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Identifying and Structuring Long-Term Community Engagement Platforms for San Francisco's Ending the HIV/HCV/STI Epidemics Initiative

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Identifying and Structuring Long-Term Community Engagement Platforms for San Francisco's *Ending the HIV/HCV/STI Epidemics* Initiative

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Abstract

Purpose: The primary objective for this project was to develop recommendations for a long-term community engagement structure and process for the ten-year implementation of the San Francisco Department of Public Health's *Ending the HIV/HCV/STI Epidemics* initiative.

Background: Community engagement offers public health practitioners, researchers, and policymakers the opportunity for open, respectful dialogue with community members in pursuit of a common goal. This project was designed to explore different community engagement coordinators' experiences with undertaking such initiatives, in order to inform a large-scale funding proposal being pursued by the San Francisco Department of Public Health (SFDPH).

Methods: Phase 1 of the project was a set of semi-structured, in-depth interviews with four coordinators of community engagement initiatives addressing health inequities in San Francisco. Phase 2 of the project was a set of semi-structured, in-depth interviews with three members of community-based organizations engaging community members throughout the *Ending the HIV/HCV/STI Epidemics* planning process.

Findings: Phase 1 of the project was useful for elucidating the general experience of coordinating community engagement initiatives, and Phase 2 of the project offered support for the community engagement processes currently being utilized by SFDPH for the *Ending the HIV/HCV/STI Epidemics* plan.

Conclusion: Using these findings, future coordinators of community engagement efforts, especially those working on the *Ending the HIV/HCV/STI Epidemics* initiative in San Francisco, can develop their participatory processes to be well-informed for their target communities. In doing so, public health practitioners can actively work toward dismantling oppressive power structures within public health and seek to uplift the voices of their communities.

 Keywords: community engagement, participation, health

Identifying and Structuring Long-Term Community Engagement Platforms for San Francisco's *Ending*

***the HIV/HCV/STI Epidemics* Initiative**

Within the field of public health, *community engagement*, or *community participation*, is a concept that describes various approaches and processes used to create an active role for community members in shaping research and/or services that will directly impact them (Harris et al., 2019). While rather difficult to define, community engagement offers public health practitioners, researchers, and policymakers the opportunity for open, respectful dialogue with community members in pursuit of a common goal. As such, community engagement is an invaluable part of addressing health disparities and inequities, particularly among marginalized and vulnerable communities (Attree et al., 2011).

Because of the purpose of community participation as a way to inform and enhance public health services, it is important to understand the practical landscape of various community engagement initiatives. This project was designed to explore different community engagement coordinators' experiences with undertaking such initiatives, in order to inform a large-scale funding proposal being pursued by the San Francisco Department of Public Health (SFDPH). In providing insight into the vastly different experiences of community engagement, I hope to offer further support with navigating potential pitfalls and enhancing community members' participation. Lastly, I aim to provide an overview of the common narratives used to describe community engagement, as these initiatives vary from place to place, and community to community.

Literature Review

Throughout this literature review, I examine central theoretical concepts and models of community engagement as they relate to improving community health and well-being. Furthermore, I provide highlights from the literature regarding facilitators and barriers to community members' participation and summarize associated benefits and costs of integrating community engagement into broader public health initiatives.

Community Engagement Definitions and Theoretical Concepts

With increasingly positive attitudes supporting the integration of community feedback into public health interventions, the term 'community engagement' has been described using various definitions. Broadly defined, community engagement involves a number of approaches and processes designed to involve "communities of place and/or interest" (Attree et al., 2011, p. 251) throughout the planning, implementation, and evaluation of health promotion activities. These activities typically range from providing participants with information to allowing community control of the entire process, with various steps in between (Attree et al., 2011; Brunton et al., 2017).

Brunton and colleagues (2017) state that the initiation of "community engagement occurs where a [health] need is identified for a particular group of individuals (i.e., a community)" (p. 5). The terms *community* and *need* are often conceptualized differently depending on the social, historical, and political context in which community engagement initiatives are being conducted. Communities can be defined and conceptualized either internally or externally; internally defined groups of people are more often referred to as *communities*, while externally defined groups of people are usually referred to as *populations*. Furthermore, according to Bradshaw's (1972) taxonomy as a framework for understanding social need, each health need can be classified into one of the following categories: "a *felt need*, which is one that is identified by community members themselves; an *expressed need*, which is inferred by a community's use of services; a *comparative need*, derived by comparing service use in a similar community; or a *normative need*, derived by comparing measures of living conditions with a society norm or standard, often set by experts" (as cited in Brunton et al., 2017, p. 6). Similarly, Adebayo et al. (2018) define a community's need as a consensus between all stakeholders on the ability of a project to address the needs of the target community. It is important to understand how a community and its needs have been identified, given that community engagement work is historically rooted in empowerment, organizing, and advocacy.

One of the fundamental themes relevant to community engagement work within public health is the acknowledgement of the longstanding uneven distribution of knowledge, which is inextricably linked to wealth, education, race, and class in the United States. Because academic and scientific institutions, in particular, were originally designed for cisgender, heterosexual, White, Christian men, marginalized and vulnerable communities have been excluded from public health decision-making processes throughout history. As a result, public health researchers and practitioners have traditionally approached their work using the positivist paradigm, which posits that the empirical creation of knowledge (i.e., through the use of the scientific method) is both bias- and value-free and, thus, qualifies as universal truth. In contrast, community engagement work is rooted in the empowerment and self-mobilization of communities in order to co-produce knowledge based on experience (Pretty, 1994). Central to this idea is the definition of local knowledge, which is "knowledge that does not owe its origin, testing, degree of verification, truth, status, or currency to distinctive…professional techniques, but rather to common sense, casual empiricism, or thoughtful speculation and analysis" (Cohen & Lindblom, 1979, p. 12; Corburn, 2005). Community engagement work within public health actively prioritizes both empirical and local knowledge in an effort to address the uneven distribution of knowledge by co-creating interventions, services, policies, and programs based on collective experience.

Another fundamental component of community engagement work concerns the iterative nature of participation as a dialogue between community members. Community engagement work acknowledges the power of communities to self-mobilize and participate in traditionally paternalistic decision-making processes. Brunton and colleagues (2017) identify levels of engagement with the following progression: receiving information, consultation, collaboration, and control. Similarly, Harris et al. (2019) categorize levels of engagement within participatory research using the following hierarchy: targeted consultation, embedded consultation, collaboration and co-production, and user-led research. Pretty's (1994) participation typology, originally introduced as a model for participation within

agricultural work, encompasses the following levels of engagement: passive participation, participation

in information giving, participation by consultation, participation for material incentives, functional

participation, interactive participation, and self-mobilization. Likewise, Arnstein's (1969) ladder of citizen

participation includes the following: manipulation, therapy, information, consultation, placation,

partnership, delegation, and citizen control. Each of these conceptualizations of participation allow for

coordinators of community engagement initiatives to check their process for continued dialogue and

potential paternalism. It should be noted that each of these hierarchical models is bidirectional,

meaning that participation can shift to higher and/or lower levels of engagement at different points.

Furthermore, engagement levels may differ between separate components of one particular community

engagement project.

Another theme central to community engagement is power. Foucault's (1982) seminal work

characterizes the exercise of power as "a way in which certain actions modify others" (p. 788).

Throughout history, marginalized and vulnerable communities have been at the receiving end of power

and control, through macro- and micro-level events (Bennetts et al., 2011). Participatory approaches

within public health allow for marginalized and vulnerable communities to address power differentials

and social disparities (South et al., 2019). One such approach, community-based participatory research

(CBPR), integrates various processes throughout the planning, implementation, and evaluation periods

of a research project as a way to understand community need and facilitate community participation in

addressing that need. In doing so, CBPR practitioners take part in active power-sharing and bidirectional

learning with community members. Brunton and colleagues (2017) explain that "empowerment is

rooted in concerns about social justice and movements promoting social and structural change by

supporting people to participate, negotiate, influence control, and hold accountable institutions that

affect them" (p. 8-9). Within this context, institutions encompass both public health researchers and

practitioners that have exercised their power over marginalized and vulnerable communities by

prioritizing empirical knowledge without addressing these power imbalances (South et al., 2019).

