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Factors Related to Community Mobilization and Continued Involvement in a Community-Based Effort To Enhance Adolescents' Sexual Behaviour

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Abstract

Purpose: This article describes and proposes a model of the factors that influenced community members' initial mobilization, continuing effort, or lack of involvement in a community based-intervention on adolescents' sexual health in Nova Scotia, Canada. Design: This study was conducted within the constructivist paradigm and guided by the principles of grounded theory. Methods: Factors related to community members' initial and continued involvement were explored using analyses of the contents of in-depth interviews and written documentation through pattern identification, clustering of conceptual groupings, identification of relationships between variables, constant comparisons, and theoretical memos. Subjects: Respondents included 14 participants, the 12 members of the Board of Directors and two paid staff (i.e., the project coordinator and the health centre nurse). Results: Specific personal, community-related, and organizational factors have influenced community members' involvement in the project. These factors were grouped into an explanatory model.

Keywords

Adolescents' Sexual Health, Community Mobilization, Sustainability of Grassroots Organizations

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Abstract

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Introduction

Studies on community health interventions continue to focus primarily on the outcomes of community based programs. Outcomes or impacts of program interventions are traditionally measured via time series or before-and-after data analyses with or without comparison groups (Weiss, 1998). The time series design involves a series of measurements on key outcome criteria at periodic intervals between the beginning and the end of the program. The before-and-after data analyses, or 'black box' design, involves measuring specific characteristics of participants at baseline before they enter the 'black box' and then measuring them again as they emerged from the black box. What actually occurs during the intervention/s (in the back box) remains largely unknown to the researcher/s; hence, the term 'black box'. While these designs allow researchers to count the number of people involved in a program, the numbers of activities that program staff has developed, participants' and program staff's satisfaction with a program, and/or participants' attitude or behavior changes, they do not help researchers gain insight into why and how things are happening. Similarly, when a program fails to achieve its desired outcomes, these designs do

not help researchers understand if the failure of the program is due to a failure of implementation, a failure of the theory behind the program, or both. As a result, factors that may affect the implementation of community-based programs and their relationships to its outcomes are poorly understood. This explains why researchers have suggested that not enough emphasis has been placed on understanding and systematically studying the implementation processes of such efforts (Butterfoss, Goodman, & Wandersman, 1993, 1996; Francisco, Paine, & Fawcett, 1993; Florin, Mitchell, & Stevenson, 1993). Research on these factors must become a priority for researchers if public health and health promotion practitioners are to implement effective community-based interventions (Butterfoss, Goodman, & Wandersman, 1996; Goodman et al., 1998; Hancock et al., 1997).

Following the above authors' recommendations, the purpose of this study was to explore the factors that affected the mobilization and continued involvement of community members in a grassroots association, the Amherst Association for Health Adolescent Sexuality, run by a core group of 12 dedicated community members. We will also show that this small, grassroots association has had a positive impact on the community.

Context for the Development of the Amherst Association For Healthy Adolescent Sexuality

The Amherst Association for Healthy Adolescent Sexuality (AAHAS) is a grassroots community organization created in response to community concerns about teenagers' sexual behavior and high pregnancy rates (Beazley, Langille, Johnston, Shoveller, & Beazley, 1993). It is a non-profit society whose membership consisted of community members, including health and other professionals (i.e., the Association has representation from each of the following organizations: the Department of Health, the local hospital, the local junior high school, Family and child Services, Family Planning, and Transition Services), parents, and teenagers. The Amherst Association, which operates through a Board of Directors and subcommittee structures, is primarily run by a core group of 12 very dedicated individuals. Its primary aim is to promote healthy sexual behaviors among Amherst adolescents. The primary activities of AAHAS include operation of a teen health clinic staffed by a baccalaureate-trained nurse in the local high school, media activities to sensitize the local community to the sexual health issues of adolescents, working with the high school to enhance sexual health education, providing resources for parents to help with communication about sexuality and providing professional development workshops on the subject of adolescent sexuality. From 1996 to 1999, a paid staff member coordinated these activities.

The AAHAS initiative is grounded in the social ecological paradigm. Social-ecological thinking infers a belief that efforts to promote well-being should be based on the understanding of the interplay among diverse environmental and personal factors. Such thinking, based on the work of Lewin (1936), Barker (1968), and Bronfenbrenner (1977, 1979) has been applied by McLeroy, Bibeau, Steckler, and Glanz (1988) to health promotion, and is receiving recognition as a viable health promotion strategy (Breslow, 1996). According to McLeroy et al. (1988), health-related behaviours are influenced by five determinants: (a) intrapersonal factors which comprise individuals' personal characteristics (e.g., knowledge, skills, self-concept, attitudes), (b) interpersonal processes (e.g., formal and informal groups and networks within which individuals

evolve), (c) institutional factors (e.g., social institutions with organizational characteristics, formal and informal rules of operations), (d) community factors (e.g., norms, beliefs and values that regulate the relationships and boundaries among organizations, institutions, formal and informal networks), and (e) public policy. McLeroy et al. (1988) and other proponents of social ecological models (Kegler, Steckler, Malek, & McLeroy, 1998a; Wandersman, Valois, De La Cruz, Adkins, & Goodman, 1996; Steckler et al., 1995) advocate that health promotion interventions are most effective when they use these channels of influence via multi-level strategies of change involving community partnerships or coalitions.

