# Antiracism and Community-Based Participatory Research: Synergies, Challenges, and Opportunities

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Structural racism causes stark health inequities and operates at every level of society, including the academic and governmental entities that support health research and practice. We argue that health research institutions must invest in research that actively disrupts racial hierarchies, with leadership from racially marginalized communities and scholars.

We highlight synergies between antiracist principles and community-based participatory research (CBPR), examine the potential for CBPR to promote antiracist research and praxis, illustrate structural barriers to antiracist CBPR praxis, and offer examples of CBPR actions taken to disrupt structural racism. We make recommendations for the next generation of antiracist CBPR, including modify health research funding to center the priorities of racially marginalized communities, support sustained commitments and accountability to those communities by funders and research institutions, distribute research funds equitably across community and academic institutions, amplify antiracist praxis through translation of research to policy, and adopt institutional practices that support reflection and adaptation of CBPR to align with emergent community priorities and antiracist practices.

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For decades, community activists and a small number of health scholars have been calling for health researchers to not just study racism but be actively antiracist and contribute to transforming our inequitable systems.[1,2] Recently, an increasing number of health scholars and mainstream public health institutions (e.g., the Centers for Disease Control and Prevention, the National Institutes of Health [NIH]) have called for more antiracist health research that directly confronts and addresses structural racism in both its process and outcomes.[3–7] For example, the NIH launched the UNITE initiative to "identify and address structural racism within the NIH-supported and the greater scientific community."[3] To fulfill these antiracist ambitions, we need bold leadership and expansion of equitable models that disrupt hierarchies embedded in our health research institutions (e.g., the NIH, major universities, nonprofit organizations). These models need to center community voices and support community–academic partnerships to foster racial justice.

Investing in community-based participatory research (CBPR) approaches offers an opportunity for health research institutions to move closer to antiracist principles. CBPR approaches—distinct from the broader term "community-based" research and only a narrow slice of all health research—often actively seek to disrupt racial hierarchies in how they are conducted (i.e., the process) and in the outcomes they seek to affect (i.e., health equity).[2,8–10] Literature reviews demonstrate that CBPR partnerships can have an important positive impact on health outcomes in marginalized communities,[11–13] but these impacts are constrained and limited by pervasive racial

inequities embedded in research and funding institutions.[14–17]

The emancipatory roots that underlie CBPR draw from the epistemic traditions of oppressed communities of color and Indigenous communities across the globe that have sought to facilitate community empowerment and agency.[18] The liberatory foundations of CBPR are anchored in Brazilian educator Paulo Freire's dialogical approach to critical consciousness and the cyclical praxis of reflection and action; in Global South movements to end apartheid (e.g., in South Africa) and build knowledge democracy; and in civil rights movements to end White supremacy in the United States.[12,18–20]

Building on these historical roots, since the 1990s a growing community of health scholars has partnered with racially marginalized communities to center their priorities, develop research to address health inequities, and disrupt traditional research models in health research institutions.[6,9,12] Over the past 3 decades, CBPR has evolved into a research approach that—when carried out according to its core principles—embraces antiracism principles and can be a tool to help dismantle structural racism in the United States. Even in this acknowledgment of CBPR's potential as an antiracist tool that can disrupt White supremacy, it was indeed the capital of White scholars that allowed this movement to gain acceptance and grow in academia. We hold these 2 truths to be in tension.

We argue that health research institutions should invest in research that funds and is led by racially marginalized communities, helps disrupt racial hierarchies, and contributes to transforming systems, structures, and institutions that are deeply implicated in reproducing racism. We cannot exhaustively cover all of the issues in this essay nor do we have all the answers; however, we hope to help our field move closer to transforming institutional practices that reproduce and reinforce racial inequities.

## RESEARCH–ANTIRACIST PRINCIPLE SYNERGY

Synergies between a CBPR approach to research and antiracist approaches provide an opportunity for addressing racial inequities in institutions of higher education and traditional research practices. Camara Phyllis Jones, leading scholar of racism and health, has defined racism as

> a *system of structuring opportunity and assigning value based* on the social interpretation of how one looks, that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through *the waste of human resources.*[4(p231; emphasis added)]

Thus, health research that is antiracist would need to restructure opportunities, reassign value, and prevent the waste of human resources. The core principles of CBPR (Box 1) are intended to guide researchers to do exactly that.

