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The External Researcher in Participatory Action Research

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ABSTRACT This article is a reflection on the first author’s experience as an external researcher guiding older Aboriginal women to assess their own health using participatory action research. Following a brief description of the research team, process, and methodology, the article addresses questions to be considered by a researcher wanting to use participatory action research, who is external to the community of participants. Roles played, challenges faced, and lessons learned illuminate the reality of an alluring yet complex approach to research for empowerment.

Introduction
This article is a reflection on my experience as an external researcher guiding older Aboriginal [1] women to conduct a health assessment using participatory action research (PAR). The inquiry was part of a 3-year health promotion project funded by a national health authority and operated by a local community clinic. The project’s goals were to conduct a health assessment of older Aboriginal women (hereafter known as the grandmothers [2]) in the urban setting, and to support them by offering health promotion programming, facilitating leadership development, and acting as a liaison with relevant service personnel. My [3] involvement was motivated by the wish to learn more about PAR as part of my doctoral studies (supervised by K. Green).

Aboriginal people in Canada have a long history of cultural invasion that has attempted assimilation but failed, and of research that has quantified and described their reality but done little to improve it. The grandmothers, due to their oppression and relocation to the city, have lived in a culture of silence, invisibility and isolation, to varying degrees. These women have experienced multiple disempowerment based on race, class, gender and age (Dickson, 1997).
Yet, within a year of starting up, about 80 grandmothers had had some contact with our health promotion project and health assessment research. Approximately 25 came out of their homes to activities on a periodic basis; the turnout at our weekly get-togethers was anywhere from 4 to 18; the ones who would not come out were visited in their homes by the staff and me. The grandmothers ranged in age from about 40 to 70 years. They were either First Nations (full Indian) or Métis (from intermarriage with the French and other Europeans), and were predominantly of the Cree Nation. Most grew up in remote or rural areas; formal schooling ranged from none to a nursing diploma; some had never been active outside the home, while a few had had long-term employment. Many moved to the city to be closer to their children and grandchildren, and for easier access to medical services.

Through their contact with the project and research, the grandmothers were able to enhance their well-being – learning additional coping skills, establishing new social support systems, and reclaiming their traditional role as sources of wisdom, guidance and love. As part of our work together, they engaged in activities for healing and personal development, appreciating their own strengths and value, and developing self-esteem and self-confidence. As sisters and aunts, they cared for themselves, one another, and others. They went public on issues they felt strongly about, speaking out and advocating for themselves and the larger Aboriginal community (Dickson, 2000).

We chose PAR as the methodology for this assessment. Because the explicit aim of PAR is to foster empowerment (Maguire, 1987; Tandon, 1988; Cancian & Armstead, 1990; Fals-Borda & Rahman, 1991; Park, 1993; Smith et al, 1997), we deemed it an appropriate approach for the grandmothers, who had experienced lifelong disempowerment. Through the study, we developed a definition of PAR: an inquiry by ordinary people acting as researchers to explore questions in their daily lives, to recognise their own resources, and to produce knowledge and take action to overcome inequities, often in solidarity with external supporters (Dickson, 1997, p. 2).

To conduct the participatory health assessment, a research team formed that included a number of groups. The project advisory committee was a group of Aboriginal women who were invited and agreed to meet and steer the early development of the health promotion project. They helped define a research design that they felt was appropriate and useful (Dickson, 1999). Aboriginal people increasingly voice their resentment of the dominant society making decisions for them. An advisory committee of a project is one way to shift more control to them.

The grandmothers were the central participants of both the health promotion project and research. They shifted the focus of the assessment from needs to strengths; provided most of the data; endorsed the technical work of the staff, research associates [4], and me in designing the interview guides, consent forms, work plan, and contracts of the associates; verified
the data through member checks as a group; did secondary analysis and verified interpretation of the data through their scrutiny and revision of repeated drafts of the assessment report; and took action on some of the findings and other issues arising.

The project staff [5], research associates and I guided, mediated, facilitated, and advocated for the assessment process, doing initial negotiation, orientation and development with the advisory committee, then conducting the technical aspects of data collection, analysis, interpretation, reporting and dissemination in collaboration with the grandmothers.

My doctoral advisory committee and reflections committee (described later) contributed to the research by their guidance, and their support of the study and methodology.

