Structural issues affecting creation of a community action and advocacy board

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Abstract

The most effective woman-initiated method to prevent HIV/sexually transmitted infections is the female condom (FC). Yet, FCs are often difficult to find and denigrated or ignored by community health and service providers. Evidence increasingly supports the need to develop and test theoretically driven, multilevel interventions using a community-empowerment framework to promote FCs in a sustained way. We conducted a study in a midsized northeastern US city (2009–2013) designed to create, mobilize and build capacity of a community group to develop and implement multilevel interventions to increase availability, accessibility and support for FCs in their city. The Community Action and Advocacy Board (CAAB) designed and piloted interventions concurrently targeting community, organizational and individual levels. Ethnographic observation of the CAAB training and intervention planning and pilot implementation sessions documented the process, preliminary successes, challenges and limitations of this model. The CAAB demonstrated ability to conceptualize, plan and initiate multilevel community change. However, challenges in group decision-making and limitations in members’ availability or personal capacity constrained CAAB processes and intervention implementation. Lessons from this experience could inform similar efforts to mobilize, engage and build capacity of community coalitions to increase access to and support for FCs and other novel effective prevention options for at-risk women.

Introduction

As the third decade of the deadly AIDS pandemic progresses, heterosexual transmission remains a tenacious problem [1]. HIV incidence among US women continues to increase disproportionately in certain populations, particularly ethnic minorities and impoverished women [2–6]. In this context, it is essential to ensure that women have prevention methods that they can initiate and control to reduce transmission of HIV and other sexually transmitted infections (STIs) [5–11]. Currently, the most effective woman-initiated method to prevent HIV/STIs is the female condom (FC) [12–16]. Prior studies by the authors [17, 18] and many other researchers [19–22] have indicated significant acceptability of FCs and potential for skills in its use by high-risk populations. Yet despite its proven acceptability and effectiveness, the FC is often difficult or impossible to find in community clinics and pharmacies and public health organizations severely ration them. Furthermore, community health and social service providers rarely promote them and often denigrate or ignore them as a prevention option [6, 23, 24]. The result of these community-level conditions is that the FC is unavailable, and many who could benefit from it are unaware of this important
prevention option and lack the knowledge and skills to use it effectively.

FC requires support for its promotion and use [25–27]. Because of common difficulty with initial insertion and novelty of the product, users often need demonstration of proper use and may also need follow-up support if problems arise with use in various contexts [17]. Often, change is also needed in health and service organizations (e.g. to increase staff capacity and administrator commitment) and in community resource allocation and policy support to expand promotion of FCs before the product can contribute significantly to HIV/STIs prevention [28]. Individual-, organizational- and community-level factors intersect in this process and require integrated attention for specific efforts to take hold.

Evidence increasingly supports the need to develop and test theoretically driven, multilevel interventions using a community-empowerment framework [29] to engage sectors of the community with an interest in or desire to move FC promotion forward in a sustained way. This mobilized force could constitute a community-embedded change mechanism able to generate interventions consistent with local community policies, norms, practices and services [22]. Community engagement offers great promise for building responses that use existing resources (human, political, economic) and are relevant to those communities [30].

We conducted an intervention development study (2009–2013) in a northeastern US city that could benefit greatly from increased access to additional effective HIV/STIs prevention tools. The city, with a population of about 125,000, had an HIV prevalence rate of 2483/100,000 in 2010 [31]. Over 40% of the urban residents were African-American/Black, 45% were Hispanic and 32% lived below the poverty level in 2010. Our intervention program was designed to mobilize community members to create and implement multilevel interventions to increase availability, accessibility and support for FCs to reduce heterosexual transmission of HIV and other STIs in their city. The study used a community-based approach to engage and build capacity of a body of key agents, called the Community Action and Advocacy Board (CAAB). This group collectively designed and piloted interventions conducted at the community, organizational and individual levels to achieve the project goals. We present here the conceptual model used to create the CAAB and guide their efforts to generate and implement their multilevel interventions. We also describe our experiences applying the model in a single case city, including the processes, challenges, successes and limitations of the CAAB to develop interventions with potential to transform the context of FC support in their community.

Methods

**Theoretical framework and model**

Framing social dynamic, multilevel intervention models theoretically and implementing and testing them requires integration of both an overarching theory of social change and specific theories of change processes at different social levels. Several theories facilitate this integrated model of multilevel change, including community empowerment [32–34], social ecological [35–37], social learning [38] and diffusion theories [39]. Empowerment theory emphasizes the power of individuals and communities to engage in their own health promotion and critically examine contextual and structural factors that either cause direct harm or indirectly reduce or eliminate options for prevention and harm reduction [33, 40, 41]. Empowerment here refers to ‘people having power to take action to control and enhance their own lives, and the processes of enabling them to do so’ [42]. Social empowerment models are designed to enhance outcomes at the social/community level and to encourage and support sustainability [43–45]. Organized social action and advocacy are key mechanisms of empowerment [46, 47]. Advocacy refers to organized efforts to change conditions that negatively affect people as individuals and as a group [48, 49]. Ecological theory focuses on social processes and mechanisms that influence change on multiple levels, such as the community, within the intermediary institutions and with individuals, who are embedded within
and interacting with institutions in a social–political and cultural context. Social learning theory [38, 50] recognizes the importance at the individual level of social modeling, skill building and efficacy to support behavior change. Diffusion theory [39] offers an important framework for understanding the processes by which innovations, such as the FC, are accepted, rejected or transformed in use. Trustworthy change agents and influential community members are keys to affect this often non-linear process.

