University-Community Partnerships: Bridging People and Cultures in an HIV/AIDS Health Intervention in an African American Community

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Abstract

As universities become more involved in real-world problems that affect racial and ethnic communities, university members are identifying strategies to effectively work with culturally diverse community partners. The Communities and Health Disparities Project described in this article is an example of collaborative scholarship that engages the university, a community-based organization, and members of the African American community. The purpose of the project was to develop a culturally tailored toolkit to correct misinformation about HIV/AIDS. In this article, the authors identify five strategies for building relationships across diverse cultural groups: connecting with cultural insiders, building collegiality, developing shared aims and goals, recognizing diverse skills and expertise, and sustaining commitments. The authors provide a conceptual framework that integrates the Freirian philosophy and the scholarship of engagement.

Introduction

*T*oday, the public service missions of universities are gaining interest from within and outside the academy *(Kezar, Chambers, & Burkhardt, 2005)*. Discussion about the public service mission focuses on the relevance of academic research for addressing the pragmatic needs of communities and practitioners *(Aronson & Webster, 2007; Sandmann, 2008)*. Boyer notes that the "scholarship of engagement means connecting the rich resources of the university to our most pressing social, civic, and ethical problems" *(1996, pp. 19–20)*. Engaged scholarship is emerging as a way of bridging the gap between university research and solutions to real-world problems *(Weerts & Sandmann, 2008)*. For example, the HIV/AIDS epidemic in the African American community is a "social, economic, and moral problem" that fits Boyer's engaged scholar paradigm *(Aloisi & Kennedy, 2001, p. 81)*. The Communities and Health Disparities Project at North Carolina State University (NC State) is an example of university engaged

scholarship oriented toward developing a culturally tailored HIV/ AIDS toolkit to correct misinformation about the epidemic in the African American community *(Baur, 2010; Nielsen-Bohlman, Panzer, & Kindig, 2004)*.

The Communities and Health Disparities Project is a collaboration of three groups: the Alliance of AIDS Services–Carolina (the Alliance) Prevention, Education, and Testing team; African American community members; and faculty members and graduate students in the sociology department at NC State. The overall goal of this pilot project is to raise the level of awareness about HIV/AIDS in the African American community through culturally sensitive peer educator training intervention workshops.

Pilot Project Challenges

Connecting with the African American community to implement the pilot project presents unique challenges. First, African Americans express distrust of university and medical researchers because of fear of being used or harmed in scientific research *(Braunstein, Sherber, Schulman, Ding, & Powe, 2008)*. This lack of trust may stem from a general distrust of mainstream society *(Smith, 2010)* or a history of unethical medical research such as the Public Health Service Tuskegee Syphilis study *(Jones, 1993; Reverby, 2009, 2011)*. Whatever the source of the distrust, its consequence is that fewer African Americans participate in health prevention programs. Second, there is strong adherence to the norm of silence in the African American community *(Laurencin, Christensen, & Taylor, 2008)*. The deep cultural understandings that underlie such norms, beliefs, and behaviors, including those related to HIV/ AIDS, may not be accessible to social scientists who are outsiders; furthermore, health-oriented prevention programs may not be culturally appropriate because of these norms *(Kreuter & Haughton, 2006; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999)*.

Third, previous research demonstrates that communication is least inhibited when respondents and researchers are of the same race or ethnicity *(Johnson & Parsons, 1994)*. In the present case, race or ethnicity is salient, as the research setting is the local African American community. Cultural differences tied to race or ethnicity have a substantial impact when community members are asked questions about their sexual behavior *(Davis, Couper, Janz, Caldwell, & Resnicow, 2010; Moorman, Newman, Millikan, Tse, & Sandler, 1999)*. The authors represent the racial diversity of the project team. The Alliance team members, including the fourth and fifth authors, are

African American. The primary investigator of the project and first author and one of the university members are African American. The remaining university members are White, including the second and third authors. The White graduate students who participated in the project were interested in engaged scholarship and public sociology as well as learning how to implement a culturally sensitive HIV/AIDS intervention for the African American community. Therefore, this project provided a learning opportunity for graduate students to work under the mentorship of an African American principal investigator and with African American community partners (the Alliance) who have diverse professional expertise and experience working with diverse racial and ethnic communities.

This article focuses on strategies for building a partnership between engaged scholars (university members) and public health practitioners in a community nonprofit organization. The authors discuss their lessons learned, which may help other university members work with culturally diverse community partners. They begin by describing the university context and the community context. They then provide an overview of the pilot project's design and implementation. They discuss how the cultural bridging strategies built a relationship between the Alliance (the community professionals) and the engaged scholars (university members). In doing so, they identify the challenges of building relationships across different cultural backgrounds and professional perspectives. Next, they discuss the major product from their efforts, the HIV/AIDS toolkit. Participants in a focus group evaluated the cultural appropriateness of the toolkit for the African American community. The focus group feedback provided a short-term evaluation of the collaborative process. Finally, the authors conclude by reviewing the five strategies used in the project for bridging cultural divides for both academic and community partners and providing suggestions for their implementation.

The University Context

North Carolina State University (NC State) is a research-extensive land-grant university with extension offices in all 100 counties of North Carolina. As a land-grant university, NC State is well situated to respond to the needs of urban and rural communities in the state. Former NC State Chancellor Marye Anne Fox initiated a task force on outreach, extension, and engagement in 1999. The task force identified ways the university could respond to the people of North Carolina, particularly the needs of diverse communities, as

a consequence of the economic, environmental, social, and public health damage from Hurricanes Floyd *(1999)* and Dennis *(2005)* in eastern North Carolina *(First White Paper, 1999)*. Two subsequent task force committees presented ideas and recommendations for focusing the university's intellectual competence and organizational resources toward sustaining optimal outcomes for the state and the southern region *(Crowling, 2005; Scholarship of Engagement Task Force, 2010)*. As a result, NC State initiated several institutional change efforts to support increased emphasis on the scholarship of engagement:

- creation of an Office of Vice Chancellor of Extension, Engagement and Economic Development;

- creation of the Collaborative for Research on Engagement, and the Institute for Nonprofits;

- integration of the scholarship of engagement with research and teaching; and

- implementation of competitive SEED Grants to support the design of community-based projects in collaboration with community partners.

In 2008, faculty members and graduate students in the Department of Sociology and Anthropology, in collaboration with the Alliance, secured a SEED Grant to develop a culturally tailored health literacy toolkit with North Carolina's African American communities.

