based Participatory Research: Community Partners Get Organized!

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Community-Campus Partnerships for Health

In their provocative pair of articles,[1,2] the West End Revitalization Association (WERA) and their academic partners articulate a model of community-owned and managed research (COMR) model that is in stark contrast to the university-owned and managed research (UOMR) model that characterizes most research, including most of what is referred to as community-based participatory research (CBPR). As COMR demonstrates, intellectual spaces exist outside of higher educational and research institutions. Communities can be hubs for discovering new knowledge, generating and testing theories, translating research into action and sharing innovations. If building community capacity, creating and mobilizing knowledge, and achieving social justice are the penultimate goals of CBPR, achieving them may only be possible when communities are at the center of learning, discovery and engagement.

Many of the authors' criticisms of the UOMR model and the remedies they put in place are reflected in the recommendations and ongoing work of community leaders from across the United States we convened in April 2006 for a Community Partner Summit to advance authentic community-higher education partnerships.[3] Summit participants – a diverse group with years of experience in service-learning, CBPR and community/economic development partnerships with universities – concluded that while combining the knowledge, wisdom and experience in communities and in academe is key to solving the major health, social and economic challenges facing our society, the predominant model of "community-higher education partnership" is not an authentic partnership and community capacity building and social justice are rarely explicit goals. They urged their peers to share their stories of "what's working" and "what's not working" in these partnerships, serving as role models by authoring case stories of their own experiences.[4] Since the Summit, work groups are advancing significant capacity building for community partners in two priority areas: peer mentoring and policy change.

The authors contend that CBPR in practice often does not go far enough and we agree. WERA was fortunate in having ingredients for successful CBPR that are often not present simultaneously: a compelling community need, a high degree of organizational capacity, willing academic partners with relevant expertise, and funding that mandates community control. To fully realize the potential of CBPR as illustrated by the COMR model, we must overcome deeply entrenched views and policies that serve to maintain university control of the research enterprise, and we must build the research capacity of community-based organizations (CBOs).

We applaud the Environmental Protection Agency and other funders that award research and research capacity-building grants to CBOs, but they are the exception and not the rule. The Examining Community-Institutional Partnerships for Prevention Research Group found that funding priorities, grant mechanisms and review processes often undermine the potential for authentic CBPR.[5] The National Institutes of Health (NIH) in particular, with its investment of $22.4 billion annually in competitive research grants, is a major driver of research priorities and practices. Although NIH does fund CBPR, its investment is quite small and is overwhelmingly of the university owned and managed variety. For example, a CRISP (federal research grant) database search using the term CBPR yields 84 "hits" for the period 2000-2006. By comparison, a similar search using the term RCT (for randomized clinical trial) yields 716 "hits."

Recognizing the central role that funding can play in how CBPR is carried out, a Summit policy work group is working to ensure that community partners participate in decision making about federal funding for CBPR and access funding as principal investigators. One work group member has been appointed to the Council of Public Representatives that advises the Director of NIH and a listserv has been established to quickly disseminate announcements of similar opportunities to serve in advisory roles to federal funding agencies.[6] Most recently, the work group submitted comments in response to two NIH requests for public input on its strategic priorities and peer review processes.[7,8] We highlight here their suggestions for how NIH could better support CBPR because we believe these reforms are essential to widespread implementation of CBPR as it should be practiced.

Build the capacity of CBOs to conduct research and to engage as equal partners in research with academic institutions. NIH supports academic institutions to conduct research, but almost no investment is made in the infrastructure needed in communities to conduct and be partners in research.[9] Funding is needed for mentoring programs that enable CBOs with CBPR expertise to guide less experienced peers and training programs that equip individuals from CBOs with knowledge and skills to become CBPR researchers in community settings (analogous to programs that prepare CBPR researchers in academic settings).[10,11]

Facilitate the ability of CBOs to be principal investigators (PIs) and directly funded organizations. Very few NIH grants support individuals without doctoral or medical degrees as PIs. It is not enough to point to eligibility criteria on paper that indicate that community and faith-based organizations can apply. The reality is that few apply and even fewer are funded. Mechanisms and metrics are needed to document and assess relevant life and work experiences of individuals who have PhDs "from the street." [12] Regulations proposed by NIH to allow multiple PIs on research grants and multiple awards from a single application would contribute to greater accountability and equity among community and academic partners.[13]

