Article

Getting Started: Initiating Critical Ethnography and Community-Based Action Research in a Program of Rural Health Studies

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Abstract

Rural populations experience higher rates of illness, less access to health care resources, and lower rates of health insurance coverage than do urban populations. A need exists to identify and address the health care needs of rural communities and other isolated populations and to contextualize the findings in the larger rural health environment. Critical ethnography combined with community-based action research is a constructive approach for improving the health status of rural elders as well as other members of isolated communities. Detailed guidelines on how to initiate an ethnographic community-based action study, as shown through a study that explores the definitions of health, health care perceptions, and health care issues for rural elders in the southwestern United States, highlight the value of this type of research for the study of the health care issues of rural populations.

Keywords: critical ethnography, community-based action research, human science, critical social theory, rural health, rural elders

Introduction

We cannot find our lives in weights and measures. Microscopes and telescopes increase our context, they do not find origins or conclusions. Like the spirit we brought to this land, they probe, they examine, they explore. "Meaning," they proclaim, "is beyond our vision. Truth is below our sight." But there is a research of a different sort. It does not move, it does not seek. It watches until stillness shifts or silence makes a sound. It drinks in a universe whose origin and every manifestation is alive, and whose every movement demonstrates its laws. That which exists beyond our boundaries is not unknown, it is simply not revealed.—Kent Nerburn (1998, p. 97)

Rural health care in the United States is in crisis. One might argue that all health care is in crisis, yet with geographic isolation; fewer fiscal, transportation, and health care resources; an aging population; and a shrinking economy, rural communities and residents experience exceptional challenges and disparities in

meeting basic health care needs. A goal of the U.S. Department of Health and Human Services' (DHHS) Healthy People 2010 initiative is to reduce or eliminate health disparities in vulnerable populations, including rural populations and those from minority ethnic backgrounds.

Approximately 25% of Americans currently live in rural communities with fewer than 2,500 residents. In general, rural populations experience higher rates of heart disease, cancer, injury-related deaths, diabetes, and depression than do urban populations. Furthermore, rural communities are characterized by lower rates of personal income, educational attainment, health insurance coverage, access to emergency and specialty care services, and reported health status of adults than are urban communities (Gamm, Hutchinson, Dabney, & Dorsey, 2003; Magilvy, Congdon, Martinez, Davis, & Averill; 2000; U.S. DHHS, 2000; Weinert, 2002). A recent companion document to Healthy People 2010 was developed for rural populations, in which access to quality health services was identified by both health care providers and residents in rural areas as the overriding health care issue (Gamm et al., 2003).

As a social group with special concerns, rural elderly populations in the United States are likely to fall out of the societal mainstream, intensifying the need for goods and services to which access is already compromised. The lived health care experiences and issues for rural elders often include inadequate access to health care resources, marginal ability to understand the workings of the managed care system, and barriers related to history, culture, language, distance from providers, and traditional norms (Hamman et al., 1999; Kienzle, 2001; Magilvy et al., 2000). Such barriers and inequities are best understood in the context of culture-specific and community-specific health care perceptions of rural elders. The perceptions are important to overall health and health outcomes because they influence the likelihood of planning and delivering health care congruent with the values and priorities of the population, and in partnership with community-based organizations (Bushy, 2000; Sen, 2001). Data are scarce regarding the perceptions of rural elders in New Mexico, a state known to be culturally diverse, with the nation's highest poverty levels (U.S. Census Bureau, 2002). Even less is known about the health care perceptions, experiences, and contextual issues for rural elders in southwestern New Mexico, which comprises part of the U.S.–Mexican border, is severely affected by the demise of copper mining and agriculture, and is currently struggling to meet the needs of a growing elderly population.

