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

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PREFACE

From Community-Campus Partnerships to Capitol Hill: A Policy Agenda for Health in the 21st Century April 29-May 2, 2000 ~ Washington, DC

Creating healthier communities and overcoming complex societal problems require collaborative solutions that bring communities and institutions together as equal partners and build upon the assets, strengths and capacities of each. Community-campus partnerships involve communities and higher educational institutions as partners, and may address such areas as health professions education (i.e. service-learning), health care delivery, research, community service, community-wide health improvement, and community/economic development. Founded in 1996, Community-Campus Partnerships for Health is a non-profit organization that fosters community-campus partnerships as a strategy for improving health professions education, civic responsibility and the overall health of communities. In just four years, we have grown to a network of over 700 communities and campuses that are collaborating to achieve these goals.

Community-Campus Partnerships for Health's 4th annual conference was designed to broaden and deepen participants' understanding of the policies, processes and structures that affect community-campus partnerships, civic responsibility, and the overall health of communities. The conference also aimed to enhance participants' ability to advance these policies, processes and structures.

This paper – one of nine commissioned for discussion at the conference – played an integral role in the conference design and outcomes and would not have been possible without the generous support of the Corporation for National Service and the WK Kellogg Foundation. On the conference registration form, participants chose a track that interested them the most in terms of contributing to the development of recommendations and possibly continuing to work on them after the conference. Participants were then sent a copy of the commissioned paper corresponding to their chosen track, to review prior to the conference. At the conference, participants were assigned to a policy action team (PAT). Led by the authors of that track's commissioned paper, each PAT met twice during the conference to formulate key findings and recommendations. These key findings and recommendations were presented at the conference's closing session and are reflected in the conference proceedings (a separate publication). These will be considered by CCPH's board of directors as part of its strategic planning and policy development process, and are expected to shape CCPH policies and programs in the coming years.

The complete set of nine commissioned papers is available on CCPH's website at http://futurehealth.ucsf.edu/ccph.html

1. Integrating student learning objectives with community service objectives through service-learning in health professions schools curricula – Kate Cauley
2. Working with our communities: moving from service to scholarship in the health professions – Cheryl Maurana, Marie Wolff, Barbra J. Beck and Deborah E. Simpson
3. Promoting collaborations that improve health – Roz Lasker
4. Public policies to promote community-based and interdisciplinary health professions education – Janet Coffman and Tim Henderson
5. Building communities: stronger communities and stronger universities – Loomis Mayfield
6. Community-based participatory research: engaging communities as partners in health research – Barbara Israel, Amy J. Schulz, Edith A. Parker, and Adam B. Becker
7. Racial and ethnic disparities in health status: framing an agenda for public health and community mobilization – Gerard Fergerson
8. Social change through student leadership and activism – David Grande and Sindhu Srinivas
9. Advocating for community-campus partnerships for health – Charles G. Huntington

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[1]

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 that stresses individual rather than social or environmental risk factors. Concurrent with this trend toward individual level analysis has been an increasing gap between the public and public health "experts" - researchers and practitioners (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

[1] This section has been adapted from an article by Israel, Schulz, Parker and Becker, 1998.

community involvement in processes that shape research and intervention approaches, e.g., through partnerships between academic, health 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 Healton 1995) is one means towards these ends. Such partnerships may also increase sensitivity to and competence in working with 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.[2]

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 & Healton 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

[2] 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).

1991; Whyte 1991) “action research” (Brown & Tandon 1983; Cunningham 1976; Israel et al. 1989; Lewin 1946; Peters & Robinson 1984; Stringer 1996), “action science/inquiry” (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 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 use of CBPR, especially the engagement of communities as equal partners in the process.

COMMUNITY- BASED PARTICIPATORY RESEARCH: OVERVIEW[3]

[3] This section has been adapted from Israel et al. 1998.

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 term "community-based research” is also commonly used to refer to research conducted in a community as a place or setting, but with limited involvement of community members. The use of “community-based participatory research” represents a critical distinction, emphasizing 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).

KEY PRINCIPLES OF COMMUNITY-BASED PARTICIPATORY RESEARCH[4]

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).[5] While presented here as distinct items, community-based participatory research is an integration of these elements.[6]

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

[4] This section has been adapted from Israel et al. 1998.
[5] 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.
[6] 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 partnership is composed of representatives from the University of Michigan School of Public Health, six community-based organizations (Butzel Family Center, Community Health and Social Services Center, Friends of Parkside, Kettering Butzel Health Initiative, Latino Family Services, Warren/Conner Development Coalition), the Detroit Health Department, and the Henry Ford Health System, 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.

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 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 collective identification through 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 shared health concerns (McKnight 1987; 1994; Minkler 1989; Steuart 1993). These may include individual skills and assets (McKnight 1994) - sometimes called human capital (Coleman 1988); networks of relationships characterized by trust, cooperation and mutual commitment (Israel & Schurman 1990) - sometimes called social capital (James et al. 1999; Lin et al. 1999; Putnam 1993); and mediating structures within the community such as churches and other organizations where community members come together (Berger & Neuhaus 1977). 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, and to build on the resources available to community members within those social structures.

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 the immediate community of identity. Thus, CBPR efforts often involve individuals and groups who are not members of the community of identity, including 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 work to 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, or academia. However, the focus of the partnership is driven by 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 such coalitions, the diverse perspectives of different communities of identity are usually not emphasized, and the 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 advantages of and the rationales for community-based participatory research as discussed in the literature are presented in Table 1.

Table 1[7]
Summary of Rationale/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

[7] Adapted from Israel et al. 1998.

