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# Participatory Action Research: Practical Strategies for Actively Engaging and Maintaining Participation in Immigrant and Refugee Communities

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In this research we examined the processes involved in implementing and maintaining a participatory action research (PAR) project by uncovering how theoretical PAR tenets hold up in the reality of a community-based project addressing immigrants' and refugees' mental health needs. Qualitative data from focus groups with these newcomers were analyzed for thematic content. Findings reveal that active participation is seen as the gateway into a PAR project, whereas knowledge attainment and empowerment are the stimuli for continued participation. The data also suggest that newcomers' motivations to participate in a PAR-oriented project might vary across ethno-cultural groups. Practitioners working in community-based initiatives would do well to appeal to the diversity of motivational factors, while endorsing individual and group strengths.

***Keywords:*** *community-based programs; immigrants; mental health and illness; participatory action research (PAR); refugees*

The process of migration, whether voluntary or forced, has implications for the health care sector, including mental health care professionals and the services they offer. Research evidence suggests a strong correlation between the cultural changes that accompany migration and the rates of mental illness among immigrants and refugees (Angel & Williams, 2000; Beiser, 2005; Bhugra, 2004; Mann & Fazil, 2006; Procter, 2005). Because of the migration experience, immigrants and refugees might lose their natural support systems, a factor known to alleviate and minimize the effects of mental illness, making mental health services even more important (Bhugra, 2004). Newcomers' culturally defined ways of seeking help, traditionally through extended family and community leaders, might mean that they are reluctant to use mainstream mental health facilities (Hassett & George, 2002; Sadavoy, Meier, & Ong, 2004). It also might mean that they have significantly different expectations about appropriate methods of treatment. For example, concepts of holism and spirituality are often missing from Western medicine (Angel & Williams, 2000; Lewis-Fernandez & Kleinman, 1995; Sadavoy et al., 2004). Within some cultures the social stigma and familial shame associated with mental illness can prevent some newcomers from utilizing services. Within other cultures mental illness is believed to be genetically inherited or the result of misdeeds either by the person with the illness or by their parents and ancestors (Bhugra, 2004; Sadavoy et al., 2004). Many cultures view mental health as an integration and balance between the physical, the spiritual, the social, and the moral. To discuss, and therefore to treat mental health and illness as separate from physical well-being is in direct conflict with their belief system (Angel & Williams, 2000; Cuellar, 2000; Kleinman, 1987; Sadavoy et al., 2004).

When newcomers attempt to access available services they can face a number of barriers. For instance, they might face linguistic, ethnic, and cultural barriers that impede communication, compounding an already sensitive and complex situation (Angel & Williams, 2000; Cristancho, Garces, Peters, & Mueller, 2008; Palmer, 2006; Sadavoy et al., 2004).

Western mental health professionals often have little understanding of newcomers' beliefs, practices, culture, and perspectives regarding mental health, which might result in a misdiagnosis (Lewis-Fernandez & Kleinman, 1995; Mann & Fazil, 2006; Procter, 2005). As well, immigrants and refugees might perceive mental health facilities to be hostile environments, designed for the dominant ethno-cultural groups (Kleinman, 1987; Palmer, 2006). In addition, mainstream mental health services are frequently located outside of communities in which newcomers reside, creating potential transportation difficulties (Hill, 1985; Palmer, 2006; Willging, 2008). Consequently, newcomers tend to have lower utilization rates of mental health services than the general population (Cristancho et al., 2008; Cuellar, 2000; Hassett & George, 2002; Palmer, 2006).

