DECOLONIZING HEALTH RESEARCH: COMMUNITY-BASED PARTICIPATORY RESEARCH AND POSTCOLONIAL FEMINIST THEORY

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ABSTRACT
Within Canada, community-based participatory research (CBPR) has become the dominant methodology for scholars who conduct health research with Aboriginal communities. While CBPR has become understood as a methodology that can lead to more equitable relations of power between Aboriginal community members and researchers, it is not a panacea. In this article, we examine CBPR’s decolonizing potential and challenges to meeting this potential. Specifically, we argue that those who use CBPR need to recognize and expose the ways in which power inequities are perpetrated if decolonization is to result from CBPR. Further, we argue that one of the ways to meet CBPR’s decolonizing potential is to utilize a postcolonial feminist approach.

It is now commonly accepted within Canada that research that is about Aboriginal peoples must be conducted by and/or with Aboriginal peoples. In fact, the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2010), the guiding document for academic research in Canada, requires Aboriginal peoples’ engagement in “Aboriginal research.” While the Policy notes that forms of engagement may vary between research projects and communities, Aboriginal peoples’ engagement and collaboration in research is no longer an option. The shift from health research conducted with and/or by rather than on Aboriginal peoples has been reflected in the growing popularity of community-based participatory research (CBPR) (Ermine, Sinclair, & Jeffrey, 2004; Viswanathan et al., 2004), as well as the requirement of the employment of this methodology in order to access some research funding opportunities (Ermine, Sinclair, & Jeffrey, 2004; Green & Mercer, 2001;
Minkler, Glover-Blackwell, Thompson, & Tamir, 2003). These changes are based on the assumption that CBPR results in a more ethical and equitable approach to health research, one that results in Aboriginal peoples’ desires and worldviews shaping research - in short, one that has the potential to facilitate the decolonization of health research. Indigenous researchers and communities are turning to Indigenous methodologies and ways of knowing, however, non-Indigenous scholars’ use of these approaches can be critiqued as a form of colonizing these approaches. As a result, we offer another way of approaching CBPR: postcolonial feminist theory. While, certainly, CBPR has its benefits, its potential drawbacks are often overlooked. In this paper, we argue that by situating CBPR within a postcolonial feminist lens, many of this methodology’s shortcomings can be addressed. As a result, we argue that when used in concert with postcolonial feminist theory, those who employ CBPR will have a better chance of ensuring that this methodology meets its considerable potential to serve as a tool for decolonizing health research.

This paper is divided into four sections. In the first section, we provide a history of the development of participatory research approaches and explain how this methodology has branched from action research (AR) to participatory action research (PAR) and community-based participatory research (CBPR). Second, we outline the strengths and weaknesses of a CBPR approach. Third, we provide an overview of postcolonial feminist theory and the ways in which this theoretical lens strengthens the potential for CBPR users to facilitate decolonization. Finally, we argue that the decolonization of CBPR can best be achieved through the employment of a postcolonial feminist lens.

**Development of CBPR**

Participatory approaches to research such as action research (AR), participatory action research (PAR), and CBPR (which we will differentiate below) are understood to have been shaped by three main influences: Kurt Lewin, Paulo Freire, and feminist theorists. Lewin (1946) coined the phrase “action research,” which he defined as a methodology where communities identify their issues, plan, take action, and then evaluate the results. Lewin emphasized that behaviour occurs within historical and social contexts, is determined by the totality of an individual’s experience, and that individuals interact in inter-connected groups (Reason & Bradbury, 2008).