The participatory assessment research with the grandmothers can be described in the following phases:

negotiation about the value, nature and approach of an assessment: initially among the project advisory committee, project staff and me; and later with the grandmothers; 

team-building within the project as a whole and more specifically around the research: building relationships of trust and clarity of purpose were fundamental and ongoing; many factors played a challenging role, including sociocultural differences among the team members, the stigma of research, expectations of project funders, demands of my own academic programme, and transiency of participants; and

joint research and action done formally and informally: we gathered data on the grandmothers’ past and present strengths and concerns; analysed, verified and reflected on themes and meanings; took action on issues that evoked a strong response and could be tackled; and wrote Sharing Our Health Circle: the Grandmothers’ Health Assessment Report (1995) to convey the grandmothers’ words to others.

The External Researcher

An external researcher (ER) in PAR is an active participant, bringing his/her own philosophy, experience and understanding to the research. Questions that ERs need to explore include: what leads me to be interested in this topic; how does my background contribute to or inform this research (Kirby & McKenna, 1989); why do I think PAR is an appropriate methodology for this inquiry; and what are my assumptions going into this research?

Research is not neutral: researchers influence their inquiries by their own ideology and biases (Janesick, 1994), the topics chosen, informed consent, decisions made, kinds of questions posed, methods used, interpretations given, and ways in which findings are reported and disseminated. PAR is intended to be instructive for those interested in empowerment and socio-political change. The intentions, beliefs and
assumptions of the researcher are important so that not only is there transparency of method (Huberman & Miles, 1994) in a study but also transparency of external researcher, allowing the other participants and readers of the study to take that influence into account.

One of the aims of PAR is to create greater equality in the relationship between the ER and the participants. This balance is enhanced by making explicit the ER’s assumptions, motives and values, rather than by the conventional exploration of the subjects’ characteristics only. A dual contribution puts all participants on a more equal footing. Further, it helps to clarify what influence the ER will have on the approach and content of the research.

Powerlessness in disadvantaged people ‘prevents them from organizing themselves or doing research’ (Park, 1993, p. 9); thus, an outside influence and resource, such as an ER, is often the catalyst. People whose daily lives are consumed by efforts to survive are unlikely to have the time, energy or interest to devote to an inquiry. An ER may be helpful by bringing additional resources to the picture, such as organizing a gathering for participants, and providing childcare, refreshments and transportation.

Often, one of the hardest steps to take for the ER is getting started. Maguire overcame her difficulty by following the personal directive of Rajesh Tandon:

> Participatory research principles are not purist. You can’t sit and wait for the ideal situation. Waiting to do it right is paralyzing.
> (Tandon, 1985, cited in Maguire, 1987, p. 127)

There may be a stigma attached to research by marginalised people who believe they are studied excessively by others. They may see themselves as no better off because of the research, and while the researchers profit at their expense. From land use studies in northern Canada, a Dene writer [6] comments:

> We know from past experiences that government research by white researchers never improved our lives. Usually white researchers spy on us, the things we do, how we do them, when we do them, and so on. After all these things are written in their jargon, they go away and neither they nor their reports are ever seen again. (Nahanni, 1977, p. 23)

In a more recent participatory research project on diabetes with Haida people in British Columbia, Herbert (1996) found a similar view of research based on the people’s past experiences. The community perceived researchers as ‘parachuting’ in, taking samples and disappearing, with nothing of value coming back to the community. From St Denis’s (1989) experience with participatory research in an urban Alaskan Native community, she now wonders if research could be called a ‘service’ and thus find more acceptability with Aboriginal people (personal communication, 1996).
The literature includes a wide spectrum of thought on the appropriate roles of the ER. Jackson (1993) summarises various authors’ differing views: the principal responsibility of the ER is to the research process – securing funding, supplying technical expertise, training local people in research skills; or the ER should take a more active pedagogical role; or the role of the ER, by rapidly conveying knowledge and skills to the community, converges and equalises with that of the other participants; or the emphasis should be on provoking critical analysis by community participants of their reality.

Clearly, the roles an ER may play are many and varied. A special early edition of the Canadian Journal of Native Studies acknowledged the role of ERs with Aboriginal communities in contributing:

- knowledge of the functioning of institutions of the larger society as they impinge on Native [7] concerns while community members provide expertise in defining the issues and in culturally and behaviourally appropriate ways of addressing them. Together both groups search for methods of linking resources to communities to solve development issues. (Jackson et al, 1982, p. 5)

The ER may become a broker or mediator between local communities and institutions of the larger society. This implies being more than ‘passive channels of communication between cultures’ (Brant Castellano, 1993, p. 153) and involves exercising judgement, discretion and influence in matching community readiness with appropriate and responsive societal resources. As well, with Aboriginal people who still may rely on oral communication, the ER provides a service by packaging the people’s views and plans into other forms of media.

