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Connect to Protect®: Utilizing Community Mobilization and Structural Change To Prevent HIV Infection among Youth

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Infection with HIV often results in myriad negative social, physical, and psychological consequences for adolescents and young adults. At the end of 2007, an estimated 25,036 adolescents and young adults 13 to 24 years of age were living with HIV in the 37 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting (CDC, 2010). HIV is not equally distributed among adolescents of all ethnic groups. In 2008, 50% of adolescents/young adults living with HIV were African American, 29% were White, 20% were Latino, and 1% each were Asian, American Indian/Alaska Native, and multi-ethnic (CDC, 2010).

Although the primary route of HIV transmission among youth is sexual activity, differences exist across gender and sexual activity categories. In 2008, males accounted for approximately 71% of adolescents aged 13–19 years diagnosed with HIV, and 80% of young adults aged 20–24 years (CDC, 2010). HIV infections resulting from male-to-male sexual activity among adolescents/young adults increased from 57% in 2005 to 68% in 2008—the rates of HIV due to heterosexual contact decreased from 32% to 25% during this time (CDC, 2010).

As HIV continues to proliferate in the adolescent and young adult populations, its impact is most predominate among young gay, bisexual, and other men who have sex with men (especially young men of color) and heterosexual young women of color. These are populations that experience varying degrees of social control and power in most societies, and experience oppression in the form of ageism, sexism, racism, and heterosexism (Diaz, Ayala, & Bein, 2004; Harper, 2007; Harper & Schneider, 2003). Such individuals may lack the social power and resources to access HIV prevention services, as well as primary medical care if they do become infected. In addition, the available HIV prevention approaches that are being implemented in communities where these young people live may be limited with regard to their cultural appropriateness (both ethnic culture and sexual orientation culture), and may not impact the larger social forces and structures that may place these youth at risk for HIV. Further, despite the disproportionately high rates of HIV infection among gay/bisexual male adolescents and other young men who have sex with men, prior reviews of rigorously evaluated HIV prevention programs for adolescents in peer-reviewed journals have almost exclusively been focused on heterosexual youth (Kim, Stanton, Li, Dickersin & Galbraith 1997; Pedlow & Carey, 2003, 2004; Robin, Dittus, Whitaker, Crosby, Ethier, et al., 2004; Rotheram-Borus, O'Keefe, Kracker & Foo, 2000; Stanton, Kim, Galbraith & Parrott, 1996).

Connect to Protect® : Partnerships for Youth Prevention Interventions

One notable exception to the limited scope of current HIV prevention efforts for youth is *Connect to Protect*® (C2P), a multi-site intervention focused on addressing the HIV

epidemic at a structural level by working with community coalitions to alter policies, practices, programs and/or the physical environment that are associated with increased risk for HIV among youth (Ziff, Harper, Chutuape, et al, 2006). C2P is the primary prevention infrastructure of the Adolescent Trials Network for HIV/AIDS Interventions (ATN), a National Institutes of Health funded network that conducts research related to youth (i.e., ages 12–14) who are living with or are at risk for HIV. Twelve research centers around the mainland U.S. and one center in Puerto Rico have been conducting C2P. The primary research objective of C2P is to determine whether structural changes achieved by C2P coalitions have an effect on individual risk factors associated with HIV transmission and acquisition in youth in intervention communities (Ziff et al., 2006).

C2P is a multiphase research project that was initiated in 2002. Each of the three phases was developed as a research protocol that was reviewed and approved by the ATN's scientific leadership groups and received IRB review and approval or exemption at each participating site's institution. ATN sites have been staffed with two research coordinators who are responsible for developing a local coalition and community mobilization effort. The C2P approach derived from the state-of-the science work of Fawcett and colleagues (Community Tool Box, 2003; Fawcett et al., 2000; Fawcett, Francisco, Paine-Andrews, & Schultz, 2000; Francisco, Fawcett, Schultz, & Paine-Andrews, 2000). The research infrastructure for C2P includes a National Coordinating Center (NCC) that provides oversight to maintain protocol fidelity, as well as technical assistance, feedback, and guidance to the sites and their community partners.

