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Improving dissemination products and practices for community-based organisations serving LGBTQ+ communities in the USA: a thematic analysis

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ABSTRACT

Background In the USA, lesbian, gay, bisexual, transgender and queer (LGBTQ+) people report higher rates of tobacco use than non-LGBTQ+ people due to diverse factors, from anti-LGBTQ stigma to targeted marketing by the tobacco industry. There is an opportunity to support behavioural changes by delivering evidence-based health communication campaigns through community-based organisations (CBOs), but an insufficient evidence base and organisational resource restrictions limit this potential. Our previous research with CBO staff and leaders serving LGBTQ+ communities identified gaps in evidence-based campaigns, such as insufficient centering of LGBTQ+ communities in campaign development and execution. This qualitative study explores opportunities to improve the products and services supporting the dissemination of evidence-based health communication campaigns for LGBTQ+ audiences.

Methods We conducted key informant interviews between January and June 2021 with individuals who direct or run health promotion programmes in CBOs serving LGBTQ+ populations in the USA (n=26 individuals from 22 organisations). Using critical and constructivist perspectives, we leveraged the analysis team and advisory committee's diverse research, lived and practice expertise related to LGBTQ+ health. We employed a team-based, reflexive thematic analysis approach.

Results We identified two key opportunities. Theme 1—show us your work: participants requested (a) details about the evidence-based campaigns, including underlying values and extent of community engagement, and (b) information about campaign mechanisms and impact. Theme 2—support us in our work: participants suggested that evidence-based campaigns should (a) be designed for flexibility and adaptation, (b) offer tools and guidance for adaptation and (c) share granular data and relevant resources. Participants nominated dissemination products and processes to address gaps, including supports to integrate campaigns into multi-level action, data collection tools for adaptation and engagement with campaign developers.

Conclusions The findings highlight the potential for CBOs to be integral partners in the development and dissemination of evidence-based health communication campaigns that address tobacco-related inequities among LGBTQ+ communities.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ A 'designing for dissemination and sustainability' approach can improve the fit between the evidence-based programs and the needs of community-based organisations (CBOs) that may use them.

WHAT THIS STUDY ADDS

⇒ This study extends the literature by exploring opportunities to improve the dissemination and utilisation of evidence-based health communication campaigns to CBOs serving lesbian, gay, bisexual, transgender and queer (LGBTQ+) communities. Staff and leaders of CBOs addressing LGBTQ+ health want campaign developers to provide additional background information about the campaign, including underlying values, details of community engagement in campaign development and expected mechanisms/impact. They also seek flexible campaigns, support for adaptation and granular data related to their communities.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Engaging CBO staff and leaders as partners in developing and using evidence-based health communication campaigns and dissemination materials may increase the likelihood of campaign adoption and utilisation by CBOs serving LGBTQ+ communities.

INTRODUCTION

In the USA, lesbian, gay, bisexual, transgender and queer (LGBTQ+) people report much higher rates of tobacco use than non-LGBTQ+ people.[1–3] These inequities are due in part to structural anti-LGBTQ+ stigma, targeted marketing by the tobacco industry, minority stress, the use of alcohol and/or other substances as a response to stress and insufficient access to appropriate healthcare.[4–10] In conjunction with complementary policy and system change, there is an opportunity to leverage effective health communication strategies (eg, digital messaging) to prevent initiation and support the reduction and cessation of tobacco use.[11] Such communication interventions can yield results by targeting factors such as norms, and there is a growing evidence base describing the impact of tobacco control campaigns among LGBTQ+ populations.[12–14] Additionally, there are challenges in implementing mass media campaigns that resonate with diverse and geographically dispersed LGBTQ+ populations. This is connected to the challenge that tobacco control interventions tend to emphasise individual-level change, with insufficient recognition of 'tobacco use inequities as indivisible from place, context and policy'.[15] These issues can be addressed in part by emphasising intervention delivery by community-based organisations (CBOs), which often have deeper reach and trust among marginalised populations than traditional public health and healthcare channels.[16 17] As mission-driven, nonprofit, local organisations, CBOs are excellent delivery channels for public health programmes.[18] A wider use of evidence-based communication campaigns by CBOs has the potential to address expand the focus beyond the individual and balance goals of broad campaign distribution and the need for adaptation to increase relevance and impact among LGBTQ+ audiences served by CBOs.[15 19 20]

