PREVENTING HIV THROUGH SOCIAL INCLUSION USING COMMUNITY-BASED PARTICIPATORY RESEARCH

The HIV epidemic is one of the most severe health crises of our time, and the United Nations Development Programme (UNDP) cites HIV as being responsible for the greatest reversal in human development (United Nations Development Programme 2005). In areas most affected by HIV, life expectancy has been reduced greatly, economic growth has waned, and household poverty has deepened. Although declines in new infections are being witnessed in some countries, an estimated 2.6 million new infections occurred globally in 2009 (Joint United Nations Programme on HIV/AIDS 2011). Currently an estimated 33.3 million people globally are living with HIV and each year almost two million people die from AIDS (Joint United Nations Programme on HIV/AIDS 2011). Increasingly, it is the poorest and/or most marginalised segments of societies affected by HIV/AIDS (Parker 2002).

The HIV epidemic is complex and necessitates social and political solutions in addition to biomedical solutions. Increasingly, researchers have realised the need for a comprehensive approach that includes the participation of impacted community members as active researchers and advocates for change to address behavioural, biological, and structural vulnerability to infection.

Promoting sexual health and HIV requires a comprehensive understanding of the social and cultural fabric of a community and the acknowledgement and inclusion of diverse perspectives, norms, values, and behaviours (Reece and Dodge 2004). Community-based participatory research (CBPR) therefore provides an important option for community and academic partners to effectively address local HIV/AIDS epidemics. CBPR provides a partnership approach to research that includes community members and academic researchers in every aspect of the research process.

This chapter aims to explore how HIV is being confronted in the U.S. through social inclusion using the principles of CBPR. After a brief overview of CBPR, we provide examples of how community-academic partnerships use CBPR to facilitate social inclusion and better understand and prevent HIV in their communities for three particularly vulnerable groups within the U.S.: African Americans, youth, and sexual minorities.

COMMMUNITY-BASED PARTICIPATORY RESEARCH

Increasingly, academic researchers, health care providers, and community members are becoming frustrated by the disconnect between research, research

translation, and policies to improve health (Israel et al 1998; Green and Mercer 2001). CBPR provides a bridge between academic researchers and communities through shared knowledge, capacity building, co-learning, and commitment to action around issues of priority in the community (Israel et al 2005).

CBPR has been characterized as:

> [A] collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities (Community Health Scholars Program 2002: 2).

Thus, CBPR is a partnership approach to research that involves community members and academic researchers in all stages of the research process; all partners share their expertise, mutually make decisions, and claim ownership of the research. The aim is to improve understanding of an issue, and then integrate the resulting knowledge into interventions, including social change and policy solutions (Israel et al 2005).

CBPR diverges from traditional research approaches by including the people most affected by the issue of concern in the development of the research question; the design and implementation of the study; the analysis and interpretation of results; and the development of the solutions. Explicit in CBPR is the democratisation of knowledge (Ansley and Gaventa 1997); the knowledge community members have gained through experience is valued and incorporated into the research process, and knowledge previously contained within the "ivory tower" of academia is physically and intellectually accessible to community partners (Minkler 2004).

Harnessing CBPR to blend the lived experiences of community members, the experiences of organisational representatives based in on-going public health practice and service provision, and rigorous scientific methods has the potential to develop deeper and more informed understandings of health-related phenomena and produce interventions that are more relevant, culturally congruent, more likely to be adopted and maintained over protracted periods of time. Consequently, these interventions are more likely to be successful (Cashman et al 2008; Wallerstein et al 2008). Similarly, study designs, including those used to evaluate interventions, that are informed by multiple perspectives may be more authentic to the community and its members' natural ways of doing things.

CBPR is therefore not a method, but an orientation to guide the research process (Shalowitz et al 2009). Nine principles guide CBPR: 1) CBPR acknowledges community as a unit of identity, 2) CBPR builds on strengths and resources within the community, 3) CBPR facilitates a collaborative, equitable partnership in all phases of the research, involving an empowering and power-sharing process that attends to social inequalities, 4) CBPR fosters co-learning and capacity building among all partners, 5) CBPR integrates and achieves a balance between knowledge generation and intervention for the mutual benefit of all partners, 6) CBPR focuses on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinates of health, 7) CBPR involves systems development using a cyclical and iterative process, 8) CBPR disseminates results to all partners and involves them in the wider dissemination of results, and 9) CBPR involves a long-term process and requires a commitment to partnership sustainability (Israel et al 2005).

