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Collaboration With Urban Parents to Deliver a Community-Based Youth HIV Prevention Program

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Abstract

This article draws on the unified theory of behavior change to examine adult community members' participation in a collaborative, community-based HIV prevention program for inner-city youth. Specifically, the impact of a training and mentorship process is examined with a sample of parent facilitators hired to deliver an evidence-based HIV prevention program in Bronx, New York. Findings indicate that the training program impacted four of five key constructs (environmental constraints, habitual behavior, social norms, and self-concept) expected to be related to parents' ability to deliver the program constructs significantly beyond any increase evidenced by the control group (HIV knowledge increased in both groups). Community-level training programs may therefore be an effective medium for increasing caregivers' intention to collaborate in community-based prevention programs.

Community collaborative processes lie at the heart of contemporary HIV prevention science. Particularly in the United States, poverty-impacted urban adolescents of color are at

increased risk for contracting HIV, and community psychologists, social workers, health educators, and prevention science researchers have focused much attention in recent years on ways to increase the efficacy, acceptability, and reproducibility of community-based prevention programs targeting this population (Abma, Martinez, & Copen, 2010; Centers for Disease Control and Prevention [CDC], 2000a; McKay & Paikoff, 2007). This article presents findings from one such program and specifically examines the ways in which parents and community members can be best supported in their collaboration with a community-based, community-delivered intervention for teens. The factors that influence and sustain the interest of adult community collaborators are also discussed.

Background

Adolescents are among the fastest growing population at risk for HIV/AIDS, with teens accounting for more than 25% of all sexually transmitted diseases reported annually (Abma et al., 2010; CDC, 2000a). Females and minority youth are disproportionately affected by sexually transmitted diseases (STDs) and the AIDS epidemic (Jemmott & Jemmott, 1992). More specifically, the incidence of HIV and AIDS infection has risen dramatically in low-income, minority neighborhoods over the last five years. African American and Latino youth are overrepresented among those living in poor neighborhoods, which increases the likelihood of exposure to HIV and other sexual transmitted diseases for sexually active youth because of higher overall rates of neighborhood prevalence, along with poorer access to preventive health care and early detection and treatment services (Wilson, 1987).

Prevention scientists have developed and tested a number of sexual risk reduction and STD or HIV prevention programs targeting urban minority youth. The CDC has published a compendium of such evidence-based programs, including Be Proud! Be Responsible!, in an attempt to more widely disseminate needed prevention services to urban youth (CDC, 2001; Jemmott, Jemmott, & Fong, 1998). However, efforts to carry out empirically supported prevention programs have encountered numerous obstacles, including insufficient school-based resources, parental opposition, poor community participation, and tensions and suspicions between community residents and outside researchers (Dalton, 1989; Glasgow, Vogt, & Boles, 1999). As a result, it is becoming clear that community-based prevention programs targeting urban minority youth are likely to fail if they attempt to provide interventions in a noncollaborative manner (Boyd-Franklin, 1993) or neglect to design and implement programs that do not appreciate stressors, scarce contextual resources, or adult caregivers' core values (Boyd-Franklin, 1993; McLoyd, 1990). Therefore, the establishment of strong community partnerships to support youth health prevention efforts are critical so that (a) effective adolescent sexual risk prevention programs can be potentially well received within urban communities; (b) community-level resources might be available to implement and sustain school-based prevention efforts; and (c) greater effectiveness might be achieved if the target communities are involved in all aspects of development and delivery of the program.

Various researchers have argued that HIV prevention programs tailored specifically for populations and contexts have the best chance of being received and used (Auerbach, Wypijewska, & Brodie, 1994). Furthermore, studies suggest that including members of the

target population in developing and implementing HIV and AIDS programs is one of the best ways to tailor programs.

Funded in 2001 by the National Institute for Mental Health, the current study (CHAMPions) includes an intensive research–community partnership as one of its core features. The partnership developed by CHAMPions was guided by a prior HIV prevention research study called CHAMP (Collaborative HIV Prevention and Adolescent Mental Health Project; McKay & Paikoff, 2007). One of the core assumptions of the CHAMP model is that the collaboration of researchers with consumers (e.g., families, providers, and communities) leads to HIV prevention programs that have the potential to be (a) acceptable to consumers; (b) relevant to the consumers' context, specific needs, and core values; and (c) potentially effective when implemented in real-world settings by providers.

