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RESEARCH ARTICLE (PEER REVIEWED)

Reducing Risky Sexual Behaviours Among Youth: A Community Partnerships Approach

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Abstract

Risky sexual behaviours in youth are a pressing public health issue. Using narrative methodology to represent the perspectives of various stakeholders, this article examines the transformative potential of community-based participatory research (CBPR), as embodied by the Tygerberg Research Ubuntu-Inspired Community Engagement model, to develop targeted interventions like the Values in Perspective curriculum for at-risk youth. This article showcases the role of ReCapturing the Vision's community partnerships in creating impactful interventions tailored to community needs. Additionally, it highlights the use of community partnerships in guiding the development and implementation of a sex education program. Our findings demonstrate the importance of prioritising community engagement to address public health challenges through CBPR. This research contributes to rigorous discussions with policy implications and emphasises the need for community-led responses to youth and adolescents, informed by community-driven research initiatives.

Keywords

At-Risk Youth; CBPR; TRUCE Model; Risky Behaviour; Community Partnerships; Community Health Improvement; Youth of Colour; Adolescent Health; Community-Driven Research; Teen Pregnancy Prevention

Reducing Risky Sexual Behaviours Among Youth: A Community Partnerships Approach

Traditionally, intervention research, research that focuses on strategies to improve outcomes, takes a top-down approach due to historical, structural and methodological factors that centre on academic expertise (Yau et al. 2024). Whilst this approach to research has many strengths, such as access to large funding structures, it often also faces significant limitations. For example, without direct input from the community, these interventions may fail to address the specific social, cultural and structural factors that shape individuals' experiences and behaviours. This lack of local engagement can result in interventions misaligned with the realities of the populations that they aim to serve, ultimately reducing their relevance and effectiveness (Moodley & Breyer 2019). Additionally, top-down interventions often struggle with implementation challenges due to minimal involvement from those directly affected by the issue. Without community participation in the design and execution phases, interventions may lack local buy-in, making it difficult to foster trust, encourage uptake or sustain engagement over time (Israel et al. 2017). Moreover, rigid, pre-designed strategies may not offer the flexibility to adapt to diverse community contexts, limiting their impact (Moodley & Breyer 2019).

In contrast, bottom-up approaches prioritise collaboration with community members, ensuring that interventions are tailored, context-specific and responsive to local needs. By involving those with lived experience, researchers gain deeper insights into the underlying mechanisms driving the targeted issue, and community members gain greater agency and ownership in the change process, leading to more nuanced understandings and sustainable solutions. Advocates of participatory models argue that they can enhance the effectiveness of interventions and empower communities, fostering long-term capacity-building and self-sufficiency in addressing public health and social challenges (Collins et al. 2018).

Community-based participatory research (CBPR) is a well-established and widely used research approach with a substantial body of scholarship spanning multiple disciplines (i.e. Collins et al. 2018; Wallerstein et al. 2020). In particular, CBPR has gained increasing traction in public health, medicine and nursing as a strategy for addressing health inequities and promoting community-engaged solutions (Collins et al. 2018). Unlike traditional research methods that usually rely on top-down frameworks, CBPR takes a more inclusive, bottom-up approach that values the knowledge and experiences of community members (Collins et al. 2018). Wallerstein and colleagues (2020) posited that this model acknowledges that researchers and community members may understand the exact issue differently and seeks to integrate these perspectives to create more meaningful and impactful outcomes.

A key feature of CBPR is its emphasis on collaboration throughout every stage of the research process. Rather than viewing communities as passive study subjects, CBPR actively involves them in shaping research questions, designing studies, collecting data and disseminating findings. By fostering this partnership, CBPR facilitates shared learning between academics and community members, ensuring that research is informed by lived experiences and remains relevant to those that it aims to benefit (Israel et al. 2017). Beyond producing valuable data, CBPR can potentially create lasting, transformative change. Because it prioritises relationship-building and co-ownership of knowledge, its impact can extend far beyond the completion of a study. The collaborative nature of CBPR may also strengthen community capacity, empower participants and lay the groundwork for ongoing advocacy and policy changes that sustainably address systemic health inequities.

The primary aim of this article was to explore how community-based participatory research approaches can be used to effectively develop and implement sexual health interventions tailored to ethnically diverse youth. This article presents the Tygerberg Research Ubuntu-Inspired Community Engagement (TRUCE) model ([Moodley & Breyer 2019](#)) as an example of how to implement measurable, reliable and relevant intervention research in complex contexts through the establishment of trusting, ongoing, multi-stakeholder partnerships. Specifically, the article documents the co-development, implementation and lessons learned from the Values in Perspective (VIP) curriculum. This school-based sexual risk avoidance education program was developed jointly by diverse community stakeholders in South Florida and ReCapturing the Vision (RTV) International. The primary goal of this article was not to test the effectiveness of a specific intervention in a controlled environment but rather to reflect on the process of its development and implementation in a complex community setting. By documenting these reflections, we hope to contribute practical, transferable lessons for other practitioners, researchers and policymakers engaged in community-driven public health work.