POLICY RECOMMENDATIONS FOR INCREASING COMMUNITY-BASED PARTICIPATORY RESEARCH

A number of challenges, barriers and facilitating factors have been identified in conducting community-based participatory research (Israel et al. 1998). While it is beyond the scope of this paper to address these issues in depth, they are listed as discussed by Israel and colleagues (1998) in Appendix 2. The focus in the following paragraphs is on policy recommendations that might be considered toward the goal of increasing the use of CBPR (with specific emphasis on enhancing the engagement of community partners in this process). 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), and subsequent discussions of this article at the Campus-Community Partnerships for Health's annual conference, the following 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 offer suggestions for policies 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 processes.

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 trustworthy 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, following the initial planning year with up to five years of funding for particular CBPR projects. While it is certainly appropriate

that there be no guarantee that a recipient of a planning grant 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 planning grant initiatives is that they funded twice as many planning grants than there were funds available for actual CBPR projects. As a result some partnerships were established, but were unable to sustain themselves when subsequent funding was not received. The trust developed between partners involved in the planning process 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 flexibility and trust on the part of funders and reviewers given that such projects could not fully specify up front all aspects of the community-based research endeavor. Rather, they could do so only after all partners had been supported 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). Furthermore, funders need to recognize that the burden for change can not be limited to residents of marginalized communities (community-level interventions), but that those initiatives need to include specific links to broader policy change efforts.

Initial and ongoing funding for infrastructure. Related to the above is the need for initial and continued funding to support the infrastructure necessary for develop and maintain CBPR partnerships. Most funding opportunities are for project-specific funds that often place greater emphasis on the particular research and/or intervention. Resources are necessary, in addition, 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 the organizational time and commitment that community partner organizations contribute to the infrastructure of the CBPR partnership. Such funds go to the partner organizations rather than to particular individuals. It is extremely difficult to obtain ongoing funds for the infrastructure itself: that is, funds that are 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 agencies need to include resources in grants to support the establishment and maintenance of such infrastructures. In addition, academic partners need to work with their development offices to raise funds specifically for creating partnership-related infrastructure. Academic institutions are in a good position to seek such funds, and in doing so they increase their credibility within the community, and enhance the potential to successfully compete for other funds.

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 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 CBOs to account for their capabilities. 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").

With community-based organizations as the direct recipient and fiduciary of CBPR grant awards, it is important to recognize that they usually have a considerably lower indirect cost rate negotiated with funding agencies than do academic institutions. The latter need to work with CBOS, upon request, in establishing their indirect cost rate, as well as the use of direct funds to cover indirect-related expenses (e.g., rent, secretarial support).

It is not always possible or appropriate that CBOs be the fiduciary of CBPR grants. There are other mechanisms through which CBOs can receive funding. For example, universities or health agency partners that are the fiduciary of a particular grant can establish procedures for subcontracting with CBOs for services provided. Such subcontracts need to be administered in ways that ensure accountability but minimize bureaucratic processes, and a mutually agreed upon indirect cost rate needs to be part of the subcontract.

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), the conditions necessary for developing and maintaining successful partnerships are not yet well understood. 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 provide useful information 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, involve individual behavior change interventions (if at all), emphasize morbidity, mortality, and risk factors as outcomes, use 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. Appropriate research methods often include non-randomized, non-control group designs, and use 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.

Given the types and level of resources needed to conduct such comprehensive CBPR efforts (e.g., including research and intervention components), it may be beyond the scope of some funding agencies to support such projects. There is a need for funding agencies, both public and private, to collaborate in developing and implementing co-sponsored grant initiatives. Several funding institutions have taken such an approach (e.g., National Institute of Environmental Health Sciences and the Environmental Protection Agency's

"Center for Children's Environmental Health and Disease Prevention Research" initiative).

Grant application and review process. In addition to changes in the type of research funded and the funding recipients, CBPR can be encouraged through changes in the grant application and review processes. 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 could include, for example: allowing for the role of community partners in the definition of "Key Personnel"; the description of the "Research Plan" to incorporate a broader range of material; and the modification of language to be more accessible to community partners. Technical assistance and pre-application consultation needs to be readily available to assist 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, Green and his colleagues (1995) have developed guidelines for participatory research in health promotion intended to be used to assess the extent to which proposed projects meet participatory research criteria. Furthermore, 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. It is essential that the necessary steps be taken to ensure that the input of the community participants in the review process be heard and incorporated into the final decision-making processes. 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.

Given that the inclusion of community members in the review process and the review criteria for CBPR projects incorporate fairly new approaches, there is a need for all members of a peer review panel to develop a common understanding of the review process and their roles prior to the receipt of grant applications. Ideally, this would be accomplished through a meeting held before the grant review, but due to the costs associated with such a meeting, a series of conference calls could serve to establish the necessary operating procedures.

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 and continuing education; 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 and continuing education. 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 and continuing education courses 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 partners involved in CBPR projects. Doctoral training is particularly important in that it is often easier for researchers to learn this approach initially rather than having to "unlearn" another perspective. In addition to the regular doctoral and post-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. In addition to doctoral and post-doctoral training, there is a need for seminars, conferences and continuing education courses for academicians and practitioners interested in gaining the competencies to conduct CBPR.

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. Universities also need to consider making existing courses available to community partners, upon request, in non-degree-granting programs, with recognition provided for successful completion of the courses.

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 by 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, include partnership responsibilities as part of one's job description, 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 has been 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 with 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 imposing 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, state and federal 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.

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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 36th 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.chrdc.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 (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.arme.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

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/pra/pra.htm

Loka Institute and the Community Research Network (CRN) Project
email: Loka@amherst.edu
http://www.loka.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 19th 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 3rd Avenue, 12th Floor
Seattle, WA 98104
(206) 296-6817
http://www.seattlepartners.org

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
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

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