Although community partnerships have been described as necessary ingredients in the dissemination of evidence-based health prevention programs for youth, guidance is critically needed in relation to how to create and sustain such partnerships (CDC, 2001; Jemmott et al., 1998). Further, there is little knowledge about what influences community members to decide to become involved or to play key leadership roles in research-oriented prevention projects. To a large extent, the literature on participatory research or community collaborative research efforts have been limited to a description of foundational principles or to case studies (Altman, 1995; Arnstein, 1969; Chavis, Stucky, & Wandersman, 1983; Singer, 1993). Although the establishment of community advisory boards as a more standard research procedure might be considered an advance (Hatch, Moss, Saran, Presley-Cantrell, & Mallory, 1993), much more attention is needed to understand the contribution of community involvement and the practicalities of maximizing collaborative efforts between community and university partners.

Theoretical Underpinnings of CHAMPions

The CHAMPions program's training and mentorship processes were designed to attempt to address these limitations by relying on empirically supported theoretical models of behavior change, referred to as the unified theory of behavior change (Jaccard, Dodge, & Dittus, 2002; Jaccard, Litardo, & Wan, 1999; Fishbein et al., 2001) that incorporates aspects of the theory of reasoned action (Ajzen & Fishbein, 1981; Fishbein, 1980; Fishbein, Middlestadt, & Hitchcock, 1991), subjective culture (Triandis, 1972, 1977, 1980), self-regulation (Kanfer, 1970, 1977, 1987), and social learning (Bandura, 1986, 1989a, 1989b, 1991).

In order to enhance the impact on the various constructs of the unified theory of behavior change, CHAMPions incorporated mentorship as a key addition to the standard preparation to deliver an evidence-based program, Be Proud! Be Responsible! (Jemmott, Jemmott, & Fong, 1992). CHAMPions, by providing training and mentorship to urban parents, attempts to increase parents' perceptions about the importance or salience of becoming involved in community-based STD and HIV prevention activities. Within the experimental condition of the study, parents who receive the training and mentoring may experience increased normative pressure to provide leadership within their community. It was also expected that the training and ongoing mentorship could bolster parents' self-efficacy and alter their self-

concept so that they would view themselves as being able to contribute to helping youth reduce their sexual health risk. Additionally, it was expected that the training would directly bolster parents' knowledge regarding STD and HIV prevention, while ongoing mentoring from more experienced community HIV prevention experts would develop the problem-solving skills necessary to address environmental obstacles to program delivery, such as potential resistance by some school staff members.

Numerous empirical studies have affirmed the conceptual utility of the constructs of the unified theory of behavior change; therefore, focusing on these variables will potentially yield positive outcomes in terms of increasing the involvement of urban parents in research–community partnerships in the delivery of HIV prevention programs.

CHAMPions Program Description

CHAMPions was meant to examine the impact of community-level delivery of an evidence-based HIV program, Making A Difference! An Abstinence Approach to Prevention of STDs, HIV and Teen Pregnancy. This intervention consists of “an eight-module curriculum that provides young adolescents with the knowledge, confidence, and skills necessary to reduce their risk of STDs, HIV, and pregnancy by abstaining from sex” (<http://www.selectmedia.org/programs/difference.html>). The intervention is highly intensive (eight 2-hour meetings as well as additional meetings with mentors), which is supported by existing findings that suggest that lengthy intensive interventions are necessary in urban contexts where there are significant stressors and obstacles (Wahler & Dumas, 1989; Webster-Stratton, 1985). The Making A Difference! curriculum provides young adolescents in the sixth and seventh grades with the skills necessary to reduce their risk of STDs, HIV/AIDS, and pregnancy by abstaining from sex. Such skills include knowledge/understanding, confidence, goal setting, negotiation, respect, and acceptance. Making A Difference! is an adaptation and extension of the original Be Proud! Be Responsible! intervention (Jemmott et al., 1992), an HIV risk reduction intervention based on three theories of health behavior change: social cognitive theory (Bandura, 1986), the theory of reasoned action (Ajzen & Fishbein, 1981), and the theory of planned behavior (Ajzen, 1991).