Coalitions are "formal, multi-purpose and long-term alliances or community organizations of individuals or interest groups to achieve common goals" (Kumpfer, Turner, Hopkins, & Librett, 1993, p. 360). They fit well with a social ecological perspective of health promotion since they work at multiple levels to promote the adoption of healthy behaviour and community change. Further, coalitions allow for the maximization of scarce resources, the rationalization of a fragmented service delivery system across geographic areas and levels of intervention, the increase of a 'critical mass' behind a project, the development of trust among individuals with diverse expertise, knowledge and skill transfer, and the involvement of citizen participation in program planning and implementation. Coalition development has been shown to go through four stages: (a) initial mobilization, (b) implementation which includes establishing an organizational structure, building capacity for action, and evaluation, (c) refinements and maintenance, and (d) institutionalization (Florin et al., 1993; Kegler, Steckler, McLeroy, & Malek, 1998b; Steckler et al., 1995).

Studies on community health promotion have focussed on the effectiveness of coalitions during the first two stages of formation (i.e., mobilization and early implementation) (Kegler, Steckler, Malek, & McLeroy, 1998a; Parker et al., 1998; Butterfoss et al, 1996). They have provided initial evidence that community members' participation, specific organizational characteristics (e.g., shared decision making; formalized rules and procedures, frequent communication), and leaders' and members' characteristics (e.g., the ability to articulate a clear vision, collaboration, and experience and/or training in community development) (Butterfoss et al., 1996; Gottlieb, Brink, & Gingiss, 1993; Kegler, Steckler, Malek, & McLeroy, 1998a; Kumpfer et al., 1993; Parker et al., 1998; Taylor, Elliott, Robinson, & Taylor, 1998) had an impact on coalition effectiveness. Lack of community participation, a major barrier to coalition effectiveness (Gottlieb et al., 1993; Herman, Wolsfon, & Forster, 1993; Kegler, Steckler, Malek, & McLeroy, 1998a; Taylor et al., 1998), can be fostered by different factors, including competing priorities, staff turnover, lack of interest in the issues at stake, turf 'wars', and the lack of available staff and/or community volunteers. However, these studies differ from ours in the follwing ways: (a) their main objective was to study factors that facilitated coalition effectiveness, participation being one of them, and not the factors that fostered coalition participation, which is the main goal of this study, (b) coalitions involved in these studies were primarily state/provincial or federal initiatives involving large budgets, a large number of organizations, and a large number of members that cannot be compared to the small, grassroots nature of AAHAS, and (c) most of these studies were conducted within the quantitative paradigm via surveys with a limited number of *a priori* hypotheses and variables. The three exceptions to the above are qualitative studies by Bloxham (1996) and by Cameron, Peirson, and Pancer (1994, 1984). However, Bloxham's study (1996) focussed on factors that facilitated inter-agency collaboration and did not include

community volunteers, and the studies by Cameron et al. (1994, 1984) were based on a provincial initiative involving 11 sites, four of which were on Native reserves.

Given the purpose of our study (i.e., to explore factors that affected the mobilization and continued involvement of community members in a grassroots association) and the lack of research in this area, we opted to conduct our research within the naturalistic approach. Qualitative research does not rely on pre-set factors and allow for the emergence of unexpected evidence from multiple sources, which makes such research particularly relevant for relatively unexplored and complex phenomena that involve a multitude of factors that are interrelated and may influence each other (Patton, 1990; Weiss, 1998). Additionally, while quantitative studies may establish whether a relationship exists between pre-identified processes and key outcomes, they do not help researchers understand why this relationship exists, how it came into existence, and how it has evolved over the years in a changing and complex environment. Finally, the choice of our paradigm was also based in our belief that "local interpreters" (Denzin, 1994, p. 506) (i.e., "people who have actually experienced" the processes under research) tend to be the best informants, since "in nearly all situations, individuals are able to articulate interpretive stories, or working theories, about their conduct and their experiences" (Denzin, 1994, p. 506). Local interpreters also provide researchers with "thick" (Geertz, 1983, p. 57) descriptions of emic, or contextual, situated experiences, which, in turn, help researchers generate concepts and theories that are actually grounded in lived experiences (Denzin, 1994; Strauss & Corbin, 1994).

Methodology

Our interest in the study grew out of the regular monitoring of the Board activities. Each Board member was responsible for the development and implementation of specific activities and it became apparent early in the process that while the development and implementation of some activities were relatively smooth and rapid, others appeared to be faced with multiple challenges.

