

# Community Action Research

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*Community action research is an alternative research method that uses the community as the unit of analysis. This approach forges research alliances with relevant stakeholders in the community to explore and develop solutions to local problems. The authors explain this broad research approach and explore the principles that guide this methodology. In particular, the focus of this article is on the complexities and dilemmas of conducting community action research. The authors use the findings from a field study to illustrate these issues.*

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**M**arketing and public policy researchers seek to understand the impact of marketing practices and governmental policies on consumer and societal welfare. However, many social problems arise at the intersection of marketing practices and public policy and involve multiple stakeholders with competing interests (Bhattacharya and Korschun 2008). For example, recent research has examined the impact of food marketing practices on childhood obesity insofar as it involves different interest groups, such as families, public schools, fast-food chains, service providers, and health experts (Goldberg and Gunasti 2007; Grier et al. 2007; Moore 2007).

The focal problems studied by marketing and public policy researchers are also complex and embedded in cultural systems; for example, the meanings of food consumption and health practices are difficult to untangle from consumer value systems. Often, the marketing perspective focuses on individual decision making and assumes that few constraints exist (Moorman 2002). Yet Chakravarti (2006) suggests that understanding the sociocultural context is important in resource-constrained environments in which people have considerable constraints on their decision making. For example, corroborating evidence suggests that neighborhoods and communities affect people's health, particularly when concentrated disadvantage exists (Browning, Cagney, and Wen 2003). While this health gap is well established among Latino and African American minorities relative to Caucasians, it is not fully explained by differences in socioeconomic status (Williams and Collins 1995). Structural barriers also exist, such as access to affordable health

care and nutritious food, which constrain consumers' freedom to choose (e.g., Grier and Kumanyika 2008).

In this article, we explore a research approach that wrestles with issues that arise at the intersection of public policy and marketing when multiple stakeholders are involved in complex and culturally embedded problems. We present a community-based participatory research method that engages consumers and stakeholders in research within their local communities to understand and solve difficult community problems. The historical and philosophical foundations of participatory action research paradigms are discussed elsewhere (Ozanne and Saatcioglu 2008). Here, we examine a specific methodological approach—community action research (CAR). The focus of this article is on the many methodological dilemmas and issues that arise as we attempt to engage in transformative research in a field study. While the penultimate goal of CAR is to employ rigorous methods and develop theory, the ultimate goal is to develop sustainable community-based solutions to pressing consumer health and social problems (Hill 2007). This research focus leads to new challenges. While valuable insights can be obtained from other methodologies that also study phenomena in context (Arnould 2001; Kozinets 2002), this approach draws from a critical tradition and attempts to develop theoretically guided interventions (Murray and Ozanne 1991).

We articulate the basic CAR process and explain the guiding principles. However, the most important contribution of this research is to foreground the complexities and quandaries of actually doing CAR and to suggest potential solutions. Throughout this discussion, we illustrate the research process using findings from an ongoing study of diabetes within a community that we call Esperanza, which is an economically depressed community in the southwestern United States. The residents of this community are almost completely Mexican American and Native American and suffer from a 23% diabetes rate, which is more than three times the national average (Centers for Disease Control 2005). The community is characterized by concentrated disadvantage in which approximately 25% of the population

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falls below the federal poverty line and two-thirds fall below 200% of the federal poverty line. The community is a medically underserved area, with 28% of the people uninsured.

## A Brief Overview of Community Health Research

Since the nineteenth century, community involvement in public health has been viewed as important to ameliorating the social conditions that lead to the spread of diseases. Early community involvement included public health services and interventions, such as increasing the rates of vaccinations, and public educational efforts, such as improving understanding of sanitation and hygiene (Blumenthal and Yancey 2004). Deriving from a medical model, community participation meant compliant consumers who followed physicians' expert advice based on sound scientific evidence. From this perspective, health was the "absence of disease" (Rifkin 1985). As such, public health measures focused on containing infectious diseases until the 1950s, when "lifestyle" illnesses, such as heart disease, became the leading cause of death in economically developed countries.

Today, public health is more broadly viewed as the "state of complete physical, mental and social well-being and not merely the absence of disease" that occurs within a specific sociocultural context and with access to different economic resources (World Health Organization 1946). Health is a human condition that may improve with advances in health care delivery, but it may also improve with many structural changes, such as better housing, access to more healthful food alternatives, and higher rates of literacy. Thus, the health scourges of the twenty-first century are unlikely to be cured by quick fixes of vaccines or simple behavioral changes of hand washing. Prevention of lifestyle illnesses will require large-scale community participation and public policy measures to enact changes in diet and exercise and structural changes, such as the availability of health screening and prevention services and programs (Blumenthal and Yancey 2004). When the health of different communities is compared, new issues in social justice arise because of the vast disparities in health among different racial and ethnic consumer groups. African American babies die at double the rate of Caucasian babies, and health treatment is poorer for blacks even when they have insurance (Minkler 2006; Smedley, Stith, and Nelson 2002). Adverse health outcomes may also arise when ethnic minority groups are targeted and respond to unhealthy product choices (Kumanyika and Grier 2006).

A paradigm shift has occurred in public health, such that the community is increasingly the focus of interventions (e.g., Racial and Ethnic Approaches to Community Health [REACH] 2010). This new community focus has led to the development of methods based on research partnerships with local communities. These methods strive to involve interconnected community members, such as the health consumers and their families, hospitals, health service providers, social organizations, and government officials.

## The CAR Approach

Despite significant diversity among researchers, most community action researchers are unified by three shared commitments (De Koning and Martin 1996; Israel et al. 2005). First, this approach attempts to include multiple partners from the community in the research process. The community members are collaborators in the research project because effective interventions require the consideration and respect of the social and cultural constructions of the people involved (Reason and Bradbury 2001). Moreover, public trust in scientific expertise has eroded. Controversies abound, such as the recently changed guidelines for the control of diabetes, which leave some consumers skeptical and distrustful. The adoption of new technology increasingly involves ethical and moral judgments that are not the purview of scientists (Liu and Pearson 2008). Growing demand exists for more democratic and deliberative forms of research so diverse public interests and expertise can be represented (Jocz and Quelch 2008; Ozanne, Corus, and Saatcioglu 2009). Consumer input is a core part of the marketing concept. Here, consumer participation is a means to develop more effective problem-solving interventions. However, participation is also an end in itself; that is, people have greater agency when they develop new skills and explore untapped expertise in the process of doing research (Ger 1997; Talukdar, Gulyani, and Salmen 2005).

Second, guided by locally defined priorities, CAR researchers try to solve practical problems and improve the well-being of people, particularly those who suffer from enduring social inequities (Koch and Kralik 2006). Community action researchers' interest in social justice aligns with the growing interest in socially responsible and sustainable business practices (Shultz 2007). Community action research is committed to social justice and assumes that all people have the right to health and well-being and that public resources should be equitably distributed (Martin 1996).

Third, this approach relies on community education and empowerment and thus encourages people to learn new skills, reflect on their social and economic conditions, and act in their own self-interest. Thus, community members coproduce not only the research but also the programs of social intervention. While CAR has a practical intent, the creation of knowledge in the form of applied theories is also important (Reason and Bradbury 2001) (for more on the philosophy of CAR, see Ozanne and Saatcioglu 2008).

Perhaps the defining aspect of CAR is the focus on the sociocultural context and the identification of the structural forces that affect consumers' well-being but are often beyond their direct control. Most sociological theory submits that individuals are both constrained and advantaged by larger structural and political orderings (Giddens 1984). Ignoring these structural factors could lead to a narrow understanding of consumer well-being such that threats to well-being are attributed solely to the individual. Sontag (1988, p. 11) notes that this is a view of illness "as the price one pays for excesses of diet and lifestyle"; likewise, infirmity is blamed on the imprudence of the consumer. In contrast, a community approach seeks to understand how

consumers operate in communities with both structural resources and barriers.

## The CAR Research Process and Dilemmas

The CAR process and methods are flexible resources that are applied according to the emergence of the precise problem to be addressed, the specific needs of the community, and the capacities of the researcher (Koch and Kralik 2006). Therefore, a strict research protocol cannot be laid out a priori. However, the guiding principles of CAR are articulated, and the challenges of applying these principles are explored. The first stage of CAR focuses on developing community partnerships and identifying needs and resources. During the second phase, a focal problem is agreed on, additional data on the problem are collected, and these data are analyzed and presented to community members so that they can participate in dialogue, reflection, and analysis to shape the research. The third and final stage of research involves developing a specific program of action and the evaluation of this intervention (for the general stages and guiding principles, see Table 1). We separate these three stages for rhetorical purposes, but the stages are overlapping, and within different studies, people may participate throughout the process in varying degrees of intensity (see Figure 1). Next, we illustrate the research problems and dilemmas using findings from the ongoing CAR study in Esperanza. Although a full interpretation of these findings is not the focus of this article, we emphasize

results that emerged from our adoption of a CAR methodology. Along these lines, we find that the emerging theme of in-group and out-group tensions is influential and impactful in the CAR research process.