Maguire identified triple roles of organiser, educator and researcher in her participatory research (1993) and acknowledged that she found those difficult to juggle. Each of these roles with related functions, she found, could be played better by different individuals. A broader team would make the initiative more manageable.

Academic support for PAR has increased over the last decade, and transformatory and action research sit more comfortably as inquiry paradigms and methodologies deemed legitimate. While any candid description of PAR would identify many hurdles faced, authors such as Maguire (1987, 1993), Park et al (1993), St Denis (1989) and Smith et al (1997) also write of the notable benefits to themselves and their participant researchers.

Challenges are inevitable and to be expected, and points of tensions that cause discomfort are many. Yet, one must learn to accept these as part of the process of inquiry, learning and change, while following one’s instincts to work through them (Kirby, 1989). Griffin (1982) proposed that
these hurdles may be a gift of knowledge in disguised form; they certainly do become an opportunity for learning.

My Experience

The external researcher (ER) is an active presence in PAR. By using PAR in conducting a health assessment, I learned much about that role that was instructive for me and may be so for others. I acknowledged that I was not an impartial or dispassionate researcher, and that I influenced how this research was conducted, what influence it had on participants, and how the findings were portrayed. My own experiences and values shaped not only my decision to study PAR, but also how I related to the grandmothers and staff, the emphasis we gave to empowerment, and my support for the research to evolve along with other activities of the project. To conduct this research, I invested part of myself and I was an ingredient of it. Rather than considering these elements as limitations to the research, I viewed them as enhancing the health assessment, the empowerment of all participants, and my development as a researcher. The diversity of influences served to enrich our knowledge and the growth of all involved (Kirby, 1989).

Personal Motives and Assumptions

Motives of ERs will differ, but making them explicit both to the other participants of the research and oneself increases trust and clarity in the relationships, purposes of the inquiry, and use of the research findings. These motives serve as guideposts for the direction and nature of the work as it progresses.

My interest in PAR comes from my personal value system, international health experiences spanning the last 25 years, and involvement with Aboriginal people and health issues in Canada for the last 15 years. In the earlier years in developing countries and to a certain extent in Aboriginal health, the phenomena of primary health care, community development and popular education were conceptualised and practised before they were discussed or used commonly in the Western world. For me, it was a natural progression to view research through these frameworks and with the same set of principles and values that gives priority to grass-roots activity, popular knowledge, equity and justice. With this background, and without being imbued with the traditional research paradigm in my formal schooling, I have moved naturally into a research approach that has social change and justice as explicit ends, and is congruent with my experiences and values.

In Canada, I gravitated to working with Aboriginal people, initially as a community health nurse on a reserve, and later coordinating a national project to attract and orient Aboriginal people into undergraduate nursing programmes. Those involvements built on my personal role of being a
mother to two adopted Aboriginal sons and on my years working in developing countries where most people are underprivileged.

A principal motivating factor for my return to graduate studies was my perception of the need to do research with Aboriginal women in a project that I had helped create on woman abuse. A doctoral programme would provide me with an opportunity to learn more about PAR, which seemed to be an appropriate methodology to use for this kind of study. However, a year and a half into that initiative, the collaborative relationship for the research between an Aboriginal women's political association and myself ended. The leadership of the association decided it was no longer interested in a small-scale study we had planned. Rather, it would use the research funding we had secured for a community-based, participatory approach as seed money to get a large budget to conduct a province-wide inquiry, using a positivist approach. The funder refused to support the change, and I withdrew, feeling confused and hurt. Gerrard’s (1990) analysis of the dynamics of racism helped me understand, however, that despite my personal friendliness with the women in the association, there was a large chasm between us. In this one incident of thwarted collaboration, I felt the powerlessness that Aboriginal women must often feel. I felt dismissed not for who I was but because of my race. Gerrard advises honouring this resistance (of Aboriginal women in this case), as it is an achievement in gaining control by less empowered individuals. As well, she advises accommodating one’s own feelings by seeing this resistance in the context of their reaction to racism in our society.