Through a narrative methodological approach, the article weaves together the experiences of program developers, educators and community partners into a cohesive narrative that integrates their perspectives. The article centres on community engagement and participation as not merely a support mechanism but as an essential driver of effective, sustainable health education programming. It emphasises the community's existing strengths, including youth leadership networks, trusted local educators, culturally grounded communication practices and established relationships between schools, families and community-based organisations as critical resources that shape program development. The research also seeks to extend the application of the TRUCE model from its origins in biomedicine into the behavioural and sexual health domains, highlighting its broader relevance and adaptability. In doing so, the article addresses a critical gap in the literature: the lack of bottom-up, community-led models and resources for addressing sexual health disparities among racially and economically marginalised youth. The work further challenges top-down intervention paradigms that often fail to account for cultural, contextual and structural factors influencing adolescent health behaviours.

We begin by discussing the critical role of community partnerships in shaping healthy youth sexual behaviour, followed by an introduction to ReCapturing the Vision and the Ubuntu-inspired TRUCE model that guided this project. We then outline our positionality as researchers and community partners, describe our use of narrative methodology, detail the development and implementation of the VIP curriculum and conclude by highlighting the outcomes, challenges and broader implications of this community-engaged approach.

The Role of Community Partnerships in Healthy Youth Sexual Behaviour

Community partnerships are integral to reducing risky sexual behaviours and sexual health inequities among ethnically diverse youth. Unsurprisingly, individuals, families and communities are affected by and contribute to sexual health and sexual behaviours. Moreover, many factors such as access to and availability of affordable sexual education and preventative services, sexual networks and the prevalence of sexually transmitted infections (STIs) in the community and violence that influence sexual behaviours are not always controlled by the individual, thus making community infrastructure and resources essential determinants of sexual health ([Rojas et al. 2016](#)). Community partnerships have been identified as the most impactful in addressing the prevention of sexual risk-taking behaviours and the most strategic in meeting the nuanced needs of ethnically diverse youth's sexual health ([Haldane et al. 2019](#); [McCustian et al. 2023](#)). Prior research suggests that CBPR significantly decreased sexual risk-taking behaviours, increased communication

with sexual partners, led to changed attitudes and promoted greater engagement in STI/HIV prevention behaviours ([Guzman et al. 2003](#); [Kwon et al. 2018](#); [McCustian et al. 2023](#)).

Multi-stakeholder community-based partnerships (i.e. schools, churches, youth groups, families and health clinics) combine resources, knowledge and outreach capabilities across sectors. These collaborations facilitate communication between researchers and community members and promote more participatory and inclusive approaches to holistic intervention development. Due to the complexity of sexual health, community partnerships help address the broader social inequities that contribute to at-risk sexual behaviours. These collaborations also create opportunities to mobilise multidisciplinary teams and initiatives, which can be effectively translated into community-based prevention programs for youth ([Bermúdez Parsai et al. 2011](#); [Schnitzler et al. 2023](#)). Through community partnerships, individual youth can be linked with community resources able to build capacity and self-efficacy and promote a more integrated, positive way to prevent risky sexual behaviours. Engaging community members who reflect the cultural diversity of the target population can enhance outcomes by better identifying the needs of youth and creating culturally responsive, tailored and sustainable interventions.

Despite the well-documented benefits of community partnerships, there is a significant absence of community partnerships with health promotion interventions for youth, partly due to the structural and practical challenges impeding successful implementation ([Terral et al. 2025](#)). Nevertheless, proposals to address risky sexual behaviours should be considered within the broader community changes required at both the societal level and within preventive service delivery. These changes must include the active involvement of ethnically diverse youth, their families and their communities in the design and delivery of preventive sexual health services.

ReCapturing the Vision: Who We Are, What We Do and the TRUCE Model

ReCapturing the Vision International is an organisation focused on building community structures to educate the whole child, specifically those from low-income backgrounds. As a result, since its establishment in Miami in 1994, RTV has engaged in numerous programs within the Miami community. At the time of writing this article, the organisation is composed of individuals from diverse racial, economic and ethnic backgrounds. What fuels the work is an unwavering commitment to social justice through community partnerships. To learn more about RTV, visit www.rtv.org.

RTV applied the TRUCE model for the first time to guide its approach to community health promotion in this project because the model emphasises mutual respect, shared power, cultural humility and sustained partnership – principles that aligned with RTV’s commitment to community-driven decision-making and culturally grounded intervention development. Ubuntu is a key concept of many traditional South African communities and depicts communitarianism ([Moodley & Beyer 2019](#)). Communitarianism is defined as a social and political philosophy emphasising that community, rather than the individual, is the primary shaper of identity, morality and values ([Moodley & Beyer 2019](#)). The Center for Medical Ethics and Law, based at the Faculty of Medicine and Health Sciences, Stellenbosch University, South Africa, developed the TRUCE model in collaboration with a biobank at Tygerberg Hospital in Cape Town in 2015. The university received a National Institutes of Health grant to better understand community engagement in the context of genomic biobanking ([Moodley & Beyer 2019](#)). This was deemed to be particularly important due to the implications of genomic biobanking for individuals and communities, given that biological samples are provided by participants. The model was designed to be used in urban settings in the developing world to connect theoretical models of community engagement with the real-world ethical, practical and logistical challenges of conducting research in under-resourced and rapidly growing urban communities ([Moodley & Beyer 2019](#)).

