Published in final edited form as:

Health Educ Behav. 2014 February ; 41(1): 100–107. doi:10.1177/1090198113492766.

The Influence of Community Context on How Coalitions Achieve HIV-Preventive Structural Change

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Abstract

Community coalition action theory (CCAT) depicts the processes and factors that affect coalition formation, maintenance, institutionalization, actions, and outcomes. CCAT proposes that community context affects coalitions at every phase of development and operation. We analyzed data from 12 *Connect to Protect* coalitions using inductive content analysis to examine how contextual factors (e.g., economics, collaboration, history, norms, and politics) enhance or impede coalitions' success in achieving outcomes. Consistent with CCAT, context affected the objectives that coalitions developed and those they completed. Results suggest that local prevention history and political support have particular impact on coalitions' success in creating structural changes. These data underscore the heuristic value of CCAT, yet also imply that the contextual constructs that affect outcomes are issue specific.

Keywords

community coalition action theory; community coalitions; community partnerships

Structural change interventions are essential to alter the course of the HIV epidemic and are crucial to shifting prevention efforts from a piecemeal crisis orientation to a long-term agenda (Auerbach, Parkhurst, & Cáceres, 2012). Structural interventions change social conditions to promote health, such as altering cultural norms, institutional practices, and social and economic policies (Blankenship, Friedman, Dworkin, & Mantell, 2006; Sumartojo, 2000). Structural interventions relevant for HIV prevention among youth include establishing school-based health centers and adopting comprehensive sex education policies.

Coalitions are a common vehicle through which structural interventions are implemented (Clark et al., 2010; Kegler & Miner, 2004). Community coalition action theory (CCAT; Butterfoss & Kegler, 2002) is one of the leading frameworks depicting the processes and

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Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

The study was scientifically reviewed by the ATN's Community and Prevention Leadership Group. Network scientific and logistical support was provided by the ATN Coordinating Center (C. Wilson, C. Partlow), at the University of Alabama at Birmingham. The ATN 079 Protocol Team members are Vincent Francisco (University of North Carolina-Greensboro), Robin Lin Miller (Michigan State University), Jonathan Ellen (Johns Hopkins University), Peter Freeman (Children's Memorial Hospital), Lawrence B. Friedman (University of Miami School of Medicine), Grisel-Robles Schrader (University of California-San Francisco), Jessica Roy (Children's Diagnostic and Treatment Center), Nancy Willard (Johns Hopkins University), and Jennifer Huang (Westat, Inc.).

factors that affect coalition formation, maintenance, institutionalization, and outcomes. Recent studies offer empirical support for CCAT propositions and elucidate the mechanisms by which coalitions achieve outcomes (Kegler, Rigler, & Honeycutt, 2010; Kegler & Swan, 2011; Stephens, 2011). CCAT proposes that context affects coalitions at every phase of their development and operation. Kegler, Rigler, et al. (2010) demonstrated that contextual features such as demographics, economics, history of collaboration, politics, and local values affected coalitions' development by influencing coalition membership, leadership, and structures. Though CCAT proposes that context influences the potential of coalitions to achieve community change outcomes, empirical examinations of the relationship between context and coalition achievements are lacking.

Aspects of community context may make structural changes difficult to attain given that these interventions are often controversial (Friedan, 2010). As noted by Blankenship et al. (2006), it is imperative to gain a better understanding of the conditions under which structural interventions are likely to be successfully implemented. The purpose of this study is to examine how contextual factors may enhance or impede coalitions' success in achieving HIV-preventive structural changes.

Method

The Adolescent Medicine Trials Network (ATN) is funded by the National Institutes of Health (NIH) to conduct research focused on youth who are living with or at risk for HIV. Connect to Protect (C2P) is a multisite project developed by the ATN. C2P's goal is to reduce adolescents' exposure to HIV through initiation of structural changes brought about by coalitions.