Israel and colleagues (2005) caution, however, that no one set of principles is applicable to all community-academic partnerships. The values and principles guiding partnerships should instead be a reflection of the collective vision of the partnerships. Indeed, these principles are applied in various ways within community-academic partnerships, demonstrating multiple approaches to CBPR.

ADDRESSING HIV PREVENTION THROUGH COMMUNITY-BASED

PARTICIPATORY RESEARCH

We present examples of CBPR occurring in the U.S. to address HIV prevention through social inclusion within three vulnerable groups: African Americans, youth, and sexual minorities. We use these examples to highlight various parts of the CBPR process, explore the various approaches taken, and demonstrate how the CBPR principles are operationalised in practice.

The Life Changing (TLC) Group: Addressing HIV among African Americans through individual and structural intervention

Almost half of all new infections within the U.S. occur among non-Hispanic blacks (U.S. Centers for Disease Control and Prevention 2011a). The Greater Rosemont community of west Baltimore, Maryland, is a predominately African American community that has been severely affected by HIV/AIDS, with three of the four zip codes reporting higher incidence of HIV compared with the city (Maryland Department of Health and Hygiene 2009). Additionally, the community is severely affected by unemployment, poverty, drug use, and crime, which affect and are affected by the HIV epidemic (Adimora and

Schoenbach 2005). This community, once a thriving centre of African American culture, sees itself as a community with identity. There are numerous grassroots organisations working within Greater Rosemont; however, the challenges are daunting at times.

To address the issues and challenges facing Greater Rosemount, a partnership formed between two community resources: GROUP Ministries Baltimore, a non-profit community-based organisation providing transitional housing and job training services to ex-offenders and former substance users, and the Johns Hopkins Medical Institutions (JHMI) including the Johns Hopkins School of Medicine, the Johns Hopkins Bloomberg School of Public Heath (JHSPH), and the JHSPH Center for Communication Programs. This community-academic partnership is working with residents in Greater Rosemont to address structural risks to HIV in the community. Multi-level interventions focus on African American males between the ages of 21 and 50 who have been released from prison or jail within the past 2 years.

Greater Rosemont is one of the most common re-entry points for citizens leaving prison, the majority of whom report a history of drug use (Visher et al 2004). The project aims to promote positive changes in individual and structural risks to decrease prevalence of substance abuse and HIV risk behaviours among

this population. Through an ecological lens, important in the CBPR framework, the connection between employment, housing, and health is realised and addressed.

GROUP Ministries' CEO/President and Deputy Director began collaborating with the JHMI partners initially through the organisation's participation in JHMI- and Baltimore City Health Department-based projects; these projects served as an initial foundation for co-learning and capacity building. Subsequently, a JHMI partner joined the GM Board of Directors, co-wrote a grant with GROUP Ministries, and served as a project evaluator for several GROUP Ministries projects. These interactions, occurring well over 5 years, facilitated the development of a mutual history, trust, and mutual respect, as well as a clear understanding of the framework through which the issues of concern were viewed by all involved: community members themselves, organizational representatives, and academic partners.

In 2006, the Abell Foundation approved a grant that allowed GROUP Ministries to purchase a new house and provide job training in the home construction trade to ex-offenders. This undertaking builds on the strengths of the community by using local talent and businesses to train ex-offenders in housing construction, a vital service needed by the ex-offenders as well as the

community at large. This project provided a catalyst for the expansion of GROUP Ministries' services. The continued collaboration and joint interest in GROUP Ministries' services and expansion plans led to an expansion of the GROUP Ministries-JHMI partnership and development of the research project incorporating these ideas.

This partnership and project, called The Life Changing (TLC) Group, grew to include the initial GROUP Ministries and Johns Hopkins partners, as well as others in the community, city, and university who joined the efforts to address the structural impediments to successful re-entry and recovery among ex-offending substance-using African American men. The community-academic partners developed a memorandum of understanding for the TLC partnership, and by signing the memorandum, partners acknowledge the community identity and targeted issues of local concern, provide a commitment to participate in the co-learning processes, develop and implement action plans to facilitate structural change, practice social inclusion, and contribute to the sustainability of the partnership.

