Context and group dynamics in a CBPR-developed HIV prevention intervention

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SUMMARY

This paper will explore in detail the effects of context and group dynamics on the development of a multi-level community-based HIV prevention intervention for crack cocaine users in the San Salvador Metropolitan Area, El Salvador. Community partners included residents from marginal communities, service providers from the historic center of San Salvador and research staff from a non-profit organization. The community contexts from which partners came varied considerably and affected structural group dynamics, i.e. who was identified as community partners, their research and organizational capacity, and their ability to represent their communities, with participants from marginal communities most likely to hold community leadership positions and be residents, and those from the center of San Salvador most likely to work in religious organizations dedicated to HIV prevention or feeding indigent drug users. These differences also affected the intervention priorities of different partners. The context of communities changed over time, particularly levels of violence, and affected group dynamics and the intervention developed. Finally, strategies were needed to elicit input from stakeholders under-represented in the community advisory board, in particular active crack users, in order to check the feasibility of the proposed intervention and revise it as necessary. Because El Salvador is a very different context than that in which most CBPR studies have been conducted, our results reveal important contextual factors and their effects on partnerships not often considered in the literature.

Key words: community-based participatory research; drugs; HIV/AIDS interventions; Latin America

The benefits of community-based participatory research (CBPR) have been argued extensively in the literature. CBPR brings together members of affected communities, service providers and academic researchers as equal partners in defining health problems, designing research questions and collecting formative data, and using data to develop appropriate interventions (Israel et al., 2003; Wallerstein et al., 2005; Braun et al., 2011). Community participation has the potential to increase the relevance of interventions meant to improve community well-being by creating interventions that reflect communities’ perceived needs and that are culturally appropriate (Anderson-Lewis et al., 2012; Andrews et al., 2012; Horowitz et al., 2011; O’Brien and Whitaker, 2011; Schultz et al., 2011; Spiegel et al., 2011). In addition, CBPR can increase communities’ capacity and commitment to implement, evaluate and sustain the intervention because they were active partners...
in its design (Andrews et al., 2012; Spiegel et al., 2011). CBPR has been used to develop and implement interventions in developing countries, with much reported success (DeCaro and Stokes, 2008; Dangles et al., 2010; Rheinlander et al., 2010; Levinson et al., 2013). CBPR can be particularly useful in resource-limited settings where public health monitoring is not ideal and community collaboration is necessary in order to gather accurate data on a community (Dangles et al., 2010; Levinson et al., 2013). Community participation in developing countries can also help expand prevention, screening and treatment of health problems, such as HIV or cervical cancer, into areas where there is little or no access to health care (Orr et al., 1997; Levinson et al., 2013).

In spite of the benefits of CBPR approaches to improving health, many gaps remain in the science of CBPR (Wallerstein et al., 2011). These include understanding the context in which partnerships are formed, the group dynamics of the partnership and the interactions between context and group dynamics (Wallerstein et al., 2011). Socio-economic, environmental and cultural factors form the context under which partnerships form. For example, some health problems that disproportionately affect marginalized communities, such as substance use and HIV, may be highly stigmatized and community residents may not wish to address them for fear of further negative stereotyping of their communities. Additional contextual factors include national and local policies. These may be particularly salient features of the context in which CBPR occurs in developing countries, where many poor residents may be mistrustful of neglectful or oppressive governments, and where their daily survival needs are seen as much more pressing than government health priorities (DeCaro and Stokes, 2008; Rheinlander et al., 2010). Finally, though seldom considered in the literature, is the effect a context of violence and insecurity can have on partnership formation and the practice of CBPR (Knox, 2001).

The project described in this paper occurred in the San Salvador Metropolitan Area, El Salvador, with its own unique macro-social context. Violence is a significant part of the urban Salvadoran context. El Salvador is one of the most violent countries in the Western hemisphere, with homicide rates in 2006 of 69 per 100 000 in San Salvador and 100 per 100 000 in Soyapango, part of the San Salvador metropolitan area (Comisión Nacional para la Seguridad Ciudadana y Paz Social, 2007). Much of this violence has been attributed to street gangs, whose numbers have steadily increased since the early 1990s, with some estimates of over 20 000 gang members in El Salvador (Alvarenga and Gonzalez, 2003). Violent crime has also been attributed to the ineffective police and judicial system in El Salvador (Winton, 2004; Cruz, 2005). Fear of repercussions from criminal elements may impede community partners from participating in CBPR and limit the issues they are willing to address.