Align the array and duration of grant mechanisms with CBPR. Just as having funding for requisite lab space and supplies is crucial to successful basic science research, funding is needed to support the relationship-building and partnership infrastructure that is essential to successful CBPR. For CBPR grants, the usual funding period of 2-5 years is insufficient to develop the authentic partnership that comprises the foundation for CBPR *and* conduct the research. New funding mechanisms established by the NIH National Center for Minority Health and Health Disparities (NCMHD) are good models to follow, with 3-year planning grants,[14] followed by 5-year implementation grants,[15] followed by planned 3-year dissemination grants.

Ensure fair and equitable peer review of CBPR. In CBPR, "peer" needs to be re-defined to include partners engaged in research who have CBPR expertise but who may not have academic degrees or peer-reviewed publications. It is crucial that CBPR applications, including those submitted in response to funding announcements that explicitly include significant community engagement components but may not use the term CBPR, be reviewed by community-based peer reviewers with expertise in CBPR. Well ahead of in-person review meetings, all reviewers should be provided guidance and training in CBPR, the NIH peer review process and any special review criteria. The few NIH review panels that include community-based reviewers are still dominated by academics and a culture that may prevent community members from speaking freely. It is time to form a standing study section to review CBPR applications, comprised of an equal number of academics and community members with CBPR experience and facilitated by community and academic co-chairs.

Use review criteria and scoring procedures that are appropriate for CBPR. Standard NIH review criteria overlook key aspects of CBPR.[16] Reviewers are asked to assess the "scientific and technical merit" of the proposed research, but in CBPR these must include the nature and extent of community participation and the authenticity of the partnership. Indicators could include the presence of a community PI or co-PI, a history of partnership activities and outcomes that are meaningful to all partners, and community-responsive research methods such as delayed intervention control groups.[17] Reviewers are also asked to assess "the reasonableness of the proposed budget," but this assessment is not included in the scoring as it should be. In CBPR, for example, one would expect to see funds flowing to research partners in relation to their roles and responsibilities, as well as for community capacity building. The review criteria and guidelines recommended by the Agency for Healthcare Research and Quality evidence report on CBPR[18] and used by the NCMHD[14] are good places to start.

Develop an aggressive and robust outreach and engagement program to ensure that CBOs provide input on NIH policy and

strategic directions, access NIH funding and serve as peer reviewers. Unless one is deeply entrenched in the NIH process, NIH is difficult to navigate and understand. As one Summit participant noted, "the walls around it [NIH] are almost impenetrable to community people."[19] NIH needs a clear and succinct communications strategy that will reach CBOs. This will require partnerships with organizations that represent and serve CBOs, including those we refer to here.

Report annually on the outcomes of these efforts. NIH should expand its existing reporting to report annually on the number and percentage of community-based peer reviewers, the number and dollar amount of applications and awards that incorporate a CBPR approach, and the number and dollar amount of applications and awards that include CBOs as fiscal agents, PIs and co-PIs.[20]

The papers by Heaney and Wilson in this issue clearly demonstrate that when CBO capacity and funding streams are aligned, CBPR can begin to realize its full potential. To move from this "promising practice" to "usual and expected practice," community partners must join together as advocates for change. Fortunately, a number of groups representing community partners are doing exactly that. In addition to the Community Partner Summit policy work group, a mentoring work group facilitates the ability of community partners to mentor and support each other in their community-higher education partnership work (e.g., by leading workshops and coaching CBOs to define the conditions under which they will and will not enter into research partnerships with universities). [21,22] The National Community-Based Organization Network affiliated with the Community-Based Public Health Caucus of the American Public Health Association provides opportunities for CBOs to provide and receive mentoring aimed at capacity-building strategies.[23] The National Community Committee affiliated with the CDC funded Prevention Research Centers (PRCs) provides a safe space for nurturing and growth specifically designed for those communities working within the PRC program.[24] We invite CBOs to join us in this growing movement by getting involved in one or more of these national groups. Together, we can move from rhetoric to reality in the conduct of CBPR and the outcomes it achieves.

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