Because community engagement in public health is highly influenced by the objective to redistribute

power and knowledge between institutions and their communities, it is important to understand the

role of coordinators in enhancing the participation of community members throughout participatory

processes.

Participation in Community Engagement Initiatives

Because of the "bewilderingly large number of inconsistent and partially conflicting definitions"

(Brunton et al., 2017, p. 11) used to describe community engagement, researchers have often tried to

identify specific facilitators and barriers to increase engagement. As such, the literature supports a wide

variety of facilitators and discourages a number of barriers relating to the entire context within which

community engagement initiatives operate:

> Contextual issues included the degree of stable funding and support throughout the project and
>
> the level of certainty over future funding or mainstreaming opportunities; the social, political,
>
> economic, geographic context and its impact on the community engagement or public health
>
> interventions; and the influence of externally-imposed government policy and targets for
>
> achieving health. (Brunton et al., 2017, p. 7)

Facilitators

Group cohesiveness and individual participation can be enhanced at various points during

community engagement initiatives through different techniques and processes. In their narrative review

of best practices, Baker, Procter, and Ferguson (2016) discuss the importance of program promotion,

timing, duration, location, setting, and size. These program components vary substantially by

community and, thus, are critical from the beginning of the planning stages of community engagement

initiatives. Organizations and individuals planning community engagement programs should be

especially attuned to participants' concerns and support needs throughout the entire initiative, as

specific participants' needs vary individually and according to external factors (Attree et al., 2011). Similarly, cultural values and linguistic preferences are also important considerations for planning community engagement initiatives, particularly for marginalized and vulnerable communities (Baker et al., 2016; Cyril et al., 2015). Logistical assistance for supporting participants throughout community engagement initiatives – travel and childcare, in particular – also have the capacity to enhance individual participation. Additionally, the literature indicates widespread support for financial compensation as a key facilitator of community engagement (Baker et al., 2016; Korn et al., 2018).

In addition to logistical facilitators of community participation, the literature supports a number of facilitators that promote relationship- and trust-building among and between both participants and coordinators. Baker and colleagues (2016) describe trust as an essential facilitator for fostering engagement with people from marginalized and vulnerable communities. In order to facilitate trust-building within community partnerships, Adebayo et al. (2018) suggest "effective regular, and bidirectional communication" (p. 479) using a number of various communication platforms. Newman et al. (2011) substantiate the importance of mutual respect and further explain that community members' time, resource, and expertise contributions should be both recognized and compensated in order to promote engagement.

Brunton et al. (2017) state that empowerment for community change and commitment to health promotion is supported through the involvement of communities as stakeholders within community engagement initiatives. Through the prioritization of experiential (i.e., that of community members) over scientific (i.e., that of providers, researchers, and policymakers) knowledge, community engagement initiatives support participants' empowerment and control over community public health concerns. Through their mixed methods analysis, Korn et al. (2018) discovered widespread support for collaborative leadership and collective impact among all stakeholders throughout the planning, implementation, and evaluation stages of community engagement programs. Together, these

components support further involvement of community members and ownership of program activities and goals, thereby enhancing program sustainability. Cyril et al. (2015) provide support for positive elements of community engagement within research, including bidirectional learning and power-sharing between the community and researchers; these learnings can be translated to non-research-oriented community engagement programs by privileging the experiential knowledge of community members, regardless of the setting. Khodyakov and colleagues (2014) stated the following:

> Successful collaboration among diverse agencies requires that they understand what is expected of them, are comfortable with the role they chose to perform, and have organizational support to meaningfully contribute to the project; study leaders may need to emphasize that roles and functions of agency representatives may vary and stress the value of even the smallest contribution. (p. 11)

Adebayo et al. (2018) also corroborated the importance of ensuring community members within partnerships should be well-informed of their roles, rights, and responsibilities.

Barriers

Although specific facilitators of community engagement have the potential to stimulate group cohesiveness and individual participation, community engagement processes and outcomes can also be hindered by a number of barriers. Structural barriers to effective community engagement for public health initiatives often include limitations on resources, staffing, system infrastructure, and service delivery (Cyril et al., 2015), which are often exacerbated when working with marginalized communities. Additional issues can arise if logistical barriers are not addressed, such as the availability of financial compensation and other resources to support participants for their time and effort (Brunton et al., 2017).

In their rapid review of community engagement strategies for addressing the social determinants of health, Attree et al. (2011) state that issues such as a "lack of continuity in

opportunities for involvement, limiting engagement to consultation exercises without conceding power

to lay people, 'tokenism' on the part of public organizations, failure to act on service users' suggestions,

and consultation fatigue" (p. 258) can discourage participation and lead to individuals' withdrawal from

community engagement processes. Similarly, Evans, Pickington, and McEachran (2010) identified

"power inequalities, exclusionary professional language…and community skepticism" (p. 423) as

common issues throughout their systematic review of participatory approaches in public health units.

Bath and Wakerman (2015) indicate that power imbalances can be a source of destabilization

throughout community engagement, further stating that, "dynamics of power can result in a kind of

'pseudo participation,' which is frustrating for community participants and has little demonstrated

benefit at a community level" (p. 5). Lastly, poor community engagement outcomes can also arise when

providers, researchers, and/or policymakers lack an understanding of community members' prior

knowledge of health issues (Cyril et al., 2015). This indicates a form of paternalism, in which community

members are unexpected to be knowledgeable about the health issues that impact them.

Consequences of Community Engagement Initiatives

Positive Impacts

Individual participation in community engagement strategies within public health has been

shown to introduce positive behavioral (Cyril et al., 2015; Korn et al., 2018), physical (Attree et al., 2011;

Korn et al., 2018), and psychosocial (Attree et al., 2011) benefits to participants' health. Among the

physical health benefits in one rapid review of community engagement strategies were improvements in

physical fitness, nutrition, and use of alcohol and cigarettes. In other studies that were also included in

the same review, individuals participating in community engagement initiatives reported improvements

in quality of life, self-confidence, self-esteem, social relationships, and feelings of empowerment.

Moreover, studies indicated decreased feelings of depression, loneliness, anxiety, and stress as a result

of improvements in social networks and accessibility to various therapies (Attree et al., 2011). Korn and

colleagues (2018) mention in their analysis that higher levels of community engagement were associated with positive outcomes compared to studies with less desirable outcomes.

Negative Impacts

Because of the aforementioned pitfalls of community engagement initiatives, it is important to recognize additional negative impacts associated with their implementation. Among the potential harms outlined by Brunton and colleagues (2017) are "social exclusion, cost overrun, attrition, and dissatisfaction and disillusionment" (p. 8). These negative impacts can arise as a result of a lack of trust among and between participants and facilitators, which can affect long-term sustainability of and participation in community engagement programs. Additionally, not addressing one or more of these potential harms throughout community engagement initiatives may lead to less participant retention and overall engagement, which could subsequently impact the desired outcomes for the process(es). In addition to these negative impacts, community engagement initiatives may also be especially harmful for people living with disabilities, particularly because of long meeting times and failure of service organizations to take into consideration participants' accessibility needs (Attree et al., 2011).

Fieldwork Agency and Project

Agency Background

The San Francisco Department of Public Health (SFDPH) was founded in 1865 as the Health Office, with a five-member Board of Health established as an oversight body in 1872. The Board of Health also maintained authority over the City and County Hospital, the Smallpox Isolation Hospital, the Almshouse, and the Harbor Quarantine and was designated as the body responsible for public health concerns facing San Franciscans. Because most of the pre-1906 meeting minutes and official documents were destroyed in the 1906 San Francisco earthquake, further historical documentation is limited in scope (*Meeting Minutes*, 1906).

