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Viewpoint

Community-based participatory research with Indigenous communities: The proximity paradox

Stephen D. Ritchie [a,b,*], Mary Jo Wabano [c], Jackson Beardy [d], Jeffrey Curran [e], Aaron Orkin [f], David VanderBurgh [f], Nancy L. Young [a,b]

[a] School of Rural and Northern Health, Laurentian University Ramsey Lake Road Sudbury, Ontario, Canada P3E 2C6
[b] ECHO (Evaluating Children's Health Outcomes) Research Centre and Laurentian University Ramsey Lake Road Sudbury, Ontario, Canada P3E 2C6
[c] Nahdahweh Tchigehgamig Health Centre, PO Box 101, 16A Complex Drive, Wikwemikong, Ontario, Canada P0P 2J0
[d] Health Services, Sachigo Lake First Nation, PO Box 51,Sachigo Lake, Ontario, Canada P0V 2P0
[e] Centre for Research in Human Development, Laurentian University, Ramsey Lake Road, Sudbury, Ontario, Canada P3E 2C6
[f] Northern Ontario School of Medicine – West Campus, Lakehead University, 955 Oliver Road Thunderbay, Ontario, Canada P7B 5E1

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ABSTRACT

Community-based participatory research (CBPR) is a promising approach used with increasing prevalence in health research with underserviced Indigenous communities in rural and remote locations. This case comparison used CBPR principles to examine the characteristics of two collaborative research projects in Canada. Both projects reflected CBPR principles in unique ways with particular differences related to community access and proximity of collaborating partners. CBPR principles are often used and recommended for partnerships involving remote underserviced communities, however many of these principles were easier to follow for the collaboration with a relatively well serviced community in close proximity to researchers, and more challenging to follow for a remote underserviced community. The proximity paradox is an apparent contradiction in the increasing application of CBPR principles for use in distal partnerships with remote Indigenous communities when many of these same principles are nearly impossible to follow. CBPR principles are much easier to apply in proximal partnerships because they afford an environment where collaborative relationships can be developed and sustained.

1. Introduction

New research paradigms are evolving to meet the health needs of Indigenous communities, and it is important to understand the implications of these approaches. According to the World Health Organization (2007), the global Indigenous population comprises over 370 million people in 70 different countries. The term Indigenous usually characterizes people who self-identify with a shared territory and heritage that predates colonial and settler societies (World Health Organization, 2007).

Over 1.4 million First Nations, Inuit and Métis people from Canada's Indigenous population (Statistics Canada, 2013)[1], many of whom live in rural and remote communities or reserves dispersed across Canada's expansive geography. There are 617 First Nation communities in Canada representing a wide variety of cultural groups with 50 distinct languages (Aboriginal Affairs and Northern Development Canada, 2013). Most of these communities are located in their traditional geographic territories which predates colonization and mass immigration from Europe and other regions of the world. In the province of Ontario, nearly 25% of the 133 First Nation communities are located in the isolated Far North region of Ontario (Chiefs of Ontario Office, 2013; Ministry of Natural Resources, 2013). The Far North region is a relatively new designation used by the Ministry of Natural Resources in Ontario to describe the vast northern region of the province. Most of the communities in this region are only accessible by air or ice road in winter. Thus, access to mainstream health services, programs, and resources is a significant challenge for many remote Indigenous communities.

In order to reflect a broader international perspective, we use the terms Indigenous in place of the terms Aboriginal, First Nations, Native American Indian, and Tribe. Similar to other colonial countries such as Australia, New Zealand, and the United States, there is a long history of imperialism and discriminatory policies in Canada that have marginalized many Indigenous people and communities. The 1996 Report of the Royal Commission on Aboriginal Peoples

* Corresponding author at: School of Rural and Northern Health, Laurentian University Ramsey Lake Road Sudbury, Ontario, Canada P3E 2C6.
Tel.: +001 705 6751151x1046; fax: +001 705 6754845.
E-mail addresses: sritchie@laurentian.ca, sritchie66@gmail.com (S.D. Ritchie), mjwabano@wikyhealth.ca (M. Jo Wabano), jacksonbeardy@knet.ca (J. Beardy), jcurran2@laurentian.ca (J. Curran), aorkin@nosm.ca (A. Orkin), dave.vanderburgh@nosm.ca (D. VanderBurgh), nyoung@laurentian.ca (N.L. Young).

[1] Indigenous people in Canada are collectively referred to as Aboriginal peoples, and the Canadian constitution recognizes three distinct groups of people: Indian (commonly referred to as First Nations), Métis and Inuit (Aboriginal Affairs and Northern Development Canada, 2013).

