

# Community Based Participatory Research (CBPR)

*Relevance and Need*

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# Purpose of the presentation

- To introduce the concept of Community Based Participatory Research (CBPR) and why it is relevant and necessary for achievements of global (and local) health goals
- To arrive at a rationale for choosing CBPR over or in conjunction with other research methods
- To consider the array of methods within CBPR that can be used to engage the community in a sustainable way

# Part 1: What is CBPR?



# What is CBPR?

- An approach or orientation to conducting research, not a method...provides a structure and mechanism for collaborative and rigorous research...with a community focus (*Horowitz 2009*)
- A collaborative process between community-based organizations and academic investigators (*Weiner 2013*)
- An orientation to research that emphasizes ‘equitable’ engagement of partners throughout the research process, from problem definition through data collection and analysis to dissemination and use of findings to help effect change. (*Cacari-Stone 2014*)
- ...Etiologic and intervention research that incorporates community cultural values and ways of knowing...critical for improving quality of life and reducing health disparities (*Lucero 2018*)



# Antecedents to CBPR

- **CBPR** emerged in the 1980s and 1990s to engage those most affected by a problem
- **Activist Participatory Research:** the idea that local people can and should conduct their own appraisal and analysis (*Freire 1968*)
- **Rapid Rural Appraisal\*** (late 1970s): response to the “biased perceptions derived from rural development tourism (the brief rural visit by the urban-based professional) and the many defects and high costs of large-scale questionnaire surveys”. (*Chambers 1994*).
- **Participatory Rural Appraisal\*\*\*** (1990) growing family of approaches and methods to enable local (rural or urban) people express, enhance, share and analyze their knowledge of life and conditions in order to plan and to act (*Chambers 1994*)



# Associated disciplines

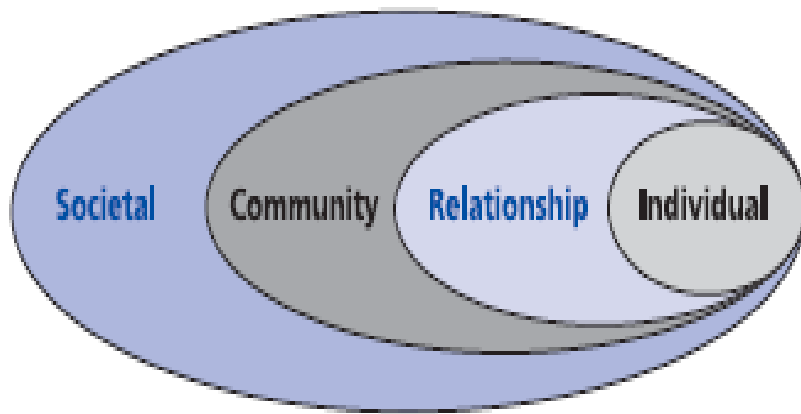
- **Action Research:** “...a comparative research on the conditions and effects of various forms of social action and research leading to social action;” uses “a spiral of steps, each of which is composed of a circle of planning, action, and fact-finding about the result of the action (*Lewin 1946*)
- **Qualitative Research:** primarily exploratory research; used to gain an understanding of underlying reasons, opinions and motivations. Includes ethnography, participant observation\*
- **Grounded Theory:** theories evolve from data and are modified according to findings (*Glaser 2009*)\*

# The ecological model

## as the product of multiple levels of influence on behavior

FIGURE 1.3

Ecological model for understanding violence



Source: WHO – WRVH;  
from Bronfenbrenner,  
U.

- **Individual level:** what each person brings with him or her (e.g., attitudes, values, beliefs, skills, abilities, but also, biological and personal factors, ethnicity, personality disorders, substance abuse)
- **Relationship:** proximal social relationships with peers, intimate partners and family members with potential to shape behavior (bidirectionally)
- **Community:** context in which social relationships are embedded (e.g., schools, workplaces, neighborhoods, social networks, employment, law enforcement, justice)
- **Societal:** factors that create cultural norms, customary laws, cultural attitudes toward gender, policies (health, education, equity/inequity)