Drawing on Lewin’s (1946) work, influential educator/philosopher Paulo Friere built upon the AR approach by further developing AR’s participatory component. Freire’s (1972) book, *The Pedagogy of the Oppressed*, is considered a key factor in shaping PAR. Freire influenced PAR through his call for the reformation of the hierarchical model of education and the production of knowledge (Leung, Yen, & Minkler, 2004). He encouraged members of marginalized communities to critically examine the structural reasons for their own oppression and to work towards social change (Baum, MacDougall, & Smith, 2006). PAR differs from conventional research methodologies in several ways: the PAR approach relies on conducting research with rather than on members of marginalized groups, which results in shared ownership of the research; PAR takes a community-directed approach; and the ultimate goal of PAR is action and positive change (Kemmis & McTaggart, 2000). PAR’s focus on change has the potential to bridge the theory-practice gap that exists in most
conventional research (Meyer, 1993; Munn-Giddings, McVicar, & Smith, 2008). Carr and Kemmis (1986) further refined the theory-practice gap and influenced a shift to a more critical approach to both theory and practice, thus shaping the critical action research discourse. Such critical approaches to AR called for self-awareness in the research process and called for the researcher to account for the way in which the research can effect and is affected by the researcher (Carson & Sumara, 1997).

The third major influence on AR and PAR methodologies was the work of feminist theorists. Feminist theories “have acted as an intentional counter to dominant theories about human experiences and strategies for change” (Frisby, Maguire, & Reid, 2009, p. 16). Traditionally, the academic lens has been one that is Western, white, and patriarchal. As such, feminist researchers challenged biases inherent in traditional research practices and called for methodological approaches that were aligned with feminist theoretical perspectives. Such a perspective, they argued, would shift patriarchal ways of understanding the world and create opportunities for greater balance of power and emancipatory knowledge seeking (Harding, 1986; Reid, 2004).

AR and PAR thus emerged as reactions to difficulties that occurred within conventional positivist research (Wallerstein & Duran, 2003). Traditional research has been criticized because there are limited attempts to employ marginalized peoples’ knowledge, there are difficulties in the recruitment and retention of participants and the research is seldom used for the betterment of the community (Jackson, 2002; Wallerstein & Duran, 2003). Moreover, in a traditional research approach, marginalized peoples are not empowered to generate their own knowledge in order to take action to work towards their own self-determined goals (Jackson, 2002; Wallerstein & Duran, 2003).

Derived from both AR and PAR, those who employ CBPR concentrate on research with communities (Etowa, Matthews, Vukic, & Jesty, 2011). Based on a systematic review of literature, Viswanathan et al. (2004) defined CBPR as follows:

> a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change. To expand this definition, we conclude that CBPR emphasizes (1) co-learning about issues of concern and, within those, the issues that can be studied with CBPR methods and reciprocal transfer of expertise; (2) sharing of decision-making power; and (3) mutual ownership of the products and processes of research. The end result is incorporating the knowledge gained with taking action or affecting social change to improve the health and well-being of community members. (p. 22)

This definition incorporates all of the major components of AR and PAR with a further distinction of defining community beyond limited inclusion criteria such as setting or location; CBPR researchers further recognize communities as social entities. For example,
George, Daniel, and Green (1998) defined a community as any group of individuals with something in common: “this definition includes cultural, social, political, health and economic issues that may link individuals who may or may not share a particular geographic association” (p. 186). The refinement of the use of the term community and the importance of researched community’s members identifying as a community provides a focused approach to this methodology.

There is often slippage in the literature with regards to classifying participatory methodologies. For the purpose of this paper, from this point on we will refer to CBPR as being inclusive of AR and PAR. While we recognize that despite sharing a common overriding framework, there are differences between these methodologies; CPBR has emerged as the current participatory approach of choice in health research.

**STRENGTHS OF CBPR IN HEALTH RESEARCH**

There are numerous, well-documented strengths to adopting a CBPR methodology. Those who use this methodology try to ensure that research is more responsive to community members’ priorities by creating a more balanced exchange than other types of methodologies for knowledge production and social action in communities (Roche, 2008). Indeed, this methodology is intended to realign traditional power relations between the researcher/researched through the creation of equitable roles between researchers and non-academic stakeholders/participants (Israel et al., 2006). Park (2001) argued that CBPR includes community members’ perspectives in the fabric of the inquiry. The building of relationships between researchers and community members can improve the quality of the research, the validity of results, and ultimately improve community health with the development of appropriate health strategies (Leung et al., 2004). CBPR practitioners attempt to strengthen a community’s problem-solving capacity through collective engagement in the research process. A participatory approach that includes community members in all aspects of its design also allows for the innovative adaptation of existing resources and can lead to creative solutions specific to the community (Uphoff, 1991).

