Am J Community Psychol (2020) 66:381–391
DOI 10.1002/ajcp.12453

ORIGINAL ARTICLE

Implementing Community-Based Participatory Research with Communities Affected by Humanitarian Crises: The Potential to Recalibrate Equity and Power in Vulnerable Contexts

Rima A. Afifi,[1] Sawsan Abdulrahim,[2] Theresa Betancourt,[3] Dima Btedinni,[2] Jenna Berent,[3] Laura Dellos,[4] Jordan Farrar,[3] Rima Nakkash,[2] Rilwan Osman,[5] Monisa Saravanan,[1] William. T. Story,[1] Moses Zombo,[6] and Edith Parker[1]

Highlights

- Research in humanitarian crises is complex, both ethically and methodologically.
- Community-based participatory research (CBPR) can address challenges of research in these settings.
- We describe application of CBPR principles in communities affected by protracted humanitarian crises.
- Choosing a CBPR approach with these communities can reverse power imbalance and recalibrate equity.
- Community psychology is uniquely placed to promote CBPR in these contexts.

Abstract Worldwide, over 70.8 million people are forcibly displaced from their homes as a result of persecution, conflict, violence, or human rights violation. In humanitarian crises, protection and the provision of basic needs are often prioritized. Research may be seen as opportunistic. However, without documenting and researching humanitarian responses, knowledge is not shared and does not accumulate, limiting the application of evidence-based interventions where they are most needed. Research in humanitarian crises is complex, both ethically and methodologically. Community-engaged research, and specifically community-based participatory research (CBPR), can address some of the challenges of research in these settings. Using case studies of research we have conducted with communities affected by humanitarian crises, we highlight challenges and opportunities of the application of the ten core principles of CBPR in humanitarian settings. Despite some challenges and barriers, CBPR is a highly effective approach to use when engaging these populations in research. We argue that the application of CBPR in these settings has the potential to recalibrate the scales of equity and power among vulnerable populations.

Keywords CBPR · Partnership · POWER · Community-engaged research · Positionality · Humanitarian crises

✉ Rima A. Afifi
rima-afifi@uiowa.edu

[1] Community and Behavioral Health Department, College of Public Health, University of Iowa, Iowa City, IA, USA

[2] Health Promotion and Community Health Department, Faculty of Health Sciences, American University of Beirut, Beirut, Lebanon

[3] Research Program on Children and Adversity, Boston College School of Social Work, Chestnut Hill, MA, USA

[4] Obstetrics and Gynecology Department, Carver College of Medicine, University of Iowa, Iowa City, IA, USA

[5] Maine Immigrant and Refugee Services, Lewiston, ME, USA

[6] Green Africa Sierra Leone, Bo, Sierra Leone

Introduction

Globally, by the end of 2018, 70.8 million people were forcibly displaced from their homes as a result of persecution, conflict, violence, or human rights violation (UNHCR, 2019a), often resulting in humanitarian crises. In this paper, we focus on "communities affected by humanitarian crises," and specifically on refugees displaced as a result of war or conflict.

In these communities, protection and the provision of basic needs such as shelter, food, and water are prioritized. Research is rarely prioritized and can be seen as exploitative (Leaning, 2001). Although research in

humanitarian crises is complex, methodologically and ethically (Mackenzie, McDowell, & Pittaway, 2007; Makhoul, Chehab, Shaito, & Sibai, 2018), it is nonetheless critical to identify priority health concerns and to document effective and equitable responses, including modes of delivery (Ford, Mills, Zachariah, & Upshur, 2009; Kohrt, Mistry, Anand, Beecroft, & Nuwayhid, 2019). The number and quality of studies on public health interventions in humanitarian crises has grown. A systematic review of interventions (1980–2014) found that only 35% of the 345 included studies were of high quality and that 77% of these had been published since 2000 (Blanchet et al., 2017). Thus, the scientific rigor of research studies and the evidence base for current practice remains weak (Ager et al., 2014; Blanchet et al., 2017). Reasons for the lack of rigor include (i) the realities of the context of these crises (limited resources, concerns about security, logistical challenges, political complexities) (ii) ethical challenges of conducting research in such settings; (iii) the vulnerability of communities affected by humanitarian crises and the imperative to save lives, and not question effectiveness; and (iv) the dearth of pre-intervention data and challenges to validity (Ager et al., 2014; Blanchet et al., 2017; Kohrt et al., 2019). Even when research is conducted in these settings, it is often not on priority health issues (Blanchet et al., 2017) and rarely scaled up (Ager et al., 2014). Methodological and ethical recommendations to strengthen research with communities affected by humanitarian crises have been suggested (MSF Ethics Review Board, 2013; Siriwardhana, Lignou, Doherty, & O'Mathúna, 2017), including engaging these communities throughout the research process (termed Community-Engaged Research, CEnR) (Ford et al., 2009; Kohrt et al., 2019; MSF Ethics Review Board, 2013; Siriwardhana et al., 2017). CEnR is depicted as a continuum of participation ranging from involvement only as study participants to engaging communities fully as research partners (Balazs & Morello-Frosch, 2013; NIH, 2011). Community-based participatory research (CBPR) has the potential to address the concerns raised above, but there has been little application of its principles to populations experiencing humanitarian crises.

Community-Based Participatory Research

CBPR is a "partnership approach to research that equitably involves..community members, organizational representatives, and researchers in all aspects of the research process" (Israel, Schulz, Parker, & Becker, 1998, p. 177). CBPR as an approach has roots in the methods and values of community psychology. Arising from the community mental health movement (Fondacaro & Weinberg, 2002), community psychologists have embraced CBPR to advance social justice goals (Chang et al., 2013; Lazarus, Bulbulia, & Taliep, 2015; Suarez-Balcazar, 2020). The CBPR process is guided by ten principles of engagement (Table 1). While acknowledging that the principles vary according to "context, purpose, and participants," commitment to each of the principles, and their integration, is critical for effective engagement (Israel et al., 1998, 2018).