# How is CBPR different?

- Focus in CBPR is on key elements of relevance to health of minority communities:
  - Establishment of Trust
  - Correction of Power imbalances (e.g., listening vs telling)
  - Capacity development in research process
  - Ability to turn knowledge into action, theory into practice
  - Engagement in the reality of the community; goes to where the community lives and builds on that
  - Reduction in investigator bias
  - Is more ‘inductive’ (i.e., hypothesis generating) than ‘deductive’ (i.e., hypothesis testing)



# Why are these differences of importance to Public Health practitioners?

- Tremendous breakthroughs from outstanding basic science and clinical investigations in research and clinical programs.
- Effective therapies developed and tested through research and disseminated through ever-improving quality of care; significantly improved life expectancy and quality of life of all socio economic backgrounds, races, ethnicities, genders
- Yet health disparities persist (and are widening in various countries), even in cases where populations have equal access to care.
- Global Public Health focuses on the need to prevent and control complex conditions by addressing non-clinical issues that impact on causality.

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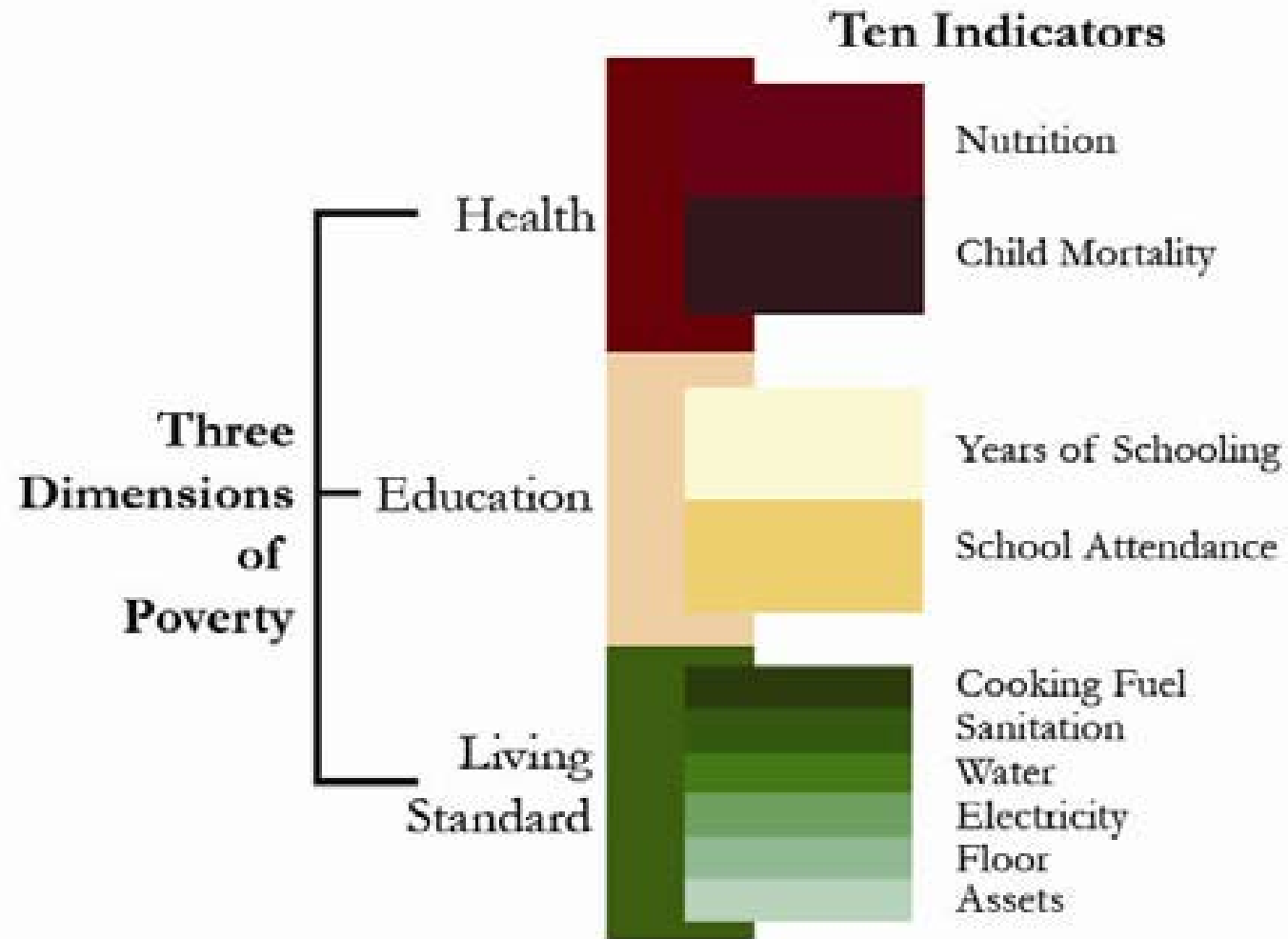
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# Social determinants of health