The TRUCE model has been referenced in various research areas and topics in addition to biobanking, including precision medicine, data science and regulating community advisory boards ([Moodley & Singh 2019](#)). To our knowledge, this model has not yet been used in behavioural research.

Positionality Statement

RTV RESEARCHERS

Authors 5, 6 and 7 are employees of RTV. Whilst they did not directly implement the components of the program, the RTV team has long-standing relationships with the schools and the partners in the schools who led the program implementation. The RTV team was instrumental in forming and strengthening community relationships. Author 5, the founder and CEO of RTV, has more than 20 years of experience in social-emotional learning and youth empowerment. Her role in this research was primarily in securing funding for the research and ensuring that the necessary resources were available to support its development. Author 6 has over 10 years of experience providing program management services to the partner communities. She works directly with RTV staff, overseeing day-to-day implementation. Author 7, a Program Director, works closely with the pre-implementation stages of the project, planning, meeting with partners and making decisions to amend services based on data and feedback. His focus is on program outcomes, reporting and management of partnerships and program structures. None of the RTV personnel had a direct influence on the data collection and analysis of the program and thus did not influence the outcome of the program.

OUTSIDE RESEARCHERS

Author 4 has maintained a 10-year professional relationship with RTV and worked closely with the organisation during the data collection phase of this program. Her established connection with RTV provided valuable insight into the interpretation of results and dissemination of findings. In contrast, Authors 1, 2 and 3 have no prior relationship with RTV and were solely involved in the writing process as research assistants to Author 4. Their contributions focused on interpretation and manuscript development, ensuring an objective and balanced discussion of the work.

Method: Narrative Methodology

We employed a narrative methodology to describe RTV's firsthand experiences of implementing the VIP curriculum in two Miami-Dade and Broward County schools using the TRUCE model. By adopting a narrative approach, we hope to convey the complexities and challenges of this process in an engaging and accessible manner. This approach allows us to share our experiences, successes and lessons learned with a broader audience, highlighting the importance of collaborating with community partners in addressing the sexual health needs of ethnically diverse youth. Narrative methodology provides a contextual understanding of the intervention implementation process, recognising that it is shaped by the social and cultural contexts in which it takes place. Authors 1 and 5 conducted in-depth, unstructured interviews and group discussions with RTV staff over a period of 3 months to gain a nuanced understanding of VIP curriculum implementation and its challenges. Researchers took detailed notes during interviews and discussions, summarising key points, themes and insights that arose during this process. These notes were reviewed to identify patterns and clarify the understanding of the implementation process. To ensure the accuracy and validity of our descriptions, RTV staff (co-authors) reviewed and edited our work as part of a quality control check. Additionally, the team reviewed relevant documents, including curriculum guides and training

materials, to provide additional context and information on the implementation of the VIP curriculum using the TRUCE model.

The Project

This article describes the development of RTV's VIP Curriculum in Miami, Florida, from 2019 to 2022. An overview of the steps taken to create the VIP curriculum and the iterative process of community participatory work is discussed in this section. The curriculum was developed and implemented at two local schools in South Florida from August 2021 to May 2022. In this article, we focus on School 1 as a case example, as there are published outcome data for this school ([Meyer et al. 2023](#)), which provide a strong justification for the value of the steps taken in project development.

The Eight-Step TRUCE Model

As outlined by [Moodley and Beyer \(2019\)](#), the TRUCE model consists of eight interconnected steps designed to foster respectful, authentic and community-driven engagement. These steps include the following:

1. conducting social mapping to identify potential communities;
2. determining the scope of community engagement (CE) and planning accordingly;
3. approaching communities early in the process;
4. co-creating strategies for CE and participation;
5. reinforcing co-ownership of knowledge production;
6. recruiting and engaging communities at each stage of the research;
7. evaluating, reflecting on and adapting CE strategies; and
8. discussing and disseminating results with the community.

Phase I: The Process

Social Mapping. Guided by the TRUCE model, RTV initially used social mapping to define the community of interest, understand the community identity and identify gatekeepers ([Moodley & Beyer 2019](#)). RTV has pre-existing and long-standing relationships with this neighbourhood and holds annual community meetings to assess and understand the evolving needs of the youth in the community. Building on these established partnerships, at their annual community meeting, RTV engaged a wide range of community members, including other youth-serving organisations, school officials, churches, healthcare providers, community leaders and local agencies in both Miami-Dade and Broward counties. By bringing different voices to the conversation through town halls and community meetings, RTV ensured that a comprehensive array of perspectives and areas of expertise were incorporated to better understand current community needs.