CBPR principles aim to restructure opportunities by enhancing opportunities for community members and organizations to build solutions to community challenges, develop research questions, collaborate on data collection and analysis, and implement strategies for addressing inequities.[8,9,12] CBPR's explicit focus on capacity building by all team members provides opportunities for community members to build their research skill set, for academic researchers to learn community-centered skills

**BOX 1— Principles for Community-Based Participatory Research**

| |
|---|
| 1. Recognizes community as a unit of identity |
| 2. Builds on strengths and resources in the community |
| 3. Facilitates a collaborative, equitable partnership in all phases of research, involving an empowering and power sharing process that attends to social inequalities |
| 4. Fosters colearning and capacity building among all partners |
| 5. Integrates and achieves a balance between knowledge generation and intervention for the mutual benefit of all partners |
| 6. Focuses on the local relevance of public health problems and ecological perspectives that attend to the multiple determinants of health |
| 7. Involves systems development using a cyclical and iterative process |
| 8. Disseminates results to all partners and involves them in the wider dissemination of results |
| 9. Involves a long-term process and commitment to sustainability |
| 10. Openly addresses issues of race, ethnicity, racism, and social class and embodies "cultural humility" |
| 11. Works to ensure research rigor and validity but also seeks to "broaden the bandwidth of validity" with respect to research relevance |

*Source*. Israel et al.,[8] Minker and Wallerstein,[9] and Israel et al.[12]

and knowledge, and for all partners to examine the ways that institutionalized, personally mediated and internalized forms of racism affect collaborative work.[4,12] CBPR teams are also intentional about expanding space for community members to be experts on the project and topic. Beyond opportunities for individuals, CBPR creates opportunities for entire communities by budgeting financial resources to community-based organizations to strengthen capacity for community change. It also entails a critical evaluation of the balance of resources applied to research and those applied to action to create change based on research findings.

CBPR approaches work to reassign values by valuing and centering community perspectives more explicitly than they are in conventional research practices. CBPR principles emphasize that expertise lies in communities and places high value on the people and perspectives in racially marginalized communities. In practice, CBPR projects and partnerships are frequently the site of advocacy, policy change, and action related to injustices (e.g., environmental racism, incarceration, and policing) prioritized by racially marginalized communities.[13]

Finally, CBPR aims to prevent the waste of human resources by creating a research structure that explicitly challenges the marginalization of scholars and communities of color and the devaluation of their knowledge. Core CBPR practices aim to do this by channeling resources from well-financed predominantly White institutions into racially marginalized communities and by creating explicit opportunities to support community capacity for both research and action.

A CBPR approach also aligns with the leading antiracism framework for health research developed by Ford and Airhihenbuwa[21]: public health critical race praxis (PHCR). PHCR was developed to identify, understand, and undo the root causes of racial hierarchies and applies principles from critical race theory (CRT) to antiracist health research.

PHCR draws on fundamental pillars of CRT to emphasize the acknowledgment of the systemic White supremacy that operates at every level of US society.[21,22] PHCR also pulls from CRT in the recognition that we need to "center the margins" for an effective antiracist praxis. PHCR and CRT are also guided by Crenshaw's and other Black feminist scholars' concept of intersectionality, which was developed in recognition of the combined and often multiplicative impact of intersectional systems (e.g., economic structures, race, culture, and gender)[22] and was later applied to analysis of health outcomes.[23] PHCR and CRT emphasize questioning objectivity, questioning the evidence, and generating knowledge from perspectives that reside outside of the academy.

In Table 1, we show selected core principles and definitions from Ford and Airhihenbuwa's PHCR methodology.[21] For each PHCR principle (drawn from CRT concepts), we demonstrate alignments with guiding principles in CBPR. In Table A (available as a supplement to the online version of this article at http://www.ajph.org), we include all the core PHCR principles.

