

**HIV/AIDS AND COLLABORATIVE SOCIAL RESEARCH:
A DISCUSSION PAPER**

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SUMMARY

Social research has made an important contribution to the Australian response to HIV/AIDS. Some social research methods, loosely called *co-research* (action-research, collaborative research, etc.), have been relatively under-utilised, their worthiness unrecognised or poorly understood. Part of the problem lies in the recent emergence of co-research as a research framework in applied social research, a field dominated by quantitative methodologies such as the pencil-and-paper survey. This discussion paper describes aspects of these newer qualitative methods, identifies some of their key elements, canvasses their applicability to HIV/AIDS, and offers some ideas about the future contribution of co-research to HIV/AIDS.

Co-research relies heavily (and sometimes takes as its research object) the social relations between researchers, practitioners and respondents. The current organisational forms in HIV/AIDS research and funding, program delivery and health promotion are factors that shape the possibilities for using co-research. These factors include, for example, the increasing professionalising of community-based AIDS service organisations, the different knowledge and practice cultures of researchers, practitioners and respondents, assumptions about community, and community-based organisational links with affected communities.

Co-research models hinge on the structure and quality of the relationships between three main groups: researchers, practitioners, and respondents. Such relationships can be configured in several ways in co-research and are generally closer and more equal than in traditional modes of research. The key features of co-research are: (a) recognition of roles for researchers, practitioners and respondents; (b) research questions focused on the concerns of respondents and/or practitioners; (c) active commitment to promoting the participation of all interested in the research; (d) dynamic research processes that employ cycles of reflection and consultation; (e) concern with the link between theory and practice; (f) more direct concern to produce practice-linked outcomes; (g) inclusion of dissemination and implementation strategies in the research design; (h) a tendency to small-scale or localised research.

For HIV/AIDS, co-research can make useful contributions where traditional sampling methods may not be useful, e.g., with non gay-identifying homosexually active men who use beats. It also might be very useful in difficult prevention and care issues requiring analyses of how education might best be delivered above and beyond the demands of the target group itself. Co-research is ideally geared to investigate educators' practice, i.e., their pedagogy, and the development of HIV/AIDS health promotion curriculum processes. It is useful in researching smaller, more localised issues in prevention for which large-scale research techniques, such as surveys, are unsuitable. It is a viable alternative to research that uses experimental control group techniques in the evaluation of educational practice.

Co-research has the capacity to respond quickly to day-to-day problems of practice and, therefore, can quickly influence practice. In this, co-research would appear particularly appropriate for the investigation and development of health promotion as educational practice. This compliments the current social HIV/AIDS research agenda, dominated by the largely behavioural research programs of the national centres and the annual, academically focused, competitive NHMRC (CARG) research funding scheme. Co-research can also offer enhanced outcomes in relation to the transfer of knowledge, compared with scientific reports, articles and conference papers, monographs and other less-accessible, more academic modes of dissemination.

INTRODUCTION

Research in HIV/AIDS has had a long and peculiar history. From the start of the HIV epidemic in Australia in 1982, the contribution of research has been central to the effective public health management of the epidemic. This has been confirmed in evaluations of the national AIDS strategies.¹ Indeed, research has remained a central part of successive strategies and received significant funding.

There has also been a long and continuing discussion as to what ought to constitute HIV/AIDS research. No one disputes the need for biomedical research, although such research has seen significant debate about its research processes, the levels of participation of 'patients' in design and management, and its ethical precepts. It is in the field of what might best be called *social* research that most contention has occurred, some of it at the very level of whether social research is needed at all!

Social research might best be defined for the purposes of this discussion paper as including work on HIV-risk behaviour and behaviour change, the cultural forms through which the epidemic is understood and manipulated, the historical and policy processes through which the epidemic is managed, the wider social and cultural impacts of the epidemic, health promotion as an educational endeavour, and program and national AIDS strategy evaluations—just to name a few areas. It is precisely because of this breadth of claim upon the term social research that much of the debate has ensued. To the social researcher, the debate about what social research, how much, how often, who does it and who funds it has dogged the Australian contribution to the fight against AIDS since it started.²

With hindsight, we now realise just how useful many social research projects have been and how often we regularly rely on their findings to argue policy and programmatic issues, and to assess just where we are up to in the fight with HIV/AIDS. An early example of that valuable social research is undoubtedly the Social Aspects of the Prevention of AIDS (SAPA) project, now ten years old, but in its time a major contributor to our understanding of the responses of the gay communities in Sydney and New South Wales (NSW) to the epidemic.³ SAPA became an important early guide to prevention strategies undertaken by the AIDS Council of NSW (ACON), in particular, and was eventually useful for quite a time to most AIDS service organisations (ASOs) working with gay men.

There are certain aspects of the SAPA project's design and processes that have bearing on the issues discussed later in this paper. But there are two important aspects of the SAPA project's contribution often forgotten: first, its findings contributed also to a growing international understanding of the responses in the late 1980s of gay communities in the developed world and this in turn helped us understand the Australian response better;⁴ second, the original project team spawned a series of subsequent and related projects, which now accumulate to provide an excellent picture over nearly a decade of the Australian gay communities experience of, and responses to, the epidemic. In a sense, we would not be anywhere as well-informed about those communities in this country without such projects.

Of course, there have been other very effective and important social research projects undertaken on gay men and on other populations at risk of HIV infection. This research has been summarised at various times and this discussion paper does not seek to assess or review that research contribution here. We note, however, this early experience of research success in order to learn more about a particular aspect of social research that HIV/AIDS has explored and yet, to an extent, failed to mobilise to good effect—and that is *collaborative research*.

What is Collaborative Research?

The kind of collaborative research we are talking about in this paper is a specific type. We are not referring to research undertaken through collaboration between professional or academic researchers from different academic disciplines; rather, it is research undertaken by researchers in collaboration with the very populations being investigated. In the case of HIV/AIDS, this would be research being undertaken with people living with HIV and/or AIDS (PLWHA), with populations at higher risk of HIV infection because of their risk-related practices (e.g., gay men, sex workers, drug injectors), or populations with higher levels of HIV seroprevalence or other health problems that enhance the risk related to those practices (e.g., among inner-city gay communities, or indigenous Australians).

In writing this discussion paper on collaborative research, we are not presenting a research needs-assessment document or a new research agenda. Rather, we are concentrating on issues relevant to social research that might be undertaken collaboratively with HIV-affected populations, how it might be pursued, what purposes it might serve, what shape it might take, what prevents such collaboration, and so on. And to save confusion about the word collaboration, we are going to use the term *co-research* in this document to describe that kind of research.

Rather than produce a text book account of co-research forms (there are many of these), we have outlined in Appendix 1 some of the different types of co-research identified in the growing literature on collaborative research techniques. Appendix 2 contains a brief discussion of the pros and cons of these methods and summarises pertinent issues, some of which we take up in the main text itself in relation to HIV/AIDS. Finally, an annotated bibliography in Appendix 3 lists a large number of books and articles that discuss in detail the various ideas behind co-research, and offers readers a possibility of pursuing these in depth, should they wish to.

SOCIAL ASPECTS OF HIV/AIDS RELEVANT TO CO-RESEARCH

It is our intention here to explore certain specific issues with reference to HIV/AIDS and possibilities for co-research. We are aiming to do this by examining:

- researcher-practitioner-community relations;
- the differences between experience, practice and research, in particular the knowledges they generate;
- practitioner-researcher relationships;

- some methodological issues such as participation, research question formation, research dissemination, and the transfer and application of knowledge.

Researcher-Practitioner-Community Relations

The Australian response to HIV/AIDS has been noted for its involvement of groupings beyond health professions (medical practitioners, nursing and health promotion staff, bio-medical and behavioural researchers, and public health bureaucrats). The newly involved groupings, e.g., gay communities, haemophilia associations, sex worker collectives and drug injector networks, are not mere 'consumers'. From the establishment of the AIDS Councils out of the earlier gay community AIDS Action Councils, the involvement of non-governmental organisations (NGOs) has dramatically shaped the Australian national AIDS strategy. Haemophilia organisations were also immediately involved, and soon organisations representing the interests of drug injectors, sex workers and those with medically acquired HIV infection filled out the picture. This constellation of NGOs is often referred to as the 'community sector' and its involvement has, more recently, become referred to as a 'partnership'. These are interesting terms and it is worth 'unpacking' them for a moment.

What do we mean by 'communities'?

The different collectivities that have formed the community sector in HIV/AIDS are neither alike nor similarly structured. They share only the commonality of their experience of HIV infection, AIDS and, at times, the politics surrounding it. Indeed, some of these collectivities are not communities at all. Let us explore three examples.

Sex workers have been among the most successful groupings to tackle HIV/AIDS head-on and were one of the earliest to recognise its health consequences. The epidemic in Australia is remarkably different from what it might have been, particularly among heterosexually active people, had sex workers not been so quick off the mark in pursuing safe sex. Sex worker activism in HIV/AIDS has paralleled their advocacy in law reform in regard to prostitution, health, and in the regulation of industrial conditions in their industry. There are undoubtedly deep friendships among sex workers and networks of sex workers activists. Sex work is an industry, but is it a community?

Similarly, those with haemophilia and their families constitute a grouping who find themselves in similar circumstances but for which they might never have met. Collective action on a specific issue does recognise and generate a commonality of interest among those with haemophilia in their struggle with HIV/AIDS and in relation to this country's health systems. Is this a community?

There is no doubt in our minds that there is no such thing as a 'heterosexual community'. There is certainly a heterosexually active population, but there is little sexual communality between, say, a group of young people taking Ekky at a rave party and the retirees of the NSW Central Coast. This term heterosexual community is a euphemism for 'everyone else' or, more frequently, the 'general population'. Indeed, in a very convincing paper recently published, Waldby et al. argue that the general population in HIV/AIDS discourse is limited often to white, heterosexually active men!⁵

Our main point is to question the use of the term community, so that assumptions about community do not confuse our discussion of co-research. Community nowadays seems to have become a catch word for everything that is *not* government. Community is used as a substitute for citizenry, for all of those outside government and its armed forces. In this sense, the term loses all usefulness, in that its singularity obscures deep divisions, differences and divergent interests among Australians. Indigenous Australians, for example, quite rightly see significant differences between themselves and other Australians, and certainly gay men and lesbians experience sufficient exclusion from mainstream Australian life to argue strongly for a separate community of their own.