This study was guided by the principles and methodology of grounded theory (Strauss & Corbin, 1994). Informants included fourteen individuals, the twelve AAHAS Board of Directors' members and the two paid staff (i.e., the project coordinator and the health centre nurse who had been hired by the Association). They had been involved in the project for about 2 years prior to the interviews.

Information was gathered through in-depth interviews and written documents. Documents included the Board of Directors' and the Committees' meeting minutes, a self-completion survey, and the project coordinator's and the nurse's daily logs. Written data were collected over a two-year period.

Interviews were based on a checklist of semi-structured and open-ended questions. The research coordinator and a psychologist developed the interview guide, which was reviewed by the members of the partnership, pilot-tested and revised following respondents' suggestions. Questions focussed on the respondents' experiences with the AAHAS and the forces that motivated them to become and remain involved in the project (e.g., Why did you choose to become involved in the AAHAS? How do you feel about your experience to date? What factors have affected your decision to remain involved in the AAHAS? If another community came to

you looking for information on how to bring community members together to improve their community, what would you tell them?). Interviews were taped and lasted approximately one hour and a half. They were transcribed verbatim following data collection and each interview yielded 60 to 95 pages of transcription.

Data were coded on an ongoing basis to allow maximum reflexivity. Data coding was done via QSR NUD*IST (Qualitative Solutions and Research Non-numerical Unstructured Data Indexing Searching and Theory-building software, http://www.qsr-software.com). This code-based software combines management of textual data with processes for indexing, linking, and searching the data. Coding included open, axial, and selective coding (Strauss & Corbin, 1990, 1994). Open coding included breaking down the data into meaningful pieces, assigning them a code, and categorizing them. Codes were grounded into the themes that emerged from the data. Axial coding (i.e., establishing relationships between already identified categories) allowed for the emergence of 'main' and 'sub' categories. Sub-categories reflected the properties or different dimensions of each main node and illuminated the data in ways not provided by the main nodes. Transcripts were reviewed several times to ensure that all relevant data were systematically coded under the appropriate categories and sub-categories. Selective coding included developing core categories and systematically linking them to the other categories. During this process, categories were organized around the main concepts that emerged from our data. The coding of data was done by two independent research analysts, one with an expertise in qualitative evaluation and the other one with an expertise in organizational behavior, who compared and contrasted their results. The final node structure reflected the use of different analytical procedures, such as pattern identification, clustering of conceptual groupings, axial coding which facilitated the identification of relationships between variables, constant comparisons, and theoretical memos (Miles & Huberman, 1994a, 1994b; Strauss & Corbin, 1990).

As recommended by Lincoln and Guba (1981, 1985) and LeCompte and Goetz (1982), the credibility, transferability, dependability, and confirmability of the findings were ensured through regular peer debriefing with two experts in coalition development and AAHAS members, inter-informants' triangulation of data, and audit trails. Debriefing sessions primarily occurred during the data collection and analyses and during presentations of our preliminary findings to the AAHAS members. Audit trails included logs of methodological decisions, data analyses, developing insights, evolving hypotheses, and emerging relationships between the nodes and sub-nodes. These trails were kept throughout the study.

This study was conducted in conformity with the ethical guidelines of Dalhousie University. At the beginning of each interview, participants were advised that they could personally withdraw or withdraw information at any time during the interviews, and that the information they shared would be confidential. Each respondent signed a consent form at the beginning of the interview. A copy of the report was given to the informants.

Results

Results have been divided into two parts. The first part examines the processes that motivated informants to become involved and maintain their organizational membership in the AAHAS.

The second part explores the factors that may have inhibited the participation of community members and/or slowed down the progress of the AAHAS from the participants' perspectives.

Community-Based Intervention's Facilitators

The processes that facilitated the informants' initial involvement and continuous membership in the AAHAS have been grouped into motivating and reinforcing forces.

Motivating Forces. The major factors that motivated respondents to become involved in the AAHAS included their awareness of adolescents' sexual issues in the community, their conviction that these issues needed to be addressed, feelings of self-efficacy, a sense of community, individual-organizational and/or inter-organizational value congruence, organizational support, the participants' belief that the AAHAS would fulfill valued expectations, and their confidence in the AAHAS' organizational efficacy.

Issue awareness. Respondents' awareness of sexual issues in the community had been fostered by 3 key factors. First, various social organizations that had teenage sexuality issues as part of their agendas existed in the community, which fostered community readiness to address these issues. For example, the local County Family Planning offered services in keeping with the AAHAS' mandate to all residents of the county prior to the AAHAS development. The establishment of partnerships with these existing community resources not only empowered the AAHAS programs, but also maximized the potential for reaching the social needs of all adolescents in this area.

Secondly, the community of Amherst recognized links between its high rate of pregnancy in young women and the extent of sexual activity, especially high risk sexual activity among its young people as evidenced by previous survey research, and the need for intervention. Data indicating that the local teenage pregnancy rate was substantially higher than the provincial average proved a "wake-up call" to the community.