During these conversations, it became clear that the stakeholders' most emerging concerns centred on youth sexual health, which they viewed as an urgent area requiring targeted support. One of the primary challenges pertained to navigating cultural considerations surrounding what should and should not be taught to youth. For example, school leaders, youth and church leaders had particular points of view grounded in their cultural contexts regarding what could and should be taught about sexual health. Furthermore, local youth-serving organisations had concerns with the state-mandated curricula. From these conversations, RTV and stakeholders voted and identified youth sexual health as the research area of interest. As such, RTV and stakeholders mapped community resources, prevalence of STDs and STIs, and teen pregnancies to identify specific areas that we wished to target with intervention. The participating

schools were selected based on their risk factors, which include teen birth rates, low economic status of attendees based on free or reduced-priced lunch, high-crime areas and low graduation rates.

As part of the research process for School 1, we engaged with school leaders to comprehensively understand their existing partnerships, assets and resources available within the institution. In this role, RTV facilitated four monthly discussions, each lasting 1 hour, with school leaders, including principals and the superintendent, to understand their sexual health curriculum targets and resource allocation. Through this collaborative effort, we identified an existing school community partner who was conducting impactful work despite having minimal resources. By integrating this community partner into our initiative, we could leverage their expertise whilst providing them access to RTV's resources, ultimately expanding their reach and amplifying their impact.

Additionally, at School 1, our observations highlighted a critical gap in mental health services for youth. Whilst social workers were present, their roles were primarily focused on social and referral services rather than addressing pressing mental health concerns. Recognising this need, we prioritised adapting the curriculum to incorporate mental health support more effectively, ensuring that youth had access to the necessary care.

Maintaining open communication with the senior school and community-based organisational leaders was crucial to understanding the youth's well-being and academic success. Indeed, community-engaged work must encompass a variety of meaningful involvement approaches to address the diverse nature of the community, ensuring that the varied characteristics within the community are considered ([Moodley & Beyer 2019](#)).

Setting the Scope of Community Work and Approaching Communities Early. The first step of engaging with diverse community-based stakeholders established a focus on integrating youth sexual health initiatives into school curricula. Due to its long-standing existing partnerships and relationships within the community, RTV became the nexus between the various stakeholders, including schools, institutions, community-based organisations, mental health clinics, community health centres, elected officials, juvenile justice centres and local school district leaders. RTV hosted monthly community discussions across a span of 6 months that included leaders from all parties to review the schools' current sexual health protocols. Initial meetings served as a platform to establish rapport between parties and acquire insights into School 1's community's specific needs. By vote, RTV and the community stakeholders decided to create a new sexual health curriculum that could be embedded in the school. The shared goal was to capitalise on a location where youth are engaged regularly to facilitate meaningful discussions around sexual health education.

Co-Creating Strategies for Community Work, Reinforcing Co-Ownership of Knowledge Production and Engaging Communities at Each Stage of Research. At all phases of the research, RTV convened structured stakeholder meetings to sustain ongoing collaboration and decision-making. Specifically, RTV organised monthly stakeholder meetings, each lasting 1 hour and held in person at partner school sites or community centres, with a virtual option available. These meetings were supplemented by quarterly town-hall style sessions for broader community input and an annual community meeting to review progress and set priorities for the coming year. Meeting participants routinely included RTV staff, school leaders, teachers/facilitators, representatives from community-based youth organisations and faith institutions, local public-health and clinic partners, social service agencies, parent representatives and academic researchers. Each monthly meeting followed a standardised agenda, with meeting minutes, action items and follow-up responsibilities circulated to attendees within 1 week. These structured agendas helped maintain focus and momentum throughout the curriculum development process by clearly outlining objectives, tracking decisions and ensuring accountability for next steps. The sessions also served as a platform for partners to

collectively develop, review and refine strategies to use for the VIP curriculum, ensuring that the emerging co-created curriculum would be responsive to the community's needs. Real-time feedback and shared decision-making ensured that the curriculum remained responsive to community needs and adaptable to emerging challenges.

Although prior community-level assessments had been conducted, an additional, targeted assessment was carried out to better understand the specific needs, strengths and contextual realities of the youth at the participating school. By conducting thorough research and gathering qualitative data from community members and school administrators, RTV team members and community partners collaboratively identified specific risk factors and needs within the community. The needs assessment helped identify gaps in existing services used to guide the development of targeted interventions. This led stakeholders to take an asset-based approach to curriculum development, settling on the 40 Developmental Assets Framework (Benson, P.L. 2007). The decision to adopt the 40 Developmental Assets Framework emerged collaboratively during stakeholder discussions, as partners sought an evidence-informed, strengths-based model that aligned with the community's emphasis on youth empowerment and holistic development rather than deficit-focused prevention.