SFDPH's vision is "to make San Francisco the healthiest place on Earth," which it achieves by operating under six pillars: safety and security, health impact, service experience, workforce, financial stewardship, and equity (*San Francisco Department of Public Health Annual Report 2018-2019*, n.d.). SFDPH's mission is "to protect and promote the health of all San Franciscans" through the work of two major divisions. The San Francisco Health Network (SFHN) is an extensive network of clinics, hospitals, and other programs operated by SFDPH to provide direct health services to San Franciscans, whereas SFDPH's Population Health Division (PHD) works to address population-level health concerns through health promotion and prevention, environmental health and safety, and emergency preparedness and response (*San Francisco Department of Public Health Annual Report 2018-2019*, n.d.). Staffing for the SFHN and PHD includes clinicians, researchers, public health professionals, and healthcare administration professionals. With a $2.4 billion budget for the 2018-2019 fiscal year alone (*San Francisco Department of Public Health Annual Report 2018-2019*, n.d.), SFDPH receives its funding for its various direct services and programs through federal, state, and local sources. Funding for initiatives within the PHD only constitute less than 10% of the total budget and are primarily funded through grants awarded to SFDPH by the Centers for Disease Control and Prevention (CDC).

I am conducting my current work under the Community Health Equity & Promotion (CHEP) branch within the PHD, which supports the overall well-being of San Franciscans through the implementation of community-based programs and initiatives that specifically center community mobilization and cultural humility. The CHEP branch does this by establishing partnerships for various community initiatives, including promoting healthy eating and active living, safe and healthy environments, and community-clinical linkages, sexual health, drug user health, and the effects of trauma" (*Community Health Equity & Promotion*, n.d.). The CHEP branch coordinates together with various community-based organizations throughout San Francisco to achieve and fulfill SFDPH's mission

of protecting and promoting the health of all community members, particularly those who are

considered to be most marginalized and vulnerable to public health concerns.

Fieldwork Project Summary

Ending the HIV Epidemic: A Plan for America

The U.S. Department of Health and Human Services (HHS) launched an initiative titled *Ending

the HIV Epidemic: A Plan for America* in order to reduce new HIV infections in the United States by 90%

by 2030 (Centers for Disease Control and Prevention, 2020). *Ending the HIV Epidemic* focuses on four

key strategies in order to address the HIV epidemic in the United States:

1. *Diagnose* all people with HIV as early as possible after infection.

2. *Treat* the infection rapidly and effectively to achieve sustained viral suppression.

3. *Prevent* new HIV transmissions by using proven interventions, including pre-exposure

   prophylaxis (PrEP) and syringe services programs (SSPs).

4. *Respond* quickly to potential HIV outbreaks to get needed prevention and treatment services to

   people who need them.

Ending the HIV/HCV/STI Epidemics

SFDPH's recognition of HIV, HCV, and STIs as intimately linked epidemics encouraged the design

of an integrated *Ending the HIV/HCV/STI Epidemics* initiative for the City and County of San Francisco.

Through the implementation of this initiative, SFDPH aims to achieve the following goals:

1. Get to and stay at zero new HIV infections, zero HIV-related deaths, and zero HIV stigma.

2. Eliminate HCV.

3. Reverse increasing STI rates and prevent congenital syphilis.

   Objective and Questions. The primary objective for this project was to develop

recommendations for an effective, long-term community engagement structure and process for the ten-

year implementation of SFDPH's *Ending the HIV/HCV/STI Epidemics* initiative based on responses to the

following overarching questions:

1. What is the overall experience like for coordinators of community engagement initiatives in San

    Francisco?

2. How can SFDPH create a platform for community engagement that centers the five key priority

    populations identified in the *Ending the HIV/HCV/STI Epidemics* initiative: Black/African

    Americans (B/AA), Latinx people, trans women, people who use drugs (PWUD), and people

    experiencing homelessness (PEH)?

Methods

Project Design

  Phase 1. The first phase of this project was a set of semi-structured, in-depth interviews with

coordinators of various community engagement initiatives addressing health inequities indirectly

related to the *Ending the HIV/HCV/STI Epidemics* initiative. The following questions were developed in

collaboration with SFDPH staff members to obtain insight into the real-life application of community

engagement initiatives within public health:

1. How do the concepts of knowledge, participation, and power play a role in community

    engagement?

2. What are the perceived facilitators and barriers of participating in and/or conducting community

    engagement initiatives?

3. What are the positive and negative impacts of community engagement initiatives?

  Phase 2. The second phase of this project was a set of semi-structured, in-depth interviews with

members of community-based grantee organizations engaging community members throughout the

Ending the HIV/HCV/STI Epidemics planning process. The following questions were designed to obtain a

comprehensive overview of these individuals' experiences, particularly within the context of engaging

each of the key priority populations:

1. Which methods worked best for engaging each of the key priority populations?

2. What special considerations were needed to effectively engage each of the key priority

    populations?

3. How did coordinators ensure that community members felt valued for their participation in the

    Ending the HIV/HCV/STI Epidemics community engagement process?

4. What were the challenges associated with reaching each of the key priority populations?

5. What were the perceived facilitators and barriers of participating in and/or conducting

    community engagement for *Ending the HIV/HCV/STI Epidemics*?

6. What were the positive and negative impacts of the *Ending the HIV/HCV/STI Epidemics*

    community engagement process?

Participants

Target Population

The target population for Phase 1 was members of the following community advisory boards

addressing health initiatives in San Francisco: Getting to Zero (GTZ), the HIV Community Planning

Council (HCPC), and End Hep C SF. The target population for Phase 2 was members of the following

selected grantees engaging community members throughout the *Ending the HIV/HCV/STI Epidemics*

planning process: Cause Data Collective and the San Francisco Drug Users Union (SFDUU).

Sampling Procedures

Both rounds of interviews were conducted using a convenience sample. Eligibility criteria for

Phase 1 included the following: sufficient knowledge of and experience with community engagement

initiatives in the San Francisco Bay Area and ability to participate in a 45-minute to 1-hour interview.

Eligibility criteria for Phase 2 included the following: sufficient knowledge of and experience with

engaging community members throughout the *Ending the HIV/HCV/STI Epidemics* planning process and

ability to participate in a 45-minute to 1-hour interview.

Recruitment Procedures

SFDPH staff facilitated introductions with potential interviewees via email. Preliminary email

introductions included a description of the project and a request for a semi-structured, in-depth

interview. Non-responsive potential interviewees were sent an additional email requesting a semi-

structured, in-depth interview and availability.

Final Samples

Out of the five individuals approached as potential interviewees for Phase 1, four individuals

completed the interview; three out of six potential interviewees completed the Phase 2 interview.

Data Collection

Instrument Development

Semi-structured, in-depth interview guides were developed with the overarching project's

objective and questions in mind, as well as the more specific questions outlined for each phase in the

Project Design section. Additional questions were added throughout the interviews to probe

participants' responses and gain further insight into their experience with community engagement

initiatives. Please refer to Appendices A and B for the final interview guides.

Data Collection Procedures

Interviews were conducted using Zoom video conferencing software. With the permission of

participants, interviews were recorded and transcribed verbatim to prepare for thematic analysis. In

addition, participants were subsequently asked to complete a demographic questionnaire.

Data Analysis Procedures

Interview transcripts were analyzed using NVivo 12 qualitative data analysis software. Thematic

analysis included reading the transcripts, determining potential themes using word frequency tools,

manually coding the data, and developing the codebook to reflect important themes and subthemes. Subsequent analysis included the observation and analysis of key findings using code reports for each of the themes identified in both phases of interviews.

Challenges

Plans for the project originally included focus groups in order to facilitate discussions surrounding experiences with community engagement initiatives. However, these plans were adjusted to comply with San Francisco's shelter-in-place ordinance in response to COVID-19. As a result, both Phases 1 and 2 were adjusted to become in-depth interviews with a few select individuals.