A 'designing for dissemination' lens can bridge some of these gaps and increase the impact of evidence-based campaigns. This perspective emphasises planning for the spread, implementation and sustainment of evidence-based health communication campaigns while the research evidence base is being generated, as opposed to the conventional (and insufficient) strategy of waiting until effectiveness research has been completed to begin such work.[19] For example, developers of an evidence-based health communication campaign must consider both the design of a product (eg, the content and format of a health campaign) and the supporting messaging, packaging and distribution that will support strategic dissemination to potential adopters and implementers.[19 21] In these ways, researchers can address common challenges noted by public health practitioners regarding the use of evidence-based interventions, such as resource limitations, insufficient staff capacity, competing demands and a mismatch between the evidence-based intervention and their context and population.[22] In contrast to passive diffusion, dissemination activities explicitly incorporate the strategic communication of information about evidence-based information to change agents (eg, CBO leaders or policymakers). This information can inform the change agents' adoption and implementation decisions.[23]

The literature highlights at least four critical types of dissemination strategies that may support the effective spread and adoption of evidence-based interventions broadly: *audience segmentation* (identifying groupings of similar actors who are the focus of dissemination efforts), *tailoring* (refining dissemination materials and messages for decision-makers who share similar attributes, such as knowledge and attitudes), *framing* (emphasising core aspects of the evidence-based intervention or problem it addresses to prompt action among target audiences) and *identifying and leveraging the power held by knowledge brokers and opinion leaders* (engaging actors that influence decision-makers to support the evidence-based intervention).[24–26] Within the field of implementation science and public health more broadly, dissemination strategies—focused on the packaging and communication of information to support the spread of evidence-based interventions—remain relatively understudied.[27 28] Furthermore, the dissemination literature focuses on evidence prioritising behavioural programmes or clinical practices—not communication campaigns.

Our previous research highlights important pain points experienced by CBO practitioners as they used evidence-based health communication campaigns to serve LGBTQ+ communities, including the insufficient centering of LGBTQ+ communities in available campaigns, the burden placed on staff to negotiate campaign use and play 'gatekeeping roles' to preserve community safety and their relationships with community members and difficulty engaging clients and community members with evidence-based health communication campaigns.[29] We extend this work by exploring the opportunities identified by staff and leaders of CBOs focused on LGBTQ+ health to support the dissemination of evidence-based health communication campaigns.

MATERIALS AND METHODS

Parent project

This is a qualitative study grounded in data from Project RESIST, which examines the effects of culturally tailored messages on increasing resistance to targeted marketing tactics used by the tobacco industry among young adult sexual minority women. We focused on this population because US women aged 18–24 who identify as lesbian, gay, bisexual, or a member of another sexual minority group have up to 4.8 times the odds of regular cigarette smoking than their heterosexual counterparts. (Note that this statistic is based on data limited to binary female/male categories.)[30] Efforts highlighting tobacco companies' targeted marketing to LGBTQ+ people have increased resistance to such tactics, prompting further study.[22–24] Although Project RESIST focuses on tobacco use by young adult sexual minority women, this study also addressed the needs of CBOs that serve a broader range of LGBTQ+ populations and health issues. We have used the Consolidated Criteria for Reporting Qualitative

Research[31] to support detailed and rigorous reporting of our methods.