Table 1 provides the theoretical framework and evaluation model that lays out components and key constructs of our community engagement approach using these integrated theories of social change. Action and advocacy were built into this study through the creation of the local CAAB. This community group was designed to coalesce around the problem of limited FC awareness and availability for reduction of HIV/STIs and to create an identity, brand and action plan for themselves defined by this issue. Furthermore, with capacity building and support, the CAAB was expected to organize itself to develop multilevel intervention(s) to address these problems.

The hypothesized processes and outcomes of this study’s community engagement and empowerment model are illustrated in Fig. 1. In this model, the CAAB, generated, guided and supported by a multi-stakeholder community Steering Committee (SC), represents a community change agent, whose mobilization and capacity building becomes a mechanism of multilevel community change. The two expected primary outcomes were (i) to generate a solidified entity (coalition) able to design and implement multilevel interventions and to sustain their efforts and (ii) the creation and implementation of a multilevel intervention. Specifically, the CAAB intervention was to target the community level (e.g. the general and at-risk populations across the city), the organizational level (i.e. the institutions and organizations that provide health and social services and their administrators and staff) and the individual level (e.g. targeted community members at high risk, their peers or health and social service patients and clients). Through developing and implementing a multilevel intervention, the CAAB was expected to affect secondary outcomes to increase city-wide awareness of FCs, general knowledge of proper FC use and access and availability of FCs in community settings. As described below, we report here only on the primary outcomes of this community engagement intervention model, which had just completed the pilot phase.

The CAAB was supported by an 11-member SC, comprising 6 members of the project’s community research team plus 5 local and state-wide health and service providers and advocates. The role of the SC was to provide scientific guidance, community knowledge, practical support, capacity-building training, technical assistance and infrastructure supporting CAAB capacity to achieve their community-wide social change goals. The SC represented significant expertise in community coalition building, participatory research, FC acceptability and advocacy, and the risks and factors affecting prevention for at-risk women and their partners. SC members represented diversity by gender, ethnicity, education, experience/training, sexual orientation, HIV status and substantive focus of work/experience. Diverse expertise on the SC facilitated their effectiveness in developing the CAAB training program, identifying and recruiting CAAB members and supporting the CAAB’s ability to create, implement and participate in evaluating their multilevel interventions.

Research design

This intervention development study used a prospective, mixed method intensive observational case study design [51–53] in a single city to document project activities and outcomes. Because of the dynamic interplay between interventionists and community-level change, testing a community empowerment intervention requires a continuous feedback and measurement design, and approaches that measure non-linear growth or change [51]. Therefore, we used continuous ethnographic observation, interviewing and process tracking to document the CAAB creation, capacity building, their intervention development, ongoing activities and initial intervention pilot efforts.
Table I. *Theoretical framework and evaluation model of the CAAB intervention program to increase FC promotion and availability in the community*

<table>
<thead>
<tr>
<th>Theoretical constructs</th>
<th>Intervention approach</th>
<th>Processes</th>
<th>Expected outcomes</th>
<th>Evaluation method</th>
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<tbody>
<tr>
<td>Community empowerment:</td>
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<tr>
<td>• Community engagement</td>
<td>Identify and recruit community members for CAAB</td>
<td>Group development of name and symbolic representation (logo, colors, tag line)</td>
<td>Complete curriculum for CAAB development and capacity-building training</td>
<td>Observations of CAAB meetings and activities</td>
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<tr>
<td>• Capacity building</td>
<td>Develop CAAB identity and build capacity to design/implement community interventions</td>
<td>CAAB development of mission statement and goals</td>
<td>Cohesive group solidified around identity/brand and mission</td>
<td>In-depth interviews of CAAB members pre-/mid-/post-training over 18 months</td>
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<td>• Action and advocacy</td>
<td></td>
<td>Inclusiveness of community members with different backgrounds</td>
<td>Sustained CAAB activities for 6 months to 1 year beyond end of training program</td>
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<td>Social ecology:</td>
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<tr>
<td>• Multilevel model of social relationships:</td>
<td>Build group understanding of multilevel processes</td>
<td>Group discussion of meanings of social ‘levels’ and possible interventions on each level</td>
<td>CAAB creation of intervention models directed at impacting each of the three social levels</td>
<td>Observations of CAAB meetings and activities</td>
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<td>- community</td>
<td>Training and capacity building to develop tri-level intervention</td>
<td>Subgroup conceptual work on potentially effective intervention on that level using logic model for social/behavioral change</td>
<td>Cross-linkages and referrals across three levels of interventions (for recruitment or dissemination)</td>
<td>Document design of CAAB interventions and mechanisms for cross-referral among three interventions</td>
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<td>- organization</td>
<td>Identify cross-linkages among tri-level intervention components</td>
<td>Re-coalescing of subgroups to maintain whole group identity and goals</td>
<td>Whole group commitment to all CAAB interventions</td>
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<td>- networks</td>
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<td>- individuals</td>
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<tr>
<td>Linkages within and across levels generating mutual influence and reinforcement</td>
<td>Designed content of sessions to explain and facilitate development of tri-level interventions on:</td>
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<td>- community level</td>
<td>Subgroup conceptual work on potentially effective intervention on that level using logic model for social/behavioral change</td>
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<td></td>
<td></td>
<td>- organizational level</td>
<td>Re-coalescing of subgroups to maintain whole group identity and goals</td>
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<td>- individual level</td>
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<td></td>
<td></td>
<td>Subgroups developed each level of intervention using logic model approach</td>
<td>Cross-linkages and referrals across three levels of interventions (for recruitment or dissemination)</td>
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<tr>
<td></td>
<td></td>
<td>Subgroups identified ways to cross-ref from each level to the other two</td>
<td>Whole group commitment to all CAAB interventions</td>
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<tr>
<td>Social learning:</td>
<td>Interactive role play and skill building focus of the training program</td>
<td>CAAB training sessions incorporate skill building in use of logic model to develop interventions</td>
<td>CAAB members assisted each other in learning to demonstrate proper FC use</td>
<td>Observations of CAAB meetings, intervention role plays and pilot interventions</td>
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<tr>
<td>• Peer modeling</td>
<td></td>
<td>CAAB training repeatedly modeled proper demonstration of FC use</td>
<td>All CAAB members could either lead or support one or more of their three interventions</td>
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<tr>
<td>• Skill/efficacy enhancement</td>
<td></td>
<td>Training sessions included peer modeling/skill building of CAAB members to deliver all interventions</td>
<td>CAAB members could effectively demonstrate proper FC use</td>
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<td></td>
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<td>CAAB members shared skills and practice of their interventions, particularly across subgroups</td>
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We present the process documentation of the CAAB creation and its development work over a 2-year period. This includes data from ethnographic observations of CAAB training sessions, ongoing meetings, intervention efforts, and group dynamics. All sessions were documented by two or more researchers and notes were compared to build the fullest observation possible. These data are supplemented with in-depth interviews of CAAB members conducted before, mid-way through, and after their training and intervention development program.

