COVID-19 has changed the way we plan, conduct, and disseminate research (Else, 2020). In this editorial, we use case examples to discuss the challenges that COVID-19 has raised for community-based-participatory qualitative research and pose potential solutions. Although we are hopeful for the end of the pandemic, unanticipated lessons learned during COVID-19 are widely applicable for scholarship in the present as well as for future crises.

Community-based participatory research (CBPR) is a collaborative research approach that involves all partners and stakeholders in the research process. For instance, CBPR focuses on research topics that are raised by, and important to, the community. The goals of CBPR are two-fold: (1) to generate knowledge and (2) achieve social change to improve health outcomes (University of Michigan School of Public Health, n.d.). CBPR goes by different names in different fields and disciplines—such as action research, citizen science, community engaged research, or participatory action research, among others (Wallerstein, 2020). Regardless of its label, this work is united by a focus on collaboration, taking initiative, and ultimately, social justice (Wallerstein, 2020).

Any method—quantitative or qualitative, can be used in a CBPR approach. Yet, given CBPR’s focus on rich and nuanced understandings of community and stakeholder needs, qualitative methods are particularly well-suited for CBPR approaches and, consequently, are most used (e.g., interviews, focus groups, photovoice, etc.) in CBPR projects (Clark & Ventres, 2016). As Clarke and Ventres noted:

Qualitative, community-based participatory research is about diving into communities, recognizing and valuing those with whom we work, and bringing our creative and engaging selves into waters of exploration and understanding... up from such collaborative milieus can arise research leading to thoughtful and efficacious outcomes. (Clark & Ventres, 2016, p. 3)

CBPR has led to significant progress in testing and care options for other (e.g., non-COVID-19) serious illnesses and people affected by them, like HIV/AIDS (Rhodes & Sy, 2020). This is in part because CBPR is flexible and responsive to community needs and rooted in trust, listening, and teamwork to solve complex health problems (Breuer et al., 2021; Nguyen et al., 2020). As Rhodes remarked:

Some of the most innovative and successful HIV prevention and research efforts sprang from the creativity of gay men, who were being directly impacted by the epidemic, and their allies. Formal and informal partnerships of community leaders, community members, activists, advocates, and researchers initiated educational and prevention programs; developed and provided needed care; advocated for both drug development and expedited drug trials; and developed, implemented, and evaluated prevention, care, and treatment strategies within the community. (Rhodes & Sy, 2020, p. 457)

With its success in addressing the HIV/AIDS pandemic in American contexts, CBPR is an obvious research approach for the COVID-19 pandemic and, inevitably, future crises. Communities that are marginalized (e.g., whether by poverty, race/ethnicity, geography, or a host of other circumstances) and who lack the opportunities to influence the policies that affect their...
lives, have been disproportionately harmed by COVID-19. Like people living with HIV, they need helpful and equitable COVID-related policies. However, as much as CBPR has been needed during COVID-19, the harmful nature of the pandemic and respondent preventive measures have seriously challenged CBPR’s reach. Ideal participants in CBPR studies have also suffered the most sickness and death and have not been able to prioritize research participation. Additionally, the trust and relationship building central to CBPR and the collaborative research process are generally compromised by social distancing and limited in-person meeting and discussions. Below, we provide two examples of our teams’ CBPR scholarship that has been hindered by the pandemic and how we are working to overcome obstacles.

Helping Missouri PrEP to Prevent HIV

At the beginning of the COVID-19 pandemic in the US (March 2020), MT (first author) learned she received funding for a project to enhance the use of Pre-exposure prophylaxis (PrEP, the “HIV prevention pill”) in rural and underserved areas in Missouri. The project was initiated by MT, an infectious disease doctor, a local community organization serving people at risk for and living with HIV, and people at risk for HIV in a non-metropolitan area of the state. These partners were concerned about the lack of awareness of prevention tools available to people in rural areas and wanted to do something to change this. The project included surveys and interviews with key stakeholders, providers, and patients about PrEP; and translation of findings into an action plan to increase PrEP across the state, especially in rural areas. The study was originally planned with a phone interview option, so the team shifted to using phone or Zoom (at participants’ requests) considering COVID-19. The University IRB helped MT move the consent process online, using check marks versus signatures to confirm consent. However, the team faced unexpected COVID-related challenges. These are summarized in Table 1. Because MT’s team was unable to meet in person, it was difficult for the study team to connect with each other and with potential participants. Although study staff could adapt to this via remote meeting methods like Zoom, connecting with participants for recruitment was much harder when in-person opportunities were taken away. MT lacked access to go to community agencies or clinics and talk to potential participants and build trust. Recruiting through online flyers lacked personal connection and was not very effective. Interview rapport may have also been compromised by electronic meetings.

While interviewing participants via Zoom, MT identified a community leader and invited him to join the team and help with recruitment. MT also amended the interview to give participants a chance to talk about COVID-19 and the study morphed to add dimensions related to COVID-19 to the original study subject, HIV prevention. Likewise, future action plans are also incorporating lessons learned from COVID-19, like the pros and cons of telemedicine for HIV prevention. Being flexible in the CBPR approach and adapting to the meet the needs of the most pressing issue of the time, is helping this project succeed.