Thirdly, the fact that respondents (adults and adolescents) personally knew or knew of pregnant teenagers, which was facilitated by the small size of the community, boosted their desire to get involved in the AAHAS. As one informant noted: "When I went to school, three of my friends became pregnant, and things haven't changed that much, so I wanted to become involved and do something about that."

These three issues, the existence of local infrastructure already involved in sexual health, the impetus provided to the community by research data related to adolescent sexual health, and personal experiences resulted in a raising of the level of consciousness of the community about this particular health concern and "paved the way' for those willing to get involved in the AAHAS' effort to promote healthy sexual behavior in the County.

Informants' feelings of efficacy. Participants' beliefs that their contributions would empower the AAHAS to make a difference to adolescents' sexual health also motivated them to become involved in the project. Feelings of efficacy were generated by the informants' training and/or

experience in sexual health issues, with the targeted audience, and/or by the respondents' knowledge of the community and/or key people residing there.

I felt [that] my experience would be useful to the Board. I have worked in this community for 15 years and I know all the key players, what's happening in the county, how to access people, who to access, who to talk to, etc... I was also already familiar with many of the issues... and most of my work has been geared toward youth.

Informants' sense of community. There were several dimensions to the respondents' sense of community. Among these were a sense of connection with the place (many respondents were born and/or had lived in Amherst for over 15 years), a sense of shared history, and a high empathy for the targeted audience. Participants reported that their altruistic concerns for young adults predisposed them to participate in the AAHAS, as illustrated in the following comments: "I knew it [the project] would touch many students, and I wanted to help;" "I wanted to do something that would benefit adolescents in my community and I felt that I could do that with the AAHAS."

Participants' empathy for adolescents arose from their identification with the targeted audience. Identification was fostered by the informants' concerns as parents, professionals, and peers via vicarious learning from significant others. As participants reported: "I had a personal stake in this issue. I have two adolescent children, so I had to become involved;" "I feel a connection to the youth. Some of my friends became pregnant, and I know what pregnant teenagers have to go through, and I wanted to help."

Value congruence. The match of individual and AAHAS values and goals and/or inter-organizational value congruence was crucial to participants' involvement in the project, as indicated in the following quotations: "I got involved because I do agree with the project. That was something I have always believed in, and so, I wanted to help;" "My organization was already involved in similar issues and most of my work was geared to youth. So, it was only natural that I became involved [with the AAHAS]."

Organizational support. Organizational support reinforced the respondents' initial desire to participate in the AAHAS. As one informant reported: "My organization is very supportive. They pay me to come to the AAHAS meetings." This support was facilitated by inter-organizational value congruence and/or by the organizations' commitment " to become involved in various community organizations as volunteers, to provide organizations like the AAHAS with input and professional expertise."

Valued expectations. Informants' involvement in the AAHAS was also motivated by their expectations. Participants' expectations were grounded in their belief that the AAHAS had the potential to fulfill some of their personal and/or professional aspirations:

I felt [that] this was going to be a learning experience for me and I also felt it would help me better serve students at the junior high level, our organization and the AAHAS both wanted to help the community, and if the project was successful, then both the AAHAS and my organization would be successful.

Informants' beliefs in the AAHAS' efficacy. Finally, many respondents commented on the AAHAS' perceived ability to "improve the quality of life and health of young people," which also prompted them to become actively involved in the project.

Reinforcing Forces. The informants' intrinsic motivation to remain in the AAHAS and exert extra effort on behalf of the organization was primarily generated by the participants' feelings of achievement and specific characteristics of the AAHAS organizational membership (e.g., commitment), its leadership, and hired personnel. AAHAS members' feelings of success were fostered by their feelings of actualization, their feelings of affiliation, the chair's leadership, felt progress, and mutual benefits. Specific characteristic of the organizational membership (e.g., commitment) and its leadership and the hired personnel were also key factors to the AAHAS members' continuous involvement.

Feelings of achievement. Feelings of success were crucial in the informants' decision to remain involved in the AAHAS. As informants suggested: "I want to continue because I feel I am making a difference;" "I do things that make me feel good, and I feel good about what we do at the AAHAS." Many informants insisted that their involvement in the AAHAS had been "very worthwhile," "exciting," or "very rewarding." In addition, participants suggested that the ratio achievement/effort made their involvement worthwhile.

It has been worth doing. It hasn't taken up too much time and it's just little things you do here and there that make a big difference.

Participants' feelings of achievement were enhanced by several processes. First, self-actualization played a big part in the informants' feelings of success. Informants' involvement in the project was described as "very valuable learning experience " that enhanced their personal and professional feelings of efficacy and their self-concept. One respondent summarized the above by emphasizing:

It has been a learning experience. I have personally grown a lot... It has broadened my whole perspective on people's role in the community, and I also believe I have become a better teacher because of that experience.

