NIH Public Access

Author Manuscript

J Prev Interv Community. Author manuscript; available in PMC 2013 November 06.

Published in final edited form as:

J Prev Interv Community. 2012 ; 40(2): . doi:10.1080/10852352.2012.660124.

Differential Challenges in Coalition Building among HIV Prevention Coalitions Targeting Specific Youth Populations

Grisel M. Robles-Schrader[1], **Gary W. Harper**[2], **Marjorie Purnell**[2], **Veronica Monarrez**[2], **Jonathan M. Ellen**[3], and **the Adolescent Medicine Trials Network for HIV/AIDS Interventions**

[1]University of California San Francisco

[2]DePaul University

[3]John Hopkins School of Medicine

Abstract

Coalitions provide the potential for merging the power, influence, and resources of fragmented individuals and institutions into one collective group that can more effectively focus its efforts on a specific community health issue. Connect to Protect® coalitions devote resources to address the HIV epidemic at a structural level. This research examines differential challenges in coalition processes that may facilitate/hinder coalition building to achieve HIV prevention through structural change. Qualitative interviews conducted with community partners participating across 10 coalitions were analyzed to compare responses of those individuals working on HIV prevention coalitions targeting adolescent and young adult gay and bisexual men versus those targeting adolescent and young adult heterosexual women. Community partner responses revealed differences across several key areas including: a) acceptability and goals in discussing sexual issues with adolescents, b) goals of sexual health promotion activities, and c) competition among collaborating agencies. Themes highlighted in this research can complement existing community intervention literature by helping community mobilizers, interventionists, and researchers understand how cultural norms affect youth-specific coalition work.

Keywords

coalitions; African American and Latino adolescent and young adults; structural change; HIV prevention

Introduction

Community coalitions are a mechanism that can be used to meet the complex health needs of diverse communities (McLeroy, Kegler, and Steckler, 1994). These partnerships may focus on bringing about community-wide changes by fostering multi-sectoral partnerships to create a comprehensive understanding of the root causes fueling risk associated with a specific public health issue (Mengis and Nicolini, 2010). In addition, they may pool resources and support to achieve a variety of changes across different community sectors to more effectively address a health issue (Fawcett, Francisco, Paine-Andrews, and Schultz, 2000; Wolff, 2001). Coalitions provide the potential for merging the power, influence, and resources of fragmented individuals and institutions into one powerful collective group. The more diversity represented within the coalition body the more likely the coalition will

Please direct correspondence to: Grisel M. Robles-Schrader; Division of Adolescent Medicine in Pediatrics; University of California, San Francisco; 414 S. Scoville Ave, Ut 18 Oak Park, IL 60302; Roblesg@peds.ucsf.edu.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

develop comprehensive and creative solutions to reduce the negative affects health issue have on the community (D'Amour, Ferrada-Videla, San Martin Rodriguez, et al., 2005; Kegler, Painter, Twiss, Aronson, Norton, 2009; Wolff, 2001). The combination of these factors has driven the popularity of coalitions as an important strategy in public health promotion (Rhodes, Malow, Jolly, 2010).

Historically, the HIV epidemic has been deeply rooted in community mobilization due to the social injustices that stemmed as a consequence of the stigma related to living with HIV (Herek, Capitano, and Widarman, 2002; Richert, 2009). Coalition work as a public health promotion strategy in the field of HIV became widespread when the Centers for Disease Control and Prevention (CDC), in 1993, mandated states and localities receiving HIV prevention funds conduct community planning efforts that involved local community members and particularly persons living with HIV and AIDS (Butterfoss, 2007; Levitt and Rosenthal, 1999). Connect to Protect® joins that history of coalition building by devoting resources to address the HIV epidemic at a structural level, as it focuses on altering policies, practices, programs and/or the physical environment believed to be associated with HIV risk among youth (Ziff, Harper, Chutuape, et al, 2006). Given the need for youth-specific sustainable HIV prevention efforts, C2P aims to mobilize researchers, as well as key stakeholders and community members, to identify and achieve locally relevant structural changes to curb the incidence and prevalence of HIV among adolescents 12-24 years of age. This can be achieved through approaches that are direct (e.g. supply condoms, clean needles) and indirect (e.g., legalize minors' access to care without parental consent, establish safe spaces in shelters for homeless transgender youth).

Epidemiology of HIV among Youth

The CDC reported that in 2006 approximately 46,000 adolescents and young adults living in the United States, ages 13 to 24, were living with HIV (CDC, 2008). During that year, adolescents and young adults within that same age range comprised 34% of all new HIV diagnoses; the majority of those infections were transmitted through sexual activity. Of those cases, 54% were among young men who reported male-to-male sexual contact (primary gay/bisexually identified) and 28% were among young heterosexual women. African American young adults comprised 60% of HIV/AIDS diagnoses among 13 to 24 year-olds in 2006 (CDC 2008). Most new infections Among Latino men who have sex with men (MSM) occurred among adolescent and young adults 13-29 years of age (CDC, 2008).

