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GUEST EDITORIAL

Community-Based Participatory Research and Community Health Development

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Community-based participatory research (CBPR) has become a primary focus for public health practice and research in the past decade and is included as a core competency in public health (Calhoun et al. 2008; Minkler and Wallerstein 2008). CBPR emphasizes inclusion of "research participants" and communities in the process of identifying and defining problems, determining what questions to ask, how to ask the questions (methodology), interpretation of the results, the development and implementation of interventions to address public health problems, program evaluation, and dissemination of results. Thus, CBPR offers the potential for addressing power differentials between researchers and communities and appeals to a broad range of professionals interested in population health improvement (Minkler and Wallerstein 2008). In a CBPR-oriented initiative communities are engaged in the research and intervention process, and the expectation is that skills related to problem definition, assessment, research, intervention development and implementation, and evaluation skills will be transferred from researchers to community members and community capacity will be strengthened (Goodman et al. 1998; Israel et al. 2008).

Related to CBPR is a strategy of community health development (CHD), which has been widely practiced in international development work but also used in the United States (Steuart 1985, 1993; Wendel et al. 2007). Community health development emphasizes the dual outcomes of improving health status of the population and building community capacity to address factors influencing health status. Rather than focusing on a single issue or need, CHD focuses on strengthening and developing community infrastructure as the vehicle and context for activities to improve the health of communities. Moreover, as described below, the underlying theoretical frame for CHD is drawn from the broad literature on community and locality development, as well as relying on the broad framework of CBPR.

CHD is based on an application of multiple theories of planned social change broadly categorized as rationale-empirical, normative-re-educative, and power-coercive (Chin and Benne 1976). In a community health development strategy, planned social change is implemented through the "mixing and phasing" of strategies (Rothman 2001). Rothman characterized three different approaches to working with communities: locality development, social planning, and social action. These models are differentiated from each other on the

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basis of both methods, theory and philosophy. Locality development approaches problem solving from the perspective of seeking to 'develop' the community's ability to solve its own problems. The normative-re-educative school of social change is the underlying strategy of locality development. The primary methods are group discussion, consensus, and emphasis on communication building between different subgroups. Members of the local power structure are seen as collaborators rather than adversaries or oppressors. The practitioner functions as an enabler, coordinator, catalyst and/or teacher of problem-solving skills with an emphasis on low profile facilitation that encourages community leadership (Burdine and Gottlieb 1980; Rothman 2001).

The social planning approach, based on the rational-empirical school, assumes that problems can be solved with adequate information, so the primary strategy is fact-finding and analysis by professional planners. Underlying this approach is the assumption that there are substantial social problems that require solutions; however, these problems may differ from those needs perceived by the community, constituency or audience. Decisions are made on the basis of the findings of assessments but not necessarily through consensus. In this approach the lower power structure is viewed as "employer" and the practitioner role is that of data collector/analyst. In contrast to locality development, social planning practitioners are often prominent as public advocates. Broad-based community participation is not a high priority (Burdine and Gottlieb 1980; Rothman 2001).

The social action model, based on power-coercive strategies, focuses on the reallocation of resources and power from the "haves" to the "have-nots." As it assumes that particular populations have been disadvantaged and deprived through systematic oppression, the primary change strategies are polarization of the oppressed and oppressor groups and crystallization of issues, real or symbolic. The methods are confrontative and conflict-oriented. The practitioner role is that of activist, advocate, and partisan. The community power structure is viewed as an external agent: the oppressors.

CHD is most closely related to Rothman's locality development model, but in the process of mixing and phasing incorporates elements of the other two models as well (Burdine and Gottlieb 1980; Rothman 2001). CHD is an approach focusing on population health status improvement. As such, it emphasizes health outcomes as the consequences for its activities (Burdine et al. 2007). The principles of CHD are also philosophically rooted in the fundamentals of democratic thinking, that collective action for a common good is optimal for problem solving. The concept of capacity building—learning from experience and applying that gained knowledge in subsequent activities—is also fundamental to CHD (Norton et al. 2002).

CHD serves as the strategy to plan, develop, implement, monitor, maintain, and evaluate a community's shared vision for the production of health. It is a managed incremental change process that operates simultaneously at the top level (i.e., structural/resource) and at the local/grassroots level of a community. This approach is designed to mobilize people in a community to improve health by building relationships among different sectors of the community (e.g., health care, faith-based, education, local government, and business) with the common objective of improving the health status of the population (Burdine et al. 2007). CHD accomplishes its goals and objectives through cycles of assessment, organizing, planning, implementing, and evaluation. The partnership approach, one example of this cycle, emphasizes the centrality of community involvement in each of these phased elements (Felix and Burdine 2000; Norton et al. 2002).