Study design and team composition

To understand the needs and health campaign-adoption processes of community organisations addressing LGBTQ+ health, we conducted semi-structured interviews with CBO staff and leaders. We approached the work with critical and constructivist perspectives, understanding that the knowledge from this study would be co-created by the study team, the expert advisory committee and the practitioners and would reflect our values and positions, as well as a shared commitment to addressing injustice through transformative processes.[32 33] The core analysis team included individuals with experience and expertise in LGBTQ+ health, implementation science, health communication, community delivery of health services, qualitative methods and cancer inequities. One analysis team member brought lived experience as a member of the LGBTQ+ community. All analysts emphasise social justice and health equity in their work and attempted to be explicit about how the boundaries of their knowledge impacted the analysis. The analysis team also drew on the expertise of a larger group of academic researchers with lived and/or research experience with LGBTQ+ health. The project uses a consultation model of participatory research[34] to engage four nationally recognised leaders in LGBTQ+ health as members of the expert advisory committee. This group brings expertise in health promotion, social movements and policy change to advance LGBTQ+ health and a rich array of organisational connections. For this study, they offered an orientation to CBOs' use of research evidence, reviewed and revised the interview guide, facilitated connections for recruitment and supported the interpretation of results. Three are co-authors of this manuscript.

Participants

We conducted key informant interviews with individuals who direct or run health promotion programmes in CBOs serving LGBTQ+ populations in the USA (n=26 individuals from 22 organisations). We sought out staff and leaders knowledgeable about the organisation's health promotion programmes (and tobacco control activities, if applicable). Our sampling method included purposeful and snowball approaches. We started with a referral recruitment strategy, reaching out to those identified by the advisory committee and taking nominations from participants. We also contacted individuals in a national catalogue of organisations serving LGBTQ+ communities in the USA (https://www.lgbthealthlink.org/). As summarised in table 1, our purposeful sampling strategy focused on attaining sufficient information-rich cases[35] among participating organisations regarding services or activities (eg, programme delivery, advocacy), US region, LGBTQ+ populations served and organisation size.

Table 1 Participating organisation characteristics, presented in order of decreasing frequency (n=22)

	Frequencies
Area of action (multiple selections permitted)	
Programme delivery	18
Advocacy	11
Policy	4
Organisation type (multiple selections permitted)	
Community-based organisations	12
Health centres (service providers)	12
Region	
Southeast	5
West	5
Midwest	4
Northeast	4
Southwest	4
Populations served (multiple selections permitted)	
Young adults	22
All LGBTQ+ identities	21
Adolescents	20
Older adults	18
Organisation size	
Small (fewer staff or relies on volunteers, smaller community base, more narrow/defined programming and services, often newer)	10
Medium (multiple staff holding multiple roles in the organisation, wider range of community sizes and geographical areas served)	6
Large (many employees (often 100+), typically with the presence of marketing team and/or resources, larger community base, and offers many services and programmes, often well-established and urban)	6

Data collection

The study team designed the semi-structured guide with support from the advisory committee. Interviews took approximately 45 min and were conducted using a videoconference platform between January and June 2021. We explained the study procedures and obtained informed consent before beginning the discussions. Interviewers included experienced qualitative researchers with doctoral degrees in public health and social and cultural psychology (SR and JR) and degrees in nutrition (MS) and health communication (EH).

We used a semi-structured interview guide (online supplemental file 1) to guide the conversation, starting with the participants' professional backgrounds and organisational contexts. Second, we discussed tobacco campaigns focused on LGBTQ+ populations, such as

'This Free Life'[36] and 'When Did Smoking Become Part of Us?'.[37] We did not present examples of materials from these campaigns or ask for responses to these specific campaigns but instead used them as exemplars to prompt discussion. In this portion of the interview, we asked about experiences finding and implementing these types of campaigns. Third, we asked about the requirements for adopting and adapting an evidence-based tobacco campaign. In this portion of the interview, we emphasised opportunities to build resistance in LGBTQ+ communities to industry targeting. Throughout, the interview guide drew on standard models describing CBO planning processes for evidence-based intervention use[38] and core concepts in designing for dissemination.[21 39] Attention to the context of evidence-based health communication campaign use was grounded in the exploration, preparation, implementation and sustainment framework.[40]

The interviewers and participants were unknown to each other before the interview. Participants received $50 gift cards as a token of appreciation. Interviews were audio-recorded and professionally transcribed. Immediately following each interview, team members independently recorded notes using a prefigured interview summary table. This allowed the team to incorporate participant feedback to inform further data collection and capture key insights. The institutional review board at Harvard University approved this study as exempt from review.