This unsuccessful first experience of trying to establish a participatory research relationship was a learning experience for me regarding the impact of my presence on a community with whom I was working. As I ventured into a second research opportunity, the one on which this article is based, I was aware that I would be seen again as one of the oppressors, despite my well-meaning intentions. Recognising this reality of researcher intrusion, I continually struggled to guide the research so that it reflected the participants’ styles, interests and interpretations more than my own. This is not to imply that I could or would try to assume the persona of an Aboriginal person. I remained one who ‘respects the enormous differences between growing up as a member of a culture, and being part of the culture through participating in its day-to-day activities and through moments of vulnerability’ (Katz, n.d., p. 68). Since I may not have experienced some or many of the same concerns as the research participants, it was important for me to enter that world. By ‘being inside the other culture, exposed to its risks, touched by its joys’ (Katz, n.d., p. 68), I would be able to contribute to telling ‘a richer and more accurate story because it is a story from within the culture as well as from without’ (Katz, n.d., p. 68). Yet, through my own family life of raising my two Aboriginal sons, I had some experiences in common with the women in the study, and this contributed to a bond between us.
Assumptions are what we take for granted, or suppose to be true, based on our ideology, values and experiences. Playing vital although often invisible roles, underlying assumptions influence our communication and behaviour (Smith, 1995). Prior to starting this inquiry, I identified a number of assumptions I held about PAR, adapting some from those proposed by Maguire (1987):

- some people are oppressed and disempowered, and therefore can benefit from empowerment;
- the ability to shape both common and scientific knowledge is a source of power for dominant social groups;
- both participants and the ER come to the PAR process with knowledge and experience to contribute;
- power and control over decision-making in the research process can and should be shifted increasingly from the ER to the participants; and
- ordinary people have an innate knowledge and, when provided with tools and opportunities, are capable of critical reflection and analysis, knowledge creation, and mobilising human resources to solve socio-health problems.

Further, I identified specific assumptions that guided me in the work with the grandmothers:

- Aboriginal people have the right to control their own health care system which emphasises a holistic approach to health;
- Aboriginal control in any field is inextricably bound to redressing inequitable power relations with the dominant system;
- women retain the fundamental role of bearing and nurturing children, and of maintaining family and community connections, which puts them in a potentially important position in their community; and
- an ER representing the dominant culture does disturb and distort the study context, yet even so may be able to facilitate a respectful, empowering inquiry.

In different ways, at different times, I shared these assumptions with other members of the research team to enhance the transparency of the external researcher.

**Getting Started**

Getting started for me meant joining in with general activities of the project, and playing whatever role I could to launch the project, developing relationships with participants, and building group coherence. My profession as a nurse gave me an understood and respected label and function, and my early tasks included small teaching sessions on health topics of the grandmothers’ interest. Most of my other early involvement was group development and maintenance, such as transporting grandmothers, making coffee, supporting the staff’s facilitation of get-togethers with the
grandmothers and keeping notes of these sessions, and joint project planning with the staff. These tasks would fall into what Ornelas calls a bridge activity – something short term to help with entering a community, and giving its members a chance ‘to size you up and get to know you’ (as cited in Smith, 1995, p. 266). In our project, the more immersed I got, at both a group and individual level, the more able I was to introduce and further the idea and initial steps of the participatory health assessment, at first with the advisory committee and staff, and later with the grandmothers. Ideally, the researcher already lives in and is of the community but I was not; therefore, getting involved in order to become known and trusted was critical, and took time and patience on everyone’s part.

The Stigma of Research

An area of tension for me throughout the inquiry was the stigma of research held by the grandmothers. Not many of them had been personally involved in a research study before, but almost all would say that their people had been researched to death and got nothing out of it. Aboriginal people here commonly believed that they had been studied excessively by others, with no benefit to themselves. It was difficult for the grandmothers to view any kind of research as being under their control and/or for their benefit. PAR can ameliorate both the perception and reality of research as exploitative through an explicit focus on participants’ empowerment and their control of the process and results. The existing stigma, however, affected our work throughout the project. It took 6 months of relationship-building among the grandmothers, staff and me before the staff risked introducing the words research and health assessment. For the duration of the project, those terms always needed some qualifying explanation to be accepted.

My Roles

My roles were varied, and changed according to what was needed and appropriate at different stages of development in the project and research. These roles combined many general project functions and others specific to the research.