Overall, CBPR has the ability to democratize knowledge and use research to advance community action and social change (Masuda, Creighton, Nixon, & Frankish, 2011). Jagosh et al. (2012) confirmed many of the aforementioned CBPR benefits through a literature review focused on the utilization of participatory research in health interventions. The authors concluded that, in line with a previous systematic review of outcomes on CBPR (see Viswanathan et al., 2004), CBPR in health research can improve research quality, empower community members, improve the capacity of local communities, and create more sustainable health interventions (Jagosh et al., 2012). Indeed, the number of publications that have engaged with CBPR has increased drastically since the 1980s (Viswanathan, et al., 2004). The increase in CBPR publications is an indication that community members are playing a greater role in health research that directly impacts their communities.
LIMITATIONS OF CBPR IN HEALTH RESEARCH

As with all methodologies, there are a number of weaknesses associated with CBPR. Kothari (2001) argued that CBPR's limitations fall into two categories: technical limitations and “theoretical and conceptual limitations of participation” (p. 139). To this list, we would add a lack of an ability to account for relations of power.

Technical limitations can include the reality that CBPR is often a very lengthy process that can be influenced by time constraints, finances, and resources (Israel et al., 2006). Additionally, the researcher has minimal control over the project and much of the control exists within local, often unstable political and societal systems (Israel et al., 2006), which can be difficult for researchers who are accustomed to having complete control over the research projects in which they are involved. Moreover, there has been no clear consensus on the definitions and descriptions of CBPR, which has led to confusion over the degree to which the criteria of CBPR must be fulfilled to meet the requirements of this methodology (Steckler & Dodds, 1998).

There are also theoretical and conceptual limitations to the CBPR methodology. The process of CBPR has been criticized with regards to its credibility in a scientific context due to the “absence of a theoretical framework” (Roche, 2008, p. 21). Despite the lack of a specific theoretical framework, CBPR has been strongly influenced by critical theory and feminist theories, particularly through these theories’ commitment to empowerment. Nevertheless, the tenets of CBPR, such as empowerment, are incorporated to varying degrees depending on community members’ desired approach to the research; this lack of consistency in approaches to CBPR can further challenge some researchers’ beliefs concerning the methodology’s integrity.

The third category of limitations to CBPR is the one upon which we will focus. CBPR cannot equalize all power relations; in fact, there are cases where CBPR may function to reproduce or re-inscribe existing power relations. Wallerstein (1999) went as far as to state that “there is never equilibrium of power in community-based participatory research” (p. 39). In this section, we examine the ways in which power can be re-inscribed through CBPR and the ways in which a postcolonial feminist approach to CBPR can resist this tendency. First, we will examine how Western worldviews/perspectives currently dominate health research landscapes. Second, we will address how the structure of the academy limits health researchers’ abilities to fully share research responsibilities with the community. Third, we will consider issues in upholding the ideals of CBPR and the distribution of power between health researchers and communities.

Dominance of Western World Views

Cooke and Kathari (2001) argued that the “discourse [of CBPR] itself, and not just the practice, embodies the potential for an unjustified exercise of power” (p. 4). Western academic discourses are embedded in a context of colonialism and oppression, which thus influence how CBPR is conducted. Health researchers exercise power to position their worldviews hierarchically above the community members with which they are working. Smith (1999) argued, “research is one of the ways in which the underlying code of
imperialism and colonialism is both regulated and realized” (p. 7). For example, as Smith (1999) pointed out, Western worldviews can (re)inscribe the dominant discourses of the Indigenous as other, homogenize the experiences of marginalized peoples, or misrepresent Indigenous peoples.