## Community-Based Project

Research and programs associated with mental health issues in immigrant and refugee populations are currently priorities of the Public Health Agency of Canada (Canadian Mental Health Commission, 1996; Metropolis Project Canada, n.d.). Consistent with this priority, we examined a participatory action research (PAR) project that addressed the mental health needs of immigrants and refugees. Participatory action research is an increasingly common approach used in community-based programs that involve marginalized populations such as immigrants and refugees. A PAR approach is a combination of community participation and research that acknowledges and uses the insights and abilities of community members to resolve issues that they identify as salient (Knightbridge, King, & Rolfe, 2006; Minore, Boone, Katt, Kinch, & Birch, 2004). Over the last 30 years, a great deal has been written by scholars and community activists about the theory and practice of PAR, showing awareness of the need for democratic research methodologies (Löfman, Pelkonen, & Pietilä, 2004). PAR requires equal participation between researchers and participants (Minore et al., 2004), promotes empowerment through enhancing people's abilities to change their immediate social and political milieus (Wallerstein, 1992), stimulates knowledge attainment (Israel, Schultz, Parker, & Becker, 1998), and aims to create positive social change (Rahman & Fals-Borda, 1991). Although there is a growing body of literature articulating the theoretical processes of PAR (Meyer, 2000) and describing particular projects using a participatory approach (Dickson & Green, 2001; Knightbridge et al., 2006; Leung, Yen, & Minkler, 2004; Minkler, Glover-Blackwell, Thompson, & Tamir, 2003; Thomas, Seebohm, Henderson, Munn-Giddings, & Yasmeen, 2006), little is known about what creates and maintains PAR-oriented initiatives (Dickson & Green, 2001). With the purpose of addressing these knowledge gaps, we studied how theoretical PAR tenets hold up within a community-based, PAR-oriented project.

The community-based project was developed by a group of multicultural health brokers and individuals from various nonprofit human service, health, and immigrant-serving agencies in a mid-size western Canadian city. The overarching goal of the project was to develop resiliency among newcomers coping with acculturation stress associated with migration and settlement processes. The specific objectives of the project were to (a) build capacities for positive health outcomes with members from immigrant and refugee communities, (b) develop institutional readiness to support community initiatives that enhance newcomers' mental health, and (c) create an environment conducive to productive collaboration among professionals providing formal mental health care services. It was designed to combine the expertise of ethno-cultural communities and mainstream (or formal) Canadian health care institutions to bring about sustainable community mental health promotion programs and activities.

The community-based initiative was organized into a steering committee and a core group. The multicultural health brokers and representatives from the nonprofit agencies comprised the steering committee, whose function was primarily administrative. The core group was composed of five to seven individuals from each of Chinese, Somali, South Asian, Spanish-speaking, and Vietnamese ethno-cultural communities. The responsibility of core group members was to build linkages between their communities and the mental health project. Individuals from both the steering committee and the core group participated in the study. To explore the connections between theory and praxis as they relate to the processes involved in initiating and maintaining a PAR-driven project, we collected members' insights about the project.

## Participants

Study participants included people who were involved in the community-based mental health PAR

project as members of either the steering committee (multicultural health brokers and representatives from various nonprofit human service, health, and immigrant-serving agencies) or the core group (representatives from five ethno-cultural communities). It is important to note that it was participants in the community-based mental health project who categorized and labeled the five ethno-cultural communities (Chinese, Somali, South Asian, Spanish-speaking, and Vietnamese) represented in the core group. In other words, the categories were not imposed by us, as researchers.

All members of the community-based project were invited to participate in our study. At the time of the study, the community-based project's membership totaled 40. The sample size for our study was 18: 4 steering group members, 2 members from the Chinese community, and 3 members from each of the remaining four ethno-cultural communities. Study participants were between 36 and 55 years of age, 78% of whom were female. Except for two Canadians (both steering committee members), all were born outside of Canada, with 31% having resided in Canada for more than 15 years and 19% for less than 5 years. Of the study participants, 31% entered the country as refugees and 69% as immigrants. Almost all indicated some religious affiliation. Furthermore, nearly all of the study participants were affiliated with nonprofit organizations, but only half were actively involved with projects other than the community-based mental health project.