Both the predetermined goal of the project to do an assessment, and I as the ER were catalysts that nudged and guided the grandmothers into an inquiry of their own health. On their own, it was unlikely they would have examined and reflected on their personal well-being in a methodical manner.

Not necessarily by inclination or design, but more by the nature of the grandmothers as participants, my involvement as ER focused primarily on facilitating community development and the research process. Because of the grandmothers’ age, wisdom, life experiences and learning style, I was
neither comfortable taking a directive or a skills transfer role with them nor successful in eliciting a deep critical analysis of their reality. With the staff and research associates, however, I felt it was appropriate to play a more instructive role whereby PAR and health promotion became better understood.

In our project and research, the staff and I frequently served as brokers between the grandmothers and other groups advocating for support to enhance their well-being. Further, I routinely transcribed the grandmothers’ formally and informally expressed opinions, ideas and hopes into written communication for transmission to other groups. Examples of this communication included the report of their own health assessment (*Sharing Our Health Circle*, 1995), a letter sent to various politicians about the grandmothers’ objections to proposed nuclear waste storage in our province, and a summary of their concerns with government social services sent to the provincial minister.

Maguire (1993) writes that she found her multiple roles difficult to handle. By contrast, varied roles served to ground me more broadly in the project and the lives of the grandmothers so that our differences were balanced by the many aspects of our lives that intersected. Furthermore, in contrast to Maguire’s work, ours had the advantage of extra personnel: initially, the advisory committee to start the research design; later, the staff who were part of the research team and assumed some of the tasks involved, especially in organising project activities in which the research was embedded; and the research associates to assist the health assessment in a number of ways.

As soon as I was given permission by staff to identify my role as guiding the health assessment, I began to call myself the research facilitator and informed the grandmothers of my interest in studying PAR and health promotion as part of my academic programme. Despite inserting this information whenever and wherever appropriate, so few of the grandmothers were familiar with graduate studies or grasped the abstract nature of our work that my presence and role in the project continued to be described as the nurse. By the last year, however, many of the grandmothers were clear and comfortable enough to say that I was working on the research about their health.

Overall, the roles I played in my position as ER included facilitator, researcher, organiser, educator, community developer, nurse, friend, staff planner and administrative assistant, project evaluator, and advocate (for the research, the project, various individuals and different issues and problems).

*Support and Benefits*

To bolster my courage and provide direction, other people became part of the informal PAR team and offered me much-needed support. At times, I
would consult with various members of my doctoral committee who had experience in PAR overall, familiarity with Aboriginal people, or just good common sense about research and people, to steer me through ‘stuck points’. Some of these individuals and others formed a reflections committee with which I met occasionally to run through progress and challenges, and/or who read an early draft of findings and gave me valuable feedback. Other kindred spirits from family and friends joined this informal team. PAR is not a solitary pursuit; many minds and many hearts do make the path clearer.

For 3 years, I invested myself in this project and research, both personally and professionally, through the roles I have described. Yet, I gained more in return. The experiment with PAR had many benefits, and was stimulating and enlightening. The field site afforded me the opportunity to return to practice after a number of years in academe. Continuing to work with Aboriginal people, but a different subset this time, further increased my awareness of strengths and issues in those communities. Equally valued, the personal benefits of the experience for me were remarkable, with close relationships built up among the grandmothers, staff, and me that were warm and satisfying. I became ill near the end of the project, and they became a circle of caring and comfort for me. That experience enhanced our relationships as power with (Starhawk, 1987) in that I, like most of the grandmothers, no longer enjoyed good health; we were wounded, yet supportive of each other.

Overall, besides influencing the grandmothers and staff, participating in the PAR experience had a profound effect on me:

- reclaiming my enjoyment of working in the field;
- restoring my faith in the wonder and worth of engaging directly with people;
- reinforcing my belief in the capacity of ordinary people to conduct research and effect change;
- bringing me into contact with structural barriers that limit people’s well-being; and
- strengthening my resolve to further incorporate my values and politics into my academic and work life.

**Challenges**

My entire time guiding the research was spent with an underlying feeling of uncertainty, wondering whether our unconventional approach would materialise into a health assessment or not. I often felt as if I were holding my breath, hoping that things would fall into place, repeating my mantra, Trust the process!