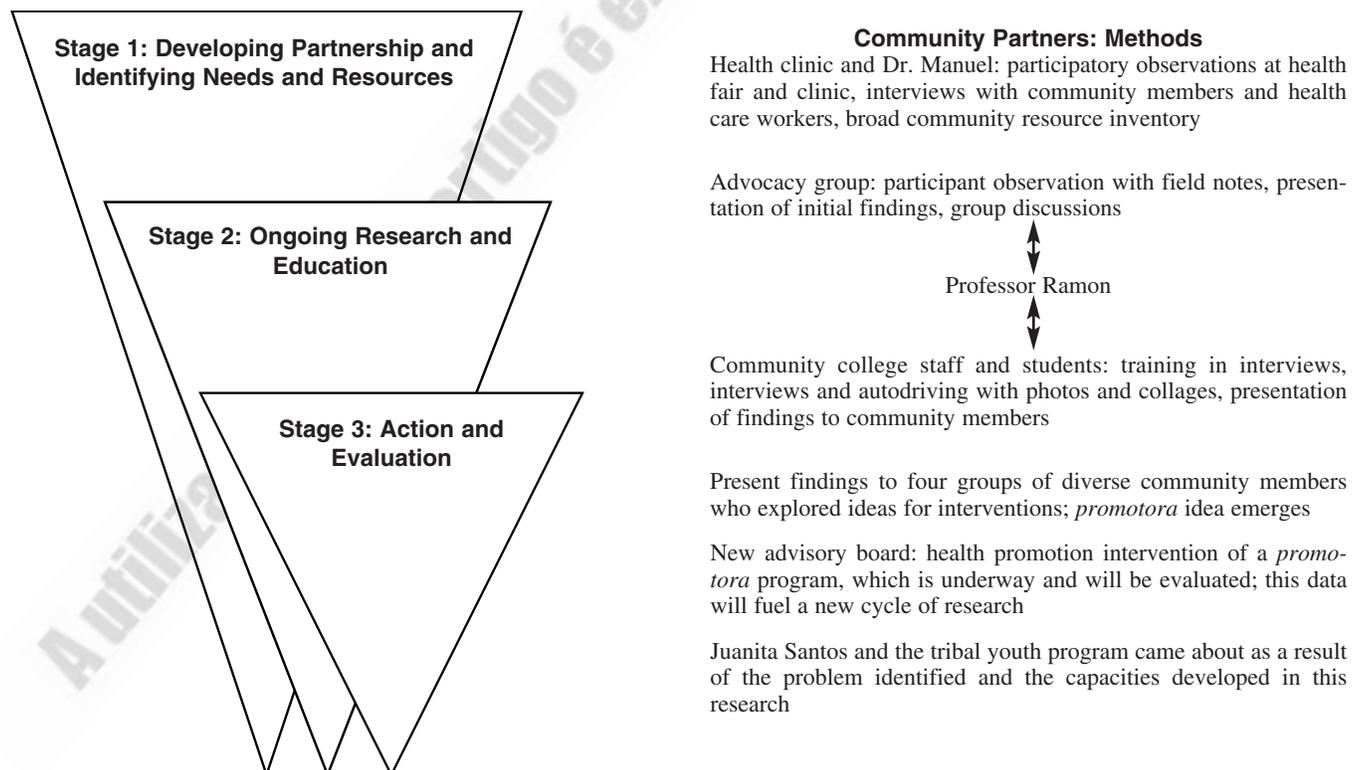
### Stage 1: Developing Partnerships and Identifying Needs and Resources

Research using the CAR approach indicates that the identification of a problem may arise from the community itself, which invites the researcher to study the problem, or a relevant problem may emerge as the researcher interacts with community partners (Israel et al. 2005). As with many ethnographic methods (Arnould 2001; Kozinets 2002), the first stage of research involves developing relationships with key members of the community to gain entry into the site and access to additional informants. Unlike traditional field methods, CAR stresses community strengths and challenges and seeks potential research collaborators. Thus, in addition to developing trusting relationships, CAR researchers face the challenge of identifying collaborators who will assist in conducting the research and implementing the actions in the community.

#### Develop Partnerships

Ideally, research partnerships are based on identifying projects that are of mutual benefit to all stakeholders involved (Martin 1996). Policy makers, health care service providers, and community leaders are people with whom it is usually easier to develop an initial relationship because the poten-

Figure 1. Research Stages, Community Partners, and Methods in Esperanza Project



**Table 1. Overview of CAR Principles, Challenges, and Solutions**

<b>Principle</b>	<b>Methodological Challenge</b>	<b>Solutions</b>
<b>Stage 1: Developing Partnerships and Identifying Needs and Resources</b>		
Develop partnerships	How do you get busy people to participate across a long research cycle?	Seek broad community participation based on mutual benefit; engage different people across different research stages.
Identify local needs	How do you respect the community's priorities and keep members involved?	Use dialogical methods such as individual interviews and group methods; invest considerable time to develop trust.
Identify community assets and constraints	What are hidden local skills and talents? What are individual and organizational resources? What are the constraints?	Employ community capacity inventories and community asset maps; document and be sensitive to constraints.
Use community as the unit of analysis	Who is the community? Who are legitimate representatives? What are important sociocultural influences?	Invest time to grasp the dynamic, complex, and heterogeneous nature of community; look for representatives with extensive community contacts; draw on sociocultural theories.
Seek collaborative research relationships	How do you gain the competencies needed to engage in social change? How do you develop relationships across differences in culture, race, class, and gender?	Find community expertise across the roles of leader, organizer, researcher, and educator; use accessible language; develop cultural competency; use multiple entry points within diverse communities; produce research on topics relevant to community needs.
<b>Stage 2: Ongoing Research: Dialogue, Reflection, and Analysis</b>		
Respect local expertise	How do you balance power in the research relationship? How do you seek out different competencies?	Specify beneficiaries and responsibilities ahead of time; include community members in planning and conducting research.
Consider sociocultural context	To what extent do existing social structures represent resources or constraints?	Leverage resources and develop solutions that work around constraints; constraints may implicate broader injustices that may involve larger-scale efforts involving structural changes.
Build local capacities	How do you develop local capacities and resources to support the program?	Begin with small, tangible changes that solve immediate problems before attempting large-scale initiatives; develop skills that are valued locally.
Seek opportunities for colearning	How do you engage the community in reflection, analysis, and interpretation?	Disseminate findings to the community; integrate community resources into the research process; share control in the research process.
Manage conflict productively	How do you manage conflict that invariably arises around important issues with different interest groups?	Work with local people who understand the norms; get basic training in conflict resolution; within reason, allow conflict to occur.
<b>Stage 3: Action and Evaluation</b>		
Share research output	Who receives credit in the research reports?	Lay out policies and procedures for publishing from the project.
Develop sustainable programs of action	How do you ensure that the social intervention continues after you leave the community?	Leverage existing social institutions to develop sustainable interventions.
Conduct high-quality research	What are the appropriate validities by which to evaluate CAR?	Achieve different validities across several research cycles.
Act ethically	How is confidentiality protected when a community is involved in public discussions? How do you navigate IRB policies that do not reflect the realities of emergent designs?	The community members should decide ahead of time on procedures used to protect confidentiality; work within existing institutional review board policies by breaking the project into stages that are reviewed.

Notes: Draws from the research of Israel and colleagues (2005), De Koning and Martin (1996), and Minkler and Wallerstein (2003).

tial benefits of a research project are transparent and relevant (Wallerstein et al. 2005). Considerable obstacles may exist in trying to involve other important community members in the research process, given that they may lack time (e.g., working parents), suffer chronic illnesses (e.g., diabetes), mistrust researchers (e.g., an African American familiar with the Tuskegee study of untreated syphilis in black men), or struggle economically to make ends meet (e.g., the working poor) (Schulz et al. 2003). Achieving broad community participation is also difficult in societies in which a tradition of passivity exists, lower castes are stigmatized, or women and marginal groups have little voice (Khanna 1996).