Guided by this framework, stakeholders intentionally mapped curriculum components onto specific internal and external assets, such as positive identity, social competencies, adult support and constructive use of time. For example, lessons were designed to strengthen communication and decision-making skills (internal assets), whilst partnerships with teachers, parents and community mentors reinforced supportive relationships and clear expectations (external assets). This asset-based approach ensured that the VIP program moved beyond risk reduction alone and instead promoted holistic youth development grounded in identified strengths.

In addition to the work noted above, RTV curated an environment where community stakeholders could meet to share information about other community updates, events, programs and knowledge. Indeed, the partnerships included organisations ranging from non-profits and local churches to businesses, educational institutions and community groups. This collaboration united individuals with different perspectives and pooled resources, knowledge and expertise to help create a shared vision. For example, one RTV staff member highlighted the following:

We have to become a collaborative of people to reach a common goal. It takes a village of partners to make sure that happens. Collaboration and partners go beyond delegating tasks; it's about people knowing you are there, who to call, and what you are working towards.

Through its collaborative partnerships, RTV gained a comprehensive understanding of the unique needs and challenges faced by the community. Engaging with community members and stakeholders ensured that interventions were precisely tailored to address the community's specific context, cultural considerations and priorities. RTV focused on partners who were equally invested in seeing positive change in youth sexual health knowledge and valued youth well-being over research. This approach ensured that the initiatives were relevant, resonant and beneficial for the community and promoted a sense of ownership and engagement among community members.

The Outcome: The Values in Perspective Curriculum

Phase I outlined the collaborative process that informed the co-development of the VIP curriculum, grounded in a comprehensive understanding of the target population's needs and existing strengths. The VIP curriculum fosters positive youth assets through didactic and interactive lessons, encouraging healthy choices and lifestyles. It is a year-long course, comprising over 130 hours of instruction, prioritising the development of socio-emotional skills, educational achievement and establishing long-term goals for the youth's future. Concurrently, the program seeks to lower adolescent pregnancy and birth rates by empowering youth to

utilise their developing socio-emotional skills to negotiate abstinence, resist pressures to engage in sexual activities and steer clear of substance use. Furthermore, the curriculum also underscores the benefits of sexual abstinence in preventing the risks of unwanted pregnancies and sexually transmitted infections whilst equipping participants with skills to delay sexual activity.

For sex education to effectively reduce risky behaviours and mitigate adverse health outcomes, it is crucial to approach education with a holistic understanding of the youth ([DiClemente et al. 2005](#)). Existing research highlights the significance of sex education programs responsive to the socioecological context of youth for a successful transition into adulthood ([Goldfarb & Lieberman 2021](#)). Consequently, the VIP curriculum was designed for implementation as a school-based initiative. Whilst teachers deliver the curriculum, they are trained to collaborate with the youth, taking on the role of group mentors who guide students at their own pace. This approach allows youth to explore their existing or potential assets, empowering them to lead healthy lifestyles. VIP fosters a 'no preach' culture, where teachers guide students in identifying personal values and motivations for leading healthy lives without imposing their values on the youth. An integral aspect of the VIP curriculum is the incorporation of 'Reality Lessons', encouraging youth to authentically respond to diverse hypothetical scenarios that are culturally and socioecologically responsive. Through these scenarios, youth aged 13–17 are prompted to jointly explore the potential outcomes of their choices on health and personal life goals.

Having established the community's strengths and needs, we collaborated with School 1 to implement the VIP curriculum. The goal was to provide accurate, age-appropriate information about sexual health, contraception, STIs, consent, healthy relationships and communication skills whilst focusing on the central concerns of a particular school as outlined by school administrators.

Phase II: Program Implementation

Youth from School 1 opted into participating in the VIP program, with parent permission. They participated in the VIP curriculum as a component of their regular academic course load. This intervention group was assessed for documented delays in sexual activity and reduced teen pregnancy (see [Meyer et al. 2023](#)). The control group consisted of students who opted to continue with School 1's basic sex education course. To address the ethical concerns of not all getting to participate in the VIP curriculum, control participants were provided with existing evidence-based information, access to general health education and referral resources that have been established at their school.

In addition to providing comprehensive sex education, we also sponsored community events for all participants (treatment and control groups) where youth and their families could access confidential, youth-friendly sexual health services, including STI testing, contraception and counselling. By partnering with local healthcare providers and organisations, we created welcoming and accessible information for youth seeking sexual health services. Community-wide awareness campaigns were also implemented to address misconceptions, reduce stigma and promote healthy attitudes towards sexuality. This campaign was achieved by distributing a *Vision* magazine in the tri-county area, disseminating flyers and brochures, sending emails and press releases, and using social media to raise awareness.

Youth voices were considered crucial in this process. Young people were recruited and volunteered as peer educators and mentors who provided support, guidance and accurate information about sexual health to their peers for the duration of the program implementation. Training programs were developed to empower young people to become advocates for healthy behaviours and positive relationships. Forums, surveys and workshops were organised where young people could express their concerns, needs and suggestions. We noticed that young people developed a sense of ownership and responsibility in the program, which was evidenced by wanting to actively participate in decision-making. Parents and families were invited to participate in sexual health education and discussions. RTV offered resources, workshops and opportunities for parents to improve their knowledge and communication skills regarding sexual health topics. These

initiatives may help foster open and supportive parent–child communication, which positively influences youth behaviours. Through our community partners network, we linked families with the appropriate resources, if necessary.