First, multiple partnerships strengthened the informants' feelings of actualization because they allowed for skill and knowledge transfer. Participants increased their knowledge in community activation, the formation and implementation of collaborative initiatives, the functioning of non-profit organizations, different aspects of teens' sexual health, and specific leadership skills.

Second, the informants' feelings of affiliation and their satisfaction at working collaboratively with other Board members further reinforced their feelings of success and enhanced their positive attitude toward the organization and its members. As one participant pointed out: "We like and we trust each other... there is a bonding that has developed, and it's really nice."

Third, the participants' feelings of success were also strengthened by the chair's leadership and some of the Board of Directors' processes (e.g., consensual decision making). Their inclusion in decision making, the AAHAS collaborative approach to designing and implementing action

plans (provided that actions plans had a clear mandate, feasible goals, and clearly outlined procedures to achieve agreed-upon goals), and the fact that the chair was an attentive and eager listener enabled informants to feel that their contributions were valued. The fact that the chair encouraged Board members to take on tasks that they excelled in further reinforced their feelings of success. Regular evaluative feedback and written reports generated by the Dalhousie research team also provided AAHAS members with a sense of accomplishment.

Having researchers has also been very positive for the project... The questionnaires and the reports about the attitudes and practices of the high school students have been very useful. They gave us scientific feedback on what we were doing... These reports were the indicators of our success with the teens... it was great for us. We definitely needed the university researchers.

Fourth, the respondents' perception that the project had progressed was essential in the participants' decision to remain involved in the AAHAS. Informants insisted that progress was felt in many different areas, such as increased community awareness around sexual issues, increased involvement in the Board, the effective implementation of multiple activities by Board members, and positive changes in community members.

We have seen the Board bring the community together around this issue in a way that hasn't happened before... It's amazing. It's wonderful... We also saw tangible things arise from our involvement. We did get the Teen Health Center up and running, and that's something very big.

Finally, perceived met expectations (each AAHAS member entered the coalition with a specific set of expectations generated by their personal or professional experiences with the issues at stake), provided that these expectations were valued by informants, and inter-organizational benefits (e.g., increased organizational visibility) further enhanced the participants' feelings of achievement and their desire to remain involved in the organization.

The partnerships with other agencies were very good for everybody. They gave the AAHAS added credibility, but the AAHAS also brought issues that these agencies were dealing with more into the front light, particularly with the media attention that we got. So, these partnerships enhanced all the organizations that were involved and we made tremendous progress because of that. It's very rewarding.

Participants expressed that the AAHAS' success was fostered by the organization membership, leadership, and the hired personnel.

Organizational membership. Participants felt that it was the membership's commitment and hard work that enabled the project to be successful and inspired them to remain in the AAHAS. Organizational members were described as exemplary role-models, with a strong task orientation, and reasonable expectations. They brought strong leadership and expertise to the initiative and were willing to share their talents/knowledge and collaborate with each other to achieve agreed-upon organizational objectives.

Leadership is essential in a project like that and it's not just leadership from the chairs, but leadership from every member. This project wouldn't have been successful without everybody's

leadership and collaboration, without dedicated people who went ahead, who had a vision and made things happen, people who were doers and experts in many different areas.

The involvement in the AAHAS of people with diverse expertise enriched the AAHAS and fostered its success. Informants emphasized the benefits of multiple partnerships in projects such as the AAHAS. These benefits included the effective use of multiple resources and talents, a broader understanding of issues, higher feelings of organizational efficacy, and increased public awareness and support. Multiple partnerships, particularly with varied provincial and health agencies, also fostered the AAHAS' visibility, credibility, and legitimacy, and facilitated reciprocal benefits (e.g., the achievement of shared goal) for all the organizations that were involved in the project.

Informants also reported that the AAHAS' linkage with researchers at the Department of Community Health and Epidemiology (Faculty of Medicine, Dalhousie University), further contributed to the success of the AAHAS. The researchers' expertise, their evaluative feedback with respect to the surveys, and their securing research funding were much valued by the participants.

Organizational leadership. Many participants emphasized that the AAHAS' success was also partly due to the chair's leadership. The chair's democratic orientation, his inclusiveness of others, openness, his ability to listen to others and to foster collaboration, his deemed reasonable expectations, and his sensitivity to people's differences and strengths increased Board members' feelings of affiliation, their satisfaction with the organization, and the AAHAS' organizational efficacy.

The key to a project like ours is that the person who is sitting in that position is able to listen to everybody's opinion and welcome ideas. This chair is very open and we feel very comfortable in bringing up any issues we want... He also encourages us to collaborate and gives us structure, gets us to do what we need to do. He leads us to where we want to be... He is very good at knowing people's strengths and at encouraging them to do things in their area of interest or expertise, and this is very good for the project and for us too.