Within Esperanza, the problem of diabetes was identified by local and tribal governments, both of which had formed committees on the issue. The town council was deliberating on the allocation of land for a kidney dialysis center, given the growing local demand for this service due to the rate of diabetes in the community. Our initial contact, Dr. Manuel, was a local physician who was actively involved in addressing the health needs of the community. He was an attractive partner because he had grown up in the community, and from initial interviews in the community, it was clear that he was a respected member of the tribe. He made his medical offices available for interviewing people, provided contacts for interviews, and offered input into the initial research design based on his understanding of the community. However, it soon became clear that this diverse community of Mexican and Native Americans would require a wider set of contacts to understand the diverse local needs. Consequently, we began working with a health and welfare advocacy group in Esperanza that met monthly with 30–40 members at any given meeting. The members of this advocacy group had expertise in different aspects of the community, including service providers of health care; social programs; public safety; education; athletic programs; and local tribal, county, and state governance. Within this group, ongoing informal interviews and observations were gathered, but we also formally presented our findings for input. The advocacy group eventually spearheaded a community action project that emerged from the research.

From this advocacy team, other important relationships were developed until a broader set of community relationships was eventually established (see Figure 1). Additional relationships were formed within a community college with 4 teachers, 6 administrators, and 21 students from Esperanza. Two classes became involved in the project. The students and faculty gave input into the research design. We provided training in conducting interviews, and the students then collected data, reflected on the findings, and made recommendations for action. We also gathered informal feedback from 21 local health practitioners and staff members from tribal programs throughout the study for their insights and feedback. A sustainable intervention works best when housed within existing community organizations because researchers eventually exit the community (Minkler 2006). As established institutions, the local college and tribal programs were attractive partners.

People with a long history and extensive contacts in the community are often invaluable resources. For example, Professor Ramon, director of the local community college,

was a hub within a dense social network. He introduced us to people in the local advocacy group and to health practitioners, as well as professors and students in local community college classes on social work and Native American culture. He organized diverse community representatives who met to discuss the ongoing findings from the study. This relationship with Professor Ramon evolved over months and needed to overcome negative feelings left by a formerly funded grant project. As he stated, “People (researchers) from the outside come in with their ideas. They don’t understand us or our processes. They step on toes, they duplicate efforts, and they leave when the grant money runs out.” Thus, research needed to be relevant and sustainable to community members to break through these previous negative research experiences. Past programs fostered this mistrust; the following quotation provides evidence of tensions arising between insider and outsider groups:

Usually when you see a program come like this, you have a lot of people who are not at all from our community. And there was one program that came in here, and it took three years. But their most successful year was their last year. Because it takes that long to build a relationship, the trust with the kids, and what are you going to do.... And then when they leave, the kids, who had come to really enjoy the program, were left high and dry. So why should I listen to you? (Margarita, community member)

Resistance to research is not unusual when studying vulnerable populations that are overresearched or when funded research develops unsustainable programs. Compared with many traditional research approaches, a CAR approach may make greater inroads in this environment of mistrust, given that community partners help work on sustainable locally grown solutions.

The CAR approach also begins by documenting community needs and assets. Research partnerships are important resources for learning about the community and shaping initial research on the issues facing the community. While any method might reveal assets, the CAR foregrounds the capacities of the community as resources that can be leveraged to solve community problems through ongoing programs (Minkler and Hancock 2003).

### ***Identify Local Needs, Assets, and Constraints***

Because the focus in CAR is on positive social change, it is important to be cognizant of local needs, assets, and constraints. Although any method could be used at this stage, a preference is for methods that allow for dialogue with community members to increase their involvement, commitment, and ownership of the project. Interviews with formal and informal community leaders provide a less structured way to discover the opportunities and challenges facing the community. Similarly, group methods that allow community members to discuss issues are also suitable, including focus groups, the nominal group technique, or informal discussions (Minkler and Hancock 2003).

Within Esperanza, our initial research began with several informal interviews with Dr. Manuel, who discussed the community broadly and gave specific research suggestions. We also conducted interviews with health care workers and

patients from his and other health clinics. At this point, we believed that Dr. Manuel's entrée would facilitate initial interviews, given that he was well respected in the tribe. Discussions and informal interviews with the advocacy group members were also invaluable for a broader community perspective. For example, these interviews fleshed out the local face of poverty, such as inadequate public transportation and cultural food patterns that affected diabetes. From this research, we began to understand the widespread problem of intergenerational diabetes and the limited medical resources within the community.

A range of approaches can be used to document community assets, which can be as simple as walking through the community and noting the condition of the infrastructure or listing the recreational facilities, health organizations, libraries, spaces for congregating, and so forth. This process can also be as elaborate as conducting a community capacity inventory, which is a survey of individual and organizational skills (Chaskin et al. 2001). Such systematic presentation of the community strengths not only identifies resources but can raise awareness of the hidden and diverse talents, which is an advantage of a CAR approach (Minkler and Hancock 2003). For example, our field notes in Esperanza document community resources, such as cultural and civic pride and significant social networks:

The next stop was in front of Our Lady of Guadalupe Church. I was surprised to see the celebration of the Quinceañera. This is the traditional Mexican fifteen-year-old party where the young lady is introduced as a young adult. The young lady was dressed with a nice pink dress. Family and friends were surrounding the young lady. She was the center of the attention and relatives were taking pictures with the girl. Family and friends were very well dressed. They were smiling, laughing, and seem proud of celebrating the Quinceañera with the young lady.... I got the feeling I was in a "small town" where everyone knew everyone and it was not unusual to walk up to anyone and start a conversation.

Community constraints and needs are also documented. While Esperanza is surrounded by a vibrant metropolis, poverty and an aging and inadequate infrastructure clearly demark the boundaries of the town. Some public investment exists, such as the community college and town hall, but small and sometimes poorly constructed homes, unpaved roads, and few sidewalks signal the lack of public and private investment in many areas. In an interview, a physician aptly said, "If you go down into deep Mexico and go into the little towns in Mexico,... you'd be very impressed by the likeness."

Community members' sense of isolation and feeling of "otherness" are reinforced by periodic immigration sweeps by sheriff's deputies who question community members' very legitimacy as citizens. One of our interviews at a children's social club was interrupted by a staff member who expressed concern over the safety of the children given that arrests were occurring within a hundred yards of the club. Perhaps the most dramatic demonstration of the community's sense of marginalization and disenfranchisement from broader civic life was the dissolution of their middle and high school and the busing of even their elementary children to surrounding communities. As one community member stated, "[T]hey said,... 'look, we're going to divide

this town....' [Y]es, they took [it] upon themselves to do this." Thus, many community members believe that they are an out-group, isolated from civic life and with important decisions made for them with little input from them. Against this backdrop, CAR is a particularly relevant method for groups that have a history of disempowerment and marginalization from civic life. A traditional research method that imbues the researcher with power and control could have had the unintended consequence of remarginalizing the community members who the researcher hoped to help by communicating that they possess neither the skills to reflect on their social conditions nor the powers to change them.

### ***Use Community as a Unit of Analysis***

Community is the unit of analysis for CAR projects and is defined as a group of people who share common needs or interests. A community may be geographic, as in the case of a neighborhood or retirement home, which makes the task of defining the boundaries less problematic, or a community may arise through group identification, as in the case of people who share a similar culture and history (e.g., native Innu) or suffer from a chronic illness (e.g., AIDS), which sometimes makes identifying community boundaries more challenging.

Our definition of the parameters of the community emerged through research. While the boundaries of Esperanza are physically defined, town members expressed social solidarity through their strong commitment to this tightly knit community that was a safe haven of warmth and social support. As one participant stated, "The community is very much about helping the entire community as opposed to individual oriented. So they will help each other."

Consistent with social identity theory, however, community members often define themselves as an in-group that exists in opposition to an out-group (Ashmore, Deaux, and McLaughlin-Volpe 2004). For example, people from outside Esperanza are approached with apprehension and caution. As one community member stated, "Because I can tell you right now, if a white woman walked into my Nana's living room, she wouldn't be.... If she saw her walking up, she would say, 'Ah what does that white woman want over here?'" This sense of being an in-group was often reinforced in medical encounters that evoked feelings of being an out-group, such as when community members felt stigmatized as apathetic victims who were "herded" for medical care or, worse, were treated as insignificant or invisible. In our interviews, health practitioners communicated perceptions of community members as apathetic and unmotivated. Moreover, medical encounters were sometimes strained. One physician suggested that his older clients did not feel comfortable with him and would often come with family members who would provide social support or act as translators.

While these insider-outsider tensions quickly emerged in the early stages of our data collection and analysis, extended contact with the community revealed a more nuanced notion of community as a unit of analysis. The use of the term "community" evokes a homogeneous group, which belies community as heterogeneous, dynamic, and

sometimes conflictual (De Koning and Martin 1996). Grappling with the complexities surrounding community is not unique to the methods of CAR (Arnould 2001). What is unique to CAR is that no community intervention is sustainable without understanding the dynamics between and within the groups.