The Community Need

In 2006, the Centers for Disease Control *(CDC, 2006)* identified the Southeast as the epicenter of AIDS deaths in the United States. State health statistics indicate that knowledge about sexually transmitted infections, including HIV and AIDS, is a critical health need for North Carolinians *(NC State Center for Health Statistics, 2007)*. In 2005, North Carolina ranked sixth in the nation for the proportion of African Americans living with AIDS *(CDC, 2006)*. The rate of HIV infection for African Americans was more than 8 times that for Caucasians. Wake County, the site of the pilot project, ranks 12th of 100 counties in North Carolina in the number of HIV cases *(North Carolina State Center for Health Statistics, 2009)*. Most new cases of HIV are transmitted heterosexually *(CDC, 2006)*, and African American women represent the fastest growing group of newly diagnosed HIV patients (36% of new HIV cases). According to state surveillance reports, the rate of new HIV infections is increasing among

young adults, especially among African American males. In their review of 735 surveillance records examining new HIV diagnoses in men aged 18 to 30 living in 69 North Carolina counties, Hightow et al. *(2005)* found that 84% were college men and 87% of the college men were African American. In short, there was a clear need to develop an HIV/AIDS prevention and intervention program tailored to the unique risks among African Americans.

The Pilot Project: An Overview of the Alliance of AIDS Services–Carolina (The Alliance)

The Communities and Health Disparities Project began as a pilot project

- to develop a culturally tailored HIV/AIDS health literacy toolkit;

- to train African American community members to be peer educators; and

- to build community engagement through peer educators sharing HIV/AIDS health information with neighbors, friends, and family members.

Figure 1 illustrates the overall design and phases of the project. Building and sustaining authentic community partnerships is illustrated in Phases I and II. Phase III involves administration and evaluation of the project.

Phase I

The Alliance is a nonprofit organization funded by the United Way of America (a network of community organizations) that provides comprehensive, skill-based, and ongoing education about HIV and other sexually transmitted infections to members of diverse communities. The Alliance serves people living with HIV/AIDS and their loved ones and caregivers as well as members of their communities. The Alliance's Prevention, Education, and Testing program provides free HIV information, group education, and individual pre- and post-HIV-test counseling.
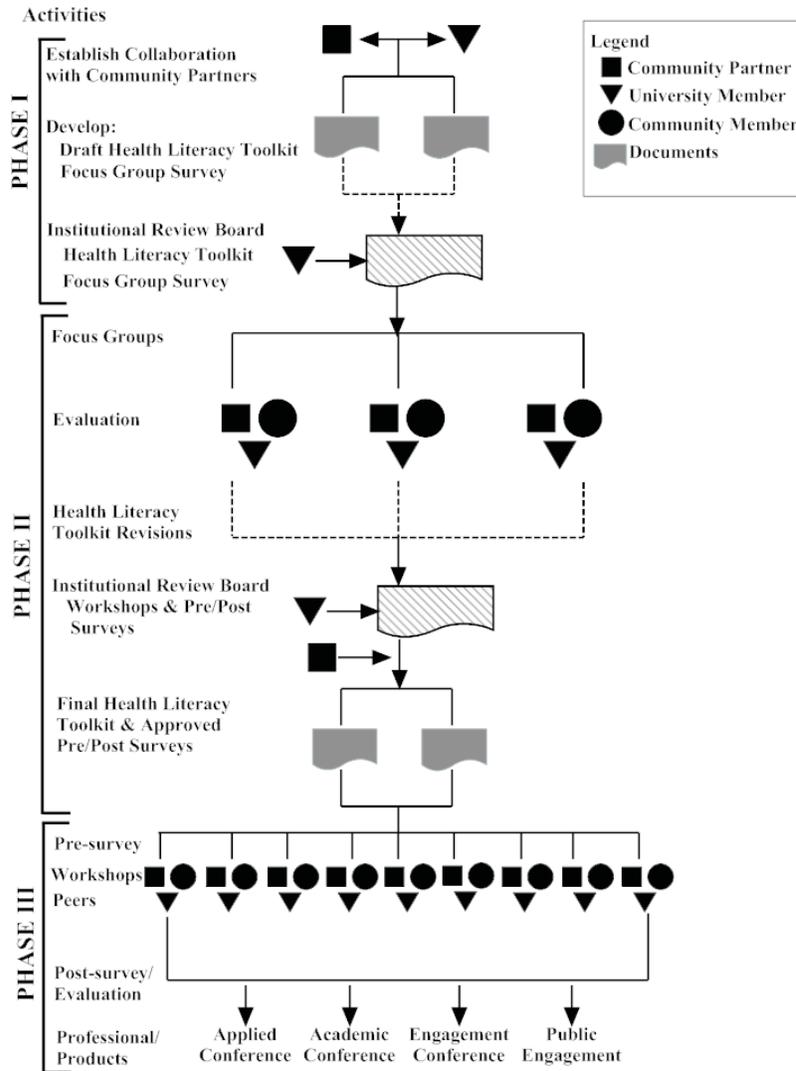
Figure 1. Community and Health Disparities Project Design

In Phase I, the Alliance and university members established a collaboration to develop the culturally tailored HIV/AIDS toolkit. The Alliance and university members developed an initial draft of a toolkit based on HIV/AIDS information from the CDC, the North Carolina Office of Minority Health, and the North Carolina Center for Health Statistics. Working with community volunteers, the Alliance recognized the need to tailor health information to the target audience, African Americans. Culturally tailored health information reflects a group's norms, values, practices, way of life,

and meanings *(Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003)*. The African American community, however, is considerably diverse, reflecting individuals' varying levels of commitment to cultural beliefs and values. Therefore, culturally tailored health messages must be designed to use a variety of approaches that capture both the shared culture and the diversity within a community *(Kreuter et al., 2003)*. The information in the HIV/AIDS toolkit is designed to be readable and usable for youth and adults, parents with children, men who have sex with men, and persons in the faith community.

Phase II: African American Community Members

In Phase II, the authors conducted three focus groups with African American community members to evaluate three aspects of the HIV/AIDS toolkit: substantive content (understandings of the causes and treatment of HIV/AIDS), cultural appropriateness of information, and visual appeal. Each focus group met at NC State's main campus on Saturday afternoons in January, February, and April of 2009. The focus group participants gave feedback on whether the toolkit would be serviceable and usable in the community. Participants engaged in conversations about social and cultural issues that affect the risk of HIV infection. The authors revised the HIV/AIDS toolkit based on information gleaned from the focus group sessions. The Institutional Review Board at NC State reviewed and approved revisions to the toolkit, the focus group protocol, and pre- and post-surveys developed to evaluate the peer education workshop.

Phase III

Phase III of the project involved recruiting community members for peer educator workshops, administering pre- and post-surveys to the peer educators, and evaluating the project. The premise of a peer education intervention strategy is that individuals from local communities can serve as role models and information providers within their respective networks *(Latkin, 1998; Latkin, Forman, Knowlton, & Sherman, 2003)*. The peer education intervention strategy has been used successfully by others to influence a range of health behaviors, including sexual behaviors, violence, and substance use *(Sloane & Zimmer, 1993)*.