The micro-social context of the different neighborhoods within San Salvador is also unique, including leadership structure, infrastructure, experience with political organizing and sense of belonging to a community. These factors differed across the two distinct kinds of low-income community with whom we partnered, Marginal Communities and Older Central Communities. Marginal Communities formed as squatter settlements on vacant land by people displaced due to natural disasters or the civil war. Residents initially constructed housing out of scrap metal and cardboard and lived for a number of years without sanitation, potable water or constructed roads. All the marginal communities included in this study went through a process of obtaining legal tenure of their lands and received housing and infrastructure improvements through international aid organizations. International aid was frequently contingent on obtaining legal ownership of the land, and residents organized politically by forming community boards of directors to obtain this legal recognition and retain their lands. Much of these infrastructure improvements and subsequent projects to improve community life have used a ‘mutual help’ approach in which local and international NGOs offer training and materials while residents provide the labor to complete projects. Thus, while marginal communities are poorer in overall community infrastructure and housing, plagued by violence and crime, and often located in areas prone to landslides, they have a history of political organization and a clear leadership structure. They also have a history of providing necessary services (Dickson-Gomez et al., 2010) to the community that are not provided by the government.

Older Central Communities are located in the historic downtown areas of the capital. These were once mixed income commercial and residential areas, but in the last decades the quality of housing stock has deteriorated considerably. Currently, Older Central Communities are characterized by a highly transient population of
drug users, ambulatory sellers and commercial sex workers who reside in mesones—boarding houses formed from old colonial style houses consisting of one room residences and communal bathroom and kitchen facilities—or emergency shelters. Religious and secular service providers, who provide meals, drug treatment, emergency shelter or HIV prevention, constitute a more permanent presence in Older Central Communities (Dickson-Gomez et al., 2010).

Group dynamics have also been understudied in the CBPR literature to date (Wallerstein et al., 2011). Group dynamics include both structural and relational dynamics. Structural dynamics include the nature of the partnership, its composition, the extent of diversity of its membership, the complexity of the membership and the issues the partnership aims to address (Wallerstein et al., 2011). Relational dynamics refers to the interactive and communicative processes used to negotiate work, relationships and identities, ways of resolving conflicts and recognizing power dynamics. Context and group dynamics also interact in various ways including who can participate, the health priorities chosen and levels of partners’ trust in the CBPR process (Wallerstein et al., 2011).

In seven different low-income communities in the San Salvador metropolitan area, local and US investigators performed 2 years of qualitative and quantitative research to understand the social context in which crack is used and sexual risk occurs. This research indicated that 60% of crack users had never had an HIV test and had very high levels of sexual risk behaviors in the last month, including sex with multiple partners (56.7%), unprotected sex (58.6%), sex for money or crack (13.1 and 15.3%, respectively) and an HIV prevalence estimated at 4.9% (90% CI 2.8–7.8%) (Dickson-Gomez et al., 2013). In-depth interviews revealed that crack users and other community residents mistrusted getting free HIV tests from the Ministry of Health, based on a suspicion that Ministry would report false negatives in order to avoid paying for anti-retroviral treatment the Salvadoran government offers for free (Dickson-Gomez et al., 2010). This research also identified a number of assets that could be used in developing and implementing an HIV prevention intervention, such as community boards’ of directors (elected legal representatives of marginal communities), experience with political organizing and community engagement, and religious and non-governmental organizations that worked to prevent or treat drug abuse or prevent HIV (Dickson-Gomez et al., 2010).

This paper presents the process of developing a multi-level HIV prevention intervention in this area of urban San Salvador and, in particular, the effects of context and group dynamics on the process and the intervention ultimately developed.

**METHODS**

Results of the formative qualitative and quantitative research were presented in town hall meetings to which all community members were invited and which were held in community centers within each of the seven communities. Invitations to attend the meetings were passed door to door within the communities by the research team and members of the community boards of directors. The research team included six research staff from the research department of FUNDASALVA (the Anti-drugs Foundation of El Salvador), a non-governmental organization with the mission to prevent and treat substance use and two university researchers from the USA. FUNDASALVA staff had university degrees and many years conducting qualitative and quantitative research with the first author. An average of 35 community members attended Town Hall meetings, including community board of director members, parents and adolescents.