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represented a turning point in Canada, since it identified many of the historical policies and practices of "domination and assimilation", such as treaty making, establishment of reserve lands for communities, and developing a network of residential schools Royal Commission on Aboriginal Peoples in Canada (1996). Research practices related to Indigenous people worldwide have followed a similar legacy of imperialism (Smith, 2012). In recent years in Canada, there has been a positive shift and evolution in ethical guidelines involving research with Indigenous people to redress earlier deficiencies (Brant-Castellano, 2004; Canadian Institutes of Health Research, 2010, Chapter 9; Martin-Hill and Soucy, 2005; Schnarch, 2004). Castleden et al. (2012, p. 166) summarized this evolution and concluded that "partnership approaches informed by community collaboration is [are] clearly necessary".

Community-based participatory research (CBPR) has emerged as a collaborative approach to health research well suited for diverse populations in many underserviced areas, such as those in rural and remote locations (Israel et al., 2005b; Minkler and Wallerstein, 2008a). Often remote populations have a "disproportionate burden of morbidity and mortality… with few economic and social resources" (Israel et al., 2008, p. 48). The literature recommends collaborative research in geographically isolated communities, as it is essential to address local research questions and needs (Israel et al., 2008; Lightfoot et al., 2008). CBPR approaches vary from project to project to adapt to the unique contextual challenges and rewards that are often encountered with Indigenous populations (Lardon et al., 2007; LaVeaux and Christopher, 2009; Maar et al., 2011; Mohammed et al., 2012; Peterson, 2010). Understanding the nature of these adaptations is essential to guide research with Indigenous populations in Canada and beyond.

The purpose of this paper is to compare two CBPR projects with two different Indigenous communities in northern Ontario, Canada, both of which are geographically isolated, but to a different degree. This comparison has global significance, since it profiles CBPR approaches with respect to the proximity of collaborating partners.

The first project was the integrated development and evaluation of an Outdoor Adventure Leadership Experience (OALE) using a mixed methods design. The collaboration involved community leaders from Wikwemikong Unceded Indian Reserve and researchers from Laurentian University. The OALE is an intervention designed to promote resilience and well-being for adolescents from the Wikwemikong community (Ritchie et al., 2010, 2012). Wikwemikong (population 2592) is a rural Indigenous community with road access. The second project was the integrated program development and evaluation of the Sachigo Lake Wilderness Emergency Response Education Initiative (SLWEREI), using qualitative methods. The SLWEREI is a community-based first aid training program with adapted curriculum for lay members in remote locations (Born et al., 2012; Orkin et al., 2012). The collaboration included community leaders from Sachigo Lake First Nation along with researchers from Laurentian University and the Northern Ontario School of Medicine. Sachigo Lake (population 450) is a remote Indigenous community with no permanent road access.

The first author (SR) was directly involved in both research projects, and was therefore in a position to coordinate the comparative analysis in collaboration with colleagues from both teams (OALE and SLWEREI). We use this comparison to advance what we dub the proximity paradox – the observation that the geographically isolated communities that might benefit most from involvement in CBPR initiatives are the very communities where a CBPR approach also becomes most challenging.

2. Community-based participatory research (CBPR)

CBPR is a collaborative approach to research that is usually characterized by community leaders partnering with university-based researchers to address a mutual health concern. There is a need for CBPR approaches when "researchers, practitioners, and community members are to address the growing disparities in health status between marginalized communities and those with greater social and economic resources" (Israel et al., 2008, 61). Maiter et al. (2008) used the term reciprocity to describe the foundational trust and respectful relationships that are essential to effective CBPR. Israel et al. (2005a) emphasized the process of sharing expertise, decision-making, and ownership through equitable involvement of partners in all phases of the research from inception through to implementation and dissemination. Minkler and Wallerstein (2008b) differentiated research that is community-based from that which is simply community placed, suggesting that the CBPR process is a cooperative alliance characterized by research, action, and education within the community.

There are many principles and guidelines for effective CBPR, however one of the most cited was originally synthesized as eight principles (Israel et al., 1998), and then later expanded to nine principles (Israel et al., 2005a, 2008). These are outlined in Table 1. Since CBPR has been used in many projects involving Indigenous communities, it may offer a decolonizing methodology (Smith, 2012) that is responsive to ethical concerns concordant with recommended approaches for community engagement (Canadian Institutes of Health Research, 2010). LaVeaux and Christopher (2009) offered nine additional recommendations for consideration by researchers endeavoring to collaborate with Indigenous communities, and these were later applied as principles in the evaluation of seven CBPR partnerships with Native American communities (Christopher et al., 2011). These are outlined in Table 2. We used the nine CBPR principles outlined by Israel et al. (2005a, 2008) and the nine CBPR recommendations identified by LaVeaux and Christopher (2009), as the basis for comparing the OALE and SLWEREI projects.

Table 1
Principles of CBPR for health[a].

1. Recognize community as a unit of identity
2. Build on strengths and resources within the community
3. Facilitate collaborative, equitable partnerships 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 also ecological perspectives that recognize and 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. Focus on a long-term process and commitment to sustainability

[a] Adapted from Israel et al., 2008.