Hired personnel. The project coordinator and the nurse educator were deemed essential to the success of the project. The project coordinator was recognized as a "key player" for her role in liaison with the AAHAS Board of Directors and the community, as well as for her commitment and positive attitude. The nurse educator was recognized for her excellent rapport with students. It was the nurse's regular participation in health classes and at extra-curricular activities, her friendliness and her ability to build positive relationships with the students that promoted the students' usage of the teen health centre.

The coordinator and the nurse are just great. They have been very energetic and enthusiastic players. The coordinator is just essential to the project. She is right on top of everything, she gets the ball rolling, and she makes sure that people are doing what they are supposed to do... She plays a big role in keeping the process going, keeping it smooth, getting the decisions that need to be made, and making sure that decisions are carried out.

Inhibitors. A few participants suggested that the issues that were addressed, economical, community-specific, and personal and organizational factors might have prevented individuals from getting involved in the AAHAS or might have limited their involvement in the AAHAS' activities.

Issues. Some participants reported that teens' sexuality was a sensitive topic and that some community members may not have felt comfortable dealing with issues related to sexual health. As one respondent suggested: "The issue of sexuality still is kind of a touchy subject for some people."

Economic factors. Unemployment, a decreasing and aging population, not enough volunteers, and competing issues/concerns (e.g., competing fund-raising) might have also affected community members' lack of interest in the AAHAS.

There's a lot of unemployment here and people who were involved in a lot of things have left the area, and nobody has replaced them... Our community is stretched out right now in terms of financial resources. We have fund-raised everybody to death... people can only give so much of their time and money... and there are other things that are going on right now in the community that have people's attention.

Community-specific factors. One informant pointed out that the provincial staffing policies and the on-going regionalization further limited the pool of volunteers to draw from.

Cumberland County is the lowest staffed [county] in the province... and now with the regionalization, the decentralization [of health services], there is even less services and less people that could help out.

Participants suggested that the low level of involvement of physicians, pharmacists, and teachers might have been fostered by varied factors such as the shortage of physicians and pharmacists, and the fear of repercussions or conflicts with parents. They also suggested that the lower than anticipated youth representation in the AAHAS might have been caused by their belief that "they were not given sufficient power and therefore found the role of dealing with a formal adult group threatening and restraining."

Personal characteristics. Informants' feelings of inadequacy tended to hinder their continuous involvement in the project. Feelings of inadequacy were fostered by participants's felt lack of expertise with sexual health issues, the targeted audience, organizations such as the AAHAS, specific organizational processes (e.g., the elaboration and implementation of action plans frustrated several informants who had no prior experience or training with such a process), and feelings of shyness and social fear (a few participants, particularly new members or volunteers, reported being overwhelmed by the proportion of professionals in the committees and by the formality of the language and decision meeting procedures used in the meetings). As well, informants suggested that individuals who already worked on sexual health issues might have been unwilling to join the AAHAS because "they were afraid they would become redundant and lose their job," or because "they were concerned that another community organization would decrease their own funding." Informants also noted that community members did not like to

make commitments that kept them busy during the summer and/or that did not have a specific end with respect to their involvement.

Organizational characteristics. Cutbacks at work, heavier workloads (and thus, felt role overload), and role conflict (i.e., informants had too many roles and/or informants' roles were conflictual) also restricted some participants' involvement in the project. In addition, inter-personal conflicts resulted in some members temporarily decreasing their involvement and, in one case, in a member leaving the organization. Finally, it was also suggested that some board members decreased their involvement because they had met their valued expectations (e.g., these members were more interested in the initial mobilization of the AAHAS than in its continuous maintenance) and/or experienced feelings of burnout.

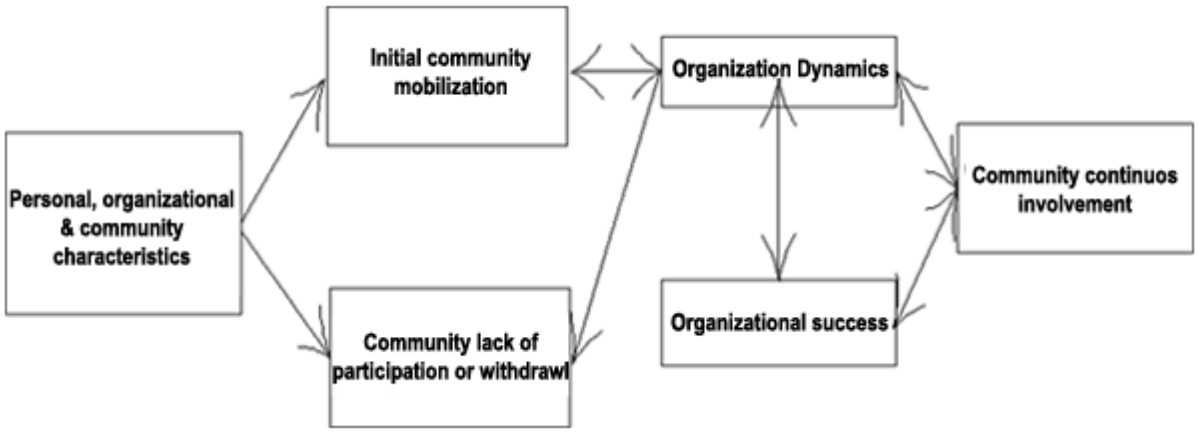
Committee-related factors. A few participants felt frustrated by the time and demand constraints that resulted from their involvement in the AAHAS. Professionals as well as volunteers felt role overload with respect to the AAHAS. Some members were also frustrated at the lack of involvement and low attendance of some of the Board members. Board members' lack of involvement increased active participants' feelings of role overload, and their dissatisfaction toward specific board members, which, in turn, affected their level of commitment.