African American and Latino gay/bisexual young men are more likely to become infected at a younger age (13–29 years), whereas Caucasian gay/bisexual young men are more likely to become infected when they are older (30–39 years) (CDC, 2009). Among young gay and bisexual men aged 13–24, young African American men had a 93% increase in HIV diagnoses—from 938 cases in 2001 to 1,811 cases in 2006 (CDC, 2009). African American women account for 60% of the cumulative AIDS cases among women ages 13- 24, yet they only constitute approximately 14% of all women within this age range (CDC 2008). Latinas represent 19% of the cumulative AIDS cases among young women; however, they comprise only about 12% of the female population this age (CDC 2008).

These disparities in HIV infection among young gay/bisexual men and young heterosexual women of color are attributed to a combination of behavioral, biological, cultural and structural factors (Harper, 2007; Simoni, Evans-Campbell, Andrasik, et al., 2010). Although both of these sub-groups of youth must contend with varying levels of oppression related to heterosexism, sexism and racism, the specific ways in which these societal-level prejudices may impact their HIV risk and protective behaviors may vary greatly (Wilson, Harper, Hidalgo, et al., 2010; Simoni, et al., 2010). Thus, coalitions working with youth need to consider the unique challenges faced by the specific populations they target. Aspects such as

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

key stakeholders to engage, resource availability (i.e., amount, type and how quickly they can be pooled), the availability of systems and structures to support and address the needs of the particular population, and the problem-solving approaches may vary across different youth populations (Francisco, Paine, and Fawcett, 1993; Roussos, and Fawcett, 2000; Wolff, 2001). Understanding these distinctions will enhance a coalition's effectiveness in creating population-specific and meaningful changes within the community to impact health outcomes.

This research examines differential challenges in coalition processes that may facilitate or hinder coalition building to achieve HIV prevention through structural change within the Adolescent Trials Network for HIV/AIDS Intervention's (ATN) Connect to Protect® (C2P) project. This project entails three phases (Ziff, et.al. 2006). During Phase I sites were charged with generating a youth HIV/AIDS epidemiological profile; using the profile to identify specific youth populations and geographic areas of need; and creating partnerships with key community members and representatives from community-based organizations and agencies that were reaching at-risk youth populations and were located within or serve in these areas. In Phase II, partnerships were formalized; sites held working group meetings and partners advised on data collection venues for youth interviews that served to inform strategic planning efforts. These partnerships then transitioned into coalitions during Phase III that fueled community mobilization to establish an HIV safety net in each community. Mobilization efforts focused on creating structural changes to address each community's specific needs. This research focuses on data collected during the third phase of the project.

Qualitative interviews conducted with community partners participating across 10 coalitions were analyzed to compare responses of those individuals working on HIV prevention coalitions targeting adolescent and young adult gay and bisexual men versus those targeting adolescent and young adult heterosexual women. Themes highlighted in this research can complement existing community intervention literature by helping community mobilizers, interventionists, and researchers understand how cultural norms affect youth-specific coalition work, thus guiding their inclusion of such differences into coalition planning strategies.

Methods

Participants

Data for this study come from qualitative interviews conducted with 1-3 *Main Partners* across 10 coalitions for total of 21 interviews. *Main Partners* were defined as coalition participants who played the most significant role in terms of time and commitment. Adolescent Medicine Trials Unit (AMTU) research staff at each site selected *Main Partners* based on a variety of factors related to youth specific interests/activities, including: (1) knowledge of at-risk behaviors and venues where the population congregates; (2) knowledge of existing or previous HIV programs in their communities; (3) interest in implementing new HIV prevention initiatives; (4) capacity to work with researchers on obtaining additional funding to implement and evaluate the chosen HIV prevention intervention; (5) strengths in terms of fostering community assent, ownership, and buy-in for the coalition's structural change goals; (6) strengths in reaching/recruiting the target population; and (7) personnel and time to devote to C2P efforts. This research focuses solely on the responses from *Main Partner* interviews conducted 18 months after each coalition held their first strategic planning meeting to identify locally relevant structural change objectives the coalition envisioned achieving.

Given their role in the coalition, *Main Partners* were expected to attend the majority, if not all, local C2P meetings and share information about their community and at-risk youth

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

populations. *Main partners* were expected to be directly involved in the decision-making process for choosing a standardized HIV prevention intervention (Community PROMISE or Mpowerment); and in the future, aid in the recruitment of youth for the intervention.

The epidemiological profiles created by each coalition informed the selection of target populations. For the current study we analyzed results from 10 coalitions, six focused on African American and Latino young gay and bisexual men (YGBM) (Baltimore, Los Angeles, Manhattan, Philadelphia, San Francisco, and Washington D.C.), and four on African American and Latina young heterosexual women (YHW) (Bronx, Chicago, Ft. Lauderdale, Tampa).