For the purposes of this paper, we would like to make a distinction between communities of circumstance or interest, on the one hand, and deeply structured communities, on the other. To give examples here: a community of circumstance might be constituted by people who find themselves in a situation as a result of something beyond their control, such as haemophilia. This commonality of circumstance certainly produces a real need for collective action and that action produces in turn alliances, networks and support structures. People with medically acquired HIV infection might also be characterised as a community of circumstance.

Communities of interest might include the agentive activities of drug injectors and their service and advocacy organisations as they do battle with HIV/AIDS, its politics and the exigencies surrounding the collective adoption of safe needle/syringe use and disposal. Similarly, sex workers constitute a community of interest as they work to regulate and regularise their industry, etc. Communities of interest or circumstance might also be thrown up at certain times, e.g., combating airport noise in Sydney, or struggling against a freeway in South-eastern Queensland.

It is with reference to the gay community in particular that HIV/AIDS has had a particular significance, and for this reason the invocation of the term community in HIV/AIDS-speak brings with it a sense of deeply structured community. The easiest examples of these deeply structured communities to see in Australia concern indigenous Australians, for whom race (and racism) constitutes an almost insurmountable distance from other Australians. Some non English-speaking ethnic Australians experience similar differentiation from the 'SkiPs', often in the form of discrimination; others may not. A deep cultural divide is in play here. Similarly, gay men and lesbians, at one level invisible in Australian society, are at another level strongly distinguished from Australian heteronormativity and have experienced the Western discursive distinction between homosexuality and heterosexuality as a deeply oppressive and painful separation from other Australians.

It is this kind of difference, this structuring of collectivity through profound, historically formed, seemingly immutable distinctions that we call *deeply structured communities*. The point of differentiating between deeply structured communities and communities of interest or circumstance is not to claim a greater legitimacy for the former or to deny the feelings of communality, the depth of solidarity or the real human relationships involved in the latter. Nor is it our intent to remove the word community from any of these collectivities. We are

trying to delineate the very different kinds of communities available in the worlds of HIV/AIDS prevention and care/support, for it is in these differences that we shall find the possibilities for, and different resources to utilise in, co-research.

(And as an aside: we would also register the need to take on board the notion of gay communities and not foolishly ignore the quite significant differences between the identifiable communities in each city and town,⁶ but also their differences as sexual cultures that have produced quite different epidemics and, consequently, different prevention problems and solutions.⁷)

Who is community?

Since the epidemic began, affected communities have seen a significant change in activity undertaken on their behalf in HIV/AIDS work. Most notably this is evident in the gay community-based ASOs, but is not restricted to them. This change has been called *professionalisation* by Cindy Patton,⁸ and is much argued about in the gay press, sometimes naively. The issue of professionalisation is, however, an important gateway to two sets of issues that are significant in pursuit of co-research: first, who is this community that might participate in co-research; second, what knowledge counts as community knowledge in co-research?

The evolution of the ASOs in Australia has been a process of professionalisation, particularly since the rapid growth of the late 1980s has ceased with relatively fixed HIV/AIDS funding in the 1990s. Government HIV/AIDS organisations involved with funding the community sector have sought to improve the quality and efficiency of output from the ASOs. Professionalising is a standard technique for improving community-sector performance by government. It is also a mechanism whereby community sector organisations claim larger funds to pay for such staff. It is in the mutual interest of both government and the community sector to obtain the best performance from a funded worker.

There is no doubt that the quality of output of the ASOs, and particularly the gay community-based ASOs, has improved in the last ten years. Part of that is due simply to the size of the epidemic and the size of the ASOs—there is, simply, more output. But that is not the real test of quality. The sophistication of the ASOs has been indicated—in evaluations, in social and behavioural research (such as on the gay communities' responses to their epidemics), and in epidemiological evidence. Professionalisation of the ASOs has meant improved efficiency and quality of output. But professionalism also brings with it other attributes, such as the elevation and sanctioning of particular skills and knowledges.

It would be quite true to say today that being a gay man or injecting drugs or selling sex is no longer a qualification sufficient to obtain a job in an ASO. It may never have been a qualification (memories get vague this far on), but there is a definite perception that such a link to the community in question was once seen as important to the capacity to work with that community. There was certainly also a time when many ASOs were more reliant, proportionately, on volunteer labour than they are today. This means that distinctions between volunteers and staff become important and the differentiation between tasks and responsibilities of volunteers and staff have become clearer and enforced. Such

differentiation takes shape in activities like project advisory committees, where volunteer members are often clearly informed that particular issues are the prerogatives of management (meaning paid staff) and, therefore, are not on that committee's agenda. Irrespective of volunteer expertise, staff exercising this differentiation are deliberately limiting volunteer or community input to 'advice'.

This example registers an important effect of the professionalisation of ASOs, and that is the structural distance created between the ASOs and their communities. In a sense, the communities have become constituencies. By default, the staff have become less community members working in their community's ASO and more health specialists discharging their professional duties on behalf of the ASO among the community of which they might also be members by dint of some related factor(s), i.e., they were also gay, or were sex workers, or injected drugs, and so on. One consequence of this shift is the question: who now constitutes the community in play? Other questions arise: what kinds of community members have become its spokespersons? Who is now best positioned to speak? Whose perspective is offered on its behalf? And whose perspective prevails?

Most ASOs are no longer simply embedded within affected communities via their membership base (always small), or because government policy declares them to be part of the HIV/AIDS community sector, or because they work for or with particular communities. It is also no longer sufficient to argue that the majority of staff being members of that community or that volunteer participation offers sufficient proof of community control or input. ASOs now *articulate* the relationship between their particular communities and government. By articulate we intend both its meanings: (1) speaking clearly for, and arguing the case on behalf of, a community; (2) providing the point of connection between the community and government. In day-to-day activity this means the ASOs now *mediate* relations between government and community, and achieve this largely through the professional voices, skills and techniques they employ.

Professional knowledge

The second consequence of professionalisation concerns the bodies of knowledge and skill that come with the professions. Part of claiming to be a professional is the claim to specialised knowledge and skill that comes with training, study, educational qualifications and recognised credentials. The work done in obtaining these knowledges and skills is hard and often long, and the reward is less often financial (ASO staff are notoriously underpaid) and more the sense of mastery and expertise one is able to deploy to an issue or concern. That is another reason why the ASOs professionalised.

These professional bodies of knowledge and skill come from disciplines within academe that guarantee credentials, such as social work, psychology, medicine, nursing and so on. These disciplinary specialties bring quite different perspectives with them. We see these differences in HIV medicine more easily where, as Cindy Patton noted, the incommensurability of virology and immunology has long complicated biomedical research. But it is also distinctly possible for a social worker and a nurse educator to see and understand the same problem quite differently.

We might refer to these different disciplinary perspectives as *paradigms*, or ways of seeing, understanding and explaining. It is quite clear that psychology has a different paradigm (it has quite a few of its own actually) from sociology or from demography. These paradigms are deeply embedded in the professions, trained as they are (and specialising as they do) in these different disciplines. The net effect for each professional working in HIV/AIDS is that he/she brings a particular vision, a certain way of understanding and analysing a problem, and a history of responses from a particular disciplinary field to problem-solving. Included in this notion of paradigms also are the more activist-academic standpoints of feminism and of gay and lesbian (or even queer) theory.

Again, this effect of professionalisation has greatly increased the bodies of knowledge engaged in HIV/AIDS work and ensures that fewer ill-considered or uninformed decisions are taken. The prevalence of professional paradigms among ASO staff also means that there must be dispute as to whether their views, perceptions and vision can any longer be held simply to convey those of the community as much as they now represent their paradigmatic proclivities. In other words, when an AIDS educator states that the community mood is such or is something else, we need to ask the questions: how is this understanding derived; in which professional arena and through which paradigmatic filter are these statements being offered?

For the individual ASO educator or support provider this argument must irritate. Indeed, for gay men working in AIDS research, prevention education and in HIV/AIDS policy development, the separation between gay-ness and work is at times difficult to distinguish—professional and personal lives (if that is what being gay is) are often intertwined. This is precisely our point. Ordinary everyday community ideas, views and information are often being unwittingly screened and filtered through professional paradigms (and maybe tailored to suit them). Such intertwining often makes it hard to distinguish when paradigmatically informed judgements are being offered as 'organic' information and points-of-view from the community. Nowhere is this more obvious than in the highly suspect practice of offering as professional information 'anecdotal evidence' (itself an oxymoron) from one's experience of community life. Moreover, there are dangers that, when ASO staff are both trained professionals and community members, their views gain a double authenticity and thereby replace community in the minds of government.

Finally, we need to remember that professional paradigms are not all equally available to HIV/AIDS. The qualifications most likely to gain favour would be nursing, health promotion, social work and psychology, we suspect, and to a lesser extent education, politics, human geography, health economics and sociology. The net consequence of this weighting is that particular paradigms gain more credence and more readily prevail. Nowhere is this clearer than in HIV/AIDS social research where psychology and behavioural sciences have dominated the field, both in Australia and internationally.

Working for or with a community

In assessing, then, what we receive from the community sector and its ASOs when it comes to information, guidance, advice, demands, and interpretations of evidence, we must conclude that no longer do ASOs and their staffs simply reflect the communities they are asked or claim to represent. In mediating relations between communities and government, the professionalised ASOs can no longer be seen unproblematically as community-led organisations. By extension, the term *community-based* must be questioned and re-formulated to register that articulation and mediation of relations mentioned previously. This recognition has important implications for the next national AIDS strategy, for prevention and care/support program design and delivery, and for future mechanisms of community representation and participation built into the framework of Australia's 'partnership' arrangements.

A first issue that merges from this argument is that, in order to start thinking about working together in co-research, we need a clearer understanding of the constitution of communities. We need to recognise and assess the effects of professionalisation in ASOs and of the paradigms through which ASOs staff interpret their work. We also need to recognise the articulation of ASOs and their communities in order to develop new mechanisms of community participation. Without this last occurring in the ASOs themselves, any prospect of co-research will in fact be limited to collaboration between researchers and professionals—no matter how good we might think our community credentials are.