Table 1 CBPR principles (Israel et al., 2018)

CBPR Principle
1. Recognize community as a unit of identity
2. Build on strengths and resources within the community
3. Facilitate collaborative, equitable partnership in all research phases and involve an empowering and power-sharing process that attends to social inequalities
4. Promote co-learning and capacity building among all partners
5. Integrate and achieve a balance between research and action for the mutual benefit of all partners
6. Emphasize public health problems of local relevance and ecological perspectives that attend to the multiple determinants of health and disease
7. Involve systems development through a cyclical and iterative process
8. Disseminate findings and knowledge gained to all partners and involve all partners in the dissemination process
9. Require a long-term process and commitment to sustainability
10. Address issues of race, ethnicity, racism, and social class and embrace "cultural humility"

By facilitating collaborative equitable partnerships in all research phases, involving an empowering and power-sharing process, and promoting co-learning of all partners, CBPR can attend to the concerns about lack of rigor, relevance, and scale-up in research with populations affected by humanitarian crises (Balazs & Morello-Frosch, 2013; Gibbs et al., 2018). An ethical framework for research in conflict settings identified benchmarks—collaborative partnerships, community engagements, and social value (Ford et al., 2009)—which run parallel with CBPR principles. Although CBPR can address health and social disparities in any community, it has most power when implemented with communities that have been marginalized or oppressed (Israel, Eng, Shultz, & Parker, 2005; Muhammad et al., 2015; Wallerstein & Duran, 2010), including those displaced due to war and conflict. Practices of CBPR, such as prioritizing knowledge of partners or centering power with community members, provide the potential to reverse power imbalance and recalibrate equity (Parker, Baquero, Gilbert, & Daniel-Ulloa, 2019; Sprague, Afifi, Ayala, & El-nasoor, 2019). Building on strengths and resources of community members uplifts their lived experiences, thus enhancing validity of data. Additionally, CBPR enhances relevance by emphasizing local problems, and increases reach and scale-up by disseminating knowledge to all partners and committing to a long-term process.

Challenges in Applying CBPR Principles in Humanitarian Settings

Although CBPR is a proven approach to address disparities in disadvantaged groups, challenges can arise when applying its principles in humanitarian settings. Below, we highlight challenges to implementing each CBPR principle with communities affected by humanitarian crises through the lens of two CBPR projects: The Congolese Health Partnership in Iowa, and the Qaderoon project in Beirut, Lebanon. We describe these projects briefly to provide context. We then further emphasize application of CBPR principles with communities affected by humanitarian crises through in-depth case studies of CBPR projects in Lebanon, Sierra Leone, and the United States.

Brief Description of Projects

The Congolese Health Partnership (CHP) is a project aimed at promoting maternal and child health in Johnson County, IA. The war in the Democratic Republic of Congo started in 1996 due to political instability and an invasion by Rwanda. In 2018, almost 8,000 Congolese refugees were resettled in the US. Currently, about 3,000 Congolese refugees and immigrants live in eastern Iowa, and face a multitude of barriers to obstetric care. The CHP—an alliance between the University of Iowa (UI) College of Public Health, the UI Hospitals and Clinics, and leaders in the Congolese community—was established in 2017 to improve knowledge about pregnancy and childbirth and build trust between families and providers.

Qaderoon (We Are Capable) was a social skills building intervention for mental health promotion among Palestinian refugee children, implemented in 2008–2009 in the Burj El Barajneh (BBC) camp in Beirut. BBC then housed 14,000-18,000 Palestinian refugees displaced after 1948, living in 1.6 km^2. Palestinian refugees in Lebanon have few rights, and live under dire conditions, including state-imposed restrictions on employment. *Qaderoon* was a year-long intervention for children (11–14 years), their parents, and teachers (Afifi, Makhoul, El Hajj, & Nakkash, 2011) developed through a partnership between researchers at the Faculty of Health Sciences, American University of Beirut and a Community Youth Coalition in BBC.

CBPR Principle 1

The experience of displacement due to a humanitarian crisis is profound. Displacement can strengthen community ties among people who share a common experience (e.g., Palestinian refugees in diaspora); or can break community ties following ethnic conflict/civil war (e.g., the Democratic Republic of the Congo, DRC) (Groupe URD, 2009). The crucial concept of "community" that is needed for CBPR may be hard to define (Yoshihama & Summerson, 2002). Displaced refugees can lose aspects of their identities such as language and culture. In struggling to maintain or redefine identity, community belonging can take on various forms. For example, the civil war in DRC caused families living in the eastern part of the country to flee to neighboring African countries where they lived in refugee camps for years before resettling in a third country. In Iowa, refugees who have resettled are joined by other immigrants from the DRC who have arrived on a Diversity Immigrant Visa, many of whom are coming from the capital, Kinshasa. The language, culture, and experiences of these two groups are vastly different. While forming the CHP, board members made a conscious decision to lay aside their identity (refugee or immigrant) and come together to serve the needs of the Congolese community. This new identity allowed the CHP to work cohesively toward a common goal. Understanding collective identities within refugee communities, and between the refugee and host communities, is critical in CBPR.

CBPR Principle 2

Strengths and resources include human capital (experience and work skills), social capital (networks, norms), natural resources (water, land), physical capital (schools, health centers), and financial resources (UNDP, nd). Often, humanitarian responders rush in to help, relying on a deficit problem-oriented model, forgetting the assets and strengths in every community. In larger scale humanitarian crises, human capital is significant. In the Syrian refugee crisis, there has been a call to utilize Syrian physicians to support the heath response (Fouad et al., 2016). Relying on local human capital can also create challenges, particularly in early phases of a crisis. Community members providing information to researchers (e.g., as translators or data collectors) may be viewed with less trust by their own communities (Mackensie et al., 2007; Muhammad et al., 2015). In protracted crises, where a sense of community may have been re-established, relying on social capital can be invaluable to CBPR efforts. As part of *Qaderoon*, youth mentors (aged 17–25 years) from the camp were hired to work as facilitators-in-training and were instrumental in liaising between the research team, the children, and broader community (Makhoul, Alameddine, & Afifi, 2012). This promoted trust and prevented pitfalls resulting from lack of cultural understanding. The project also used physical capital in the community; one of the schools was a site for the intervention with children, and a local NGO office for the intervention with parents. The *Qaderoon* project also bought all food supplies from local grocers in the camp.