After presenting results, we asked for volunteers and invited participants to attend monthly community advisory board (CAB) meetings to help develop an intervention. CAB meetings were held between October 2008 and June 2009 to address the needs and use the resources identified in the formative research. Based on research findings, the research team identified three general objectives while leaving intervention components to achieve these aims open to the CAB: 1) to increase testing rates among crack users; 2) to change the social context of drug use sites to reduce sexual risk; and 3) reduce sexual risk behaviors of individual crack users. CAB meetings followed a social-ecological model to identify causes and potential solutions to drug use and HIV risk, and used small group work, team building and an assets-based approach to identify community resources that could be used in the intervention. CAB meetings used a co-learning process, with research partners providing information about drug addiction, HIV transmission and
successful HIV prevention interventions and community members helping to define the causes of the problems of drug use and HIV in their communities, and feasible ways of addressing these. The CAB had a total of 36 participants throughout the 8 months, in addition to the research team, although no partners were able to attend all 9 sessions and some stopped attending altogether. Community partners attended a mean of three sessions, with a range of one to seven sessions.

**Data collection**

Salvadoran project staff who were not involved in facilitating Town Hall or CAB meetings wrote observations on laptop computers as the meetings took place. These notes were then expanded into ethnographic fieldnotes that included the topics discussed, members who participated and those who did not, participants’ comments, reactions and questions, attendance and any information regarding absences (e.g. someone called to say they would miss due to a conflict with work). A total of 14 observation fieldnotes were recorded (8 CAB and 6 Town Hall meetings).

Four semi-structured interviews were conducted and audio-recorded by M.C., a US community health educator with a Master’s in Public Health. Participants (n = 8) were CAB members who resided in different communities and who attended most or all of the CAB meetings, and included two community board members from Marginal Communities, two active Marginal Community residents, a health promoter for an Older Central Community, a director of a soup kitchen for indigent drug users from an Older Central Community and a reverend who ministered to a congregation serving lesbian, gay, bisexual, transgender and questioning (LGBTQ) communities and his wife. Interview participants reflected the overall CAB composition which included community leaders, religious and NGO staff, active residents, crack users and health promoters. Interview topics covered structural dynamics and context that influenced the CAB process, including facilitators and barriers to participating in the CAB, what partners hoped to achieve through participation, whether partners felt that they had reached their goals in participating, and what they felt their role in the CAB was. In addition, we asked about relational dynamics including the general functioning of the group, how conflicts were resolved, how decisions were made, power dynamics, and whether all relevant voices were represented and heard in the CAB. We then asked about the initial intervention proposed and whether they felt it would be feasible and acceptable in their communities. Finally, we asked partners to reflect on how they were able to communicate the work of the CAB to other members of their communities, and whether community members were in agreement with the proposed intervention.

In a debriefing session with the six members of the FUNDASALVA staff, M.C. led a discussion to follow-up on questions that remained after the in-depth interviews, such as why particular partners stopped participating, as these were people we also were unable to successfully locate for in-depth interviews. We also asked for insights into community changes that affected partners’ participation in the CABs and the reactions of the community to their participation and the proposed intervention. Finally, we asked staff about their perspectives on misunderstandings and conflicting ideas among partners regarding the proposed intervention and next steps.

Focus group interviews were conducted and audio-recorded by G.B., a clinical psychologist who directed the FUNDASALVA field team, with two groups of community residents (n = 8 in each group) and two groups of crack users (n = 5 and n = 6) to present the two major intervention components: an intervention to increase HIV testing among crack users and a network-based HIV prevention intervention. Participants for all groups were invited by members of the CAB. Focus groups lasted ~90 min and participants received $5 for attending. Participants were asked whether they felt the proposed intervention components would be feasible and acceptable, potential problems with the approach and proposed solutions. These focus groups were necessary to gather opinions of affected community members that were not present in the CAB meetings in spite of our efforts to include them, in particular crack users.

**Data analysis**

All interviews, focus groups and the debriefing session were transcribed verbatim. Observations were written into detailed field notes. All data were analyzed using Atlas.ti (Muhr, 1997–2004). Data were coded for broad themes related to context (e.g. community of origin, community resources, community priorities), group dynamics
(e.g. partners present, degree of participation, disagreements, conflicts, facilitators to participation, barriers to participation) and reactions to the intervention (concerns about confidentiality, safety). All data were coded collectively by the field team. Disagreements were discussed until consensus was reached.

RESULTS

Context and social dynamics

Community partners/leaders

The differences in context between Marginal Communities and Older Central Communities determined the structural dynamics of the CAB membership, i.e. who communities chose and who was able to participate as community partners. Partners from Marginal Communities included members of the Community Board and other residents actively working to improve their communities, such as running youth groups, providing catechism classes or working with the Ministry of Health’s health promoters to organize vaccinations and other health-related events ($n = 15$). Community partners from Older Central Communities, on the other hand, consisted entirely of staff working in religious or non-governmental organizations that provide services to indigent drug users or the LGBTQ community ($n = 10$), as there were no organizations that represented community residents. Similarly, there were few formal NGOs in Marginal Communities. Crack users from both Marginal and Older Central Communities ($n = 2$) and government health workers serving the communities were also invited ($n = 2$), but inconsistently attended CAB meetings. Leaders from the Salvadoran Ministry of Health’s Division of HIV/AIDS and STIs were also invited and attended at key moments to gauge the Ministry’s potential support for particular intervention ideas.