Research, Practice and Experience

Despite the blurring that really exists for many working in HIV/AIDS between our job, our professions and our particular strengths in fighting the epidemic, it will help for the sake of the pursuit of co-research if we draw a few distinctions between the potential co-researchers. These distinctions do blur and many people in HIV/AIDS are skilled in more than one field; but for the sake of clarifying the argument here, we are using three distinct categories of potential co-researchers. We are going to employ the terms *researchers*, *practitioners*, and *respondents*.

By *researchers*, we mean those people working in HIV/AIDS research who do so professionally as academics working in universities, as consultants working for private agencies or organisations, and those who undertake research as their main task working in government. Our definition here aims to delineate people who do research as their major daily task rather than, for example, prepare and develop policy or implement programs.

By *practitioners*, we mean those people who work for organisations or agencies developing policy, designing programs or implementing them. Included here are educators, counsellors, administrative staff, planners and management staff, carers and support workers, and service delivery staff, e.g., those providing a transport or housing program. Increasingly, it is recognised that these people are required to have the professional qualifications mentioned above. But beyond that professional training, there is also a recognition that there is need for on-the-job, HIV/AIDS-specific staff development. As an example of this recognition, consider the situational analysis recently commissioned by the Commonwealth Department

of Human Services and Health regarding the training needs of AIDS Councils educators—the National Training Agenda for HIV/AIDS Educators. The consultation is seeking to develop national standards for skill and requisite training. Such 'benchmarking' represents an important initiative representing government involvement in—and reliance on—the identification and development of practitioners' skills in the community sector.

By *respondents*, we mean those members of the HIV/AIDS-affected communities, on whose behalf the practitioners work and for whom the programs and services are designed and provided. If there is doubt about the value of this distinction, remember how 'client' has become the principal term for referring to these people in almost all community agencies in their planning and in service delivery documents and processes. We chose respondent rather than client, because the relationship we wish to describe is a research relationship and, for all intents and purposes, in almost all the research in HIV/AIDS we are familiar with, community members respond rather than participate. (This is in itself an interesting shortcoming in much HIV/AIDS research to date.)

The main purpose in making these distinctions is to register the need to think about co-research as involving three groupings of people. These three groupings bring different knowledges, experiences, skills and purposes to research. They often desire different things from such research. If co-research is to be pursued, these differences and their points of convergence in any potential research project need to be recognised and incorporated. It is important to try and delineate the differences between these groupings, and we start with knowledge and practice.

Knowledge and practice

Do these three groups have distinct knowledges and do they have a vested interest in the production of that knowledge? This is simply answered. Researchers specialise in the production of knowledge. That is what research is. Researchers accumulate knowledge through research processes, particularly through the sheer intensity of information collection that is research. In addition, every researcher will bring a distinct disciplinary framework, or paradigm, and a particular pattern of accumulated knowledge from previous research experience to each new project.

Practitioners also have and create knowledge, but it is 'grown' differently. Often, as noted above, their training and professional tasks shape and concentrate practitioners' knowledge in certain ways—they do use those paradigms. But it is the use of these paradigms on the problems of day-to-day practice that produces much of the 'operationalised' knowledge that practitioners employ. How practitioners in HIV/AIDS work in Australia learn what they know from their daily practice has recently been documented by McConachy and Booker.⁹ The experience of program design and execution, the skills employed and accumulated in administration, or creating and maintaining the techniques and efficiencies of service delivery and care/support activities, for example, are a kind of experience different from the experience of doing research. The knowledge of a problem, an issue or a community concern generated by practitioners in their daily work is a valid, distinct, and invaluable kind of knowledge. But it is always important to remember that this daily accumulation of experience

and knowledge is constantly filtered, often unwittingly, through the particular professional paradigms in play.

Respondents (we recognise that in HIV/AIDS the distinctions begin to blur a little here) bring different ideas and understandings of those experiences to the problem or issue at stake. Irrespective of any other knowledge from a professional training or work experience, a person with HIV or AIDS, as we well know, brings a distinct and valid experience to working on this epidemic. Similarly, a sex worker brings to any consideration of HIV/AIDS a breadth and intensity of experience and understanding of the dynamics of worker/client interaction. Gay men also bring to HIV/AIDS distinct understandings of the choreography of male erotics and of the culture of community built on that erotics. If this were not the case, respondents would not exist in research; after all, they are the ones who provide the information in the first place for practitioners and researchers to deal with. It is important, however, also to note the occasional overlap between researcher, practitioner and respondent knowledges in HIV/AIDS that has occurred at times in specific activists, educators, health professionals and researchers. This overlap has produced some of the richest and rigorous contributions to the fight with HIV/AIDS in this country. But the majority of us do not have all these skills and knowledges together most of the time.

This discussion does not suggest that respondents' knowledge, by definition, guarantees accuracy or authenticity. Similarly, there is no automatic guarantee of accuracy or authenticity in the experiences that give rise to the particular character of respondents' knowledge of any situation, including HIV/AIDS. Indeed, there is considerable debate among social researchers about the authenticity of experience and how it is regarded as evidence in research.¹⁰ For example, being a person with HIV or AIDS or being a gay man is not, by itself, sufficient 'proof' of truth or a more legitimate claim to knowledge. It is precisely for this reason that research methodologies have been developed, tested and validated: *they take, accumulate and verify experience as evidence.*

We also want to argue in addition to specific knowledges discussed above, each of the three has also a distinct *practice* that produces a certain kind of knowledge and shapes the understandings each group has and employs in its day-to-day activities. We would argue that this relationship between practice and knowledge is a crucial one for co-research.

Social researchers apply quite distinct knowledges and tried-and-true research practices in their work. Quite apart from the paradigmatic differences between the academic disciplines already noted, researchers bring to any research task experience in designing research programs, techniques for undertaking research (methodologies), and technologies of description, classification, analysis and theorisation used to understand, interpret and represent research findings. The 'object' of the researchers' gaze is, usually, the knowledges and experiences of others. To the task of understanding that object, researchers also bring institutional and professional techniques for guaranteeing the scientific validity and reliability of their findings and interpretations. These guarantees are important and are part of the stock-in-trade of a good researcher; their aim is to ensure quality and honesty. Often, the institutional processes and pressures that implement these guarantees are not well understood by non-researchers (some researchers are also less scrupulous than they ought to be in these

guarantees), but any agency seeking a researcher's assistance should ensure that the researcher can demonstrate an active engagement with these guarantees.

To the researcher, the daily action of these guarantees in practice means such things as: peer scrutiny of research designs in applications and grant proposals; institutional ethics approval for research projects; accountability through annual report-writing to funding authorities; working under the oversight of steering committees; considering input from advisory committees; release of findings at professional conferences and in peer-reviewed publishing; final approval of released reports by funding authorities.

There are other mechanisms in play, but the point is that researchers are bound by these institutional and professional procedures and pressures, and any agency seeking the assistance of researchers needs to plan for these processes and pressures. While to some these may appear arcane and time-consuming, it is ultimately in the interest of all participating in research that findings and results are honest, reliable, valid and relevant. Otherwise, such findings can simply be discounted by opponents or brushed aside by those seeking to prevent an important issue being investigated or revealed.

Practitioners have their own distinct practices, and these are not simply actions done in the course of daily work; they are also encoded and systematised through repetition, through ritual, through institutional exigencies and policies. These practices also create the work done by practitioners, that is, they inform decisions about what to do next, how to handle issues, processes and people. In this, they organise and can sometimes limit the capacity of practitioners to participate in conventional research, for there maybe no time for the kind of activities that research relies upon (e.g., detailed information collection). Yet, another importance of practitioner practice is that it is often a legitimate object of research itself. This is the case with evaluations and process research in particular.

Beyond these issues, practitioner practices represent a response to the repeated exposure to the often diverse experiences of respondents. In this regard, practitioners develop an acute understanding of respondents, an understanding that can bring richness and depth to research. This is often neglected in research designs that connect the researcher to the respondent and omit the vital link provided by the practitioner. Finally, if for no other reason, practitioner practice is vital to register because the practitioners are ultimately responsible for implementing any policy and programmatic recommendations that might arise from research.

Respondents clearly have practices also, and in HIV/AIDS prevention these are usually understood to be the behavioural responses people make or have made to the risk of HIV infection. There is a broader definition of respondents' practices though, and it relates to notions of social and cultural contexts in which behavioural responses to health promotion and service delivery are engendered. There are also the responses of respondents as communities and groupings dealing with the impact of the HIV epidemic on the fabric of their culture—on this issue, the gay communities are perhaps the most articulate in Australia with regard to art, literature, performance, street culture and their collective sexual/emotional life. This is rarely the object of research and we shall return to this issue later in relation to a discussion of prevention research. But we want to signal here that we have used a limited

notion of respondent practices so far in HIV/AIDS research, and it is important to broaden that for any consideration of co-research.

Yet we also see difficulty here. It is far easier to envisage practitioner knowledges and practices informing co-research design and processes, and simultaneously remaining the object of research, than it is to transform respondent knowledges and practices from research object into material informing co-research design and process. Are we simply giving up on doing co-research with respondents as full participants? Not really, but let us take, for example, the issue of young men who are sexually active with other men of their own age or older, who do not identify as gay, who will not be found in gay venues, and who do not see gay community as a haven. These young men form a prevention problem that HIV/AIDS researchers, practitioners and policy makers know well. Among this population (they do not form a recognisable *group*), there seems to be no logical commonality of interest—this is not a community and, moreover, this population has no sense of itself as a community. How, then, can it act on its own behalf collectively? The question at issue is this: can homosexually active men (as distinct from gay men) act on their own behalf as a community at all in order to participate in some way as co-researchers?

A different example might offer another angle on this issue. There is a dearth of research of sex workers' clients. These men (and women) definitely do not form a community at all. Sex workers are undoubtedly the best source of information about their clients. Therefore, the involvement of sex workers in the design and fieldwork of a research project on their clients is an obvious move, but even if clients are included as some kind of respondent, it is unlikely that clients will ever be full participants in such research.