- The social, economic, political and environmental conditions responsible for a great share of health.
- Uncovering these in communities with persistent and increasing disparities requires greater insights to community beliefs, politics, and environments that an external investigator may be prevented from seeing due to distrust\* arising from historical forces: hegemony, colonization, and other power imbalances.
- Traditional scientific inquiry believed that objectivity could only be maintained by a distance between researchers and their research subjects.
- CBPR puts researchers on a path to partner with inside 'experts': members of communities who live with the problems being studied.

# Multidimensional Poverty





# Positive attributes of CBPR

- Offers **flexibility**, particularly as an inductive form of research, i.e., theories evolve from data and are modified according to findings (*Glaser 2009*). Seeks and pursues ‘deviant’ cases as triggers to modify theory.
- Is a **constructivist** paradigm, i.e., reductionist thinking does not always appropriately consider the potential for ever-changing multiple and socially-constructed realities; tribal groups apply indigenous values, practices and knowledge to address health issues.
- Offers **triangulation** particularly when linked to multiple qualitative methods, and quantitative data as well.
- Is a **reflexive** methodology as the intermediate step in *Observation, Reflection, Action*



# Troublesome attributes of CBPR

- Takes time to develop a trusting partnership
- Is dependent on funding for sustainability since knowledge gained from CBPR is turned into actions that require funding to be continued; (without follow-up and implementation, trust may be lost)
- Is interdisciplinary requiring many partners from different areas of expertise and knowledge in both academic center and rural communities
- Exists in a competitive environment (academically) and may be resisted by other colleagues in same or different departments

# Examples of Need

- The cases to be reviewed expose the limitations of only quantification of a problem:
  - National surveys influenced by the improved situation of an ethnic or economic majority may show significant improvement in all nutrition and economic indicators
  - Even countries that achieved a majority of MDGs saw an increase in the inequity gap and the relevance of measuring other indicators as a part of multidimensional poverty

# Types of inequity and the need for mixed methods of research

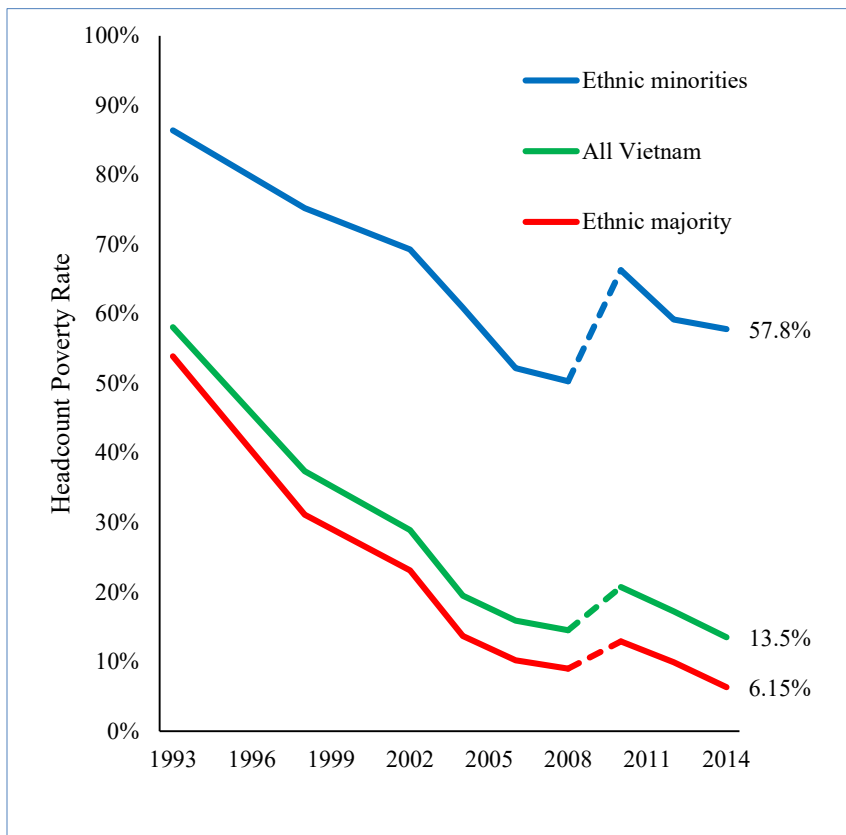
- Difference between:
  - **Vertical Inequity** measured through quantifiable means and directed at sampled households
    - i.e., Individual households are sampled that, because of low percentage of population, are widely scattered
  - **Horizontal inequity** measured through qualitative means directed at clusters of households with similar circumstances in context.
    - A country with an extensive health sector that covers the majority of the population may not be able to benefit entire groups of culturally or socially linked minorities with a similar reduction in stunting as the main indicator of improved nutrition.