A study funded by the National Institutes of Health (NIH)/National Institute of Nursing Research (NINR) and under way in 2005-2007 aims to identify, critically analyze, and collectively resolve key health care issues and disparities for rural elders, from their perspective, in the context of their sociocultural environments, and to examine the policy and practice impli-c ations of the elders' perceptions of their health, health care, and health needs (Agar, 1996, 1999; Albert, Im, & Raveis, 2002). The importance of reducing disparities and understanding rural perspectives is judged more urgent than research aimed at specific outcomes, for which scarce contextually congruent indicators exist. The principal investigator (PI) expects to

> 1. analyze definitive indicators of health care disparities for rural elders, such as affordability of prescription medications, access to basic and specialty care services, and effectiveness of interactions between elders and health care providers; and

> 2. construct preliminary explanatory models based on informants' definitions of health, indicators of disparities, cultural variations, and health care issues identified by rural elders.

The population of interest to this study represents health disparities along the lines of rurality, aging, geographic location, economic status, and culture. Specific characteristics of a rural region and sample cannot be assumed to resemble those of other groups in alternative locations. A need exists to identify and address the health care needs of this population and to contextualize the findings in the national rural health environment (Weinert, 2002). In the context of the aims, disparities, and a collaborative approach

to the rural communities, critical ethnography and community-based action research comprise a timely research design. The purpose of this article is to offer an overview of the existing study and to present methods used by the PI to initiate such a design in rural communities of southwestern New Mexico. Because the investigation is just under way, overall findings are reserved until sufficient data suggest preliminary conclusions.

It is useful to preface the discussion with an explanation of how the author interprets critical ethnography and community-based action research and how those strategies interface in the research activities. In this way, the conceptual underpinnings are more easily linked to the operational aspects of the research.

Critical Ethnography and Community-Based Action Research

The study arises from a critical ethnographic paradigm, in the traditions of ethnographic inquiry, critical social theory (Agar, 1996; Kincheloe & McLaren, 2000), and community-based action research (LeCompte, Schensul, Weeks, & Singer, 1999; Minkler & Wallerstein, 2003; Stringer, 1999). The focus is on the discovery, interpretation, and application of local knowledge to practice, rather than on testing hypotheses or outcomes. Common elements in these traditions include partnership between investigators and participants with respect to planning and interpreting research, and subsequent partnering in the development, implementation, and evaluation of any interventions.

Critical ethnography has emancipatory implications and is depicted by Thomas (1993) as

> a way of applying a subversive world view to the conventional logic of cultural inquiry. It does not stand in opposition to conventional ethnography. Rather, it offers a more direct style of thinking about the relationships among knowledge, society, and political action. The central premise is that one can be both scientific and critical, and that ethnographic description offers a powerful means of critiquing culture and the role of research within it. (p. vii)

Critique of the cultural scene is embedded within the ethnographic process in this framework (Noblit, Flores, & Murillo, 2004).

The purpose of scientific research in this tradition is to uncover not only sociocultural knowledge about an unfamiliar or little-known group but also patterns suggesting exclusion and social injustice. For example, limited or no access to basic health and social services, prescription drugs, and opportunities for social interaction for a group reflects an example of resource rationing and inequity. Examination of the multiple contexts surrounding the rural communities invokes a variety of data collection strategies and sources—interviews/narratives, memos, newspaper accounts, library and historical records, casual conversations, group discussions, photographs, epidemiologic statistics about usage patterns, and so forth. The current study combines ethnographic interviews and dialectical partnership, ethnographic participant observation, photography, review of pertinent local archives, and community-based action research efforts to reduce health disparities. A more detailed description of these techniques is beyond the scope of the article but can easily be found in the literature (Averill, 2002a, 2oo2b, 2003). The fundamental idea behind these methods is to involve participants in the research process, securing their active role in identifying research priorities and empirically grounding the researcher's conclusions in situations and contexts relevant to participants' expressed concerns. To strengthen the overall knowledge base of rural health, collaborative research such as this is needed to establish reliable health status indicators across cultural groups (Weinert, 2002).