Priorities and objectives

Priorities and objectives of partners from Older Central and Marginal Communities differed, affecting relational dynamics. Leaders from the Older Central Communities were primarily motivated to participate to better serve their clients, for example finding ways to help clients who were homeless crack users with their addictions. Those who worked in HIV prevention were motivated to expand HIV prevention to crack users. At the time the CAB meetings occurred, no HIV prevention interventions existed in El Salvador for active drug users. Rather, prevention efforts were focused on the general population, through general education and a national HIV testing day, or, to a lesser extent, men who have sex with men and commercial sex workers (Dickson-Gomez et al., 2010).

Older Central Community Partner, Reverend of a Ministry for the LGBTQ community: Right away, when they told us crack users, that attracted us, because I’ve been in HIV for 4 years, and with multi-sector coordination at the national level, where decisions are made about this and the topic of crack users isn’t considered. Of course, it requires a lot of material, management, training, and we don’t have it, but we do have all the will and that’s why we came.

In contrast, although crack use was seen as a big problem among partners from Marginal Communities, crack users were often seen as part of the problem. Direct intervention with crack users was not a priority for Marginal Community partners. In a values clarification exercise, for example, many Marginal Community partners endorsed statements such as ‘Drug addiction is a vice’ and ‘Crack users don’t want to stop using’. Partners, while personally knowing many family members and neighbors with drug problems, did not have much experience seeing substance abusers successfully recover from their addictions. Similarly, although Marginal Community partners generally recognized that anyone could become infected with HIV, many endorsed statements such as ‘HIV is a punishment from God’ and ‘Homosexuality is a sin,’ and associated HIV with ‘immoral’ behavior. Partners from Older Central Communities were less likely to endorse such statements, even though many came from religious organizations, probably due to these organizations’ missions to assist drug using LGBTQ populations. Marginal community members, thus, wished to focus on youth so that they might avoid falling into drug use, HIV risk and gang membership.

Marginal Community Partner, Board of Director Member: My motivation always has been the youth, the school children, because the children worry me a lot. The gains that I wanted was always to give this help to youth . . . so that the children aren’t lost, to bring them something good, but starting with them early . . . because my little girl, she’s suffered a lot, psychologically they traumatized her. The other little girls, little sisters of older gang members.
As can be seen in the quote above, many partners from the Marginal Communities had very direct experience with violence and drugs, and real fears for themselves and their children. However, as we will discuss further below, for partners from communities plagued by violence, working in educational programs through the schools also may have seemed safer than working directly to confront drug use, or to address the problem indirectly through HIV prevention with active drug users. Thus, community context (violent crime) affected structural dynamics as partners were not only motivated to address the problems that seemed most salient in their communities but also to address them in ways that would not put themselves or their families at risk.

Differences in values between partners from different communities were discussed in small groups. Although no one attempted to persuade others to change their beliefs and there was no open conflict in these discussions, consensus was reached through mutual understanding and negotiation, at least according to the partners who participated in in-depth interviews.

Older Central Community Partner, Reverend: There were disagreements and I remember some on the topic of HIV that agreed that it was a divine punishment... but at least in the groups I was participating in we resolved them negotiating or seeing both sides that were in dispute and you participated trying to conciliate, right, and maybe first agreeing with each but establishing differences, or in time trying to reconcile because there really were disagreements in the group dynamics.

Information was provided by researchers in subsequent meetings explaining the changes in the brain caused by substance use and comparing substance abuse to other chronic conditions such as diabetes. These helped persuade some members that addiction is a disease rather than a moral failing. It should be noted, however, that the decision to focus on crack users was already decided upon in the funded research proposal. Thus, Marginal Community partners were limited in their power to negotiate intervention priorities. While Marginal Community partners may have come to see crack users as worthy targets of intervention efforts and capable of change, they remained steadfast in their desire to intervene with the youth in their communities. A compromise in intervention goals was thus reached and will be described in more detail below.

Intervention expectations

In the Salvadoran context where many basic services (such as community infrastructure) are not provided by the government, all community partners had experience collaborating with national and international organizations to improve their communities or meet their organizations' missions. However, these were most often ‘top-down’ programs and partners had little experience with helping decide their directions or components. Community residents' role was often to organize themselves quickly to put into practice already funded projects.