## Methods

A non-PAR approach qualitative research design, with data gathered through focus group interviews, was employed to examine the PAR process as experienced by the community-based project members. Ethical clearance for this study was granted by the relevant health ethics review board. Participants were given a copy of an information letter about the project and two copies of the consent form. The consent forms were discussed in detail; potential participants were reminded that participation was voluntary and they could withdraw at any time with no consequences to themselves or their involvement with the community-based mental health project. Participants agreeing to take part signed the consent forms. To ensure confidentiality and protect the anonymity of participants, numbers were assigned to all focus groups and each participant was assigned a letter. Any identifying factors were deleted or changed to generic terms (e.g., immigrant serving agency, nonprofit organization).

Focus group interviews, which were conducted in English, were guided by questions that were consistent with the objectives of the study and questions that were based on the responses to a short, open-ended questionnaire that we distributed to all members of the community-based project prior to the focus groups (43% response rate). Using a pre–focus group questionnaire increases the likelihood that both minority and dominant views are included in focus group discussions, and it can serve as a springboard for in-depth dialogue (Berg, 2001; Fink, 1993). The questionnaire included questions that were generated from similar studies (Lawrence, 1997; Lindsey & McGuinness, 1998) and that were consistent with our objective to examine the processes involved in implementing and maintaining a PAR project. The questionnaire data were thematically analyzed for similarities and differences between participants' involvement with the community-based mental health project. From the themes, we developed a set of focus group questions intended to facilitate additional exploration of the issues and ideas raised in the questionnaire responses, and which were consistent with the four tenets of PAR within the community-based mental health project: participation, learning, empowerment, and social action. Separate focus groups were conducted with members of each of the five ethno-cultural communities and the steering committee.

Focus group interviews were audiotaped, transcribed verbatim, and analyzed for thematic content. Preliminary data categories were developed and organized according to participants' perspectives on the four tenets of PAR. The analysis moved from participants' concrete experiences to increasingly general and abstract thematic categories. The model that emerged from this analysis is discussed later in this article. Because of the mental health project's small membership, the sample size from which to invite participants for this study was limited. Consequently, it was necessary to use caution when interpreting conclusions. Findings used to develop the model came from consistent statements from multiple sources. Other findings, such as those suggesting ethno-cultural differences, are more tentative, as the number of participants from each ethno-cultural community was small.

## Findings

The four tenets of PAR were used as an organizing framework for considering how the theoretical tenets were upheld within the community-based initiative. From the findings we uncovered practical strategies for creating and maintaining PAR-oriented projects. Where appropriate, participants' words are used to substantiate the findings. The source of each quotation is identified to highlight both the differences between and similarities among the five ethno-cultural groups and the steering committee. Each focus group was assigned a number from 1 to 6, and these numbers are used as identifiers to track the focus groups from which the quotes were drawn.

### Participation

The key principle distinguishing PAR from other social science research is participation, a joint venture in which decision making, planning, and responsibilities are shared among participants (Löfman et al., 2004; Meyer, 2000; Minore et al., 2004). Green et al. (1995) suggested that PAR-oriented initiatives should emphasize participants' unique strengths and shared responsibilities, thereby enabling both researchers and community members to combine their strongest resources in ways that create a balance in responsibility and power.

During focus group discussions, the study participants talked about factors that motivated initial participation. Participants from the ethno-cultural communities indicated the importance of tangible rewards (e.g., learning skills that could enhance present and future employment, a job, and money for their community), cultural norms (e.g., traditions, values), and altruism for initiating involvement:

> They had to really see what they could get out of it, instantly or at the most 3 or 5 years. It was hard for them to imagine the future, because they live in the present. (6)

> We have our culture, our values, our passions, our motivation, our needs. But in Canada it was different. We were more socially oriented, I believe, than those who were born here. We have a long history of PAR. That is why we were here. (4)

> I got interested in the program because I saw the opportunity to share, to help the communities to understand and to be empowered on mental health issues. I learned from the needs of other people and I shared the resources from our immigrant service agency. (4)

Although some overlap exists between what motivated initial and continued participation, there were notable differences. Generally, continued participation was enhanced by the operational design of the project; the real, and perhaps perceived sense of opportunity; and participants' willingness and desire to learn. Specific features of the project's design that promoted continued involvement included a democratic process, involvement of community members, and flexible timelines. As articulated by one participant, a democratic process engendered respect among members:

> There was an openness and sincere-ness that allowed every person to put forward what he thought and what he believed. And every person and every group tried not to harm the other person but listened to his ideas and what he believed. Valuing each other's opinions and contribution in terms of ideas was also important in participation. (2)

The salience of democratic processes in maintaining participation is also evident in other studies. Ochocka, Janzen, and Nelson (2002) found that participants in a PAR initiative focusing on equal power distribution and knowledge transfer among people with mental illnesses and researchers referred to the democratic process as having a "voice and choice" (p. 384). Their study established that the values integral to the process include survivor empowerment, genuine caring relationships, an environment of continual learning, and social justice.

The involvement of community members throughout the mental health project, especially during the initial planning phase, was also crucial in promoting continued participation. The steering committee attached importance to sustained involvement and genuinely desired to understand participants' cultural knowledge and their ways of working. These actions and attitudes validated participants' internal knowledge, making them feel valued and respected:

> But in terms of this project, from the beginning the steering committee asked the communities what they needed help with instead of coming with the answers to the community. They asked the community what the solutions were, what the answers were to their questions. (2)

> Especially at the beginning of the project the people from the community were involved. Especially people not coming from the high administration but there were frontline people and people who were

> involved with the community. Then we got a much clearer idea as to what the people really needed from each community. (5)

The existence of flexible timeframes and activities further enhanced participants' continued involvement. Whenever possible, the steering committee moderated funding agencies' strict outcome-oriented deadlines, which enabled communities to work at their own pace and in a manner relevant to them:

> One of the reasons that people were excited about the project was that each community could tailor-make their own project. They could mold this project and make it something that fit their own community's needs, and that was something really new, something we have never had before. (2)

Focus group participants also discussed barriers to participation, which were framed in terms of communication difficulties, lack of connections, lack of clearly defined roles, and insufficient resources. Participants believed that insufficient resources jeopardized participation in two ways. First, the project's limited financial resources prevented the hiring of full-time employees who might have completed the community-based mental health project's objectives. And second, community members' personal financial situations meant they had insufficient time to volunteer because they were working multiple jobs:

> When people were really into survival mode they didn't care too much about the preventative; for example in one community it has been hard to mobilize people and get volunteers or people willing to come out. But the little that I know from talking to the community was that the people were very much in the 2 to 3 jobs. To squeeze that [volunteering] in as a priority was really quite difficult. (1)

Some study participants speculated that an individual's socioeconomic status determined his or her ability to participate in community activities. For example, participants who perceived their ethno-cultural community's socioeconomic status to be lower than another community believed that low participation correlated directly to struggles with daily life:

> Some communities were more established financially in terms of education, integration; they were just really a lot further ahead than us. And the reality was that most people in our community were struggling still and they felt, whether it was a reality or not or perceived, that they didn't have the time to volunteer. (2)

> Community members who are affluent they don't care, they do not need the services or they have no passion for the people who need it. (1)

Despite this perception, however, focus group participants who perceived that their ethno-cultural community was relatively affluent indicated that financial security did not guarantee involvement of other people from their communities. These apparently conflicting findings seem to imply that although insufficient personal finances can limit participation, financial stability is not on its own a sufficient basis for motivating participation. Findings from another PAR initiative reinforce the notion that competing demands on time and financial struggles restrict involvement (Dickson & Green, 2001).

## Attaining Knowledge

Knowledge attainment is the second tenet of PAR. Within PAR projects, knowledge attainment is a dynamic process of engagement, education, communication, action, and reflection (Dickson & Green, 2001). Learning is viewed as a two-way process because it provides opportunities for practitioners and community members to learn new ways of attaining and interpreting knowledge (Minore et al., 2004; Woodward & Hetley, 2007). Additionally, within this multiethnic mental health PAR initiative, learning occurred across communities as community members shared their unique perspectives and perceptions about mental well-being and/or realized commonalties. Opportunities for learning included a desire to discover personal strengths and weaknesses and a willingness to understand other cultures and traditions, as well as Western ideologies surrounding the concepts of mental well-being. By understanding the biomedical constructs of mental well-being, and by knowing their community's readiness to accept these concepts, participants hoped to bridge the gaps in ideologies, open dialogue on issues considered taboo in their communities, and act as a conduit between their community and mainstream culture. They expressed a desire that newcomers might one day receive culturally sensitive care and integrate into Canadian society with greater ease:

> The other thing was the whole issue of mental health and mental illness. Something that was new for me because in our culture it was something new, it was

> not how I previously perceived. One of our [community's] achievements would be if we could break down that type of word and people realized that mental health is not mental illness. So our success would be if we taught the people and that people realized that there is mental health, and that it was something we could talk about. (2)

Our findings are consistent with those from a PAR initiative addressing mental health care inequalities as experienced by members from Black and minority ethnic communities. Participants from that study expressed the importance of "acting as a bridge between the communities and services" (Thomas et al., 2006, p.13).

Focus group participants in our study indicated that an opportunity for learning was crucial in stimulating both their initial interest and continued involvement in the project. For example, participants appreciated the opportunity to gain concrete skills and information about mental well-being and illness, as well as proficiency in working cross culturally:

> I liked the fact that we had lots of learning events. It is something that will be with us and we can use the rest of our lives. Every experience was a learning one and we learned from mistakes and we tried to fix them. (2)

A direct consequence of the multiethnic mental health project was that communities learned about and from one another. Highlighting the importance of cross-cultural learning within multicultural societies such as Canada, participants reflected that they gained respect for the hardships encountered in other communities and became acutely aware of the compatibility of their goals:

> And also we learned from each other. Myself, I was totally ignorant about the [name of another cultural group] community. I now have a lot of respect for them, specifically the way they have adversity and so little resources. The same kind of respect that I now have for the [name of a different cultural group] community because I did not know how diverse they were, their diversity has been an eye opener for me. I really learned a lot. (3)

Participants in all focus groups revealed that their involvement offered them opportunities to learn about themselves and experience personal growth. Being in an environment in which they could practice new skills resulted in building self-confidence. That participants gained confidence is evident in the following comments:

> I have empowered myself to help my people. (5)

> The project helped us to know ourselves and helped us know what in real life our attitudes were, with respect to other cultures. I think that helped us change our assumptions. (4)

Findings from two other PAR initiatives reinforce the importance of providing opportunities for training and learning. In one study, minority ethnic community participants noted a lack of confidence in their abilities to act as liaisons because the project had limited opportunities for training and skill building (Thomas et al., 2006). Similarly, in a study addressing continuity of health care in Aboriginal communities, participants highlighted the importance of interdisciplinary interactions and learning opportunities between professionals and paraprofessionals to facilitate greater awareness about the role of nontraditional healers within those communities (Minore et al., 2004).

## Empowerment

Empowerment, a crucial component of PAR, is a process that "promotes participation of people, organizations, and communities toward the goal of increased community control, political efficacy, improved quality of life, and social justice" (Wallerstein, 1992, p. 198). Reflections from the participants suggest which aspects of the project led to their empowerment: mutual respect and reciprocal information transfer among all members, the creation and control of the project by community members, and active involvement in a project designed for the betterment of their communities. Participants also mentioned that access to information and resources better equipped them to help community members experiencing mental health challenges:

> To facilitate the tools needed by community members to make changes in their lives or in the communities. Provided them with information about different resources, taught them how to use these resources, and taught them about the country so that they could make informed decisions. (4)

Involvement in a multiethnic initiative provided members with direct experience in cross-cultural teamwork that was, in and of itself, empowering. Participants in all focus groups called attention to the notion that, through their interactions with other communities in the project, they became aware that they shared similar concerns and needs:

> Maybe it was a universal problem, we just looked at it in a different way. . . . we thought our community had one problem but when five communities came together we realized that they all had similar problems, too. (6)

The recognition of shared challenges and common goals is especially salient for newcomers, as individual and collective well-being are frequently intertwined (Beiser, 2005). Participants were comforted in the knowledge that other ethno-cultural groups also experienced growing pains while integrating into Canadian society, and hence did not feel isolated in their struggles. This was an empowerment-enhancing realization, because they recognized that with collective group effort across diverse ethno-cultural communities there was greater potential for influencing mainstream policies. Most importantly, all participants indicated that their involvement with the project provided evidence that more could be accomplished by working together than by working in isolation.