In 2009, the TLC partnership was awarded a grant by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAHMSA) to conduct a multi-level intervention based on

GROUP Ministries' existing services and increase HIV testing in the community. As before, the TLC Group seeks to provide members of the local community with stability through addressing employment and housing needs immediately upon release. This is provided through job training in construction and transitional housing. These programs strengthen the potential for success after re-entry among African American males, and allow them to join a supportive environment.

While in the housing or job training program, the men receive two evidence-based interventions: Motivational Interviewing and *Modelo de Intervención Psicomédica* (MIP). The interventions, designed to reduce drug use and high-risk sexual behaviours, are individually delivered by a trained peer educator from the community, and is supervised by GM's Deputy Director. The peer educator is a community resource that through careful training can be harnessed; being a member of the community he or she understands what is meaningful to those who are similar. The peer educator also builds his or her capacity that can be key for communities as they address other issues within communities.

The community-academic partnership developed an expanded program that combined GROUP Ministries' service components and the Connect to Protect®

coalition building model (Ziff et al 2006), and addressed SAMHSA's goals of increasing HIV testing to vulnerable groups. The TLC Group partnered with the Baltimore City Health Department to conduct HIV testing in the Greater Rosemont community in mobile HIV testing vans and through HIV testing at the GROUP Ministries offices.

Using the funding from the Abell Foundation, SAMHSA, and from an additional grant received from the Open Source Institute, the TLC Group program expanded GROUP Ministries' service efforts to ex-offenders and former substance abusers, improved the stability and well-being of the community, and redeveloped its neighbourhood through employing local community members in housing renovation projects. Through the SAMHSA grant, GROUP Ministries was able to expand their services utilizing local strengths and resources, hire additional staff members from the local community, and train four housing members as community outreach workers and educators (including ex-offenders and former substance users). The outcomes of these activities will be evaluated to demonstrate the role of individual and structural intervention in reducing substance abuse and HIV risk behaviours.

The evaluation will provide partners needed detail to guide group decision-making; it will focus both on the outcomes for ex-offenders and former substance users and the application of CBPR. This commitment to evaluation aligns itself with CBPR principles including co-learning, capacity building, and knowledge generation. Through evaluation, partners can discover what works and what does not work for the benefit of improved programming as well as improved CBPR processes.

The community-academic partners developed the survey to evaluate whether the HIV testing and evidenced-based interventions were reaching the target population, to identify additional needs and resources of the population, and determine if the interventions were successful in meeting their goals. The community and academic partners created two versions of the surveys used to evaluate the program. These were developed over 11 months through discussions and negotiations regarding the question material and wording. Some questions were required by funders; however, the additional questions were discussed, debated, and tested until all partner members were comfortable with the content and wording. The survey development was an iterative and co-learning process, and partners equal participation throughout, blending sound behavioural theory with the lived experiences of community members.

These direct services activities complement the structural change focus of the community coalition, whose members are working to produce an environment where employment and housing are available. Through this, it is believed that the community's reliance on drug use and related high HIV risk behaviours will be reduced. By applying to the state for a Community Development Corporation status, the TLC Group works with a community coalition of community leaders, advocates, and city representatives to acquire houses for renovation by local community members trained or to-be trained in construction.

The TLC Group partners understand that broad community-level change is a long-term process. Committed to sustainability, partners are working to develop a business plan that will allow this work to continue without dependence on external funding. An important component of CBPR is the commitment to sustainability, and by developing this business plan, it is hoped that the TLC Group can continue their work without the reliance on external grant funding.

YOUR Blessed Health: A faith-based intervention to holistically address HIV prevention for youth

Young people are another sub-group at persistent risk of HIV and other sexually transmitted infections (STIs) for a number of behavioural, biological, and cultural reasons (U.S. Centers for Disease Control and Prevention 2011b). Although young people make up only 25% of the sexually active population, they acquire approximately half of all new STIs in the U.S. (U.S. Centers for Disease Control and Prevention 2011b). Youth of minority races and ethnicities are particularly affected (U.S. Centers for Disease Control and Prevention 2010a).

YOUR Blessed Health provides an example of a program aimed at increasing the capacity of faith-based institutions and faith leaders to address HIV/AIDS and other STIs among 11 to 19 year old African Americans. YOUR Blessed Health was developed in collaboration between the YOUR Center, Flint Odyssey House Health Awareness Center, Faith Access to Community Economic Development, Pastors' Spouses of Genesee County, and the University of Michigan School of Public Health (Robinson et al 2010). The primary partner was the YOUR Center, which was established by a social worker in the Flint, Michigan community in response to a community-wide survey that identified gaps and barriers affecting community health and well being.