To process and analyze the qualitative data, the research team constructed a coding structure using key themes relevant to the study design and theoretical model. Examples of key codes included the following: capacity building (enhancement), group identity, relationships, decision making/negotiation, leadership, concerns/conflicts, contributions, resources needed, empowerment, facilitators/barriers to development and implementation, freelance work of FC promotion, motivation, support and sustainability, among others. Multiple researchers coded text documents for key themes, including overlapping and co-occurring themes. Analyses proceeded by seeking patterns both in individual responses to research questions in the context of their personal experiences and background situations, and in group responses of overlapping and co-occurring themes.

All CAAB members provided informed consent prior to interviews and recruitment as a CAAB member. They were compensated $25 for each 1-hour in-depth interview, $100 for attending a day-long initial training retreat, $20 for attending ongoing monthly CAAB working meetings and $20 for attending ongoing monthly CAAB working meetings over 24 months. All compensation, data collection procedures and the CAAB development and intervention study design were reviewed and approved by the Institute for Community Research Institutional Review Board.

The following describes the process of creating and mobilizing the CAAB and building their Table I. Continued

<table>
<thead>
<tr>
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<th>Processes</th>
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<tbody>
<tr>
<td>Innovation diffusion:</td>
<td>CAAB membership includes stakeholders</td>
<td>Steering Committee identifies and recruits influential community members (advocates, service/health providers) for CAAB membership</td>
<td>CAAB members deliver their intervention to co-workers and peers</td>
<td>CAAB member role modeling of FC support and promotion leads to adoption by peers and co-workers and dissemination through work/community networks</td>
<td>In-depth interviews of CAAB members</td>
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<td>Trustworthy change agents</td>
<td>CAAB members lead peers in adopting changes</td>
<td>CAAB members become leaders and role models for proposed change</td>
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<td>Repeated community assessment surveys</td>
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<td>Key opinion leaders</td>
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<td>Peer norms change</td>
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Engaging community to develop multilevel intervention
capacity to design and implement multilevel interventions, as well as the specific interventions they developed and piloted in their community (i.e. the primary outcomes of the study in Figure 1). We also describe important dynamics affecting this process and lessons derived from it relevant to community engagement efforts to increase HIV/STIs prevention options in the community.

**Findings**

**Building the CAAB**

The SC began CAAB construction by generating a comprehensive list of 54 names from their extensive knowledge of community members, advocates and people in strategic positions in clinics, community-based organizations and other organizations in the city, who they felt would be trusted and effective FC change agents in the community. The list of potential CAAB members included substance abuse and HIV case managers and counselors, health and social service providers from local general health and women’s reproductive health clinics, clergy, staff of domestic violence, youth and women’s programs, community activists and at-risk community residents.

The SC organized and prioritized the list to construct a purposive sample of at least 20 people representing different community stakeholders to participate in the CAAB training. The list was prioritized by factors such as representation from the major clinics and service agencies in the city, profession, gender, age group, community residence, etc. We anticipated attrition throughout the study and expected final CAAB membership to include (i) 8–10 ‘full’ participants who agreed to attend every meeting and create, direct and carry out the interventions; (ii) five to eight ‘intermittent’ participants expected to participate in CAAB activities but not commit to all meetings; (iii) three to five honorary advisors or supporters who would make resources available to the CAAB or facilitate implementation of CAAB activities but not attend meetings and (iv) a variable number of non-CAAB volunteers recruited by CAAB members to assist with community actions.

Project ethnographers called all these candidates to seek their interest in participating on the CAAB and, if so, to arrange an initial in-depth interview. Of the initial list of names, 22 either could not be reached or declined an interview (either because of lack of available time or lack of interest) and 32 CAAB candidates agreed to the initial in-depth interview. These interviews were conducted from

Fig. 1. Community empowerment model to develop and implement multilevel interventions to promote FCs to prevent HIV and other STIs.
from August to December, 2009, by which time 23 had indicated strong interest in participating in the group, were confirmed as good candidates and were invited to participate. Most of the nine interviewees who did not agree to participate indicated that the time commitment was too great for them.

