Davydd Greenwood and Morten Levin’s *Introduction to Action Research: Social Research for Social Change*, describes action research as “processes of collaborative knowledge development and action design involving local stakeholders as full partners in mutual learning processes.”¹ In its most basic sense, participatory action research (PAR) is action, research and participation. In order for research to be participatory, the researcher must collaborate with local stakeholders from the outset; the very definition of what the problem is that shall be researched needs to be agreed upon by all stakeholders. Reaching agreement on the definition of the problem and the subsequent research to be done will only be legitimate if all relevant stakeholders have an opportunity to shape that definition and decide on the process moving forward.

Massachusetts General Hospital’s 2012 *Community Health Needs Assessment and Strategic Planning Report* is a representative case study of participatory action research. Part of Massachusetts General Hospital’s (MGH) mission outlines a commitment to actively and meaningfully engage with the communities that it serves in order to engender change. The assessment and report exemplify this commitment, and the particular process for conducting the community health needs assessment (CHNA) alongside community stakeholders, jointly deciding on the major issues that plagued each community and creating an implementation strategy that addressed said issues embody the principles of participatory action research.

Although PAR has its roots in advocacy planning and participatory planning rather than applied phronetic research, it is valuable to understand the attempts to ground social science in practice and action. In order to think about the ways in which to approach research and understand the role it plays within a larger framework, Bent Flyvbjerg’s works, *Making Social Science Matter: Why Social Inquiry Fails and How it Can Succeed Again*, and *Real Social Science: Applied Phronesis*, introduce the concept of *phronesis*. Phronesis, a notion crafted by Aristotle, is defined as “a true state, reasoned, and capable of action with regard to things that are good or bad for man.”

Unlike *episteme* or *techne*, which encompass analytic and technical knowledge respectively, phronesis incorporates judgment and embraces practical wisdom. It is this practical wisdom that Flyvbjerg believes is necessary when conducting research in social science, and the practicality of such research is underscored by the importance of context. Phronesis and context are what he claims sets social science apart from the natural sciences, and his ultimate goal in making this distinction is to “restor[e] social science to its classical position as a practical, intellectual activity aimed at clarifying the problems, risks, and possibilities we face as humans and societies…”

*Real Social Science* takes Flyvbjerg’s concepts a step further by compiling various real-life examples of applied phronetic social science. To Flyvbjerg, phronetic research becomes action when it enters the public sphere. In his view, by

---


simply publishing or drawing attention to the results of a research study, he has moved his work into the realm of action. Although *Real Social Science* builds on his initial concepts of social science research, what is not made explicit is how one is to transition from research to true action, or from what *is* to what *ought* to be done. Participatory action research addresses the gaps in Flyvbjerg’s approach to social science research in outlining how to truly move research to action, while encompassing issues of community collaboration, power, legitimacy and equity that are either not addressed or adequately developed in Flyvbjerg’s work.

The community health needs assessment and implementation strategy outlined in MGH’s report demonstrates participatory action research and the types of positive social change that can be created through such a collaborative and reflexive process. In addition to being a great example of PAR, I chose this report as a case study because I am interested in studying non-profit hospitals in New York and Massachusetts and their community benefit programs as part of my thesis. Both states have guidelines in place that are very similar to the new provisions added under the Affordable Care Act, which not only mandates that all non-profit hospitals provide community benefits to the communities in which they are located, but also calls for conducting a community health needs assessment (CHNA) once every three years, in addition to creating an implementation strategy to address the issues highlighted in the CHNA. The provisions also emphasize that the assessment and implementation strategy process needs to seek input from all relevant stakeholders in the community. It is clear that the guidelines effectively underscore the
importance of participatory action research; however, it is up to each hospital to interpret what those guidelines may look like in practice.

Massachusetts General Hospital is one of the hospitals in Boston that embraced the voluntary community benefit guidelines, which were issued by the Attorney General in 1994. In 1995, the hospital conducted its first community health needs assessment and has continued to do so periodically since then, focusing on the communities of Charlestown, Chelsea and Revere. Beyond the temporal commitment to conducting CHNAs and creating implementation strategies, MGH as an organization acknowledges that they must “engage in deep and transformative relationships with local communities to address the social determinants of health.”

Because of this thinking, the hospital decided to create The MGH Center for Community Health Improvement (CCHI), which “builds relationships and works with community partners to make measurable, sustainable improvement on some of [their] toughest health problems.”

With an organizational culture that recognizes its role as an institution distinctively poised to aid communities in a more holistic manner, MGH’s CHNA process and implementation strategy exemplify its pledge to working with communities to understand their problems and develop viable solutions. In looking at what the CHNA process calls for, its strength lies in the fact that hospitals are

---

5 Massachusetts General Hospital Center for Health Improvement. *About Us.* [http://www.massgeneral.org/cchi/about/]
strongly urged to engage with communities to truly understand what the issues are that they deem to be related to public health.

For the community health needs assessment process, which began in 2012, MGH chose to use the Mobilizing for Action through Planning and Partnerships (MAPP) framework. This framework, created by the Center for Disease Control, also underscores the recommendation that CHNAs are “community driven, involve diverse sectors of the community, and that data be collected through multiple sources...” 6 This framework led to the creation of assessment committees in each of the three communities, which were composed of relevant stakeholders, including leaders, residents, and organizations. It is important to note that MGH also explicitly reached out to residents and groups that may not have traditionally been involved in such a process to create a truly representative group. 7 As an example, Revere CARES, a substance abuse coalition, was involved and became the “backbone” for that community’s assessment committee. In choosing this organization, MGH relied on the relationships and legitimacy that Revere CARES represents, which helped to ensure that the stakeholders brought in with their help would be representative of the community.