Older Central Community Partner, Reverend: When we came the first time, we thought that FUNDASALVA had made a decision to implement a project now, that same day, the same week, and we were collaborating as volunteers. But in reality we had to decide to continue or not, or leave or stop when they told us that there were nine sessions, nine Saturdays or nine months to attend. Maybe we misunderstood because we thought that it was going to start that same day, but it wasn’t like that, but we made the decision to finish all the workshops, alternating [attendance with him and his wife].

Although the research partners explained at every CAB meeting that this was a process to develop an intervention, and that we would then seek funding to implement and evaluate it, many partners continued to believe that the meetings were the intervention itself. For these participants, their job as community partners or leaders was to impart the knowledge that they were learning to others in their community, and even to bring people that they felt needed help to the sessions themselves.

Partner, Marginal Community, Active in Community Organizing: For me [the intervention is] in my community you can do a meeting so that everyone knows what we’ve learned, right? So that what we’ve learned can multiply... For example in my community there’s a man who is a drug addict. And I already told him, ‘Look, this is bad what you’re doing’. ‘I can’t quit,’ he says. I tell him, ‘Next time I go to a meeting I’m going to take you, because you don’t believe me what I’m learning’.

Part of this misunderstanding had to do with community partners’ lack of experience with evidence-based interventions and research in general. For most, HIV prevention consisted of giving out condoms and providing information
about how to prevent HIV, as most HIV or other health interventions in El Salvador are not theory based. Thus, the woman’s desire to impart the knowledge she gained to others in her community, and Marginal Community partners’ initial desire to focus on providing information to school children on ways to prevent drug use and HIV infection is understandable.

In addition, the context of ‘mutual help’ in marginal communities in which foreign NGOs provided training and materials which community residents were then expected to use to improve their communities infrastructure may also have contributed to the misunderstanding. The type of ‘mutual help’ provided to communities by international NGOs also was most often short-term projects, and long-term partnerships between marginal communities and non-governmental organizations were relatively rare. In fact, many participants had experiences of projects, particularly those to do with drug addiction or community health, which stopped at giving residents information. While CAB members were used to this model, they also saw its limitations, in particular, in addressing problems that required sustained effort.

(CAB: Female marginal community resident). A little while ago we had a talk [about HIV] from a doctor that had come from Cuba . . . She gave us a talk to like 30 to 35 youth and a few adults. So it was really nice, it was enriching but it stayed there, right, because sometimes the community forces, I mean as community leaders we try to support a part but when there isn’t any support from some institutions or from the Ministry of Health, it’s not much you can do. So it just stayed in talks, and we know real cases [of people at risk for or infected with HIV], unfortunately.

These experiences may have led some CAB members to mistrust the CBPR process, seeing it as simply giving talks and not providing support for action. For many CAB members then, it may have made sense in this context to try to disseminate HIV prevention information as widely as possible so that the people in their community who they felt needed it could benefit.

Community context and structural dynamics

Marginal Community and Older Central Community partners also differed considerably in their ability to make decisions for the communities they represented. In other words, differences in communities’ historical context led to differences in structural dynamics. This became evident after intervention plans were formalized and we sought letters from community partners to include with our funding proposal. One of the Marginal Community partners, who was active in the community but not a member of the board of directors, volunteered to present the project to her community’s board of directors and to petition their support. The board of directors initially declined to support the project. After this experience, she stopped participating in the CAB board meetings and was unable to be reached. In the debriefing session, members of the research team reported that they suspected that she was avoiding their calls. They also suspected that many important voices with the capacity to make decisions were not in attendance at the meetings.

VN, Salvadoran Research Partner: I think that working to involve all the institutions might be more productive . . . I think a representative of an organization might have much more impact than the person that just comes from a particular community, because for us they’re the representative of that community, but for the community someone who is working in [an institution] might be more representative.