C2P coalitions, still funded by NIH, are based in the United States (see Table 1); lead agencies include local university medical centers or hospitals. C2P coalitions developed through three phases (Ziff et al., 2006). In all phases, national coordinators provided the coalitions with technical assistance, facilitated cross-site communication, and oversaw protocol adherence (Ziff et al., 2006). During Phase 1, geographic information mapping was conducted to develop an HIV/AIDS epidemiological profile in each community. These data helped hone in on specific geographic areas where youth had the highest HIV rates and identify a target population. Half the coalitions identified young men who have sex with men (YMSM) as their target population; the other half identified racial minority females.

Ecological assessments were conducted during Phase 2. C2P staff (each coalition has paid, full-time staff) gathered information about where targeted youth congregated and surveyed youth regarding their HIV risk behaviors. Staff developed partnerships with individuals who might help carry out C2P's mission and become members. Each coalition reported 13 to 21 partners during the time period we studied, most of whom worked for service organizations, medical establishments, local government, or faith-based organizations (Straub et al., 2007).

Phase 3 entailed coalition mobilization. To develop local action plans, members engaged in the "VMOSA" (vision, mission, objectives, strategies, action) planning process (Fawcett et al., 2000) and root cause analysis (i.e., a group critical analysis process aimed at arriving at underlying structural determinants of risk; Willard, Chutuape, Stines, & Ellen, 2012). Action plans delineated locally relevant structural change objectives (SCOs), defined as "new or modified programs, policies, or practices that are logically linked to HIV acquisition and transmission and that can be sustained over time" (Ziff et al., 2006, p. 513; see Table 1 for examples of SCOs). Elsewhere, C2P's mobilization approach is described (Chutuape et al., 2010; Straub et al., 2007; Ziff et al., 2006). These data were collected the first 2.5 years following Phase 3 and prior to institutionalization of the coalitions. During this time,

coalitions were allowed to develop as many objectives as they desired (range = 14–44 across coalitions).

Measures

This analysis draws from interviews with staff, members, and local health experts and coalition records listing the coalitions' SCOs. Interviews ($N = 201$; range per coalition = 9–20) were conducted with coalition staff and members to ascertain the coalitions' health and functioning. Key informant interviews ($N = 56$; range per coalition = 2–9) were conducted with local health experts (i.e., noncoalition members who have knowledge of the city's HIV/AIDS epidemic) to garner insight on the contexts within which the coalitions operated. Interviews were conducted by the national coordinators approximately every 6 months. These interviews contained questions on coalition health and functioning (only for staff and members), activities carried out by the coalitions and others in the community, and lessons learned by the coalition members and staff. Interviews documented how features of the community were perceived to influence the formation and completion of objectives. Much of this information was derived from interview questions inquiring about community changes of relevance to HIV prevention and the circumstances surrounding those changes. All participants were compensated \$25.00.

Analysis

In previous analyses (Miller et al., 2013), we examined various intermediate indicators of success in achieving structural changes. In the current analysis, we used two of these indicators to examine aspects of context associated with comparative success across the coalitions. During the 2.5 years that we examined, coalitions completed 136 objectives (range = 7–17 across coalitions) and completed 30% to 65% of the objectives they formed. Coalitions were classified as above and below average based on the percentage of objectives completed. We also assessed the quality of the completed objectives by coding the objectives for whether they used a change strategy that was structural (e.g., policy change) or used a change strategy that was not structural (e.g., information distribution). Coalitions were classified as high- and low-structural change based on the percentage of objectives completed that used structural strategies (range = 0% to 46%). For each indicator, we compared coalitions scoring above and below the mean for the presence of particular contextual themes (see below).

Data were analyzed using inductive content analysis (Thomas, 2003). Interviews were analyzed with an eye toward the ways aspects of community context as articulated in CCAT (e.g., demographics, economics, politics, collaborative history, and local values) influenced the formation of objectives. Interviews were reviewed to identify contextual influences on the development of objectives. For example, text may have documented a relationship between economic conditions and the pursuit of objectives. Review of the transcripts resulted in an initial set of themes related to how aspects of community context influenced selection of objectives. Two analysts reviewed each coalition's data and identified text representative of each theme. Analysts discussed the designation of each theme until reaching consensus on its application to each coalition. Themes observed at three or more coalitions were maintained. Thereafter, we conducted cross-case analysis by examining whether the presence or absence of these themes was associated with above-average success (described above). Higher order themes, as depicted in headings throughout the article, correspond with Kegler, Rigler, et al.'s (2010) contextual constructs described in their CCAT framework. Second-order themes are organized and defined under their respective headings.