In joining the committee, everyone involved agreed to the following: 8

1. Oversee the community health needs assessment and planning process
2. Provide guidance about how to best gather community input and data

---

3. Assist in convening the community
4. Assist in data collection through focus groups, key informant interviews, and/or other sources
5. Participate in identifying key community issues and assets
6. Prioritize the community’s key issues after data gathering and analysis is complete
7. Create a community strategic plan

The points above, when discussed and negotiated among each member involved in the three committees, led to a rubric in how to conduct the needs assessment, and also clarified and formulated a procedure for how to synthesize the information from the assessment and create an implementation strategy.

In the following phase (Phase 3), data collection occurred. The report stated that prior to the collection, the members of the community “developed a collective vision of their ideal community that guided the distinct phases.” In creating a space for such conversations to occur, the community was able to jointly construct their vision, which again builds validity in both the research/assessment process and the strategy to tackle the issues that arise out of the assessment; this ability to have the communities in which the research is being done collaboratively shape the process is a fundamental tenet of PAR.

Another aspect of the report that exemplified PAR were the varied forms of data collected that helped inform the assessment and the pursuant strategic plan. Research was done via a quality of life survey; public forums; focused discussions; focus groups with underrepresented individuals; and the collection of public health

---

data. Similar to the Bronx Development Study, these wide-ranging methods of gathering information and engaging the community—particularly underrepresented members—allowed for “different ways of seeing” both the communities as a whole and the lives of the residents within these neighborhoods. The focused discussions, for example, covered topics including the assets and challenges of each community, in addition to existing services and resources to which residents have access. This diverse assemblage of information is not only helpful to MGH in understanding the health of its communities, but also in gaining a truly comprehensive understanding of the context in which residents live, work, and socialize, and the issues that matter most to them.

The subsequent phases 4, 5, and 6 were dedicated to synthesizing the information gathered and, again, involving the entire community in the discussion and development of priorities and possible solutions. Based on these meetings, each community was called upon to develop goals, objectives, and strategies, which were incorporated into a larger strategic plan. In identifying priorities, the report mentions that community members differed in their views on how to address issues that may have already been receiving attention from organizations or other groups. Each community ultimately made a decision, but since it was the first instance in the report that mentions potential conflict or disagreement, it would have been enlightening to understand how each community arrived at its decision.

Based on those conversations, however, it became apparent that Charlestown, Chelsea, and Revere all considered substance abuse and violence and public safety to be the most significant issues that needed to be addressed. To develop the implementation strategy that would begin to confront these issues, the committee members and respective subcommittees began to outline a framework.\textsuperscript{12}

In this way, the community health needs assessment transitioned from participatory research to participatory \textit{action} research, as what ought to be done was made explicit in order to carry out viable solutions. Strategies highlighted included collaborating with organizations and the police to “reduce drug activity...and increase perception of safety” and policy development that included “positively impact[ing] identified health priorities.”\textsuperscript{13}

The report’s conclusion section exemplifies a critical part of PAR, encompassed in the \textit{creation of opportunities for learning and reflection in and on actions} that is part of Greenwood and Levin’s Cogenerative Action Research Model.\textsuperscript{14}

MGH’s Center for Community Health Improvement states that it will continue to monitor and measure progress and, in turn, improve the quality of the plan and pursuant outcomes that the center is working on. The \textit{creation of opportunities} section in the cogenerative model comes after solving problem through acting, and is meant to lead to further reflection that will in turn continue to influence the


problem definition and pursuant research process. This is especially valuable for MGH and CCHI given the fact that they conduct community health needs assessments every several years, and such reflection and learning further serves to create better, more collaborative, and effective assessments and strategic plans moving forward.

In a process that is meant to inform MGH as to how they should expend their required community benefits, the participatory action research conducted via the community health needs assessment and strategic plan is an extremely collaborative and equitable method to identify and develop what form those benefits should take. Beyond doing the minimum necessary to demonstrate that the community was involved in some capacity with the assessment and creation of the strategic plan, MGH and CCHI created a truly collaborative process, involving a total of almost 3,000 participants in 2012. Indeed, the report highlights the strength of both community health needs assessments and participatory action research in creating a framework to engage with communities to truly understand what the issues are that they deem critical and develop strategies to address those issues. In this way, the research done in conjunction with the community was able to identify concerns, which might not have been obvious from the outset. For example, as a hospital, MGH could’ve very easily chosen to use a much narrower definition of health and not have acknowledged the major role that social determinants play in influencing health. Thus, PAR in this case (coupled with the hospital’s understanding of community health and its role in addressing it) allowed for problems such as violence and public safety to come to the fore. Again, the importance of different
ways of seeing as evidenced by the varied forms of research and community input to arrive at the critical issues allowed for a more nuanced and comprehensive understanding of the state of health in these neighborhoods.

Because the community health needs assessment and implementation strategy is revisited and the process is conducted every few years, it also lends itself very well to reflexive practices, another critical component of participatory action research. In being able to look back on previous work and analyze the programs that were implemented, MGH along with Charlestown, Chelsea, and Revere can continually assess progress and change (or lack thereof), and adjust accordingly. This makes PAR especially practical and valuable as a method, as it allows for constant research, observation, reflection, and subsequent action, and hopefully ultimately leads to, in this case, healthier communities in the broadest sense.