CHAMPions further adapted the Be Proud! Be Responsible! curriculum by incorporating community consultants and trained parent facilitators (in lieu of professionals and paraprofessionals) from the community, using collaborative training and mentorship. Given previous findings that Be Proud! Be Responsible! has been associated with significant decreases in youth sexual risk behavior (Jemmott et al., 1992), it is imperative to identify mechanisms to help this program be adopted by communities in need. Although Be Proud! Be Responsible! has been replicated across national sites (Kennedy, Mizuno, Hoffman, Baume, & Strand, 2000), numerous obstacles to program acceptance have been shown to exist at the school and community levels. Urban school systems are often exceptionally overburdened with few resources to expend on programming other than those most relevant to academic learning (Anderson & Portnoy, 1989; Cahill, 1996). CHAMPions attempts to fill this gap by providing a cadre of trained community members who can assist schools in delivering the program without further burdening urban schoolteachers. In addition, parents of middle-school students often have concerns regarding sexual health curricula delivered in

schools. The current approach of community sponsorship for Be Proud! Be Responsible! by a relatively large group of parents per school could address some of the parents' and communities' concerns, because trusted community stakeholders would be involved in the project. Information on the curriculum for Be Proud! Be Responsible! can be found on the following CDC website: http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/Be_Proud.htm.

All parents received 16-hour training to deliver the Making A Difference! curriculum to youth in school-based settings. Mentors for the project were selected from community applicants who had previous experience being community educators as mentors. The training also provided spaces to discuss potential problems with mentors and ideas and resources to help with the delivery of the program within the schools. Mentors served as resources in addressing parents' concerns about the delivery of the program. A mentor-ship handbook and workshop training were developed and implemented in collaboration with hired mentors. Mentors were matched with participants (1:5) who enrolled in the training program and were responsible for the following: (a) participants' orientation and interview processes, (b) facilitator training and post-training refresher workshops, (c) reminder and follow-up calls for training, (d) building a strong relationship with their mentees, (e) scheduling make-up sessions with mentees who missed sessions or were not grasping the material, and (f) overseeing their mentees' delivery of the youth intervention curriculum.

In addition to providing ongoing mentorship, consumer consultants were also involved in the identification and recruitment of various middle schools of the Morris Heights neighborhood of Bronx, New York, for dissemination of CHAMPions for the experimental group. As long-standing members of the community, consumer consultants had increased access to school staff as well as face recognition for community parents and their children, because they were often seen within the context of the schools.

Methods

Research Design

The current research study involves a comparison of pretest and posttest changes of two samples of urban parents drawn from the same inner-city community. These comparisons were conducted between the randomized sample of parents who received the community collaborative training and mentorship to become community HIV educators as part of the CHAMPions program and a cohort of parents living in the same inner-city community who received standard training (control group) to deliver the Be Proud! Be Responsible! intervention. The comparison cohort of parents received standard preparation and training (eight 1-hour training sessions and the curriculum manual) to deliver the Making A Difference! program. The control group, however, did not benefit from the involvement of consumer consultants and relied solely on professional staff for in school recruitment.

For the experimental cohort, in addition to the Making A Difference! program, parents also received community collaborative training and mentorship from community parents who were currently involved in local HIV prevention efforts. Impact of community collaboration on recruitment of schools and youth for eventual dissemination of the program was also

assessed. Approval and clearance to conduct this study were granted by the institutional review board at Mount Sinai School of Medicine, and informed consent was obtained from each participant involved in the study.

Sample

Convenience sampling methods were used to recruit participants. Community Collaborative Board members and participants reached out to institutions to which they were linked (e.g., community centers and churches). Parents were randomly assigned to either the experimental ($n = 49$) or comparison ($n = 66$) cohorts. Table 1 summarizes the sample of the urban parents who received training as part of the CHAMPions study.

Measures

Parents who received training through CHAMPions and the comparison cohort were assessed before the training program (pretest) and at the completion of the program (posttest). Data gathered at pretest and posttest data collection points are presented here for both the experimental and comparison cohorts. Each parent completed paper-and-pencil instruments, and parents in both groups were compensated monetarily for their time and transportation costs.

The following instruments were used in assessments for both groups. HIV knowledge and stigma were assessed via a series of questions about HIV/AIDS that were adapted from the Youth AIDS Prevention Project and the Aban Aya Project (Levy, Lampman, Handler, Flay, & Weeks, 1993). Items address the degree to which parents understand how HIV is caused and transmitted (HIV knowledge) and address their comfort in discussing HIV, AIDS, sexuality, and substance abuse with their child (HIV stigma). Knowledge items are scored on a 3-point scale (as *true*, *false*, and *not sure*), and communication comfort items are scored on a 4-point scale (from *strongly disagree* to *strongly agree*, or *very comfortable* to *uncomfortable*).