In-depth interviews of CAAB candidates were designed both to recruit CAAB members and to document their pre-training perspectives, attitudes and background experiences. The interview explored trends they perceived in heterosexual HIV risks, their views on FCs and male condoms, their perceptions of co-workers’ and peers’ views about FCs and its promotion, their views on the potential of a community group to develop and implement effective interventions to increase FC availability and support in community settings, their personal interest in participating in such a group and experiences or expertise they would bring to the group. In-depth interviews and a brief pre-training FC knowledge survey revealed participants’ variable prior knowledge of and experience with FCs. They averaged 76% correct scores on the FC knowledge pre-test before beginning the training. Only 46% reported ever having previously attended training on FCs, and 45% had demonstrated proper FC use to someone in the prior 6 months. However, all CAAB candidates expressed strong belief that FC is an important prevention tool and that the community needs more knowledge about it and access to it [H. Hilario, M. Abbott, M.R. Weeks et al., manuscript in progress]

Of the 23 people who signed a letter of commitment to a 1-year engagement on the CAAB, 19 were women (9 African or Caribbean American, 7 Latina, 1 White and 2 of mixed ethnicity) and 4 were men (3 African American and 1 Latino). Stakeholder representation included seven community residents and peer advocates, five health or social service managers, four case managers, two registered nurses, one church elder, one health educator and one pharmacy technician. All 23 CAAB candidates attended a welcoming reception and initial 1-day retreat.

CAAB capacity-building training program
The SC designed the original CAAB training program based on their combined knowledge of theories of community engagement and mobilization [54, 55] and social and behavioral change, and their rich community experience. The training included (i) coalition building mechanisms to build group cohesion and identity; (ii) capacity building to assist members to achieve the goals of the project, including understanding the concept of ‘multilevel’ in the social ecological framework and using a logic model approach to design interventions; (iii) identifying goal compatibility with group member and community interests and (iv) defining key constructs related to community engagement for social change, including modeling, mobilization and social action. We also included several practical components to the CAAB training program, including (v) addressing myths or misinformation and biases about FCs; (vi) opportunity for participants to see and feel the FC and practice demonstrating proper FC use; (vii) training on troubleshooting and FC negotiation to address partner resistance and (viii) male participation in promotion efforts.

We approached the CAAB training recognizing that members were grassroots ‘experts’ and ‘leaders’ in key areas of HIV/STIs prevention, women’s health and empowerment and community health needs. However, this disparate and diverse group also needed to focus their interests and direct their actions as a coordinated coalition. This required, first, creating a name, ‘brand’ and other aspects of their identity and developing a clear mission statement. Second, it required building group cohesion, teamwork and relationships among CAAB members to facilitate their ability to work in a concerted effort as volunteers over a long period of time to achieve their common goals. This was enhanced by recognizing and using each person’s special capacity and ideas as well as their skills and networks. Finally, group coalescence required assisting CAAB members to develop a leadership and organizational structure to facilitate decision making and coordinate activities over time.

The CAAB training curriculum was implemented from January through June, 2010. It began with a welcoming reception to introduce participants to each other, give a brief overview of FCs and other women-initiated prevention options (such as
microbicides in development) and an overview of the project, including a discussion of their roles and responsibilities. The reception was followed with a 1-day retreat to introduce the primary components of the training and capacity-building plan and an overview of the project design and goals; establish ground rules for interaction; review female anatomy, the FC, and CAAB roles and responsibilities; and discuss research ethics, including potential ethical dilemmas, and next steps.

The remainder of the training was conducted in 10 sessions, each lasting 2½–3 hours. Every session included didactic information delivery, interactive group identity-building and skill-building exercises and increasingly sophisticated discussion of multilevel intervention goals and the driving concept of community members as multilevel change agents. The ten sessions covered CAAB identity, mission and logo development; brainstorming and prioritizing community-, organizational- and individual-level projects; developing a FC Frequently Asked Questions flier prepared on CAAB letterhead to be used for all their interventions; designing prioritized projects at each level and closing up by planning next steps after the training ended to cover a period of 6 months to 1 year.

During the training, CAAB members were divided into three intervention development working groups targeting the community, organizational and individual levels to expedite the development of action projects at each level. SC members guided them to follow a logic model to facilitate conceptualizing projects they could implement while incorporating known evidence-based processes of behavioral or social change. The logic model required them to specify intervention goals and objectives, target audiences, products to be generated, logistics or steps to implement it, resources needed (people, materials, funds), expected outcomes and evaluation methods.

After the 1-day retreat, three CAAB recruits chose not to initiate the 6-month long, 10-session training program, because of scheduling conflicts and for reasons they did not disclose to us. Of the 20 CAAB members who started the capacity-building training, 2 left before completing the program; an additional 3 left immediately after completing the training and 2 others left over the next 6 months, leaving a group of 13 to carry the program forward beyond the initial 1-year commitment period. Reasons for attrition of these seven participants included changes of work responsibilities or schedule (n = 2), and personal barriers such as lack of transportation (n = 1), difficulties with childcare (n = 2), death in the family (n = 1) and entry into inpatient drug treatment (n = 1). Six of these seven who left during the initial year were employed. However, despite these challenges to participation, we were able to retain the planned group size of at least 10–12 full members for the 1-year commitment or longer. After the training, the CAAB continued to meet monthly at regularly scheduled times to move intervention concepts forward and organize implementation plans for more than 18 months. Nine of the original CAAB members continued regularly to attend monthly meetings more than 1 year after the training ended, and eight remained active 2 years after the CAAB welcoming retreat.