It is important to note that not all CBPR partnerships prioritize the study of racial influences on health outcomes (e.g., "primacy" from PHCR principles in Table 1). Rather, some partnerships focus on disrupting other systems of oppression, such as patriarchy, colonization, and heteronormativity, that often interlock with racism.[23] In addition, it is critical that CBPR partnerships discuss and determine the principles that will guide their work, including the integration of PHCR and CBPR principles relevant for their goals and context. As a result, principles will vary across partnerships.[8] Nonetheless, CBPR's focus on centering marginalized communities and disrupting various forms of inequities is consistent with PHCR principles.

## CHALLENGES IN OUR CURRENT ENVIRONMENT

> "White supremacy is not a shark; it is the water."
>
> —*El Guante*

The waters of White supremacy in which we swim[24] pose major barriers to actualizing antiracist CBPR partnerships for health. These waters have been created and constructed over centuries to value the lives, institutions, and knowledge of White people and devalue the human dignity and lives of Black, Indigenous, Latinx, Arab, Asian, and other marginalized groups. In this sense, the impact of any programmatic or policy-based intervention is bound by linked oppressive systems.[15] The potential impact of CBPR on health equity is bound by larger oppressive systems' impact on resource and power distribution.

These waters are why both the NIH and US philanthropies dramatically underfund sickle cell disease—a disease predominantly afflicting Black Americans—compared with similar diseases that have a greater impact on Whites.[15,25] It is why the NIH has hardly invested in research on structural racism, despite it being a fundamental cause of so much death and disease.[5,26] It is why there is limited growth in public health faculty racial diversity, especially at research-intensive institutions and in tenured

**TABLE 1— Selected List of Public Health Critical Race Methodology Principles and Application to CBPR Principles**

| PHCR Principle[a] | PHCR Principle Definition[a] | Application to CBPR Principles |
|---|---|---|
| Race consciousness | Deep awareness of one's racial position; awareness of racial stratification processes operating in a colorblind context | Focuses on equitable academic–community partnerships that recognize and attend to racial (and other) inequities; openly addresses racism (CBPR principles 3 and 10) |
| Primacy of racialization | Fundamental contribution of racial stratification to societal problems; central focus of CRT scholarship on explaining racial phenomena | Not all CBPR partnerships focus on racialization and racism; however, most work with communities of color and openly address issues of race, ethnicity, and racism (CBPR principle 10) often as these intersect with other dimensions of inequality (e.g., gender, class) |
| Ordinariness of racism | Racism is embedded in the social fabric of society | CBPR principles do not explicitly state this but aim to explicitly discuss issues of racism (CBPR principle 10); recognize and attend to power dynamics caused by racism in partnerships (CBPR principle 3) |
| Structural determinism | The fundamental role of macrolevel forces in driving and sustaining inequities across time and contexts | CBPR explicitly focuses on an ecological perspective that recognizes macrolevel forces as fundamental for causing inequities (CBPR principle 6) and attends to power dynamics rooted in racism that occur in partnerships (CBPR principle 3) |
| Social construction of knowledge | Established knowledge in a discipline can be reevaluated using antiracism modes of analysis | CBPR principles explicitly value and seek knowledge based in communities that may be different than traditional academic knowledge (CBPR principles 2, 4, and 5) |
| Intersectionality | Interlocking nature of cooccurring social categories (e.g., race, gender) and the forms of social stratification that maintain them | CBPR principles do not explicitly state this but aim to explicitly discuss issues of racism and social class (CBPR principle 10) and recognize and attend to power dynamics caused by social inequalities that occur in partnerships (CBPR principle 3) |
| Voice | Prioritizing the perspectives of marginalized persons; privileging the experiential knowledge of outsiders within | CBPR often occurs in racially marginalized communities where community members are equal partners in the research decision-making (CBPR principle 3) and focuses on issues identified and prioritized by members of the community (CBPR principle 6) |

*Note*. CBPR = community-based participatory research; CRT = critical race theory; PHCR = public health critical race praxis.

[a]This column is quoted directly from Table 1 in Ford and Airhihenbuwa.[21]

positions.[27] And it is why the overwhelming majority of budgets and indirect costs for multimillion-dollar racial health inequities research goes to historically and predominantly White research universities with predominantly White faculty instead of to racially marginalized communities, community-based organizations, or historically Black colleges and universities. We highlight a few of the barriers to an antiracist health research agenda.