Findings

Participant Demographics

The final sample of Phase 1 participants (n = 4) was predominantly non-Hispanic/Latino (100%), White (75%), between the ages of 35-44 years old (75%), and female (75%). All Phase 1 participants (100%) had obtained a master's degree at the time of the interview. Phase 1 participants' responses to the question of sexual orientation were evenly split between four categories: straight (25%), lesbian/gay (25%), bisexual (25%), and queer/pansexual/questioning (25%).

The final sample of Phase 2 participants (n = 3) was predominantly Hispanic/Latino (66.7%), White (66.7%), and male (66.7%). Phase 2 participants were evenly split between three age categories: 25-34 (33.3%), 35-44 (33.3%), and 45-54 (33.3%) years old. Participants' education levels fell into three distinct categories: some college (33.3%), bachelor's degree (33.3%), and master's degree (33.3%). Lastly, participants' sexual orientation responses were split between the categories of lesbian/gay (66.7%) and queer/pansexual/questioning (33.3%).

Themes

As shown in Table 1, the analysis of the transcripts revealed major themes related to community engagement concepts (knowledge, participation, power), models, facilitators, barriers, positive impacts, negative impacts, and recommendations.

Table 1

Content Themes and Descriptions

Theme	Description
Knowledge	Content relating to positivism vs. hermeneutics, scientific knowledge vs. local knowledge, etc.
Participation	Content relating to expectations of participation within community engagement initiatives.
Power	Content relating to power dynamics within community engagement.
Community Engagement Models	Structures for community engagement initiatives.
Participation Facilitators	Process facilitators to implementing and/or participating in community engagement initiatives. **Subthemes and descriptions:** Champions – Content relating to the 'championing' of community engagement initiatives by a specific person and/or organization. Incentives – Content relating to the use of incentives for participation within community engagement initiatives. Logistics – Content relating to specific logistical facilitators, including scheduling, transportation, etc. Structures – Content relating to specific structural facilitators, including staffing, infrastructure, etc. Trust – Content relating to trust-build among members of community engagement initiatives.

Theme	Description
Participation Barriers	Process barriers to implementing and/or participating in community engagement initiatives.
	Subthemes and descriptions:
	Logistics – Content relating to specific logistical barriers, including scheduling, transportation, etc.
	Paternalism – Content relating to the propagation of paternalism within community engagement strategies.
	Structures – Content relating to specific structural barriers, including staffing, infrastructure, etc.
	Tokenism – Content relating to 'tokenizing' members of marginalized communities within community engagement initiatives.
Positive Impacts	Positive outcomes of community engagement initiatives.
Negative Impacts	Negative outcomes of community engagement initiatives.
Future Recommendations	Future recommendations based on past experiences with community engagement initiatives.

Knowledge

One participant identified community engagement as "a dialogue, it's back and forth, it's ongoing, it's respectful, it sets expectations upfront." (Participant P1-4) In addressing the bidirectional knowledge transfer between community members and coordinators, one participant stated:

For some people, being around a table in a meeting for 4 hours is just part and parcel of your job. For some community members, it's the most foreign thing in the world. The way in which people's ability to work in a meeting is always a challenge when you have community there and the health department there because they don't always speak the same language. There's tech…and acronym transfer that needs to be done. (Participant P1-2)

In response to a question regarding how knowledge transfer was addressed, this same participant explained, "…What it required is that we took every planning council member from 0 to 100% understanding about what we were doing before we launched the project." (Participant P1-2)

Participation

When asked to provide a definition for community engagement within public health, one participant elaborated:

Going to them and asking them what they need and then involving them from the beginning. And throughout any processes that we have, always going back to them and giving not just their input, but their leadership on what we're doing to make sure that it's working. (Participant P1-4)

Another participant proposed that councils be composed of members of the communities that reflect the epidemiological profile of the jurisdiction in which they are operating. This participant further explained that, in his experience, "the planning councils had to have inclusion by race, ethnicity, gender, [and] sexual orientation, with very explicit demands about what [was] meant by inclusion." (Participant P1-2)

One of the Phase 2 participants mentioned that they originally hired community members to conduct the community engagement as part of the *Ending the HIV/HCV/STI Epidemics* initiative. This participant then addressed the community members' lack of self-confidence in being able to finish the community engagement work by stating the following:

For me, in general, it's important the [community members] do it. That they don't get to the end of the project and hijack it just so they don't feel stressed out or something. It's important that they do it and finish it because they got to feel proud about it. Otherwise, what am I doing? If these are the people that want to get jobs and want to build and organize their lives in a certain way, then they need to learn those skills. If they don't then I'm failing. What am I doing? Even if it's not the most perfect document, who cares? They did it." (Participant P2-2)

Power

One Phase 1 participant responded to a question regarding the power role that SFDPH has in addressing health disparities and inequitable outcomes across different populations:

What about the actions that we do as a council? Are they aiding and abetting a system that

perpetuates disparity? Or are they about dismantling current public health structures that aid

and abet, and introducing wholly new systems [to eradicate] disparity? (Participant P1-2)

Another participant, during the Phase 2 interviews, addressed power dynamics among and between

service providers and community members by attesting:

Post-colonialism is a real thing, it's not just a theoretical thing that someone made up. I don't

like to see a class divide between provider and clients. I try to get rid of that because it's very

easy to fall into that. There's a lot of classism in the Latinx community, there's a lot of classism in

Latin America. There's racism, too. (Participant P2-1)

Community Engagement Models

One Phase 1 participant mentioned the collective impact framework that established one

community group, which allows for individuals throughout San Francisco to mutually agree upon a

collective strategy informed by various stakeholders. This participant explained that the benefit of the

collective impact framework is that, "instead of all of [the community members] working in these

isolated areas, [they're] coming together with this central primary agenda [and] in mutual agreement…"

(Participant P1-3) Another Phase 1 participant stated that her community engagement initiative,

"prioritizes ensuring that [it has] community members and people with lived experience on [its]

coordinating committee. That's a centralized part of [its] leadership." (Participant P1-1) Regarding

particular methods used for the *Ending the HIV/HCV/STI Epidemics* planning process, one Phase 2

participant elaborated:

> We had a team of 3 and we went through the document and picked out all the stuff that we
>
> wanted to talk about or know more about or knew that our people would have opinions about.
>
> Then we sort of formatted a really informal discussion." (Participant P2-2)

Participation Facilitators

General. One Phase 1 participant identified and another confirmed, that "offering a…menu of

options for lower versus higher threshold participation" (Participant P1-1) is one way to involve a

greater number of people throughout a community planning process. Other participants stated that

simply knowing community members' names and greeting them warmly during meetings and events is

one facilitator for enhancing participation. One participant indicated the following as a way to increasing

participation among community members:

> I think what's really helpful is sharing information back. Coming back and saying, 'This is what
>
> we did. We heard you. These are the changes as a direct result of what you said. This is how
>
> you've helped your community. Is this good? Do you feel like this is working? Did we understand
>
> what you meant? (Participant P1-4)

This participant also identified the following questions as important toward the beginning of the

process: "Do you want to be part of this process? If so, how? Who do you want to talk to? Who do you

want asking the questions?" (Participant P1-4)

Champions. Two participants noted the importance of champions as key factors contributing to

community members' participation, one participant stating, "One of the things that I think is necessary

for these kinds of joint processes and these kinds of community planning processes to work, is that you

have to have individuals who are willing to really champion them. (Participant P1-2) Another participant

supported this notion:

> It's critical that you really have champions for the work. Champions that can really get to some
>
> of those skeptics, perhaps some of those folks that don't think they would be interested or

involved, to really get people excited about the work that's being done. We have some real

champions. (Participant P1-3)

Incentives. Participants from both Phases 1 and 2 all agreed on the powerful role that incentives

play in motivating community members to participate in both community engagement processes and

uptake of services. One participant explained the role of incentives as financial compensation for doing

work:

We have a policy for our coordinating committee that if you're not being paid by your job to be

in the room…then we pay you to come to our meetings. And if you do extra stuff for us, we pay

you for that, too." (Participant 1-1)

Another participant's response added the role of incentives as motivators:

For me, whatever motivates someone to do something, why not do that? If that's that they

need money, a gift card, or whatever, why not? They come in the door and they get their needs

meet…" (Participant 1-4)

Lastly, incentives as financial compensation for the telling of lived experiences were identified by one

participant:

These people experienced a lot of hardship and somethings they don't even have money to get

on the bus to go find you, so they're risking getting a ticket from the city getting on this busy,

they're standing in front of a lot of people who have a lot of privilege and who are highly

educated or about to be highly educated and telling their story of hardship. It basically makes

them feel like their life didn't have value and your life does have value and they're supposed to

do that from the goodness of their heart? No, pay them. (Participant P2-2)

Logistics. Two Phase 1 participants stated that the location of community engagement meetings

can be a facilitator, with one stating:

Instead of being like, 'Okay, how you can participate is [by being] on the coordinating committee

and [being] a community member that attends these monthly meetings,' we decided to create

more…inclusive spaces that didn't involve having meetings at the health department, which we

find is not always a way that community members want to be involved in our initiatives.