The Pilot Project's Philosophical Underpinning: Freirian Philosophy

Paulo Freire's *(1970)* pedagogical philosophy and problem-posing method served as the guiding framework for the project. Freire's pedagogical philosophy emphasizes empowering members of marginalized communities through cooperative learning. This focus was directly applicable to the pilot project's goal: to empower African Americans by giving them health information about HIV/AIDS. It is difficult, however, to reach the goal of empowerment when confronted with cultural differences that can produce apathy or mistrust. Power differences in traditional teacher-student roles often lead to passive learning among students (for example, students listening to the teacher; *Freire, 1970*). In addressing community health problems such as HIV/AIDS, however, it is important for community members to become change agents rather than to be passive students. The Freirian technique of problem-posing engages community members through questions that may not necessarily have answers (e.g., "Why do you think the rates of HIV are so high among African Americans?"; *Wallerstein & Bernstein, 1988*). Community members are encouraged to reflect on these questions, explore how their everyday lives and common experiences are related to HIV/AIDS, share knowledge, and form an action plan.

Figure 2 illustrates a conceptual framework for integrating the Freirian pedagogy philosophy with collaborative engagement. The bidirectional arrows represent the continuous flow of communication *(Sandmann, 2008)*. Phase I of the model reflects an ongoing dialogue among the African American community members, the Alliance members, and the university members to collectively discover barriers to HIV/AIDS prevention *(see Minkler & Cox, 1980; Smith-Maddox & Solórzano, 2002 for additional examples)*. In the second phase of the model, the barriers to HIV/AIDS prevention are represented through language and visual images in the HIV/AIDS health literacy toolkit. Barriers to and opportunities for preventing the spread of HIV are highlighted during the peer education workshops through videos, role-playing, and visual devices. The materials, for example, show how to correctly use both a male and a female condom. The third phase involves all participants taking action to address the spread of HIV in the African American community by empowering peer educators. For example, peer educators share information about HIV/AIDS and contact and service information (HIV testing information) for the Alliance and other HIV/AIDS organizations.

Figure 2. Integrating Freirian Pedagogical Philosophy and the Scholarship of Engagement

Strategies for Bridging Cultural Divides

During the Communities and Health Disparities Project, the authors identified five strategies to help overcome these cultural divides between community partners and university members. The bridging strategies are not steps in a process but are guidelines for working with community partners. In the following sections, we elaborate on the strategies and how they unfolded during the implementation of the Communities and Health Disparities Project.

Strategy I: Connecting with Cultural Insiders

A key strategy for addressing cultural diversity is to connect with cultural insiders. Paulo Freire's *(1970)* pedagogical philosophy emphasizes knowing the cultural context and the historical and psychosocial processes that underlie a social problem. Discovering and learning the cultural context is essential for university members to identify barriers to safe sex and HIV/AIDS knowledge. HIV-related stigma, discrimination, homophobia *(Brooks, Etzel, Hinojos, Henry, & Perez, 2005)*, HIV conspiracy beliefs *(Bogart & Thorburn, 2005)*, and mistrust *(Smith, 2010)* are barriers to HIV/AIDS prevention among African Americans. Culturally tailored health messages address HIV-related social biases as well as the unwritten social norms and cultural scripts for sexual behavior *(MacLachlan, 1997)*. Outreach programs that do not consider cultural context are rarely successful or sustainable *(Meade, Menard, Martinez, & Calvo, 2007)*.

The Alliance team members, as cultural insiders, have a well-established relationship with the African American community. The Alliance recognizes the importance of integrating African American cultural values and health information for relaying HIV/AIDS prevention information. For example, social responsibility is an important cultural value in the African American community. Social responsibility emphasizes the importance of communal relationships rather than individuality *(Halbert et al., 2007; Nobles, 1991)* and is manifested through concern for others, family security, respect for traditions and elders, and cooperation *(Jagers & Mock, 1995; Nobles, 1991; White & Parham, 1990)*. Previous research reveals that African Americans attach greater importance to family values *(Landrine & Klonoff, 1995)* than do Whites, Latinos, or Asians. Moreover, regular family contact *(Parker & Calhoun, 1996)*, extended family households *(Hays & Mindel, 1973; Landrine & Klonoff, 1996)*, and shared family practices are more important to African Americans than to Whites or other racial and ethnic groups *(Lozoff, Wolf, & Davis, 1984; Mandansky & Edelbrock, 1990)*.

The social responsibility theme is included throughout the health toolkit to motivate peer educators to share information with friends and family members. To promote the idea of social responsibility, the Alliance and university members identified the message of then presidential candidate Barack Obama from the 2008 Democratic Convention: Individual Responsibility + Mutual Responsibility = Social Responsibility. The message of social responsibility urges community members to take proactive steps to know one's HIV status, to share HIV test results with sexual partners, and to practice safe sex to protect the individual and the community.

Fear and social stigma also contribute to the prevalence of misinformation about HIV/AIDS in the African American community. An earlier draft of the toolkit included language such as "AIDS is a killer disease" and "AIDS is a 'serial' killer." Sensational themes are frequently part of the mass media's coverage of HIV/AIDS in the African American community *(Russell, 2006)*. According to the Alliance, however, facts and statistics from credible sources (such as the CDC) are more important to community members than sweeping generalizations. The Alliance felt strongly that sensational themes are not appropriate, as demonstrated by this conversation about the toolkit:

> Male Alliance team member: Do y'all believe statements like "AIDS is a killer disease" and "AIDS is a serial killer"?

Research team member: We thought members of the community would identify with Reverend Jackson's comment as he was referring to the disparities in HIV infection rates.

Female Alliance team member: Using statements like "AIDS is a killer disease" will incite more panic. People with HIV are living longer now than in the 1980s and 1990s due to the many different HIV medications . . . . And most people die from AIDS-related illnesses, not AIDS. Take out the word 'killer' and use the word HIV, not AIDS. The title should read "HIV in the Black Community."

Male Alliance team member: Make sure to avoid sweeping statements because that will also create misinformation. Instead of statements like "a few years ago," restate the exact number of years or year of the information. People in the community want to know the source of information—and give them a way to access the information. I'd suggest taking out the footnotes and putting the references in the text, and add something like "for more information on X go to Y."

Moreover, use of sensational themes promotes fatalistic attitudes (e.g., "we're all going to die of something"). Consistent with the suggestions of the Alliance, the project avoided emotion-laden language to create HIV/AIDS awareness *(Randolph & Viswanath, 2004; Witte & Allen, 2000)*. Most important, the toolkit includes culturally appropriate language, situations, and visual displays as themes for medical concepts and terminology. The toolkit provides "how to" example conversations to help peer educators talk with their friends and family about HIV/AIDS myths and misperceptions, barriers to safe sex practices, sexually transmitted infections as gateway diseases for HIV infection, knowing one's status, and the need for repeat HIV testing.