First, current academic structures incentivize short-term profit for universities and center knowledge production in individual academic faculty members rather than incentivizing long-term investments in communities and community expertise.[14] Academic researchers who would like to conduct antiracist CBPR research are often discouraged because it is too slow, underfunded, perceived as service, or not perceived as rigorous science.[28] Universities often prioritize federal grant funding—especially in decisions about faculty hiring, tenure, and promotion—and thus can sometimes disincentivize academic-based researchers from creating equitable partnerships that share grant dollars with communities.[17] Academic researchers, especially those who are scholars of color, are sometimes forced to exit partnerships because they could not find a job that supported their research or that earned tenure or because they felt the university environment was too toxic.[29] This dynamic is exacerbated by "health equity tourists"—primarily White scholars—who opportunistically seize on expanded health equity funding or publishing opportunities to advance their careers despite a lack of expertise.[30] The commitment to antiracist research and CBPR principles often rests on the individual researchers rather than institutional commitment.

Second, the NIH and other large health research–funding institutions prioritize research that focuses on proximate causes of diseases, biology, and individual health outcomes and have less emphasis on understanding and intervening in the sociopolitical roots of health and inequality. Of the $41.7 billion in NIH funding in 2020,

just 7% fit into the broad NIH-defined category of social determinants of health research.[31] (Most of the research categorized by the NIH as social determinants of health does not engage with the sociopolitical roots of health and does not adequately account for structural racism.[32]) CBPR partnerships aim to follow community priorities for research and intervention, but the pool of funding available severely constrains those choices. For example, in many cases, communities would prioritize ending police harassment and imprisonment of their residents,[26] but the funding agencies with the largest health research budgets continue to focus on proximal causes and medical solutions, rather than addressing the root causes of harm to racially marginalized communities.[31]

Third, there are substantial barriers—attributable to structural racism—that inhibit racially marginalized scholars, first-generation college-educated researchers, and community partners from receiving competitive research grants for large-scale funding.[5] Often (but certainly not always), academic researchers work for predominantly White institutions located outside the communities with whom they partner.[10] They are also often spawned from legacies of educational White privilege or do not belong to communities most affected by racial health inequities. Additionally, scholars from racially marginalized communities are often dissuaded from conducting research in partnership with their own community because it is unfairly perceived as biased.[29,33] Meanwhile, White academics are rewarded for conducting health research with these same communities.[30] Collectively, these inequitable practices systematically advantage White researchers and simultaneously discredit and marginalize scholars of color—a dual function of White supremacy in the academy.

Finally, CBPR partnerships occur in a White supremacy culture that places values on certain forms of knowledge prominent in predominantly White institutions and devalues those coming from institutions in racially marginalized communities. Excellent CBPR research is conducted by researchers at historically Black colleges and universities but does not receive the same recognition and support.[34] Despite the intentions of CBPR principles to center members of racially marginalized communities as experts with valuable knowledge, the society we live in—and our very own research institutions—continues to call on experts based in predominantly White universities to provide input on what is happening in racially marginalized communities.

These are but a few of the structural barriers CBPR partnerships face in living up to their principles. With these in mind, we recognize CBPR principles as aspirational, commonly eroded, or compromised because of the institutional and societal challenges described. They also represent a set of tools and perspectives that can help to chip away at the very structural barriers just described. Indeed, CBPR partnerships have played an important role in shifting institutions and policies, which we describe in several examples in the next section.

## PARTNERSHIP AND ADVOCACY EXAMPLES

These examples—most of which are unpublished because of some of the barriers described in the preceding section—draw on the experiences of the authors.

### Advocating in Local Government

A CBPR partnership in Flint, Michigan, played a fundamental role in the Genesee County, Michigan, government declaring racism a public health crisis on June 10, 2020, and the subsequent work to act based on the declaration. Researchers from Michigan State University and the University of Michigan–Flint worked in partnership with the Faith Subcommittee of the Greater Flint COVID-19 Taskforce on Racial Inequities and the community-based organization partners to conduct focus groups and community dialogues that informed a strategic plan for the county government to act on their declaration. This CBPR partnership had an antiracist outcome because it resulted in antiracist policy changes, such as a line item in the budget to support antiracism training, education, and initiatives.