The CHAMPions Collaboration Scale included two sets of measures to predict parents' participation and intention to participate in a collaborative HIV prevention program. All items used a 5-point Likert response scale (1 = *strongly disagree*, 3 = *neither agree/disagree*, 5 = *strongly agree*). Results of factor analysis, as well as high Cronbach's alpha levels among scales, indicate that the instrument used possessed an acceptable degree of internal consistency and validity (Guilamo-Ramos, Jaccard, Dittus, Gonzalez, & Bouris, 2008).

Determinants of participation—The scale contained an item pool designed to represent the five major psychological characteristics believed to influence participation of urban parents in participating in a collaborative HIV prevention program: (a) the individual's intention or decision to participate, (b) knowledge and skills for participation, (c) perceived environmental constraints to participation, (d) the salience of participation for the individual, and (e) the habitual and automatic processes fostered by the individual for participation.

Determinants of intention to participate—The second part of the CHAMPions Collaboration Scale consists of five psychological influences on the intention to participate in a collaborative HIV prevention program: (a) attitude toward participating in HIV prevention, (b) social norms related to participation, (c) expectations about the benefits of participating in HIV prevention, (d) self-concept in relation to participation in HIV prevention, and (e) self-efficacy in relation to the same.

Results

Assessment Data Comparisons

Data from the pre- and posttest assessments were analyzed to test for changes in the key variables of the unified theory of behavior change among the urban parents trained to become facilitators as part of CHAMPions and as part of the comparison cohort.

Comparison of pretest data—Comparisons of pre-test data showed that there were no statistically significant differences between intervention and comparison groups across all variables at baseline.

Comparison of pre- to posttest changes—Paired sample *t* tests were then used to compare pretest to posttest scale mean changes for intervention and comparison groups (Table 2). Both groups showed a statistically significant increase in HIV knowledge. The intervention groups showed a mean increase of 1.6, $t(55) = 49$, $p < .001$, and the comparison group showed a mean increase of 1.3, $t(40) = 25$, $p < .05$. Additionally, the intervention, but not the control group, reported positive changes in two of the variables hypothesized to directly affect parents' participation in HIV prevention. The intervention group showed a trend toward fewer environmental constraints, $t(65) = 1.8$, $p < .10$, and a statistically significant increase in their endorsement of habitual behaviors related to participation in HIV prevention, $t(64) = 2.2$, $p < .05$. They also reported statistically significant increases in two of the scales measuring determinants of intention to participate in HIV prevention: social norms, $t(63) = 3.8$, $p < .001$, and self-concept, $t(65) = 2.8$, $p < .01$. The mean changes of these scales for the control group were not statistically significant.

Comparison of posttest-only data—Table 3 presents posttest data from both groups. Using independent sample *t* tests, the intervention group had higher means than the comparison group at posttest in two domains. The intervention group reported fewer environmental constraints than the control group, $t(110) = 2.49$, $p < 0.05$, and a trend toward a higher mean on salience of participation in HIV prevention, $t(111) = 1.95$, $p < 0.1$.

School Recruitment Data

The experimental group was able to deliver the program to 205 adolescents, while the control group delivered to 62 adolescents. These figures reflect the experimental group's ability to recruit a greater number of schools for dissemination of CHAMPions. While the control group relied solely on academic researchers to recruit schools and youth, the experimental group benefited from the additional support of consumer consultants for

recruitment purposes. The involvement of consumer consultants led to increased access and buy-in from the local schools and greater recruitment of youth.

Discussion

CHAMPions is an example of a preventive strategy to deliver evidence-based HIV prevention programs, informed by input from a collaborative partnership within an urban community, empirical data, and the unified theory of behavior change. There has been much discussion about the need for evidence with respect to the role of active collaboration between researchers and the community for the dissemination of innovative community-based interventions. Standard procedures for evidence-based HIV prevention interventions, including the Be Proud! Be Responsible! curriculum, involve using professional or para-professionals in program delivery. However, transfer of these programs to low-income, minority communities is often fraught with challenges and obstacles because community members often hold distrustful views of university-based staff. Additionally, this study highlights the potential benefit of an evidence-based, abstinence-only program. Not only are abstinence-based interventions appropriate given the age of the youth involved in this study but they also have demonstrated efficacy in previous trials (Jemmott, Jemmott, & Fong, 2010). There are, of course, recognized benefits of other approaches to HIV prevention, such as risk reduction and abstinence-plus intervention programs (Underhill, Montgomery, & Operario, 2008). Nevertheless, this particular study focused on examining an empirically informed, abstinence-based, CDC-endorsed intervention, with the results suggesting favorable outcomes from CHAMPions program's approach to HIV prevention.