The re-inscription of dominant worldviews can occur with CBPR. An example of this potential re-inscription is the concept of empowerment in CBPR. The practice of empowering marginalized peoples assumes that the health researcher has the ability to exercise power over the marginalized – s/he is able to empower these individuals. Ultimately, such efforts to empower can, in fact, further marginalize participants. Mohan (2001), a postcolonial scholar, examined local knowledge and empowerment and pointed out that the Western concepts of empowerment for community members involved in participatory health research can further the process of domination in power relations. The concept of empowerment is viewed differently across cultures and the assumption that empowerment can be achieved through a Western research process can be problematic. The example of empowerment is just one instance that illustrates how CBPR is riddled with complex issues of power and authority on a number of levels. Differentials of power exist within institutional structures and discourses and are reinstated within social hierarchies, such as those within the academy.

Limits from the Academy
The academy is designed in such a way that it sanctions the health researcher as more powerful than the community members involved in the research – though community members are often referred to as “full partners” in the research. As noted by Cooke and Kothari (2001), power differentials can be identified within the responsibility structure where the academic researcher has to meet formal and informal bureaucratic goals bestowed on them by their institutions and funding bodies. For example, Cooke and Kothari (2001) pointed out that outsiders and experts often apply for the funding and set the research agendas instead of engaging in full community consultation and collaboration, which ultimately results in immediate power imbalances demonstrated in communication with funding sources and control over funding.

Furthermore, institutions pressure health researchers to produce documents and publications at rates that often exceed the timeframes of community meetings, which can result in insufficient community consultations and a failure to involve community members in all aspects of the research. Demanding academic or organizational deadlines may result in situations where quick decisions have to be made and where the researcher has to make decisions without consulting the community (Ponic, Reid, & Frisby, 2010). Overall, health research networks/systems are often not conducive to the achievement of more equitable power relationships.

Difficulty in Upholding CBPR Ideals
Cooke and Kothari (2001) have challenged the idea that CBPR is effective and positive for the community members involved in such research. They have charged that the ideals of CBPR are not upheld to the point of equal distribution of power between researchers and
community members. Furthermore, the existing power relationships or status of the participants can greatly influence the research process and outcomes. Cooke and Kothari (2001) argued that participatory approaches can reinforce existing inequalities in power within communities, which does not uphold the ideal of empowering the most marginalized. Power imbalances can be identified within communities, where existing hierarchies persist and the more outspoken community members can dominate the research processes. Israel and colleagues suggested that such inequalities within communities affect who can attend planning meetings or interviews and participate and whose opinions are valid (Israel, Schulz, Parker, & Becker, 1998). Goebel (1998) also identified problems with power inequalities in communities and recognized the possibility that CBPR approaches can be “prone to the silencing of marginal or dissident views” (p. 284). The marginalization of non-conforming views can occur within CBPR, where methods such as focus groups may create group dynamics that allow for the dominance or passiveness of particular individuals in shaping the research (Fontana & Frey, 2005). Indeed, Cooke and Kothari (2001) examined the issue of local knowledge reflecting local power relations and found that the powerful members of the community can shape the research process or the research outcomes.

Thus, despite the appeal of CBPR processes, there remain several important limitations to this approach. We argue that the adoption of a postcolonial feminist lens can assist CBPR practitioners in maximizing CBPR’s considerable potential.

**Postcolonial Feminist Theory**

Health research is often understood as being deeply rooted in relationships of inequitable power, with researchers as the “experts” who have the monopoly over the production of knowledge and the “social power to determine what is useful knowledge” (Gaventa & Cornwall, 2001, p. 173). This notion, in turn, produces health research participants, particularly marginalized individuals, as powerless. Such a dichotomized understanding of the powerful versus the powerless fails to recognize power’s complexity. Though CBPR has been heavily influenced by feminist and critical theory, it is not tied to one theoretical lens per se. Thus, in order to more adequately address the complexity of relations of power in CBPR, we turn to postcolonial feminist theory.