First and foremost, two ethnic groups, Native and Mexican Americans, composed the in-group of Esperanza. Formal membership in the Native American group is determined by a person's percentage of native blood and is an objective requirement for being a registered tribal member. Although both ethnic groups were members of the Esperanza in-group, group membership was sometimes conflictual, such as that of a community health worker who was torn by her identity as a health professional and tribal member. Conflict was also apparent since the groups had access to different resources because the town's budget was modest, but the tribe had a broader set of health and social services generated by casino revenues and additional federal sources. Resources might be differently distributed even within one family, as the following informant explained:

[T]he tribe can utilize all of those services, whereas if you are just a resident of the town, you don't get those services,... and within one family,... the mother might be part of the tribe, but the children—because the father was not a Native—are not tribal member,... so that plays a part in it,... and again the tribe has money.

Moreover, the boundaries of this community are porous; some community members (e.g., Dr. Manuel) left the community, were exposed to new experiences, and, after returning, were viewed as "outside insiders." Similarly, an "outsider" who worked in a children's program in the community for almost a decade was well trusted and embraced affectionately as an adopted member of the community—an "inside outsider." Thus, community is a complex and multifaceted set of interweaving and overlapping relationships, and sustained and extensive contact is required to understand local dynamics.

The issue of determining who best represents "the community" and how to involve them is a unique but central methodological challenge of CAR. People with strong, long-standing relationships with the community are usually viewed by the community as legitimate representatives (Sullivan et al. 2003). However, it is difficult to get community members to participate throughout a research project that may span months and even years. One solution is to have people participate in different ways, at different times, and with varying degrees of intensity. For example, in Esperanza, community members who were students at the local community college were trained in interview techniques and then conducted some interviews during this CAR process, which were analyzed and presented to the community participants. It is widely believed that good CAR needs direct involvement of community members so that they may provide input throughout the research process. Although an ethnographic study might also reveal these complex community dynamics, findings such as the in-group/out-group theme might not have emerged as readily without the focus on obtaining effective community partners in the action research. Thus, a key difference of

CAR is that the community is collaborating in the research and is likely to take greater ownership of the findings, as we discuss next.

### ***Seek Collaborative Research Relationships***

Community action research is part of a broad plan of social change; research is one step in this larger process. Few academic researchers can fulfill all the roles required within this broad plan: leader, organizer, researcher, and educator. A leader is needed to initiate the project; such a person needs to have legitimacy in the community and excellent communication skills (e.g., Dr. Manuel, working in his medical clinic, had legitimacy within the Native American community). A community organizer is desirable to bring together various health practitioners, consumer advocate groups, businesses, local governmental leaders, and community members (e.g., Professor Ramon, working through the community college, was at the hub of many social networks). A researcher well versed in a range of methods and possessing strong analytical skills is needed (e.g., the coauthors were trained in a range of critical field methods). Finally, an educator is required who can translate these findings back to the community (e.g., Juanita Santos, a tribal case worker, translated some of the research insights to a youth program). Thus, the researcher needs to identify complementary individual and organizational strengths in potential partnerships given the larger goal of social change (Stoecker 2003).

Within CAR, the most novel methodological feature is that researchers and community participants form some degree of a collaborative partnership (Ozanne and Saatioglu 2008). Community action research cannot occur without these research partnerships. Ideally, these relationships are based on mutual understanding in which decision making is shared in nonhierarchical relationships characterized by interaction, trust, and dialogue (Wallerstein et al. 2005). However, research relationships can vary from projects initiated and controlled by outside researchers to studies directed and initiated by the community. Researchers must navigate different power sharing across partnerships for a variety of reasons. It is not unusual for the researcher to initiate the research project. Such a path will take considerable investments to develop trusting relationships in the community. Alternatively, a community may be aware of its problem but lack the time to engage in research. In this case, researchers are sought as collaborators in the research process. In any case, a good CAR adviser will encourage and seek community input throughout the research process. Thus, the degree of involvement of the researcher and the community in the different stages of CAR varies. The more difficult and demanding challenge is for the researcher and community participants to forge a collaboration in which they share power by respecting mutual expertise; the outside researcher contributes expertise in methods and theories, and the community participants contribute insights into theories-in-use, their assets and needs, and the local social and cultural dynamics (Stoecker 2003).

We initiated the research in Esperanza with Dr. Manuel and began by broadly exploring the concept of well-being in initial interviews. He conveyed to us the problem of the rising rates of diabetes in Esperanza despite prevention pro-

grams, a town committee on diabetes, past attempts at education, and several tribal educational programs. Thus, it was apparent that this was a problem identified by the community. As researchers, we provided the expertise and leadership on the methods and research process. Consistent with the collaborative spirit of CAR, we sought input from Esperanza community participants regarding which methods might work best and their reactions to emergent findings. At the early stages of research, our positionality began as outsiders who most local people politely ignored because it is the custom to be courteous. As we worked with the advocacy group and the local college and tribal programs, our positionality became that of an “inside outsider,” and we were respected given our expertise, involvement, and commitment to the community. As a member of three advisory boards for new health promotion interventions and a participant in actions initiated by the tribe, we became more trusted, and the relationship moved toward a more collaborative partnership in which our voice was one of many working to improve health outcomes. Although it is difficult to untangle all the factors that led to a shift in the quality of our relationships within the community, a sustained presence in community activities, such as helping at health fairs and sharing research findings, was clearly important. The following excerpt from field notes explores this evolution:

What a difference! It makes me feel so good to come to a community get-together now. If I ever need cheering up, this is the place to come! At points, earlier on, I did not always look forward to coming to Esperanza. I have so many people coming up to me now with an issue they think I would want to know about, introducing their children, grandchildren, nanas, giving me a hug or a touch as they go by me, telling me that their baby has finally arrived, or sharing their recipes with me (now that is a big one!!). I remember a couple of years ago the frustration and lack of understanding when I could get so few of them to even sign up for interviews let alone show up for an the interview. I wanted to quit doing the research and move on to something else that was easier! This is the second year that this program for children has been run using the photo documentation technique that I taught them. It is heartwarming. What a warm community! And I used to think that they didn't like me and that they thought I was faking my interest.

Given the demands exemplified in these field notes, researchers may take a year just to develop a presence and basic understanding of the community, particularly when diversity exists across culture, race, or ethnicity and when barriers exist in gaining acceptance within a community. In addition, though not unique to CAR, a significant degree of cultural competency is needed to interact respectfully with community members. In Esperanza, many of the residents employ traditional health rituals and folk healing. One of the authors brought considerable experience from her past research on *curanderos* and herbal remedies. This knowledge was mainly of Mexican American health practices, and more effort was necessary to gain cultural knowledge of tribal health practices.

## Stage 2: Ongoing Research and Education: Dialogue, Reflection, and Analysis

During Stage 2, community partners commit to work on the project, and consensus develops on the most relevant com-

munity problem. The process of building relationships continues throughout the field work but is a less prominent feature of later stages (see Figure 1). A multimethod approach is codeveloped among the researchers and members of the CAR partnerships based on the problem that has been identified and the community's needs and assets.

A wide range of data-gathering techniques are viable, from quantitative tools, such as surveys, to qualitative tools, such as open-ended interviews. At a minimum, potential methods should be discussed with community members for their input. When we ran into obstacles in conducting the research, community members' insights and suggestions were invaluable. For example, some methods were perceived to be engaging and, thus, were evaluated to be more appropriate (e.g., creating collages). Ideally, community members participate in the research process, collecting and analyzing the data. For example, we trained community members to conduct interviews and develop photo essays. More widely known techniques, such as observations, interviewing, and surveys, tend to be used so that community members can participate, but any data-gathering technique is potentially feasible. Members often lack the time to participate fully, and the analysis of data is often the responsibility of the researchers. However, if community members are involved, they will have greater opportunities to learn and build capacities and may have greater commitment and ownership of the project (Martin 1996).

Next, the emergent findings are presented to different community groups for dialogue, reflection, and analysis. It is not unusual for this cycle of research and education to occur several times. In Esperanza, the research team, sometimes with members of the community, presented the emergent findings to groups four different times, twice to the advocacy group and twice to community gatherings of 21–30 community members. We also regularly discussed the results with other community partners. Community members were receptive, enthusiastic, and involved during these presentations, such as one woman who jumped up and proudly took ownership exclaiming, “That's my quote.” The meetings at times evolved into discussions about shared challenges within the community, such as intergenerational conflict. Consider the following example:

[W]e were brought up to be housewives, even though we have to work [outside the home] and things like that; my grandmother always believed that we should do our job at home also—is cleaning, and cooking, and I guess maintaining the house for our husbands and our children. And if we don't do that, she says we should be ashamed of ourselves.