A crucial component of CBPR is the translation of research into action strategies that address local issues of concern. In Flint, Michigan, HIV and other STI infections were plaguing youth (Michigan Department of Community Health 2007). The YOUR Center, which had become an established local authority in HIV/AIDS prevention and outreach, was approached by a group of pastors' wives who were concerned about the increasing rates of sexually transmitted diseases and teenage pregnancies among African American youth. The pastors' spouses desired guidance in increasing their role in providing HIV/AIDS and sexually transmitted disease education and outreach in their churches (Robinson et al 2010).

Faith-based organisations are considered to be the cornerstone of African American communities and have historically served as an entryway to the community. In response to the pastors' spouses request for guidance, the YOUR Center director asked the faith-based institutions about the possibility of developing an HIV prevention intervention to be conducted within the churches.

 In studies examining the obstacles precluding African American churches from taking a more active role in HIV prevention, the negative religious and moral attitudes about behaviours associated with HIV have been noted. These

attitudes include perceptions about sexual behaviour outside of marriage, homosexuality, and injecting drug use as routes of transmission for HIV (Francis and Liverpool 2009). Partners therefore felt it was important to frame HIV/AIDS as a health issue, and not a sexual or moral issue. The goal for the YOUR Blessed Health was to provide HIV prevention information to youth in the Flint area by improving the capacity building of churches to discuss sexual health and HIV prevention in a non-judgmental manner to their congregation.

From continued meetings with the pastors' spouses, the YOUR Center director began developing an intervention that respected and built upon the faith-based institution's capacity to address HIV prevention. The director approached the intervention development with the viewpoint of the churches as autonomous units whose dignity and self-worth were to be respected (Griffith et al 2010b). These concepts are fundamental aspects of a CBPR framework (Israel et al 1998). The director then reached out to academic researchers and staff from the University of Michigan School of Public Health for further assistance.

Based on the partner's knowledge of the community, the YOUR Center director's history of work in the community, and discussions with the pastors' spouses, the partners developed the multi-level intervention, YOUR Blessed Health. This intervention was respectful of church doctrine and built capacity

around HIV prevention within the faith-based organisations. Although training young people was the primary goal of the YOUR Blessed Health program, changing the norms of faith-based institutions as well as communities was a secondary goal. Through continued engagement, the YOUR Center staff cultivated support for the intervention concept with local faith-based organisations.

YOUR Blessed Health is a unique program for addressing HIV among youth because it educates and trains both youth and adults to address HIV/AIDS, utilising a culturally congruent curriculum for the church setting. Its development was informed by inclusion of the pastors' spouses, participation of the YOUR Center and University of Michigan School of Public Health staff in the churches, and iterative discussion with the church members. The YOUR Blessed Health intervention has five components: 1) a 10-hour, five-session youth training program using the HIV Outreach, Prevention, and Education curriculum (HOPE) which focuses on the basics of HIV/AIDS, STIs, sexual knowledge, communication skills, and helping young people to create individualised risk-reduction plans; 2) a 10-hour, five-session training program for adults in the church and community based on the HOPE curriculum, which provides basic STI and HIV/AIDS knowledge; 3) initial (16-hour) and on-going training and support for pastors, pastors' spouses, and other church leaders who

will conduct the youth and adult training sessions to provide them with the basic knowledge, skills, and resources to lead the YOUR Blessed Health sessions and conduct other church HIV/AIDS educational activities; 4) church-wide activities, including sermons and presentations during the primary weekly service to raise awareness and reduce stigma of HIV/AIDS; and 5) community-wide activities such as health fairs that educate and raise awareness about HIV/AIDS and promote collaboration among different faith-based institutions on HIV prevention (Griffith et al 2010a).

In response to the expressed needs of the pastors' spouses, and through continued discussion with them, the YOUR Blessed Health intervention was developed to allow church leaders and members, including the youth, to select from a menu activities that they desired. Activities included in-reach activities by the church leadership (i.e., "Boys Nite In"), participation in community events (i.e., AIDS Walk Flint), HOPE parties, and pastor-led education in their churches and within the larger community (Griffith et al 2010b).

