Cross-cultural Considerations in the Conduct of Community-based Participatory Research

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This article explores cross-cultural challenges that arise when university and community members collaborate in community-based participatory research. As part of a project for primary prevention of human immunodeficiency virus (HIV) infection, researchers trained community leaders to jointly develop a research question and conduct a pilot qualitative study in a Puerto Rican community in Massachusetts. Different priorities of the community and university members about HIV as a research topic underscored the need to continuously reflect on developing a research question in community-based participatory research. Recognizing the cultural assumptions of both university and community members is an important component of capacity building among collaborative research teams. Key words: community-based participatory research, community-academic collaboration, HIV prevention

COMMUNITY-BASED PARTICIPATORY RESEARCH (CBPR) has been defined by the federal Agency for Healthcare Research and Quality (AHRQ) as "a collaborative research approach designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change." In a report evaluating CBPR, the AHRQ noted that university researchers need to credit community members (CMs) with the ability to understand complex research challenges, and “One of the many benefits of making research partners of community members is that they begin to see the long-term gains associated with research, in comparison to the relatively short-term nuisance of data collection activities.”

The AHRQ also observed that CBPR studies were more likely to report capacity building in the community than in the cadre of researchers or their institutions. This article takes the AHRQ’s observation as a point of departure to explore inherent cross-cultural challenges when university and community members collaborate to conduct research. The discussion draws from the authors’ experience of a pilot project, “Protecting the Next Generation,” undertaken between April and December 2005 in a Puerto Rican community of Holyoke, a small city in western Massachusetts. The aim of the pilot project was to train a small team of longtime community leaders in qualitative research. The goal...
was to build capacity among a community–university research team for future endeavors in CBPR to prevent human immunodeficiency virus (HIV) infection.

THE PROMISE OF CBPR

CBPR is a promising research framework designed to achieve social and behavioral change.2 The potential benefits of CBPR to the community have been documented,2,3 as well as multiple challenges involved in conducting CBPR.1–6 The underlying assumption of CBPR is that it has the potential to bridge cultural gaps in conventional research design that inevitably result from differences in worldview and educational experience between members of the community under study and university researchers. To bridge these gaps, CBPR builds on existing community resources, knowledge, skill, and attributes.

The knowledge produced from the CBPR experience is intended to be an impetus for increasing critical consciousness among CMS, which can lead to the development of sustainable interventions, community-based decisions, and plans for meaningful change.7–9 Critical evaluation of CBPR initiatives have demonstrated long-term community involvement after the departure of outside academic influences and facilitation.1,10

In community health, CBPR appears to be an appropriate approach to the elusive goal of reducing well-documented disparities in health.11 Sociologists Kretzmann and McKnight12 have elegantly articulated the process by which researchers external to a community often study problems and propose solutions. Studying problems “from the outside” may inadvertently serve to perpetuate such problems, since people within the communities come to see themselves and their community as bearers of problems, rather than participants in the solution. A strong justification for implementing the model of CBPR is provided by the US government’s agenda, as set forth in Healthy People, which aims not only to reduce but also to eliminate health disparities by 2010.13

Furthermore, few epidemiological findings have been effectively translated into programs to improve health.14 Knowledge produced in university settings is often not effectively disseminated to those who stand the most to gain from it (L. Green, DrPH, oral communication, June 2004). The application of knowledge cannot keep pace with the rate at which knowledge is produced. Indeed, knowledge generated from universities is too voluminous to be widely disseminated even among the scientists who produce it. Almost 75% of articles in the Social Science Citation Index have not been cited within the last 5 years.15

CBPR AND HIV PREVENTION IN A HISPANIC COMMUNITY IN MASSACHUSETTS

The history of the authors’ particular university–community partnership is important to understand the context for the project, “Protecting the Next Generation.” In many ways, Holyoke is an excellent place to conduct university–community collaborations to address health disparities. Not only does it have a large Puerto Rican community but also the city is only about 12 miles from several prestigious and well-endowed liberal arts colleges (Amherst, Smith, Mt. Holyoke, Hampshire) as well as public institutions of higher learning (Holyoke Community College and the University of Massachusetts Amherst). The University of Massachusetts is the flagship campus for the public land grant university in Massachusetts, and is home to the oldest and largest university-based nursing training program in western Massachusetts. Holyoke has been long been the site of various research projects, clinical rotations, and community-based learning from these institutions.