Data analysis

We employed a team-based, reflexive thematic analysis approach, guided by the process outlined by Braun and Clarke, with modifications for pragmatic considerations, such as the scientific and practice-related goals of the work.[41–43] The initial codebook followed the semi-structured interview guide and included deductive codes based on the guide and inductive codes identified from the transcripts and regular team analysis meetings. Four transcripts were coded using the initial codebook, and then the team met to review, modify and finalise the codebook. At that point, two coders (MS and EH) independently coded the transcripts and systematically resolved discrepancies in coding. We used Nvivo software to manage the dataset.[44] After coding was complete, study team members summarised selected codes of interest. The full analysis team (MS, SR, AR, EH, JR) engaged in biweekly meetings to review these summaries, identify code connections, develop themes and select representative quotes. Reflecting the value placed on practice-based expertise and experts, we did not edit the language in the quotes, except for omitting pauses and word fragments when participants were determining what to say.[45] The study PI (AT) was engaged throughout.

RESULTS

Findings highlight the need for products and processes that communicate the details of evidence-based health communication campaigns and related data while supporting campaign adaptation and integration into broader work conducted by CBOs focused on LGBTQ+ communities (figure 1).

Theme 1: show us your work

1 a: CBO staff and leaders desire details about how the campaign was developed, including community engagement and underlying values, for example, social justice or system change CBO staff and leaders described working with members of the community who are consistently experiencing barriers in access to healthcare because they live at 'the intersections of race and identity and socioeconomic demographics' (Interview 22). To this end, campaigns developed without consideration of factors beyond the individual level were seen as insufficient, given the immediate concerns faced by the communities served. Participants described the importance of explicitly acknowledging the multiple ways in which discriminatory systems drive health behaviours and inequities and

Figure 1 Synthesis of requests from community-based organisations for products and processes related to dissemination and implementation.

ensuring communication is delivered in ways that avoid shaming:

> *The campaign messaging] comes across as like judgmental and we're gonna hold you accountable for your bad habits or lack of care for your health without recognizing actually there's a whole bunch of things going on socially, in society, in terms of the systems around that keep people out.* Interview 22

Keeping with the systems frame, campaigns focused on targeting individual behavioural change were described as needing to be framed within this broader context of harmful systems, and participants described feeling more open to messaging campaigns when the greater context was also explicitly considered by researchers.

> *I think that for a lot of the people that I work with that would be interested in tobacco prevention, they might see that this is targeting individual behavior and they might instantly have that same reaction that I had, well, what about all of the – what about the historical trauma, and what about the military culture, and all those really huge things that tie into this? And so, I think making it clear that this fits into that puzzle would be important.* Interview 2

Participants emphasised the need for campaign developers to integrate an understanding that specific populations may face more immediate, pressing concerns than the campaign's focal behaviour.

> *My recommendation in talking to somebody like me, whose first reaction would be like, no, we don't have time for that… is [to say] I understand that there are immediate life pressing concerns. And integrating this is a way to negate long-term life- threatening concerns. You'd have to loop it back around. Because a [client] of mine dying of cancer 30 years from now from smoking is less a concern than the legislature meeting currently, like they're actually in session right now debating whether or not a kid getting hormones is child abuse.* Interview 17

Participants also emphasised a positive, inclusive orientation to health, given the stressors and discrimination faced by the LGBTQ+ communities their organisations serve. Some participants described examining campaign materials for inclusivity regarding race, ethnicity, sexual orientation and gender identity, body sizes and other attributes.

> *Something that feels its intent is to shock or low-key traumatize the viewer is not something that we're gonna be willing to share on our social media. I think having information that feels welcoming and it's giving options to people is wonderful and doesn't do so in a way that is shaming whatsoever.* Interview 15

Regarding campaign development, participants described needing details about a given campaign's underlying values and philosophy, for example, taking a transformational perspective. They also wanted to know whether community members were involved in the process and if materials reflected a community need.