CBPR Principle 3

In refugee settings, power structures can evolve when "community leaders" are selected and given formal roles by those managing the camps, though they may not be perceived as such by the "community." Researchers also tend to assume "cultural homogeneity," though it is rarely present (Mackenzie et al., 2007). Every community has multiple stakeholders who are often vying for leadership and advancing their own interests (Groupe URD, 2009; van der Haar, Heijmans, & Hilhorst, 2013). These socio-political dynamics are exacerbated in communities affected by humanitarian crises, particularly if they are displaced, as the host community also has multiple stakeholders with varied agendas. Understanding this complex environment is critical to the task of facilitating equitable partnerships (Groupe URD, 2009; van der Haar et al., 2013; WHO, 2016). The CHP in Iowa encountered inequitable power dynamics between the Congolese community and the healthcare providers. To overcome this, the CHP started by forming two advisory boards so that community voice would not be overshadowed by opinions of the healthcare providers. Throughout the first year of the CHP, community leaders and healthcare providers were given opportunities to interact at a community venue. After one year, a mutual respect was established between the community and healthcare providers and the two advisory boards were merged.

A further concern with respect to facilitating equitable partnerships is the dynamics between researchers and community members. A critique of CBPR highlights its lack of emphasis on researcher "identity" (Muhammad et al., 2015). Researchers are urged to be reflexive and examine their positionality and privilege—differential access to knowledge, power, and resources—as they engage with communities (Groupe URD, 2009; Muhammad et al., 2015). In *Qaderoon*, researcher privilege was evident in taken-for-granted norms. Researchers approached the project with a "no tolerance for violence" policy, which seemed obvious as a "privileged group" norm. But, they quickly learned that in contexts of structural violence such as humanitarian crises, this norm may cause "harm." For young adolescent boys who are coming of age in a marginalized violent context, walking away from a physical fight can destroy a sought-after masculine identity and potentially lead to harm for the boys and their families.

CBPR Principle 4

Authentic co-learning is closely linked to genuine equitable partnerships, and requires reflexivity and cultural humility, particularly of researchers (Goodkind et al., 2017). "Knowledge (the voices at the table), authority (power imbued to various stakeholders), and subjectivities (stereotypes of individuals and groups)" affect a comprehensive understanding of any phenomenon and resulting action (Tschakert et al., 2016, p.184). Interactive strategies to create safe spaces that allow all knowledge to be shared are needed. These can include accessing social networks and agencies that work with those most marginalized, and implementing lay ways of knowing, such as storytelling, drama, and community maps (Ndulue, Peréa, Kayou, & Martinez, 2012; Tscharkert et al., 2016). Strategies include hiring and training lay workers from the community to be engaged in the research; partnering with multiple grassroots organizations to help build capacity; and building relationships with these organizations prior to launching the research. Issue selection is also critical; choosing a "divisive" issue may threaten community trust (Minkler, 2004). The stress of the humanitarian crisis and migration may also affect the ability of displaced persons to enter a "co-learning" situation. The CHP was established to address an issue that would bring the community together (i.e., maternal and newborn health), rather than drive them apart. The CHP initiated learning opportunities on topics informed by the community and delivered by healthcare providers, with the aim of acquainting the community with healthcare practices in Iowa. But the tables quickly turned when healthcare providers realized that they needed to better understand Congolese culture and care practices to provider better quality care. New learning opportunities were developed, informed by healthcare providers, and delivered by the community.

CBPR Principle 5

In humanitarian settings, the balance between research and action may be hard to achieve. Although consensus is building on the importance of research in these settings, service provision remains the priority. In addition, the balance between research and action may be perceived differentially by researchers and community members. Community members may also have different priorities that influence their participation in research. In *Qaderoon*, parents were concerned that the content of the intervention was not "educational," which was their priority for their children. They thus began limiting their children's attendance at the intervention sessions. In response, the research team began offering extra English language instruction (not originally part of the "intervention") to the children, and attendance increased again (Makhoul, Nakkash, Harpham, & Qutteina, 2013).

CBPR Principle 6

Structural and policy factors influencing refugee health are quite difficult to change. Also, in acute humanitarian

settings, issue selection generally occurs by outside researchers, and may not be the problem perceived to be most relevant by the community. In more protracted humanitarian situations, an ecologic analysis of health and social issues leading to community-identified priorities is possible. This occurred in *Qaderoon*. A robust planning process led to the identification of mental health and school dropout as key priority issues (Afifi et al., 2011). An ecologic analysis identified evidence-based and community-experienced determinants. Yet, based on the perceived lack of ability to change State policies, the coalition agreed to focus the intervention on intrapersonal, interpersonal, and organizational levels.

CBPR Principle 7

CBPR aims to imbue communities with skills to iteratively develop partnerships, assess concerns, and identify then sustain solutions. This requires functional informal and formal systems imbedded in communities, but these systems can be impacted by humanitarian crises. Informal systems are affected by the displacement of persons and rupturing of social support networks. Formal health systems are often set up to respond to acute needs and are transient. Many refugee crises are becoming protracted (≥25 000 refugees from the same nationality exiled for five or more consecutive years; UNHCR, 2019a). Yet, development programs are still nascent in refugee humanitarian settings. A humanitarian-development nexus has been suggested, including integration of refugees into national health systems (Spiegel, 2017). This may facilitate systems development and the iterative process for CBPR. This occurred with the CHP in Iowa. After the first community event, which focused on health insurance, a pediatrician who was part of the advisory board was struck by the lack of health insurance options for pregnant immigrant women. She advocated for a policy that would allow pregnant lawful permanent residents to access Medicaid without a five-year waiting period in Iowa. Family medicine physicians have also addressed health system issues by starting a refugee clinic that allows for better interpretation, longer appointment times, and more flexible hours.

CBPR Principle 8

Another challenge faced when applying CBPR to the humanitarian context is the dissemination of findings to all partners. Some of the findings may result in harm to the community, or to individuals who provided the data, should they become public (Minkler, 2004; Muhammad et al., 2015). In addition, sharing results can be problematic due to high mobility of these communities (Mackenzie et al., 2007). Despite the challenges, disseminating findings is a critical CBPR component as it fosters trust and can inform future research and policy. Community advisory boards (CABs) can be instrumental to the successful dissemination of findings to the rest of the community and other stakeholders (Newman et al., 2011). The CHP in Iowa has faced challenges with the dissemination of maternal and newborn health messages to an evolving and diverse Congolese population. Using multiple languages (Swahili, French and Lingala) has helped, but it was also important to get ownership from community gatekeepers (e.g., pastors, community leaders) and to identify mechanisms to reach socially excluded community members (i.e., new to the community, semi-literate, unemployed).