Interview Procedures

The National Coordinating Center (NCC), administered in-depth qualitative interviews with *Main Partners* for all coalitions' involved in C2P. The first administration occurred after the coalition's initial strategic planning meeting during Phase III. These interviews were conducted approximately every six months thereafter, to assess the "health" of the coalition. Data for the current study come from the third set of interviews. The authors chose to analyze these data since the interviews occurred approximately 18 months into the collaborative relationship that was developed during Phase III of the project. It was felt that at this time point *Main Partners* presumably could offer more in-depth reflections on the coalition and its work.

Interviews were conducted either over the phone or in person and took approximately 45 minutes to complete. The face-to-face interviews occurred at locations that were appropriate for such activities and convenient for respondents. Interviews were audio-taped when permitted by the interviewee and saved as WAV files. Some interviews were not able to be recorded and in those cases interviewer notes were utilized as the primary data source. *Main Partners* who completed the interviews were compensated $25.00 for their time since this was in addition to the coalition responsibilities. Trained research assistants transcribed the interviews verbatim.

The qualitative interview (*Healthy Coalition Interview)* includes elements from the Critical Events Interview (Fawcett, et al., 1995c) and has four primary sections: (1) the general health and functioning of the coalition; (2) critical community events (both those enacted by C2P coalitions and those enacted by others); (3) general lessons learned by coalition members; and (4) open-ended "wrap up" questions about community events.

Analysis

The first step in data analysis involved reading all interview transcripts in order to increase familiarity with the data. Authors then re-read the transcripts with a focus on words, phrases, or paragraphs within the interviews that exemplified the operational concepts relevant to the research questions. The authors initially coded interviews individually. Marginal notes and preliminary thematic codes were then created based on the initial patterns observed. When an initial set of codes was developed, the list was used to re-examine the data to ensure validity of codes. The research team members met weekly to review, discuss, and develop consensus on codes. Old codes were amended or new ones were created, and transcripts were re-examined and recoded where necessary to ensure that all transcripts were coded accurately and completely. Finally, meta-matrices of codes were created to assist in data analysis, including comparisons of sites focused on gay and bisexual young men versus young heterosexual women. Information in the meta-matrices included actual quotes from the interview and the page number, as well as a unique identifier label (e.g. site, time point, member type, member number and interview date).

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

The first step of the analyses was to identify *challenges* members discussed in their interviews with regard to participating in C2P coalitions. The themes were then classified between *process-related issues* or *content-related issues. Process* themes referred to issues that emphasized "how" the coalition organized (e.g. meeting structure, membership, communication, etc.). These themes included decision-making strategies, meeting structure, membership and other features related to organizational structure. *Content* themes referred to issues related to "what" the coalition was attempting to accomplish. These themes included issues related to coalition goals, objectives, and strategies in achieving structural changes.

These broad themes were further broken down into *direct* and *indirect* issues affecting the coalition work. Themes organized as *direct process challenges* were defined as characteristics, actions, or aspects of the coalition that specifically hindered the condition of work, and *indirect process challenges* referred to secondary consequences resulting from a characteristic, action, or aspect of the coalition that hindered the condition of the work. *Direct content challenges* referred to an outcome of the coalition that specifically hindered the type and/or quality of work. *Indirect content challenges* described a secondary outcome that specifically hindered the type and/or quality of work.

Results

Themes from *Main Partner* interviews targeting YGBM and those targeting YHW are reflected in Table 1. Results described in this section are organized by the four thematic categories outlined above: a) direct process challenges, b) indirect process challenges, c) direct content challenges, and d) indirect content challenges. Similarities and differences across coalitions are outlined within each category, and representative quotes are offered.

Direct Process Challenges

Members working with both populations indicated challenges working on a coalition focused specifically on targeting structural level changes. These challenges included: a) attaining continuity of participation due to changes in membership (specifically changes in the agency representative sent by the member agency) and addressing members' competing commitments which affect the coalitions' progress and momentum, b) sustaining the coalitions' strategic plan, c) engaging new participants strategically, and d) functioning within perceived limitations stemming from the research protocol (i.e., feeling overburdened by documentation responsibilities, feeling hindered by the narrow focus of the study, and having to check-in before the coalition could take action on their plans.)

Coalition participants focused on young gay and bisexual men expanded on the discussion of challenges by also indicating that they experienced challenges in planning for the long-term sustainability of the coalition, achieving tangible outcomes, and building group cohesion. In addition, some members were concerned about how to plan for sustainability.

> "...self-sufficiency issue that continues to be brought up, how do we move forward and identify our own funding?" (YGBM coalition)

> "...but in general coalition work there's always something that you have to be concerned about. A[n] other coalition, um funding ended and very little continued in terms of the work that was there,...once they lost their funding for that kind of work it just went in all other directions and didn't keep any of the momentum of the things that folks worked together on doing." (YGBM coalition)

Other partners discussed the need for concrete and visible products of the group's efforts.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

> Individuals involved in C2P need to see something tangible, see some changes. (YGBM coalition)

For this member tangible outcomes served as an indicator of coalition progress and impact on the epidemic in their community. Finally, one member noted disrespectful behavior by new members caused a decline in membership and participation.