In recognizing the problem of member attrition, CAAB members decided to invite friends to join to assist with pilot intervention implementation. An additional four community members joined the group soon after the CAAB began its second year. Members who joined received a condensed version of the CAAB training, as a considerable portion of the 10-session capacity-building training focused on group branding and intervention development, phases of the project that had been finalized. Prior to their first meeting with the CAAB, new members attended a special 2½ hour training focused on: project design and goals, CAAB roles and responsibilities, FC overview, FC and female anatomy and practicing FC demonstrations. The new member training was facilitated by both SC and CAAB members, and original CAAB members were invited to attend as a booster session. Additionally, the CAAB organized the first three meetings with the new members to focus on intervention training, so that they would immediately become educated on the CAAB interventions that were already developed. A plan was devised so that the new members would attend pilot FC interventions as ‘helpers’
for additional hands-on training to be able to lead an intervention in the future.

Outcomes of CAAB development and capacity building

CAAB identity

As part of the effort to create an identity and build group cohesion, CAAB members selected a name for the group. Agreement by a majority required discussions across several training sessions, several votes and, eventually, the merging of two proposed names into one. They also defined their mission as follows: to educate people about the FC to increase its availability, accessibility and use for HIV/STIs and pregnancy prevention. An outside communications expert provided two 1-hour workshops on brand and logo development and provided graphics support. The CAAB finalized the logo for CAAB member business cards, letterhead and all educational materials the group generated. The group name, mission and insignia were key signals of group purpose and solidification. Members repeatedly used them to reflect their ongoing commitment to the program and pride in their membership in the group. The name itself, SWEET Inner Power (SWEET: Sexual Wellness Education and Empowerment Training), affirmed the empowerment value of the group and the FC for women’s health.

CAAB-developed multilevel intervention

Several initial sessions of the training provided both didactic and interactive discussion of key theoretical constructs framing the project, including the social ecological concept of ‘multilevel’ intervention. The CAAB reviewed definitions and examples of community-, organizational- and individual-level interventions and ways to focus and distinguish each. This was challenging for many CAAB members because the concepts are abstract and few had ever engaged in a critical discussion of intervention targets and change mechanisms on different ‘levels’. We returned to these distinctions and definitions throughout the intervention development period until members were clear on the meanings and key components of each.

The three CAAB working groups (organizational, community and individual level) each developed a project to contribute to the overall multilevel intervention effort. The community-level working group chose to develop a Facebook page with interactive messages, resources, information (e.g. links to the CDC website and the Female Health Company which produces the FC) and mechanisms for further social networking to promote FCs to local ‘friends’ networks. In deciding on this approach, the working group considered the value of electronic social networking to reach a large audience and build on CAAB members’ personal networks with intriguing content and reliable and in-depth information. They also considered the increasing popularity and relevance of Facebook as a source of information among a broad spectrum of target audiences, but particularly young people. To evaluate the individual-level intervention, they planned to monitor number of people who ‘liked’ their page, visited or commented on it. However, they recognized the limitation to this approach for being able to assess impact on ‘friends’ use or attitudes toward FCs on the basis of this informational and promotional page. Several working group members identified additional limitations of this intervention. They argued that Facebook would not reach some important members of the high-risk populations in their community. Others countered that use of electronic media was rapidly increasing even among low-income, ethnic minority, middle-aged and older community members, and this would be an attractive and effective method to influence people, particularly when coming from ‘friends’. Ultimately, the majority decided to use Facebook as the community-level intervention component. Two members of the working group created and launched the page, populating it with the desired multimedia and interactive information. However, both of them subsequently left the CAAB, and others in the group had less capacity to maintain and expand the page over time.

The organizational-level working group developed a 30-min presentation that CAAB members could deliver to local health and service organizations encouraging incorporation of FC education/
promotion and support into standard service delivery. The program includes a PowerPoint slide show that introduces FCs to staff (since many have limited or no knowledge of it), explains the benefits for clients/patients and the community, summarizes findings from local research on FC attitudes and use, emphasizes the power of service providers to promote FCs, provides tips for success in presenting it to clients/patients and for encouraging their coworkers to do the same and ends with information on how to obtain a free monthly supply of FCs from the Community Distribution Center, a state-funded resource available for eligible non-profit organizations and to purchase low-cost FCs for free distribution. The workshop also includes a guided FC demonstration, which provides an opportunity for all audience members to practice demonstrating proper FC use so they are able to repeat this with their clients or patients. Thus, key social learning, diffusion and empowerment components included skill building, peer modeling and support, and advocacy for broader FC promotion. Immediate audience feedback on the presentation content and effectiveness and audience intention to promote FCs with patients/clients or seek other ways to increase FC availability and support in their organization as a result of participating in the workshop was gathered through an anonymous evaluation form collected at the end of each session. A CAAB Intervention Documentation Form, to be completed by a CAAB member or other observer, assessed whether each required component of the workshop was completed in that session.

The individual-level working group designed the ‘Girls’ Night Out’ (GNO), a 1-hour health education ‘party’ to be held in the homes of community member ‘hosts’. CAAB members would deliver the program in the host’s home to her invited female friends and family members. The GNO was designed exclusively for women. It focuses on FC education, skill building and peer support for women’s empowerment in HIV/STIs prevention. It also emphasizes sensualization of FCs to increase sexual pleasure. The session includes ice-breaking games to encourage women to feel comfortable talking about sex and their bodies designed to facilitate direct discussion of proper FC insertion and use. An entertaining DVD with music, words and images highlights positive aspects of FCs as part of sexual health, pleasure, women’s empowerment and caring for sex partners. Hands-on demonstration of FC insertion using hands or a plastic vaginal model provides both skill building and partner negotiation support for FC use. These sessions were evaluated with a brief pre-/post-knowledge, attitude and skill survey conducted with each participant in the GNO session assessing what they learned from the session, their intention to try FCs and/or recommend it to a friend and their general reactions to the session. Participants are also asked to complete an anonymous evaluation form giving general feedback on the session.