Results

We first describe the contextual factors that influenced the development of objectives. Then we explore the relationship between themes and indicators of success.

Community Demographics and Economics

Influenced by their ecological assessments, coalitions created objectives to account for local demographic features, trends, and shifts. They considered local rates of drug use, sexually transmitted infections, pregnancy, incarceration, sexual abuse, hate crimes, and homelessness.

Objectives targeted local HIV/AIDS service loss. Staff and members noted a proliferation of funding cuts to HIV/ AIDS service organizations. Members, many of whom were a part of these organizations, were *just trying to hold on* and at times needed to decrease or cease coalition participation because of funding constraints. To incentivize membership and address emerging gaps, coalitions created objectives that addressed funding cuts at members' organizations. For example, when members' organization no longer had funding for condom distribution, C2P found a source of free condoms to fill the void.

Historical and Current Prevention Experiences

The history of HIV preventive approaches favored by members influenced objective development. Members preferred approaches that they believed had worked in the past. At one coalition where objectives were focused on increasing access to condoms, a member expressed: "Having condoms everywhere you go would create a norm. They are hard to get to now in comparison to in the 90s where they were everywhere in gay bars." Staff believed that a history of work within the HIV service field precluded the development of structurally focused objectives:

HIV prevention work right now deals with more on an individual-based interventions ... a problem we've always had with this particular project is shifting gears and having people look at HIV from a larger perspective.

Collaboration

The local history of collaborative partnerships influenced objective development. In environments deemed "coalition rich" or "saturated" where members had previously worked on "unsuccessful" coalitions, staff felt compelled to show that C2P coalitions would be different. To assuage misgivings, staff incited members to work toward easily attainable objectives. In these contexts, objectives were often contingent on the programmatic efforts of members, as building on current efforts was a tactic for attaining quick wins and avoiding duplication of preventive approaches:

[city] is so saturated regarding HIV services, and so it is hard to find creative ways and ideas that people are not already doing. So we are seeing what our partners are up to and supporting our partners and helping move their efforts forward.

The efforts of local non-HIV related coalitions influenced objective formation. Noting that other coalitions were "doing similar upstream prevention," coalitions partnered with coalitions addressing issues such as teenage pregnancy, homelessness, and poverty to work toward city and statewide objectives:

We need to have our coalitions really work together and create the really lasting policy changes that will have a great and sustained impact.

Community Norms and Beliefs

The social norms and beliefs of the coalitions' target communities and members influenced objective development. At female-focused coalitions, the community was perceived as ignorant of the epidemic's epidemiology. As a consequence, members perceived a need to increase awareness about the prevention needs of heterosexual youth: "It's still considered a gay man's disease.... I think that it's gotta be worked in somehow as not being seen as just a gay man's illness." At YMSM-focused coalitions, the need for HIV prevention awareness was less acute: "young people already know about HIV. We're not in the 1980s."

Target population normative practices influenced objectives. At female-focused coalitions, religious norms dictated a focus on faith-based communities. For example, a member at a coalition targeting the faith-based sector explained:

It's the faith-based sector, which our youth and families reach out to for guidance, education, support. The faith based sector is the primary resource our community goes to.

Members' beliefs influenced objective formation. At a few coalitions, members valued doing things "the right way," which meant doing things that were evidence based and aligned with C2P's emphasis on structural change. One coalition wanted to implement objectives for which there was evidence of effectiveness (e.g., comprehensive sexual education). Two coalitions aspired to be model C2P coalitions.

The priority communities placed on HIV prevention influenced objective formation. Coalition members were cognizant of pressing prevention priorities within their communities, especially those that took precedence over HIV prevention. In communities focused on young women, other priorities included the following: unplanned pregnancies, poverty alleviation, or general youth development ("the big thing is youth development right now"). Coalitions sought to align objectives with these other priorities.