> New groups coming in were not respectful of others and caused issues because people dropped off. (YGBM coalition)

Coalition participants targeting YHW noted only one contrasting direct challenge as compared to the YGBM coalitions. They indicated that differences in decision-making processes among the individual partner agencies often affected the coalition's ability and timeliness in determining courses of action.

> "Sometimes one organization can do that, sometimes the coalition can do that, but sometimes people have to go at a different pace because they have a different set of instructions or different set of orders..." (YHW coalition)

> "...my agency is very big and it takes a very long time to kind of get collaborations approved and going through things...other agencies don't have that.... So when we want to collaborate on something it's going to take us at least a couple of weeks to go through a chain of command and get things approved..." (YHW coalition)

Participants of the YHW coalitions pointed out that forging collaborations among community members holding differing perspectives on how best to address the epidemic was a challenge. Members discussed the difficulties of attempting to cultivate relationships between members of agencies that represent two philosophical camps in addressing HIV prevention—those supporting an abstinence-only approach vs. those with a comprehensive sex education approach.

> "You know, we have to sit at these tables with people who are saying abstinence is the only way. And still at the same time, try to form a relationship with them." (YHW coalition)

Direct Content Challenges

One identified challenge by partners in both YGBM and YHW coalitions was marketing the relevance and value of structural change in addressing the HIV epidemic to community agencies. A member from a YGBM coalition explained that some members found it challenging to see how C2P's goals related back to the work at the agency they represented.

> C2P seen more as additional thing. They don't relate it to their work, to what they are doing. (YGBM coalition)

A coalition member from a YHW coalition emphasized the value of marketing to members of the community who are not involved in C2P.

> "...when C2P does something, to let people know...marketing...letting people know who are the partners and what is going on, what is the source of linkage for people to do this." (YHW coalition)

The YGBM coalitions revealed only one unique direct challenge to the coalition's goals, which was oversaturation of services in the neighborhood which was targeted by the coalition for structural change efforts.

> "You know this one thing I think about, it is a, a specific area where they identified the problem to be around Chelsea, that location...there's just so many other services and agencies and folks are going around giving out condoms, giving out books to

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

> providing them with so much services, offering counseling and testing...” (YGBM coalition)

The YHW coalitions also revealed unique challenges related to: a) figuring out how to work with systems/organizations that have opposing viewpoints about how to address the HIV epidemic, and b) remaining updated with rapid shifts in youth culture that create barriers in achieving coalition goals. The following quotes illustrate norms from one site associated with addressing and discussing sex with adolescents that acted as barriers to the group's work.

> “I...anticipate that we are going to be engaged in these discussions with the [name deleted] schools , and the health systems, and other things around what do we do with this taboo issue: sex and it's outcomes...I think we're going to ram heads, people will say, “no sex in the school, and you can't give condoms here, or you can't test here,” or whatever. How do we navigate that? And how do get to the population and serve the population we need, but at the same time not be offensive to people and not shut them out.” (YHW coalition)

Additionally, the same coalition member acknowledged the difficulty of staying abreast of a constantly changing youth culture when addressing the HIV epidemic.

> “But the problem that exists today might not exist the same way tomorrow. And when you are dealing with young people things are always tenuous...” (YHW coalition)

Indirect Content Challenges

Although members from both coalitions discussed challenges in overcoming external factors that negatively influence the coalition's ability to achieve their goals, both types of coalitions shared none of the specific challenges. For the YGBM coalitions these factors were associated with oversaturation of YGBM-focused HIV prevention services and messages, which resulted in a lack of attention to messages or the inappropriate use of HIV testing sites by youth in order to obtain financial compensation for getting tested.

> “...is the overload of prevention messages going out into the community that is actually working against us.” (YGBM coalition)

> “... I think young people know that they can get HIV testing and get money, and they may know their status, but it doesn't necessarily translate into, ‘okay we want to be healthy,” it's more like ‘okay I'll take a test, what can you give me?’ Almost like some of the services that you see it's a hustle to get something...” (YGBM coalition)

Another challenge presented by the YGBM coalitions addressed the issue of needing to go beyond a singular focus on HIV and to address the range of stressors that negatively impact the sexual health and well-being of gay and bisexual adolescents.