> *I think it is important to know why we're part of campaigns and why it works…I think that that is really helpful talking points for our staff at least because then if they're working on the campaign or utilizing the tool kit… they have more of a picture behind why this is important or why you found that this works.* –Interview 12

1b: CBO staff and leaders desire details about the campaign's expected mechanisms of change and impact

Participants also emphasised the importance of deeply understanding the target change and expected impacts. This was particularly critical for a social media-based campaign as some participants expressed concern that it would just be sent out without additional follow-up and thus have no impact. For others, the emphasis was on tracking the success of implementation with a clear view of the goal.

> *It's hard for me to measure if what "it" is is working if I don't know what it is that's supposed to be working… Knowing what the aim is, as a consumer of that information, is really helpful in planning and then implementing a strategy or a campaign at our organization with our patients.* Interview 5

In addition, given the limited number of staff and/or funding available for the development and implementation of campaigns, participants—particularly leaders of small- and medium-sized CBOs—described wanting to have a sense of what would be required of them beforehand to know if it would be worth allocating limited resources.

Theme 2: support us in our work

2a: CBO staff and leaders want to see campaigns designed for flexibility and adaptation, particularly given the variation in size and resources of CBOs

CBO staff and leaders described the influence of organisational context and clients' social context on their use of campaign materials. Thus, campaigns with built-in flexibility were noted to better support CBOs in addressing their community members' needs. At the organisational level, participants emphasised the utility of approaches that account for the range of resources available to CBOs based on the organisation's size. Needed flexibility included going beyond stock images or nods to inclusion and instead depicting mixed groups that accurately reflect how young adults engage one another. Similarly, participants emphasised the need to capture current moments and trends, such as social media trends or local events, to make the content seem more timely and relevant.

> *The ability of the campaign…to read the room of the current social mores, the social moment that we're in, also current, being able to respond to current news is really important.* Interview 14

The operationalisation of this flexibility varied greatly by organisation size. For organisations with large budgets, many described having in-house communications teams that would customise materials to reflect their brand and meet audience needs. For organisations with limited budgets, staff or other resources, the availability of ready-made materials was described as a priority, with tools that required minimal staff input to adapt and were easy to share as being most helpful.

> *I think we would just want you to give [the materials] to us in complete form. …We would never use anything that would come to*

> *us and say… This is an editable flier or an editable brochure. We don't want to do that, and we never would.* Interview 21

Some participants were interested in engaging campaign developer teams during the implementation process. They described wanting opportunities to learn more about the campaign through direct and ongoing interaction.

> *That's how we were able to do what we needed to do with the American Lung Association was through our relationship with the technical assistants that were helping us roll that out.* Interview 5

The CBO size was identified as a central factor driving their requests for products and approaches, suggesting how the need for flexibility takes quite different shapes for small and large organisations. Leaders of smaller CBOs described heavy reliance on volunteers and board members to fill some of the resource gaps, so dissemination of products and processes that required minimal additional effort were described as most useful. Exemplar products included language and graphics that need minimal resources to customise. CBO staff and leaders of smaller organisations also described valuing the possibility of co-branding materials as part of efforts to expand their reach. Some leaders from larger organisations described having in-house research, marketing, communications and graphics departments. For these organisations, support that could be offered at different stages of development was highlighted, for example, being provided with visuals and messaging that they could then tailor themselves, targeted technical assistance at a particular point, or, for an organisation with the capacity to develop the product themselves, support with getting that final product 'out into the world'.

2b: CBO staff and leaders seek practical guidance and tools from developers to support adaptation and implementation of campaigns

A desire was expressed for tools that would facilitate the process of adapting original materials to better suit the needs of the communities they are working with. A central focus surrounding requests for guidance was the diverse and intersecting identities of LGBTQ+ community members served by the CBOs. Some participants described the usefulness of including detailed instructions on the process of customising campaign materials:

> *If there were instructions on how to customize it and really lay it out, if I can see your process for developing that communication, then it's easier for me to wrap my mind around how to shape it for my population. Because otherwise, it feels like I'm going back through the steps of figuring out how you created it, and then recreating it.* Interview 2

Survey and interview guides were also mentioned as being beneficial to support CBOs in assessing community response to a campaign to support adaptation. Participants wanted to access and use data collection tools to gather local data without the burden of creating data collection instruments. This was seen as the only way to achieve systematic adaptation goals for organisations without staff with this expertise.