A valuable adjunct to critical ethnography is the incorporation of community-based action research. Based on a partnership between the researcher and community members/participants, community-based action research is a strategy to ensure that system or institutional change in health care for rural elders is

planned, contextually congruent, and proactive (not reactive). This strategy teams the researcher and community members (e.g., health care planners, managers, and providers; rural elders; other key citizens) in a kind of team ethnography, the intent of which is to identify, analyze, and resolve important health or social problems (Agar, 2004; LeCompte et al., 1999; Stringer, 1999). It ensures the relevance of the research questions and consensus among partners as to key issues and priorities, as well as the long-term involvement of rural community members in identifying and reducing health care disparities and providing effective, socially/culturally appropriate, equitable health care services to rural residents (Agar, 2004; Drevdahl, Kneipp, Canales, & Dorcey, 2001; Morgan, 2002; Sen, 2001; Wallerstein & Duran, 2003). Minkler, Blackwell, Thompson, and Tamir (2003), acknowledging the challenges of such collaborative research, supported it as "an important tool for action-oriented and community-driven public health research" (p. 1210). Underlying assumptions for community-based action research include:

1. the idea that changes in the health care system for rural elders are based on accurate data, rigorously obtained and situated in contexts deemed most salient by participants;

2. the conviction that people traditionally regarded only as research subjects should instead be active participants in the research process; and

3. the belief that research should lead to a practical and beneficial outcome (e.g., reduction or elimination of health disparities, positive change in health care practices and policies) related to the needs and daily lives of the rural elders (Albert et al., 2002; Austin, 2001; Stringer, 1999). Dickert and Sugarman (2005) proposed four ethical goals or outcomes for this kind of research design: added protection from specific risks and hazards, increased benefits to the health of the overall community, opportunities for residents' political participation, and research partnership with others conducting the study.

Processes fundamental to community-based action research are compatible with ethnographic interviews and participant observation. The overall processes are summarized as Looking, Thinking, and Acting (Stringer 1999), and Looking is the major focus of the current study. The Look-Think-Act research routine is best conceptualized as a blueprint or roadmap that provides guidance to the researcher. In the context of this routine, and in support of this study's overall purposes, the purpose of Looking is to develop a collective description of how the health care experiences of rural elders occur, what the relevant contextual details are, and ultimately what insights can contribute to resolving the identified disparities and problems. The collective description arises from the perceptions of both the researcher and the participants, especially a core group of key community participants who will serve as contextual experts and consultants throughout the inquiry.

Consistent with the study aims, the procedures attached to Looking include: (a) collecting, recording, and analyzing information; (b) constructing reports that capture key elements and situational factors; and (c) validating and disseminating the findings among participants and stakeholders in the community (Stringer, 1999). In this research model, Looking must not be construed passively. Rather, it implies the responsibility and commitment of the researcher to situate the findings of the study in the broader context of previous research. In this way, the overall knowledge and theoretical understanding of rural elders' health care can be expanded and enriched for the purpose of reducing health disparities in similar populations throughout the United States. Thinking and Acting are planned for future research, to extend and clarify the collective understanding of key health care issues and to build a supportive coalition to identify priorities for community-based action and interventions in southwestern New Mexico.

This investigation is based on nursing and social science propositions that the processes of defining and explaining health care perceptions, issues, disparities, and experiences involve complex interactions among rural elders, the economic and political realities of local communities, and the contexts of rurality,

poverty, ethnicity, and culture. The intent to generate preliminary explanatory models for identified issues depends on social engagement, dialogue, deliberate actions, epidemiological trends, documentation, and policy implications (Agar, 1999; Bushy, 2000; Kincheloe & McLaren, 2000). A more complete discussion of how critical ethnography and community-based action research integrate, including a proposed diagram to illustrate the linkages among essential concepts and procedures, appears elsewhere in the literature (Averill, 2005). In the next discussion, I focus on the initial implementation of this critical ethnographic, community-partnership study, in particular, in rural communities, with the intent to share what has been successful and to extend the dialogue on how to intervene collaboratively in marginalized settings.