We used multiple methods in our CAR in Esperanza. To understand the social construction of diabetes, we interviewed community members and did “autodriving” (Heisley and Levy 1991) with photographs. Participants were asked to take photographs of what they did to be healthy, what their family did, and what is done within their culture. After exploring the meaning of their pictures, we specifically interviewed people on practices related to diabetes. Given that diabetes is a lifestyle illness, it was important to understand the lived experience and social construction of this illness and how it affects behavior. Photographs and in-depth interviews provided different modalities for explor-

ing these insights. Many people found photography to be a creative way to express their thoughts and feelings. In the interviews, community members were able to reflect on their lived experiences, which led to greater self-awareness. Often, people explored contradictions between their beliefs and actions, which can be an impetus for change.

Flexibility is crucial when implementing methods because the design invariably evolves. For example, we began doing interviews with young adults but expanded our interviews to be multigenerational because diabetes had a tremendous impact across generations. Our original interviewees, young adults, faced the demands of one and sometimes two jobs, as well as home, family, and community responsibilities. Thus, the four-step process of meeting to obtain the cameras, taking photographs, returning the cameras, and then meeting again for an interview proved infeasible. Given input from community members at a meeting, we then developed an alternative one-step method in which community participants could develop collages during the interview; these collages were then used to autodriven the interviews in lieu of the photographs.

Throughout Stage 2, key challenges involved respecting local expertise, understanding and leveraging the sociocultural context, encouraging capacity building and opportunities for colearning, and managing conflict. We discuss these challenges next.

### **Respect Local Expertise**

A guiding principle throughout this research process was to respect local expertise (see Table 1). Within the Western medical model, expertise is located within the community of health professionals, which is exemplified by medical phrases such as “compliance with the medical regime.” However, community members have evolved both beneficial and detrimental health practices, and CAR must start with where people are and understand and build on beneficial practices if action plans are to be feasible. For example, Khanna (1996) finds within a poor rural Indian district that 80% of the local herbal remedies had a sound pharmacological basis. Thus, researchers developed holistic women’s health programs that affirmed this native expertise by encouraging the growth and use of these medicinal herbs, which was both economically feasible and empowering for the women. In Esperanza, some of the traditional foods were healthful in terms of diabetes prevention and health maintenance, such as a vegetable stew that is customary within the tribe, while other foods, such as the use of lard in tortillas, were detrimental to health.

Respecting the local experience in this study meant trying to understand the experience of diabetes from the perspective of those who are experiencing the disease. As one informant noted, in Esperanza, “There are so many people with diabetes that it is almost accepted with a ‘no surprise’ attitude.” Despite the prevalence of diabetes among a person’s circle of family and friends, many people are “scared” to discuss the disease, are tired of thinking about it, and are faced with other and more pressing demands of daily survival. As another informant stated, “Most people are willing to avoid going to the doctor if it means that they have another \$25–\$30 to help pay the mortgage.” Thus, diabetes is an illness that competes with the many other stressors of

living in poverty. Notably, for a disease that is so prevalent, little discussion occurs among community members. Diabetes is treated as a taboo subject, and some of the informants did not even know if their family members have diabetes. One of our presentations to the community was called “Shhhh ... Don’t Call It Diabetes” because of our findings regarding this taboo.

### **Consider Sociocultural Context**

The sociocultural institutions and practices can be either resources that can be leveraged or challenges that must be addressed. In Esperanza, medical decisions are viewed as family decisions. When medical decisions are approached as decisions of the individual, the patients often experience anxiety or fail to make any decision. The practice of group decision making on medical problems conflicts with U.S. medical practices of patient privacy and confidentiality. Thus, interventions need to consider the prevailing social and cultural structures and practices that may affect any health intervention.

Similarly, it is difficult to untangle the inexpensive food selections made by families within Esperanza from the more controversial issue that community members hold jobs that do not provide for a living wage.

Once in a while my mom would buy a round steak, you know? That’s a tough piece of meat. She would chop it up into little pieces and cook it with potatoes and that was a meal. It would make a lot for a large family. At most maybe three or four times a year. The rest of the time it was just beans and rice, or macaroni, or potatoes.

However, the most important sociocultural finding that arose in this study was the symbolic meanings of food. “Well, I think a lot, there’s, you know, the Mexican culture, the Indian culture, and it’s all about food, food, food.” Traditional food is the social glue that binds families intergenerationally, and within their frequent social gatherings, serving traditional foods binds the community intragenerationally. One participant captured this pervasive sentiment when talking about traditional foods and traditional ways of making food: “It’s something that kind of keeps you connected to your grandparents or whatever ... almost precious, special ... aunt and uncles ... a big family thing.” The “old ways of cooking” are appreciated, and resistance was expressed to health messages that negated the very cultural heritage that defined the community: “Now they are going more into being a little more healthy, except for the cultural foods—that won’t change.” As one health practitioner said, “They don’t want to change. They’re very proud and they stick with their heritage and they stick with their food.” One informant said that her in-laws used to visit regularly when she served traditional food, but they stopped coming over after she started cooking more healthfully.

Another important sociocultural understanding is that personal information spreads quickly throughout the tightly knit community of Esperanza. Some informants confided that they would not work with a local tribal case manager for fear that her community ties would trump her promise of patient confidentiality. In contradiction, community members voiced a strong preference to work with local community health workers. Any practical solutions must

take into account this social interconnectivity by, for example, ensuring that health workers have extensive training in establishing trust and protecting confidentiality. This contradiction might also be overcome by hiring native case managers from another tribe who are not part of the local social network but still possess a deep understanding of local cultural practices.

### **Build Local Capacities**

Schulz and colleagues (2003) find that one of the largest motivations for community members to participate in CAR is to gain new skills to effect changes in their communities, such as skills in problem solving, organizing, public speaking, and leadership. The community partnerships are also attractive because they create social spaces in which people can share experiences, become aware of latent talents, develop confidence, and build social solidarity (Khandekar 2004). People become committed to the CAR, not for the abstract promise of research findings but rather for the concrete help that the partnerships provide for solving immediate problems. As we mentioned previously, the members of the community enjoyed developing photo essays and then engaging in auto elicitation. Tribal case managers subsequently adopted this technique and used it in an educational camp for tribal teens. Other skills gained by community members include skills in interviewing and public speaking.

### **Seek Opportunities for Colearning**

Learning by both the researchers and the community members occurred throughout the extended research process, and emerging insights were used to shape the research direction. For example, initial attempts to schedule interviews were often rebuffed, or people failed to show up for interviews. In subsequent group discussions, the research team learned that community members often juggled two jobs and a family. Moreover, norms of politeness often led people to agree to interviews that their busy schedules did not permit.

Similarly, the research team and Dr. Manuel initially conjectured that young parents would be most interested in engaging in healthful behaviors as role models for their children, but these people were the family members most pressed by the dual demands of family and jobs. What we found instead was that people who had the most healthful lifestyles had observed traumatic events related to diabetes as children (e.g., amputations, diabetic shock, dialysis). In addition, community discussions revealed that parents and grandparents were more likely to engage in informal healthful practices for the benefit of their children than to participate in formal programs to improve their own health. Our emergent findings suggested that children were viewed as their most precious resource. One participant expressed the feelings of many when talking about her children:

Absolutely, encouraging them.... I'm very emotionally attached to them and try to express it, kissing their forehead, little things. No matter what happened in the world out there, I want them to have this security at home.

Thus, a resource to be leveraged was the feelings that parents and grandparents had toward their children, and these

feelings became an eventual entry point for a community-organized intervention initiated by the tribe.

In another instance in Esperanza, community assets were used in the research process to facilitate colearning. For example, strong kinship ties were cemented through regular and frequent community get-togethers, cultural traditions were preserved by enjoying food together, and the family was valued above all other aspects of life. As we mentioned previously, when the research findings were shared with the community and input was sought, we respected these traditions by adopting a festive spirit, sharing food, and inviting families. This sensitivity to cultural practices created a relaxed and comfortable context that facilitated communication and exchange.

Another important insight was that the existing diabetes educational efforts seemed to be a one-size-fits-all approach in which information was pushed at people through tools, such as brochures, rather than through any type of colearning that was customized to the needs of the individual or was culturally appropriate. Culture was viewed as an obstacle to learning rather than a resource, reinforcing an out-group perspective. As one physician noted, “[W]e have a huge teaching program here. But it’s on an individual basis. Every single person gets *the same thing* (emphasis added),... but the roadblock is incredible—lifestyle and tradition changes—you just can’t get through.”