Marginal Community partners included people who were leaders of the board of directors or in other community activities. An informal selection process by community residents themselves occurred during the Town Hall Meetings in Marginal Communities where community board members or others involved in community organization efforts were encouraged by other residents to volunteer for the CAB. In Marginal Communities, few organizations exist that could represent the community or any segment of it. However, representing a diverse community of residents and being able to make decisions on their behalf is considerably more complicated than representing or making decisions for an organization with a unified vision and mission. We worked with community residents by necessity in order to include Marginal Communities in our intervention development process. In contrast, Older Central Community partners did not have the same problems in committing their institution’s support, although in many ways the ‘community’ they represented consisted only of their institutions and not the transient population of drug users and commercial sex workers who lived there.
Changing contexts

In addition to differences that context made on structural dynamics in general, communities’ context also changed over time. This too affected structural dynamics. In the case above, the board of directors’ reluctance to commit their support to the project may have had to do with changes within the community as violent crime increased. The board of directors of this community was very supportive during the formative phase of the project. However, gang- and drug-related violence had increased within the community during the same period that our community partner was soliciting support from the community board. Thus, board members of this community may have felt that working with active drug users might antagonize gang members and drug dealers and they may have feared reprisals.

MOZ: Also we’ve learned that [the community] has become a little difficult in terms of the violence, the gangs, and drug selling too. So the zone has become more difficult... So now it seems that every entrance is guarded and the people of the community don’t want to talk... Any time it’s drugs, gangs, or any concrete question, the people say, ’I can’t talk about that’.

MC: Even though it doesn’t have anything to do with the intervention, that’s just about offering the [HIV] test?

KR: Exactly, exactly. But, you know what happens? What happens is that the gangs don’t understand that, the people in gangs are just, ‘Ah, but it could be that it will hurt me in some way’ and so they simply close the doors, and they’re right to say no, really with all the things that happen in our country.

It is important but seldom noted in the literature that in communities of violence and high crime, like low-income communities in San Salvador, context can change rapidly and profoundly affect the CBPR process.

Intervention

Contextual factors influenced structural group dynamics, i.e. who was able and willing to collaborate in intervention development. This, in turn, influenced the intervention initially developed. Because some voices were noticeably absent in the CAB, in particular active crack users, it was necessary to include other community members in focus groups to check the feasibility and acceptability of proposed intervention components. In debriefing sessions, FUNDASALVA staff attributed the inconsistent attendance of crack users to relapse or increased drug use. Most crack users who participated even sporadically were in recovery and not active crack users. While it was also difficult to get active crack users to come to focus group interviews, there may have been additional barriers to their participating in the CAB. As expressed above, crack users were highly stigmatized by other members of their community. Many crack users expressed, ‘We are a sore on society’.

In order to increase testing rates among crack users, the CAB initially came up with a plan to train community members to offer free rapid HIV tests within their communities of residence. Partners felt that this would overcome the mistrust of obtaining accurate results from Ministry of Health clinics, as well as address the concerns of community partners who wanted to offer services to youth, whom they felt were also at risk for becoming infected with HIV. We presented this idea to two focus groups, one made up of crack users and the other of community residents who had not participated in the CAB meeting. Both groups expressed considerable concern regarding the ability of community members to maintain the confidentiality of HIV test results, feeling that community members trained as HIV testing counselors would feel obliged to reveal that someone is positive in order to protect their neighbors, friends and family from becoming infected.

Participant 4 (Male Crack User): I was born in the colonia and everything. You know your people, the people around you. Something happens and there it goes in a chain. So maybe the people you choose to give the test... wouldn’t say anything, but yes you would feel that fear that it’s going to get out, if it’s positive or negative... I think it’s our culture... Well, an example, imagine you come out positive and that person, you’re maybe going out with one girl and with another, and suddenly that person who gave you the test and who supposedly lives in the same community comes to see you with a person, then I think that that person in order to prevent the sickness from spreading, can come and say to the other person, ‘Hey, look this person has AIDS’

Participant 1 (Male Crack User): I’m going to tell you something. Once I fell into a depression. My mother had died and I was three months without leaving my house and people thought that I had AIDS. You know? That I had AIDS! From one mouth all this spread to the whole colonia, the whole colonia!!
While these crack users lived in urban environments, marginal communities in particular are very small and enclosed communities where everyone knows everyone else. This in part has to do with the physical layout of marginal communities, where houses are arranged along pedestrian only alleys, not through streets. Gossip and rumor ties, where houses are arranged along pedestrian ways, not through streets. Gossip and rumor have been recognized as a form of social control in closed communities by anthropologists for years (Rosnow and Fine, 1976). These mechanisms of social control are particularly important in contexts such as urban San Salvador where formal mechanisms of social control such as the police force or public health system are viewed as ineffective (Dickson-Gomez et al., 2010; Dickson-Gomez, 2010). Crack users participating in the focus group came up with a solution to this problem and suggested that we use social networks to bring people in for an HIV test administered within the community by non-residents, using a system of coupons and dual incentives.