For over a decade, the Holyoke Planning Network, a loose collaboration of the 6 colleges and many community-based organizations, has dialogue about ways to sustain reciprocal community and educational
programming in Holyoke and the surrounding area. The need for the Holyoke Planning Network was manifest by the volume of students seeking community-based learning in Holyoke over the years, resulting in a consensus among involved faculty that “the process of researching the Holyoke community remained inequitable.” This inequity was due to students’ need for learning experiences exhausting already overburdened community agencies.

The Holyoke Planning Network secured funding in 2004 through the University of Massachusetts under a Community Outreach Partnership Center grant from the US Department of Housing and Urban Development. One of the activities funded by the Community Outreach Partnership Center grant was the faculty–community Puerto Rican Studies Seminar (PRSS). The goals of the PRSS, which included 8 faculty from the 6 participating colleges and 8 leaders from community-based organizations, were to mutually focus upon the history, culture, and politics of Puerto Rico and to adequately prepare faculty to work “respectfully and productively” in Holyoke. A highlight of the seminar was a joint field trip to Puerto Rico to study successful community–university partnerships there. Five of the 6 members of the research team for “Protecting the Next Generation” attended the PRSS in 2004–2005 and agreed to work together in the future.

The 2 university members (UMs) of the pilot-project research team were a faculty member and student at the School of Nursing at the University of Massachusetts, who both also held degrees in anthropology. The faculty UM had worked clinically as a nurse-midwife in a community hospital in Holyoke for a decade before becoming a university researcher, so she already had established relationships and was known to the CMs before the seminar. These longstanding community relationships and the positive and respectful relationships developed within the PRSS suggested that the UMs and CMs would have good working relationships in the pilot project. Community–university partnerships are known to fail when researchers do not take enough time to be known locally before initiating projects.

The 4 CMs were Puerto Rican women who represented a wealth of experience and history in Holyoke. Their combined experience included leadership in HEADSTART, the preschool readiness program; a construction vocational and GED (general equivalency diploma) program; a community organizing program; and a bilingual adult literacy education program. Although the team recognized the importance of male participation in the project and recruited a valuable and committed male community leader, he could only participate for 2 months.

The UM–CM team of the “Protecting the Next Generation” project met monthly for 10 months; explored research questions; devised a semistructured interview guide; learned the value of and process to obtain informed consent; practiced interviewing skills; recruited a convenience sample to interview; interviewed and taped 6 participants; read, coded, and identified recurrent themes in the transcripts; and discussed the dissemination of results.

The UMs had received a small intramural grant to focus on HIV prevention among Holyoke youth. This focus on HIV prevention seemed a rational choice to the UMs, who had conceived the project on the basis of powerful data about HIV prevalence in Hispanic subpopulations. Specifically, in the western Massachusetts health service region (which includes Holyoke), Hispanics accounted for the largest proportion of people recently diagnosed with HIV between 2002 and 2004. The HIV mortality rate per 100,000 was 8 times higher for Hispanics than for White non-Hispanics, and the age-adjusted prevalence rate of HIV/AIDS per 100,000 for Hispanics in Massachusetts was almost 10 times the rate for non-Hispanic Whites (64.1 vs 6.5 cases per 100,000, respectively).

The western Massachusetts health services region also had the highest proportion of females among people diagnosed with HIV.
infection between 2002 and 2004. Furthermore, Holyoke had the highest percentage of adolescents at risk for HIV infection in Massachusetts (C. Martorell, MD, MPH, oral communication, October 2005).

Similar data are reported nationally. The fastest growing segment of the population affected by the HIV epidemic is young ethnic minority women; these women now account for three quarters of all women living with HIV. For Hispanic adolescents, unprotected sex is the major mode of HIV transmission, and they are the group least likely to use condoms. Despite progress in developing effective behavioral interventions, HIV prevention programs have been challenged by problems of relapse and lack of sustainability.

These data indicated to the UMs an urgent need for qualitative information about the community’s understanding of HIV infection in relation to their everyday practice. Therefore, the UMs proposed to jointly develop with the CMs a semistructured interview guide that would elicit how individuals in the community understood HIV infection in relation to their everyday lives. Moreover, the UMs were intentionally nondirective about the explicit formulation of the research question, since they believed that sharing the public health knowledge with the CMs would speak for itself. The UMs presumed that the CMs would be inspired to articulate a culturally sensitive research question to elicit responses about participants’ experience with sexual health, HIV, and gender relations.