Headliners Whole YOUniversity

LP (second author) led the “Headliners Whole YOUniversity” II project, which was designed to offer booster trainings addressing social determinants of HIV, to improve overall wellness among people living with HIV. Three free classes included modules that were selected in close consultation with Headliners (e.g., the project’s community advisory board) and feedback from the board’s social network members and peers during previous pilot programs. The three classes focused on body positivity, through: (1) exploration of the root of the dissatisfaction including links to self-esteem, social expectations,
past trauma, and other mental health challenges; (2) mental health, to introduce the concept of mindfulness and offer training on how to overcome conditioned responses and create space between anxious moments and reactions using beginner meditation and yoga practice; and, (3) safe sex, including strategies for how to be safe during COVID-19. Whole YOUniversity differed from MT’s PrEP project because it was planned to be in person and included groupwork. LP’s team faced several challenges, outlined in Table 2.

Not being able to meet in person challenged LP’s teams’ ability to offer communal meals—a common draw—and invite and refer network members to attend subsequent trainings. Participants struggled to access virtual platforms and schedule time to attend virtual trainings which often conflicted with their work schedules, for example. Like the PrEP study, recruitment and attendance faltered without face-to-face community connections. Group work over Zoom was possible but not as interactive and it was more difficult to get rich feedback about participants experiences. The group setting also posed challenges for anonymity. Although LP responded with adaptive Zoom guidelines, it is possible that these restrictions (e.g., no faces) compromised the ability of group members to share information and strategize individual and community problem-solving; the logistical limitations imposed by the pandemic undermined the aims of CBPR, unfortunately.

### Conclusions

Qualitative CBPR is important during all times to form important academic-community collaborations, build community skills and knowledge, and address health issues in an informed and effective way. During a crisis or pandemic, community input is especially necessary. Crises generally hurt the communities who also most benefit from CBPR, however, so it is understandably difficult to maintain CBPR during a crisis. In addition, the relationships, trust, and rich discussions necessary to enhance community voices are hindered by electronic communication.

Rhodes and Sy (2020) provide guidelines on how to conduct CBPR safely during a pandemic and remind researchers that:

Community-engaged research activities that potentially may add to the risk of these individuals (both physical and financial) and to the overall burden of COVID-19 within already disproportionately affected communities deserve special attention. However, terminating or eliminating community-based and community-engaged research within these communities may exacerbate the profound COVID-19 and non-COVID-19 disparities they experience. For example, by excluding communities that are at increased risk for severe illness from COVID-19, we will know less about how to reduce COVID-19 disparities experienced. (Rhodes & Sy, 2020, p. 462)

They advise helpful practical tips such as conducting research online, following mandates like masks at events, distributing incentives virtually, and rethinking food to build community at CBPR sessions (Rhodes & Sy, 2020, see Table 2, p. 463). Some of these tips match challenges that MT and LP also faced (e.g., incentives). We add lessons learned to this list, to address tips for doing and maintaining qualitative CBPR during crises:

1. Zoom and other electronic platforms are not a substitute for in-person connection (Goldstein et al., 2020), but they are useable if they are the only safe tool available. Asking community members for ideas about how to improve safety, use, and connection on electronic platforms may make them better tools. Incorporate questions about processes, like Zoom, in qualitative protocols.
2. The numbers of people in CBPR studies may not be as high during crises but that does not mean that the voices incorporated matter any less. Qualitative CBPR studies generally include purposive sampling, and the goal is not to achieve a certain “N” for success anyway. Value the voices you can include and their input.
3. Remain open to expanding core study teams to key stakeholders who emerge as particularly capable of engaging participants during the crisis. These added members may be able to expand recruitment.
4. CBPR requires flexibility and at this point, any study taking place during COVID-19 is about COVID-19. Consider expanding interview protocols to allow participants to talk openly about COVID-19 and/or how it relates to the original study question.
5. Likewise, all study findings and translation to action plans may now incorporate the lessons of COVID-19. Remain aware not to ignore these if they did not fit into the original study goal.
6. CBPR prioritizes community gain and growth. It is possible that during times of isolation, like COVID-19, that the interview process itself is empowering. Includes questions about the CBPR process during qualitative interviewing, to learn about challenges and opportunities.

### Table 2. Issues and Solutions for Whole YOUniversity.

| Issue                        | Response/Solution                                                                 |
|------------------------------|----------------------------------------------------------------------------------|
| Slow recruitment             | • See Table 1.                                                                   |
| High pre-session registration but low attendance | • Implemented livestream training sessions using tools to expand broadcast access to IG, YouTube |
| Could not conduct classes in person | • Used Zoom platform                                                            |
| Post session evaluation      | • Embedded survey in the zoom and used phone for qualitative interview           |
| Incentive distribution       | • Used digital e-cards                                                           |
| Maintain anonymity in group sessions | • Loosened zoom etiquette restrictions (camera off, chat box directed to host, screen profiles pseudonyms) |

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COVID-19 changed the way we conduct research and live and interact in our communities. It posed tremendous challenges to connection and communication, that affect CBPR. Qualitative CBPR approaches are critical to health solutions however and should continue despite challenges. The very heart of these methods—in-depth information, skill sharing, flexibility, and adaptiveness to participant needs—guides the answers for using them during crisis times.

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