> “I think that we have to...address the issue of housing, job readiness, and getting young people jobs... Like the focus can't just be HIV. Because young people already know about HIV. We're not in the 1980's. So if we say you gotta get tested, you gotta know your status, they look at us and say, but I'm homeless. So I can find out I'm negative today but I'm going to turn a trick in half an hour because I know I gotta eat. Versus having a program that can get them jobs but also have them get tested. Like I've never seen anything like that...”.” (YGBM coalition)

For the coalitions targeting YHW, external factors that presented challenges to the coalition's work primarily consisted of pressures that arose from cultural norms related to not discussing sex and HIV prevention methods with adolescents.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

> "You know, the debate today is, teaching young people about sexual transmitted diseases or whatever, things like that, does it encourage people to have sex? How much of it is teaching young people about STD's and things like that, or does it encourage them to have sex? Does it talk about prevention, or does it encourage them to have sex. As a society we are not ready to take this head-on. There are religious implications, there are moral implications, and there are family value implications and all these other kinds of things." (YHW coalition)

> "...and some of that is because people just don't want to talk about that. It goes beyond HIV. It's really about sexual responsibility and sexual health." (YHW coalition)

In addition, challenges were discussed that centered on youth perceptions about the consequences of pregnancy, and misperceptions about the efficacy of prevention tools.

> "...when young girls get pregnant here, they want to have their babies. And young boys, it's a sense of manhood: if you impregnate a young lady that gives you a sense of manhood. So, it flies right in the face of safe sex or protection from other things." (YHW coalition)

In this example, pregnancy is viewed as a positive component of adolescent identity development and transition into adulthood. Finally, members discussed myths related to the efficacy of current HIV prevention methods as negatively affecting their efforts in addressing the epidemic among adolescents.

> "Or things about condom efficacy, that condoms don't work, we've really got to dispel those myths, because as long as they are out there people are not going to use protection" (YHW coalition)

Discussion

Given the different contextual and environmental factors that may impact the sexual risk and protective behaviors of gay/bisexual young men versus heterosexual young women, this research explored the differential challenges experienced by coalitions serving these two populations. Findings indicated that challenges faced by the coalitions did in fact vary based on the coalition's target population. Partner responses revealed differences across several key areas including: a) acceptability and focus in discussing sexual issues with adolescents, b) goals of sexual health promotion activities, and c) competition among collaborating agencies. Although these thematic differences were observed across gender specific sites, it is not possible to determine if they occurred due to their focused population or individual site characteristics.

In addition to these population-specific differences, several similarities also emerged, including a) attaining continuity of participation and addressing members' competing commitments b) sustaining the coalitions' strategic plan, c) engaging new participants strategically, d) functioning within perceived limitations stemming from the research protocol, and e) sustaining the coalition and its efforts. These align with previous research which has demonstrated that various types of coalitions are confronted with these process challenges (Kegler, Steckler, McElroy, and Malek, 1998; Mattessich, Murray-Close, and Monsey, 1992; Wolff, 2001).

Cultural norms, such as the acceptability of discussing sexual issues with adolescents, were a dominant theme among members of YHW coalitions. Members of these coalitions spent time trying to forge relationships between pro- and anti-abstinence-only organizations. This had an impact on achieving consensus regarding the prevention approach that would ultimately guide the coalitions' efforts in reducing the HIV epidemic among YHW. While

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

structural change goes beyond these individual-level approaches to HIV prevention, values clarification processes needed to take place before members could work together cohesively.

In contrast, YGBM coalitions were concerned with the oversaturation of HIV prevention services and messaging targeting young gay and bisexual male adolescents. One explanation for this over saturation may be due to the degree to which the epidemic is impacting gay and bisexual male youth and men compared to other populations. As a result, agencies spend a lot of time and effort targeting these populations. Over time, the perception of HIV as a health threat decreases and prevention messages become less urgent and/or relevant as people living with HIV/AIDS live longer, healthier lives (Ostrow, Silverberg, Cook, et al., 2008). Oversaturation of prevention efforts targeting YGBM may also be attributed to the specific cities where these coalitions were located. Some of these locations (e.g. San Francisco, Manhattan) have more experience dealing with the epidemic as a public health issue, when compared to other locations. Consequently, these cities may encounter a greater degree of “safer sex fatigue” than other locations (Ostrow, Silverberg, Cook, et al., 2008; Rowniak, 2009). Finally, members articulated the importance of concentrating on other critical issues, such as increasing access to jobs and mental health services, as a new method in dealing with safer sex fatigue.

Coalition members also noted that the goals of sexual health promotion efforts for the two populations differed. For YHW, HIV prevention efforts were often coupled with pregnancy prevention; whereas for YGBM, HIV prevention efforts were often coupled with prevention of sexually transmitted infections. These distinctions illustrate members’ beliefs about the sexual health risks and consequences each population encountered.

For coalitions working with YGBM, members mentioned competition between partner organizations over funding and “numbers” of clients served as a challenge affecting group cohesion. One rationale for the existence of such a competitive environment among organizations serving gay and bisexual youth may be that the majority of the funding available to work with gay youth targets HIV prevention. In comparison, funding streams targeting YHW may have a broader focus than just HIV prevention (e.g. increasing sports programs, job training, and educational opportunities).