Initiating the study in the rural communities

This NINR-funded study was approved by the University of New Mexico Human Research Review Committee (HRRC) for adherence to all standards of human participants protection, assuring and monitoring ethical comportment. Getting such a study under way in distant rural communities presented both challenges and opportunities for the researcher. In the context of critical ethnography, Stringer's (1999) Looking, and the current NINR study, the point of the early phase of inquiry was to accomplish the accurate generation or collection, recording, analysis, and dissemination of baseline information, all within appropriate sociocultural context and from the perspective of the local residents. The activities attached to this phase are not linear; in fact, all research-related actions proceed in more of a circular fashion, because the researcher and the community informants generate dialectic about key issues, questions, assets, and possible solutions. However, it is useful to propose a few details about distinct phases of actualizing critical ethnography and community-based action research. The researcher introduces an approach or set of suggestions based on the acronym G-R-O-W, aimed at engaging local residents in the process of social change, applied in the immediate study and described as follows: G = get ready, get set, go; R = respond, revisit, revise; O = oblige, offer, outreach; W = watch, wonder, widen.

Get ready, get set, go

Do the homework

Prior to traveling to rural communities near the international border, the researcher had first to learn about the region and setting by studying the geography, culture, climate, population and migration trends, economic history, health status indicators, and unique local assets/strengths (e.g., an active community health council focused on issues across the life span for residents). Doing so strengthened rapport with residents, demonstrated an interest that went beyond consideration of research alone, and ensured a warm reception with opportunities for meaningful conversation. The emphasis was on the communities and residents rather than on the research agenda.

Inform the local community about the research

Using a combination of telephone calls, postal mail, and e-mail, the researcher set the stage for a first visit, noting that key contacts or stakeholders represented important entry points into a rural population of interest. She contacted health care managers, planners, and administrators in both the public and private sectors of health care and social services (e.g., for home health agencies, hospices, hospitals, care centers, senior centers, meal sites, volunteer centers, and housing offices), striving for multiple viewpoints, opinions, and kinds of experiences among participants.

A brief explanation of the study purpose, an idea of how the local communities could benefit from such ventures, and an invitation to partnership in the implementation of the study were presented in simple language. The researcher then asked permission to contact the key stakeholders in person once she

actually arrived on site a few days or weeks later, acknowledging their busy schedules and proposing a meeting of no more than 45 to 60 minutes, at a time and place convenient for them. This mode of action conferred information, asked permission, and respected both the time and importance of the people instrumental in reaching the group of greatest interest (the elders). The research design is openly value laden and political, with obvious importance accorded to the local voices and contextual experts in the communities—the residents themselves.

Operationalize the plan

Based on input from the most responsive and enthusiastic early contacts, the next phase involved setting actual appointments, with precise but flexible plans for time and place. Social options, such as meeting for coffee, tea, a light meal, or, in one case, an outdoor picnic, were woven into the planned meetings, pending openness on the part of informants, to nurture the relationships at the core of this kind of inquiry. Arranging personal encounters to coincide with actual interviews, the PI was able to evoke rich and informative narratives about the issues, local contexts, and communities of interest. Lincoln (2002) described this approach as "communitarian because it recognizes that research takes place in, and is addressed to, a community" (p. 334).

Another helpful strategy involved the crafting of a news release for local media. The short announcement was initiated and written by a senior community member, shared with the researcher for her input and editing, then given to the local newspaper. In the release, a few short sentences described the overall purpose of the study and the exact time and place the researcher would attend a public meeting, and issued an open invitation for anyone interested to come listen, ask questions, and have input into the planning of the investigation. The meeting was attended by approximately 20 individuals, ranging from interested elders to an array of health, educational, and social service providers, planners, and managers. Other possible venues for such releases could include public bulletin boards, local radio programs, local schools and colleges, and churches.

At the close of the meeting, the researcher provided contact information that could be used at any time by anyone interested. This included professional affiliation, work address, telephone number, e-mail address, and relevant local contacts (e.g., the key informants described earlier). In the modern world, one is mindful of personal safety issues, but this style of providing appropriate, reliable contact information sent a message of accessibility and accountability to local residents. Since that time, the PI has had several of the contacts use e-mail to express interest, ask questions, or make referrals to additional individuals. Central to this strategy is the notion that the researcher attends the settings, gatherings, and occasions of significance to the community, much more in a posture of explanation and invitation than of direction. The inquiry takes place in the community as part of the everyday life there, rather than apart and distinct from it.