Right from the start, articulating the research question was a challenge. The CMs voiced concerns about focusing exclusively on HIV. They felt that emphasizing the disparity in HIV infection rates stigmatized and racialized Hispanics. The CMs were also concerned about confidentiality when speaking of HIV, given the small size of the community. The CMs pointed out, and the UMs agreed, that many other health issues besides HIV infection were influenced by gender, such as obesity, and depression. One CM reported that a cohort of adolescent mothers felt that health insurance, safe neighborhoods, and violence were the most pressing issues for their health. HIV was important, but not front and center. “People don’t want to hear about what affects them,” said one CM. “They want to put it to the side.”

After considerable dialogue, the team agreed upon a semistructured interview guide (Figure 1) to open up topics about gender and health for study participants to consider. The team reflected together on how gender impacts the issue of health in the community. They acknowledged cultural norms regarding the differential rules parents created for boys and girls in the community. The CMs spoke about their own experience, which differed markedly by gender.

“When I was growing up, I was not allowed to leave the house,” said one CM, “but boys were allowed to go out and bailar, brincar, y saltar (dance and jump around).”

To this, the male CM replied, “I have two sisters, and they had to stay at home when I could go out on the streets. So, they didn’t have as much freedom as I did. But, at the same time, they were not exposed to the violence that I was. So, there are good and bad aspects of being allowed to be more independent as a teenager.”

The interview guide that was ultimately created did not focus exclusively upon HIV infection and invited a much broader discussion. Rather, the focus was on differences of lived experience as men and women. When the CMs interviewed others in the community (all women), concerns about HIV infection were not specifically named, even with a prompting question about sexual practices. The content of the transcript data overwhelmingly placed intimate partner violence (IPV), not HIV infection, as the issue central to gender and health. The CMs found the personal narratives of living through IPV had much more power to foster desire for change than data about the soaring incidence of HIV infection in the aggregate Puerto Rican population. An excerpt from one of the interviews tragically illustrates this point.

Well, my father would beat me up every day; he would give me really bad pelas [severe beatings].
And why would be hit you?

Because when I was coming home from school, I would always be with a friend. He wouldn’t give me money for the bus fare, then I would have to walk for half an hour through an area where there were no houses. Then if I would talk to anyone, people would tell him, “I saw your daughter talking to someone.” I told him, “When you go over the bridge, you will see the sign that says [town name],” and that was it, I just gave him directions. Someone saw me talking to this man and told my father. He beat me up so bad. He hit me all over my body. I was in my second year of high school.

What about your mother?

My mother wouldn’t say anything. She wouldn’t dare because he would hit her too. He drank a lot. He hit my mother, my brothers too, but I was the one who got hit the most.

There is always one who gets hit the most.

Yes. So, the next day when I went to school, the teacher saw me, she checked me out and she wanted to call the police, I told her no. In my mind I knew that I couldn’t go back home, it was too much.

Uh hum.

I was tired. I wanted to study but I was tired of the hitting. I didn’t want anyone to be called, so after school I went to a house near the bakery that was abandoned, and I cried and cried, and there was this man. I didn’t know him; he was the owner of the bakery. And he said, “Girl, what is wrong? Why are you crying?” So I started telling him. I was ignorant.

Yes, the desperation and the loneliness.

So I started telling him and he said, “Do you want to come to my house with my family? I’ll bring you to my family’s house on the beach, there are girls there that are your age, and then I am going to talk to your father.”

...So he left me there, and he went to talk to my parents. As soon as he got there and he asked
my mother, “Are you the mother of the girl?” She said, “If you took her then you need to marry her quickly.”

**Without giving him the opportunity to explain anything?**
Yes. . . . Every time he tried to explain something, they would interrupt him. So he came back and told me, “Your parents are very stubborn, they didn’t want to listen to me.” . . . Then he said, “They told me that you need to marry me.” And I said, “What? How is that possible?” So he went back for a second time the next day, and it was the same. So it came to the point where they went to the judge and planned on the marriage. . . . So they took me and we went in front of the judge and when we were there, I said to my mother, “Mom, I need to talk to you.” And she said, “I don’t need to talk to you! You are a ‘malcriada’ ” [disobedient, disrespectful and rude child.]. I said to her, “Mom, I don’t want to go with him.” She said, “You want to go with him.” But they married me to him anyways.

All 6 interviews conducted by the CMs reflected the theme of IPV in the interviewees' lived experience. For one woman, relocating to Holyoke was an escape from abuse she suffered in Puerto Rico. Another participant shared the following:

*And what negative things have happened in your life? Throughout your childhood, infancy, adolescence?*

. . . .perhaps due to immaturity I would say, I was living in a circle of verbal violence, thinking that perhaps if I was alone, at that time that is what I thought, I was going to go through a rough and difficult time having 4 girls.