Although we doubt that the clients of sex workers will ever be convinced that they might benefit from seeing themselves as a community of interest or circumstance, the same cannot be said of other 'at-risk' groups in HIV. There is considerable evidence that the connection of homosexually active young men to a gay community might offer support for both sexual behaviour change and a shift from social isolation and possible self-oppression. But this 'community development' impetus, which often lies behind democratic arguments about participation, should not be confused with the construction of co-research relationships. It is all very well to talk about getting together young men already in the gay community and empowering them in/through co-research activity, rather than merely researching them. But when you consider the more difficult questions of homosexually active men and youth who have as much sense of communality as a bus queue, this notion of participation in co-research is relying on a collectivity that cannot be sustained. Any type of research founded on such slippery ground will fail.

This example exposes a difficulty in what amounts to a kind of simplistic democratic drive behind co-research at times. To some, the ideal of co-research is driven by a politically correct notion of participation and empowerment. For an experienced researcher, such ideals need grounding first in the issue to be researched itself. Certain kinds of research cannot always include respondents equally, e.g., research on HIV-related dementia may be difficult for people with dementia to undertake as equal partners. The research question that grows from such an issue into a do-able research project, whether co-researched or otherwise, will

produce the actual possibilities and limitations for participation by respondents. Participation then becomes a methodological problem, not just a philosophical or political one.

This is the reason why we started this paper with an attempt to 'unpack' community a little. Before principles of the participation of respondents can be formulated in abstract, the very different natures of communities must be considered. It is much easier to conceive of co-research with gay communities: they are not only an easily targeted population, but their own deeply structured community will allow a recognition of what is collectively at stake in HIV/AIDS research. We doubt that drug injectors and sex workers can deploy that sense of community as easily, or at all, to produce the kind of participation by respondents envisaged by those mounting democratic or community development-driven arguments for co-research. With these populations, it is possible only the practitioners can provide the solid basis for co-research relationships.

Co-research on fully democratic principles cannot be applied in all situations; to attempt to do so ignores the social realities of people's lives. Therefore, co-research must take into account the complex patterning of social relations between individuals and between groups in our society. Practitioners necessarily have to represent respondents at times in the development and implementation of research. The articulation and mediation provided by the ASOs and the paradigms of practitioners become more pressing concerns as a result of this representation.

This mediation is a serious issue for people with HIV infection, who may not form a deeply structured community at all, except where the overlay of gay community is involved. Early research undertaken at Macquarie University with and among PLWHAs noted processes of inclusion and exclusion in relation to HIV identity and culture, which then has effects on some health management practices.¹¹ Since co-research can also be extremely useful in action-research techniques focused on health enhancement strategies, on care and support service delivery, and on other programs for PLWHAs, utilising a more sophisticated understanding of the structuring of communities of interest or circumstance, such as PLWHAs, will be important. This underscores the problem of determining whose needs are represented as being the needs of PLWHAs. Beyond PLWHAs, it forces all research to consider the representation of those who are disempowered, particularly in relation to the production and use of research. Co-research offers an important methodological innovation for the more effective investigation of living with HIV and AIDS. Co-research is particularly effective in getting close to day-to-day issues and concerns, and can quite quickly yield insights that might assist practice. But we must be careful of simplistic understandings of the possible research relationships that can be employed.

Practitioner-Researcher Relationships

Part of our argument, then, on the distinction between these three groupings and on the articulation of the ASOs to their communities is to establish the fact that in HIV/AIDS co-research we shall have to recognise, at the outset, that the key relationships will probably be negotiated between the researchers and the practitioners. We would argue that in most cases the respondents will not often be able to be equal partners unless their relation to ASOs and

their practitioners changes dramatically. This is increasingly unlikely, as the ASOs become even more professionalised and as the epidemic wears on.

In order to develop co-research capacity that accepts this dilemma of differentiation in participation, a major first step is the establishment of sustained researcher-practitioner communication and liaison. This means networking researchers and practitioners together through various strategies (researchers on program steering committees, community liaison meetings, community representatives on research advisory committees, and so on). But beyond these standard techniques, which are often difficult to sustain long-term, ongoing researcher-practitioner relationships are best established by a strategic link being developed between a set of researchers and a set of practitioners.

One example of a sustained link in Australian HIV/AIDS social research has been the ten-year collaboration between ACON and Macquarie University. This link began with the SAPA project and was deliberately built into that research project's processes. Subsequent research projects, e.g., the Class Homosexuality and AIDS Prevention (CHAP) project, the Triple S (Sustaining Safe Sex) survey, and the Sydney Gay Community HIV/AIDS Social Impact Study, built on that relationship. A current example is the SMASH (Sydney Men and Sexual Health) project, in which ACON, the National Centre in HIV Social Research and the National Centre in HIV Epidemiology and Clinical Research are partners. Other States have not had the benefit of similar, *sustained* researcher-practitioner relationships, although there are certainly other researchers with ongoing connections to ASOs in some States, and the injecting drug use area has seen a number of nationally coordinated projects with ASO participation.

In order to increase the possibility for good quality co-research, it is important that these relationships be established, for it is the sustained nature of the link that grounds co-research in useful and productive enterprises. South Australia, through its 1995 and 1996 'Out There' conferences organised by their Health Commission's HIV/AIDS Programs Unit, has begun developing these links. There is a crucial task to be undertaken by each State HIV/AIDS unit/bureau and the Australian Federation of AIDS Organisations to foster such systematic and sustained links across the country. We are firmly convinced that unless these links are actively encouraged quite deliberately by those committed to develop co-research capacity, they will not occur through the traditional kinds of HIV/AIDS research funding mechanisms in place in Australia at present.

This section has outlined a number of social aspects of co-research that need to be taken into account as organisations attempt to pursue and develop co-research as a techniques for their use. We are arguing for a more complex understanding of the way people are brought together into potential co-research relationships. We are calling for a recognition of a more sophisticated understanding of what is brought to co-research by way of professional knowledge and practice. We are arguing against naive calls for co-research, based on specious arguments about 'democracy' or 'participation'; instead, we are arguing that patterns of social differentiation are in play in the relationships, which co-research needs to work with and upon, and these will structure potential co-research activity in important ways. Finally,

we are arguing that establishing these relationships, especially between researchers and practitioners, can no longer be left to chance or good fortune, but need to be actively pursued.

THE CONTRIBUTION OF CO-RESEARCH TO HIV/AIDS

With these systematic links between researchers and practitioners in place, developing co-research requires that we plan for the mixing of those different knowledges and practices discussed above. We do not mean simply recognising that there will be a range of skills and perspectives involved in any research project; rather, we mean deliberately planning to incorporate these distinctions and differences into the research design. It means recognising the potential broadening and deepening research can undergo when active incorporation occurs. Let us take an example from our own work.

Our experience in working with a ACON beats worker for six months on developing enhanced beats education techniques, particularly addressing bisexually active men, was a unique opportunity to see this mixing in action.¹² The net effect of this collaborative effort was that the knowledge and observation techniques of the researchers were added to those of the beats worker's practice and experience of beats education. The project became an action-research project in a sense, with the regular de-briefing meetings between the researchers and the educator about the *problems of practice* occurring in the developmental work being undertaken at the beats.

We noted earlier that the knowledges and practices of practitioners themselves often become the object of research. This was precisely the case with this short beats project. The debriefings allowed for a *systematic reflection on the practice* of beats educators—something less likely to happen in the hurly-burly of day-to-day beats education programs. This is one of the key areas for the development of effective co-research and a ripe field for the development of educator/researcher model of practice, something McFee refers to as the *reflective practitioner*.¹³ There are many ways to research how educators educate.¹⁴ A co-research approach, however, would seek not just to understand how ASO educators (or carers) do their work, but also to do so *with* the educators (or the carers), in order to produce that systematic reflection of their practice, or a *metapractice* as Yeatman terms it.¹⁵

In this metapractice, the problems of daily practice (educating, caring, program design or management, administration, etc.) and the practices and knowledges involved become the object not just of evaluation (the usual reflective mechanism) but of co-research as a technique central to the re-production of that practice. Its chief benefit is that of immediate usefulness in the improvement of practice and the systematic growth in knowledge and skill among practitioners involved, over and above any more general contribution to knowledge production through research. This enables both a staff and program development dynamic to be built into programs, but ensures that the rigour of research is also part of that dynamic.

Research Purposes

Often in discussions with practitioners, researchers get requests for research to be done on a long list of issues or concerns. Among ASO staff it is often reported that these research

agendas are ignored, or so it seems. The issue here is one of research purposes. For example, it is considered important in many developed countries that we regularly monitor the behavioural responses of populations with high HIV-seroprevalence in order to evaluate the effect of our prevention efforts so far and to assess current issues in prevention. Australia has been quite successful in this kind of research, particularly among gay and homosexually active men. Studies such as the Sydney AIDS Prospective Study, SAPA, SMASH, Project Male-Call, the Melbourne Prospective Study and others have taught us a lot about the way in which gay men and other homosexually active men are (or are not) practising safe sex and in which contexts they are most likely to do so. Such findings provide the underpinnings for confidence in much prevention policy and priorities.

But we should never confuse such monitoring studies with prevention research, irrespective of any deeper analytic enabled by the design of such studies at times. Neither the SAPA project nor Project Male-Call, for example, researched prevention *per se*, only some of its outcomes. Prevention is the activity that precedes and follows from such research findings, and the problems of *doing* prevention itself have rarely been researched in this country or elsewhere. Where it has occurred, such research, rather than being co-research on the *practices of prevention* undertaken with prevention educators themselves, has tended to rely on an increasingly discredited experimental model involving de-contextualised prevention activity and control groups.¹⁶

In essence, prevention and, indeed, all health promotion are forms of education—i.e., relations of teaching and learning—and, as such, involve a *curriculum* (the body of information in play) and *pedagogy* (the teaching activities that package information and provide the experiences through which learning occurs). There has been little research on prevention as an educational practice. How is it done? How do prevention educators think about their pedagogy? Do they? How do they develop curriculum? How do they assess what learners (e.g., peer education group members or media campaign audiences) have learned? How do educators think their way through the making of improvements in their programs? What works best for whom? How do educators change direction when things are not working well?