Significant discussion emerged both within the individual-level working group during the development period and in the whole CAAB about the exclusive focus of the individual-level component on women. Some argued strongly for the importance of including male partners in the process of FC negotiation and use and men’s value as advocates for increasing availability of the device. Others argued that women need their own time and place to discuss issues of FC negotiation and use, sexuality and self-esteem, which would be minimized or made light of in the presence of men. They also reasoned that for some women, prior experiences with sexual violence or abuse would make them unwilling to discuss sexual matters in the presence of men. This discussion reflected a broader divergence of viewpoints that CAAB members frequently expressed passionately, regarding whether FCs should be approached exclusively as an empowerment tool for women or promoted as much for men’s benefit as women’s. This difference of perspectives remained strong among CAAB members throughout the project. Ultimately, the group decided by majority to retain the exclusive focus of the individual-level component on women and to reach men through the two other CAAB interventions. The group also discussed plans to develop an additional individual-level intervention targeting couples, in which the FC could be introduced to both partners at the same time.

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Although significant conceptual development of all three interventions was completed during the 10-session training, none was fully developed at that point. The CAAB used subsequent monthly meetings to finalize the interventions and organize themselves to implement them. The organizational-level presentation and individual-level GNO required an additional 10 months before they were finalized. To date, in addition to launching the Facebook page, the CAAB has piloted both the organizational presentation and the GNO in three settings each, reaching an average of 25 service providers (range 17–31) and 13 community members (range 10–15) at each session.

Initial feedback on all three interventions using the CAAB developed evaluation tools has been very positive. Since its launch, 176 people have ‘liked’ the Facebook page. On the anonymous evaluation forms provided at GNO sessions, most GNO participants to date have indicated their intention to use FCs and expressed interest in hosting a GNO themselves. At least one GNO participant later reported to her host that, because of the session, she had finally given FC a try after having refused to do so in the past. However, except for this anecdotal example, we do not know the full effect of GNO on participants’ FC use. Likewise, a few service providers who attended the organizational workshops reported having begun introducing FCs or increasing its promotion with their clients as a result of the presentation, and some have sought further information from CAAB members. These small effects suggest the potential of the interventions to impact recipients’ behavior, although at present there has been insufficient implementation to assess the real potential of the interventions to achieve sustainable individual-, organizational- or community-level change.

**CAAB leadership structure**

The CAAB developed a leadership structure out of the intervention working groups by selecting one representative and one alternate from each of the three groups to form a six-person leadership team. Members of the leadership team agreed to meet between the monthly CAAB meetings to plan the agenda and coordinate efforts of the working groups and the whole CAAB so they could finalize and begin to implement their interventions. These meetings were open to all CAAB members. Throughout the CAAB development and intervention implementation stages, decisions were made through a combination of whole group, working group or leadership team, depending on the context of the decision under discussion, until reaching majority agreement. After the three intervention designs had been completed, the working groups were disbanded and all members regrouped as a full team to coordinate and implement the interventions together.

Throughout the course of the project, and especially after completion of the training as the CAAB gained autonomy to organize and lead their own activities, power differentials between members of the group emerged and sometimes generated significant group conflict. This primarily centered on the process of leadership decision making. Participants with greater skills at organizing groups and speaking in public were usually the first to take leadership roles when others held back, but these tended to be the better educated and employed members of the CAAB. Unemployed community members or those with less training and experience felt challenged in taking leadership roles and also expressed frustration when decisions were made without their input. The group had numerous discussions to try to resolve or balance these issues, but even recognizing the conditions that contribute to power and skill differences does little to generate permanent solutions, and the CAAB continued to be challenged by this in their decisions and leadership structure. However, they agreed that majority rule would settle most decisions of the group to facilitate moving forward on implementing their interventions.

**CAAB member feedback**

CAAB member views were captured in observations of training sessions and monthly meetings and through in-depth interviews [54]. All members who completed the training reported that they felt...
the CAAB was very important and that they had gained significant experience and knowledge as a result of participating in the capacity-building program. All indicated that involving community members like themselves increased the potential for the community to trust the messages they developed and delivered about FCs. All six CAAB members employed in health and social services reported integrating FC promotion into their routine work with clients or patients and encouraging their co-workers to do the same. Most CAAB members also reported sharing FC information in conversations with friends and family members and even conducting demonstrations to members of their networks. However, they also indicated concerns about being able to implement the interventions over the long period needed to effect community change because of the group dynamics, declining membership and their own commitments and personal barriers to implementation efforts. Nearly all CAAB members reported in final interviews that their views of FCs were transformed by this experience and their commitment to its promotion solidified.

Discussion

Our experiences implementing an experimental trial of this community engagement model suggested the feasibility of creating, mobilizing and building capacity of a community coalition and facilitating its ability to become an effective group with an identity and clear mission. The CAAB demonstrated members’ ability to understand, conceptualize, plan and initiate a multilevel community change effort by building promising interventions targeting the community, organizational and individual levels in their own city. Through a bi-directional process of research input with community vision and experience, they developed theory-based interventions incorporating social learning theory (through skill building and peer modeling of FC use and promotion), diffusion theory (in peer dissemination through their own networks and those of their intervention recipients) and empowerment theory (both in the enhancement of their own capacity and in their focus on women’s sexual empowerment in the interventions).

