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Crisis-Resilient and Antiracist Approaches to Community-Based Participatory Research During COVID-19 and Beyond

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Abstract

Social and health inequities among communities of color are deeply embedded in the United States and were exacerbated by the COVID-19 pandemic. Community-based participatory research (CBPR) is a powerful approach to advance health equity. However, emergencies both as global as a pandemic or as local as a forest fire have the power to interrupt research programs and weaken community relationships. Drawing from Public Health Critical Race Praxis (PHCRP), as well as our research experience during the pandemic, this article proposes an expansion of prior CBPR principles with an emphasis on advocacy and storytelling, community investment, and flexibility. The article summarizes key principles of CBPR and PHCRP, contextualizes their relevance in COVID-19, and outlines a practical vision for crisis-resilient research through deeper engagement with antiracism scholarship. Structural barriers remain an issue, so policy changes to funding and research institutions are recommended, as well, to truly advance health equity.

Keywords

health equity, antiracism, CBPR, community-based participatory research, social justice

Impact Statement

The COVID-19 pandemic has negatively affected both community-based research programs and the communities they work with, especially communities of color. With researchers seeking ways to meaningfully engage with communities and respond to acute needs, we provide recommendations for CBPR practice for use both during the pandemic and into the future. While a great deal of prior research has documented best practices for CBPR, much of this work does not specifically incorporate an antiracism lens nor prepare researchers for emergencies within their respective communities. This article presents an expansion of existing CBPR tenets to emphasize advocacy and storytelling, community investment, and flexibility to ensure crisis-resilient and equitable solutions.

Social and health inequities among communities of color are deeply embedded in the social fabric of the United States (Williams & Cooper, 2019). These inequities were exacerbated in salient ways with the advent of the COVID-19 pandemic (Gauthier et al., 2020; van Dorn et al., 2020). The virus disproportionately affected Black, American Indian and Alaska Native, and Hispanic communities; hospitalization rates in each of these racial and ethnic groups were at least three times those of non-Hispanic White individuals in 2020 (Centers for Disease Control and Prevention, 2021). The stark inequities in reported COVID-19 cases and deaths among communities of color both underscore significant structural disadvantages rooted in historical and contemporary racist policies, practices, and norms that predate the pandemic and highlight the need for immediate and enduring programs and policies to promote health equity (Bailey & Moon, 2020).

Community-based participatory research (CBPR) is a particularly powerful and effective approach to reducing health inequities among communities of color that have been subject to mistreatment and unethical research practices (Chávez et al., 2008). This approach brings together community members,

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academic researchers, and organizations with diverse backgrounds, skills, and knowledge bases as partners to ensure all voices are heard throughout all phases of research (Leung et al., 2004; Wallerstein et al., 2017).

Complementary to CBPR is the body of literature surrounding antiracism praxis, a relational and reflexive process of confronting, undoing, and eradicating racism in systems, structures, and policies (Came & Griffith, 2018). Two major frameworks inform antiracism praxis in public health: critical race theory (CRT) and Public Health Critical Race Praxis (PHCRP). Critical race theory emerged from critical legal scholarship in the 1980s and posits that racism is deeply embedded in American society and ordinary life, thus shaping social, political, and economic structures (Delgado & Stefancic, 2017). Ford and Airhihenbuwa (2010b) translated the legal framework into the public health field with the introduction of PHCRP, a semi-structured process that combines theory with action to center racial equity in research.

The relevance of CBPR and PHCRP has been highlighted by the unprecedented events of 2020—the COVID-19 pandemic, overt instances of racialized police violence and murder, and the movement for Black lives. Each of these events demonstrate the need to challenge racist systems and continually center our work in the margins—making the voice of the socially marginalized groups the focus, rather than those belonging to the dominant group. Missing, however, from these two frameworks is an explicit focus on research in the face of crisis. This past year, numerous CBPR programs were forced to curtail in-person activities due to COVID-19, jeopardizing the trust and progress of community–academic partnerships (Christopher et al., 2008).

While the COVID-19 pandemic represents a global crisis unique in scale, it is not entirely unique in the way it has slowed public health practice and research. Public health activities are often interrupted by smaller scale, local events. In tight-knit Native reservations or village communities, the death of a respected elder can bring significant disruption, as well. Thus, while we discuss public health resilience during the COVID-19 pandemic in this article, the principles apply to any range of crises that upset community life and stability.