Research on prevention of this kind is an urgent issue in HIV/AIDS and one likely to lend itself well to co-research. In co-research on such issues, practitioners' knowledges and practices themselves are at the very heart of what is to be researched. These knowledges and practices become the research 'object', rather than the respondents from the community in question (and on whom we concentrate in the monitoring studies). By focusing on preventive educational practice as the research issue, we are also focusing on the *structure and character of relations between practitioners and respondents* as the centrepiece of prevention education, rather than the behavioural responses of those respondents to that education. These relations are obviously important in peer education strategies, but all education strategies—even social marketing and health maintenance—are constituted in relations between educators and learners. Focusing on these relations in all education should be the pre-eminent research object in co-research in HIV/AIDS today.

The key reason for this focus is that large-scale behaviour change is not the major HIV/AIDS problem in Australia any more—most gay men, for example, have changed their sexual behaviour and done so ages ago. Obviously, initial and sustained behaviour change still needs to be actively sought, encouraged and reinforced among all at risk of HIV infection, but this is also less an issue today in Australia than it was five years ago. The key issue, today, is developing the processes of prevention education that will initiate and sustain behaviour change and address its ever-evolving twists and turns, its ever-changing *sexual contexts*¹⁷ in a *post-AIDS* environment.¹⁸ This kind of approach will demand a different prevention pedagogy than used to date and a re-focusing of the tried-and-true strategies that are generally favoured. But the shift in the frame of reference here is from a respondent seen as 'object' of an educative process to be assessed on an impact or outcome measure, to *respondents seen as engaging in continuous educational experiences developed within the dynamic relationship between ASOs and their communities.*

To explain by a related example: one can assess a learner's progress by examining him/her in a test. This is what we do in high school matriculation examinations; by doing so, we find out how much high-school students have learned. (HIV/AIDS researchers do something similar in some kinds of behavioural surveys.) But we will not find out in this kind of testing why the students learned what they did, which teaching and learning techniques worked best for some, or why they did not work for others, and so on. Alternatively, we can investigate the teaching and learning experiences that students underwent during the last two years of high school, and evaluate these processes as learning relationships structured by both teachers and learners (i.e., in HIV/AIDS, between the ASO practitioners and the members of the very communities they assist). The research purpose here is the production of better educating, not simply assessing and monitoring of its outcomes.

Such research is not restricted to education. All health promotion, including that addressing health maintenance among PLWHAs, can benefit from this kind of research. Similarly, research directed at policy formation to support and develop programs of health promotion and service delivery can benefit from such *practice-focused* research. And the best way to do that kind of research is co-research.

The Research Question

How is the research (and the researchable) question to be determined in co-research—by the researchers, by the practitioners, by the respondents? Certain kinds of research projects determine certain priorities as to who makes the decisions and who determines the research question. The discussion of community early in this paper now leads us to consider how much respondents can participate in the determination of a research question.

The mediation between communities and government noted previously applies also to relations between researchers and respondents. That is why so many researchers rely on ASOs to assist in recruiting respondents into research programs. We would argue that it is almost impossible to go back to a kind of community-led research where an ASO staff member or a researcher went into the venues or onto the streets to recruit respondents actively to be a research group as co-researchers (not just as a group of 'subjects'). This kind

of action research may be possible in some settings at some times, and it may be possible that there are questions in this epidemic that might still be formulated and answered in this way, but we would argue that most research (and co-research) questions will tend to be oriented toward practice and/or policy. This emphasises the practitioner-researcher relationship as the key site for the development of research questions.

This conviction relates to the size of the various Australian HIV epidemics and the ASOs dealing with them. We believe that the scope of programmatic response to HIV/AIDS today is too large in many places to lend itself a fully inclusive process in which respondents equally determine the research agenda, although in smaller epidemics more inclusive options might still remain. This necessitates the development of systematic consultation and assessment techniques so that practitioners are well-informed about respondent issues and needs. Again, co-research that features ongoing information collection and reflection offers the best way of ensuring that practitioners are as faithful as possible in their representation of respondents' needs and concerns.

Finally on this point, we would like to raise serious doubts about to the usefulness of respondent recruitment approaches and the understanding of sampling commonly used in prevention education focus-group testing activities. Focus-group testing is precisely a situation and technique that lends itself well to co-research, in order to combine the strengths of researchers' knowledges and experiences of methodology with practitioners' understandings of health promotion issues, the respondents and their community. A co-research approach would consciously recognise and respond to the problems of articulation, professional paradigms, differential knowledges and practices, and so on, that we have been discussing in this paper. Focus-group testing then could become a more reliable and valid health promotion research and evaluation tool.

Knowledge Transfer

Often in discussions about research findings, knowledge transfer appears to be regarded as one of the most important aspects of the relationship between researchers and practitioners. Knowledge transfer is an outcome that people value—but we do not know whether it works. One of the products of research, no matter what kind of research it is, is new knowledge. The issue of knowledge transfer as distinct from dissemination—dissemination is the process, transfer is the outcome—is less often addressed in research design than it should be. We would like to register two issues here: the first is the issue of whether knowledge transfer is conceived of as a two-way or a one-way relationship (maybe even three-way if respondents are included); and, second, how to build efficient and effective processes for knowledge transfer into institutions' daily work practices and training programs.

Since the beginning of HIV/AIDS social research on gay and homosexually active men at Macquarie University, Sydney, in 1985, one author of this paper has undertaken well over thirty different staff workshops with ASOs in five States. (This tally omits official conference presentations and publications.) There are other researchers—not enough we admit—who have participated in similar activities. We now doubt the overall and long-term efficiency and effectiveness of these one-off activities. We are less convinced than we once were that it is a

useful kind of knowledge transfer process, for it is (usually) a very one-way technique. Knowledge (occasionally wisdom?) is disseminated, but is it transferred?

The same may be said for the oft-tried but essentially unsexy community feedback seminar that attract very small audiences (and they are audiences), most of whom are professionals from the ASOs anyway. Technical reports delivered at such events often remain couched in researchers' terms—rarely in the practitioners' and never the respondents'—and a small, barely accurate and rarely detailed paragraph in the HIV/AIDS or gay press caps the effort. This expenditure of energy and intention seems to us inversely related to the effectiveness of the effort.

How might we develop more effective mechanisms of knowledge transfer? We need to recognise that knowledge in all its forms, including that produced by research activity, is not borne or applied in a value-free manner. The transfer of knowledge generated in research is not a simple exchange of facts, but a structured relationship between two or more sets of knowledge critically engaging new knowledge. In this engagement there are two major dynamics we would note. The first is the professional paradigms that act as frameworks for the interpretation and application of research information. These frameworks produce effects that may filter information derived from research activity, selecting and selectively using those aspects of research that suit certain purposes and emphasises, and possibly neglecting or misinterpreting other aspects, e.g., the often (mis)quoted SAPA construct 'gay community attachment' is a case in point. The second dynamic is the community practices that provide and constitute a collective consciousness that also mediates the transfer of knowledge—we do not know much about this process, but would suggest as examples the importance of gay culture in shaping gay community-based ASOs, and the impact of participation in research itself on sexual practice, e.g., what effects does being a regular respondent in SMASH have on sexual practice and culture in Sydney's gay community?

The difficulties of knowledge transfer are exacerbated in traditional forms of research, where academic prerogatives prevail. Co-research methods, with input from all participants and their interactive research relationships offer possibilities for regular, more direct and iterative knowledge-making and transfer. This is not just a simple facilitation of exchange; rather, co-research produces an critical engagement of those paradigms, knowledges, skills and practices of researchers, practitioners and, where possible, respondents. This critical engagement is important because most other dissemination practices produce problems of their own. We note only briefly here some of the factors that confound the best of intentions concerning the transfer of concepts, ideas and knowledge and its incorporation into practice: the researchers' capacity to conceptualise research linked primarily to practitioners' needs; the logic of the academic disciplines, which organises knowledge in packages and sequences better suited to academic purposes; differentials in language usage and jargon, including practitioners' jargon and community argot; distinctions between theory-driven and practice-driven research questions.

These factors cannot be ignored, because good research, as we have noted, relies on rigour, and sometimes difficult or emerging ideas are hard to transliterate. Co-research, with its generative heart located formally in the ongoing relationship between the research

participants offers a real possibility of the production of new knowledge, emerging concepts and fledgling ideas in terms produced by the co-research participants themselves. This increases the immediacy of comprehension by all research participants and facilitates the application of new knowledge in practice. This demands, however, the planning of such knowledge dissemination and transfer activity into the research design from start, and that planning amounts to something much more, for example, than budgeting for a community-reportback seminar.

CONCLUSION

In this paper we have tried to show just why co-research is a form of research ideally suited to HIV/AIDS, in prevention education and other forms of health promotion particularly. But we would also argue that policy development and evaluation, service delivery, and other aspects of HIV/AIDS work in the community sector are also ripe for co-research activity.

However, we have also argued that co-research is not an easy or light-weight option. It is a rigorous form of research and knowledge production. In presenting this argument, we are trying to promote an understanding and pursuit of co-research that will satisfy the demands made of research findings for validity, reliability and relevance. At the same time, we argue for co-research because of its usefulness, its focus on the problems of practice, and its potential for the creation of the reflective practitioner. We see in co-research the possibility for an immediacy and an objectivity that provides a more certain base for prevention education and health promotion than theory, methodology, experience, anecdote, professional paradigms or training on their own. It is the potential for blending of all these in a critical engagement of researchers, practitioners and, wherever possible, respondents that is exciting about co-research.

We also want to register as our final point that co-research demands that all participants find benefit in the outcomes. By that we mean that, even if researchers and practitioners are working on problems of practice, there must be some spin-off for the researchers too—if only to keep their academic institutional masters happy. But more than that, the successful production of new knowledge and the re-production of practice warrants rapid dissemination. This has implications for the training of the new cohorts of professionals coming up through the universities and colleges. HIV/AIDS has been poorly served to date in providing such training to those who eventually become its key practitioners in the community sector, in government and in research. Here, the seemingly arcane rituals of academe come into their own.

The development of HIV/AIDS co-research activity in Australia will not come about by accident. Someone need to take the lead in bringing together ASOs and researchers who are interested in pursuing such research possibilities. AFAO would seem to be in a central and important position to stimulate and develop the kinds of research relationships, particularly in the smaller States where extra assistance might be needed. There is much to be gained from these efforts and in the light of these days of smaller government, initiatives from the community sectors will be more important than ever.