It's hard to get some people really involved. People commit to do something and then something else comes up, and nothing gets done. It's hard on the other Board members. It's discouraging.

Informants also suggested that inter-group conflicts may have temporarily hindered their enthusiasm toward the project. There were temporary tensions between the Dalhousie research team and a few Board members. Issues of disagreement centered on role ambiguity (i.e., who should do that and/or what was supposed to be done) and deadlines with respect to the implementation of some activities. As well, a few informants expressed concern that research needs rather than community needs had at times directed specific community activities. Finally, there were also issues related to the Board of Directors' meetings that bothered some members, particularly the meeting times (e.g., meetings too late in the evenings), the number of meetings (e.g., too many), and meeting structure (too rigid).

In summary, the study findings suggest that specific personal (e.g., community members' awareness of the community issues, the informants' feelings of efficacy and community, the respondents' beliefs in the AAHAS potential for success), organizational (organizational support regarding the informants' participation in the AAHAS, respondent-AAHAS value congruence regarding the AAHAS' goals and priorities), and community (e.g., the community's SES) related factors influenced community mobilization, continuous involvement, and/or lack of interest in the AAHAS. The inter-relationship of organizational dynamics and feelings of achievement strengthened the participants' desire to remain involved in the organization. Nonetheless, organizational dynamics (resulting from the relationship between AAHAS members, including its leader, the participants' sense of role overload and competing priorities, as well as from the AAHAS' relationship with the Dalhousie researchers) also caused some participants to withdraw from or limit their participation in the organization. The above is summarized in Figure 1, which emerged from the data analyses.

Figure 1: Factors influencing community mobilization and involvement in a coalition effort to promote sexual health



Discussion

Our research indicates that the AAHAS, a small grassroots coalition, has been successful in mobilizing the community to respond to adolescents' sexual health issues. It also demonstrates that a community can act upon an issue that traditionally has not been easily addressed on a community level. Partnerships with dedicated volunteers, policy makers, and researchers can increase the viability of successful programs that address important health issues. To date, 6 years after its inception, the AAHAS is still active in the community and has been able to participate in the implementation of a health centre in the local high school, secure funding for its part-time nurse and a physician's weekly visits, secure continued operational funding for the association from the Regional Health Board, and impact the rate of teenage pregnancies (Langille, Flowerdew, & Rigby, 2000). It is currently seeking funding through its own initiative to have the clinic open five days a week. The school health centre has proven popular for young people who seek sexual-health-related services that they are provided in a safe, convenient and confidential environment.

This study presents a coherent and comprehensive model of the factors that foster mobilization and continuous involvement in a grassroots coalition. While research suggests that participation may foster effective coalitions, there has been little or no systematic or comprehensive research on the factors that facilitated or hindered the mobilization and maintenance of grassroots coalitions. Findings indicate that community members' positive attitudes towards the addressed issues, recognition of mutual needs and purposes (i.e., individual-organizational and inter-organizational of value congruency), a sense of community, organizational support, feelings of self and organizational efficacy, and positive expectations with respect to personal and organizational gains fostered community members' initial mobilization. Informants identified further predisposing factors that influenced their sense of efficacy (e.g., previously positive experiences with community programs, the targeted audience, the addressed issues, and/or knowledge of the persons susceptible to have a powerful influence on the program) and their awareness of adolescents' sexual health issues before the implementation of the AAHAS (e.g., other voluntary or provincial organizations' previous involvement and work in similar or related

issues, previous research efforts on sexual health, and multiple media releases around these issues). As well, the current study has indicated that participants' sense of community was more complex (i.e., had more layers or dimensions) than Wandersman, Florin, and Friedman (1987) definition (e.g., our informants' sense of rootedness was shaped not only by the number of years spent living in the community, but also by their identification with the targeted audience). Finally, our respondents further suggested that the community's empathy toward the targeted audience was generated by the respondents' personal experiences (as parents), peers, and as professionals involved with young people.