A postcolonial feminist perspective draws particular attention to the forces that maintain, sustain, and encourage uneven relations of power (Anderson, Khan, & Reimer-Kirkham, 2011; Reimer-Kirkham, 2003). Furthermore, a postcolonial feminist lens can be used to demonstrate how power is embedded in, and operationalized through, both history and place (Anderson et al., 2011). Postcolonial feminist researchers attribute existing power relations to the colonial legacy that still dictates what is deemed normal and appropriate in research (Cargo, Delormier, Levesque, McComber, & Maccaulay, 2011). Postcolonial feminist theorists work to “expose, describe, and change ideological and social structures that maintain inequities between Aboriginal and non-Aboriginal populations” (Smith, Edwards, Varcoe, Martens, & Davies, 2006, p. 31). A postcolonial feminist lens provides a tool to understand how power, through advantage and disadvantage, operates based on historical positioning, class, race, and gender (Anderson & Reimer-Kirkham, 1999). In the
world of academic health research, this means recognizing that academics are typically in an advantageous position of power and must be cognizant of this privilege. Postcolonial feminist perspectives are particularly complementary to the methodological tenets of CBPR because they share a commitment to challenging and disrupting dominant relations of power, including colonialism, and work to validate culturally-specific forms of knowledge. A postcolonial feminist lens acknowledges and brings to the forefront marginalized populations’ experiences and histories, not just women’s. As such, we argue that it is an appropriate and useful theoretical approach for CBPR practitioners to use.

**POSTCOLONIAL FEMINIST THEORY: ADDRESSING CBPR’S LIMITATIONS AND FACILITATING DECOLONIZATION OF HEALTH INTERVENTIONS**

There are a number of ways in which the adoption of a postcolonial feminist approach to CBPR can challenge dominant relations of power at work in health research at both the micro and macro levels, which in turn, can facilitate decolonization. In this section we argue that health-related CBPR that is informed by a postcolonial feminist approach can challenge dominant relation of power through displacing the health researcher as being the centre of relations of power. Further, through the process of reflexivity, CBPR practitioners are encouraged to continually examine relationships of power. CBPR also encourages a process of co-construction of data, which facilitates the production of health research that reflects marginalized peoples’ worldviews.

**Decolonization**

Adopting a postcolonial feminist lens in CBPR allows for an analysis of and action upon the historical relations and the Western worldviews that have contributed to such deep structural inequalities in research, which in turn, works towards the larger project of decolonization. Decolonization is the ongoing process of exposing and challenging colonialist power, including all the institutional and cultural influences that have remained since colonialism (Ashcroft, Griffiths, & Tiffin, 2007). Decolonization of health research and CBPR requires a shift of perspectives in both the theoretical and research arenas to understand and acknowledge Indigenous peoples’ worldviews. Smith (1999) argued that this does not imply a total rejection of Western knowledge; however, in order to understand marginalized peoples, those in dominant positions must hear marginalized peoples’ stories from their own perspectives.

In order for decolonization to occur within health research, the effects of colonialism have to be examined and exposed. Postcolonial feminist theorists use the term decolonization to denote “a process of centering the concerns and worldviews of the colonized Other so that they understand themselves through their own assumptions and perspectives” (Chilisa, 2012, p. 13). These scholars recognize the potential of research to essentialize, exoticize, and reify colonial relations of power over marginalized peoples (McEwan, 2001; Mohanty, 2003). Postcolonial feminist theorists further caution against the homogenizing of research processes or communities of people to prevent further marginalization and power differentiation. From a postcolonial feminist perspective, health research environments are still dictated by colonial powers and discourses. Conscientious efforts that explicitly work towards decolonization through the intersections of CBPR and postcolonial feminism
inherently challenge the framing, defining, and homogenizing of communities and can instead co-create beneficial outcomes.

**Power**
The decolonization of research processes is possible in CBPR when paired with postcolonial feminist theory’s challenge of larger systems of power. Understanding power differentials within CBPR requires macro-level examinations of the factors that may impact individuals’ positions and worldviews in research. Postcolonial theorists’ formations of power work to disrupt “historical racist views and structural inequities that have emerged through the practices of colonization” (O’Mahoney & Donnelly, 2010, p. 443). Recognizing, representing, and creating space for Others through health research requires challenging structural inequalities and adopting a lens that is open to worldviews that vary beyond those typical of Western academia. By adopting a postcolonial feminist lens, one is able to examine power structures and focus on regular experiences of marginalization, micro-politics, and macrostructures that intersect to perpetuate oppressions (Reimer-Kirkham & Ryerson, 2010). CBPR practitioners who take up postcolonial feminist theory pay attention to power imbalances that exist on a large scale, such as the distinctions between the dominant Western research paradigm and non-Western societies. CBPR researchers can support the concept of decolonization through using a framework, like postcolonial feminism, that privileges the worldviews of the oppressed and marginalized (Roche, 2008).