CBPR Principle 9

The unfortunate nature of protracted crises enhances the possibility of a long-term process. However, mobility of refugees in some contexts is high, and thus, the nature of "community" is constantly changing, challenging sustainability. Sustainability is further challenged by the reality of funding. Access to funding for research is easier than access to funding for scaling up programs. Even when sustainability is built into the project from its inception, funding remains a main barrier. In *Qaderoon*, the research team engaged youth mentors as trainees and co-facilitators of intervention sessions, with intent to prepare a cadre of facilitators from the community to continue the intervention once the research project had ended. The research team also implemented a thorough process evaluation to understand the "black box" as a mechanism for quality improvement (Nakkash et al., 2012). Though the youth mentors gained skills (Makhoul et al., 2012), no further funds were received to sustain the intervention.

CBPR Principle 10

Since oppression and othering are likely drivers of humanitarian situations (Groupe URD, 2009), researchers may have difficulties addressing these structural and political issues. Yet, it is important that interactions between researchers and communities be authentic, empowering, and fully inclusive, providing opportunity to change paradigms and enhance equity and dignity. Ensuring representation by all social groups in the community (irrespective of their political, religious, or social beliefs) is critical to the true inclusiveness of the project. This likely requires partnership with an ally that has deep understanding of the historical context of the country/ community. Even when researchers identify with their community partners and understand the culture and history, they likely remain

different in their positioning and associated privilege (Muhammad et al., 2015). Although the researchers that were part of *Qaderoon* were Palestinian or Lebanese with deep insight into culture, language, and history of the refugee camp, none had lived in a refugee camp nor been treated (by the State or others) as a refugee. This privilege created a schism that required partnering with a project coordinator who had lived and worked in the camp for decades, and with the youth mentors, to ensure practices that uplifted all partners.

In what follows, we expand on the application of CBPR principles among communities affected by humanitarian crises using three in-depth case studies. For each case study, select CBPR principles are described as they occurred in the project, rather than in numerical order.

Cases

Case Study 1: Project *Amenah*: Addressing Early Marriage among Syrian Refugees in Lebanon through Community Engagement

Background

Amenah is a pilot project implemented in 2018 and designed to mitigate the drivers of early marriage among Syrian refugee adolescents who reside in Lebanon's Eastern Governorate (Bekaa). Syrians began arriving in Lebanon as asylum seekers following the 2011 violent conflict between Syrian government and opposition forces in what has become one of the most complex global humanitarian crisis. As of August 2019, 924 161 Syrian refugees were registered at the office of the United Nations High Commissioner for Refugees (UNHCR) in Lebanon. The highest proportion (37%) resides in the underserved Bekaa region (UNHCR, 2019). The Lebanese government has adopted measures to control the massive number of Syrian refugees, which negatively affected their livelihoods. The 2018 Vulnerability Assessment of Syrians in Lebanon report indicated that more than half of refugee children below age 17 were not enrolled in school, and a third of girls aged 15–19 were married (UNHCR, UNICEF, & WFP, 2018).

CBPR Impetus and Structure

In 2016, researchers in the Faculty of Health Sciences at the American University of Beirut met to discuss the possibility of developing an action research program on early marriage among refugee adolescents. Skeptical of a victim-blaming discourse that focused on the fertility rates of refugees, the researchers decided to conduct a survey to investigate the prevalence and determinants of early marriage in three towns in Bekaa (Adulrahim et al., 2017). They trained women from the Syrian refugee community as data collectors, and later engaged them in dissemination events and as partners in the thinking process as the *Amenah* project moved forward. While, initially, *Amenah* was not conceptualized as a CBPR project, the researchers invested in building a collaboration with a local organization serving Syrian refugees and nurtured a mutual and long-term relationship with a group of Syrian community workers (CWs) who delivered the pilot project.

Application of CBPR Principles

CBPR Principle 6. In 2017, the researchers organized a series of meetings with Syrian refugee mothers of adolescents to understand community perceptions of early marriage and its social drivers. Researchers learned a great deal about the perspectives and needs of mothers whose responsibilities multiplied following displacement. The mothers came from rural areas in Syria, were married at a young age and expected to contribute to the maintenance of the family inside the home. Post-displacement, many of them became the main breadwinners in the family while continuing to provide gendered domestic and caregiving duties. The mothers highly valued education and perceived lack of access to education in Lebanon as the primary obstacle they faced as refugees. They spoke of the challenge of registering their children (girls and boys) in school in Lebanon and the academic and social barriers their daughters encounter. Mothers considered girls marrying too young as a social problem, but also saw marriage as a form of protection for adolescent girls who were perceived vulnerable to harassment in public spaces.

CBPR Principle 2. The meetings with mothers uncovered positive assets that were leveraged in the design of *Amenah*—for example, value for education came out as a strong community asset. In presenting their plan to the broader community, researchers incorporated a strong focus on education, keeping girls in school and reducing their risk of dropout. Reducing early marriage was presented as a secondary, long-term outcome and within a framework of protecting the physical and mental health of adolescent girls. The researchers also framed the project as one advocating that adolescent girls deserve to be protected and that the family and school can provide this protection. Indeed, the title of the project, *Amenah*, meaning a girl/woman who is protected, was selected to reflect both the mothers' desires to protect their daughters and the researchers' proposition that adolescent girls deserve to be protected without having to marry.

CBPR Principle 4. As the project progressed into the implementation phase, researchers sought to enhance the

capacity of women from the Syrian refugee community to deliver it. A total of 14 CWs were recruited and trained. The training placed emphasis on enhancing the skills and knowledge needed to improve the quality of baseline data collection and other research components. It also incorporated diverse topics, including gender equity and human rights, empowerment, leadership, facilitation skills, and research ethics. There was strong focus on education during the training, as it was expected that the CWs would disseminate knowledge about the education system for refugee children in Lebanon among their social networks. The training was of mutual benefit to the CWs and the researchers. The researchers continued to learn about the community through the narratives of the community workers, and CWs built the skill set to improve the quality of the pilot project and to enhance their chances of gaining employment after the project ended. With a trained cadre of CWs, researchers were able to secure additional funding to ensure the continuity of the project, through scaling up the pilot and incorporating a stronger focus on adolescent girls' access to sexual and reproductive health knowledge and services. The collaborative relationship between CWs and researchers and the mutual exchange of knowledge continued during the delivery of the pilot project and beyond.