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APPENDIX 1 - OVERVIEW OF COLLABORATIVE RESEARCH METHODS

There are different forms of co-research, and the literature advocating these offers many and varied accounts of the qualities and pitfalls of such research techniques. These are reviewed briefly here and references to the Annotated Bibliography in Appendix 3 are listed in parentheses to enable the reader to pursue each one in detail.

1. Action Research

In action research, research and daily activities (or *practice*) are intertwined in an ongoing sequence of investigative activities, normally linked with real world problems, e.g., curriculum development in school education, community-based health education initiatives. The researchers and other participants are not necessarily clearly defined in terms of specific tasks or goals. The division between theoretical concerns and issues of daily practice tends to be broken down, and the process of doing the research is as important as the outcome (see Nyden & Wiewel 1992; Collora Flynn et al. 1994; Dolch & Handy 1985; McFee 1993; Sarri & Sarri 1992; Truman et al. 1985; Uzzell 1979; Ward 1993).

2. Participatory Action Research

Participatory action research involves an approach similar to action research but more attention is paid to the membership of participants in the research activity. Understanding and communicating with critical reference groups constituted by the community members is a key feature of participatory action research. The researcher is taken to be a 'helper', assisting other participants to research the issues that concern them (see Greenwood et al. 1993; Hall 1984; Himmelstrand 1981; Lammerlink 1994; McTaggart 1991; Parsons et al. 1994; Simonson & Bushaw 1993; Wadsworth 1993).

3. Standard Collaborative Research

In some definitions, collaborative research has similar goals to action research and participatory action research, but there is a clear distinction made between the skills and interests that various participants bring to the research process, e.g., it is recognised that researchers have different sets of skills from practitioners. The tasks of researchers and practitioners do not overlap, and their research objectives may only partly overlap. However, successful collaborative research relies on the same process-related issues that affect the success of participatory action research and action research (see Ammar & Weaver 1992; Brieger et al. 1985; Curtis 1989; Greenwood et al. 1993; Nyden & Wiewel 1992; Stevenson & White 1994, Wadsworth 1993; Weaver & Ammar 1991).

Other research methods that are sometimes used interchangeably or are closely allied with action research, standard collaborative research and participatory action research are:

4. Advocacy Research

In advocacy research a client group 'purchases' research expertise in order to meet needs identified by the client group itself. There is a tendency in this relationship for traditional approaches of objectivity and bi-partisanship to be less important than fulfilling the client group's need for information. The researcher provides a service and the clients become responsible for the use of that information (see Nyden & Wiewel 1992).

5. Ethnographic Research

This is derived from anthropology. Researchers participate in the social and organisational life of respondents in order to analyse particular phenomena. The researcher is a 'participant-observer' (see Curtis 1989; Herrel 1991; Kotorba 1990; Maton 1993; Parker et al. 1991; Smith 1990).

6. Dialogic Method

Dialogic method is an extension of participatory action research. The critical reference group in this case is facilitated through a repeating cycle of problem specification, data collection, reflection and action. The method is explicitly communicative and unending in the sense that the cycle of critical reflection precedes the research and will continue after it. Dialogic method is used in order to promote change in groups and organisations (see McGuinness & Wadsworth 1991).

7. Interpretive, Democratic or Self Evaluation

These are evaluation research types where the emphasis is on practitioner-led evaluation activity rather than external evaluator-run research (see McTaggart 1991; McTaggart et al. 1991). Evaluation research often has many collaborative features and is the major form of research undertaken on programs in the field of health promotion, but is not a substitute for co-research.

APPENDIX 2 - KEY ASPECTS OF MODELS OF COLLABORATIVE RESEARCH

The collaborative elements in these types of research are many. First, these models use combinations of researchers, practitioners and members of communities, interest groups or organisations with a stake in the research project, rather than limit research activity to trained researchers alone. Second, the focus is on problems or concerns of the populations being researched, and those who are experiencing the problems being researched are to be involved in the research processes, including analysis and resolution. Third, there is an active commitment to enhancing the participation of all interested in the research, although each model favours a different balance or emphasis in the level and type of participation. Consultation mechanisms are therefore quite important and can take many different forms. There is often a strong commitment to regard researcher and client as equal partners, while recognising that researchers and practitioners have different goals and skills. Fourth, there is a dynamic element built into the research process because of this focus on participation, which produces a different kind of reflection inside the research process, particularly when utilising the various knowledges and experiences of the different participants. Fifth, there is always a concern with the link between theory and practice, not just theory and academic concerns or the concerns of practice alone. So although there is a strong tendency toward problem-solving research and a focus on practice, there is often an attempt to link this to more scientific understandings. For this reason, co-research is very useful for examining such things as collective projects or exercises, social relations and the operation of power, and the culture of working groups or institutions, and often possesses reaction and reflection spirals allowing change to become part of the research process. Sixth, such research is often smaller scale than larger, more typically academic projects, and can have more rapid effects if implementation and dissemination are planned as part of the research process, something these participatory models demand almost by definition.

According to some commentators, co-research can demystify research and build research capacity in communities. This should increase the likelihood that results will be used by non-researchers. Weaver and Ammar (1991) argue that the research methods used in co-research tend to improve the quality of the research through access to community and local knowledge, thereby assisting sampling and implementation of findings. By encouraging practitioners to be participants in research, co-research also promotes a sense of community ownership of the research. This encourages more input from research participants because the research is iterative. As one result, Simonson and Bushaw (1993) report that co-research can have more positive consequences, for example, on service delivery than research done by 'experts'. This is because such research may be more appropriate to action and intervention than natural 'scientific' models of research (Uzzell 1979).

For such collaboration to work properly there are some activities that need always occur. First, there needs to be agreement on the research problem and on the combination of emphases, goals and purposes of the research by all participants. Second, the collaboration between researchers and practitioners needs to be sustained throughout the research process. Third, there needs to be planned dissemination and knowledge transfer processes so that findings are communicated effectively and have an effect. This requires attention to the complexity of language used to communicate results, and a balance between all participants'

needs and purposes. Fourth, there needs to be agreement about and support for these research methods and techniques, and this may require a somewhat lengthy preparatory process of negotiation and refinement.

There can be difficulties in co-research, such as incompatible time frames, contesting professional ideologies and organisational cultures. Sometimes various authorities will not recognise the results because of the lack of 'scientific' imprimatur offered by more traditional academic processes and research design attributes. It takes more time to explain research techniques to non-researcher participants and to undertake the consultation processes; funding authorities are not always sympathetic to extended time lines. At times the different goals and purposes of participants can produce difficulties in balancing needs of practitioners, community, and researchers. The various skill levels can produce different levels of commitment and produce 'insider/outsider' problems, thereby damaging the sense of ownership. Researchers and other participants do have different knowledges, perceptions of fact and ideas, and objective and subjective ways of knowing. There are difficult issues to be worked through about 'experts' and 'non-experts', and this can be exacerbated by limited contact between researchers and practitioners. This contact can also depend on the extent of activist orientation on the part of researchers.

Reflection on practice can become its own reference point, and the critical relationship between practice and theory can be neglected in favour of a practitioner's seamless account of practice. On this issue, McFee (1993) argues that co-research has an important part to play in the critique of practice. There is always potential for a negative impact of research on practice, on research participants, through inappropriate publication and inaccurate perceptions of research participants. Research outcomes can be unpredictable and this can produce tensions in the research process.

If these pitfalls and barriers are not dealt with, various problems emerge: research can ask the wrong questions; suggest inappropriate interventions; limit use of findings; produce inaccurate interpretation of research results; provide research findings that conflict with practice observations; reinforce existing stereotypes and social relationships.

It is clear from this short discussion that there are some essential and common elements to collaborative research and the literature is extensive. No research is without its strengths and weaknesses, but the key issue raised by this brief summary of the literature on collaborative research activity is that the relations between those involved are central to getting co-research right.

For further detail, we refer readers to Appendix 3 - The Annotated Bibliography.

APPENDIX 3 - ANNOTATED BIBLIGRAPHY

Ammar, N.H. & Weaver, R.R. (1992) A collaborative approach to applied survey research: the interview process, *Sociological Practice Review*, 3(1), 32-36.

Collaborative research seen as providing advantages for enhancing response rate and accuracy. Appropriate collaboration is achieved by ensuring consultation throughout the course of research.

Aubel, J. & Mansour, M. (1989) Qualitative community health research: a Tunisian example, *Health Policy and Planning*, 4(3), 244-256.

Group interview method applied to community health. Lays out steps for group interview methods.

Brieger, W.R., Ramakishna, J. & Demisse, P. (1985) Issues in collaborative research between health educators and medical scientists: a case study, *International Quarterly of Community Health Education*, 5(3), 229-237.

Argues for enhanced collaboration between health educators and clinicians in relation to health issues. Such collaboration vital to success in improving health action.

Bruce, C.S. & Russell, A.L. eds, (1992) Transforming Tomorrow Today, Proceedings of the Second World Congress on Action Learning: Reflecting the philosophy of collaborative change in government, industry, education and the community. University of Queensland, Brisbane.

Collection of papers from the congress, includes AIDS specifics work, discussions of reflective practitioner issues, community action and social change, action research in education , management and training.

Burns, N. & Kieschnick, P. (1991) Overcoming Barriers to the integration of practice and research in the field of domestic violence, *Response to the Victimisation of Women and Children*, 14(3), 9-17.

Discusses interplay between research and practice. Barriers to effective dialogue includes: competition for resources, crisis management versus “ivory tower” work settings, gender, class and educational differences (social status, pay differences, language), debate between objective and subjective ways of knowing, the potential for negative impact of research on practice (impact on research participant, publication and public perception of research participants), experts versus non-experts, limited contact between researchers and practitioners, extent of activist

orientation of researchers. Barriers can lead to the following negative outcomes: asking the wrong questions, inappropriate interventions, usefulness of limited findings, inaccurate interpretation of research results, damaging and inaccurate interpretation of data in the media, research findings that conflict with practice observations, reinforcement of existing stereotypes and social relationships. Cooperative model relies on: a consciously facilitated dialogue, collaborating in relation to any concerns over funding, improved dissemination of information, encouraging practitioner research.