Here, we summarize key principles of CBPR and PHCRP, contextualize their relevance in COVID-19, and then call on public health professionals to widely adopt CBPR with a greater emphasis on advocacy and storytelling, community investment, and flexibility to center community needs and promote community-led, evidence-based solutions. We propose ways to act on and reimagine CBPR tenets to promote deeper, long-term investment to ensure health equity in times of emergency, global or local. We credit much of this piece to the lessons learned from the resilient, compassionate, and flexible Tribal leaders and partners who have saved hundreds of lives in their communities.

Community-Based Participatory Research

Background and Tenets

CBPR represents not a specific set of research techniques or methods, but rather a research orientation based on the belief that community members can and should hold both decision-making and leadership roles in research (Burhansstipanov et al., 2005; Wallerstein & Duran, 2006). This community centered approach ensures that the research is relevant to the needs of the community, knowledge and resources are equally shared, and findings can be used to inform social transformations necessary to address adverse health outcomes (Israel et al., 1998; Israel et al., 2001). Unlike in Westernized traditional research practice, CBPR research questions originate from community concerns and are addressed in collaboration between researchers and community members (Wallerstein et al., 2017). The varying perspectives of these partners allow for understanding the social, political, and economic systems that underlie health inequities and shape health behaviors and outcomes (Berge et al., 2009).

Over the years, various researchers have proposed key principles of CBPR; the most cited being the eight first discussed by Israel et al. (1998):

1. Recognizes community as a unit of identity
2. Builds on strengths and resources within the community
3. Facilitates collaborative partnerships in all phases of the research
4. Integrates knowledge and action for mutual benefit of all partners
5. Promotes a co-learning and empowering process that attends to social inequalities
6. Involves a cyclical and iterative process
7. Addresses health from both positive and ecological perspectives
8. Disseminates findings and knowledge gained to all partners

Since the late 1990s, CBPR has expanded and morphed, becoming a widespread practice outside academia, such as in community nonprofits and local public health organizations (Berge et al., 2009; Brush et al., 2020).

CBPR approaches can be most effective when supported by a practice of PHCRP. The four focus areas of PHCRP—*contemporary racial relations*, *knowledge production*, *conceptualization and measurement*, and *action*—include 10 principles researchers can follow to move beyond "documenting disparities" to challenging the roots of health inequity (Ford & Airhihenbuwa, 2010b). Many of the 10 principles are at the foundation of CBPR—such as, *social construction of knowledge*, *critical approaches*, *intersectionality*, and *voice* (Ford & Airhihenbuwa, 2010b). For example, by promoting a

co-learning and empowering process, experiential knowledge is shared and valued in tandem with technical knowledge. Or by addressing health from an ecological perspective, the primacy or role of race in outcomes is considered. Additional linkages between CBPR principles and PHCRP principles are mapped in Table 1.

Challenges in Implementation

CBPR approaches provide a roadmap for meaningful community partnership, but following this roadmap can be challenging in practice. Constraints of conducting meaningful CBPR are not new, but many have been exacerbated during the COVID-19 pandemic. Such constraints include the following: institutional legitimacy of conducting CBPR, lack of funding to support community-oriented research, and the time required to build meaningful community partnerships (Ahmed et al., 2004; Jardine & James, 2012; Nyden, 2003).

The COVID-19 pandemic has also presented unique challenges around CBPR, particularly in partnerships, like ours, with American Indian and Alaska Native reservation communities. These include maintaining community relationships when travel is limited due to safety concerns and, thus, in-person meetings cannot be held; maintaining staff on-site in communities when research activities are on hold and grant funding can be used only for specific allowable expenses; and being responsive to pressing community needs (e.g., masks, hand sanitizer, access to food) that are independent of research efforts. Thus, although challenges of CBPR are not new, the COVID-19 pandemic has highlighted areas where research relationships can be stretched during times of crises; CBPR approaches should be amended to accommodate broader public health goals.

Opportunities to Recalibrate CBPR Toward Crisis-Resilience, Using PHCRP

Researchers frequently have little time or resources for the level of community engagement necessary for effective CBPR (Wallerstein, 2006). The COVID-19 pandemic has forced an unprecedented pause in in-person research activities; we took this unexpected turn of events as an opportunity to slow down and deepen our focus on community engagement and health equity. In reflecting on this process, we propose a new framework to support community partners in responding to the COVID-19 pandemic and future crises. This framework honors traditional principles of CBPR but also acknowledges the need for new tenets that leverage advocacy and storytelling, community investment, flexibility, and aligns CBPR tenets more directly with PHCRP principles (Table 1).