Community Politics

Local political support, or lack of it, influenced objective formation. Some communities had more supportive political allies than others ("[among] the politicians in [city]—from the Mayor down to police department—there seems to be an investment in working with the LGBT community"). Lack of political support posed "barriers" to objective attainment, so coalitions aligned objectives with political priorities. Coalitions created objectives as a function of their relationships with politicians. As one staff member said, "There is a mayoral election today and the results of that will have to be addressed;" in particular, "testing in schools should be pursued, especially if the mayor changes."

Existing or planned policies influenced objective development. As one member said, policy changes influenced "the things we're gonna take on ... in the coming months." In places where HIV preventive services were only offered to adults, coalitions extended policies and practices to youth. Members believed that the extension of current policies would be met with fewer obstacles ("because STD and HIV testing and counseling has been accepted in the adult jail, there may be more support and a greater push to incorporate this same program in juvenile facilities"). Additionally, objectives were formed to account for the unintended consequences of policies. For example, one coalition formed safe space objectives after the city's smoke-free ordinance led to people "congregating outside to smoke" and "displacing the kids' hangouts."

Are Themes Associated With the Completion of Objectives?

We compared the coalitions above and below the average rates of completion based on the presence or absence themes (see Table 2). An “X” indicates that a theme was evident in all the coalitions in the particular success category. As displayed in the table, all coalitions with above-average performance operated in contexts where they enjoyed political support for HIV/AIDS prevention and LGBT rights. In these contexts, cooperative efforts with non-HIV-related coalitions were readily formed. Coalitions achieving comparatively fewer objectives described their political environments as conservative and as mistrustful of collaborative efforts. Coalitions that completed objectives at below-average rates had target populations with strong faith-based traditions and had members who valued implementing evidence-based prevention approaches and creating objectives to address funding losses among coalition member organizations.

Are Themes Associated With the Completion of Objectives Employing Structural Strategies?

Members’ previous work in the HIV/AIDS field impeded their ability to think structurally and they had difficulty crafting objectives with structural qualities. Two themes were specifically associated with low structural change coalitions: preferring historic approaches to prevention (e.g., condom distribution) and believing HIV/AIDS awareness was low among the target population.

Themes distinguished high structural change coalitions. These coalitions operated in contexts where other prevention or community-building priorities within their cities were addressed to their target populations. High structural change coalitions valued evidence-based approaches and tailored their objectives to the policy landscape.

Discussion and Implications

Coalitions operate within contexts that differ on levels of political support, experiences of economic constraints, and the nature of their prevention history and norms. Coalitions took these aspects of context into account when they considered the extent to which objectives were beneficial to their communities, advantageous for maintaining their coalitions, and feasible. As others have found, community context affected the objectives coalitions completed (Allen, Javdani, Lahrner, & Walden, 2012).

Coalitions that were above average in creating structural changes attempted to assuage members’ funding losses by creating objectives that would address their organizational needs. Increasing community resources is a structural strategy that is unlikely to meet with resistance among coalition members because it builds on and supports the work already occurring at members’ organizations. Objectives addressing the target population’s needs by continuing funding for services and members’ organizational needs serve the dual purpose of meeting the coalitions’ goals and enhancing member commitment. Economic constraints pose a barrier to member involvement (Kegler, Rigler, et al., 2010), so achieving this type of objective may affect coalition viability and collaborative synergy.

The high structural change coalitions aspired to be model coalitions and employed evidence-based strategies, yet were relatively low achieving overall. Many of the structurally based approaches to prevention heralded in the literature are apt to meet political resistance (e.g., needle-syringe exchange programs) and community push-back (e.g., comprehensive sex education; Auerbach, 2009; Rothrum-Borus, 2000). Structural objectives may not be obtained swiftly and may require significant resources (e.g., school-based health centers, housing for homeless youth) that impinge on their feasibility. These objectives may require

significant effort on the part of coalition members, preventing them from devoting time to many objectives at once or from those that could lead to quick success.

Coalitions operating in places with entrenched prevention traditions found developing structural objectives difficult. Difficulty forming structural objectives may be acute when coalitions work on public health issues that have historically emphasized individual-level prevention activities. Formal training in root cause analysis may help coalition members to think structurally (Willard et al., 2012). Given that those who focused on the past had trouble achieving structural objectives, it may be important for structurally focused coalitions to have members who are not wedded to a prevention paradigm that runs counter to the coalitions' aims.