YOUR Blessed Health was piloted in 2006 and 2007 in 12 churches using evaluation materials developed collaboratively by partners through an iterative and co-learning process. Following the pilot, the partners received funding to

expand the intervention and evaluation to 30 more churches who were interested in the program.

YOUR Blessed Health utilized the strengths of faith-based organisations, and assured that intervention messages and components were consistent with the teachings of faith leaders, demonstrating respect for the denominational doctrines and visions of the pastors and their spouses. Working with faith leaders, the partners were able to accommodate the individuality of faith-based organisations and their congregations to improve the acceptability of the curriculum and the comfort of the faith leaders and their congregations. For example, several of the churches did not incorporate all components of the YOUR Blessed Health curriculum (e.g., nonabstinence forms of safer sex) until support from the congregation increased, and some churches began distributing condoms and providing condom use skills building activities off church grounds to improve the comfort level of congregational members. While the core materials and goals were consistent throughout church settings, churches were able to determine the frequency and timing of sessions and the outreach activities desired. This allowed the church leaders and congregants to adhere to their institutional beliefs, doctrines, and cultures.

Through the process of developing and piloting the faith-based HIV-prevention intervention, the partners demonstrated that interventions must consider how HIV/AIDS and its routes of transmission can be discussed and acknowledged in ways that are respectful to the churches' culture. Working with the pastors' spouses, the YOUR Center and academic partners were able to create an intervention that allows organisations to maintain their individuality and respects the doctrine and vision of the pastor. Building on strengths in the faith-based organisations, an important principle in CBPR, the YOUR Blessed Health curriculum was aimed at producing a sustainable and systemic change in the way that faith leaders and members of congregations address the HIV epidemic in the African American community, and they accomplished this goal through practicing social inclusion in research.

CyBER/Testing: An online intervention to increase HIV testing among men who have sex with men

Men who have sex with men (MSM) are a behaviourally defined subpopulation that is severely affected by HIV/AIDS in the U.S., representing more than half of new HIV infections each year (U.S. Centers for Disease Control and Prevention 2010b). For many MSM, the Internet has emerged as an important tool for social networking and support, meeting friends and sexual partners, and

building community (Rhodes et al 2008). However, seeking sex on the Internet has been found to be a risk factor for HIV and STIs among MSM (Rhodes et al 2002). Thus, many community-based organisations, AIDS service organisations, and public health departments and clinics provide HIV education within Internet spaces such as chat rooms that facilitate social and sexual networking among MSM (Noar et al 2009).

Cyber-Based Education and Referral/Men for Men (CyBER/M4M), an Internet-based intervention designed to reduce HIV exposure and transmission among gay men and MSM who use geographically defined chat rooms, was developed through a community-academic partnership in North Carolina that has existed for more than 10 years and has over 50 current members. The evolving partnership reflects demographic trends and the evolving impact of the HIV epidemic. Partners include representatives from public health departments (local and state level); six AIDS service organisations; community-based organisations, including Latino soccer leagues and teams, the North Carolina lesbian, gay, bisexual, and transgender (LGBT) pride organisation, a local LGBT foundation, local businesses, including media organisations, Internet companies, bars and clubs, a video production company, and *tiendas* (Latino grocers); the U.S. Centers for Disease Control and Prevention; and five universities. Partnership members may be involved with and committed to

different projects; however, the partnership is not study specific. Members may join and leave, but despite transitions the partnership remains. Moreover, partners are not merely tied to a single study or funding source; rather, within the CBPR partnership, members are passionate about HIV and committed to one another – with or without funding. CyBER/M4M developed through this partnership as a result of a request for assistance from a local AIDS service organisation to develop and evaluate an online intervention.

In developing the intervention, however, the partners also looked outwards and took intervention ideas and materials to groups of MSM in the community to get their feedback. Often these MSM were less involved and had perspectives that were not affected by on-going participation in a partnership. Partners understand that the members of their partnership differ at least slightly from those who are not as involved, and the interventions are designed for those who are not involved. Partners, however, valued all perspectives and believed that an intervention for Internet-using MSM could benefit from the perspective of someone who is not a gay man or MSM. Thus, the dialogue that partners engaged in as ideas and perspectives are shared contributed to creativity in intervention development. Not only did the partners want to have diversity of sexual orientation, for example, but they valued diversity of geographic location; it is known that chat-room use differs by geographic community.

Partners also recognised the differences in perspectives that socio-economic status influences. Thus, the partnership goes beyond race/ethnicity and orientation and sexual behaviour and worked to ensure diversity in other proxies of privilege.