Moreover, at School 1, we established regular stakeholder meetings to maintain the curriculum's effectiveness and address emerging challenges. These meetings provided a structured space to review program progress, discuss ongoing issues and identify resources to alleviate obstacles. This continuous engagement allowed for dynamic adjustments to the program, ensuring that it remained responsive to the needs of both youth and service providers. Within this collaboration, RTV staff members provided periodic updates to school leadership and informed them about progress. In contrast, school leadership observed behaviour change and engagement among youth, which led to an iterative development process.

Evaluate, Reflect and Adapt Strategies. Data on sexual health outcomes, knowledge, attitudes and behaviours were gathered to evaluate program implementation, assess community partnerships' impact and guide future program improvements (see [Meyer et al. 2023](#)). We focused on cultural sensitivity, inclusivity and respect for diverse perspectives throughout the partnership. The collaborative efforts prioritised the well-being, autonomy and rights of youth, ensuring that interventions were evidence-based, age-appropriate and grounded in principles of sexual health promotion and harm reduction.

One example of this process is that one of the key challenges encountered during the program implementation at School 1 was the shortage of teachers originally intended to facilitate the program. This required the development of alternative strategies to implement effective program delivery despite staffing limitations. Adapting to these constraints involved leveraging existing personnel, adjusting implementation timelines and exploring innovative methods such as recruiting RTV staff from other projects as instructors to maintain program integrity.

Additionally, shifts in political leadership introduced new challenges, as incoming state government leaders brought different agendas and varying levels of comfort in addressing specific topics within the school system. This necessitated careful modifications to the curriculum to align with the evolving educational landscape whilst preserving the program's core objectives, which required a nuanced approach that balanced institutional priorities with the needs of the students.

A yearly meeting is held with the principal and other school leaders to maintain the program's effectiveness and ensure continuous improvement. These meetings are a platform to share preliminary results, gather feedback and make necessary modifications to enhance the program. This iterative process allows for ongoing refinement, establishing that the program remains responsive to both institutional shifts and the needs of the students it serves.

Furthermore, funding was secured by the Department of Health and Human Services Administration grant. If funding is not renewed, RTV has already prioritised training stakeholders and school teachers in the curriculum and demonstrated how to connect students to outside resources such as mental health services, social services and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs. Therefore, the VIP curriculum is not dependent on RTV to remain sustainable.

Discussing and Disseminating Results. Community members were integral at every stage of the research process, from interpretation to dissemination of results. Through collaborative discussions, the team compiled the findings into an academic journal article ([Meyer et al. 2023](#)), and community mailers were distributed to RTV's mailing list to ensure accessibility of the findings for all community members. Youth participants in our program reported significant improvements in socio-emotional functioning, increased sexual risk avoidance behaviours and substance abuse avoidance behaviours, as documented in [Meyer et al. \(2023\)](#).

Additionally, to share the research findings with community partners and school leaders, RTV organised school presentations and invited community feedback on the results. These presentations served as the first stakeholder platform to share program outcomes, highlighting statistically significant improvements and demonstrating its effectiveness in meeting its goals. Feedback from school principals was incorporated into the analysis, ensuring that the data analysis accurately reflected the program's impact over time. We used a collaborative writing process whilst developing this and the earlier research article, [Meyer et al. \(2023\)](#).

Discussion

In many low-income urban areas, there is often a lack of support structures to foster young people's success and the community's overall well-being. This deficiency is primarily a result of insufficient funding for programs in schools and the broader community, compounded by economic changes in these areas. However, communities that establish partnerships can help bridge these resource gaps and enable collective action for community improvement ([Butterfoss & Kegler 2009](#)). These types of partnerships, especially in resource-challenged communities, create an environment that promotes shared power and where people feel heard. This approach encourages collaboration and interaction that would otherwise be limited to harnessing the collective use of resources that can drive positive community change. In this article, we show how a pressing public health issue, risky sexual behaviours among youth, can be addressed through CBPR by pooling resources and voices for a shared goal. This process of development and implementation demonstrates that such a process can be achievable. Furthermore, it provides valuable insights into tailoring interventions in similar communities worldwide.

[Walter and Hyde \(2012\)](#) emphasised that forming community partnerships brings together community members and stakeholders to discuss and plan how to allocate resources, initiate change, implement these plans and shape the future of their community. These coalitions provide a platform where individuals from diverse backgrounds can come together to address and counteract issues that affect the broader community ([Enriquez 2014](#)). Research evaluating the effectiveness of community partnerships shows how they can be a dynamic tool for mobilising resources to bring about meaningful positive change in the community ([Kegler, Rigler & Honeycutt 2011](#); [Lardier et al. 2018](#)). Additionally, these coalitions encourage and support interconnected work among community members and organisations to facilitate resource pooling and influence community outcomes ([Cacari-Stone et al. 2014](#)).