The CAB had also proposed a peer-led HIV prevention intervention in which we would train active crack users to provide HIV prevention information and materials among their peers in community settings. This was initially appealing as such interventions have been shown to be successful among drug users in urban settings in the USA and developing countries (Latkin, 1998; Latkin et al., 2003; Hammert et al., 2006; Weeks et al., 2009), and because crack users would have access to crack users at the times and places where risk occurs (Dickson-Gomez et al., 2006). Crack users who participated in a focus group to discuss this idea, however, feared that HIV prevention outreach to their peers in community settings would cause violent reprisals from drug dealers.

Male participant: [The drug dealers'] fear is about everything. First, because we can take away his business. Second because we could kill him. A person who deals drugs is at great risk. The dealer down the street can take his business. Look between friends, brothers there’s a fatal selfishness. If you’re doing well, the other doesn’t like it, and if you don’t give it to me the easy way, I’ll take it by force. Besides, there’s a lot of detectives that are, ‘I want rock’ to see where they’re selling drugs. How many years do they get in prison? It’s a risk. It’s true… they earn bills [but] they get into big problems inside [prison]. Look, there on the block I could [talk to drug users about HIV] because they know me… but in San Miguelito I won’t go because they don’t know me… They’ll put a gun to my forehead and you can see me as really bad ass, but with a gun at your head, who’s going to fight?

According to crack using focus group participants, in the context of drug selling in El Salvador, stakes are too high for drug dealers to tolerate groupings of crack users on the street and are unlikely to believe that they are there simply to improve the health of their peers. Drug dealers’ fear is not just about getting arrested, but about getting killed or injured as someone tries to take away their business. More importantly, crack users expressed that they simply were not willing to take the risk of conducting peer outreach themselves in this context.

Crack users in the focus group were also concerned that having HIV prevention interventions focused exclusively on crack users might serve to further stigmatize them. To avoid this, they suggested having HIV prevention activities that were open to the entire community.

Male participant: People are dumb. There are people who don’t know what HIV is. They only know it as AIDS. In the Tinetti market if you put ‘HIV’, the women in the market say, ‘What is that HIV?’ and then when you say ‘AIDS’ and see addicts lining up, ‘You have AIDS? What are you doing there?’ So you need to involve people, leave it open, not just to the addicts, because I assure you that if you go to the community where I live and you put ‘HIV test’ only for addicts, then everybody, including if there are incentives, all the people will point and would say, ‘Oh, you have AIDS’. They would shout so you would feel bad. Although they may be really crazy in the head [high], they would feel bad. So it should be for the community in general.

Again, crack users were highly concerned about rumor and gossip within their communities.

In the end, the CAB decided on an intervention with small social networks made up of crack users who knew each other and community-wide HIV prevention events and monthly HIV prevention talks that would be open to the entire community. These larger community-wide events have also allowed us to focus on populations, such as school aged youth, that were priorities for Marginal Community partners. The intervention is in process as of the writing of this paper.

DISCUSSION

Our results indicate the importance of considering the interactions of social context and...
group dynamics in analyses of CBPR partnerships. Our community partners, or those who were identified as leaders or representatives of their communities (structural group dynamics), differed greatly according to the type of community they were representing (context). Leaders from Older Central Communities were volunteers or service providers in organizations dedicated to serving commercial sex workers, homeless drug users or LGBTQ communities. In contrast, leaders from Marginal Communities were members of boards of directors or active in organizing other groups to improve their communities, e.g. youth groups. In turn, this diversity in group structure and context affected partners’ values and priorities. Marginal Community partners initially tended to see crack users as problems in their communities and wanted to focus on preventing youth from becoming drug users, gang members or HIV infected. Older Central Community partners, on the other hand, saw value in intervening with this ignored and marginalized population.

The interactions between context and structural dynamics were not only present during intervention development, but also when CAB members attempted to gain wider community support to implement the developed interventions. Although Marginal Community members may have come to believe in the intervention approach, the larger communities they represented had not gone through the CBPR process and did not initially support intervention ideas. It was difficult for Marginal Community partners, albeit influential leaders in many ways, to represent the diversity of opinions of a residential community. Older Central Community partners, on the other hand, had no such difficulties, as it is easier to build consensus within an organization with a unified mission. Barriers to participation were also greater for some partners, particularly active crack users. This and the fact that not all voices of Marginal Communities could be represented in the CAB necessitated additional focus groups with crack users and community residents not part of the CAB to gather their input on intervention ideas.