In order to lay the groundwork for coalition development, Phase I consisted of assessing community assets and risks (Geanuracos et al., 2007; Griffin-Deeds et al., 2008; Straub et al., 2007). C2P staff compiled extant data including local health department disease surveillance data for STIs and HIV, crime data, and demographic data to generate a youth HIV/AIDS epidemiological profile for their urban area. Using the profiles, C2P staff determined high-risk geographic areas, and a youth subpopulation (i.e., young men who have sex with men, young heterosexual women of color, young drug users) on which to focus C2P efforts. Throughout this phase, C2P staff attended and hosted community events to promote C2P and youth HIV-related issues. They also met individually with community agency representatives to discuss interests in partnering with the C2P coalition. The initial coalition make-up ranged in size from 10–25 members from various community sectors (e.g., community-based health and social service organization, education, government, judicial services, law enforcement, faith-based and business) (Straub et al., 2007). Partnerships were formalized by signing a memorandum of understanding agreeing to contribute to the development of C2P community-based efforts.

Phase II advanced the project by (1) collecting data from at-risk youth on HIV risk behaviors and (2) initiating a series of meetings with community partners to begin to develop the coalition infrastructure and to build partner capacity. In order to collect youth data, 3–5 venues (e.g., clubs, parks and shopping malls) were identified by each site where interviews and HIV sero-surveys, to determine HIV prevalence, were conducted. To build the capacity of coalitions, the NCC developed new and/or adapted existing materials on topics including the epidemiology of HIV, structural change as an intervention option, coalition infrastructure requirements, advocacy skills, and media/marketing, among other topics.

The primary objective of Phase III was for each coalition to develop a local strategic plan that included identification of structural changes determined to be relevant for reduction in HIV risk in their community. The C2P approach for strategic planning emphasizes development of objectives and action steps through the “VMOSA” strategic planning

process (Community Tool Box, 2003; Fawcett et al., 2000; Fawcett, Francisco, Paine-Andrews, & Schultz, 2000; Francisco, Fawcett, Schultz, & Paine-Andrews, 2000). The coalitions engaged in the VMOSA process by completing a series of activities that resulted in developing a vision and mission for their coalition and specific structural change objectives, strategies, and ultimately, action plans detailing specific steps to bring about the objectives. Structural changes are defined as new or modified programs, policies, and practices that were logically linked to HIV acquisition and transmission and could be sustained over time. Examples of structural changes include “offering testing in juvenile correctional facilities” or “requiring community organizations to demonstrate cultural competency as part of a grant application.” As structural changes were developed by the coalition, they were shared with the NCC to ensure they met the project definition of structural change. The C2P staff documented progress towards achieving their structural changes, allowing both the coalition and the NCC to monitor coalition progress. As Phase III progresses, the coalitions meet regularly to review their strategic plans, develop new structural change objectives, and to continue the necessary capacity building to sustain the coalition effort.

The articles in this issue explore various aspects of C2P across multiple sites, and offer valuable recommendations for others who wish to use this type of community mobilization approach to HIV prevention. Doll, Harper, Robles-Schrader, Johnson, Bangi, and Velagaleti begin the issue by exploring the organizational and contextual factors that impacted C2P coalition functioning at all sites during the first year of their existence using a longitudinal mixed-methods approach. Willard, Chutuape, Stines, and Ellen then describe the implementation and impact of a root cause analysis process which assisted coalitions in identifying fundamental structural-level contributors to risk, as well as appropriate solutions. Their methodology consisted of coding structural change objectives generated by coalitions. Reed, Miller, & Francisco also analyzed structural change objectives, as well as the progress made toward the objectives, across a two year time frame in order to assess how programmatic capacity affects coalitions’ ability to achieve structural HIV prevention interventions.

The final three articles in this issue focus on specific populations that are addressed at various C2P sites, and how coalition activities were unique to the needs of these populations. Robles-Schrader, Harper, Purnell, Monarrez and Ellen examine differential challenges in coalition processes that hindered or facilitated coalition building for coalitions focused on young gay/bisexual men vs. young heterosexual women. Data for this study came from in-depth qualitative interviews with community partners involved in each coalition. Lin, Dudek, Francisco, Castillo, Freeman, Martinez, Sniecinski, Young and Ellen conducted an analysis of data from C2P staff members who coordinate coalition activities in the seven communities that focus exclusively on young men who have sex with men of color, and explored the unique challenges they experienced with regard to forming community partnerships, maintaining the coalition, and facilitating structural-level coalition objectives. In the final paper, Castillo, Palmer, Rudy, and Fernandez use multiple data sources to present a detailed case analysis of one C2P site in Philadelphia which is focused on providing HIV prevention and testing services to young men who have sex with men who are members of the House and Ball Community.

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Appendix

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