

Community-based participatory research is not political

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The field of public health is under attack and facing a profound crisis of trust. Scientific expertise, once considered a cornerstone of societal progress, is increasingly questioned, reframed, or dismissed. Ideas that center marginalized or racial ethnic groups in the United States are either labeled as “woke” or “divisive”, inferring this work is not useful or dangerous. This erosion of trust in public health, spanning across rural farming towns to urban cities,^{1,2} seems politicized, lacking understanding of how health issues can cut across demographics and geographic regions. Although accountability in federal funded research is essential, growing politicization of studies on groups and scientific approaches risks dismantling models uniquely equipped to rebuild public trust. Community-Based Participatory Research (CBPR)³ can provide a solution to skeptical politicians and scientists who wonder how to do meaningful work with people, and community members who have diminished trust in science and public health.

In CBPR, researchers and community stakeholders equitably share decision-making authority across all stages of the research process, from problem identification to data interpretation and dissemination.^{3,4} CBPR merges academic expertise and lived experience to produce research that is scientifically rigorous and contextually relevant. CBPR scholars recognized that the exclusion of community voices from knowledge production perpetuated inequities and limited the applicability of scientific findings. CBPR fosters mutual learning, builds local capacity, and supports systems development,³ empowering participants by enhancing their ability to influence conditions affecting their lives while balancing generational knowledge and implementing actions that address community-identified needs.

CBPR emphasis on participation and action evolved from two influential traditions: “action research” introduced in the 1940s by Lewin,⁵ and the alternative research paradigms advanced in the 1970s by Freire.⁶ Lewin’s model centers on active engagement by those experiencing a problem, addressing it through an iterative cycle of fact-finding, action, and evaluation. Over time, CBPR became an established scientific methodology with defined principles, ethical frameworks, and

evidence of efficacy in producing sustainable interventions.

My work in Paterson, New Jersey provides an example of CBPR’s impact in an urban, under-resourced community.⁷ Paterson, a city of 160,000 residents, is characterized by economic inequality and high proportions of racial-ethnic minoritized residents.⁸ Over nearly a decade, we cultivated partnerships with community-based organizations, schools, and youth to address pressing mental-health and substance-use issues among adolescents. Iteratively, we co-developed an anxiety-prevention program rooted in cognitive-behavioral-therapy principles with a community partner, shaped by priorities and lived experiences of local youth.⁹ The program’s feasibility, acceptability, and effectiveness directly grew from sustained relationship-building, decision-making, and commitment to mutual capacity building.

In urban cities, CBPR has a well-documented track record of addressing health disparities through interventions in housing¹⁰ and food insecurity.¹¹ In the multistate Appalachian region, the Appalachia Community Cancer Network mobilized community leaders to co-create interventions targeting high cancer incidence and mortality.¹² In Ottumwa, Iowa—a predominantly Caucasian Midwestern town, the University of Iowa partnered with local leaders to design community-wide health interventions, balancing a focus on health disparities impacting their growing Latino population while centering community needs to improve health outcomes for all.¹³ While there are few studies on CBPR in higher income suburban communities, participatory approaches can be expanded on further to suburban America to address a range of health issues, such as cardiovascular disease, cancer prevention, and Alzheimer’s awareness. While these health concerns cut across demographics, income levels, and regions, the strategies to achieve sustainable solutions and regain trust are community-specific and driven.

CBPR ensures research questions emerge from local priorities rather than external agendas. It proceeds through co-design, developing the study protocol collaboratively, followed by capacity building to strengthen local institutions and leadership. Evaluation captures health outcomes and partnership dynamics, and sustainability is pursued through institutionalizing successful programs and securing long-term resources. Although CBPR findings may inform policy change—the methodology itself is apolitical. Its ethical imperative is inclusive by nature, accounting for all perspectives and addressing doubts from community partners

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and members. This approach has the power to coproduce knowledge and raise the voices of those who may have felt ignored.

I urge policymakers across the political spectrum and public health leaders to lean into CBPR and other community-engaged approaches as a necessary method. CBPR can reduce the tension between scientists and community members. Policymakers and health-agency administrations should direct federal, state, and local resources toward fostering sustained collaborations between academic researchers and local communities. Examples are state health departments funding regional “community research hubs”, jointly managed by universities and community coalitions, or federal agencies offering competitive grants that require power sharing between academics and community partners.

Funding mechanisms must prioritize long-term relationship-building alongside scientific output, recognizing that trust must build over multiple grant cycles. Policymakers should champion dedicated funding streams for CBPR that span multiple years, shield funds from abrupt political shifts, and mandate shared governance between researchers and communities. Legislative bodies could allocate percentages of public-health budgets to participatory research or require community representation on grant-review panels.

Academic institutions should use this shift to ensure promotion and tenure criteria, explicitly rewarding community-engaged research such as reports co-authored with community partners, community-driven policy recommendations and interventions, and evidence of community capacity-building, as markers of scholarly excellence, rather than as diversions from “real” science. Universities can institutionalize support by creating endowed chairs or fellowship programs in community-engaged research and integrate CBPR training into graduate curricula across public health, medicine, and social sciences.

The urgency of these actions cannot be overstated. Without intentional engagement, communities continue to turn to sources of information that confirm preexisting beliefs, regardless of accuracy. CBPR offers a countervailing force: aligning scientific inquiry with community priorities, fostering mutual respect, and demonstrating that science is responsive to—and reflective of—the people it serves. In doing so, CBPR

helps insulate public health from the political currents that threaten to erode its foundations. The question is not whether we can afford to support CBPR, but whether we can afford not to.

Contributors

IO: conceptualization, investigation, literature search, writing-original draft.

Declaration of interests

The author declared no conflicts of interest.

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