With regard to relational dynamics, while CAB members who participated in in-depth interviews felt that differences in values and priorities were overcome through listening and consensus building, it is possible that these differences may have led some participants to stop attending the CAB. This is a limitation to the analysis presented here, as we were unable to interview those who stopped attending CAB meetings. FUNDASALVA continued to contact and invite all members who had attended any CAB meetings. Staff heard from other CAB members from their communities who continued to attend that the reasons for non-attendance included work conflicts and, for crack users, drug relapse. It is difficult to determine, however, the extent to which relational dynamics, including differing values or disagreement with the decisions made in meetings contributed to non-attendance among some. In El Salvador, it is often considered impolite to openly disagree with someone or express negative emotions. Rather, criticism or disagreement is often expressed through ‘indirect’ comments, in which someone comments on a disapproved behavior or opinion in the third person within earshot of the offending party, or by not accepting an invitation. Much has been written in the CBPR literature about the role power differences can play in the partnership process (Chavez et al., 2003; Israel et al., 2003). Researchers involved in CBPR in other countries also must be sensitive to cultural norms around expressing differences of opinion in order to interpret indirect expressions correctly.

Results from our study demonstrate the importance of looking at CBPR processes longitudinally. Community context changed over time, which affected whether partners could participate in the CAB and support the intervention (structural dynamics). Partners from one Marginal Community suspended activities with the CAB due to increases in violence and lack of support from the board of directors. It is important that research partners be aware of these changes in the community, not only to help explain the evolution of the CBPR partnership over time, but in order to adjust intervention and research ideas to address the real fears and concerns of those whose lives are plagued by violence.

Differences in the perceived threat of violence among different partners also affected structural dynamics, namely partners’ intervention priorities and expectations. Marginal Community resident partners were less inclined to focus on providing direct interventions with crack users, perhaps due to fear of reprisals from drug dealers or gang members who may see such an intervention as interfering with their business. This fear was more directly expressed in separate focus groups with active crack users who were clear that providing HIV intervention information and materials in the community would cause a violent response from drug dealers. Violence in
the context of urban El Salvador affects almost every decision citizens make, including whether to participate in community-building activities. Participants expressed doubts about the ability of the police to protect them from criminal reprisals (Dickson-Gomez et al., 2010). Fear of violence may be qualitatively different than in developed countries where, while police may be mistrusted in the community, some semblance of the rule of law and the power of the state to intervene to prevent violence and punish offenders remains, and where homicide rates are comparatively low.

While fear of violence affected community partners’ ability and willingness to participate in the CAB, their sensitivity to potential violence resulted in the eventual development of more feasible community interventions. While peer-led interventions, in which members of at-risk groups conduct HIV prevention interventions with their peers in the community, have been found to be effective in many developing countries (Latkin et al., 2003; Purcell et al., 2004, 2009), an intervention of this sort would likely have failed in urban San Salvador. After consulting with crack users in a focus group, we opted to intervene with small networks of crack users in order to build social support and group norms around risk reduction. This approach has been used successfully with drug users (Trotter et al., 1995; Rothenberg et al., 2001), and may be particularly effective in contexts in which drug users are mistrustful of people outside their immediate social group. Similarly, crack users were concerned about HIV testing confidentiality and stigmatization in the context of neighborhoods in which all residents know one another and gossip is prevalent and suggested encouraging HIV testing by using coupons and dual incentives (for the recruiter and the person recruited). Results from social network interventions to increase testing rates among populations most at risk for HIV had just recently started being published when this suggestion was made, and researchers and partners agreed that this would work well with this population (CDC, 2007; Kimbrough et al., 2009).

While this paper described the effects of context, group dynamics and the interactions among the two on intervention development, it is also important to carefully examine their effects on the implementation and effectiveness of CBPR-developed interventions (Wallerstein et al., 2011). Evaluations of outcomes of CBPR-developed interventions are rare in the literature (Wallerstein et al., 2011). The intermediate step of examining how group dynamics and context affect implementation is perhaps equally or more important. For example, it is likely that the context of violence and community members’ responses to that violence will affect the effective implementation of the intervention. Some intervention activities may need to be suspended due to increases in violence, or intervention components may be adapted to changing contexts. Likewise, changes in community priorities or leadership structure are likely to impact implementation of the intervention. These, in turn, are likely to affect outcomes and may help explain different outcomes in different contexts or implemented by different partners. Expanding CBPR’s long focus on partnership dynamics and context into questions of implementation and effectiveness may help answer new questions in public health research. As CBPR interventions are developed, implemented and evaluated in community settings, research on their implementation may help identify best practices that can be translated into the dissemination of interventions into new contexts, or the scale-up of multi-level community interventions to a city wide or national level, resulting in more sustainable programs and interventions to reduce health disparities and improve public health.

REFERENCES


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