Based on piloting the resulting intervention, CyBER/M4M, and the promising results regarding improving HIV testing (Rhodes et al 2011), the partners refined the intervention to focus solely on the promotion of HIV testing. The refined intervention was known as CyBER/testing. This intervention was based on natural helping (Eng et al 2009), and was implemented by an interventionist from the local gay community who had an intimate understanding of the online and geographic MSM communities and who was employed by a community-based organisation partner. The interventionist was trained in HIV transmission, disease progression, and local testing options and processes, as well as in social cognitive theory (Bandura 1994), empowerment education (Freire 1973), effective communication, and the ask-advise-assist model (Whitlock et al 2002). Collaboratively, the partners developed the training manual used.

The interventionist entered chat rooms designed for social and sexual networking among MSM in the catchment area at preselected times of the day and posted standardised triggers about HIV testing and his availability to

provide information. Once contacted by a chatter, the interventionist could provide information about HIV and HIV testing as well as answer questions. To be respectful of the cultural context of the chat room, the interventionist did not send unsolicited instant messages to other chatters. These details are good examples of how social inclusion can positively impact implementation. By working closely with community members, the intervention meets community expectations; at no time was the interventionist ever removed from a chat room. After all, the intervention takes place in Internet rooms designed for social and sexual networking. It was important that the community was involved in the development of the intervention and its protocol to ensure that the intervention met its potential.

Over a six-month period in 2009, the interventionist recruited the chatters to complete a brief online assessment by posting instant messages in the chat rooms advertising a quick and anonymous survey using a different alias. The seven-item survey used binary or drop-down lists to expedite completion and reduce respondent burden. The survey asked about demographics, HIV testing, and knowledge of and interaction with the interventionist. For those who had interacted with the interventionist, an additional question asked if the chatter viewed a video recommended by the interventionist. Preliminary evaluation data of this pilot intervention, based on this quasi-experimental, pretest-posttest

design, suggested this intervention had promise to reach MSM and increase HIV testing rates. However, the partners wanted to confirm this through the use of a longer and more rigorous design.

To develop the more rigorous evaluation study, all partners fully engaged one another in intensive decision-making about all aspects of this study, including research and evaluation methods, intervention strategies, and implementation and dissemination plans. A repeated cross-sectional matched-pair community randomised design with intervention and delayed-intervention arms (Murray 1998) was selected to evaluate the effectiveness of the CyBER/testing intervention. Randomisation of individual participants was not practical due to the communication structure of chat rooms (e.g., all those in the chat room can see public instant messages), and thus one community within each matched pair was randomised to the intervention or delayed-intervention group. As a result of concerns about the ethics of withholding a potentially valuable intervention from some members of an already vulnerable community, a delayed-intervention design was utilized. Evaluation is on-going.

The partnership was successful using a stepwise approach moving slowly from formative research and pilot studies to more rigorous designs. During this process, community members learned about the power and usefulness of

evidence and non-community members learned what is both feasible and meaningful within communities.

CONCLUSION

The projects discussed above utilize the nine CBPR principles to include community in the research, intervention, and evaluation process to reduce HIV/AIDS disparities in the U.S. No one set of principles is applicable to all community-academic partnerships (Israel et al 2005), and these examples demonstrate the diverse ways in which partnerships and projects use CBPR as a form of social inclusion. The principles guiding partnerships are instead a reflection of the collective vision of the partnerships. These principles, therefore, are applied in various ways within community-academic partnerships, demonstrating multiple approaches to CBPR.

As documented through these examples, CBPR can address the immediate risks to HIV infection through the development of community-relevant research and interventions to address individual behaviours and structural vulnerabilities. As other research has demonstrated, CBPR can also address the deep-seated causes of disparities through social inclusion and building community capacity to address social determinants of health (Schulz et al 2002). Throughout this

chapter, we have provided detailed examples of how CBPR is being used in the U.S. to include affected communities in research to prevent HIV/AIDS through community-academic partnerships. Partnerships that develop are unique, as are the projects chosen to address local HIV prevention, and thus we have provided a snap shot into a diverse field by describing these projects at various stages in the research process. However, guided by the principles of CBPR, these partnerships and projects are united in their belief that through social inclusion in research, community-academic partners can develop a more comprehensive approach to prevent HIV among our vulnerable populations, and address the inequities in health.

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