Many of the women talked about a disconnection existing between the message to eat healthfully and their own practice of trying to cook and eat more healthfully. Women spoke of a need for demonstrations (“they need to show us how”) and cooking classes that could help them implement healthful changes into their traditional recipes and find acceptable substitute ingredients. Moreover, educational efforts targeted at families and friends were perceived to be more culturally appropriate than efforts focused on isolated individuals.

### **Manage Conflict**

Given the nature of CAR research that involves exploring complex problems in situations with different stakeholders, conflicts can emerge in real time. Community action research involves working with diverse groups of people who have different experiences and interests and different types and amounts of power relative to one another. It is unsurprising that conflict can and will emerge during participatory processes that attempt to get people to collaborate on research on important issues. While conflict is often perceived as a negative and threatening emotion, it often reveals relevant tensions that need to be considered. If CAR aims to achieve greater self-awareness and community understanding to inform social transformation, well-managed conflict can be an important catalyst (Cousins 1998).

As such, it is important for the researcher to have some basic skills in conflict management. For example, conflict emerged during one of the group feedback sessions when one woman admonished another for not managing her diabetes. She said that the diabetic woman “owed it to her children” to do so. Within limits, the researcher must be comfortable allowing conflict so that contested aspects and different social constructions can emerge. In addition, this challenge highlights the benefits of collaborating during

these interactions with community members who are more aware of local norms regarding conflict and the appropriate boundaries.

### Stage 3: Action and Evaluation

Within Esperanza, the findings from Stage 2 informed the action plans that eventually emerged. For example, past diabetes interventions came from outside the community and relied on external capacities. These past programs were implemented neither with an appreciation for the in-group needs and time needed to develop strong and trusting relationships in the community nor with an eye toward sustainability. The programs often made health recommendations that had a poor cultural fit. As in many cultures, food is a symbolic boundary that defines and expresses ties to the in-group.

In both our interviews and the group meetings, people freely shared recommendations for action, and consensus emerged on three general points. First, community members believed that the actions should be conducted by trusted people from within the community (in-group) who understood the culture and would ensure that the program would not evaporate when outsiders left. Second, they wanted educational methods that were experiential. Rather than having information imparted from an expert, they wanted demonstrations and translations to be cocreated to fit with the world in which they lived. Finally, they wanted the programs to focus on local children who were potentially most receptive. They treasured their children and wanted them to be healthy, even if the older generations were not. They were also well aware that the rate of juvenile diabetes was soaring within the community. These understandings guided the researchers and community partners as they entered the action stage.

#### Share Ownership of Research

The final stage involves working with community partners to devise and implement action plans that are then evaluated. A core assumption of CAR is that the local community has the right to benefit directly from the research.

Research practices that take away information and knowledge, no matter how valuable in other respects, miss the opportunity to contribute to a process of thinking, reflecting and acting, and deny groups in the community the chance to fight inequities (De Koning and Martin 1996, p. 16).

One of the participants articulated this idea from a community perspective: “[T]hey need to feel like they’re contributing and you’re not taking pity on them and you’re not wasting their time.” To have the most transformative impact, CAR researchers may need to go beyond writing specialized academic articles to include writing articles aimed at general audiences, publicizing their research, or, as in the case of CAR, getting involved in the practical application of their findings.

A good research principle is to decide ahead of time with community partners just how the research can be used. Voice and power can be balanced in the research relationship if all partners agree on how the research findings will be used. Many examples of protocols for informed involvement exist that specify who will be involved, who will

benefit, how disputes will be resolved, and how the findings will be used (see Brown and Vega 2003; Israel et al. 2003).

#### Develop Sustainable Programs of Action

As we noted previously, within Esperanza, a university program ran a successful program for teens that was unsustainable when grant funding ended. In parallel with our participants’ admonitions, the CAR approach leverages existing community resources and partners to develop sustainable programs. Moreover, this research process is organic and arises from community members who are considering results and suggesting interventions that they desire and on which they are willing to work. The results were presented to community groups across four different feedback sessions. A challenge for the researcher is to be patient; it takes time for these ideas to percolate and take hold in the community. Initially, our lack of patience was evident in field notes that documented our desire for some “action, any tiny bit of action” to be taken by the community. A dilemma exists because if the researcher spearheads a local solution or program, this intervention may fall apart when the researcher leaves the community.

One action that emerged from the study was the development of a *promotora*, or local health worker program at the local community college. The research findings revealed insider–outsider tensions between the community members and outside health practitioners. As members of the local community, the lay health workers can work with locals to develop prevention programs that are culturally appropriate and experiential, which were important requirements the community identified. Consistent with the general recommendations for sustainability, the program could be housed in an existing community organization and could employ locals.

This idea emerged initially after discussing the research results with Professor Ramon, who suggested the exploration of creating a program using local community members trained in health promotion. He then organized a diverse set of community advocates to explore the viability and nature of a *promotora* program. Our findings were presented, and after considerable deliberation, the advocacy group decided to develop a lay health worker program in conjunction with the community college. One of the researchers was invited on the *promotora* advisory board to help develop the program. In subsequent meetings, consensus emerged to base the curriculum design on Brazilian educator Paulo Freire’s ideas of problem-centered learning, in which adult learners work to cocreate materials through group discussions (Freire 1970). This program is scheduled to begin in spring 2010. Consistent with the community’s recommendations for action and the findings regarding in-group/out-group tensions, health services will be provided by community (in-group) members who are trusted and understand the culture.

Another action arose through the work of a tribal case manager who was a research participant. She used the photo essay technique that she learned from participating in the research when she developed a summer camp to help tribal teens explore both their cultural heritage and their views on diabetes. As a final output of this camp, the teens created a community mural to express their understanding of the

impact of diabetes on the community. This camp ran for a second year during the summer of 2009 and is anticipated to be an ongoing tribal program. Again, this action arose from both the recommendations of the community participants and the empirical findings.

The pivotal question in bringing about social change is who decides how best to improve the well-being of the community. Does the medical expert on diabetes decide? Should the visiting marketing researcher decide? Or should the community, which must live with the outcomes of the decision, decide? A CAR approach assumes that decisions must be made in collaboration and dialogue with the community if the program is to prosper. In *Esperanza*, with its long history of disenfranchisement, the right to choose is important for the development of community efficacy.

We offer a strong caveat at the action stage of research. Researchers must always be cognizant of the limits of their expertise and ensure that some other people in the multidisciplinary team have substantive expertise in the focal problem. In designing action, as with the design of a product, we have expertise in consumer behavior, marketing, and research methods. Most marketing researchers are not experts in the problem area and, as such, must be cautious not to overstep the boundaries of their expertise. Thus, it is inappropriate for researchers to develop independent action plans beyond their expertise. It is appropriate to be the consumer behavior expert, the marketing expert, and the methodology expert. Although one researcher in the team has a medical background, we are not experts in diabetes. Our goal in the research was to stimulate the community, with the aid of experts in diabetes, to participate in developing community-based research that ultimately informs the development of actions. As a result of the research, the community adopted two long-term educational programs that were appropriate for an illness such as diabetes that requires long-term lifestyle changes.

## Evaluation of CAR

Although the ultimate desired outcome of the research in *Esperanza* was social change that would lead to a decrease in the rate of diabetes, given the long-term nature of this outcome, intermediate goals are necessary. In recognition of this, one desired outcome was for the community to develop actions. A sustainable action plan requires that the community, not the researchers, implement the plan. Although the long-term action plans in *Esperanza* are still underway, the intermediate signs are promising. As we mentioned, the *promotora* program is set to begin. The camp for tribal teens ran again for a second year, and enrollments and family involvement doubled. This year, when the teens gave a final presentation of their work to the community, the event was moved to a larger venue because so many people attended. Next, we explore the validity assessments to be considered in CAR. We again use examples from *Esperanza* to illustrate assessment criteria, with the acknowledgment that actions are still ongoing and underway in the community.

## Conduct High-Quality Research

Overall evaluation of CAR is an area of considerable interest, and significant ongoing debate continues over best practices. However, the evaluative criteria need to involve the community members and reflect priorities that are meaningful to them (Springett 2003). Although differences will arise as a result of the specific community health projects, in general, research value is established by five evaluative criteria: outcome validity, democratic validity, process validity, catalytic validity, and dialogical validity (Ozanne and Saatcioglu 2008).