2c: CBO staff and leaders seek granular data to serve their clients and communities more effectively

Several participants described needing granular data about the groups within the LGBTQ+ community they serve. This was positioned as a contrast to typically available data, with broad groupings that limit the CBOs' ability to understand the nuances of health issues and behavioural patterns among groups of interest. For example, state-level tobacco use data were discussed as having limited utility because LGBTQ+ populations were all grouped, without the ability to examine data for a particular sexual orientation or gender identity or for rural versus urban residents of the state. Similarly, participants noted that researchers tend to have invested in deep study of the populations of interest and can share summary information to support CBOs' broader work.

> *Bisexual outcomes is something that we would want to see. Especially knowing that bisexual populations are more adversely affected by tobacco use than others. Just making sure that [they're] not just lumped in as a datapoint, I think, would be really important.* Interview 11

Exemplar dissemination products/processes nominated

As summarised in figure 2, participants suggested a range of products and processes that allow CBO leaders and staff to understand the nuances of campaigns and access rich support for adaptation and implementation.

Many participants suggested products such as fact sheets and briefs to describe the campaign's development, mechanisms and impact. They noted the need for both summary and detailed information so that CBO staff and leaders could access varied levels of detail. They also spoke of the importance of products facilitating local data access and synthesis. These products were expected to reduce work for organisational staff and make the research's central aspects (eg, literature reviews, findings) more accessible. Additionally, numerous products and processes were nominated to support adaptation, including customisable surveys and focus-group interview guides, webinars, storytelling activities and technical assistance. In this vein, participants also highlighted the importance of direct interactions between campaign developers and CBO staff. Other adaptation-focused nominations were directly tied to products intended for distribution via social media. These included social media templates that support minor adjustments, for example, adding a logo; social media elements that can be integrated into a range of platforms and allow for intense adaptation; a range of text choices and images that communicate core messages; and brief videos.

DISCUSSION

This study examined how staff and leaders of CBOs focused on LGBTQ+ health to conceptualise unmet dissemination needs related to evidence-based campaigns, using

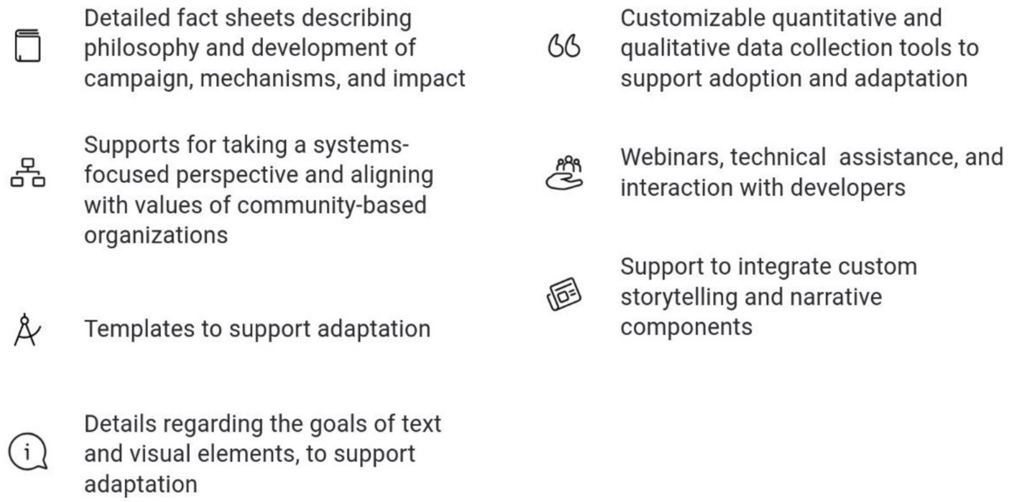

Figure 2 Exemplar nominated dissemination products and processes.

the example of Project RESIST to ground the conversation. Participants identified two main groups of needs: (1) products to increase access to campaign details to ensure alignment and protect against harm and (2) supports for campaign adaptation and implementation.

Opportunities to improve communication about evidence-based campaigns, from values and activities driving campaign development to expected mechanisms and impact.