*And you said that you found the experience for the first time in your marriage . . . the experience of domestic violence . . . verbal violence . . .*

Yes, which I consider is worse than physical violence because it hurts your heart so much, the words, the humiliations, when a person thinks that they are superior to you, and you have to stay quiet because of the fear . . . fear that I had of being left alone with 4 girls. . . .

Several months after the pilot project ended, the UMs attended a community theater production that featured one of the CMs. The topic of the play, which was well attended by CMs and those involved in Holyoke community activities, was IPV. This production showed the centrality of IPV in the consciousness of the Holyoke community.

**DIFFERENCES IN RESEARCH PRIORITIES: A PITFALL?**

The discrepancy between the UM and CM priorities for the focus of the research question is consistent with the experience of Mosavel and colleagues. ⁴ Working in South Africa among women needing cervical cancer screening, these university researchers were challenged when a particular health issue or research question was not prominent in the consciousness of the prioritized community.

The discrepancy in priorities instigated discussion among all members of the team. High rates of HIV infection must be understood within a system of inequalities in relations between men and women, of which IPV is one manifestation and a more immediate and pressing concern than HIV infection for women in disenfranchised communities. The UMs pointed out the relationship between HIV infection and IPV, which has been clearly articulated by Wingood and DiClemente, ²² who tie women’s vulnerability to HIV infection to the theory of gender and power. This association was recognized by all members of the research team. All team members also understood that inequality is not uniquely linked to gender, but also includes wider systems of inequality tied to race and income.

The most compelling aspect of CBPR for the UMs was that research originating by and for the community could result in positive social and behavioral change. This premise is rooted in the Freirean understanding of conscientization, which proposes that a community will be inspired to act if given the opportunity to name their social condition and reflect upon it. ⁸ The lives of all the CMs in this program validated this premise, for they had organized and participated for more than 20 years in multiple projects and programs to improve the lot of their community in the city.
Nevertheless, the CMs were much more critical than the UMs of the CBPR process. They expressed frustration that sustained community mobilization was so challenging and that funds to support such efforts were diminishing and allocated in increasingly episodic and fragmented ways. When the CMs expressed skepticism about future funding at levels that could make an impact either on IPV or HIV infection, the UMs could not dispute the increasing difficulty of obtaining and sustaining funding for research or service in the community. The outcome of positive behavioral change as a result of community participation in producing knowledge is a theory within the university culture that CBPR endeavors to apply. The CMs were less optimistic that CBPR would be a force for change. Their attitudes were shaped by their real-life experience: funding for all community projects (research or maintenance of services) had been, and would likely continue to be, precarious, fragile, and insecure.

The CMs' skepticism gave the UMs pause to self-reflect. The authors agree with Baum, who said, “Most published research presents a sanitized view of the research process. A newcomer to research would gain the impression from published accounts that research was generally a smooth, logical process in which little goes wrong and which is immune from the vagaries and politics of everyday life. In practice it is rare for such immunity to operate.”23(p112)

The UMs' commitments to the community made them rethink the process of CBPR in the community. Strategies for mobilizing the community around HIV prevention would need to be redesigned to assume a more holistic approach to risk reduction that includes social structural interventions based on the everyday experience of the CMs. Is CBPR an effective mode of research after all?

Since true CBPR efforts are by nature long term, even the AHRQ has recognized that capacity building in the community may result in positive health outcomes that have little or nothing to do with the initial research design. Although the pilot project with UMs and CMs did not produce a specific plan for HIV-related future research, it did establish a collaborative team of dedicated, bright, and capable researchers with expertise as cultural insiders. Despite their skepticism about the ultimate success of CBPR, the CMs were eager to work on research with the UMs in the future. The pilot project is over, but the collaborative relationship as a team is not.

To simply conclude that CBPR is not effective as a mode of research in promoting social and behavioral change obscures the notion that communities with significant health disparities might also benefit from UMs' effectively naming and reflecting upon their own condition in the university, one that perpetuates inequities within the community through its mechanisms and hierarchies in funding.

As the culture of the university increasingly recognizes the need for translational research, the value of building long-term commitments to community researchers has never been greater. The UMs of the research team have the responsibility to continue educating other researchers in the academy about the issues and pitfalls inherent in CBPR as a mechanism to cocreate knowledge. Equally important, however, is our responsibility to support CMs to continue to teach us and help make us aware of our own cultural assumptions, and despite the challenges, to stay at the table.

REFERENCES

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