Table 1 outlines an expanded, crisis-resilient set of CBPR tenets, including four tenets from the original approach to CBPR (Israel et al., 1998) and three new tenets. Four of the eight original tenets were highlighted here because of their critical importance in any crisis response; the other four original CBPR tenants remain important, however. We map the relationship of each CBPR tenet to PHCRP principles, propose ways to practice the tenet both prior to and during any community crisis, and finally, outline potential benefits for community and research partners.

The new tenets are drawn from more recent literature (Brush et al., 2020; Burhansstipanov et al., 2005; Collins et al., 2018; Ford & Airhihenbuwa, 2010a), the foundations of PHCRP (Ford & Airhihenbuwa, 2010b), and our own experiences during the COVID-19 pandemic. For example, the tenet of *storytelling*, or the act of recounting personal stories and narrative, is drawn from the tradition of counterstories in antiracism work (Solórzano & Yosso, 2002). Counterstories challenge the dominant discourse on race, have a rich tradition in many communities of color such as in Native communities, and have substantial evidence as a healing methodology (Jackson et al., 2015; LeBron et al., 2014; Solórzano & Yosso, 2002).

The new CBPR tenets to ensure crisis resilience include the following: (1) *advocacy and storytelling* to support community needs and challenge dominant discourse, (2) *community investment* to reduce collateral damage and protect community infrastructure, and (3) *flexibility*, both in research timelines and priorities, as community needs can change in an emergency (different from the original tenet of "cyclical and iterative process" in that research needs to be agile from moment to moment and responsive to local emergencies). The tenets we propose are not mutually exclusive and are intended to reflect decolonizing methods and solutions.

Practical examples from our experience conducting research in partnership with Native communities during COVID-19 illustrate these tenets in action. First, team members (inclusive of community and university research staff) *built on strengths and resources within the community* by relying heavily on local expertise and tribal policies when making COVID-19 revisions to their program. Our team practiced *collaboration in all phases* by partnering with community members in paper writing, safety protocol formation, and other activities undertaken during the pause. Team members practiced *co-learning* by creating community of learning forums to build capacity among community partners and deepen cultural and contextual understandings among academic partners. The pause also provided time to create family-friendly and culturally relevant infographics and games to *disseminate findings and knowledge*. Team members practiced *advocacy* by asking for mask donations in the face of a mask shortage and COVID-19 outbreak on the reservation. The project lead demonstrated *community investment* by volunteering staff time to monitor real-time disease morbidity and mortality indicators. *Flexibility*, perhaps the most practiced tenet during the pandemic, has been critical as we continue to change and shift research plans, safety measures, and timelines to align with local priorities and policies during COVID-19.

Central to each of these examples has been the practice of identifying, challenging, and disrupting unequal power and resource distributions, especially those patterned by race. For example, the tribe as a sovereign nation has the right to determine when they would like to resume in-person research, yet our university institutional review board requires extensive

Table 1. Framework for Crisis-Resilient and Antiracist CBPR Practice.

Existing and new CBPR tenets	Aligned PHCRP principle	Actions to build crisis-resilience	Benefits
Build on strengths and resources within the community[a]	Acts on *structural determinism* by challenging power inequities	• Help identify community assets and support local organizations to mobilize response efforts • Promote and emphasize community-level strengths, local knowledge, and community values when developing health communication materials	Ensures the response is community driven and sustainable
Facilitate collaborative partnerships in all phases[a]	Acts on *voice* by prioritizing the perspectives of marginalized individuals	• Emphasize shared decision making within research team, especially when pausing or changing study protocols • Offer to serve as a bridge between local, regional, and national organizations to help with response efforts	Reinforces shared ownership of research process and commitment to supporting community
Promote co-learning and empowering processes[a]	Acts on the *primacy of racialization* by seeking to disrupt power imbalances	• Help reassess current priorities by facilitating virtual listening sessions or surveys to understand community concerns and how the crisis is affecting them • Promote thoughtful conversations with community partners and offer ways to support community-led responses • Identify and host community learning and training opportunities with crosscutting topics that are relevant to the crisis and research focus	Promotes trust, cultural humility, and opportunities for enrichment within the team and community
Disseminate findings and knowledge[a]	Acts on the *social construction of knowledge* by reevaluating knowledge production using antiracism	• Consult with community leaders to understand local needs and priorities • Engage in thoughtful conversations with broader community, stakeholders, and funders to make them aware of community needs and how the research team is helping with the response • Work with community partners to identify whom people trust in the community to deliver public health information and engage them as champions in dissemination activities	Ensures community consultation before dissemination and leverages community champions in knowledge sharing
Advocacy and storytelling[b]	Acts on *voice* by prioritizing the perspectives of marginalized individuals	• Use advocacy to mobilize university and external partners to help secure resources for community-driven efforts (e.g., donations for food, masks, cleaning supplies, diapers, care packages, transportation) • Use storytelling methods to center personal narratives and spotlight untold stories from the crisis	Elevates community as storytellers and mobilizes additional support
Community investment[b]	Acts on *structural determinism* by changing macro-level forces of funding	• Ensure resources stay in the community (e.g., protecting pay for local staff) in the event of a pause or delay in activities • Identify ways to leverage research resources, networks, and expertise to help respond to emergent needs (e.g., disaster mental health team, food distributions, virtual or home visits for preventive and behavioral health services) • Offer in-kind time from additional faculty and students who can help with community needs and priorities	Demonstrates ongoing commitment to the community and prevents collateral damage
Flexibility[b]	Acts on *disciplinary self-critique* by examining White supremacy conventions of productivity	• Develop flexible plans for when/if research activities pause in the event of an emergency (e.g., safety protocols for home visits, virtual activities) • Maintain communication and strengthen connection with participants via phone or social media • Advocate for flexible funding that moves away from fiscal periods and toward open ended, need-based funding	Ensures team has a plan to identify and respond to immediate needs