Strategy II: Building Collegiality

Building relationships or collegiality depends on developing personal relationships between university members and community partners. Shared and equal participation, open communication, and trust develop over time. The key for the engaged scholar is to ground his or her research in the reality of community

practitioners during the problem formulation stage *(Van de Ven, 2007)*. The early stages of the current collaboration focused on getting to know each other and building trust. During this initial phase, university members were not sure whether the project would move forward because most of the interactions and conversations were informal. At the same time, the Alliance members withheld their full commitment until they reached an interpersonal level of comfort. This took time and many meetings among the project members. The collaboration solidified after a lunch meeting between the primary investigator and the Alliance's prevention, education, and testing director, as this comment demonstrates:

> Director: We like you, Dr. X, and we're going to help you with the project.

> Dr. X: That's great! Let's not be formal. I feel more comfortable if you call me [*first name*].

The director's comment includes two significant details. First, the partnership with the Alliance depended on making a relational connection. In other words, a mutual personal investment had to occur before the partnership could move forward. Second, the formality of courtesy titles (such as "doctor" and "professor") within the African American community is well established *(Cai, Wilson, & Drake, 2000)* as a form of social recognition and respect. Removing the use of professional titles in conversations avoids hierarchical lines of communication and builds trust.

Who travels and where to meet are decisions that reinforce acceptance and respect. To avoid any expressions of academic dominance, the university members met at the Alliance's office during times that fit the Alliance team's schedule. The Alliance and university members rotated providing snacks during project meetings. During the informal gatherings around food, the teams shared stories about their backgrounds and experiences. It was also an important time to learn about the Alliance's outreach program and experiences in the community. Furthermore, meeting at the Alliance office and during the team's working hours ensured that the Alliance team members were paid, which was a consideration because the project did not have resources to compensate the Alliance team for their efforts. Respect for the Alliance team's values and expectations early in the collaboration established the groundwork for building a supportive collegial working relationship.

Strategy III: Developing Shared Goals and Aims

Engaged scholarship requires involving community stakeholders in deciding which goals and aims to pursue *(Sandmann & Thornton, 2008)*. Sharing goals and aims is also a form of accountability to partners, because collaborators must both be aware of and attend to each other's interests. In some instances, accountability may require reorienting the project aims or goals (or both) to negotiate the needs of one or more partners. The outcomes or products from the collaboration, however, should always be mutually beneficial.

In the case of the Communities and Health Disparities Project, the Alliance's organizational mission matched the research team's goal for peer education training. Developing a comprehensive, culturally tailored HIV/AIDS health toolkit had an added value for the Alliance because the toolkit could be used in volunteer training and education outreach programs. In accordance with peer education intervention strategy, the toolkit recognizes the importance of social influence and cultural diffusion of norms. For example, the "How To" section in the toolkit contains practical information for Alliance volunteers to use when discussing HIV/AIDS with different social groups, such as persons in the faith community, the elderly, and teenagers.

Strategy IV: Identifying Complementary and Diverse Skills

To highlight its collaborative nature, the scholarship of engagement emphasizes and draws on the complementary skills and diverse areas of expertise of the respective groups *(Sandmann & Thornton, 2008)*. Neither community partners nor university members should act as passive recipients of information. Further tension may arise between the partners when participation is masked in tokenism. For example, an engaged scholar might assume that community partners are not committed to the scientific rigor of the research process or knowledgeable about theory and methods of evaluation. Conversely, community partners might assume that researchers are primarily interested in collecting data and other information and lack an understanding of how the reality of everyday living connects to the problem *(Boyer, 1996)*.

During this project, both the Alliance and the research team recognized mutual expertise and acknowledged expertise or knowledge limitations. Our ability to do so was particularly facilitated by the team's sensitivity to what a successful integration of perspectives entailed. In one of the early meetings, the Alliance

director was careful to discuss the wording of an initial draft of the HIV/AIDS health toolkit. Noting her hesitancy in making suggestions, one of the university members said, "You are the experts. We are here to learn from you and need your ideas to help make our project a success." Elevating the community partner's skills and expertise over those of the university members contributed to the partner's investing in the project and to sustaining the partnership.

Strategy V: Sustaining the Collaboration

Sustaining an engagement partnership is instrumental to a long-term relationship between a university and community partners *(Brown et al., 2006)*. For the most part, limited funding of the pilot project presented serious challenges to sustaining the project for the long term. Strengthening the partnership in the short term became our immediate goal. We approached sustaining the partnership as an ongoing process by careful attention to open and honest communication, trust and respect, and shared aims and goals *(Israel et al., 2006)*. These efforts were undergirded by our joint ownership of the health literacy toolkit, collaborative presentations at professional meetings, joint publications, and shared recognition of our work through public venues. Our short-term successes of presenting papers from our work at professional meetings reinforced a commitment from members of both teams. The positive payoffs of our efforts stemming from these joint activities led to a mutual interest in identifying strategies for continuing this initiative and planning future and potential projects. Participation in the public activities sponsored by the Alliance (such as the AIDS Walk, Pride Festival, and World AIDS Day) and private donations to programs such as the AIDS Awareness license plate project are examples of our participation in other activities that contributed to building momentum as a team and deepening the partnership.

A personnel change at the Alliance was one threat to sustaining our partnership. One of the key members of the Alliance team accepted a position at a local university that suited her talents as a community coordinator of an AIDS research team. Nevertheless, she remained linked to the team and participated in implementing and planning the workshops and collaborating on joint professional presentations. In the end, the change in personnel did not threaten the partnership but instead reflected that a sustainable relationship had developed.

Assessment: Connecting with the African American Community

According to McNall, Reed, Brown, and Allen *(2009)*, partnership outcome measures are rare and studies of the relationship between partnership characteristics and outcomes are even scarcer (for a review see *Granner & Sharpe, 2004*). However, Harper and colleagues argue that a partnership is successful if the intervention is acceptable and responsive to community needs and norms *(Harper, Bangi, Sanchez, Doll, & Pedraza, 2009; Miller, 2010; Miller & Campbell, 2006)*. Therefore, the success of the partnership was evaluated based on the feedback from community members who participated in focus groups. Three focus groups were conducted in 2009 to evaluate the HIV/AIDS toolkit.