From the point of initially proposing PAR to potential participants in the thwarted first initiative to the completion of this health assessment, I functioned with some trepidation. In both cases, I was the one, not the
potential participants, proposing the research, asserting that there was a need for it, and insisting that research could be empowering rather than exploitative. Yet, I was making this argument as someone from the oppressors’ population to people who were the oppressed. The grandmothers distrusted research yet I was asking them to be co-researchers. With them, I felt I had to constantly rationalise, defend, justify and persuade, a role I did not like. Furthermore, the staff felt uneasy in the early months of the project about broaching the topic of research and my role in it for fear of driving the grandmothers away from the project altogether. Their caution exacerbated my feelings of discomfort and added an element of deception to my relationship with the grandmothers. Since it was not the grandmothers who had identified a need to examine their own health picture, I would have preferred to work with them in an open-ended, community development way, encouraging them in personal and group growth and advocacy, and guiding them in inquiry and analysis as a natural part of their development. As it was, there was a pre-set agenda of doing a health assessment as one of the funded project goals, and of using PAR and examining its impact on participants within a certain time frame for my academic programme. The spectre of failure loomed because of the importance of this work to the achievement of project goals and to the success of my doctoral programme, and because of the scepticism of mainstream health researchers towards PAR.

Despite my interest and background, there were constraints to my role in PAR. As a researcher who is external to the study community, I had to acknowledge to myself and to the other research participants the inherent contradiction between my role and presence in the research and the aim of PAR to reduce power inequities. I implicitly represented many aspects of contemporary and historical social, economic and cultural dominance; I am privileged – white, middle class, university educated – and am part of a global and local power structure. Yet this reality of who I am is a paradox: it is an advantage in that it gives me the opportunity both to learn about PAR and to become involved in a project in which its use may be appropriate and functional; but at the same time, a disadvantage because I am, inherently, an agent of racism and classism working with a group of less empowered participants who are the victims of these forms of oppression.

Gerrard (1995) and Haig-Brown (1992) have both considered, with perception and sensitivity, the position of the external researcher in the border world, the area between warring nations (Haig-Brown, 1990). Haig-Brown justifies her work with Aboriginal people in that her efforts are on the side of the oppressed to combat racism, although she concedes her role is transitory and dependent on others’ acceptance. Gerrard conducted research with women of colour on their experiences in the mental health system. During her search for subjects, she was welcomed by a few, insulted by some, and rejected by many (1990). Out of the resulting mix of her anger, pain and insight, Gerrard learned about her own racism and that
of the women of colour with whom she talked. Both authors, in their respective articles, further illuminate their experiences as external researchers.

Because I was an outsider and from the oppressor population, I endeavoured to be inconspicuous enough to avoid dominating or shifting the focus off the grandmothers, or precipitating their silence. In my efforts to be unobtrusive and thus foster growth of the grandmothers, I consciously abrogated an active animator role, one that might have enhanced group development and critical analysis. Maguire (1993), too, writes of her reluctance to act like a trainer utilising her full range of skills and techniques. She admits that this reluctance was a mistake: out of her fear of intimidating people, she lost opportunities to use techniques to enhance participation. As with our grandmothers, few women in her research had experience or skill as group members, or in critical reflection and social action. I, too, did not use all my abilities in group facilitation, yet pondered this possibility throughout the research. Did I decide correctly? For me, it remains unclear.

Lessons

During the life of the project and research and the exercise of writing about the experience, many insights about PAR and specifically the role of the ER became apparent to us. The value of relationships cannot be overemphasised; time and personal commitment of all involved are essential; the process must be flexible and the researcher facilitative; the process of working together is of value in and of itself; PAR demands a good personal and political fit among all participants; power and prestige inequities exist within the team and need to be addressed; and PAR can contribute to a more just society. These key lessons are briefly described here.

Developing relationships of trust within the research team is fundamental. As relationships among the grandmothers, staff and me developed, the concept and language of health assessment research could be introduced, and acceptance cultivated for doing research together as one of the components of the project. There were a number of elements that fostered trusting relationships between the grandmothers and me. Home visits were the single most effective activity. Yet, I felt comfortable making these visits only after we had got to know one another in the group for several months. An aspect of these visits was to offer what Labonte (1993) calls respectful services – meeting needs of the grandmothers that I was able to, such as inquiring about a medication, providing transportation to a funeral, or writing a letter. As women and mothers, we shared common joys and pains. Despite our differences, we could relate well to one another about some issues, such as our children’s alcoholism and conflict with the law, and through our similar responses of caring and compassion. Mutual
respect grew, became recognised, appreciated and articulated, and was accompanied by a growing affection for one another.