CBPR Principle 1. Finally, as the delivery of the project required a team effort, it was important to create a group identity among the CWs themselves and an equitable relationship between them and research team members. While one of the main principles of CBPR is to recognize community as a collective of individuals who share similar experiences, this may not be the case when working with persons displaced as an outcome of civil war. As such, the researchers were extremely cautious at first in not making assumptions about whether the women held similar political views vis-à-vis the events in Syria; for example, whether they were on the side of the regime or of the revolution or rebel forces. Moreover, as some of the research team members were Lebanese, the CWs were discreet in expressing critiques of Lebanese exclusionary policies toward Syrian refugees. There seemed to be an unspoken agreement to focus on the well-being of adolescent girls and not instigate discussions that may uncover political disagreements. It took time before trust was built and individuals felt comfortable expressing social and political views.

Whereas *Amenah* was not designed as a CBPR project at inception, a mutual partnership developed between researchers and Syrian CWs over time. This partnership was shaped by the iterative and dynamic research process but also by displacement-related contextual factors that the researchers were not privy to at the beginning of the project.

Case Study 2: LSWAY and Youth FORWARD in Sierra Leone

Background

Sierra Leone, a country of 7 million on the West coast of Africa (Togoh, Turay, & Komba, 2017) endured an 11-year civil war (1991–2002). The war displaced about two-thirds of the population (Gberie, 2005) and heavily relied on the use of children, with over 20,000 children associated with armed groups during the conflict (Human Rights Watch, 2005). The Longitudinal Study of War-Affected Youth (LSWAY) launched in Sierra Leone in 2002 as the first longitudinal study in sub-Saharan Africa to follow a cohort of former child soldiers and other war-affected youth. Since 2002, four waves of data have been collected, and the original cohort has expanded to include caregivers, intimate partners, and offspring. LSWAY began with the goal of illuminating risk and protective factors shaping social reintegration and psychosocial adjustment over time (Betancourt, Brennan, Rubin-Smith, Fitzmaurice, & Gilman, 2010); and has since expanded to understand how war experiences and post-conflict hardships impact adult functioning, family dynamics, and developmental outcomes in offspring. LSWAY findings have also led to the development of a stabilization- and skills-focused group intervention, the Youth Readiness Intervention (YRI), which aims to address co-occurring mental health symptoms and functional problems that may impede positive life outcomes and interpersonal functioning in war-affected youth (Betancourt, McBain, et al., 2014).

CBPR Impetus and Structure

LSWAY began as a collaboration between researchers and a large international NGO. The LSWAY project falls along the continuum of CBPR work and relies on many of the central strategies for community-engaged research, which have been instrumental in LSWAY's ability to continue despite the inherent barriers of conducting research in a post-conflict setting. A local humanitarian and reintegration worker working to reunite war-affected children with their families, joined the project as a major collaborator and has collected data from participants and their families at every stage of data collection. As LSWAY has grown from a longitudinal to a longitudinal intergenerational study, this worker has remained a constant piece of the partnership, deepening his role as a core advisor on ethical and cultural issues.

Beginning in 2010, a formal partnership was established with Caritas Freetown—the development and relief wing of the Catholic Church in Sierra Leone. Caritas

research assistants have overseen several aspects of LSWAY including outreach and community mapping of participants, collection of qualitative and quantitative data, and response to risk of harm referrals. The partnership with Caritas has also expanded to include YRI experts who have delivered the YRI and are now part of a collaborative research partnership known as Youth FORWARD.

Application of CBPR Principles

CBPR Principle 3. Community Advisory Boards (CABs) have been operationalized as one way to formalize academic-community partnerships and provide a mechanism for communities to assume a leadership role in research activities (Newman et al., 2011). LSWAY launched during a long period when there was no formal Institutional Review Board operating in Sierra Leone. As a result, the study was conducted with the inclusion of a local CAB, and with the input of experts and researchers who had a high degree of familiarity with the Sierra Leonean context, as well as local stakeholders who were invested in the mental health and overall well-being of youth in Sierra Leone. Two different types of CABs were used: a community CAB and a policy CAB. The former met quarterly to ensure LSWAY study measures were relevant, culturally appropriate, and contextually complete. The policy CAB met annually and helped to formulate key messages for working with local government and child protection partners. CAB activities have evolved given the needs of the research and the reality on the ground. As part of the power-sharing process, LSWAY CABs were instrumental in selecting, refining, and adapting study measures, which continue to be used in Youth FORWARD and shared with collaborators. When developing the YRI, CABs were created to include parents, youth, teachers, and staff from youth serving organizations, and representatives of local family support units in the police (Betancourt, Newnham, et al., 2014). CAB meetings ensured YRI was grounded in LSWAY findings, qualitative key informant interviews meant to illuminate barriers facing war-affected youth, and relevant delivery modalities considered salient (Betancourt, Newnham, et al., 2014).

CBPR Principle 6. The LSWAY research draws from a social ecological perspective (Betancourt & Khan, 2008) to consider the many socially mediated factors and resources at all levels of the social system (family, peer, and community) that influence child development and mental health in vulnerable populations. This has allowed for the creation of the YRI, which is currently being integrated into an entrepreneurship training program as part of an alternate delivery strategy for bringing evidence-based mental health services to Sierra Leone.

CBPR Principle 4. The YRI was further conceptualized to be deployment focused. Political, financial, environmental, and human resources limitations were threaded through phases of YRI development. Thus, and in line with targeted capacity building efforts, Caritas staff have received several rounds of training and supervision in YRI delivery. Currently, YRI developers assume a more technical oversight role with Caritas staff, overseeing in-country YRI training, selection of facilitators, and supervision and fidelity monitoring of YRI delivery. As the YRI evidence base grows, we anticipate that Caritas will lead expansion efforts with a goal of creating a community of YRI practitioners spread across several in-country organizations.

Case Study 3—The Somali Bantu community of Lewiston, Maine, USA

Background

Lewiston, Maine, a small city with a population of nearly 36,000, is home to over 5,000 resettled refugees from Somalia, many of whom identify as Bantu, an ethnic minority (US Besteman, 2016; Census Bureau, 2018). Most of the Somali Bantu were brought into Somalia as slaves in the 1800s and generations later continued to work as subsistence farmers in the Jubba Valley. Considered second-class citizens by many ethnic-Somali, the Bantu faced frequent discrimination and persecution. The oppression continued during and after the Somali Civil War, including while in refugee camps in Kenya. Identified as a persecuted minority group, the US government accepted over 10,000 Somali Bantu refugees between 2004 and 2006 (Besteman, 2016).