Respond, revisit, revise

Hit the ground running

When the researcher arrived for the first real effort at generating data, the experience became an exercise in stamina, persistence, and flexibility. A cell phone was indispensable, so that contacts could be made, confirmed, or rescheduled as needed and as circumstances changed in busy lives. The calls also served as reminders of appointments and evidence that the PI was following up on commitments made earlier, all of which increased the likelihood that fruitful interviews would take place. Very often, the PI invited informants to coffee, tea, or a meal. If that was not possible, such as when visiting isolated elders in more remote locations, she brought along healthy snacks, juices, or bottled water. People appeared to appreciate such gestures and were usually more likely to offer their time for interviews and discussions. All

participants who agreed to be interviewed for the study were asked to read and sign consent forms prior to providing information. Two levels of informants emerged from these efforts: the multicultural rural elders themselves (primary participants, as they are the focus of the study), and the secondary participants, comprising adult family members, local planners, providers, care managers, and other community members.

The researcher found it helpful to offer short, simply written summaries of the research plan (available in either English or Spanish), including the roles of both participants and researcher, along with her contact information. Most often, she was also asked to offer a verbal summary of the work, in straightforward language free of jargon, to one or more interested informants around a table or desk, generally within just a few feet of each other. At all phases of the conversation, she invited questions or comments, including criticisms and suggestions (all part of the dialectic process and critique). The PI concluded the interviews by asking supplemental questions designed to enhance the partnership, such as: What questions should be asked that have not yet been addressed?; Whom should I contact for additional information, and where do I find them?; and What would you/your organization like to see come out of this research, and what would be most helpful to you?

In most instances, participants appeared surprised by this but then offered input they considered important. Besides eliciting the local thinking on key questions, the researcher found that providing incentives was valuable to the process of engagement and tangible thanks for the contributions people made to the study plan and data generation. For example, in the current study, a $20 Wal-Mart gift card was given to all participants, regardless of whether they were primary or secondary participants. Regardless of how people felt about the retail giant in their area, they welcomed the opportunity to obtain groceries or personal items at no cost in return for their time and effort.

Oblige, offer, outreach

After a community visit was completed, informants' time and contributions to the data generation were freshly and formally acknowledged. The researcher sometimes did this personally and on site, prior to leaving, and/or in the form of a newsletter, e-mail, or telephone call after returning home. For enhanced follow-up, the PI and her research assistant (RA) team currently circulate a newsletter to all participants approximately every 8 weeks to give updates on the work, to review what has been learned and what questions remain, and to post a schedule of upcoming trips and research-related plans. The newsletters are also an opportunity for members of the research team to introduce themselves. Student RAs and others involved in the project have written short paragraphs about themselves, and photographs are planned for future editions because the grant will proceed over 2 years. The photographs and personal introductions help to humanize the team from a faraway location to the local residents.

The entire research team emphasizes readiness to answer any questions or concerns people might have, making contact information prominent and accessible in all communications. Efforts are ongoing to invite additional suggestions or issues that need to be addressed, affirming the role of full partnership with participants because many of the lifelong elders read very little, if at all, in any language. The PI offers to make presentations during the upcoming visit in case anyone wants a more public review of what is unfolding, keeping the research project vital, active, and visible to residents, regardless of the passage of weeks or months.

Watch, wonder, widen

Maintaining congruence with the purpose of the study and a human science perspective, and having set in motion responsiveness, active listening, gentle probing, genuine curiosity, ongoing communication, and evocation of the local views, the PI and RA teams retreated between travels to examine and analyze the

information acquired—a time reserved to wonder what the findings revealed and to widen the lens of the study to incorporate important elements identified by informants. A kind of intensive reflection began as to the content, process, and meaning arising from the investigation and the dialogues. By reflection, the PI refers to the act of engagement with the voices in the text of the interviews, for purposes of interpretation and translation in a way that ethically and authentically captures the point of the conversation. van Manen (2002) distinguished this kind of covenant with qualitative data by observing, "While physical science tends to classification, experimentation and mathematics, human science tends to experience, consciousness, writing and language" (p. 239).