Members of the YHW also highlighted coalition decision-making processes as a concern, specifically ensuring efficient mechanisms for obtaining buy-in from the individual organizations (i.e. approval from executive directors, or boards of directors). This same concern was not mentioned by members of the YGBM and may be attributed to several factors. First, HIV was first discovered and thought to only affect gay men, which suggests that the organizations with the most experience working in the field of HIV were either gay specific or served a large gay population. Second, early federal funding streams required collaborative approaches to improve the availability of HIV prevention, care, and treatment. As such, organizations targeting YGBM may have more time invested in figuring out how to best work together. Finally, YGBM coalitions do not have to contend with anti- and pro-abstinence-only ideologies preventing partner collaborations.

Strengths and Limitations

This study is unique in that it was able to utilize data from an extensive multi-site coalition-based HIV prevention study to explore differential challenges for coalitions working with similar, yet unique populations of youth. The scope of the C2P project is vast, thus data were collected from coalitions working in a range of urban cities throughout the United States who have been most impacted by the HIV epidemic. The data offer critical information regarding concerns that may arise and adjustments that may need to be made when working with coalitions focused on different target populations.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Regarding limitations, the time and resource-intensive nature of C2P presents challenges in replicating such an effort, especially in non-research settings. Many community agencies do not have the time and resources to execute the C2P intervention detailed in this research. Another limitation of the study is a sole reliance on coalition members' self-reports, which may be susceptible to social desirability and recall biases. However, confidentiality of responses was assured during data collection to address this. Changes in coalition membership was another potential limitation, as this resulted in different coalition members participating in data collection during the various time points. However, this may not be a severe limitation since the study's purpose was to capture group-level experiences within naturally-evolving community coalitions, which often involve fluidity of membership over time.

Implications and Conclusion

This study supports the need for coalitions to collect feedback from community partners and incorporate those insights into coalition strategic planning efforts in an ongoing manner. As anticipated, each type of coalition shared some similarities in addressing HIV prevention among high-risk populations, such as maintaining consistent participation, sustaining the coalition's strategic plan, engaging new participants strategically, functioning within perceived protocol limitations, and sustaining and marketing the coalition. At the same time, each type of coalition had a different set of factors identified as challenges specific to their target group, including acceptability and goals in discussing sexual issues with adolescents, goals of sexual health promotion activities with adolescents, and competition among collaborating agencies. These findings highlight the importance of considering the complete identity of the population targeted by a coalition—age, gender, sexual orientation, racial and ethnic factors and community setting.

Tailoring public health approaches based on a comprehensive understanding of the target population is also supported by the cultural adaptation literature (Bernal, Bonilla, and Bellido, 1995; Cunningham, Solomon, and Card, 2009; Dévieux, Malow, Rosenberg, and Dyer, 2004; Malow, Jean-Gilles, Dévieux, Rosenberg, and Russell, 2004). Cultural adaptation is an important concept within public health promotion because to be effective, intervention approaches should be respectful of, and responsive to, cultural and linguistic needs of the population they aim to serve (Bernal, Bonilla, and Bellido, 1995; Office of Minority Health, 2001). The same holds true for coalition's striving to achieve structural changes that will support health promotion or prevent risk activity among high-risk adolescent populations such as YGBM and YHW.

Community-based organizations have the community pulse regarding factors that influence the scope and diffusion of coalition activities. Coalitions can benefit from taking the time to pool this type of information in a systematic way and transfer it back into the coalitions' objectives and strategic plans. Understanding the nuances of the target population can increase the success and sustainability of the coalition's achievements.

Acknowledgments

The Adolescent Trials Network for HIV/AIDS Interventions (ATN) and Connect to Protect® were supported by grants U01 HD040533 and U01 HD040474 from the National Institutes of Health through the National Institute of Child Health and Human Development with supplemental funding from the National Institutes on Drug Abuse and Mental Health. Additional grants that supported this work at the ATN sites include: Children's Diagnostic and Treatment Center: U01 HD040476; Children's Hospital of Los Angeles: U01 HD040463; Children's National Medical Center: U01 HD040562; John H. Stroger Jr. Hospital of Cook County and the CORE Center: U01 HD040515; Montefiore Medical Center: U01HD040499; Mount Sinai Medical Center: U01 HD040505; University of California at San Francisco: U01 HD040506; University of Maryland: U01 HD040584; University of Pennsylvania and the Children's Hospital of Philadelphia: U01 HD040481; and University of South Florida: U01

HD040497. The authors thank the investigators and staff of the ATN listed in Harper, Willard, & Ellen's (this issue) “Connect to Protect®: Utilizing Community Mobilization and Structural Change to Prevent HIV Infection among Youth” for their valuable contributions to this project. In addition, the authors are grateful for editorial assistance from Douglas Bruce and Kate Chutuape, and transcription support from Laura Thomas and Carolina Rodriguez.

References

Bernal G, Bonilla J, Bellido C. Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. Journal of Abnormal Child Psychology. 1995; 23:67–82. [PubMed: 7759675]

Butterfoss, FD. Coalitions and partnerships in community health. Jossey-Bass; San Francisco, CA: 2007. p. 3-25.