After resettling to the United States, a community of Somali Bantu began to form and grow in Lewiston, ME. With that, came new services and resources to help meet the needs of the growing population. In 2008, a local Somali Bantu community member, with a team of like-minded leaders, founded Maine Immigrant and Refugee Services (MEIRS)—a service agency developed to address the needs and well-being of Somali Bantu youth, and later, adults and families from all refugee and immigrant groups residing in the area.

CBPR Impetus and Structure

The partnership began in 2016 with a visit from the academic research team from the Research Program on Children and Adversity (RPCA) in Boston to Lewiston, to begin building a relationship with the MEIRS leadership and learn about the Somali Bantu community of Lewiston. A previous CBPR partnership had been formed by

this team with the Somali Bantu community of Greater Boston, which allowed for the adaptation of an evidence-based intervention—the Family Strengthening Intervention for Refugees (FSI-R) (Betancourt, Frounfelker, Mishra, Hussein, & Falzarano, 2015), and piloting it with 40 Somali Bantu families (Betancourt et al., 2019).

CBPR was a new concept for the community. Most had not engaged in research projects before, and an equal partnership between the community and an academic institution was particularly novel. Early meetings included learning about the strengths and challenges of the community, meeting with other service providers in the area, exploring the neighborhoods, and "mapping" out the families who lived there. In 2017, the teams would together launch an effectiveness study of the FSI-R with 150 Somali Bantu families from Lewiston.

Application of CBPR Principles

CBPR Principle 3. As noted above, CABs can facilitate collaborative, equitable partnerships (see Table 1). The CAB members, eight adults who meet quarterly, serve as liaisons between the research staff and the community. The CAB also serves as an ideal mechanism for disseminating research findings back to the community (CBPR Principle 8). They can relay study findings and updates, while equally importantly, communicate back to study staff community developments and aid in decision making. With balanced representation of age, gender, and occupation, the CAB members share unique perspectives and provide valuable insight to the research team. In 2018, a youth CAB was established to represent the Somali Bantu youth of Lewiston, provide their own unique perspectives, and share challenges and needs that differ from adults. Engaging youth is an important component to community-based interventions that involve families.

CBPR Principle 4. Another critical CBPR approach applied in this project is capacity building and creation of paid roles that involve opportunities for community members to advance skills. The program requires five roles supported by community staff: research assistants, community health workers, fidelity monitors, a clinical supervisor, and a local manager. Hiring and training staff from the communities is essential to successful home-visiting interventions, as the staff speak the local languages, understand the culture and unique challenges and strengths of the community, and are often already trusted individuals that community members welcome into their homes (Singh, McKay, & Singh, 1999). Building trust and rapport with families is essential for interventions that involve discussion of sensitive topics, such as mental health and family functioning, especially among communities with trauma history. Trusted community members as staff can aid in study retention, acceptance, feasibility, and ultimately, better outcomes. Community members also are provided economic opportunity and professional development.

Through allowing time and mechanisms to build trust and strong relationships with community members, CBPR practices foster cultural humility and co-learning. Researchers develop a stronger understanding of the community's history, experiences, and relations, and are better able to understand the cultural constructs of mental health and trauma. This allowed the community to be heard and validated and aided in development of the intervention. Strong relationships with key informants also provide insight into community in-group dynamics and cultural implications of decisions, which foster better decision making and prevent set-backs.

Ultimately, the relationship with MEIRS and the Somali Bantu community in Lewiston, ME has grown deep and the collaboration has fostered successful FSI-R implementation, capacity building within the community, and frequent stakeholder engagement. The program has adapted to meet the community's needs and ultimately deepened a strong partnership.

Conclusion

Research with communities affected by humanitarian crises is often driven by expert assessment of needs and solutions. By marginalizing community voice, research in these settings risks further traumatizing populations by exacerbating inequities experienced prior to the onset of crises and ensuing displacement. CBPR is a research approach that can address the challenges of research with communities affected by humanitarian crises. Just as CBPR has enhanced rigor, relevance, and reach in other research settings (Balazs & Morello-Frosch, 2013), it can do the same in research with communities affected by humanitarian crises. Further, we argue that it has the potential, when focused on integration of the ten principles of CBPR, of recalibrating equity and power in vulnerable contexts, restoring dignity, and rebuilding effective community.

CBPR exists on a continuum of CEnR. All the case studies in this paper approached communities with intent to develop equitable partnerships. While application of all the ten CBPR principles may not be possible in all communities affected by humanitarian crises, choosing from the menu of CBPR principles, without commitment to equity and justice or to an equitable partnership, risks a slippery slope towards tokenistic engagement (Parker et al., 2019). In this review, we have highlighted application of CBPR principles in communities affected by war-related protracted humanitarian crises. Other humanitarian

crises (acute and natural disasters) will require adaptation of these principles to the context.

Community psychology is uniquely placed to promote CBPR in humanitarian settings, through application of its principles of community strengthening, inclusion and diversity, and participation (Velaquez, Rivera-Holguin, & Morote, 2017). Community psychology can contribute to advancing "ethical, theoretical, methodological, and practical" knowledge in disaster settings (Herrenkohl, Mersky, & Topitzes, 2019; Morgato, 2020; Velaquez et al., 2017). We urge community psychologists, public health, and other researchers to commit to recalibrating the scales of equity and justice among communities affected by humanitarian crises by using CBPR as a core research approach.

Funding

Wellcome Trust (081915/Z/07/Z), National Institute of Mental Health (U19MH095705), National Institute of Child Health and Human Development (R01HD073349), National Center on Minority Health and Health Disparities (R01MD010613), Ford Foundation, International Development Research Center, Canada.

References

Abdulrahim, S., DeJong, J., Mourtada, R., & Zurayk, H. (2017). Estimates of early marriage among Syrian refugees in Lebanon in 2016 compared to Syria pre-2011. *European Journal of Public Health*, *27*(suppl_3).

Afifi, R.A., Makhoul, J., El Hajj, T., & Nakkash, R.T. (2011). Developing a logic model for youth mental health: participatory research with a refugee community in Beirut. *Health Policy and Planning*, *26*(6), 508–517.