As part of the reflexive process, the research team debriefed frequently about apparent themes and patterns in the data, in part to avoid overemphasizing the PI's influence on the data. As Denzin (1997) noted, "The . . . narrative text is reflexive, not only in its use of language but also how it positions the writer in the text and uses the writer's experiences as both the topic of inquiry and a resource for uncovering problematic experience" (p. 217). Alvesson and Skoldberg (2000) further posited that "reflection means interpreting one's own interpretations, looking at one's perspectives from other perspectives, and turning a self-critical eye onto one's own authority as interpreter and author" (p. vii). Based on communications from the local residents in rural settings, they benefited from the time of apartness, as it gave them the opportunity to think about what significance and usefulness the work holds for the future.

For the immediate future, as the research team retains an attentive posture toward the rural communities and informants, they continue to analyze existing data for themes and patterns and to initiate fresh contacts with individuals or organizations, usually suggested or referred by local residents. A part of this phase, therefore, involves expanding the scope of the sample while nurturing and planning contacts for future visits and dialogue. Often, as a result of analysis, reflection, and input from participants, specific questions can be targeted more precisely to future informants. For example, if the team learned about a new mechanism for assisting elders to obtain prescriptions, then the PI can inquire as to the perceptions, availability, eligibility criteria, and success of such a program in neighboring communities with different samples of residents.

Prefatory findings

Only two of the planned three counties have been incorporated into the preliminary findings, a situation that is congruent with the overall timeline for the study. In addition, more interviews, public dialogues, and meetings will take place in all three counties before the research team assembles sufficient data for early conclusions. Procedures for data generation include ethnographic interviews and dialectic process, participant observation, photography, archival data review (historical accounts, patient education materials from public and private sectors, newspaper stories, etc.), demographic data for participants, and creation of community-based consultant groups for each of the three counties. Data analytic methods are ongoing throughout the investigation and include conceptual coding, thematic analysis, and matrix analysis (Averill, 2002a; Patton, 2002).

Very early findings suggest that the following issues are significant for multicultural rural elders: affording expensive prescriptions needed to manage chronic illness, accessing adequate primary and specialty care providers, finding reliable transportation to distant medical specialists, and developing community infrastructure (e.g., social and recreational resources) to accommodate increasing numbers of retirees entering the region from elsewhere.

In the current study, as well as in others, the researcher has found local residents to be enthusiastic about sharing in the formal description, interpretation, analysis, and problem-solving efforts for their communities. Once they realize that they share ownership of the process and the outcome of the work,

their interest in the research deepens. They begin to believe that research need not be a dry academic exercise with no local relevance. This kind of research design combines the rigor of good inquiry with the practicality of community-based problem-solving. It is labor intensive, and it causes the work to "be concerned not only with how we humans reason and think, but also with how we act toward each other, thus engaging questions of human relationship and of ethics" (Scheper-Hughes, 1992, p. 21). In the words of Madison (2005), "Critical ethnography begins with an ethical responsibility to address processes of unfairness or injustice within a particular lived domain" (p. 5). Key to all of this is the idea of personalismo (Marin & Marin, 1991), or the personal energy invested in establishing and maintaining reciprocal, caring relationships between the research team and the community residents involved in the study. No such qualitative inquiry, planned to unfold over several years, could proceed in the absence of this deeply personal dimension. As Coffey (1999) suggested, "Qualitative research generally and ethnographic endeavor in particular is, by its very nature, interpersonal and intimate" (p. 56). The study under way is not an end point for the PI, but will instead unfold into additional "layers of evidence" (Morse, 2001, p. 204) aimed at bringing improvements to the health of and health outcomes for the rural elders.

Given what we know of the major health disparities facing rural communities, combining critical ethnography and community-based action research is a constructive approach for improving the health status of rural elders, as well as other members of the isolated communities. Getting that kind of study off the ground effectively depends on successfully attracting, engaging, and maintaining key contacts within the rural communities, in part, by applying the strategies introduced here.

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