CDC. [March 22, 2010] Cases of HIV Infection and AIDS in the United States and Dependent Areas, 2007. 2007. http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/table1.htm

CDC. HIV/AIDS among Youth Fact Sheet. 2008. August. http://www.cdc.gov/hiv/resources/factsheets/youth.htm

CDC. HIV/AIDS Surveillance Report, 2006. 2008. p. 18

CDC. Persons tested for HIV—United States, 2006. Morbidity and Mortality Weekly Report. Aug; 2008 57(31):845–849. [PubMed: 18685551]

CDC. Subpopulation Estimates from the HIV Incidence Surveillance System—United States, 2006. MMWR. 2008; 57(36):985–989. [PubMed: 18784639]

Centers for Disease Control and Prevention. HIV/AIDS Surveillance in Adolescents and Young Adults (Through 2007) Slide Series. Last updated May 19th, 2009.. 2009. Retrieved from http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm

Cunningham, Shayna; Solomon, Julie; Card, Josefina. How to Adapt Effective Programs for Use in New Contexts: A step-by-step workbook for HIV prevention practitioners. Sociometrics Corporation; Los Altos, CA: 2009.

D'Amour D, Ferrada-Videla M, San Martin Rodríguez L, Beaulieu M. The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. Journal of Interprofessional Care. 2005; 1:116–131. [PubMed: 16096150]

Dévieux J, Malow R, Rosenberg R, Dyer J. Context and Common Ground: Cultural adaptation of an intervention for minority HIV infected individuals. Journal of Cultural Diversity. 2004; 11(2):49–57. [PubMed: 15453004]

Fawcett, SB.; Francisco, VT.; Paine-Andrews, A.; Lewis, RK.; Richter, KP.; Harris, KJ., et al. Work Group evaluation handbook: Evaluating and supporting community initiatives for health and development. Lawrence, KS., editor. Work Group on Health Promotion and Community Development, University of Kansas; 1995.

Fawcett SB, Francisco VT, Paine-Andrews A, Schultz JA. Working together for healthier communities: A research-based memorandum of collaboration. Public Health Reports. 2000; 115(2/3):174–179. [PubMed: 10968751]

Francisco VT, Paine AL, Fawcett SB. A methodology for monitoring health action coalitions. Journal of Health Education Research: Theory and Practice. 1993; 8(3):403–416.

Harper G. Sex Just Isn't That Simple: Culture and Context in HIV Prevention Interventions for Gay & Bisexual Male Adolescents. American Psychologist. Nov.2007 :806–819.

Harper GW, Bangi AK, Contreras R, Pedraza A, Tolliver M, Vess L. Diverse phases of collaboration: working together to improve community-based HIV interventions for adolescents. American Journal of Community Psychology. 2003; 33:193–204. [PubMed: 15212178]

Hays CE, Hays SP, DeVille JO, Mulhall PF. Capacity for effectiveness: the relationship between coalition structure and community impact. Evaluation and Program Planning. 2000; 23(3):373–379.

Herek GM, Capitanio JP, Widaman KF. HIV-related stigma and knowledge in the United States: Prevalence and trends, 1991-1999. American Journal of Public Health. Mar; 2002 92(3):371–377. [PubMed: 11867313]

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Jenkins C, McNary S, Carlson BA, King MG, Hossler CL, et al. Reducing Disparities for African Americans with Diabetes: Progress made by the REACH 2010 Charleston and Georgetown Diabetes Coalition. Public Health Reports. 2004; 119(3):322–30. [PubMed: 15158111]

Levitt M, Rosenthal DB. The third wave: A symposium on AIDS politics and policy in the United States in the 1990s. Policy Studies Journal. 1999; 27(4):783–795.

Kegler M, Painter JE, Twiss JM, Aronson R, Norton BL. Evaluation findings on community participation in the California Healthy Cities and Communities Program. Health Promotion International. 2009; 24(4):300–310. [PubMed: 19884242]

Kegler MC, Steckler A, McElroy K, Malek SH. Factors that contribute to effective community health promotion coalitions: A study of 10 project ASSIST coalitions in North Carolina. Health Education & Behavior. 1998; 25:338–353. [PubMed: 9615243]

Kegler M, Williams C, Cassell C, Santelli J, Kegler S, Montgomery S, et al. Mobilizing communities for teen pregnancy prevention: Associations between coalition characteristics and perceived accomplishments. Journal of Adolescent Health. 2005; 37(3):S31–S41. [PubMed: 16115569]

Malow R, Jean-Gilles M, Devieux JG, Rosenberg R, Russell A. Increasing access to preventive health care through cultural adaptation of effective HIV prevention interventions: A brief report from the HIV Prevention in Haitian Youths Study. The Association of Black Nursing Faculty Journal. Nov-Dec;2004 :127–132.

Mattessich, PW.; Murray-Close, M.; Monsey, BR. Collaboration: What makes it work. 2nd ed.. Amherst H. Wilder Foundation; Saint Paul, MN: 1992.

McLeroy K, Kegler M, Steckler A. Community coalitions for health promotion: summary and further reflections [editorial]. Health Education and Behavior. 1994; 9:1–11.