CHD is governed by several key principles that resonate strongly with those of CBPR (Norton et al. 2002; McLeroy et al. 2003; Minkler and Wallerstein 2003). Table 1 provides a comparison of the two. It can be argued that CHD is a methodology for conducting CBPR; CBPR is an approach to conducting research with communities, whereas the process and outcomes of CHD are focused on health status improvement and community capacity building. The authors suggest that the more important distinction is that CHD—at any stage of the process—is at once a tool and an outcome for the community partners engaged in it.

This theme issue of *The Journal of Primary Prevention* provides examples of both community-based participatory research and CHD. The emphasis of this collection is to examine how and why CBPR and CHD may be complementary and address both community health problems and strengthen community capacity. In the first article, Felix et al. provide an overview of both the underlying tenants of the CHD

Table 1 Parallel principles of community health development and community-based participatory research principles

Community Health Development Principles (CHD)	Community-Based Participatory Research Principles (CBPR)
The unit of practice and unit of solution is the community	Community is the unit of identity, practice, and community
CHD recognizes that it is necessary to understand both the causes of problems in a community as well as the resources available to address those problems	CBPR builds on strengths and resources within the community
Conducting community-based, community directed health status assessment provides opportunities to not only measure and identify priorities for health status improvement, but also serves as a key organizing and community development tool	CBPR facilitates collaborative, equitable partnership in all research phases and involves an empowering and power-sharing process that attends to social inequities
Adopting a broad definition of health, recognizing that social determinants provide a framework to help define community health indicators in the assessment process	CBPR promotes co-learning and capacity building among all partners.
A comprehensive involvement approach and assessment of community health takes time and resources that should be obtained from as many different organizations and individuals within the community as possible	CBPR integrates and achieves a balance between research and action for the mutual benefit of all partners
Moving from the medical model of problem definition and problem solving to the community health development model broadens the base of social accountability for the improvement of community health status from health care providers only, to all segments of the community	CBPR emphasizes local relevance of public health problems and ecological perspectives that recognize and attend to the multiple determinants of health and disease
Steps in the community health development process need to be shaped to address the unique characteristics of the community undertaking the effort	
Developing local capacity for health status improvement and the ability to sustain that capacity are critical to improving a community's health status	CBPR involves system development through a cyclical and iterative process
	CBPR requires a long-term process and commitment to sustainability

approach and highlights the evolution of the model. This discussion suggests that a unique characteristic of CHD is the focus on population health outcomes, typically at the community level. Whereas many other community-based interventions share some of the theoretical underpinnings and community change strategies, it is this broad-based community change effort's focus on population health outcomes that is most unique. The overview also stresses the importance of the ecological model—that is, seeking solutions to community issues by targeting a wide array of ecological levels (e.g., individual, family, community). Finally, the authors suggest that the strength of the model, in practice, hinges on the capacity of the change agent or facilitator to help all key community players recognize each others' enlightened self-interest and appreciate the common goals targeted, despite the case that reasons for supporting the common goal may differ. Of course, ultimately, the success of CHD-based community interventions lies with the capacity of the facilitator to pass the organizing leadership skills onto key community members who are committed to the long term.

Felix et al. describe two community-based interventions that are built on the CBPR, CHD, and community partnership models. The first, the Brazos Valley Health Partnership, was initiated by initially bringing together a series of key community partners to help underwrite a seven-county community health assessment. The community summit that followed provided the impetus to establish the Brazos Valley Health Partnership. The partnership led to the creation of planning committees that sorted through the community assessment data and served as the basis for establishing local and regional priorities. Ultimately, community resource centers, supported in part by local county government, were established. These resource hubs included a local staff person who served as a knowledge resource to county residents and provided case management assistance. As

original federal start-up funds diminished, two critical events occurred. First, the local counties successfully maintained the resource centers on local funds. Second, the collective decision was made to establish the seven-county partnership as the Brazos Valley Health Partnership, a *501(c)3* not-for-profit organization that could better support ongoing county level activities. The university-based Center for Community Health Development continues to work closely with the partnership, employing the CBPR/CHD models for engagement.

Felix et al. provide a second, concurrent example of the partnership approach in Colorado. In this instance the collaborative again brought together a wide array of local and regional providers while seeking to improve access to key services by simplifying the complex array of service access points, supporting better coordination of services, and provides a more user friendly access mechanism for residents. The implementation of changes in these systems included individual behavior change, as well as changes in organizations, inter-organizational relationships, community-level changes, and engagement in local and state level policy advocacy efforts. This exemplifies the changes that occur in ecological systems as a result of CHD.