The interventions they developed are feasible and focused on priorities the group identified as relevant to community members who would receive them. This increases the likelihood that these interventions are culturally appropriate for the local populations most directly affected by the HIV epidemic. This conclusion was supported during the pilots by initial feedback from intervention recipients, who almost universally responded positively and enthusiastically to the programs in which they participated. Each CAAB intervention emphasizes the importance of FCs for overall prevention (both disease and pregnancy) and for women’s health and empowerment. They also incorporate enticements to use FCs for sexual pleasure; encouragements to support greater FC promotion by providers and use by community members; opportunities to see, feel and practice with FCs and strong and impassioned assertions about the necessity of making this effective prevention device more available and supported in the community.

The most evident and sustained outcome of the CAAB creation, training and multilevel intervention development process for community empowerment to leverage change was the passion it engendered in group members. Although CAAB recruitment sought members who expressed initial interest in the FC, nearly all members reported that their commitment to fight for real FC availability in the community was kindled by their participation in the CAAB capacity-building training. This unexpected, unwavering and powerful fervor, which focused on the benefits of FCs for women’s empowerment and health and insistence that it should be available and accessible to all, appears to have aided CAAB members to overcome most challenges the group faced. It was clearly an evident force compelling many members to remain in the CAAB, despite the labor intensity of the effort. Even those who could not remain active CAAB members reported that their passion about the value of and need for FCs had led them to redouble their efforts to spread the word and press for increased availability and support of FCs through
other channels, at their workplaces or in their daily lives. CAAB members’ zeal for FCs was a primary reason they gave for wanting to increase group membership to reduce the impact of inevitable attrition over time. However, as our experience has demonstrated, passion alone is insufficient to maintain the group indefinitely without additional resources and supports.

Limitations and emergent challenges of the CAAB model

Implementation problems emerged with all three CAAB interventions despite positive participant feedback on content and potential effectiveness from pilot efforts. As mentioned, expanding the Facebook page was hindered because of limited capacity among CAAB members. Furthermore, scheduling, coordination and implementation of organizational and GNO sessions proved challenging. CAAB volunteers had limited time and capacity to structure and coordinate their efforts. Those with greater capacity to present the organizational intervention to providers were mostly employed themselves and not available during hours when the intervention could be delivered to organizational staff. However, many of the unemployed CAAB members had less capacity to conduct the intervention without support from more experienced members, who tended to be employed. Likewise, the GNO parties were usually scheduled for weekend evenings, thereby reducing the number of available CAAB members to implement them. These implementation challenges identified the need for additional community resources to aid the CAAB in leading or staffing their interventions.

Several important social dynamics emerged that affected the overall CAAB development process. One was the challenge of decision making. Large group decision making with total member input slowed progress, as in the example of selecting a group name. However, small group decision making sometimes resulted in challenges by the larger group, as with resistance to the selection of Facebook and the women-only GNO. Power differentials in the decision-making process also generated complications. These were evident among CAAB members, exacerbated by their unequal skills and comfort in leadership roles on the CAAB, within the working groups and in implementation of the interventions. Nearly all CAAB members sought to have input and to influence the shape of the interventions and group efforts. Fostering ongoing interactions and communication that engendered mutual respect and recognition of each person’s contributions and experiences was very important.

Inherent differences in CAAB member perspectives on the FC as an empowerment tool for women only versus including men reflected ambiguity in the concept of woman-initiated prevention options. It also indicated variation in understandings of the importance of gender and sexual power in women’s heterosexual relationships, and recognition of gender imbalanced factors, like abuse history and male domination, that impact women’s negotiating skills and options to ensure their own protection from exposure to infection. Likewise, emphasis on promoting the FC as offering sexual pleasure as well as protection demonstrated the group’s recognition of the need for men’s participation and potential for balance in sexual negotiation around FC use.

Aspects of the CAAB goals and capacity-building training created challenges for the study. The concept of ‘multilevel’ intervention was difficult for some CAAB members to understand, as was the distinction between different social levels (community, organizational, individual). This is in part because these are abstract concepts that can be operationalized and experienced in multiple ways. Furthermore, such ‘levels’ and the targets they are intended to reach are to some degree overlapping. For example, social media and social networking can reach and affect individuals and organizations, although these approaches are designed to work at the broad network or population level. Likewise, organizational interventions target change in organizational characteristics (staff capacity to promote FC effectively, administrative commitment to increasing availability of FCs for clients/patients, etc.), but ultimately also affect individual clients and patients who use those services. SC researchers
helped CAAB members distinguish their targets for each intervention component.

The training program and intervention development process were likewise affected by the complexity of the intervention goals and variation in CAAB member capacities. The training covered a significant body of informational, analytical and practical material in a relatively short period of time, engaging people with diverse interests and educational backgrounds, as well as with sometimes divergent beliefs about priorities and needs of their community. The training also had to keep participants interested and help to sustain their motivation to complete the program, continue to develop and establish their independence in leadership and functioning and carry forward their intervention actions. Yet we found that ten training sessions were insufficient. For example, the CAAB could have benefitted from more training in group process and leadership skills during the formal program and more time to complete their intervention designs.