Outcome validity is the extent to which the health problem was resolved or improved. Donabedian (1968) suggests that quality health care is best assessed by examining whether appropriate processes are followed, whether adequate structures are in place, and whether, over the long run, actual health outcomes improve.<sup>1</sup> In our CAR approach, we discovered informal practices in the community that were working toward preventing diabetes unbeknownst to health care workers. For example, families walk together for enjoyment, and older residents share healthful native recipes with younger community members who had grown up on fast food. These informal processes are now being built on in the *promotora* programs. The intermediate goal of community-led action programs arose as the CAR results sparked interest and guided the development of the *promotora* program and the teen camp program. Documenting the long-term changes in lifestyle that could affect the rate of diabetes and overall health outcomes will take more time. A different health problem, such as the H1N1 virus, could have generated a communication program advocating more immediate and measurable outcomes, such as increases in hand washing.

Democratic validity is the extent to which key community members participated in shaping the research and the action. In this study, democratic validity was increased by seeking community members' advice on the appropriate methods throughout the research process. Community members were also part of the research team and helped collect data. They also shaped the research during the several cycles when we presented the findings to different groups of community members for discussion and input. Throughout the research, they stipulated the aspects of action that they believed were the most crucial and then developed corresponding actions.

Given the desire by CAR researchers to leave behind greater human capacity, process validity is the extent to which opportunity and time existed for learning. For example, community members were trained to conduct interviews, to provide visual documentation, and to present findings, which helped them develop new skills. The *promotora* program, based on adult-centered learning, holds promise for new learning opportunities. If lay health workers collaborate with family and friends within *Esperanza* to cocreate healthful and culturally appropriate recipes, process validity will improve.

Catalytic validity is the extent to which people were energized to be involved in and continue the work (Brad-

<sup>1</sup>We thank an anonymous reviewer for this useful point.

bury and Reason 2003). Notably, community members were most engaged and energized when commenting on the research findings and when making recommendations for action. Two formal community-initiated actions emerged from the research that will continue the work to decrease the prevalence of diabetes in the community: the *promotora* program at the community college based on the community recommendations and the ongoing camp for teenagers.

Dialogical validity is the extent to which the research process facilitated two-way communication with the research participants (Reason and Bradbury 2001). Informal interactions and presentations occurred at each stage of this collaborative process. This communication was integral throughout the research in Esperanza. Through dialogue with stakeholders, the focal problem was identified, partners were found, the methodology evolved, results were explored, and action plans emerged.

### **Act Ethically**

Ethical principles in CAR research are no different from those established by the Declaration of Helsinki (see <http://www.cirp.org/library/ethics/helsinki/>) and the Belmont Report (see <http://ohsr.od.nih.gov/guidelines/belmont.html>). In many ways, the CAR approach is fundamentally compatible with these basic ethical principles. The principle of respect for people means that participants should be treated as autonomous individuals and that people whose autonomy may be diminished should be shielded. Because the CAR approach assumes that power should be shared in the research relationship and that local expertise should be leveraged, this principle of respect is built into the very process of conducting CAR. The principle of beneficence suggests that people should not be harmed and that they should have an equal opportunity to benefit from the research. Similarly, because CAR attempts to include marginalized community members, develop local capacities, and disseminate research findings, the principle of beneficence is affirmed. Finally, the principle of justice means that the benefits and burdens should be fairly distributed (Jenkins, Jones, and Blumenthal 2004). The principle of justice is affirmed by community action researchers' goal to improve consumer well-being, particularly the welfare of people who suffer disproportionately.

From a practical standpoint, considerable challenges still exist. Part of the research process is to present the ongoing research findings to the community, which often makes it difficult to protect the confidentiality of participants. We made a special effort to ensure that the sources of our quotations would not be identifiable. Notably, though, our experience was that many participants wanted to publically claim ownership of their words and ideas. Thus, it is important to have community partners decide ahead of time regarding the policies guiding confidentiality.

Navigating institutional review boards (IRBs) can also be problematic because, in general, their procedures do not account for emergent designs. Community action research involves several research cycles that emerge over months, if not years. Thus, it is impossible to lay out a fixed research protocol. However, this problem can be partially resolved by viewing the research process as a series of projects that occur in stages; across each stage, separate IRB procedures

can be approved. For example, we managed this process by submitting IRB forms in the early stages of needs assessment and another set of IRB procedures as we moved into the investigation of diabetes. We also managed the dynamic nature of the research process by amending the protocol when our sampling of participants broadened. We invested time getting to know our IRB contact, carefully explaining the study to her, and developing a respectful professional relationship. Given the quality of this relationship, she responded quickly when we needed to make timely changes as the design evolved. Finally, community members who are trained to conduct research must understand the ethical norms so that they can follow proper IRB protocol.

## **Conclusions**

Ultimately, the difference between CAR and other approaches is action. People in the community actually took action as a direct result of the study. The community became efficacious and engaged in two homegrown programs of education that fit within the guidelines they had collaboratively set. One program appears to be ongoing. The other program is set to begin. Little evidence suggests that a study that employed the usual qualitative and/or quantitative approaches would have moved the community to action. These approaches do not dwell on the solutions to social problems as defined by the community. These approaches do not focus on capacities and institutional resources that can be leveraged in solutions. These approaches do not engage community members in finding solutions to their problems. Research done *without* the collaboration of the community would be someone else's research—outsiders' findings. Why would such research be a catalyst for a community's social change when it is not even published in the outlets read by the community? A CAR approach to social problems speaks with the community, not to the community. It acts as a social mirror not only reflecting back their problems but also shining light on their capacities and ability to act. Although another approach might have discovered the community's love for its children, this study documented that people in Esperanza actually engaged in social change for their children.

In summary, the CAR approach offers an alternative research methodology for researchers interested in doing research that can directly improve consumer well-being. While social marketing is a widely used tool for guiding programs focused on changing voluntary behaviors, CAR aims to collaborate with communities, build local capacities, and inspire locally based sustainable programs that are within the control of the community. Similarly, the new transformative consumer research movement has the laudable goal of seeking social change but currently lacks a way to link research findings to local social action (Mick 2008). A CAR approach provides the link. We reviewed the basic principles that guide this emergent research approach and focused on highlighting the dilemmas and potential solutions to conducting this type of research by using examples from an ongoing field study of diabetes. Because of the nascent nature of this methodology in marketing research, unrecognized challenges exist that were identified, and then solutions were suggested. The challenges of this type of

research are significant. Nevertheless, the social and health problems facing communities today are tremendous, and it is time for academic researchers to move out of the safe comfort of the academy and into the field where they can make a difference in the well-being of consumers.