### Transformation in Universities

To build the cadre of underrepresented scholars of color in health research, the Transdisciplinary Research, Equity and Engagement (TREE) Center at the University of New Mexico is shifting the conditions for CBPR partnerships between scholars of color and communities of color. Scholars of color are supported by an academic and community of color mentor from the development of competitive pilot project proposals to the implementation of interventions in real-world settings as a model for centering community voice and building new lines of inquiry toward racial healing, social justice, and health equity. The TREE Center fosters the development of scholars of color by providing a community of mentors

across 12 disciplines in the health and social sciences. A formal training and technical assistance program provides support for academic success (e.g., preparing tenure and promotion portfolios, development, and review of research proposals). The TREE Center also develops tools for engagement with communities that shift power dynamics and advocate changes in university procedures and policies that incentivize CBPR scholars.

## Changing Funding Models

In the early 2000s, the National Center for Minority Health and Health Disparities convened a group of CBPR experts from across the United States to advise them in establishing a CBPR program at the center (subsequently "institute"). It incorporated a primary recommendation of the advisory group, which was the creation of a 3-phase funding cycle spanning an 11-year period. The 3 phases were (1) an initial 3-year planning and pilot project grant, (2) a 5-year intervention implementation grant, and (3) a 3-year dissemination grant to share findings and lessons learned. This extended timing allowed CBPR partnerships the time and resources needed to genuinely follow CBPR principles. This example of CBPR researchers advocating institutional transformation follows the PHCR and CRT concepts of "disciplinary self-critique" and "structural determinism" in that status quo norms at the NIH are perpetuating inequities in health research processes.

Another example of this is how at the urging of CBPR scholars and environmental justice advocates, the National Institute of Environmental Health Sciences (NIEHS) has experimented with innovations that shift power as part of their Research to Action program. The Environmental Justice: Partnerships for Communication program request for proposals sought to amplify community voices in identifying and defining problems related to environmental exposures, shaping research approaches to the problem, and setting priorities for intervention strategies. Particularly notable was that the study section that NIEHS convened for this funding mechanism included both academic-based researchers and environmental justice advocates to examine the science, the distribution of funds, and whether proposals reflected community priorities. This example follows principles from PHCR and CRT because it shifted the voices of environmental justice advocates from the margins to the center to shift funding processes and outcomes.

Finally, Tribal nations and Native scholars across the United States have recently challenged White supremacy by demanding cultural-centered CBPR and Indigenous-led research through 2 NIH initiatives: the Native American Research Centers for Health and the Intervention Research to Improve Native American Health (IRINAH) funding. A major goal has been to center funding in Native communities and organizations and increase the number of Native scholars and their success in the academy, including increased access to R01 (research project grant) funding. For more about the IRINAH initiative, see the special issue in *Prevention Science*.[7] Although Native scholars have begun to replace their White colleagues as principal investigators, the NIH has not yet adopted a similar initiative for other scholars of color. Like the previous examples, this example of CBPR research draws on PHCR and CRT principles of centering the margins and disciplinary self-critique to create antiracist processes for conducting research.

## RECOMMENDATIONS AND CONSIDERATIONS

In the short term, research funders should shift substantial funds to focusing on structural racism and encouraging research approaches that align with both antiracism and CBPR principles. A recent request for applications from the NIH for projects with the goal of "understanding and addressing the impact of structural racism" focused funding on racism but did not take an explicitly antiracist approach to how funding decisions were made or which types of projects were eligible for funding. These types of funding opportunities are limited and are subject to the whims of new federal leadership because they are not institutionalized. Most universities and research institutions are motivated by funding, and thus if funders transform how they allocate resources they can also transform these academic research institutions.

The examples we have provided show how CBPR researchers can advocate funding mechanisms to facilitate long-term commitments with racially marginalized communities. In addition, ensuring that NIH and other funders' funding decisions are shaped by members of racially marginalized communities—like the NIEHS study section example—can help make sure that funding provides community resources and focuses on fundamental causes of multiple health issues (e.g., systems of incarceration, finance, policing, environmental protection, housing).