An ER must be prepared to commit time and self beyond what would be called for in most research and work broadly for development of the community of participants. Time together, without the usual researcher detachment, creates comfort, builds trust and fosters friendship. The grandmothers, staff and I spent countless hours together, in each others' homes, at project activities, at committee meetings, and at special celebrations. As Maguire says about her own relationship-building with abused women participants, 'There is no way to short-circuit the process' (1993, p. 175). Furthermore, PAR and community development are two sides of the same coin; the former cannot be done without the latter.

As these relationships are built and project and research activities established, the ER lives with considerable uncertainty regarding the direction, nature and extent of the evolving research that is only clarified as the process continues. I continuously played mental tapes to myself: go with the flow, hang loose, and trust the process. The corollary to uncertainty is giving up control and giving it over, something conventional researchers or high-achieving professionals are not practised at doing; nevertheless, it is essential in PAR. The key decisions in PAR must be made and owned by the participants, with the ER functioning as facilitator and resource person. To play that supportive role, I trained myself to be low key and a background organiser rather than take a front-and-centre role the way one learns to do in academic teaching and research settings.

Another critical lesson is to truly value the process at least as highly as the outcome. This was brought home to me a year after the project finished and our health assessment report was published. On their own, the grandmothers organised a community workshop with a grant awarded shortly before the project closed. The health report was part of the registrants' packet and served as the printed resource for small group discussion during the workshop. The report was referred to more by the other participants in the workshop than by the grandmothers. This told me that the grandmothers used their experience in the health assessment to develop clarity and confidence, enhancing their capacity to articulate their opinions and advocate for their own health. The process of doing the health assessment was instructive and empowering, and this was of more value to the grandmothers than the printed report.

An ER in PAR cannot be a detached scientist with a well-defined agenda and timetable but must be willing, indeed enjoy immersing her/himself in the lives of the participants. It helps to have a philosophical commitment to the people and their issues. For me, because of my own children, my work in developing countries and with Aboriginal people, my belief in social justice, and my interest in women's empowerment, working with the grandmothers was a natural and satisfying fit that sustained my interest and involvement for the long term. Furthermore, researchers and

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practitioners need to recognise political activity as part of our professional mandate, bringing our work life closer in line with our personal belief system. If we believe in social justice and people-centred development, our research and practice should reflect those values.

When working cross-culturally and representing the oppressors of a colonised society, an ER faces a delicate balance – how to appropriately guide, provoke, and contribute skills without dominating, distorting or controlling. I found myself in an ongoing state of self-censorship, scrutinising the words I used, the roles I played, the direction in which I was steering the project, and its pace. Representing the stereotypical whites was a burden which was relieved over time as the grandmothers, staff and I became individuals, and friends to one another, but the image would reappear at times and remind me of who I was and the differences our histories brought to the picture. Increasing trust did dispel the barrier much of the time, and we became friends and colleagues. Additionally, the benefits are enormous, producing rich portrayals of real-life phenomena, an experience that is enjoyable and rewarding, and the satisfaction of knowing that one’s pursuits empowered rather than exploited others.

Belief in the principles of PAR is essential for the ER because there are many obstacles to surmount. Social and political change is neither popular in many quarters nor easy to achieve. Each PAR inquiry needs to be judged in terms of whether it contributes to participants’ well-being and thus to a better life, not whether it, in itself, transforms society. All of us involved in community development and PAR must realise that although our initiatives will not ameliorate injustices on their own, what matters is that we are carrying out our work respectfully, in ways that increase, rather than diminish, equity. Most important, we are each part of a larger, collective movement to improve the well-being of all. Many small successes can build on one another to create the revolution.

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Notes

[1] Aboriginal is the general term commonly used in Canada to refer to all indigenous people (Indian/First Nation, Inuit and Métis).

[2] ‘Grandmother’ and ‘grandfather’ are terms commonly used by Aboriginal people in our area to address older people in a respectful manner, and are not confined to blood relations, but are general designations.

[3] Throughout this manuscript, where the first person singular is used, it refers to the first author.

[4] Two Aboriginal women who were hired short term and trained in basic research skills.

[5] Two women, one Aboriginal and one non-Aboriginal married to an Aboriginal man, who were employed as coordinator and outreach worker.

[6] The Dene people are one of Canada’s First Nations (formerly referred to as ‘Indians’).

[7] In Canada, contemporary use of the term Native is being replaced by Aboriginal.

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