Our work revealed that the TRUCE model can be employed to centre the community. The model emphasises the importance of understanding community definitions, conducting social mapping, engaging community gatekeepers, determining CE scope, tailoring strategies to community needs, fostering co-ownership, promoting continuous recruitment and engagement, undertaking rigorous evaluation, and collaboratively interpreting and disseminating research outcomes, which can serve the needs of a community ([Moodley & Beyer 2019](#)). By applying this model, our work demonstrated that community partnerships extend the reach and accessibility of top-down research interventions. Collaboration brings diverse perspectives and insights into program design and evaluation, leading to more comprehensive and evidence-based approaches. This type of initiative fosters active community participation and ownership in the interventions to ensure cultural appropriateness and responsiveness to local needs.

Challenges and Lessons Learned

Implementing the VIP program came with several challenges, many of which were shaped by structural limitations, shifting community dynamics and the lasting impact of the COVID-19 pandemic. Many of the challenges were deeply rooted in systemic issues that predated the program and were significantly exacerbated by the global crisis.

One of the most significant hurdles was the shortage of personnel within the education and community service sectors. Following the pandemic, a substantial portion of the workforce failed to return to pre-pandemic levels, leaving key positions unfilled. This shortage was felt by both school-based staff and our community partners, with many positions remaining vacant, impacting our program delivery. The resulting combination of turnover and burnout among facilitators led to disruptions in program continuity, necessitating ongoing retraining of new personnel.

A second challenge arose from the evolving operational models of community-based organisations. Whilst the pandemic accelerated the shift towards virtual service delivery, many community partners struggled to adapt to online modalities. Several community partners entered a prolonged period of inactivity, lacking the necessary technology infrastructure to deliver services online. This severely limited the availability of supplementary supports such as mental health counselling, youth mentorship and parent engagement workshops, which were intended to complement the VIP curriculum. The absence of these supplementary programs increased the pressure on VIP program staff to fill those gaps, further complicating our program execution. Many community partners who previously provided services ceased operations for nearly 2 years, leading to gaps in community support. These closures disrupted long-standing partnerships that were essential to program retention. Even as programs resumed, there was a notable shift in both the care delivery method and the level of engagement from participants. Youth participants and their families demonstrated hesitancy in returning to in-person gatherings due to health concerns and logistical barriers (e.g. transportation and caregiving), and their overall commitment to programming declined. This shift in program engagement highlighted significant differences in the effectiveness of virtual versus in-person programming. Whilst virtual platforms allowed for continuity in some cases, they also introduced accessibility challenges, including a need for supplementary programs through our community partners, and limitations for youth without stable internet access, quiet learning environments or digital literacy skills. As a result, participation in virtual programming was inconsistent. Moreover, the relational aspects of the program, central to building trust, fostering dialogue and promoting behavioural change, proved more difficult to cultivate in digital spaces.

Despite these challenges, our ability to navigate uncertainties was strengthened by contingency planning. We leveraged and mobilised existing RTV staff and worked alongside community partners who were adaptable and committed to achieving program goals. Interestingly, some partners who lacked the bandwidth to pivot created opportunities for us to step in and provide services where needed.

A key factor in overcoming obstacles was securing buy-in from the community. Ensuring that stakeholders were engaged and aligned with program objectives helped sustain momentum. Ultimately, the program's success was rooted in the dedication of staff and community partners who were deeply invested in making a difference. Whilst challenges persisted, the experience underscored the importance of flexibility, resourcefulness and a proactive approach to problem-solving in program implementation.

Reflecting on challenges during the VIP program, several takeaways emerged that inform how we would approach similar interventions in the future. One takeaway is the importance of designing programs that are flexible and capable of being implemented across multiple delivery modalities, both virtual and in-person. Whilst the transition to virtual services was a result of the pandemic, future program models must be built intentionally for hybrid delivery, as society pushes towards the inclusion of more technology. This may involve investing in digital literacy training, securing reliable technology and creating content tailored for digital platforms. Creating this programming early would allow for a smoother transition and sustained engagement regardless of external factors.

The pandemic exposed vulnerabilities in staffing continuity and institutional knowledge retention. In future implementations, we would develop formal contingency and succession plans that go beyond short-term stopgaps. This would include cross-training staff, creating living documents for curriculum delivery and

establishing communication chains that ensure continuity even when key personnel are unavailable. These processes would help insulate the program from disruption due to turnover or sudden shifts in operational capacity.

Whilst post-program surveys offered valuable insight, future programs should incorporate real-time feedback mechanisms to make iterative improvements throughout implementation. Youth participants, caregivers and educators could participate in brief biweekly or monthly check-ins, allowing the team to quickly identify issues, adapt programming and affirm youth voices as central to the intervention process. Such feedback loops would also enhance program relevance and responsiveness.