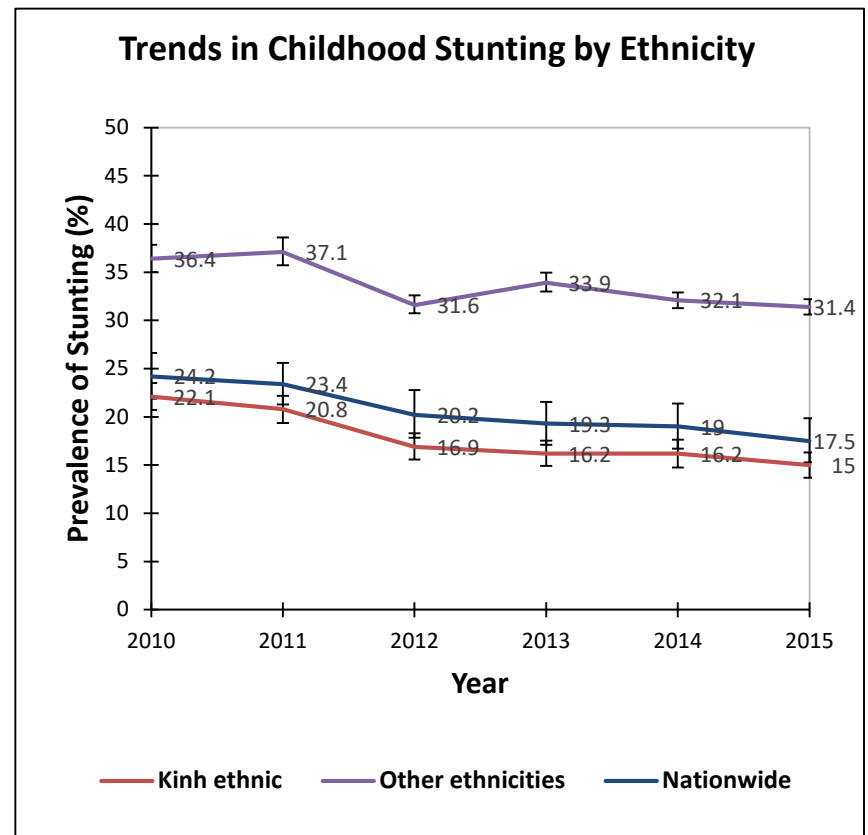
# Part 2: Case Studies

# Case study 1: Nutrition in Vietnam

## Vietnam: Poverty head count



## Vietnam: Trends in stunting



# Case Study 1: Nutrition in Vietnam

- Between 1993-1998: a 15% decrease in chronic malnutrition accompanied a period of rapid GDP growth that averaged 8.4% per year.
- Despite the assumption that the improvement in stunting was the result of strong economic conditions, analyses of the data did not identify a clear causality and only 3.5% could be explained by economic growth.
- The robust economy reduced national monetary poverty but increased inequality



# Case Study 2: Community Based PHC in Lao PDR

- Economy has grown significantly by 6-8% per annum over the past decade.
- Because of persistent inequalities among some of its 49 different ethnic groups, families were relocated from remote areas to bring them closer to the mainstream of Lao service delivery with better access to housing, health and education.