Findings with respect to the factors that reinforced the respondents' continuous involvement in a community-based project indicate that organizational membership, leadership, hired personnel, and felt success were crucial to sustain community members' interest and involvement. As well, participants' feelings of efficacy and subsequent active participation in a specific community project were facilitated by specific organizational processes, such as consensual decision making and the implementation of action plans with feasible goals, leadership, transfer and acquisition of new knowledge via linkages with multiple organizations, social support and recognition, and regular performance feedback. Informants additionally indicated that increased feelings of affiliation with organizational members, self-actualization, and the fulfillment of valued expectations, whether personal or organizational, further motivated them to maintain their organizational membership. Moreover, the organizational leader's ability to be task-oriented, collaborative, open, sensitive to people's differences and strengths, and to hold deemed reasonable expectations with respect to the participants' involvement and roles also strengthened their desire to remain in the organization. Interestingly enough, many of the factors that fostered community mobilization and continuous involvement are similar to those fostering the effectiveness of state/provincial or federal initiated coalitions (Butterfoss, Goodman, & Wandersman, 1996; Gottlieb et al., 1993; Kegler, Steckler, Malek, & McLeroy, 1998a; Kumpfer et al, 1993; Parker et al., 1998; Wandersman, Valois, De La Cruz, Adkins, & Goodman, 1996).

Some of the participants' identified barriers to community's mobilization, including lack of community support and participation, community members' negative attitudes towards specific issues, the difficulty of mobilizing individuals in economically disadvantaged communities, felt lack of expertise and technical support, inter-person and group conflicts, unrealistic time-frames, role overload, and felt inadequacy (i.e., lack of training and/or experience with community programs, specific issues, and/or specific organizational processes). Some of these findings support the barriers Cameron et al. (1994) identified for resident participation in the Better Beginnings Better Futures project (e.g., lack of time, felt lack of skills, residents feeling intimidated by professionals). As well, respondents suggested that certain board-related factors (e.g., some organizational members' lack of commitment, meeting structure and times) tended to foster withdrawal from some members. Our findings also suggested additional inhibitors to community involvement. Our participants reported that felt role conflict (i.e., informants had too many roles and/or informants' roles were conflictual), role ambiguity (i.e., participants had different or unclear expectations with respect to their roles), specific individuals' fear (e.g., fear of professional redundancy, shyness and social fear), and specific community-related factors (e.g., an "apathetic" community, too little or already overworked volunteers) might further hinder community participation and the intervening organization's efficacy. However, the presence of participant-perceived barriers may not be as important as the fact that these barriers are

addressed to the satisfaction of the organizational members and continued to be addressed in that manner.

Recommendations for policy and practice

- Building upon existing community resources is critical for successfully obtaining community support for focused initiatives in promoting sexual health. Communities wishing to promote sexual health for their youth should examine and catalogue existing strengths (e.g., organizations already involved in similar issues and/or individuals with specific expertise in the diverse domains of the identified issues), and find means of bringing those strengths together.
- Successful coalitions involve multiple partnerships that facilitate skill and knowledge transfers and acquisitions, and allow coalition members to maximize their power through joint action, which increases their feelings of personal and organizational efficacy. Multiple partnerships also increase coalitions' visibility, credibility, and legitimacy, and facilitate reciprocal benefits (e.g., the achievement of shared goals) for all the organizations that are involved in the project.
- Leadership skills, hired personnel, and commitment are essential to community involvement. Inversely inter-group conflicts, lack of training, unrealistic time frames, participants' role overload and competing work priorities may be barriers to effective coalitions.

Table 1: Factors that Influenced Participants' Initial Mobilization and Continuous Involvement in the AAHAS

Mobilization's Motivating Forces	Mobilization's Barriers
Personal Characteristics: • Awareness of issues and belief that issues need to be addressed • Feelings of efficacy • Feelings of community • Positive expectations • Participants' belief in organizational efficacy Value congruency • Individual-organizational & inter-organizational value congruency Organizational characteristic	Personal Characteristics: • Perceived sensitive issues • Feelings of inadequacy • Social fear/shyness • Fear of conflict, repercussions Role characteristics: • Role overload • Role conflict • Fear of professional redundancy Community Characteristics: • Economically disadvantaged community • Aging population

• Organizational support	• Too few volunteers or overworked volunteers • Shortage of human power in specific professions

Reinforcing Forces to Initial Involvement	**Barriers/Limitations to Active Involvement**
Feelings of achievement: • Feelings of actualization (and deemed satisfactory ratio effort/success) • Feelings of affiliation • Felt and visible success Felt and visible success was fostered by: • Organizational membership • Multiple partnerships • Organizational leadership • Specific organizational processes (e.g.,. consensual decision making, evaluative feedback) • Hired staff	Personal Characteristics: • Feelings of inadequacy • Inter-personal conflict/Lack of affiliation • Participants' understanding of commitment Organizational characteristics: • Inter-group conflict • Members' lack of commitment • Specific organizational processes (meeting structure and times) • Too tight deadlines. Role characteristics: • Role ambiguity • Role overload

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