(Participant P1-1)

The other participant that mentioned location advised the following for determining the location of a

meeting:

Think about going to the community and meeting in a location that feels very safe if you're

going to have a group that meets. A place that they know that they're safe, people will know

where they are, won't recognize them, I think that can really help. (Participant P1-4)

One participant provided advice for ensuring that different community members had the ability to speak

up throughout meetings:

We would break off and have discussions at the very end of the meetings around important

topic areas and we varied the way we did that. Sometimes it was dyads, triads, small groups, or

large groups, and even in those settings we used a sticky board or we had prioritization or we

had rank voting or keyword voting or keyword contributions. Then we turned around all that

stuff and we'd bring it back to the council the next meeting to show how it impacted what we

were discussing. (Participant P1-2)

In response to a question regarding specific cultural and linguistic considerations required for

increasing participation throughout the *Ending the HIV/HCV/STI Epidemics* community engagement

process, one Phase 2 participant explained:

In the beginning, we had to pay a lot of attention to the language that we were using for the

questionnaire and also the outreach to people. How much information was there? How much

people were getting paid? All of those things. Things like simple language to help people

understand, that was really important. (Participant P2-3)

Structures. Upon discussing specific structural facilitators, one participant stated the following

as an important consideration when designing service delivery systems:

If you can't target the person at the lowest end of entitlement, if you can't design a service

delivery system for that person, then you're never going to design a system that's going to work

for everybody. But if you do target people for whom access is hardest, entitlement is hardest,

respect is hardest, and flip the system on its end and give them exactly what they need to help

them take care of themselves and reduce risk and stay healthy, then the system will fall in line.

(Participant P1-2)

One Phase 2 participant's response somewhat corroborated this notion by describing her organization's

structural setup: "We set up our organization to be very open and easy-to-access for lots of different

people. We have space for people to sit down, so people just came in whenever we set up an

appointment with them." (Participant P2-2)

Trust. When asked about cultural considerations needed during a previous community

engagement initiative, one participant specified the following:

Some of the communities had greater degrees of trust because of different building blocks that

you need to think about when you're introducing interventions. The Latino community had

issues of deportation and fear of government…was far more important than exterior community

support. (Participant P1-2)

Another participant suggested that coordinators of community engagement initiatives should be upfront

about expectations in order to build trust among community members:

Being really explicit upfront with how the information is going to be used. Both having

community agreements for any kind of conversation, but also is the information going to be

completely anonymous or not? Where's the information going to go? Who's it going to be

shared with? And how's it going to be used? (Participant P1-4)

Another participant exemplified this during the *Ending the HIV/HCV/STI Epidemics* initiative:

For the people I don't know, we do a preview of the questions we're going to ask. I ask them if

they feel comfortable or not, and then I always ask, 'What can I do to make it more comfortable

for you?' I would say the relationship is the first step for me, since I reach out to people more

than once before they agree. (Participant P2-3)

Participation Barriers

General. One participant stated that time constraints are often present as barriers during

community engagement, "I think things end up being siloed, just not connected. Something is done for a

grant project and then lessons learned are not necessarily always carried over because you're onto the

next thing." (Participant P1-4) Two Phase 2 participants stated that the cultural and linguistic diversity of

the Latinx community was a barrier when initiating community engagement plans for *Ending the*

HIV/HCV/STI Epidemics:

If you think about the category of Latinx…it's very diverse. You have people who are newly

arrived. You have people who have been here for 3 generations and still claim Latinx identity.

You have people who speak Spanish, other people who don't speak any Spanish. You have

people who speak Portuguese but don't speak Spanish or English. So, it's a very diverse category

and, frankly, it's also a category that encompasses race. You have light-skinned Latinos, Black

Latinos, Afro-Latinos, etc. So, it's incredibly diverse. Then it's stratified along class lines. How do I

distinguish between a Latinx person who came here to study at Stanford and decides to stay

around from a middle upper-class family in Latin America and a *jornalero*, a day laborer?

(Participant P2-1)

Logistics. One Phase 2 participant stated that shifting the *Ending the HIV/HCV/STI Epidemics* community engagement process to comply with San Francisco's shelter-in-place response to the COVID-19 pandemic was a major barrier, citing the severity of "the digital divide, the digital divide. Frankly, not everybody is internet savvy enough or has access to the internet to do what we're doing right now." (Participant P2-1) Special accommodations, including the ability of individuals to phone into Zoom meetings, were required to allow for the participation of community members without access to internet. Similarly, another participant explained that Zoom focus groups made some of the participants uncomfortable:

> Some of them don't like to participate in a group, but they're willing to do one-on-one sessions, that's okay. Especially for those that don't want to be on camera, they don't want to do that either because their immigration status or just because they don't feel comfortable (Participant P2-3)

Paternalism. When asked about the restrictions on incentives by certain agencies, "there's some paternalism and stuff that's underlying the idea of 'you can't give people money that are poor or have HIV or use drugs or whatever." (White, female, 35-44 years old) Another participant identified paternalism within the community of service providers as the following:

> A lot of times what'll happen is that, through informal discussion with me or the staff, we take what we think we've heard and tell government structures or other nonprofits what we think we've heard and should be changed and it is so much different when those people are actually in the room and getting paid for their words. (Participant P2-2)

Structures. One participant acknowledged the role of systemic racism and oppression, as well as the harm that has been done to many marginalized communities by public health institutions:

There's a lot of understandable and valid mistrust of the government and the field of medicine,

like doctors, research, all of that...is a huge barrier that really requires buy-in from community

and also leaders from the community to do the work..." (Participant P1-4)

In response to a question about addressing such mistrust among community members, one participant

advised the following:

You have to send the message that the government's big, that there are different levels to it,

different layers, different actors, and there are some actors in there that do care about the

Latinx community. That's the way I think you have to sell it. (Participant P2-1)

Tokenism. When acknowledging tokenism as a major barrier in community engagement, one

participant indicated:

I think what's important is to just have people not feel tokenized and not feel like they're just a

box that's being checked off like, 'we asked the community members something,' but that

you're really engaging folks in a meaningful way that's not just tokenizing. (Participant P1-1)

However, another participant commented on the prevalence of tokenism throughout community

engagement initiatives:

[Tokenism] happens all the time. I don't even know how many times I've seen it. Whether it's

like, all of a sudden, we need to hear from a certain racial group quickly, let's get 5 people

together and make sure they think this is great. (Participant P1-4)

Furthermore, one participant stated that tokenistic processes can be harmful because of the frequent

depersonalization of PWUD:

When you use drugs, there's a narrative that's given to you. You actually don't get a story

anymore. Your personalized life story of what you've been through, what you've gone through,

how you got into drugs, all of that's taken away and you're given a story of how you succumbed

to a substance that took over your body and now you've got like tracks all over yourself. It's a