## References

- Arnould, Eric J. (2001), "Ethnography, Export Market Policy, and Economic Development in Niger," *Journal of Public Policy & Marketing*, 20 (Fall), 151–69.
- Ashmore, Richard, Kay Deaux, and Tracy McLaughlin-Volpe (2004), "An Organizing Framework for Collective Identity: Articulation and Significance of Multidimensionality," *Psychological Bulletin*, 130 (1), 80–114.
- Bhattacharya, C.B. and Daniel Korschun (2008), "Stakeholder Marketing: Beyond the Four Ps and the Customer," *Journal of Public Policy & Marketing*, 27 (Spring), 113–16.
- Blumenthal, Daniel S. and Elleen Yancey (2004), "Community-Based Research: An Introduction," in *Community-Based Health Research*, Daniel S. Blumenthal and Ralph J. DiClemente, eds. New York: Springer, 3–24.
- Bradbury, Hilary and Peter Reason (2003), "Issues and Choice Points for Improving the Quality of Action Research," in *Community Based Participatory Research for Health*, Meredith Minkler and Nina Wallerstein, eds. San Francisco: Jossey-Bass, 201–220.
- Brown, Leland and William A. Vega (2003), "A Protocol for Community Based Research," in *Community-Based Participatory Research for Health*, Meredith Minkler and Nina Wallerstein, eds. San Francisco: Jossey-Bass, 407–409.
- Browning, Christopher R., Kathleen A. Cagney, and Ming Wen (2003), "Explaining Variation in Health Status Across Space and Time: Implications for Racial and Ethnic Disparities in Self-Rated Health," *Social Science and Medicine*, 57 (7), 1221–35.
- Centers for Disease Control (2005), "Fact Sheet," (accessed April 15, 2008), [available <http://www.cdc.gov/od/oc/media/pressrel/fs051026.htm>].
- Chakravarti, Dipankar (2006), "Voices Unheard: The Psychology of Consumption in Poverty and Development," *Journal of Consumer Psychology*, 16 (4), 363–76.
- Chaskin, Robert J., Prudence Brown, Sudhir Venkatesh, and Avis Vidal (2001), *Building Community Capacity*. New York: Aldine Gruyter.
- Cousins, Tessa (1998), "Giving Space to Conflict in Training," in *The Myth of Community*, Irene Guijt and Meera Kaul Shah, eds. London: ITDG Publishing, 58–70.
- De Koning, Korrie and Marion Martin (1996), "Participatory Research in Health: Setting the Context," in *Participatory Research in Health: Issues and Experiences*, Korrie de Koning and Marion Martin, eds. London: Zed Books, 1–18.
- Donabedian, Avedis (1968), "Promoting Quality Through Evaluating the Process of Patient Care," *Medical Care*, 6 (3), 181–202.
- Freire, Paulo (1970), *The Pedagogy of the Oppressed*. New York: Herder and Herder.
- Ger, Guliz (1997), "Human Development and Humane Consumption: Well-Being Beyond the Good Life," *Journal of Public Policy & Marketing*, 16 (Spring), 110–25.
- Giddens, Anthony (1984), *The Constitution of Society*. Cambridge, UK: Polity Press.
- Goldberg, Marvin E. and Kunter Gunasti (2007), "Creating an Environment in Which Youths Are Encouraged to Eat a Healthier Diet," *Journal of Public Policy & Marketing*, 26 (Fall), 162–81.
- Grier, Sonya A. and Shiriki K. Kumanyika (2008), "The Context of Choice: Health Implications of Targeted Food Marketing Environments to African-Americans," *American Journal of Public Health*, 98 (2), 1616–29.
- , Janell Mesinger, Shirley H. Huang, Shiriki K. Kumanyika, and Nicolas Stettler (2007), "Fast-Food Marketing and Children's Fast-Food Consumption: Exploring Parents' Influences in an Ethnically Diverse Sample," *Journal of Public Policy & Marketing*, 26 (Fall), 221–35.
- Heisley, Deborah D. and Sidney J. Levy (1991), "Autodriving: A Photoelicitation Technique," *Journal of Consumer Research*, 17 (December), 257–72.
- Hill, Ronald Paul (2007), "Journal of Public Policy & Marketing Scholarship: Changing the World One Article at a Time," *Journal of Public Policy & Marketing*, 26 (Spring), 1–3.
- Israel, Barbara A., Eugenia Eng, Amy J. Schulz, and Edith A. Parker, eds. (2005), *Methods in Community-Based Participatory Research for Health*. San Francisco: Jossey-Bass.
- Jenkins, Bill, Camara Jones, and Daniel S. Blumenthal (2004), "Public Health Ethics and Community-Based Research: Lessons from the Tuskegee Syphilis Study," in *Community-Based Health Research*, Daniel S. Blumenthal and Ralph J. DiClemente, eds. New York: Springer, 47–62.
- Jocz, Katherine E. and John A. Quelch (2008), "An Exploration of Marketing's Impacts on Society: A Perspective Linked to Democracy," *Journal of Public Policy & Marketing*, 27 (Fall), 202–206.
- Khandekar, Sujata (2004), "Literacy Brought Us to the Forefront: Literacy and Empowering Processes for Dalit Community Women in a Mumbai Slum," in *Women, Literacy, and Development*, Anna Robinson-Pant, ed. London: Routledge, 206–218.
- Khanna, Renu (1996), "Participatory Action Research in Women's Health: SARTHI, India," in *Participatory Research in Health: Issues and Experiences*, Korrie de Koning and Marion Martin, eds. London: Zed Books, 62–71.
- Koch, Tina and Debbie Kralik (2006), *Participatory Action Research in Health Care*. Oxford: Blackwell.
- Kozinets, Robert V. (2002), "The Field Behind the Screen: Using Netnography for Marketing Research in Online Communities," *Journal of Marketing Research*, 39 (February), 61–72.
- Kumanyika, Shiriki K. and Sonya Grier (2006), "Targeting Interventions for Ethnic Minority and Low-Income Populations," *The Future of Children*, 16 (Spring), 187–207.
- Liu, Yuping and Yvette E. Pearson (2008), "Direct-to-Consumer Marketing of Predictive Medical Genetic Tests: Assessment of Current Practices and Policy Recommendations," *Journal of Public Policy & Marketing*, 27 (Fall), 131–48.
- Martin, Marion (1996), "Issues of Power in the Participatory Process," in *Participatory Research in Health: Issues and Experiences*, Korrie de Koning and Marion Martin, eds. London: Zed Books, 82–91.
- Mick, David Glen (2008), "Introduction: Special Issue on Consumer Welfare," *Journal of Consumer Research*, 35 (October), 377–79.

- Minkler, Meredith (2006), "Improving Health Through Community Organization and Community Building: A Health Education Perspective," in *Community Organizing and Community Building for Health*, Meredith Minkler, ed. New Brunswick, NJ: Rutgers, 1–22.
- and Trevor Hancock (2003), "Community-Driven Asset Identification and Issue Selection," in *Community-Based Participatory Research for Health*, Meredith Minkler and Nina Wallerstein, eds. San Francisco: Jossey-Bass, 135–54.
- and Nina Wallerstein (2003), "Introduction to Community Based Participatory Research," in *Community-Based Participatory Research for Health*, Meredith Minkler and Nina Wallerstein, eds. San Francisco: Jossey-Bass, 3–26.
- Moore, Elizabeth S. (2007), "Perspectives on Food Marketing and Childhood Obesity: Introduction to the Special Section," *Journal of Public Policy & Marketing*, 26 (Fall), 157–61.
- Moorman, Christine (2002), "Consumer Health Under the Scope," *Journal of Consumer Research*, 29 (June), 152–58.
- Murray, Jeff B. and Julie L. Ozanne (1991), "The Critical Imagination: Emancipatory Interests in Consumer Research," *Journal of Consumer Research*, 18 (September), 129–44.
- Ozanne, Julie L., Canan Corus, and Bige Saatcioglu (2009), "The Philosophy and Methods of Deliberative Democracy: Implications for Public Policy and Marketing," *Journal of Public Policy & Marketing*, 28 (Spring), 29–40.
- and Bige Saatcioglu (2008), "Participatory Action Research," *Journal of Consumer Research*, 35 (October), 423–39.
- Reason, Peter and Hilary Bradbury (2001), "Introduction: Inquiry and Participation in Search of a World Worthy of Human Aspiration," in *Handbook of Action Research*, Peter Reason and Hilary Bradbury, eds. Thousand Oaks, CA: Sage Publications, 1–14.
- Rifkin, Susan B. (1985), *Health Planning and Community Participation*. London: Croom Helm.
- Schulz, Amy J., Barbara A. Israel, Edith A. Parker, Mulisa Lockett, Yolanda R. Hill, and Rochelle Willis (2003), "Engaging Women in Community Based Participatory Research for Health," in *Community-Based Participatory Research for Health*, Meredith Minkler and Nina Wallerstein, eds. San Francisco: Jossey-Bass, 293–315.
- Shultz, Clifford J. (2007), "Marketing as Constructive Engagement," *Journal of Public Policy & Marketing*, 26 (Fall), 293–301.
- Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson, eds. (2002), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: Institute of Medicine and the National Academy Press.
- Sontag, Susan (1988), *Illness as a Metaphor*. New York: Farrar, Straus, & Giroux.
- Springett, Jane (2003), "Issues in Participatory Evaluation," in *Community-Based Participatory Research for Health*, Meredith Minkler and Nina Wallerstein, eds. San Francisco: Jossey-Bass, 263–88.
- Stoecker, Randy (2003), "Are Academics Irrelevant? Approaches and Roles for Scholars in Community Based Participatory Research," in *Community-Based Participatory Research for Health*, Meredith Minkler and Nina Wallerstein, eds. San Francisco: Jossey-Bass, 98–112.
- Sullivan, Marianne, Stella S. Chao, Carol A. Allen, Ahoua Kone, Martine Pierre-Louis, and James Krieger (2003), "Community-Researcher Partnerships," in *Community-Based Participatory Research for Health*, Meredith Minkler and Nina Wallerstein, eds. San Francisco: Jossey-Bass, 113–30.
- Talukdar, Debabrata, Sumila Gulyani, and Lawrence F. Salmen (2005), "Customer Orientation in the Context of Development Projects: Insights from the World Bank," *Journal of Public Policy & Marketing*, 24 (Spring), 100–111.
- Wallerstein, Nina, Bonnie Duran, Meredith Minkler, and Kevin Foley (2005), "Developing and Maintaining Partnerships with Communities," in *Methods in Community-Based Participatory Research for Health*, Barbara Israel, Eugenia Eng, Amy Schulz, and Edith Parker, eds. San Francisco: Jossey-Bass, 31–51.
- Williams, David R. and Chiquita Collins (1995), "US Socioeconomic and Racial Differences in Health," *Annual Review of Sociology*, 21, 349–86.
- World Health Organization (1946), preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, (June 19–22).