The Assessment Questions

Participants provided feedback to a series of open-ended semistructured questions. The questions focused on the visual appeal and amount of information as well as raising HIV awareness. Examples of design and information questions included: *Are there any sections you found most useful? Are there sections that are least useful? Is the booklet [toolkit] user-friendly? How would you use this document?* Assessment questions posed as problems provided an opportunity for participants to examine the impact of HIV in their community: *Why do you think African Americans have higher rates of HIV infection? Who is most at risk for getting HIV? Do you think African American churches try to raise HIV awareness? Since there is no cure for HIV—what can we do to stop the spread of HIV? What are some reasons that people do not get tested for HIV?* The open-ended format during the focus groups provided flexibility to explore knowledge of HIV in the African American community.

The Sample

Using a snowball sampling method, members of the African American community were recruited to participate. To be eligible, respondents had to self-identify as African American and as 18 years of age or older. Participants were recruited through

- announcements in bulletins at African American churches;

- fliers distributed in Southeast communities of a large metropolitan city in North Carolina;

- public service announcements on a public access television station;

- announcement postings on social networking sites (e.g., Facebook, Craigslist), and an e-billboard system at a large state university; and

- fliers distributed on local college campuses.

Twenty-four African American community members participated in the three focus groups. Participants ranged from 18 to 65 years of age; nine of the focus group participants were male and 15 were female. To maintain participants' confidentiality, the university IRB guidelines limited the personal information to gender and age, and a pseudonym was to be offered to each participant. All participants declined to use pseudonyms.

Data Collection Methods

Each 90-minute focus group session was video recorded. During the focus group discussion, the authors matched the race of university members with African American community participants. The two African American university members (the primary investigator and graduate student) were present during each focus group; one facilitated the focus group discussion, and the other operated the video recording equipment and took detailed observational notes. Each participant received $20 for participating. Focus group participants reviewed and contributed critical reflections on the initial draft of the toolkit.

Data Analysis

A modified style of grounded theory *(Strauss & Corbin, 1990)* was employed by incorporating Freire's *(1970)* focus on emergent themes. Grounded theory offers a systematic approach to data analysis that stresses comparison, verification, and the "grounding" of theory in data *(Strauss & Corbin, 1990)*. Freire *(1970)* emphasized that through problem-posing, community members can identify emergent themes and collectively develop plans of action to change community problems.

Findings

Data from the focus groups form the basis of the findings to assess the success of the collaboration between the Alliance and university members. The findings confirm the central themes presented in the toolkit (e.g., cultural appropriateness and social responsibility) as well as revealing points of disagreement in message framing. The data provide evidence that the Alliance and NC State's university members produced an authentic toolkit

that reflects the HIV/AIDS concerns in this particular African American community.

Cultural Appropriateness of the Toolkit for the African American Community

Some of the cultural themes and message framing included in the toolkit resonated well with the focus group participants. Overall, focus group participants felt that the design and layout of the toolkit would appeal to members of their community. One participant commented, "I think it's appealing because you're focusing toward African Americans. You have African Americans on the cover. So, it's more appealing to you." Another participant thought that the inclusion of pictures of Barack Obama being tested for HIV would encourage other African Americans to also get tested.

Participants felt that specific sections of the toolkit provided information that would help members of the African American community understand whether they are at risk of becoming HIV/AIDS infected, and what they can do to protect themselves. For example, focus group members noted that the toolkit provided useful, easily accessible information that dispelled myths and misperceptions about HIV and AIDS in the African American community. Reflecting this sentiment, one female participant stated:

> I think in the African American community for a long time it's been gay people or people who use drugs who are the most at risk but to see . . . that it's everyday people that can become infected with HIV and AIDS and just to really see that information here would help a lot of people to understand they are at risk. It's not just a particular population of people who are using drugs or are in the gay/lesbian community.

The focus on social responsibility also appealed to the focus group participants. The participants' comments echoed the importance of concern for one's family and community. For example, one male participant commented:

> My reason [for getting an HIV test] would be the fact that it doesn't just affect you. It affects your family and your future partners and then your kids too. Your kids being the biggest part because you know they don't have a choice if they are your kid. So that would be my biggest reason for knowing if I am [HIV] positive.

Social Responsibility

The Alliance of AIDS Services–Carolina has a strong faith-based program. Faith ministries in the area provide food drives and host meetings, trainings, and support groups for persons living with AIDS. However, focus group participants perceived the church as a barrier to promoting safe sex behavior, and as resistant to sexual expression *(Ward, 2005)*. The limited role of the church in promoting HIV/AIDS prevention was an unexpected finding. Several focus group participants suggested that the "gatekeeping" role of the church hinders the promotion of HIV health information. As one female participant asserted, there is a need to impart HIV/AIDS knowledge to members of the faith community:

> You know there are a lot of people that are on the "down low." You have churchgoing, God fearing women who [are] being infected but nobody wants to talk about it. It's nothing to be ashamed of. If that's what you choose to do, then [you should] go ahead and do that; but you need to be safe about it.

A male participant noted that disapproval from the church community about sex, in general, is a barrier to discussions about HIV/AIDS or safe sex:

> The main problem with the churches is that the stigma starts as soon as they find out you're having sex. As soon as you start having sex, there's like a brick wall. They don't want to talk to you. They don't want to deal with you afterwards. They don't want to deal with the aftereffects. You have to get past the whole myth that if you're in church you're not having sex. You have to get past that because it happens.

A female participant continued:

> Regardless of what goes on, we're still a people that are churched; whether you go every Sunday, we are still church-bound. And, for a lot of us, whatever the church says, that's what it is. And so you have some pastors and some churches that will preach hell and brimstone and the fire coming down, you turn into a pillar of salt, they [pastors] won't discuss it in real terms. As far as AIDS is concerned, the fire and brimstone and God's condemned you. But you [church] don't talk to them about what's really going on in the community. So if you go to

church and that's all you hear, why would I say anything to anybody?

Focus group participants also felt that the "How to Talk About HIV/AIDS" section of the toolkit for persons in the faith community would be helpful in addressing these issues *(see Leong, 2006)*. This section included information on sensitive points in conversations with persons of faith, including how to show respect for denominational differences, how not to challenge religious beliefs, and how to avoid stereotypes about people who attend church.

Message Framing

Focus group participants found some aspects of message framing in the toolkit culturally appropriate and useful; however, there were also aspects that they questioned. Notably, they challenged the focus on the African American community and expressed concerns that this focus might perpetuate negative stereotypes of African Americans. Another critique concerned the use of fear-based messages to encourage safer sex practices. Many focus group participants favored the use of fear-based messages, while the Alliance members adamantly opposed such tactics.

Racial awareness or racial targeting?

Although the majority of focus group members agreed that HIV/AIDS is a leading health problem in their communities, some participants raised concerns that the HIV/AIDS toolkit focused too heavily on the epidemic among African Americans. One male participant pointed out:

> You don't want someone to read it and be like "I don't want to have sex with Black girls because they have STDs. I should go for a White girl 'cause they don't have HIV."