CHAMPions proposes to generate evidence that is required for involving target communities in all aspects of development and delivery of programs. Because the intervention is grounded in the highly regarded unified theory of behavior change, it has the potential to positively influence parents to participate in research–community collaborations. Preliminary results reveal that participation in CHAMPions led to strengthening of certain variables of the unified theory of behavior change, including increases in HIV knowledge, decreases in perceived environmental constraints, and increases in endorsement of habitual behaviors. Unfortunately, long-term data on actual involvement in the study are not yet available. At the proximal level, however, these preliminary findings offer encouragement for the continued development of CHAMPions.

Implications for Practice

The involvement of community parents in every aspect of the CHAMPions project, including the design of the intervention, pilot testing, delivery, and research, enhances the likelihood that this is a relevant program capable of delivering HIV prevention to families in communities of need. Use of community consultants in place of professionals or paraprofessionals in some preventive interventions—particularly those seeking to address health risk behavior in majority-minority, poverty-impacted, and high-risk urban contexts—poses certain challenges, such as additional training costs and concerns related to the fidelity of the intervention (Fantuzzo & Atkins, 1992). Yet, the results of the study presented herein indicate that these potential obstacles can be surmounted, and that the benefits of involving

community representatives outweigh the risks associated with their involvement, particularly in terms of their effect on recruitment and school buy-in (Holden, Lavigne, & Cameron, 1990; Kreibick, 1995). As data continue to be collected concerning the outcomes associated with participation in CHAMPions, the preliminary results presented here serve as initial evidence that more substantive research on innovations to support community collaboration is needed, and that wider and deeper involvement of community members in prevention interventions should be encouraged.

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IMPLICATIONS FOR PRACTICE

- Acknowledging the challenges in using community consultants in place of professionals in some preventive interventions, the benefits do have the potential to outweigh the associated risks, particularly in terms of their effect on recruitment and school buy-in.

Table 1

Comparative Demographics of Samples

Characteristic	CHAMPions % (n = 49)	Control group % (n = 66)
Gender		
Male	23	16
Female	77	84
Race/ethnicity		
African American	52	59
Latino	34	35
Both African American and Latino	8	2
Neither African American nor Latino	6	4
Born outside the United States	34	25
Marital status		
Married	14	13
Divorced/ separated	17	20
Single/ with live-in partner	24	9
Single/ without live-in partner	45	58
Employment status		
Employed	49	38
Employed intermittently	13	15
Unemployed	38	47
Receiving public assistance	26	57

Table 2

Mean Changes From Baseline to Posttest

Scale	CHAMPions (<i>n</i> = 49)	Control group (<i>n</i> = 66)
HIV stigma	ns	ns
HIV knowledge	14.7–16.3***	14.5–15.8*
Intention	ns	ns
Knowledge and skills	ns	ns
Environmental constraints	19.8–20.6 ⁺	18.5–18.9
Salience	ns	ns
Habitual behavior	34.6–36.6*	34.0–36.4
Attitude	ns	ns
Social norms	16.7–18.6***	17.1–17.8
Expectations	ns	ns
Self-concept	15.5–16.7**	16.0–16.9
Self-efficacy	ns	ns

⁺
 $p < .10$;*
 $p < .05$;**
 $p < .01$;***
 $p < .001$.

Table 3

Mean Differences Between Groups at Posttest

Scale	CHAMPions (<i>n</i> = 49)	Control group (<i>n</i> = 66)	<i>M</i> diff.
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	
HIV stigma	11.1 (1.9)	10.9 (2.3)	0.2\
HIV knowledge	16.2 (1.9)	15.7 (2.8)	0.5
Intention	35.7 (6.8)	34.2 (7.8)	1.5
Knowledge and skills	39.2 (7.5)	39.6 (7.6)	0.4
Environmental constraints	20.6 (3.7)	18.9 (3.2)	1.7*
Salience	31.7 (4.6)	29.9 (5.1)	1.8 ⁺
Habitual behavior	36.4 (7.7)	36.4 (6.1)	0
Attitude	40.6 (7.2)	39.9 (5.9)	0.7
Social norms	18.5 (3.5)	17.8 (4.0)	0.7
Expectations	16.8 (3.7)	16.1 (3.1)	0.7
Self-concept	16.7 (3.5)	16.8 (3.1)	0.1
Self-efficacy	55.5 (9.4)	55.5 (6.4)	0

⁺
p < .10;*
p < .05.