Mengis J, Nicolini D. Root Cause Analysis in Clinical Adverse Events. Nursing Management. 2010; 16(9):9–20. [PubMed: 20222223]

Metzler MM, Higgins DL, Beeker CG, Freudenberg N, Lantz PM, Senturia KD, et al. Addressing urban health in Detroit, New York City, and Seattle through community-based participatory research partnerships. American Journal of Public Health. 2003; 93(5):803–811. [PubMed: 12721148]

Minkler M. Ethical challenges for the “outside” researcher in community-based participatory research. Health Education & Behavior. 2004; 31(6):684–697. [PubMed: 15539542]

Office of Minority Health. National standards for culturally and linguistically appropriate services in health care: Final report. U.S. Department of Health and Human Services; Washington, DC: 2001. p. 3-131.

Ostrow DG, Silverberg MJ, Cook RL, Chmiel JS, Johnson L, Li X, et al. Prospective study of attitudinal and relationship predictors of sexual risk in the multicenter AIDS cohort study. AIDS and Behavior. 2008; 12:127–138. [PubMed: 17410419]

Rhodes S, Malow R, Jolly C. Community-based participatory research: A new and not-so-new approach to HIV/AIDS prevention, care, and Treatment. AIDS Education and Prevention. 2010; 22(3):173–183. [PubMed: 20528127]

Richert L. Reagan, Regulation, and the FDA: The US Food and Drug Administration's Response to HIV/AIDS, 1980-90. Canadian Journal of History. 2009:467–87. Winter ISSN 0-008-1107.

Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. Annual Review of Public Health. 2000; (21):369–402.

Rowniak, Stefan. Safe sex fatigue, treatment optimism, and serosorting: New challenges to HIV prevention among men who have sex with men. Journal of the Association of Nurses in AIDS Care. 2009; 20(1):31–38. [PubMed: 19118769]

Schensul JJ. Organizing community research partnerships in the struggle against AIDS. Health Education & Behavior. 1999; 26(2):266–283. [PubMed: 10097969]

Simoni, JM.; Evans-Campbell, T.; Andrasik, MP.; Lehavot, K.; Valencia-Garcia, D.; Walters, KL. HIV/AIDS among women of color and sexual minority women.. In: Landrine and Russo. , editor. Handbook of diversity in feminist psychology. Springer Publishing Co.; New York, NY: 2010. p. 335-365.

Wilson BD, Harper GW, Hidalgo MA, Jamil OB, Torres RS, Fernandez MI, Adolescent Medicine Trials Network for HIV/AIDS Interventions. Negotiating Dominant Masculinity Ideology:

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

Strategies Used by Gay, Bisexual and Questioning Male Adolescents. American Journal of Community Psychology. 2010; 45:169–185. [PubMed: 20082238]

Wolff T. A Practitioner's Guide to Successful Coalitions. American Journal of Community Psychology. 2001; 29(2):173–191. [PubMed: 11446275]

Ziff MA, Harper GW, Chutuape KS, Deeds BG, Futterman D, Francisco VT, et al. Laying the foundation for Connect to Protect®: A multi-site community mobilization intervention to reduce HIV/AIDS incidence and prevalence among urban youth. Journal of Urban Health. 2006; 83(3): 506–52. [PubMed: 16739051]

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

Table 1

Summary of Themes from the Qualitative Interviews

	Coalitions working with African-American and Latino young gay/bisexual men	Coalitions working with African-American and Latina heterosexual young women
Direct process challenges	• Maintaining consistent participation (11)	• Maintaining consistent participation (11)
	• Sustaining the coalition's strategic plan (4)	• Sustaining the coalition's strategic plan (4)
	• Engaging new participants strategically (4)	• Engaging new participants strategically(4)
	• Functioning within perceived protocol limitations (2)	• Functioning within perceived protocol limitations (2)
		• *Streamlining coalition decision-making process* (2)
	•*Sustaining the coalition* (2)	
	• *Achieving more tangible outcomes* (1)	
	•*Building group cohesion* (1)	
Indirect process challenges	• Sustaining individual agencies within the coalition (2)	• Sustaining individual agencies within the coalition (2)
		• *Forging collaborations across diverse approaches to HIV prevention* (1)
	• *Funding competing among partner* (2)	
Direct content challenges	• Marketing relevance of structural change work (2)	• Marketing relevance of structural change (2)
		• *Discussing sex with adolescents* (2)
	• *Dealing with oversaturation of services* (1)	• *Following community trends* (1)
Indirect content challenges	• *Over saturating youth with prevention services and messaging* (3)	• *Discussing sex with adolescents* (4)
		• *Responding to youth perceived consequences of teen pregnancy* (1)
	• *Changing approaches to HIV prevention* (1)	
		• *Dealing with myths about the efficacy of prevention tools* (1)

Notes. 1) Comments listed by frequency with which statements were made. The frequency appears after each statement. 2) Statements in italics are those that only appear in one column for that category.