> Hollywood version of whatever drug us is, right? It depersonalizes and dehumanizes everybody
>
> who uses drugs. (Participant P2-2)

Positive Impacts

One participant stated the simple benefit of community engagement within public health

initiatives:

> The benefit of community planning in its broadest sense, whether you have an advisory board or
>
> a legislatively-mandated body…is a belief in faith that the community knows what it's doing, and
>
> that inclusion, parity, representation, diversity, and accountability measures are required.
>
> (Participant P1-2)

Similarly, a Phase 2 participant offered the following explanation of the benefits of community

engagement:

> The obvious reason, those are the people that went through whatever we're trying to fix or
>
> make better. It's for them so they should be able to say what's working or what's not working.
>
> Our primary source of what needs to change is going to come from the lived experience now.
>
> (Participant P2-2)

Other participants identified better service delivery/resource allocation and tangible benefits, including

potential employment and certification opportunities, as positive outcomes of community engagement

initiatives. Community planning processes were also identified as being highly adaptable to the changing

needs and demands of the community. Another participant pointed out that her community group

facilitated connections between different types of health providers and researchers, which proved to be

beneficial in addressing HIV in San Francisco. On a similar note, one participant explained that the

current HIV/AIDS system of care in San Francisco originally initiated because of community advocacy

and organizing in order to influence policy, services, and funding. One Phase 2 participant stated that

the *Ending the HIV/HCV/STI Epidemics* community engagement process can be used as a demonstration project for other jurisdictions.

Negative Impacts

Participants' responses regarding negative impacts of community engagement were mainly related to paternalistic and/or tokenistic processes. As an example, one participant stated that automatic deferrals of decisions to physicians and/or the health department can make community members feel tokenized and does not take them seriously. One participant stated that community engagement initiatives can have negative impacts when "it's clear that [community members are] not there to be meaningfully consulted, that they're there just to kind of check a box." (Participant P1-1) Another Phase 2 participant mentioned situations in which the health department or other officials limit modes of communication after a project has been formed based on community input, asserting:

> Sometimes I notice that when things are governmental or bureaucratic, it turns into like, 'This is the way now. You made it this way, now live with it.' How are we supposed to know what it'll look like in practice? We have good ideas, but when we do it maybe it sometimes will be shitty. (Participant 2-2)

Future Recommendations

Phase 1 participants only mentioned the importance of allowing community members to control the community engagement process. For example, one participant commented:

> Putting the power more into the hands of community and to not just be like, 'You're invited, you get a $50 gift card for coming,' but sort of like having them run the agenda, set the priorities. That's hard to do, particularly for DPH folks that aren't really up for anything like that. But if you want to move towards inclusion and community involvement, that's what that looks like. (Participant P1-1)

One Phase 2 participant recommended maintaining an open dialogue throughout the implementation of

Ending the HIV/HCV/STI Epidemics:

> Maybe they could pay a few people to go through the system and give a firsthand account and
>
> they get paid to give their feedback. Stuff like that would be best. Sometimes I feel like these
>
> survey things happen and then it's done. There's no more communication and it's done.
>
> (Participant 2-2)

Another participant stressed the importance of planning and implementing a career development

program:

> It would be a great idea to engage more people, like to create a career development program
>
> that would be attached to a volunteer program. Like if we wanted to increase the number of
>
> Latinos that would be able to provide services to the Latinx community. I see there are a lot of
>
> people that don't work in that field because they don't have that opportunity. (Participant P2-3)

Another participant confirmed supporting the career development program for the following reason:

> The pipeline idea that the project makes about training folks, I think that has to be real. I think
>
> that's one place where, frankly, I've seen some resistance. Some people say, 'Well only people
>
> with Master's [degrees], only people with PhDs carry weight.' There needs to be an educational
>
> pipeline that's respected by people in power. The pipeline idea is powerful, but I have too many
>
> people saying, 'Well, why don't I get credits for going to a training that DPH put through if I
>
> don't have an MSW or an MPH or LCSW? (Participant 2-1)

Discussion

Interpretation of Findings

The interviews from both phases of the project demonstrated key insights into community

engagement processes, which will be useful for SFDPH's *Ending the HIV/HCV/STI Epidemics* planning and

implementation periods. Phase 1 of the project was useful for elucidating the general experience of

coordinating community engagement initiatives, and Phase 2 of the project offered support for the

community engagement processes currently being utilized by SFDPH for the *Ending the HIV/HCV/STI*

Epidemics plan. Using these narratives, SFDPH can structure a long-term community engagement

process that centers community voice and lived experience throughout its ten-year implementation

period.

        Knowledge, Participation, and Power. Participants' responses indicated that community

engagement initiatives should actively work toward bidirectional learning, diversity, equity, inclusion,

and power-sharing in order to effectively empower and engage community members. Some participants

identified effective coordinators' roles as being able to facilitate knowledge and skill transfer between

community members and SFDPH. Other participants defined certain measures for racial/ethnic, sexual

orientation, and gender inclusion within community engagement initiatives. Lastly, some participants

mentioned the role of power dynamics in perpetuating the health disparities currently being

experienced by marginalized and vulnerable communities. Overall, these findings reflect the literature's

broad support of shared learning (Adebayo et al., 2018; Cyril et al., 2015), equitable and collaborative

partnership (Adebayo et al., 2018; Cyril et al., 2015; South et al., 2019), and power-sharing (Adebayo et

al., 2018; Brunton et al., 2017; Cyril et al., 2015; South et al., 2019) within community engagement

initiatives.

        Community Engagement Models. Participants' responses demonstrated a wide range of

experience in using different types of models to conduct community engagement efforts. Among the

models mentioned was the collective impact framework, which is a social change model used to bring

stakeholders together in pursuit of a common agenda (Kania & Kramer, 2011). There were only positive

attitudes among participants toward collective impact as a useful framework within public health.

Participants also mentioned simple ways of introducing community voice into processes, such as

ensuring that coordinating committees are made up of people with lived experience and conducting

informal discussions, rather than formal meetings, with community members. This wide variation in

types of models mentioned throughout the interviews indicates the adaptability and versatility of

community engagement processes. Coordinators of community engagement initiatives must ensure that

their processes are attuned to the members of the community that they are trying to reach.

   Participation Facilitators. Participants mentioned numerous facilitators of community

engagement throughout the interviews, including the following:

- general facilitators, such as sharing information back to participants, offering a menu of options

  for varying levels of participation, knowing community members' names, and greeting

  participants warmly during meetings;

- logistical facilitators, such as identifying a safe location for meetings, breaking off into smaller

  group discussions to offer more opportunities for feedback, and remaining attuned to the

  various cultural and linguistic considerations of the communities being engaged; and

- structural facilitators, such as targeting individuals for whom access is most difficult and

  ensuring that community engagement processes provide low-barrier access.

Additionally, some participants stated that the 'championing' of, or advocacy for, community

engagement initiatives is critical to their success. These statements corroborate thematic findings from

Korn and colleagues' (2018) systematic review that includes champions and leaders into the *coalition*

partnership dynamics construct of the CBPR Conceptual Model, a model used to conceptualize the

various factors that can impact participatory research approaches. Similarly, participants also defined

incentives as financial compensation for both participating in initiatives and, depending on the

community in question, telling of personal hardships. Incentives are identified throughout the literature

as important motivators and integral to providing support to participants during community

engagement processes (Brunton et al., 2017; Korn et al., 2018). Furthermore, most participants

emphasized the role of trust- and relationship-building in community engagement, stating that

coordinators should

- be upfront about expectations for participation

- remain attuned to different degrees of trust between communities, and

- ask participants about how to make them feel comfortable in the community engagement

    space.

Participation Barriers. Participants did not hesitate to provide important insights into the

potential barriers of conducting community engagement initiatives, including the following:

- general barriers, such as time constraints and the wide variation within communities of identity

    (e.g., the Latinx community);

- logistical barriers, such as the digital divide between community members who have access to

    internet and those who do not and the platform through which community engagement is

    conducted (i.e., Zoom); and

- structural barriers, such as the longstanding history of systemic oppression of marginalized and

    vulnerable communities and mistrust of the government among community members.