We observed it was advantageous for C2P coalitions to partner with other coalitions. Working with existing coalitions may have offered models of success and provided a ready infrastructure for and sensitivity to cross-cutting prevention work. The presence of these collaborations indicates that members were cognizant that other prevention priorities coincided with a structurally based approach to HIV prevention. Coalitions that took note of other local prevention priorities were more likely to complete structurally based objectives. Aligning objectives with non-HIV-related priorities and collaborating with non-HIV focused coalitions facilitated the creation of structural objectives, as structural changes often address multiple social issues (Link & Phelan, 1995). Structurally focused coalitions might consider partnering with other coalitions to address interconnected social issues.

Coalitions that worked in contexts for which it was important to focus on faith-based communities to reach young Black women encountered resistance to HIV-related structural changes. Faith-based institutions are well documented as difficult places in which to pursue public health (Kegler, Hall, & Kiser, 2010), especially for issues such as HIV. The coalitions targeting YMSM encountered stigma associated with homosexuality that affected the completion of objectives (Miller et al., 2012). Arguably, these are the features that define a context in which the need for structural change is acute. Yet these are the contexts where conflicting interests may affect implementation (Blankenship et al., 2006). At female-focused coalitions, it was perceived that young heterosexual youth had low HIV knowledge; female-focused coalitions limited objectives to individually focused activities, such as the distribution and production of information—approaches consistent with a conventional prevention agenda. Individual-level causal attributions precluded structural, transformative change efforts. In challenging contexts, coalition maintenance and the need to maintain member investment through visible successes may preclude a sole focus on evidence-based structural objectives.

Operating in supportive environments is often a prerequisite for the success of budding coalitions (Allen et al., 2012). Coalitions' achievements were associated with a political climate favorable to their missions. Structural changes were most often completed in settings that had supportive structures in place, environments rich with cross-cutting prevention initiatives and where HIV prevention was already a priority. Coalitions might be wise to examine the local policy environment to determine how favorable it is to structural change and what changes are unlikely to meet with political resistance. Coalitions in unfavorable conditions may elect to focus on creating a supportive climate as an initial step.

Limitations bear on the study's findings. First, data were not collected as a means of testing CCAT constructs. Rather, data were gathered to assess coalition health and processes. Data were restricted to interviews regarding community change. Other forms of contextually relevant data articulated by the CCAT framework (e.g., indicators of community capacity) may elucidate other aspects of community context that bear on outcomes. Despite this

limitation, interviews were conducted with staff, coalition members, and key informants—people with a diverse array of community knowledge and insight on coalitions' context and its influence on coalitions' priorities.

Second, numerous contextual factors influenced SCO formation and completion, if not directly, then through their influence on coalition structure, processes, and membership (Kegler, Rigler, et al., 2010). As our emphasis was on coalition outcomes, we restricted analysis to looking at how context influenced objective creation (on which, completion is contingent). As a result, our analyses are artificially simplistic and may have obscured aspects of how the contexts within which the coalitions operated impacted on completion.

Finally, since these data were collected, coalitions have moved to a predominant focus on policy-level objectives. The ways in which context now influences what coalitions seek to complete may differ from what we observe when looking at their early years.

Conclusion

By identifying how community context affects coalition outcomes, the results of our study underscore the heuristic value of CCAT. Although we illustrated that contextual constructs were associated with coalition outcomes, the results also suggest that the specific relationships among contextual conditions and coalition outcomes implied by CCAT may be unique to specific public health issues. Calls for structural change to prevent HIV are longstanding. Yet the political and community climate necessary to support structural approaches does not exist in all of the communities where such approaches are needed. Coalitions should seize every opportunity to create the supportive environments necessary for HIV-related structural change initiatives to succeed.

Acknowledgments

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article:

The Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN) is funded by Grant No. 2 U01 HD040533 from the National Institutes of Health through the National Institute of Child Health and Human Development (B. Kapogiannis, MD), with supplemental funding from the National Institute on Drug Abuse (N. Borek, PhD), National Institute on Mental Health (P. Brouwers, PhD), and National Institute on Alcohol Abuse and Alcoholism (K. Bryant, PhD).