Colins, C. & Chippendale, P., eds, (1991) *Proceedings of The First World Congress on Action Research and Process Management, Volume 1 - Theory and praxis frameworks*, AEBIS Publishing: Brisbane.

Collection of papers - includes concepts of action learning in management and organisational change.

Colins, C. & Chippendale, P., eds, (1991) *Proceedings of The First World Congress on Action Research and Process Management, Volume 2 - Case studies and experiences*, AEBIS Publishing: Brisbane.

Collection of papers - includes discussions of the application of action learning in work, management and organisational change.

Collora Flynn, B., Wiles Ray, D. & Rider, M.S. (1994) Empowering communities: action research through healthy cities, *Health Education Quarterly*, 21(3), 395-405.

Discusses action research to promote health action. Five key elements: focus on community, consumer participation, information and problem solving, sharing of power, and quality of life. Researcher has a role in suggesting information resources and assisting development of skills of analysis. Action research is a key element in community development process. Via dialogue, researcher and community members grow in understanding of phenomena under investigation.

Crosswaite, C. & Curtice, L. (1994) Disseminating research results-the challenge of bridging the gap between health research and health action, *Health Promotion International*, 9(4), 289-296.

Description of research project in the UK examining mechanisms for improving the impact of research on health service provision and health promotion. Outlines cultural, organisational and policy related opportunities and barriers to successful dissemination of research results. Argues for more attention among researchers to methods of dissemination, accountability for research, adequate resources for

dissemination activity, promotion of collaborative models of research activity and better integration of research evaluation and policy development.

Curtis, K.A. (1989) Help from within: participatory research in a low income neighborhood, *Urban Anthropology*, 18(2), 203-217.

Ethnography in needs assessment. Elements of collaborative research: 1 - agreement on the problem to be addressed, 2 - agreement on explanations/causes of the problem, 3 - agreement on the role of research in needs assessment. Advantages of action research: 1 - transdisciplinary in effect, 2 - demystifies research, 3 - builds research capacity in communities, 4 - increases likelihood that results will be used by non-researchers, 5 - improves quality of research through access to the community and key elements of local knowledge.

Dolch, N.A. & Handy, K.M. (1985) Community groups, needs assessments and AMISS methods: reflections on collaborative research, *Sociological Practice*, 5(2), 177-192.

Discusses some of the pitfalls for achieving community participation in action oriented research. Problem areas were: the differing timeframes of researcher and community members, varying commitment among community members for the completion of research, time needed to explain research techniques to community members.

Duignan, P.A. (1981)Ethnography: an adventure in interpretive research, *Alberta Journal of Educational Research*, 27(3), 285-297.

Examines the continuous cycle of hypothesis testing inherent in ethnographic work [useful insight for HIV/AIDS action research]. Compares ethnography with other forms of data collection. Survey research offers one chance at data collection and interpretation and is fixed in time. Ethnography is iterative and allows for collection of information over a period of time and thereby fosters input from research participants. Discusses tensions in research question formulation and language. Researchers use technical language and frameworks in order to make observations intelligible. Everyday language may lead to semantic ambiguities and so on. [Use of technical language reflecting the needs of science, leads to inbuilt tensions for consumer - researcher dialogue].

Frey, L.R. (1994) The Naturalistic paradigm: studying small groups in the postmodern era, *Small Group Research*, 25(4), 551-577.

Application of the naturalistic paradigm research method to HIV/AIDS. Discusses method assumptions that guide research. Describes a refined model of enquiry that

examines the group in social context. Describes group level analysis and argues for some of the failures of other forms of research.

Greenwood, D.J., Foote Whyte, W. & Harkavy, I. (1993) Participatory action research as a process and as a goal, *Human Relations*, 46(2), 175-192.

Participatory action research is a dynamic process that has to be actively supported. Sits on a continuum with academic research at the other end. Key features: 1 - collaboration needs to be sustained throughout the research process, 2 - incorporation of local knowledge, 3 - eclecticism and diversity, 4 - case orientation, 5 - emergent process, 6 - linking scientific understandings to social action. NB page 189 - critical of academic research for its own sake, but also intervention agents simplify problems to match them to the available solutions. Authors caution to be wary of collaboration as a "straw man".

Hall, B. (1984) Research, commitment and action: the role of participatory research, *International Review of Education*, 30, 289-299.

Sets out activities and principles of participatory research. Activities: 1 - involvement in every day life, 2 - critique of method, 3 - emancipatory view of education, 4 - contributing to knowledge as a way of transforming society. Principles: 1 - consumers involved in all stages of research, 2 - clear benefits to those studied, 3 - systematic creation of knowledge involving those without research skills as well as researchers. Practical issues: attention to language use and the communication of results, alternative research methods leading to other social products, time and costs, balance grass roots/macro analysis, class as an analytic tool, blurring of research, learning and action.

Hammersley, M. (1992) *What's wrong with ethnography? Methodological explorations*, Routledge: London.

Exploration of methodological issues of ethnography and interpretation.

Herrell, R.K. (1991) HIV/AIDS research and the social sciences, *Current Anthropology*, 32(2), 199-2203.

Report of a meeting of social researchers to discuss method advances linked with HIV/AIDS social research activity. Discussants noted reluctance of researchers to become involved in HIV/AIDS and stigmatised groups. Argued for a shift from risk categories for purposes of analysis to "social interfaces" - the social contexts in which transmission is likely to occur. Agenda for social research should be promoting prevention through mapping cognitive aspects of sex behaviour and the ways in

which sexual encounters are organised, and providing the basis for culture specific research. Participants agreed that intervention must be an essential part of research on HIV/AIDS and that this requirement poses critical ethical and method problems for the investigator. Team research was advocated as an appropriate method for controlling for the biases of individual investigators in “applied” research. HIV/AIDS raises longstanding issues in ethnography of insider - outsider relationships. Some discussants argued the need for research to be aligned with community based organisations.

Himmelstrand, U. (1981) Innovative processes in social change: theory, method and social practice, *International Social Science Journal*, 33(2), 227- 247.

Theoretical account of the interlocking of cultural factors, domains of action, structures and processes. Discusses diffusion of innovation and action research. Refers to class analysis. “Participatory action research is ... an inseparable combination of theory, research and practice characterised by a dialogue between actors and researchers enlightening the actors as well as researchers about the meaning of intended action, and ultimately resulting in an increasing autonomy of actors in relationship to researchers, and to an emancipation from questionable and restraining beliefs in the inevitability of the given order of things.”

Kotorba, J.A. (1990) Ethnography and AIDS, *Journal of Contemporary Ethnography*, 19(3), 259-270.

Discusses dilemmas for ethnography and contributions to AIDS research. Ethnography often linked with practical outcomes, ie AIDS education. Ethnography involves innovative sampling methods that tend to reflect social organisation of phenomena accurately - particularly “invisible” socially marginal individuals and groups. Method more holistic in the sense that action and research tend to become linked in fieldwork. Conventional view of research subjects supplanted by “participant” oriented rhetoric. Contemporary issues - activist ethnography, blending of quantitative and qualitative methods and data.

Lammerlink, M.P. (1994) People’s participation and action research in community development: experiences from Nicaragua, *Community Development Journal*, 29 (4), 362-368.

Encouraging practitioners to be participants of research is a way of transforming practice. Method of “discovery learning” is outlined, where the focus of activity is on the exchange, analysis and systematisation of experience. Outlines process in action research with participants with no research experience.

Lieberman, A. (1993) The meaning of scholarly activity and the building of community, *Equity and Choice*, 10(1), 4-10.

Research enquiry in relation to education takes three forms: 1 - studying educational practice, 2 - developing new frameworks for action on knowledge, 3 - building collaborative structures (allows collaborative and critical ethnography and the construction of new forms of knowledge). Need to be clear about the role of academic research in the production and use of professional knowledge.

Losak, J. & Morris, C. (1985) Integrating research into decision making: providing examples for an informal action research mode, *Community/Junior College Quarterly*, 9, 55-63.

Discusses problems of traditional research and evaluation models and impact on practice. The action research model seen as a way of enhancing the impact of research activity on practice. Action research generates information about needs, solutions and implementation and gets the information back to the users. Action research not seen as advancing scientific knowledge but rather provides knowledge for immediate decision making. Action research stresses the participation of research users in problem specification, conduct of research and assessment of policy implications. Basic principles of an informal action research model - 1 - know your decision makers and establish informal communication channels, 2 - anticipate information needs before they arise, 3 - provide concise and timely data, solicited or not, in easy-to-read language, 4 - get these data to the powerful using multiple channels.

Marks, J.T.W. (1992) Theory, pragmatism and truth: post-modernism in the context of action, *Canadian Journal of Sociology*, 17(2), 161-173.

Challenges post-modern perspectives by arguing for a pragmatic approach to theory. Theory should be useful in practical terms. Meaning and action are linked.

Maton, K.I. (1993) A bridge between cultures: linked ethnographic-empirical methodology for culture anchored research, *American Journal of Community Psychology*, 21(6), 747-773.

Discusses method issues in ethnography. Notes techniques for overcoming subjective bias in ethnography. Ethnography lends itself to collaborative action. Outlines step in ethnography from a method standpoint.

McFee, G. (1993) Reflections on the nature of action-research, *Cambridge Journal of Education*, 23(2), 173-183.

Discussion of reflective practitioner, the status of action research in science and the epistemology of practice based on reflection in action. A professional's "knowing in action is embedded in the socially and institutionally structured context shared by a community of practitioners". Problematic to mistake craft knowledge for professional knowledge. Discussion of characteristics of practitioner held knowledge/practice. Key issue in action research is generalisability and blending with other sorts of information. Problem of reflection on practice is that it is its own reference point - leads to the reproduction of a point of view and difficulties generating research questions (hypotheses become the position of the practitioner's 'seamless' account of practice). [Research has a role in providing a critique of this reflection]. Agenda of action research: 1 - attention to reflection practices and relationships with other forms of knowledge, 2- action research is generally research with practical outcomes, research into practice and craft knowledge, 3 - natural science criteria do not apply.

McGuinness, M. & Wadsworth, Y. (1991) *'Understanding, anytime' - a consumer evaluation of an acute psychiatric hospital*, Victorian Mental Illness Awareness Council Inc.: Victoria.