The authors conclude with the suggestion that this model could provide a model for national health reform, "one community at a time." They recommend a multi-stage approach to the dissemination of CHD across the country that includes targeted efforts addressing the social determinants of health with appropriate federal, state and community level investments in the training of professionals to assist communities in these change efforts and support nationwide implementation. Finally, the authors suggest that such an approach would both be much more likely to succeed politically and be retained locally, which allows for local control of much of the detail in design emphasis. This article provides two strong illustrations of the CHD/partnership approach that are very different in certain implementation details but clearly are based on the same underlying premise—that community control is critical in fostering collaboration among the varied key constituents at the local level and in ensuring the success and longevity of the effort.

The national health care reform theme is also developed in the perspectives paper co-authored by Drs. Ciro Sumaya and Eduardo Simoes. The co-authors discuss how Prevention Research Centers and community health development are complimentary strategies for addressing national health reform. While not all of the articles include a national perspective, the underlying assumptions of CHD and CBPR as described in this volume, should be carefully considered in the design and implementation of national health care reform strategies. The Griffith et al. examine partnerships between university researchers and community-based organizations (CBO) as a means of improving health outcomes. Their intervention includes strategies for assessing priorities identifying health outcomes, including health disparities. CBOs are often the most critical component of successful efforts to affect health disparities in African American communities because they reflect an appropriate cultural focus and are more likely to target relevant factors in the production of ill health, such as economic and educational factors that ultimately have considerable impact on health seeking behaviors and health status. The authors also note that university-linked partnerships with CBOs can lead to improved community access for researchers and improved capacity in the CBO. Further, sustainability of health disparities interventions hinges on the capacity of CBOs to continue functioning effectively. Griffith et al. describe the university/CBO partnership that was established, provide illustrations of collaborative projects between the university and CBOs, and illustrate how the partnership may strengthen the ability of CBOs to perform their missions.

One specific concern the university community had regarding success in the target community was the wide disparities in CBO resources. Thus, this project actively sought to increase the capacity of CBOs while simultaneously increasing the understanding among other partners of the degree to which the CBOs can make important contributions to the overall effort. One project developed to improve the strengths of the CBOs was to involve them in the development, refinement, and use of the community population health survey. Although not seeking to establish them as independent survey researchers, the premise was that by providing the CBOs with greater input, they could also gain insights into community issues of importance to them as well as the overall project. This process both empowered the CBOs and

increased their extra-organizational capacity to be a fully participating member of the overall partnership. This had an impact of creating greater equity among the CBOs and other members of the larger partnership.

The second project provides an illustration of the overall effort to enhance CBO capacity by linking a CBO with a number of church groups with parallel interests in reducing HIV prevalence rates in the community. This exercise led to a successful proposal to a local foundation for a pilot project that involved 11 church groups. By engaging in collaborative activities with the overall partnership, they successfully documented impacts of the pilot project and were able to impress the local foundation with their collective work. This, in turn, led to a larger project that expanded the role of the CBO in the partnership, enabling them to play a greater role in subsequent activities in the community.

These projects add to the growing literature that suggests that successful community health disparity interventions may increase the value of their efforts by increasing the capacity of local CBOs to participate in the process. By increasing the capacity of the CBOs to target community health, the entire CBPR collaborative is strengthened and the sustainability of efforts in the community is greatly enhanced.

The Parker et al. paper suggests that environmental disparities (differential exposures to asthma episode stimulating environmental events) are linked to lesser political clout of urban disadvantaged minorities. They suggest that although individual level interventions are appropriate, community-level policy interventions are also necessary. Thus, CHD approaches "targeting social and political triggers" for asthma.

This project is also an illustration of an effort that was initiated with Centers for Disease Control and Prevention (CDC) resources and expanded to include National Institute of Environmental Health Services funding as well. Qualitative data were collected via 20 interviews over a four-month period from a pool of community members, research team members, coalition members, and key community leaders. Data indicated community members were much more aware of environmentally degrading activities in the community and the dangers associated with exposure. Collaborative efforts led to increased influence with the city on concerns about environmental triggers and exposure. Although this population generally struggled with simple day-to-day necessities, the critical component of the project involved getting the message of the importance of attending to these environmental exposures that directly impact health. A major change that occurred as a result of this community engagement effort was that community residents became sufficiently educated about these issues and were able to influence city officials and city council about their concerns. The fact that the community members now had access to local data about the impact of environmental contaminants in their own community and knew how to raise issues about these concerns in a public forum had a large effect impact on the strength of the community to address asthma issues. Moreover, the project led to the community being much more engaged in other civic activities.

The Wendel et al. paper provides an overview of a community partnership approach and the effectiveness of CHD. The CHD process outlined in this paper began with an extensive community health assessment that was used to organize community agencies and other groups and to provide local data for identifying community health and establishing community priorities. Although this project follows a theme similar to others in this volume, this paper addresses the effects of the planning and organizational process on strengthening inter-organizational relationships and linkages. Thus, the analyses consider the degree to which organizations begin to work more closely together over the course of a successful CHD intervention. Although conceding the fact that both individuals and organizations enter into community-based collaborative based upon enlightened self-interest, they nevertheless develop stronger linkages with others if the CHD process is truly successful. Wendel et al. examine the degree to which inter-organizational networks in the Brazos Valley CHD project were strengthened and the extent to which inter-organizational networks became more diverse.