This statement underscores focus group participant concerns of perpetuating negative stereotypes about African American female sexual behaviors. Another male participant made a point about the racial boundaries of friendship groups:

> If our goal is to empower our peers, we don't want to exclude our peers. We don't want to make it seem like well, if we give them the booklet, then they have to be the same color as us or if we give them the booklet we're giving it to them because of . . . race. It's because we want to be educated.

This participant questioned the assumption that intimate relationships in the African American community are solely intra-racial. More important, the statement points to the heterogeneity in the community's friendship groups.

Based on these types of focus group comments, the Alliance and research team members re-examined the implicit link among race, stereotypes, and sexual health in the toolkit. University members then revised the document so that it represented the association between race and HIV prevalence by reference to race as a marker of health problems rather than a cause *(NC State Center for Health Statistics, 2007)*. The authors also incorporated into the toolkit the following statement:

> **Myth:** Since HIV is a problem in the African American community, I don't need to worry about getting it from someone who isn't Black.

> **Fact:** Although HIV is more common in the African American community than it is for other racial groups, persons of any race can have HIV. It's not who you are, but what you do.

Fear mongering or telling it like it is?

As stated earlier, the Alliance members were adamant that the authors remove emotion-laden language from the toolkit, as they felt that it promotes fear and misinformation. Several focus group participants, however, expressed the feeling that without such language, some members of the African American community would not take HIV seriously or would view sexually transmitted diseases too lightly. Participants argued that to have an impact, it is necessary to reinforce the reality that there is no cure for AIDS. One focus group participant commented, "I think sometimes scare tactics may be the best tactics." Another participant pointed this out:

> The issue that I have with is that they [teenagers] take it [STD and HIV infection] as a joke. Chlamydia—get a pill. Gonorrhea—get a shot. . . . When you talk of STDs, I'm talking 12 through 17 [year olds]; when you say you could get a disease well, you know, all I got to do is go to the clinic and get a pill. They're [teenagers] not thinking or taking it [STD infection] seriously. How this

[infection] affects your body. I have a 19-year-old neighbor who thinks, and she's relatively intelligent, that it [STD infection] will never happen to me. [The neighbor] Got two STDs while she was pregnant....You gotta hit 'em first page. BAM! This will kill you!

The same female participant indicated that she used fear tactics with her son:

You know what I told my son? Your thing [penis] gonna fall off. If you don't use a condom, two or three, your thing gonna fall off! It's gonna rot! My daughter, I said, it [vagina] will shrivel all up. He [the son] took it seriously when I said your thing could fall off.

The Alliance members had extensive experience and knowledge about HIV/AIDS and sexually transmitted diseases, and they believe that scare tactics do more harm than good. For example, using two condoms, as the participant argued, is not effective and more likely will fail. The Alliance members and university members considered the community members' perspective, but decided to avoid fear-based messages that potentially promote misinformation.

Conclusion

The pilot project goals were to raise the level of awareness of HIV/AIDS in the African American community in North Carolina and, through raising such awareness, to encourage behaviors that will benefit the community (e.g., safe sex practices, HIV testing). Although the HIV/AIDS epidemic in the African American community represents a type of social and moral problem for the engaged scholar under Boyer's paradigm *(Aloisi & Kennedy, 2001)*, cultural mistrust of scientific research, and the norm of silence about sexual topics, presented unique challenges for engaging members of the African American community in this HIV/AIDS intervention project. From this pilot project, the authors affirmed five strategies for successfully collaborating with community partners, as previously described. Table 1 lists the strategies for implementing a collaborative partnership, provides reflections by the authors from their pilot project experience, and gives suggestions for readers who may want to test these strategies in their university-community projects.

Table 1. Critical Reflections on University-Community Projects

Cultural Bridging Strategies	Reflections from Pilot Project	Suggestions for the Reader
1. Connect with cultural insiders. Know the community	The social context is important. A community is not geographically bound. Community members are not homogenous.	What are the values and norms of the local community? What are the practical realities? What are the behaviors that support the norms and values? Who are the key players and carries of culture?
2. Build collegiality by building trust and mutual respect.	The partnership is an untested relationship; trust and mutual respect grow over time.	A priority for a collaborative team: Begin early, and maintain open and clear communication throughout.
3. Develop shared goals and aims with community partners.	The overarching goal of the project was to increase awareness of HIV/AIDS. The university members and the Alliance members had to prioritize other organizational objectives.	Listen. Use open and direct communication. Define mutual goals that are practical and obtainable. Allow for revisions of the original goals and serendipity.
4. Identify complementary skills and diverse areas of expertise (i.e., practice bidirectional reciprocity).	The university members and the Alliance members integrated ideas about the workshop agenda.	Determine the objectives of the project that require particular areas of expertise. Focus on the project goals. University members must relinquish the traditional academic researcher role.
5. Sustain a collaborative relationship by working toward mutually beneficial outcomes.	The pilot project participants worked toward shared outcomes (e.g., joint authorship on journal articles and professional presentations; university member particpation in Alliance-sponsored community events.)	Discuss the successes and problems of the partnership as a team. Include partners' comments in grant reports. Identify next steps based on current outcomes.

The Nonprofit Organization

The Alliance members and the university members mutually benefited from the collaboration project. As cultural insiders, the Alliance members offered invaluable knowledge of the African American community to the university members. They provided direction on where to begin and how to make contact with the community. In addition, the Alliance's affiliation lent credibility, making the project and toolkit more likely to be viewed as useful by members of the African American community. The benefits for the Alliance included the health toolkit, which can be used in its volunteer training programs, and increased visibility for its outreach efforts. In addition, the Alliance and research team members were co-presenters at three professional conferences, and are working as coauthors on journal manuscripts.

The University Members

The most valuable experience in building the partnership for the university members was trusting others with aspects of the

project, including the contents of the toolkit and peer education curriculum. In academic research, investigators typically have control of the project from beginning to end. Building collegiality through reversal of the student-teacher role can be a humbling experience. Following the lead from partners who are cultural insiders requires releasing academic competitiveness and embracing cooperation. Through the project, a team of majority White graduate students led by an African American faculty mentor and by African American community partners had the opportunity to learn how to do research that benefits a local community where the majority of participants have a different racial background.

The traditional research model in the academy is a lone entrepreneur model: The researcher works in his or her office, has complete control of the research process, and engages the community through public presentations. The scholarship of engagement paradigm, however, is a collaborative model in which decisions are shared and are guided not only by theoretical concerns but by public concerns. Negotiating the project's objectives to meet the aims and goals of all partners was a challenge that required readjustments and moving outside the researchers' typical comfort zone.