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Table 1

Connect to Protect Coalitions and Example Structural Change Objectives.

Coalition City	Target Population	Example Structural Change Objectives
Baltimore	YMSM	By March 2008, there will be a new process of providing HIV posttest results and linking HIV+ youth to care for school-based health centers staff in five high schools and one middle school in zip codes 21201, 21202, 21215, and 21217.
Chicago	YWSM	By October 31, 2008, the juvenile temporary detention center will have a new protocol adopted to provide condom packets, HIV information, and community provider information to youth at discharge from the juvenile temporary detention center.
Ft. Lauderdale	YWSM	By June 2009, five faith-based organizations in the 33311 zip code will expand their existing programs by providing regular HIV/AIDS counseling and testing on site to their congregation members.
Los Angeles	YMSM	By June 2007, El Camino College–Compton community educational center health classes will require all students to get HIV tested and STD screened as part of their class assignment.
Manhattan	YMSM	By August 2008, the David Geffen testing center at Gay Men's Health Crisis will integrate a citywide working group focused on coordinating HIV mobile testing targeting YMSM of color.
Miami	YWSM	By December 2008, the Miami Dade regional juvenile detention center will have developed and implemented a program to link HIV infected detainees on their release to an HIV medical facility, including the transfer of medical records.
New Orleans	YWSM	By December 2008, the Dryades Street YMCA will dedicate a safe space at their facility where young women of color can socialize, participate in HIV prevention interventions, and provide input on program design/development.
Philadelphia	YMSM	By December 2008, Youth Emergency Services will establish three safe havens for youth in the Gayborhood.
San Francisco	YMSM	By 2009, all SFUSD high schools will have wellness centers to provide students with health education.
Tampa	YWSM	By July 2009, Tampa Housing Authority will establish neighborhood watch programs at three of their four housing.
The Bronx	YWSM	By September 2009, the Bronx Community Pride Center will create a new program to manage a sexuality training network for the Bronx.
Washington, D.C.	YMSM	By September 2008, Child and Family Services Agency will formalize an LGBTQ cultural competency training component for foster care parents.

Note. YMSM = young men who have sex with men; YWSM = young women who have sex with men; STD = sexually transmitted disease.

Table 2

Above and Below Average Coalitions by Presence of Context Themes.

Themes	Coalition Classifications by Objective Achievement Status			
	Above-Average Overall Achievement		Below-Average Overall Achievement	
	Above-Average Structural Achievement (<i>n</i> = 3)	Below-Average Structural Achievement (<i>n</i> = 4)	Above-Average Structural Achievement (<i>n</i> = 3)	Below-Average Structural Achievement (<i>n</i> = 2)
Demographics and economics				
To incentivize membership and address gaps due to funding losses, coalitions created to address members' organizational needs	X		X	X
History				
Members exhibited preference for preventive approaches that they believed worked in the past		X		X
A history of work within the HIV/AIDS prevention and service field was a barrier to the development of structurally focused objectives		X	X	X
Collaboration				
Staff incited members to work toward easily attainable SCOs where there was a history of mistrust among member or skepticism of coalitions			X	
Coalitions partnered with local coalitions to address other social issues related to HIV/AIDS	X	X	X	
Norms/beliefs				
Low awareness of prevention needs among heterosexual youth dictated focus on informational SCOs		X		
Religious norms dictated a focus on faith-based communities			X	X
Coalition members and staff valued using evidence-based approaches and wanted to be a model C2P coalition			X	
Coalitions sought to align SCOs with other local prevention priorities	X		X	
Politics				
Conservative local political agenda dissuaded policy-focused SCOs			X	X
HIV/AIDS and/or LGBT political support in local government dictated policy-focused SCOs	X	X		
Coalitions made policies relevant to other groups relevant to target population, ensured policy implementation, or addressed unintended consequences of policies	X		X	

Note. Themes were evident in all sites for the categories under which an "X" appears. SCO = structural change objective; C2P = Connect to Protect project; LGBT = lesbian, gay, bisexual, transgender.