Innovative evaluation method including service provider and consumer perspectives. Uses 'dialogic' method, an extension of participatory action research whereby the discourse of critical reflection is perpetuated and becomes incorporated into the joint communication practices of participants. Lengthy method. Highlights importance of critical reference group perspective in the development of evaluation questions and analysis of data. Demonstrates the richness of information that can be gleaned through the method. Also demonstrates the capacity for action research to deal with complicated relationships in data and 'fuzzy' data. Demonstrates that action research can make useful recommendations and have far reaching impacts on practice.

McTaggart, R. (1991) Principles for participatory action research, *Adult Education Quarterly*, 41(3), 168-187.

Principles include: identifying the individual and collective project, examining social relations and power, changing the culture of working groups, institutions and society, action and reflection spiral, unifying the intellectual and practical project, knowledge production, methodological resources, creating the theory of work. Discusses such principles in relation to training for aboriginal teachers.

McTaggart, R. (1991) When democratic evaluation doesn't seem democratic, *Evaluation Practice*, 12(1), 9-21.

Discussion of implementation problems of “democratic” evaluation. Distinction of participatory and representative democracy needs to be acknowledged. Uses a case study to examine issues. Principles of dissemination of information: ethical statements about the construction and distribution of information collected in an evaluation. Problems with democratic evaluation: evaluators role is difficult, assumptions about democracy, evaluators have power over some participants. Argues for a shift from externally managed evaluation to self - or participant evaluation.

McTaggart, R., Caulley, D. & Kemmis, S. (1991) Evaluation traditions in Australia: distillation of the old, wellspring of the new, *Evaluation and Program Planning*, 14, 123-130.

Mounts argument for the role of self-evaluation and action research that “engages participants in the organisation of enlightenment”. Application of interpretive evaluation approaches in Australia, eg case studies, social/power relations as the context, action research, participatory action research important in Australia in the 1980s. In the 70s two main assumptions of evaluation were deconstructed: 1 - possibility for consensus in purpose of programs, 2 - method in social enquiry was value free. Describes “reactionary reductionism” in the 90s as a backlash in evaluation. Emphases have come to be on “performance”. Paper provides important background for evaluation and action research. Authors assert that it is important to examine the tendency to equate evaluation and accountability. Evaluation should not become solely an instrument of accountability and management. Rather, focus on participatory critical reflection is on self understanding of practice, forms of organisation, conceptualisation of social and educational work. Discusses importance of Habermas’ “Theory and Practice”.

Nyden, P. & Wiewel, W. (1992) Collaborative research: harnessing the tensions between researcher and practitioner, *The American Sociologist*, 23(4), 43-55.

Collaborative research equates to a situation where researcher and client are equal partners and where skills and knowledge are combined in relation to a research concern. Closely related to, but distinct from, advocacy research or action research. Advocacy: agenda set by client, client needs prevail, abandons neutrality of findings. Action: breaks down theory and practice divides, process and goal equally important. Collaborative: equality, recognition of research expertise, community involvement is sought out, knowledge is communicated/translated effectively for the consumer, recognises that researchers and practitioners have goals that are not always the same and bring different skills to the issues. Problems: collaborative research not highly regarded by journals and does not get published frequently, exists a need to substantiate the ‘collaborative research’ model, not always easy to balance the needs

of researchers and the community, tensions between researchers and practitioners may be inevitable in that the outcomes of research are not always comforting, crux of researcher/practitioner tensions is the unpredictability of results - in terms of outcomes and timeframes. Furthering the collaborative effort in the academy: deconstruct/diversify research to encompass rewards for “practical” research, open up research critique to community interests, do away with the idea that “pure” research is more intellectually challenging, community oriented research politically difficult, promote transdisciplinary approach to community problems, avoid jargon, academese. Furthering collaborative effort in the community: gain greater understanding of researchers need to question everything (particularly things that practitioners take to be the truth), CBOs need to be more proactive in gaining access to and organising their research understandings, eg community development literature reviews [NB - applied questions exist outside of academic discourse].

Parker, R.G., Herdt, G. & Carballo, M. (1991) Sexual culture, HIV transmission and AIDS research, *The Journal of Sex Research*, 28(1), 77-98.

Discusses the place of ethnography in cross-cultural aspects of sexuality and importance in area of HIV/AIDS.

Parsons, C.D.F., Blackford, J. & Street, A. (1994) *Multicultural Australia: Nurses in Action*. Penfolk Publishing: The Centre for Research in Public Health and Nursing.

Report of a Victorian Health Department funded study of nurses and health care provision for people from NESB. Discusses use of participatory action research method to promote change in practices of communication and service delivery that incorporate understanding of cultural differences. Useful example of application of the method to Australian health care system. Discusses pitfalls of action research method: primarily time needed to use the method appropriately. Time demands for action research need to be weighed against the quality of benefits and potential for longstanding effects. Developed workshops as part of the project.

Peavey, F. & Hutchinson, V. (1993) *Strategic questioning for personal and social change*. Action Research Issues Centre: Melbourne.

Outlines an orientation to the use of critical reflection in the form of identification of questions. Questions range from personal to wider social concerns. Encourages a dialogue in relation to questioning where the construction of the question is on clarifying focus, observing, analysing, examining feelings, creating a vision, promoting change, and identifying forms of action in relation to the question. Purpose of the method therapeutic and emancipatory.

Sarri, R.C. & Sarri, C.M. (1992) Organisational and community change through participatory action research, *Administration in Social Work*, 16(3-4), 99-122.

Sets out key aspects of action research. Action research seen as a method for increasing the effectiveness of service delivery. People who experience a social problem need to be involved in its analysis and resolution - hence action research.

Schuklenk, U. (1994) Against manipulative campaigns by 'community based' AIDS organisations, *Health Care Analysis*, 2, 253-261.

Debate about the extent to which gay community organisations represent affected communities. Analyses Australian gay media.

Simonson, L.J. & Bushaw, V.A. (1993) Participatory action research: easier said than done, *The American Sociologist*, 24(1), 27-37.

Review of outcomes of a number of participatory action research (PAR) cases. Problems with PAR: results unclear in terms of community empowerment, links between research and program improvement unclear. PAR found to be an appropriate way of accurately measuring community perceptions. Participation in a research project not enough to produce change in program delivery. PAR nevertheless found to have more positive consequences than "expert" model research. Quality of implementation of PAR varies.

Smith, G.W. (1990) Political activist as ethnographer, *Social Problems*, 37(4), 629-648.

Discussion and case studies of ethnography with marginalised groups. Includes discussion of authors research in bath-houses. Discusses aspects of "regimes" equally applied to AIDS bureaucracies and other organisations. Ethnography seen as potentially providing a science base for political and social action. However, such research does not in itself provide for social action. Describes fieldwork in detail.

Stevenson, H.C. & White, J.J. (1994) AIDS prevention struggles in ethnocultural neighborhoods: why research partnerships with community based organisations can't wait, *AIDS Education and Prevention*, 6(2), 126-139.

Survey of AIDS managers called for (among other things) researcher-practitioner collaboration in research activity, power sharing and cultural competence among the researchers.

Truman, B., Gruther, C.H., Vandebareg, L. Fera, F.A., Madden, J.J., Joesting, L. & Kimball, W.J. (1985) 'When the tire hits the pavement': a case study of the dilemmas associated with conducting action research, *Journal of the Community Development Society*, 16(1), 105-116.

Steps in action research: 1- build trust, 2 - deal with agenda of different project stakeholders, 3 - creating community when non-community exists, 4 - determining the appropriate educational strategy, 5 - dealing with changing community power structures, 6 - making “ expert” decisions, 7 - using research information in the community development process. (See end of the article for summary of how to implement action research.)

Uzzell, D. (1979) Four roles for the community researcher, *Journal of Voluntary Action Research*, 8(1-2), 65-75.

Roles include: Traditional model - researcher as chronicler of social activity, Researcher as agent of social change, the researcher as broker, researcher as an educator. Action and intervention oriented research seen as more appropriate to community action than natural science models of research.

Wadsworth, Y. (1982) The politics of social research: a social research strategy for community health, education and welfare movement, *Australian Journal of Social Issues*, 17(3), 232-246.

Provides analysis of social research politics with reference to Australia. Topics include: conventional science - assumptions and consequences, conventional science and community needs, self managed action research as an alternative, history of social research in Australia. Argues for action research and collaborative models for resolving problems of science and community needs.

Wadsworth, Y. (1993) *How can professionals help groups do their own participatory action research?* Action Research Issues Association: Melbourne.

Discusses the role of professionals in collaborative research. Issues professionals need to be aware of: time, professional ideologies, organisational culture and inertia, insider/outsider problems, uninformed funders, problems associated with the participatory action research cycle.

Wadsworth, Y. (1993) *What is participatory action research?* Action Research Issues Association: Melbourne.

Brief discussion of the elements of participatory research practices from a non-researchers point of view. Issues include: comparison of conventional and cyclical research processes, action and participation.

Ward, J. (1993) The grounded community development research method: exercise your right to listen to people on their terms, *Community Quarterly*, 29, 49-53.

Raises concept of grounded community development research. Describes a non-deductive research method, embracing emancipatory principles, where the research question is negotiated via the social situation of consumers.

Warry, W. (1992) The eleventh thesis: applied anthropology as praxis, *Human Organisation*, 51(2), 155-163.

Discussion of anthropology and the place of practical action informed by theory as the focus of applied research. Uses case study of health and indigenous culture in Canada. Role of researcher is to assist community members by making theoretical assumptions clearer and to advise about the research process. Praxis - the relationship of theory and practice is central to action- and collaborative research.

Weaver, R.R. & Ammar, N.H. (1991) A collaborative approach to applied survey research, *Sociological Practice Review*, 2(4), 275-280.

Collaborative research can be designed to enhance the quality of sampling and the quality and implementation of findings. Building a sense of community ownership of the information is seen as the key to achieving collaborative research.

Zuber-Skerritt, O., ed. (1991) *Action Learning for improved performance - Key contributions to the First World Congress on Action Research and Process Management*. AEBIS Publishing: Brisbane.

Collection of papers and summary reflections on the congress itself. Major interest is the Australian and non-western applications of action research models.