Many of the logistical barriers mentioned by participants relate to the COVID-19 global pandemic's

impacts on the original plan to conduct in-person focus groups. As a result of the shelter-in-place

ordinances related to COVID-19, the digital divide between coordinators and community members was

only increased, thus limiting participation in the *Ending the HIV/HCV/STI Epidemics* planning process.

Participants also noted the role of both paternalism and tokenism as major barriers throughout the

community engagement process. Some participants mentioned paternalism among service providers

that assume the needs of community members, and others identified paternalism within the use of gift

cards, rather than money, as financial compensation for community members. Moreover, participants

also stated that tokenistic community engagement processes occur somewhat frequently within the

system of service providers, particularly as a result of time constraints. Lastly, one participant mentioned that tokenistic processes within community engagement can lead to the depersonalization of PWUD, which is harmful to members of the community. The literature confirms the identification of tokenism as a major barrier, as Attree et al. (2011) caution against tokenism as a factor leading to withdrawal from participating in community engagement processes.

Positive Impacts. Among the positive impacts recognized by participants were the following:

- the community's ability to play an active role in shaping their health, thereby informing service delivery and resource allocation;

- the belief that inclusion, parity, representation, diversity, and accountability measures are essential within public health; and

- the high adaptability of community engagement initiatives to respond to the needs of different communities.

In a systematic review of CE-informed research studies, Cyril et al. (2015) found reductions in health inequities and improvements in health behavior, lending further support to participants' responses and their implications on community engagement work within public health. Participants also noted that these benefits can be seen through San Francisco's system of care for HIV, which was originally initiated by community members through advocacy and self-mobilization to influence policy, services, and funding. This is a clear example of the 'real-world' implementation of community engagement in public health and its resulting impacts on large-scale healthcare service deliver.

Negative Impacts. Although participants spoke about the potentially negative impacts of community engagement, their responses were mainly relegated to outcomes of paternalistic and/or tokenistic processes. Most participants stated that these types of processes can lead to community members feeling as if they are not being meaningfully consulted, coordinators automatically deferring to the health department's decisions, and communities being disconnected from the health

department. Such impacts can lead to further harm, particularly among marginalized and vulnerable communities, that can hinder the community engagement process. Similarly, Brunton and others (2017) remark on the potential harms of "social exclusion, cost overrun, attrition, and dissatisfaction and disillusionment" (p. 8), which can result from tokenistic and paternalistic community engagement processes. Overall, participants' responses confirm the literature's cautioning against tokenism and paternalism in public health program development.

Future Recommendations. For future recommendations throughout the ten-year implementation of the *Ending the HIV/HCV/STI Epidemics* initiative, participants stated the following:

- community members should be allowed to control the agenda and priorities throughout the community engagement process,

- SFDPH should remain in open dialogue with community members,

- SFDPH should implement a leadership development program and integrate community engagement into future career opportunities.

Strengths and Limitations

Because the selection of participants for both phases of interviews were based on a convenience sampling method and a small sample size, these findings are likely not *generalizable* to the larger population of community engagement coordinators. Furthermore, participants' responses are based upon their personal accounts of occurrences, rather than the specific phenomena which led to these accounts. With this being said, these findings add to the literature that supports the use of community engagement strategies within public health. Lastly, findings from this study are potentially *transferable* to similar public health settings, in which community members are engaged to further understand their needs and feedback on specific public health programs.

Next Steps

While the planning period for the *Ending the HIV/HCV/STI Epidemics* initiative is still underway,

SFDPH can already begin using these findings to enhance their proposal's section on current and future

community engagement processes. Phase 1 findings offer rich insight into the experiences of community

engagement coordinators, which can be useful when determining a long-term community engagement

structure for the initiative's implementation. Phase 2 findings demonstrate that the decision to conduct

community engagement through different grantee organizations was successful for reaching at least

two of the key priority populations (i.e., Latinx people, PWUD). The inclusion of representative quotes

demonstrating both Phase 1 and Phase 2 insights into the *Ending the HIV/HCV/STI Epidemics* proposal

would provide support that these community engagement initiatives were carefully considered and

evaluated throughout the planning process. For future program development unrelated to *Ending the*

HIV/HCV/STI Epidemics, SFDPH should continuously inform and update their services and interventions

through community voice. Prior to the implementation period of any particular service or intervention,

community members should be provided with ongoing opportunities to provide feedback and inform

resource allocation. In doing so, SFDPH can play an active role in uplifting the needs of different

communities and prioritizing them in the development of community-level health programs.

Further research is needed to develop valid and reliable evaluation instruments that external

program evaluators can use to measure successes and/or areas of improvement for different

community engagement initiatives. Many of the current evaluation approaches are conducted

internally, which can lead to bias within evaluations. The development of instruments for external

program evaluators can minimize potential bias throughout the evaluation and lead to specific,

actionable feedback on community engagement processes and outcomes. Furthermore, future research

is necessary to develop valid and reliable survey instruments for measuring individuals' participation in

community engagement initiatives. These instruments should take into account community members'

motivations and barriers, capacity for involvement, and self-efficacy for participation. Integrating

different health behavior models (e.g., the Health Belief Model and the Theory of Planned Behavior) into

future instruments may provide a deeper look at behavioral characteristics of individuals that have the

potential to facilitate or inhibit participation in community engagement initiatives.

As a health agency at the forefront of public health research, policy, and service delivery, SFDPH

has an opportunity to establish internal policies related to engaging community members on an ongoing

basis through various platforms. Procedural specifications regarding financial compensation and

protections for participants can begin to shift power dynamics between SFDPH and the communities

that it serves. Additionally, SFDPH should begin to implement policies that require intentional,

meaningful community engagement to inform community-wide interventions and services, particularly

when those interventions and services impact marginalized and vulnerable communities. In doing so,

SFDPH can actively work toward both addressing health inequities and dismantling oppressive power

structures within public health.

Conclusion

Beyond providing practical recommendations for future community engagement initiatives,

these findings add narrative value to the literature that supports community engagement as an effective

strategy for informing community-level public health programs. Using these findings, future

coordinators of community engagement efforts, especially those working on the *Ending the HIV/HCV/STI*

Epidemics initiative in San Francisco, can develop their participatory processes to be well-informed for

their target communities. In doing so, public health practitioners can actively work toward dismantling

oppressive power structures within public health and seek to uplift the voices of their communities.

References

Adebayo, O. W., Salerno, J. P., Francillon, V., & Williams, J. R. (2018). A systematic review of

  components of community-based organisation engagement. *Health & Social Care in the

  Community*, *26*(4), e474–e484. CINAHL Complete. https://doi.org/10.1111/hsc.12533

Arnstein, S. R. (1969). A ladder of citizen participation. *Journal of the American Institute of Planners*,

  35(4), 216–224. https://doi.org/10.1080/01944366908977225

Attree, P., French, B., Milton, B., Povall, S., Whitehead, M., & Popay, J. (2011). The experience of

  community engagement for individuals: A rapid review of evidence. *Health & Social Care in the

  Community*, *19*(3), 250–260. CINAHL Complete. https://doi.org/10.1111/j.1365-

  2524.2010.00976.x

Baker, A. E. Z., Procter, N. G., & Ferguson, M. S. (2016). Engaging with culturally and linguistically diverse

  communities to reduce the impact of depression and anxiety: A narrative review. *Health &

  Social Care in the Community*, *24*(4), 386–398. CINAHL Complete.

  https://doi.org/10.1111/hsc.12241

Bath, J., & Wakerman, J. (2015). Impact of community participation in primary health care: What is the

  evidence? *Australian Journal of Primary Health*, *21*(1), 2–8. CINAHL Complete.

  https://doi.org/10.1071/PY12164

Bennetts, W., Cross, W., & Bloomer, M. (2011). Understanding consumer participation in mental health:

  Issues of power and change. *International Journal of Mental Health Nursing*, *20*(3), 155–164.