The project team interviewed partnership members at 35 different agencies and asked about whether they (a) share information, (b) jointly plan or coordinate activities, (c) share resources, and/or (d) establish formal written agreements related to shared work. Surveys were completed at two points in time, first in 2004 and again in 2006. Findings suggest that the inter-organizational networks were stable over time

and strengthened the degree to which they shared resources and developed stronger working relationships. In addition, the organizations involved in this partnership developed more linkages and several of the participating organizations took on more central roles in the community partnership.

The Reinschmidt et al. paper targets the implementation of a Latino-focused diabetes secondary prevention program disseminated from a federal model. The authors examined factors related to the importance of fidelity and adaptation and explored the role of family and cultural influences. The authors undertook a qualitative examination of the implementation of the program in two different border communities. Interviews were conducted with university-based researchers, in-the-field project implementation staff, and with the Promotoras working in the community. The authors argue that a balance between fidelity and cultural adaptation is critical to successful project dissemination.

The project was completed by PRC staff who developed the initial *promotoras*-based diabetes intervention program. The two dissemination sites were also operated by the same PRC staff. The projects were both community-based participatory research exercises. Both sites had similar demographic characteristics. Yet, the degree to which the two communities pushed for adaptation of the original model varied considerably. The authors concluded that two factors were important in their influence on program design. First, local community cultural issues influence the degree to which adaptations are pushed, even in a setting where the original program model is a very good fit with the communities. Second, *promotoras*-based intervention models play to the strengths of the promotoras themselves when adaptation is allowed or even encouraged. They suggest that the better *promotoras* take advantage of a program and its materials, but are very tuned into individual case demands. It is suggested that practitioners should be cognizant at all times of the opportunities presented by adaptation, but one must balance those demands with the need to retain sufficient fidelity. The adaptation and fidelity issues are consistent with Felix et al.'s suggestion that CHD is a model for national change, one community at a time (Table 2).

The Riley-Jacome et al. paper is also based on a Prevention Research Center CBPR community assessment. In this instance, the community assessment led to the creation of a rural exercise program that used existing local resources. Because the initial assessment was conducted in both an urban and rural setting, the authors were able to identify important differences between rural and urban areas that affected the design of the rural program. For example, there were rural urban differences in the proportion of respondents (104 diabetes patients in each setting) who exercised regularly, with rates considerably lower in the rural setting. Rural areas frequently lack sidewalks, and there are few buffers from traffic. Rural communities tend not to have many resources that they can bring to bear on problems of this magnitude. The critical need for diabetics to be able to exercise is compounded in rural settings by the lack of settings to undertake exercises as simple as walking.

Although this pilot effort did not gather extensive impact data, the authors did document attendance, hours walking, and for a subset of participants, steps

Table 2 Key community health development components present in the six special issue articles

CBPR/CHD components	Felix	Griffith	Parker	Wendel	Reinschmidt	Riley-Jacome
Build relationships	Yes	Yes	Yes	Yes	Yes	Yes
Identify priorities	Yes	Yes	Yes	Yes	No	Yes
Define problems	Yes	Yes	Yes	Yes	No	Yes
Plan/develop interventions	Yes	Yes	Yes	Yes	Yes	Yes
Conduct intervention(s)	Yes	Yes	Yes	Yes	Yes	Yes
Evaluate interventions	Yes	Yes	Yes	No	Yes	Yes
Translate/disseminate	Yes	Yes	Yes	No	Yes	No
Knowledge transfer						
Capacity building	Yes	Yes	Yes	Yes	Yes	No

taken. Survey data indicated that many of the regular attendees did report feeling better, the ability to walk longer and faster without being out of breath, etc. They also suggest that the success of programs of this nature may be linked to the degree to which a setting is established where walking is safe (e.g., walking indoors at a school involves minimal weather impact and does not require watching out for children running around the mall, potholes, traffic, or dogs).

The projects described above all flowed from CBPR/CHD framework that typically involves a direct effort to build relationships between the research community, which is typically university-based, and key players in a target community (see Table 2). Frequently the initial relationship building efforts are established around a process of priority identification activities that often include a structured community assessment survey. Then strategies for action are identified through consensus/priority building exercises. Typically some evaluation activities are integrated into the project that both provide the community with evidence of the benefits of their efforts and provide the research community with information for scholarly work as well. More recently, efforts have incorporated some aspects of a broader effort to translate findings into improved state-of-the-art practices through some set of dissemination activities. Ultimately it all concludes with an expanded capacity to take on tasks important to the community in the community.

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