### Social Change

The collective realization that more is accomplished through collaboration leads to the final PAR precept: social change (Rahman & Fals-Borda, 1991). Theoretically, PAR stipulates that participants' personal change is a prerequisite for societal change. In other words, social change cannot occur without personal change. Participants commented on the small-scale, incidental learning (described as the willingness by professionals to learn about other cultures and ways of doing) that was occurring within mainstream health care institutions, and postulated it to be the foundation required for significant institutional and societal change. Again, these findings are consistent with the Minore et al. (2004) study that emphasized the role of interdisciplinary relationships and learning activities in attaining the ideals of PAR. Although focus group participants recognized changes in their assumptions about other cultures as a result of their involvement in the project, more time is needed to determine the extent to which this personal change will lead to social change. Participants from all focus groups implied that small changes in mainstream society were steps in the right direction:

> We heard that in Canada there was a very fragmented mental health care system, where everything was divided. But now we created a link between the people in the hospital and the people in the community. It was very slow but there was a process here where we worked together with the community and with the institutions. (4)

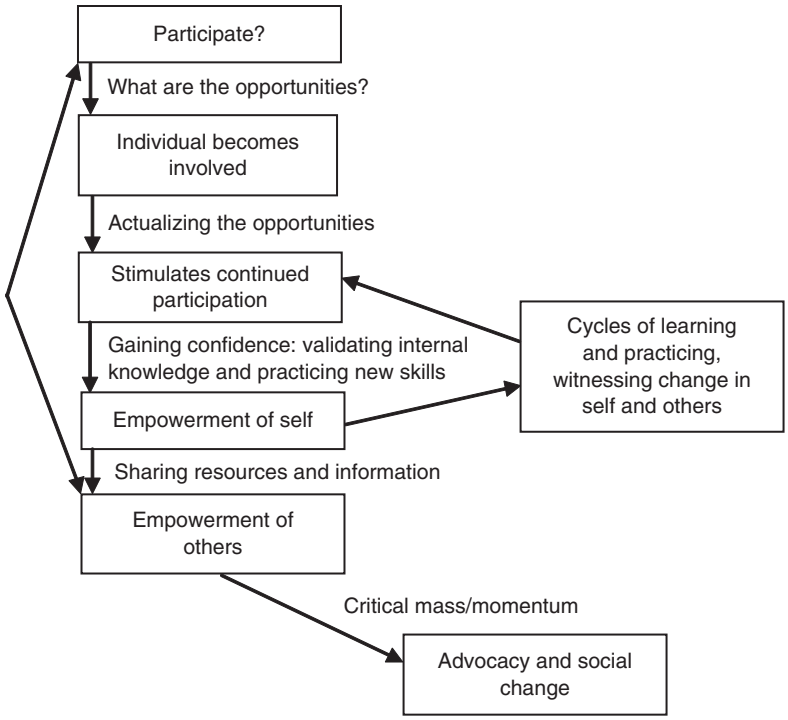
References to a fragmented mental health system and the necessity of offering holistic services were echoed by participants in another PAR study examining various integrative strategies to address mental illness (Knightbridge et al., 2006). Chow (1999) postulated that networking between mainstream and community-based human service agencies and raising public awareness about the challenges that newcomers encounter increase the prospect of social change. Nevertheless, participants in our study feared that changes were one sided. They believed that immigrants and refugees were adapting to a new way of life, whereas many in the host society remained resistant to learning about their traditions. Despite concerns that changing perceptions and policies within mainstream society might be an unattainable goal, participants were, overall, hopeful about the possibilities.