Research relationships tend to reflect power dynamics that are influenced by broader social inequalities, such as race, education, and class (Israel et al., 1998). These dynamics can result in the researcher being produced as being superior to the community members. Baum, MacDougall, and Smith (2006) noted that inherent in CBPR is the questioning of the nature of knowledge and the examination of the ways in which knowledge can further represent the interests of the powerful to preserve status in society. A postcolonial feminist approach to CBPR removes the health researcher from the central position of power and asserts that researchers and community members have equally valuable contributions to make to the research. By displacing the researcher from the central position, there can be a more equitable power relationship.

**Reflexivity**
At the core of CBPR is reflexivity, which is a strategy that both health researchers and participants engage in to understand and improve research practices and outcomes. Such a strategy acknowledges existing power dynamics prior to the initiation of research and encourages the constant questioning and re-evaluating of the ways in which a more equitable balance of power can be achieved. Such evaluation and challenging of power throughout the research process is central to the process of decolonization through a postcolonial feminist lens. This process can work to resolve unequal power relations due to differences in class, gender, and ethnicity that may exist between researchers and participants, between participants themselves, and between researchers. Constantly and reflexively examining how power is manifested in research and then acting to make its exercise equitable and beneficial to those who are marginalized aids in the decolonization of academic health research.
Co-Construction of Knowledge

The co-construction of knowledge through CBPR is another way in which a more equitable balance of power is purported to be achieved in CBPR. Boser (2006) stated, “assuming that knowledge is power, action research embraces a democratic ideal of seeking to locate research within a normative process in order to share power that knowledge brings” (p. 12). Thus, CBPR researchers seek to share power and decision making in the generation of knowledge (Boser, 2006). Co-construction of knowledge can lead to relevant findings and solutions for the community with anticipation of a greater equilibrium of power at the community level. The adoption of a postcolonial feminist lens ensures that knowledge is not centred within a mainstream paradigm, but rather in the perspective of marginalized peoples (Racine & Petrucka, 2011). CBPR that is approached through a postcolonial feminist lens thus attempts to address micro-level issues of power in research while challenging dominant systems of knowledge and power.

Despite the benefits that can be accrued to attempts to facilitate decolonization in health research, there are conflicts that can arise; nevertheless, conflict with regards to power can be productive. In a systematic review on CBPR literature and health research, Jagosh et al. (2012) found that there can be positive outcomes that emerge through conflict between researchers and community members in the research process. Conflict can function as a means through which stakeholders can renegotiate power relations and reinforce commitment to the collaborative work. Furthermore, power, as discussed from a feminist CBPR approach, can be generative when it is used “with” rather than “over” others (Ponic et al., 2010), which is one of the tenets of CBPR. A power “with” approach challenges dominant relations of power that can be identified in conventional research practices that rely on a hierarchical expert approach to generating knowledge. Given the potential to challenge and disrupt dominant power relations, CBPR is a valuable methodological approach that can benefit marginalized populations and realign power distribution when paired with postcolonial feminist theory.

CONCLUSIONS

The importance of participatory approaches in health research cannot be understated. In order to destabilize systemic power imbalances, there is a need for continued shifting and evaluating of power dynamics within research, particularly to ensure that power differentials are not knowingly or unknowingly reinforced. CBPR continues to be recognized as the most effective way to work on health related issues with Indigenous peoples and other marginalized populations. As we have shown, however, this approach is not without its shortcomings. We argue that a postcolonial feminist approach to CBPR offers another approach and a stronger commitment to theorizing power in a way that can more effectively lead to decolonizing praxis within CBPR.
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