Ager, A., Burnham, G., Checchi, F., Gayer, M., Grais, R.F., Henkens, M., … Spiegel, P. (2014). Strengthening the evidence base for health programming in humanitarian crises. *Science*, *345*, 1290.

Balazs, C.L., & Morello-Frosch, R. (2013). The three R's: How community based participatory research strengthens the rigor, relevance and reach of science. *Environmental Justice (Print)*, *6* (1), https://doi.org/10.1089/env.2012.0017

Besteman, C. (2016). *Making Refuge: Somali Bantu refugees and Lewiston*. Maine: Duke University Press, Durham NC.

Betancourt, T.S., Berent, J.M., Freeman, J., Frounfelker, R.L., Brennan, R.T., Abdi, S., … Beardslee, W.R. (2019). Family-based mental health promotion for somali bantu and bhutanese refugees: feasibility and acceptability trail. *Journal of Adolescent Health 66*(3):336–344.

Betancourt, T.S., Brennan, R.T., Rubin-Smith, J., Fitzmaurice, G.M., & Gilman, S.E. (2010). Sierra Leone's former child soldiers: a longitudinal study of risk, protective factors, and mental health. *Journal of the American Academy of Child and Adolescent Psychiatry*, *49*(6), 606–615.

Betancourt, T.S., Frounfelker, R., Mishra, T., Hussein, A., & Falzarano, R. (2015). Addressing health disparities in the mental health of refugee children and adolescents through community-based participatory research: a study in 2 communities. *American Journal of Public Health*, *105*(S3), S475–S482.

Betancourt, T.S., & Khan, K.T. (2008). The mental health of children affected by armed conflict: protective processes and pathways to resilience. *International Review of Psychiatry (Abingdon, England)*, *20*(3), 317–328.

Betancourt, T.S., McBain, R., Newnham, E.A., Akinsulure-Smith, A.M., Brennan, R.T., Weisz, J.R., & Hansen, N.B. (2014). A behavioral intervention for war-affected youth in Sierra Leone: a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *53*(12), 1288–1297.

Betancourt, T.S., Newnham, E.A., Hann, K., McBain, R.K., Akinsulure-Smith, A.M., Weisz, J., …Hansen, N. (2014). Addressing the Consequences of Violence and Adversity: The Development of a Group Mental Health Intervention for War-Affected Youth in Sierra Leone. Available from CUNY Academic Works.https://academicworks.cuny.edu/cc_pubs/387

Blanchet, K., Ramesh, A., Frison, S., Warren, E., Hossain, M., Smith, J., … Roberts, B. (2017). Evidence on public health interventions in humanitarian crises. *Lancet*, *390*, 2287–2296.

Chang, C., Salvatore, A.L., Lee, P.T., Liu, S.S., Tom, A.T., Morales, A., … Minkler, M. (2013). Adapting to context in community-based participatory research: "participatory starting points" in a Chinese immigrant worker community. *American Journal of Community Psychology*, *51*(3–4), 480–491.

Fondacaro, M.R., & Weinberg, D. (2002). Concepts of social justice in community psychology: Toward a social ecological epistemology. *American Journal of Community Psychology*, *30*, 473–492.

Ford, N., Mills, E.J., Zachariah, R., & Upshur, R. (2009). Ethics of conducting research in conflict settings. *Conflict and Health*, *3*, 7.

Fouad, F.M., Alameddine, M., & Coutts, A. (2016). Human resources in protracted crises: Syrian medical workers. *The Lancet*, *387*(10028), 1613.

Gberie, L. (2005). *A Dirty War in West Africa: The RUF and the destruction of Sierra Leone*. Bloomington: Indiana University Press.

Gibbs, L., Block, K., MacDougall, C., Harms, L., Baker, E., Richardson, J. … Forbes, D. (2018). Ethical use and impact of participatory approaches to research in post-disaster environments: An Australian bushfire case study. *BioMed Research International*, *11*, 5621609.

Goodkind, J.R., Amer, S., Christian, C., Hess, J.M., Bybee, D., Isakson, B., … Shantzek, C. (2017). Challenges and innovations in a community-based participatory randomized controlled trial. *Health Education & Behavior*, *44*(1), 123–130.

Groupe URD. (2009). Participation Handbook for humanitarian field workers, 2009. Available from https://www.urd.org/en/publication/participation-handbook-for-humanitarian-field-workers/

Herrenkohl, T.I., Mersky, J.P., & Topitzes, J. Applied and translational research on trauma-responsive programs and policy: Introduction to a special issue of the American Journal of Community Psychology. *American Journal of Community Psychology*, *64*(3-4), 281–285.

Human Rights Watch (HRW) (2005). Youth Poverty and Blood: the lethal legacy of West Africa's regional warriors. Available from https://www.hrw.org/report/2005/04/13/youth-poverty-and-blood/lethal-legacy-west-africas-regional-warriors

Israel, B.A., Eng, E., Shultz, A., & Parker, E. (2005). Introduction to methods in community-based participatory research for health. In B.A. Israel, E. Eng, A. Shultz & E. Parker (Eds.), *Methods in Community-based Participatory Research for Health* (pp. 3–26). San Francisco, CA: Jossey-Bass.

Israel, B.A., Schultz, A.J., Parker, E.A., Becker, A.B., Allen, A.J. III, Guzman, R., & Lichtenstein, R. (2018). Critical issues in

developing and following CBPR principles. In D. Wallerstein, & O. Minkler (eds). *Community-Based Participatory Research for Health: Advancing Social and Health Equity*, 3rd Edition. San Francisco, CA: Jossey-Bass.

Israel, B.A., Schulz, A.J., Parker, E.A., & Becker, A.B. (1998). Review of community-based research: Assessing Partnership Approaches to Improve Public Health. *Annual Review of Public Health*, *19*(1), 173–202. https://doi.org/10.1146/annurev.publhealth.19.1.173.

Kohrt, B.A., Mistry, A.S., Anand, N., Beecroft, B., & Nuwayhid, I. (2019). Health research in humanitarian crises: an urgent global imperative. *BMJ Global Health*, *4*, e001870. https://doi.org/10.1136/bmjgh-2019-001870.

Lazarus, S., Bulbulia, S., & Taliep, N. (2015). Community-based participatory research as a critical enactment of community psychology. *Journal of Community Psychology*, *43*(1), 87–98.

Leaning, J. (2001). Ethics of research in refugee populations. *The Lancet*, *357*, 1432–1433.