# Case Study 2: Community Based PHC in Lao PDR

- These relocations were sometimes voluntary, and at other times not. In both cases the new locales were not always compatible with the previous semi-nomadic existence with shifting agriculture and close dependency on forest products.



# Case Study 2: Community Based PHC in Lao PDR

- Ethnic groups in these villages have not participated in government programs despite free education, free health care, and subsidized (sometimes free) housing
- There is a persistent gap in health indicators



## Case Study 3: Alcohol and drug abuse

| Community Health Issue   | Surveys  | Discussion Groups   | Community health status indicators  |
|--|--|---|---|
| <p><b>Alcohol and drug misuse prevention, treatment and recovery</b></p> | <p>Prevention of substance misuse, addiction (#3) and access to substance misuse treatment and recovery services (#4) were top issues identified in combined responses of community survey respondents and key stakeholders.</p> | <p>Community discussion groups identified substance misuse issues as a high and continuing priority for community health improvement. The relationship between mental health and substance use was discussed, and the need for more effective education and prevention.</p> | <p>About 15% of adults in the service area reported binge drinking in the past 30 days. In 2016, the rate of all drug-related fatalities in the White River Junction Health District of VT was 16.7 per 100,000 population, a rate that has approximately doubled since 2010.</p> |

# Case Study 4: Domestic violence

| Community Health Issue  | Surveys   | Discussion Groups   | Community health status indicators  |
|---|---|---|---|
| <p><b>Family strengthening including parental stress and childhood trauma</b></p> | <p>Community survey respondents identified child abuse and neglect as a top priority across all age, income, and sub-regional groups. Domestic violence was also a top 10 issue identified in combined responses of community survey respondents and key stakeholders</p> | <p>Discussion group participants reported concerns about the effects of parental stress, financial stress, substance use and mental health on the health and welfare of children in the community</p> | <p>About 26% of children in the DH-APD service area live in households with incomes below 200% of the federal poverty level</p> |



# Case Study 5: Access to mental health services

| Community Health Issue                         | Surveys  | Discussion Groups  | Community health status indicators  |
|--|--|--|---|
| <p><b>Access to mental health services</b></p> | <p>Access to mental health care was the highest priority issue identified in combined responses of community survey and key stakeholder survey respondents. ‘People in need of mental health care’ was the top underserved population identified by key stakeholders</p> | <p>Identified as a high and continuing priority for community health improvement by all community discussion groups. Issues included lack of workforce / insufficient capacity. “Mental health is the big one” (local employer).</p> | <p>About 11% of adults in the service area report 14 or more days in the past 30 days when their mental health was not good, a measure that is correlated with depression and other chronic mental health concerns as well as overall health-related quality of life.</p> |

# Case Study 6: Social Determinants of Health

| Community Health Issue   | Surveys   | Discussion Groups  | Community health status indicators  |
|--|---|--|---|
| <p><b>Social determinants of health including affordable housing, transportation and poverty</b></p> | <p>Affordable housing was a top 10 issue identified in combined responses of community survey respondents and key stakeholders. Key stakeholders also identified lack of transportation as the top barrier to accessing services.</p> | <p>Community discussion groups identified transportation as a significant issue and also addressed issues of homelessness, home affordability, and related needs for being able to recruit a diverse workforce</p> | <p>About 1 in 3 households have housing costs exceeding 30% of household income and 6% of households have no available vehicle. The most common type of referral from VT 211 from the service area is for housing/shelter (44% of all referrals).</p> |

# Suggestions to increase use of CBPR

- Each person has 2 PostIt®
- Write **ONE** suggestion on each PostIt® drawn from the 5-6 scenarios.
- The suggestion should follow these criteria:
  1. Likely to be effective in increasing the implementation of CBPR in your area
  2. For which human and financial resources will not be a major constraint, and
  3. For which there is a realistic chance that there will be enough political and professional will to get the suggestion discussed and/or implemented.