Note. CBPR = Community-based participatory research; PHCRP = Public Health Critical Race Praxis.
Source. PHCRP principles drawn from Ford and Airhihenbuwa (2010b).
[a]Original CBPR principle described by Israel et al. (1998). [b]New CBPR principle we propose to redistribute power and resources to community members, especially in times of crisis.

documentation to apply for resumption approval and imposes their own restrictions. Our community partners frequently ask for the ability to decide how and when research occurs in their community without the paternalistic oversight of academic polices, such as those governing fiscal or transportation decisions. *Advocacy* and PHCRP intersect when we push back against these university systems that perpetuate power imbalances and structural racism.

It is worth noting here that "resilience" is a word with complicated uses and origins. In traditional models of public health, its use has placed undue burden on individuals to endure unjust circumstances rather than implicating the environments and structures that necessitate resilience (Payne, 2011; Ungar, 2011). Crisis-resilience, in this context, refers to a state of durability within research systems and community resources; it is not intended to suggest that individual community members should be expected to be resilient in the face of inequitable experiences.

Discussion

This commentary reviews various strategies for research–community teams to strengthen partnerships and research programs in the face of inevitable challenges. The examples provided are by no means exhaustive of all the actions researchers and community members could take to strengthen partnerships, build capacity, or shift power and resources during a time of crisis. They are, however, examples of what can be done to keep moving forward when other activities are stalled—and of what should be done as a matter of course.

Community-based researchers play an essential role in bringing crisis-resilient and antiracist public health into reality, as the bridge between communities and institutions. Their dual position has the potential to unlock a wealth of knowledge, resources, and capacity that can be leveraged to bolster community-driven efforts. When working with communities of color, researchers should be driven by community priorities, informed by local knowledge and values, and attuned to local assets and vulnerabilities.

However, this roadmap remains constrained by structural barriers, including limitations to funding, institutional legitimacy, and time for relationship building (Ahmed et al., 2004; Jardine & James, 2012; Nyden, 2003). To complement a crisis-resilient CBPR practice, we call on funding agencies and academic institutions to build structures that are resilient and responsive to community crises, no matter how small (Boland et al., 2021). On a case-by-case basis, we have seen funders and academic institutions respond differently to the COVID-19 pandemic (Stoye, 2020). Some funders have been supportive of continued investment in community partnerships during the pause; others have not. To advance health equity, researchers need funding structures that are flexible to community needs, such as the ability to repurpose research funds for emergency supplies (e.g., masks and hand sanitizer, in the case of the COVID-19 pandemic). University staff need mechanisms to ensure job security during a research pause so that investments in research staff capacity are not lost. With intentional institutional structures in place, a crisis-resilient CBPR practice is achievable.

Conclusion

The COVID-19 pandemic, like many other national and local crises, highlighted the profound and unjust health inequities among communities of color (Gauthier et al., 2020; van Dorn et al., 2020). The pandemic also reminded us of the risks of delaying community-driven work, such as reversing the gains made over the past several decades through successful academic-community partnerships. However, the resulting pause in in-person research inadvertently provided the space we needed to critically examine CBPR and our work. As a result, we have more deeply engaged with antiracism scholarship and reprioritized advocacy and storytelling, community investment, and flexibility, all rooted in PHCRP approaches. The lessons learned from this experience provide the beginnings of a roadmap for how community–academic partnerships can collaborate more effectively to advance health equity.

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