Mackenzie, C., McDowell, C., & Pittaway, E. (2007). Beyond 'Do No Harm': The challenge of constructing ethical relationships in refugee research. *Journal of Refugee Studies*, *20*, 299–319.

Makhoul, J., Alameddine, M., & Afifi, R.A. (2012). 'I felt that I was benefiting someone': youth as agents of change in a refugee community project. *Health Education Research*, *27*(5), 914–926.

Makhoul, J., Chehab, R.F., Shaito, Z., & Sibai, A.M. (2018). A scoping review of reporting 'Ethical Research Practices' in research conducted among refugees and war-affected populations in the Arab world. *BMC Medical Ethics*, *19*(1), 36.

Makhoul, J., Nakkash, R., Harpham, T., & Qutteina, Y. (2013). Community-based participatory research in complex settings: clean mind–dirty hands. *Health Promotion International*, *29*(3), 510–517.

Minkler, M. (2004). Ethical challenges for the "outside" researcher in community-based participatory research. *Health Education & Behavior*, *31*(6), 684–697.

Morgado, A.M. (2020). Disasters, individuals, and communities: Can positive psychology contribute to community development after disaster? *Community Development*, *51*(1), 3–16. https://doi.org/10.1080/15575330.2020.1714685

MSF Ethics Review Board (2013). *MSF Research Ethics Framework – Guidance Document*. Available from http://hdl.handle.net/10144/305288.

Muhammad, M., Wallerstein, N., Sussman, A.L., Avila, M., Belone, L., & Duran, B. (2015). Reflections on researcher identity and power: The impact of Positionality on Community Based Participatory Research (CBPR) Processes and Outcomes. *Critical Sociology*, *41*(7–8), 1045–1063.

Nakkash, R.T., Alaouie, H., Haddad, P., El Hajj, T., Salem, H., Mahfoud, Z., & Afifi, R.A. (2012). Process evaluation of a community-based mental health promotion intervention for refugee children. *Health Education Research*, *27*(4), 595–607.

National Institutes of Health (NIH). (2011). *Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement (No. 11–7782)*. NIH Publication. Available from https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

Ndulue, U., Peréa, F.C., Kayou, B., & Martinez, L.S. (2012). Team-building activities as strategies for improving community-university partnerships: lessons learned from Nuestro Futuro Saludable. *Progress in Community Health Partnerships: Research, Education, and Action*, *6*(2), 213–218.

Newman, S.D., Andrews, J.O., Magwood, G.S., Jenkins, C., Cox, M.J., & Williamson, D.C. (2011). Community advisory boards in community-based participatory research: a synthesis of best processes. *Preventing Chronic Disease*, *8*(3), A70.

Parker, E.A., Baquero, B., Gilbert, P.G., & Daniel-Ulloa, J. (2019). Community engaged research. In M. Bolton (Ed.), *Maxcy-Rosenau-Last Public Health and Preventive Medicine* (16th ed.). Chicago: McGraw-Hill.

Singh, N.N., McKay, J.D., & Singh, A.N. (1999). The need for cultural brokers in mental health services. *Journal of Child and Family Studies*, *8*(1), 1–10.

Siriwardhana, C., Lignou, S., Doherty, S., & O'Mathúna, D. (2017). R2HC Ethics Framework 2.0. https://www.elrha.org/wp-content/uploads/2015/01/ELRHA-Interactive-Flipcards-F3.pdf

Spiegel, P.B. (2017). The humanitarian system is not just broke, but broken: recommendations for future humanitarian action. *The Lancet*, *23*(13), 196–202. https://doi.org/10.1016/S0140-6736(17)31278-3.

Sprague, L., Afifi, R., Ayala, G., & El-nasoor, M.L. (2019). Participatory praxis as an imperative for health-related stigma research. *BMC Medicine*, *17*(1), 32.

Suarez-Balcazar, Y. (2020). Meaningful Engagement in Research: Community Residents as co-creators of knowledge. *American Journal of Community Psychology*, 1–11.

Togoh, G.P., Turay, A.B., & Komba, A. (2017). Sierra Leone 2015 Population and Housing Census: Thematic Report on Population Projections. Available fromhttps://sierraleone.unfpa.org/sites/default/files/pub-pdf/Population%20projections%20report.pdf

Tschakert, P., Das, P.J., Shrestha Pradhan, N., Machado, M., Lamadrid, A., Buragohain, M., & Hazarika, M.A. (2016). Micropolitics in collective learning spaces for adaptive decision making. *Global Environmental Change*, *40*, 182–194.

U.S. Census Bureau (2018). QuickFacts: Lewiston City, Maine, July 1, 2018. Available from https://www.census.gov/quickfacts/lewistoncitymaine

UNDP.(nd). Guidelines for Community Participation in Disaster Recovery. Available from https://www.gfdrr.org/sites/default/files/Guidelines%20for%20Community%20Participation%20in%20Disaster%20Recovery.pdf

UNHCR, UNICEF, & WFP (2018). VASyR 2018: Vulnerability Assessment of Syrian Refugees in Lebanon. https://www.wfp.org/publications/vulnerability-assessment-syrian-refugees-lebanon-vasyr-2018

United Nations High Commissioner for Refugees (UNHCR) (2019a). Syrian refugee response. Available from https://data2.unhcr.org/en/situations/syria/location/71. October 3, 2019.

United Nations High Commissioner for Refugees (UNHCR), (2019b). Global trends. Forced Displacement in 2018. Available from https://www.unhcr.org/5d08d7ee7.pdf

van der Haar, G., Heijmans, A., & Hilhorst, D. (2013). Interactive research and the construction of knowledge in conflict-affected settings. *Disasters*, *37*(s1), S20–S35.

Velázquez, T., Rivera-Holguin, M., & Morote, R. (2017). Disasters and postdisasters: Lessons and challenges for community psychology. In M.A. Bond, I. Serrano-García, C.B. Keys & M. Shinn (Eds.), *APA handbooks in psychology®. APA handbook of community psychology: Methods for community research and action for diverse groups and issues* (pp. 425–439). American Psychological Association.

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. *American Journal of Public Health*, *100*(Suppl 1), S40–S46.

Yoshihama, M., & Summerson, C.E. (2002). Community participation reconsidered: feminist participatory action research with hmong women. *Journal of Community Practice*, *10*(4), 85–103.