Moreover, the benchmarks for success in the scholarship of engagement were unclear. University faculty members often do not know how to evaluate community engagement research or value engagement research as scholarship *(Driscoll & Sandmann, 2001; O'Meara & Jaeger, 2006)*. This was relatively true for this team, but we found that with diligence, evaluation is possible. Some of the activities essential to the scholarship of engagement—such as building relationships with community partners, recruiting and maintaining the interest of community participants, and producing products that are useful to the community—do not figure clearly in the evaluative equation for faculty productivity within the academy. However, each activity is integral to success in building and sustaining collaborative engagement projects in the community.

How to maintain the balance of accountability to the needs of the partners and the community was another challenge, particularly when concerns of meeting discipline-based definitions of scholarship are omnipresent. In addition, the intensity and time investment to accomplish the project were greater than expected. Underestimating the time to establish the dialogue with the partners, time for design and development of the toolkit, and time management of the research task and process required adjustment and flexibility throughout the project.

In summary, the Alliance and university members laid a foundation for continuing their work toward goals of research-based HIV/AIDS health intervention. Together they plan to submit grant proposals to the National Institutes of Health and the CDC to continue the project. Their future research efforts will include pre- and post-assessments, and a long-term evaluation of the impact of HIV/AIDS health intervention activities on community members.

References

Aloisi, R., & Kennedy, P. (2001). HIV: Opportunities for faculty engagement. *Journal of Higher Education Outreach and Engagement, 6*(3), 79–87.

Aronson, K. R., & Webster, N. (2007). A model for creating engaged land-grant universities: Penn State's engagement ladder model. *Innovative Higher Education, 3*(5), 265–277.

Baur, C. (2010). *National Action Plan to Improve Health Literacy*. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

Bogart, L. M., & Thorburn, S. (2005). Are HIV/AIDS conspiracy beliefs a barrier to HIV prevention among African Americans? *Journal of Acquired Immune Deficiency Syndromes, 38*, 213-218.

Boyer, E. (1996). The scholarship of engagement. *Journal of Public Service and Outreach, 1*(1), 11–20.

Braunstein, J. B., Sherber, N. S., Schulman, S. P., Ding, E. L., & Powe, N. R. (2008). Race, medical researcher distrust, perceived harm, and willingness to participate in cardiovascular prevention trials. *Medicine, 87*(1), 1–9.

Brooks, R. A., Etzel, M. A., Hinojos, E., Henry, C. L., & Perez, M. (2005). Preventing HIV among Latino and African American gay and bisexual men in a context of HIV-related stigma, discrimination, and homophobia: Perspectives of providers. *AIDS Patient Care and STDs, 19*(11), 737–744.

Brown, R. E., Reed, C. S., Bates, L. V., Knaggs, D., Casey, K. M., & Barnes, J. V. (2006). The transformative engagement process: Foundations and supports for university-community partnerships. *Journal of Higher Education Outreach and Engagement, 11*(1), 9–23.

Cai, D. A., Wilson, S. R., & Drake, L. E. (2000). Culture in the context of intercultural negotiation: Individualism-collectivism and paths to integrative agreement. *Human Communication Research, 26*, 591–617.

CDC. (2006). *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2006 Disease Profile*. Centers for Disease Control and Prevention http://www.cdc.gov/nchhstp/publications/docs/2006_disease_profile_508_final.pdf

Crowling, E. (2005). Recommendations for enhancement of the commitment of NC State to serving the people of North Carolina. www.ncsu.edu/.../FirstWhitePaperonExtensionandEngagement--RecommendationsandAddendum.doc

Davis, R. E., Couper, M. P., Janz, N. K., Caldwell, C. H., & Resnicow, K. (2010). Interviewer effects in public health surveys. *Health Education Research, 25*(1), 14–26. doi:10.1093/her/cyp046

Driscoll, A., & Sandmann, L. R. (2001). From maverick to mainstream: The scholarship of engagement. *Journal of Higher Education Outreach and Engagement, 6*(2), 9–19.

First White Paper. (1999). *Recommendations for enhancement of NCSU's commitment to serving the people of North Carolina.* www.ncsu.edu/.../FirstWhitePaperonExtensionandEngagement-- RecommendationsandAddendum.doc

Freire, P. (1970). *Pedagogy of the oppressed.* New York, NY: Continuum.

Granner, M. L., & Sharpe, P. A. (2004). Evaluating community coalition char-acteristics and functioning: A summary of measurement tools. *Health Education Research, 19*(5), 514–532.

Halbert, C. H., Barg, F. K., Weathers, B., Delmoor, E., Coyne, J., Wileyto, E. P., . . . Malkowicz, S. B. (2007). Differences in cultural beliefs and values among African American and European American men with prostate cancer. *Cancer Control, 14*(3), 277–284.

Harper, G. W., Bangi, A. K., Sanchez, B., Doll, M., & Pedraza, A. (2009). A quasi-experimental evaluation of a community-based HIV prevention intervention for Mexican American female adolescents: The SHERO's program. *AIDS Education & Prevention, 21*(Supplement B), 109–123.

Hays, W. C., & Mindel, C. H. (1973). Extended kinship relations in Black and White families. *Journal of Marriage and Family, 35*(1), 51–57.

Hightow, L. B., MacDonald, P. D. M., Pilcher, C. D., Kaplan, A. H., Foust, E., Nguyen, T. Q., & Leone, P. A. (2005). The unexpected movement of the HIV epidemic in the southeastern United States: Transmission among college students. *JAIDS: Journal of Acquired Immune Deficiency Syndromes, 38*(5), 531–537.

Israel, B. A., Krieger, J., Vlahov, D., Ciske, S., Foley, M., Fortin, P., . . . Palermo, A. (2006). Challenges and facilitating factors in sustaining community-based participatory research partnerships: Lessons learned from the Detroit, New York City and Seattle urban research centers. *Journal of Urban Health, 83*(6), 1022–1040.

Jagers, R. J., & Mock, L. O. (1995). The communalism scale and collectivistic-individualistic tendencies: Some preliminary findings. *Journal of Black Psychology, 21*(2), 153–167.

Johnson, T., & Parsons, J. (1994). Interviewer effects on self-reported sub-stance use among homeless persons. *Addiction Behavior, 19*, 83–93.

Jones, J. (1993). *Bad blood: The Tuskegee syphillis experiment.* New York, NY: Free Press.

Kezar, A. J., Chambers, A. C., & Burkhardt, J. C. (2005). *Higher education for the public good: Emerging voices from a national movement.* San Francisco, CA: Jossey-Bass.

Kreuter, M. W., & Haughton, L. T. (2006). Integrating culture into health infor-mation for African American Women. *American Behavioral Scientist, 49*(6), 794–811.

Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003). Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education & Behavior, 30*(2), 133–146. doi:10.1177/1090198102251021

Landrine, H., & Klonoff, E. A. (1995). The African American Acculturation Scale II: Cross-validation and short form. *Journal of Black Psychology, 21*(2), 124–152.

Landrine, H., & Klonoff, E. A. (1996). Traditional African-American family practices: Prevalence and correlates. *Western Journal of Black Studies, 20*(2), 59-62.

Latkin, C. (1998). Outreach in natural settings: The use of peer leaders in HIV prevention among injecting drug users' networks. *Public Health Reports, 111*, 151–159.

Latkin, C., Forman, V., Knowlton, A., & Sherman, S. (2003). Norms, social networks and HIV-related risk behaviors among urban disadvantaged drug users. *Social Science and Medicine, 56*, 465–476.

Laurencin, C. T., Christensen, D. M., & Taylor, E. D. (2008). HIV/AIDS and the African-American community: A state of emergency. *Journal of the National Medical Association, 100*(1), 35–43.

Leong, P. (2006). Religion, flesh, and blood: Recreating religious culture in the context of HIV/AIDS. *Sociology of Religion, 67*(3), 295–311.

Lozoff, B., Wolf, A. W., & Davis, N. S. (1984). Cosleeping in urban families with young children in the United States. *Pediatrics, 74*(2), 171–182.

MacLachlan, M. (1997). *Culture and health*. New York, NY: Wiley.

Mandansky, D., & Edelbrock, C. (1990). Co-sleeping in a community of 2- and 3-year-old children. *Pediatrics, 86*, 1987–2003.

McNall, M., Reed, C. S., Brown, R., & Allen, A. (2009). Brokering community-university engagement. *Innovative Higher Education, 33*(5), 317–331.

Meade, C., Menard, J., Martinez, D., & Calvo, A. (2007). Impacting health disparities through community outreach: Utliizing the CLEAN look (Culture, Literacy, Education, Assessment, and Networking). *Cancer Control, 14*(1), 70–77.

Miller, R. L. (2010). Developing standards for empirical examinations of evaluation theory. *American Journal of Evaluation, 31*(3), 390–399.

Miller, R. L., & Campbell, R. (2006). Taking stock of empowerment evaluation. *American Journal of Evaluation, 27*(3), 296–319.

Minkler, M., & Cox, K. (1980). Creating critical consciousness in health: Applications of Freire's philosophy and methods to the health care setting. *International Journal of Health Services, 10*(2), 311–322.

Moorman, P., Newman, B., Millikan, R., Tse, C.-K., & Sandler, D. (1999). Participation rates in a case-control study: The impact of age, race, and race of interviewer. *Annals of Epidemiology, 9*(3), 188–195.

NC State Center for Health Statistics. (2007). *Running the numbers: Selected data related to health literacy in North Carolina*. Raleigh, NC: North Carolina Medical Journal.

Nielsen-Bohlman, L., Panzer, A. M., & Kindig, D. A. (Eds.). (2004). *Health literacy: A prescription to end confusion*. Washington, DC: The National Academies Press.

Nobles, W. (1991). African philosophy: Foundations for Black psychology. In R. Jones (Ed.), *Black Psychology*, 47-63. Berkeley, CA: Cobb and Henry.

North Carolina State Center for Health Statistics. (2009). SCHS and ethnic minority health data and publications. Retrieved from http://www.schs.state.nc.us/SCHS/

O'Meara, K., & Jaeger, A. J. (2006). Preparing future faculty for community engagement: Barriers, facilitators, models, and recommendations. *Journal of Higher Education Outreach and Engagement, 11*(4), 4–26.

Parker, K. D., & Calhoun, T. (1996). Predictors of life satisfaction among Black Americans. *Western Journal of Black Studies, 20*(3), 134–139.

Randolph, W., & Viswanath, K. (2004). Lessons learned from public health mass media campaigns: Marketing health in a crowded media world. *Annual Review of Public Health, 25*, 419–437.

Resnicow, K., Baranowski, T., Ahluwalia, J., & Braithwaite, R. (1999). Cultural sensitivity in public health: Defined and demystified. *Ethnicity & Disease, 9*(1), 10–21.

Reverby, S. M. (2009). *Examining Tuskegee: The infamous syphillis study and its legacy*. Chapel Hill, NC: The University of North Carolina Press.

Reverby, S. M. (2011). "Normal exposure" and inoculation syphilis: A PHS "Tuskegee" doctor in Guatemala, 1946–1948. *The Journal of Public History, 23*(1), 6–28.

Russell, S. (2006, August 15). Black leaders call for more HIV testing: Disease disproportionately affects African American women. *San Francisco Chronicle*. Retrieved from http://www.avert.org/hiv-african-americans. htm#refs

Sandmann, L. R. (2008). Conceptualization of the scholarship of engagement in higher education: A strategic review, 1996–2006. *Journal of Higher Education Outreach and Engagement, 12*(1), 91–104.

Sandmann, L. R., & Thornton, C. H. (2008). The bridging scholarship. *Journal of Higher Education Outreach and Engagement, 12*(3), 223–229.

Scholarship of Engagement Task Force. (2010). Integrating learning, discovery, and engagement through the scholarship of engagement: Report of the Scholarship of Engagement Task Force North Carolina State University. Retrieved from http://www.ncsu.edu/extension/documents/ SET2010.pdf

Sloane, B., & Zimmer, C. (1993). The power of peer health education. *Journal of American College Health, 41*, 241–245.

Smith, S. S. (2010). Race and trust. *Annual Review of Sociology, 36*(1), 453–475. doi:10.1146/annurev.soc.012809.102526

Smith-Maddox, R., & Solórzano, D. G. (2002). Using critical race theory, Paulo Freire's problem-posing method, and case study research to confront race and racism in education. *Qualitative Inquiry, 8*(1), 66–84.

Strauss, A., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage.

Van de Ven, A. H. (2007). *Engaged scholarship: A guide for organizational and social research*. New York, NY: Oxford University Press.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education & Behavior, 15*(4), 379–394.

Ward, E. G. (2005). Homophobia, hypermasculinity and the US Black church. *Culture, Health and Sexuality, 7*(5), 493–504.

Weerts, D. J., & Sandmann, L. R. (2008). Building a two-way street: Challenges and opportunities for community engagement at research universities. *The Review of Higher Education, 32*(1), 73–106.

White, J. L., & Parham, T. A. (1990). T*he psychology of Blacks: An African-American perspective*. Englewood Cliffs, NJ: Prentice Hall.

Witte, K., & Allen, M. (2000). A meta-analysis of fear appeals: Implications for effective public health campaigns. *Health Education & Behavior, 27*(5), 591–615.

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