Implications

This approach highlights the value of building durable partnerships with schools, community organisations, healthcare providers and local leaders to address complex public health issues such as risky sexual behaviours among youth. These partnerships allow for the co-creation of interventions that not only are context-specific but also promote a sense of ownership and empowerment among all stakeholders involved. From a policy perspective, the program emphasised supporting initiatives by prioritising community engagement and collaboration to address public health challenges. Policy development should facilitate partnerships between community organisations, schools and other stakeholders, providing resources and support for collaborative efforts to improve youth sexual health outcomes or other health initiatives. Additionally, policies should prioritise funding programs that incorporate community input and involve community members in decision-making processes, ensuring that interventions are culturally sensitive, relevant and effective.

From a practical standpoint, several implications stand out. Effective sexual health programming must begin with and continually involve the community. Building trust with schools, parents, faith leaders and healthcare providers allows the development of culturally relevant and contextually appropriate interventions. These partnerships help bridge gaps in service delivery and improve youth engagement and retention, especially in under-resourced urban settings. Additionally, by embedding the VIP curriculum in existing school infrastructures and training school staff and community members in its delivery, the research offers a model for sustainability beyond external funding. This ensures that knowledge and capacity remain within the community, which is especially critical for long-term public health impact in communities with limited access to health resources. Lastly, real-time feedback loops with students, parents and educators, such as regular check-ins or short surveys, can improve responsiveness and allow for iterative program improvement during implementation.

Institutionally, the research highlights the importance of including community voices when adapting school curricula to provide comprehensive, evidence-based programming that addresses the specific needs of diverse communities. Schools should be encouraged to collaborate with community organisations and healthcare providers to deliver comprehensive sexual health education programs that are responsive to the needs and preferences of students and families. Additionally, institutions should prioritise building relationships with community partners and stakeholders by fostering open communication and collaboration to address complex public health issues collaboratively. By prioritising community engagement and partnership, policymakers and institutions can collaborate to develop and implement effective interventions that promote positive sexual health outcomes for youth.

The political context in which this work takes place significantly shapes the feasibility and impact of policy advocacy efforts. Public health initiatives, particularly those addressing sensitive topics such as youth sexual health, are often influenced by shifting political priorities, funding constraints and ideological debates. In this case, the political climate may affect the ability to secure ongoing institutional and governmental support, requiring strategic engagement with policymakers, funders and community leaders to advance the program's goals. The need to navigate these challenges emphasises that public health

interventions never operate in neutral environments; instead, they must adapt to the broader sociopolitical landscape to remain effective and sustainable.

Given these realities, policy advocacy must be strategic and flexible, leveraging research-backed data and trusted community partnerships to push for systemic change. Recommendations for others working in similar contexts include cultivating strong, long-term relationships with community stakeholders; aligning advocacy efforts with existing policy frameworks to gain institutional support; and ensuring that interventions remain adaptable to political shifts. By recognising and addressing these challenges, practitioners and researchers can better position their work to influence policy and drive meaningful, lasting change.

Limitations

Whilst this study offers valuable insights into program implementation, it is important to acknowledge that the narrative data presented are derived primarily from program observations, stakeholder reflections and practitioner insights. As such, this research does not follow a traditional empirical framework with formal hypothesis testing, control groups or statistically driven outcome measures. Instead, it utilises a descriptive and experiential approach, focusing on the lived realities of program staff and community partners as they navigated implementation challenges. This methodological choice limits the generalisability of findings and precludes definitive claims about program efficacy. However, this format allows for rich, contextualised understanding of real-world barriers and facilitators, which can inform future implementations in similar settings. Future research with more rigorous impact evaluations is needed to validate these insights across contexts.

Conclusion

Reducing risky sexual behaviours among youth requires simultaneous multifaceted strategies and community partnerships to develop a robust framework that supports such endeavours. By integrating local resources and expertise, these collaborations can make a tangible difference in the sexual health of young people to ensure that they transition to adulthood with knowledge, responsibility and confidence. One of the pressing concerns is the risky sexual behaviours observed among ethnically diverse youth ([CDC 2018](#)). This article details the role of community partnerships whilst utilising an array of strategies to decrease at-risk youth's propensity to engage in unhealthy sexual behaviours. Addressing risky sexual behaviours among ethnically diverse youth requires understanding, empathy and collaboration. Community partnerships can be used to promote the implementation of tailored and effective interventions. By harnessing the power of these partnerships, society can ensure that all its youth transition into adulthood with the knowledge and tools they need for a healthy sexual life.

Given the current global focus on adolescent health and the rising concern about sexual health inequities, the sustainability of interventions, particularly those aimed at improving the sexual health education of youth, is of utmost importance. Such sustainability is achieved through community partnerships, which promote shared responsibility and resource mobilisation. Moreover, the collaborative efforts of these partnerships extend beyond immediate interventions, addressing broader systemic issues and advocating for necessary policy changes. These efforts are geared towards creating supportive environments that deliver long-term benefits to the community, further solidifying the indispensable role of community partnerships in health education initiatives.

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