  CINAHL Complete. https://doi.org/10.1111/j.1447-0349.2010.00719.x

Bradshaw, J. (1972). Taxonomy of social need. In *Problems and progress in medical care: Essays on

  current research* (pp. 71–82). Oxford University Press.

Brunton, G., Thomas, J., O'Mara-Eves, A., Jamal, F., Oliver, S., & Kavanagh, J. (2017). Narratives of

  community engagement: A systematic review-derived conceptual framework for public health

interventions. *BMC Public Health*, *17*, 1–15. CINAHL Complete. https://doi.org/10.1186/s12889-

017-4958-4

Centers for Disease Control and Prevention. (2020, March 18). *Ending the HIV Epidemic: A Plan for*

America | CDC. https://www.cdc.gov/endhiv/index.html

Cohen, D. K., & Lindblom, C. E. (1979). Solving problems of bureaucracy: Limits on social science.

American Behavioral Scientist, *22*(5), 547–560. https://doi.org/10.1177/000276427902200509

Community Health Equity & Promotion. (n.d.). San Francisco Department of Public Health.

https://www.sfdph.org/dph/comupg/oprograms/CHEP/default.asp

Corburn, J. (2005). *Street science: Community knowledge and environmental health justice*. MIT Press.

Cyril, S., Smith, B. J., Possamai-Inesedy, A., & Renzaho, A. M. N. (2015). Exploring the role of community

engagement in improving the health of disadvantaged populations: A systematic review. *Global*

Health Action, *8*(1), 1. CINAHL Complete. https://doi.org/10.3402/gha.v8.29842

Evans, D., Pilkington, P., & McEachran, M. (2010). Rhetoric or reality? A systematic review of the impact

of participatory approaches by UK public health units on health and social outcomes. *Journal of*

Public Health, *32*(3), 418–426. CINAHL Complete. https://doi.org/10.1093/pubmed/fdq014

Foucault, M. (1982). *The subject and power*.

Harris, J., Haltbakk, J., Dunning, T., Austrheim, G., Kirkevold, M., Johnson, M., & Graue, M. (2019). How

patient and community involvement in diabetes research influences health outcomes: A realist

review. *Health Expectations*, *22*(5), 907–920. CINAHL Complete.

https://doi.org/10.1111/hex.12935

Kania, J., & Kramer, M. (2011). *Collective impact*. FSG.

Khodyakov, D., Sharif, M., Dixon, E., Mendel, P., Chung, B., Linkski, B., & Jones, J. (2014). An

implementation evaluation of the community engagement and planning intevention in the CPIC

Depression Care Improvement Trial. *Community Mental Health Journal*, *50*(3), 312–324. CINAHL

Complete. https://doi.org/10.1007/s10597-012-9586-y

Korn, A. R., Hennessy, E., Tovar, A., Finn, C., Hammond, R. A., & Economos, C. D. (2018). Engaging

coalitions in community-based childhood obesity prevention interventions: A mixed methods

assessment. *Childhood Obesity*, *14*(8), 537–552. CINAHL Complete.

https://doi.org/10.1089/chi.2018.0032

Meeting minutes. (1906, May 17). Office of Board of Health meeting, San Francisco Department of

Public Health Records (SFH 63), San Francisco History Center, San Francisco Public Library.

Newman, S. D., Andrews, J. O., Magwood, G. S., Jenkins, C., Cox, M. J., & Williamson, D. C. (2011).

Community advisory boards in community-based participatory research: A synthesis of best

processes. *Preventing Chronic Disease*, *8*(3), A70.

Pretty, J. N. (1994). Alternative Systems of Inquiry for a Sustainable Agriculture. *IDS Bulletin*, *25*(2), 37–

49. https://doi.org/10.1111/j.1759-5436.1994.mp25002004.x

San Francisco Department of Public Health Annual Report 2018-2019 (DPH Annual Reports). (n.d.). San

Francisco Department of Public Health.

South, J., Bagnall, A.-M., Stansfield, J. A., Southby, K. J., & Mehta, P. (2019). An evidence-based

framework on community-centred approaches for health: England, UK. *Health Promotion

International*, *34*(2), 356–366. CINAHL Complete. https://doi.org/10.1093/heapro/dax083

Appendix A

Phase 1 Sem-Structured, In-Depth Interview Guide

Thank you for taking the time to speak with me today. My name is Adam Landeros and I'm a graduate

student studying public health and behavioral health science at the University of San Francisco. I'm

working with the San Francisco Department of Public Health to identify some long-term community

engagement strategies for a citywide HIV/HCV/STI prevention initiative. For this interview, I'm looking to

get a sense of your experiences with community advisory boards, including any benefits and/or

challenges you've had along the way. At any point, feel free to stop and ask me to explain something

further.

1. Tell me about how you became a member of a community advisory board.

2. How many community advisory boards have you been a part of? How long were you a part of

   each?

3. How regularly do the community advisory boards you're a part of hold meetings? Who

   participates in these meetings?

4. What are some of the things that make you feel valued as a member of community advisory

   boards?

5. Are there any incentives for your participation as a member of community advisory boards? If

   so, please explain.

6. Tell me about where you believe an impact was made as a result of your participation on a

   community advisory board.

7. Tell me about any positive physical, mental, emotional, or social health effects that you think

   resulted from your participation on community advisory boards.

8. Is there anything that makes you feel undervalued as a member of community advisory boards?

   If so, please explain.

9. What are some challenges that you've experienced as a member of community advisory

    boards?

10. Tell me about where you believe a greater impact could have been made as a result of your

    participation on a community advisory board.

11. Tell me about any negative physical, mental, emotional, or social health effects that you think

    resulted from your participation on community advisory boards.

12. Based on your previous experiences, tell me about any changes that you would make to the

    structure of a long-term community advisory board.

13. Based on your previous experiences, what do you think are the most effective ways of keeping

    participants of community advisory boards engaged?

14. On a scale from 1-10, with 1 = no impact and 10 = greatest impact, how big of an impact do you

    think you had on your community as a result of your participation on a community advisory

    board? Please explain your answer.

Once again, thank you for your taking the time to speak with me today. I truly value your lived

experience as a member of community advisory boards and I wish you all the best.

Appendix B

Phase 2 Semi-Structured, In-Depth Interview Guide

Thank you for taking the time to speak with me today. My name is Adam Landeros and I'm a graduate student studying public health and behavioral health science at the University of San Francisco. I'm working with the San Francisco Department of Public Health to identify some long-term community engagement strategies for a citywide HIV/HCV/STI prevention initiative. For this interview, I'm looking to get a sense of your experiences with community advisory boards, including any benefits and/or challenges you've had along the way. At any point, feel free to stop and ask me to explain something further.

1. Tell me about your method for engaging community members in meaningful discussions around *Ending the HIV/HCV/STI Epidemics*.

2. What special considerations did you have to keep in mind while conducting community engagement with your specific priority population?

3. How did you ensure that community members felt valued for their participation in your community engagement effort?

4. What challenges did you encounter while trying to conduct community engagement among your specific priority population?

5. Based on what was provided to you by SFDPH, how prepared was your organization to conduct community engagement efforts as part of the *Ending the HIV/HCV/STI Epidemics* planning process?

6. How effective do you think the particular method you chose for community engagement was for receiving feedback on *Ending the HIV/HCV/STI Epidemics* components?

7. What were the common facilitators and barriers to community members' participation in your community engagement effort?

8. What were the common benefits and costs to conducting community engagement as a part of the *Ending the HIV/HCV/STI Epidemics* planning process?

9. Based on your current community engagement method and any challenges you've encountered, what changes would you make to a long-term community engagement structure throughout the ten-year implementation of *Ending the HIV/HCV/STI Epidemics*?

Once again, thank you for your taking the time to speak with me today. I truly value your lived experience as a member of community advisory boards and I wish you all the best.