The decision to break into small groups to develop the interventions had positive and negative outcomes. The three working groups were created so that decisions could be expedited in designing each level’s intervention components. As a result of this concerted effort, the working groups’ members felt strong buy-in to their own intervention. However, the intention was for all CAAB members to stay involved across all activities and interventions. This was a significant challenge. Most CAAB members agreed that using the logic model approach to develop three interventions with 20 people in the room would have been inefficient and was likely to have been ineffective. Yet it took concerted effort by the SC to bridge the working group boundaries that were generated by the break-outs and to re-establish a single-group concept after interventions had been completed, even though feedback from the whole group was built into each of the intervention development sessions. It is possible that other approaches that engaged all CAAB members in the development process of each of the interventions at different stages might have lessened or averted this problem.

Another challenge inherent in the CAAB model is the basic limitation of the group to implement their interventions. Volunteers had to balance personal demands on their time, life circumstances and pressures, with their passion and commitment to remain active CAAB members. This became more difficult as some members dropped out, leaving the rest to carry a greater burden. CAAB member attrition was clearly an issue for long-term group sustainability. The process of getting a diverse community coalition to develop a group identity and collectively design and implement multilevel interventions is quite ambitious and intensive; it required great commitment and continuous effort from CAAB members. This was challenging for both employed and unemployed members of the CAAB, and both groups had similar attrition rates, although generally for different reasons. While attrition is inevitable from such a long-term, labor-intensive program, those who remain are extremely committed to the group and are intent on seeing their interventions succeed.

To counteract inevitable attrition and its effects, the group established a process for adding new members and quickly getting them up to speed on the CAAB mission, identity, goals and interventions. With the support of the SC, they also identified and agreed to a process of linking with a local AIDS service organization to provide ongoing infrastructural and staffing support to this volunteer group so they could sustain their efforts over time. Despite the real challenges of maintaining membership, the benefit of this diverse group of community volunteers remains their breadth of representation, embeddedness in the community and impassioned commitment to achieve the primary goal of increasing locally available prevention options for women, particularly the FC.

Several additional structural barriers in the community hindered the CAAB from achieving its goals. Limited state-level policy support for promotion of FCs for prevention efforts limited the resources CAAB members could garner and weakened the message they sought to convey, particularly to local health and service providers, of the importance of FCs. The cost of FCs will also continue to remain a structural barrier to its adoption until the demand for FCs from the community.
increases. Currently, state resources allow a monthly supply of FCs to qualified non-profit organizations. Information about sources of free or subsidized FCs for community distribution as well as locations where they can be purchased in bulk at a discounted rate was included in the CAAB organizational presentation. In this way CAAB members sought to minimize the impact of cost on FC accessibility and availability in their community and to emphasize the importance of allocating more resources to this valuable prevention tool, which, they stressed, has great benefits for women and importance for everyone’s health.

**Recommendations**

Lessons learned from our experience with the CAAB suggest both the potential and the challenges of organizing community engagement to generate and sustain pressure and efforts to bring about multilevel change in the community. The model has not only clear benefits but also clear limitations. We tested the model by constructing the CAAB as an independent coalition supported by an SC, which was also an independent community coalition. It may be more effective and sustainable if the CAAB model is implemented from the start within a single local community organization that can provide sustained infrastructural and personnel support to the volunteer group. In particular, health or service community organizations that include in their mission community engagement or public health may be best suited to generate, host and support the CAAB centered on promotion of FCs or other woman-initiated prevention options.

Considerable effort was put into group building as part of the CAAB development process. Using an existing community coalition instead of generating a new one could reduce the effort needed to build group identity and develop leadership structure. However, most coalitions existing in the community have already defined their mission and organized their passion around a different problem. In fact, it was the passion for their FC mission that appears to have been a key mechanism holding the CAAB together for more than 2 years, despite multiple challenges. The introduction into the community and sustained, substantial support for innovative, woman-initiated prevention options like FCs suggests the need for a group focused specifically on this issue. This is particularly true in a climate of increasing concerns about growing HIV and STIs epidemics, unwanted pregnancies, limited community resources and increasing impoverishment of urban residents—a climate that demands a complex response from within the community.

It appears that a process of change was initiated through this model program, as evident in the activities of the CAAB and in their interventions. The latter have potential to set a process in motion in the city that could have broad impact if implemented over sufficient time and with enough support to reach target audiences. The CAAB’s multi-pronged approach providing consistent, engaging and effective messages, skill enhancements, resources and support for FC use on multiple levels could transform the prevention environment in the city. This is because the passion they have for the issue as well as the passion derived from the CAAB creation and mobilization process are the result of buy-in from group members, which leads to their consequent commitment to the interventions and community change goals that they themselves developed. Furthermore, the CAAB’s understanding of the concept of ‘multilevel’—i.e. their recognition that efforts on one level alone are insufficient—changes their focus from being a group of individuals (who take their learning and apply it only to their own personal settings and lives) to being a community change mechanism (a coalition that seeks as a whole to do more than any individual CAAB member can do).

However, their ability to achieve their goals depends entirely on continued efforts as a group, not a set of individual operators, with sufficient foundational training and capacity, including in group process and group leadership, to be able to organize their efforts to implement their own interventions. They also need adequate and ongoing infrastructural supports to sustain their efforts long enough to have a measurable effect. Variation in CAAB member perspectives, expertise and
experiences both enhanced and challenged the group dynamic and productivity.

Any kind of community-level change requires a long-term commitment because of the counteracting processes that obstruct such broad change efforts. Yet, this could potentially occur exponentially if given enough time. This case example suggests the value of further examining and testing the CAAB as a community engagement model to achieve broad-based impact on social and health issues, in this case, to further the potential for FCs to reduce the HIV and STIs epidemics and empower women for their own sexual protection.

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None declared.

References

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