Longer term, we need to work toward a future in which racially marginalized communities are allocating and receiving public funding and directing antiracist health research that can have an impact on their own communities.[35] This change will require fundamental

transformation in how universities operate and how research is defined, originated, and funded. Substantial rethinking and reorientation among research institutions to shift funding allocations will be required to ensure that funds are available to support action to address the inequities that are the focus of the research. The research to action mechanism described in the preceding section is an example of such a funding mechanism. There is a critical need for focused attention to expand and create additional mechanisms for directing funding to support antiracist actions.

## Accountability to Communities of Color

Long-term commitment and community-driven policy change can enhance trust and accountability with communities of color, an essential aspect of antiracist praxis. Universities and other research institutions that are committed to antiracist practices need to build in measures of accountability to communities affected by racism and racial health inequities. Long-term commitment is a key principle of CBPR partnerships, and we need institutional support for larger partnerships between universities and communities and cities to help ensure the long-term sustainability of CBPR research. Such partnerships might be established in the form of community–academic centers or institutes (e.g., the TREE Center or the Detroit Urban Research Center), which extend beyond any single externally funded project. Ideally these would have university funding for core infrastructure support in addition to external funding to foster, promote, and build capacity to conduct antiracist CBPR.

It is essential to build in accountability metrics and mechanisms to ensure a continued focus on social impact to address structural racism. A practical model for social change links research efforts to policy change to transform the racial structures through distributive, procedural, and restorative justice approaches that remediate unfair policies.[13,36,37] Examples include working to ensure that indirect costs received as part of grant funding are equitably invested in communities instead of adding solely to a university's budget, dedicating a portion of project funds to scholarships for community youths, and demanding that universities divest from companies and other institutions that harm their community through, for example, incarceration or climate change. These forms of accountability can help move research institutions into closer alignment with antiracist and CBPR principles and ultimately help disrupt structural racism and White supremacy. These types of actions—and not just platitudes—can help to build trust over time.

## Reflection and Adaptation

Given that racism adapts over time, antiracist CBPR approaches will also need to adapt over time. CBPR principles of colearning and capacity building—and openly addressing issues of racism and social classism—require CBPR researchers and community partners to follow guided approaches that allow continued critical self-reflection and collective reflection regarding racial equity in the partnership.[10] Being adaptive means that the current CBPR core principles may and should be revised in the future to better align with community priorities or antiracism ideas. Dialogues will be essential in partnerships, recognizing that racism is shaped by local histories and relationships, and thus will vary not only over time but by location.[38,39]

In this reflection, we cannot overlook that the development of CBPR approaches has historically been led in academia predominantly by White scholars. Many of the authors of this essay benefit from the waters of White supremacy while simultaneously fighting for the CBPR partnerships and principles that swim against the currents. Given the racism embedded in the academy, White scholars' ideas have been more likely to be legitimized and shared. Furthermore, in some instances the voices of scholars of color are marginalized when they are relinquished to secondary authors or investigators in funded research with communities of color.[29,33] The future of antiracist CBPR needs to own and address this dynamic. Candid reflection and courageous conversations regarding internalized privilege among White scholars and internalized oppression among scholars of color can facilitate processes of healing for racial justice in CBPR.

The possibilities for CBPR have been changing as Indigenous researchers and other scholars of color have advanced to senior positions in predominantly White institutions, as historically Black colleges and universities have made innovations in CBPR principles,[40] and as tribes and communities have demanded equitable distribution of resources and community-prioritized and -led decisions.[7] This is an opportunity to raise the critical nature of antiracism conversations in partnerships and demand change in academia and funding institutions.

# CONCLUSIONS

Health research urgently needs to follow antiracist research principles.

Alignments between a CBPR approach and antiracist approaches provide a path toward addressing historical and contemporary racial inequities embedded in institutions of higher education and in traditional research processes. Achieving racial justice and ameliorating inequities is a call to action for the field of health research to address racism in health research, center scholars and communities of color, and work together as intercultural allies in confronting White supremacy with focused deliberative action toward racial healing, justice, and reconciliation. AJPH

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