## Discussion and Implications

This research enhances current PAR knowledge by exploring the process of PAR within a community-based initiative and by providing information on what participants perceived to be necessary for their (and potentially for others') participation. Understanding the processes for initiating and maintaining participation has significant implications for community-based practitioners, as one of the challenges associated with PAR is getting—and keeping—people actively involved.

The model that emerged from the data demonstrates that within PAR there appears to exist a natural flow, an ordered set of relationships among the tenets (see Figure 1). Community-based practitioners should focus on stimulating initial participation and then on supporting and maintaining active participation. The remaining PAR tenets (knowledge attainment, empowerment, and social change) are likely to emerge as a consequence. Simply stated, without participation, there can be no PAR. Consequently, the model depicts participation as the gateway into PAR, whereas knowledge attainment and empowerment are the stimuli for continued participation, eventually resulting in social change. Based on the findings from this study, we hypothesize that the impetus for wanting to participate is determined by the opportunities presented by

**Figure 1**
**Factors That Stimulate and Maintain Participation in Community-Based Projects**




and within a project, with the value of these opportunities determined by an individual's interests, culture, and traditions. Support for this hypothesis is buttressed by participants' comments regarding initial motivational factors: tangible rewards and cultural norms.

As Figure 1 shows, once an individual becomes involved with a project, the real and perceived opportunities must be actualized to engender additional involvement. Creating an environment that nourishes respect and openness, maintains flexible timeframes and scope of activities, and establishes a learning milieu enhances continued involvement. Study participants gained confidence by having their internal knowledge validated (the knowledge they brought to the initiative), by learning and practicing new skills (the knowledge they gained because of their involvement) and by witnessing changes in other participants and themselves. These experiences fueled further involvement and led to a sense of personal empowerment. Over time, as the PAR cycle progresses, more individuals become empowered, collectively begin advocating for change, and accumulate momentum to influence mainstream health care policies. Our findings, in combination with those from other studies (Rahman & Fals-Borda, 1991; Thomas et al., 2006), suggest that a few cycles of learning, practicing, and observing change must occur before participants gain assurance that they can be resources for their communities.

## Strategies for Engaging and Maintaining Participation

Especially important in pluralistic societies, the findings from this research suggest the need for practice to incorporate the diversity of cultures into programs and initiatives. Although it would be beneficial for PAR projects in Canada and other migrant-receiving countries to have a multiethnic focus, findings from our study tentatively suggest that some of the motivational factors promoting participation are culturally unique. Within the community-based mental health project for instance, the Spanish-speaking participants appeared to become involved as a means to help strengthen their communities and create a nurturing environment for individuals with mental illnesses. The incentives to participate for the Chinese and South Asian communities seemed to be related to opportunities to influence mainstream health care policies to

become more culturally responsive, and to advocate for communities at all levels of government. An opportunity to learn how other ethnic communities developed "togetherness" within the new cultural context of Canada appeared to stimulate Somali community members' involvement. Vietnamese community members seemed to participate to gain knowledge about resources and information about Western constructs of mental well-being, and thereby become a resource for families needing assistance. In light of these findings, community-based practitioners might enhance program participation by emphasizing aspects of a particular project that appeal to diverse motivational factors.

Although the findings reveal that factors inspiring participation are not universal, overarching similarities across cultures seem to exist in the factors that maintain participation. These similarities include sustaining an environment of mutual respect and openness, demonstrating flexibility in adapting a project to work at the pace of participating communities, involving the community from the beginning, and incorporating community members' physical and intellectual resources. Our study findings suggest that community-based practitioners would do well to appeal to the diversity of motivational factors, endorse individual and group strengths, and create an environment of reciprocity between communities and practitioners; only then can advocacy and change occur. In summary, McFarlane and Fehir (1994) said it best:

> We can never give to the community. Everything is there and theirs from the beginning. We can increase awareness, connect people, and validate respect for culture and the many ways of knowing, believing, and doing. It is essential to trust in the people to decide for themselves what is best and most needed even if those needs are different from funding priorities and our preferred action plan. (p. 393)

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