This study highlights the importance of communicating the details of the development of the evidence-based health communication campaign, not simply in terms of study activities and results but also the underlying values and worldviews. Indeed, in the context of our study, we found that the positionality of our research team and the explicit articulation of shared values and shared identities related to LGBTQ+ health were crucial for developing trust and cultivating collaboration. For example, a campaign grounded in a health justice framework[46] could name that perspective as a driving force and allow CBO staff to evaluate alignment with organisational values. The focus on communication also links with participants' interest in learning about the extent to which LGBTQ+ community members were involved (not simply as sources of information but as part of the campaign development team). The need for explicit communication about worldviews and paradigms links with requests for positive, compassionate, system-focused frames on what is often addressed as an individual-level issue.[47 48]

In addition to understanding the 'how and why' of campaign development, there was a clear call for researchers to demonstrate humility about what is/is not known and transparency about potential impact. Notions of humility tie to ongoing discussions related to CBOs serving marginalised communities, regarding what constitutes 'evidence' and the common disconnection between research and practice audiences.[49] Related to potential impacts, a helpful example is the potential tension between the positive, affirming frames espoused by participants and the health communication literature that suggests fear appeals can have an impact if people feel they have the resources to address the health issue.[50] However, fear appeals research tends to focus on the effects of fear appeals on health issues of interest.[51] In contrast, CBO staff and leaders described a clear need to avoid messaging that might stigmatise, traumatise or otherwise harm LGBTQ+ community members they serve. Instead, they emphasised their roles as caretakers, trusted resources and knowledge creators for their communities, and understanding this will be critical for campaign development teams. Communication about expected impact may also address potential disconnections between the scope of a campaign (eg, tobacco control) and the scope of the CBO's work (eg, health promotion in the context of food or housing insecurity). This reflects a challenge with the current, researcher-driven model of dissemination and implementation, which often uses a technology transfer approach, emphasising the movement of a campaign through the system versus a health promotion approach CBOs may use, which emphasises the broader community goals.[52]

Opportunities to support practice more effectively

Another set of findings related to the needs CBOs have to engage with evidence-based campaigns. Despite the importance of local, granular data for adapting dissemination campaigns for context,[26] gaps in access to data and the resources to facilitate the local use of these data are common in community health.[53 54] The challenge is exacerbated for organisations serving LGBTQ+ populations, given the uneven and often insufficient collection of data related to sexual orientation and gender identity.[55 56] As data dashboards and similar structures proliferate, they can easily contribute to and exacerbate inequities if they do not include data on LGBTQ+ populations or provide tools to enable community-based data users to use these data.[57 58]

Another set of practice supports relates to adapting and implementing evidence-based health communication campaigns. The findings regarding dissemination supports fit with a recent participatory study of crucial considerations for tools derived from research, which emphasises the ability to tailor, the importance of providing evaluation tools, offering details about the study setting and contributions to the evidence base, providing a description of who needs to act and information to support implementation and drawing a clear link between the tool and practice-based action.[59] The importance of flexible design to support adaptation, whether through the development of modules, backup images and text and other similar resources, has been identified elsewhere.[22] Participants described a series of potential supports related to adaptation, ranging from flexible products (eg, a template for social media) to pre-developed surveys and focus group guides to support data collection. They also suggested technical assistance and other forms of support would be valued. While these suggestions are consistent with the literature (though still not the norm), a unique aspect is the emphasis on interaction and engagement with the campaign developers. Additionally, in contrast to the emphasis placed in the literature on other activities as competing demands that hinder the uptake of an evidence-based intervention,[60] CBO staff and leaders described this as an opportunity to support ongoing programmatic goals with evidence-based campaign materials.

Ways to move forward

This study highlights the importance of CBOs serving LGBTQ+ populations as integral partners in campaign development and dissemination activities. Increasing the diversity of teams is known to improve problem-solving and support impact-focused solutions.[61–63] Demands by adopters may prove to be another critical driver of needed change. We recognise that engaging CBOs as partners in developing, disseminating and implementing campaigns requires commitments of time and resources. Many of the nominated dissemination products and processes, such as technical assistance or ongoing adaptation support, are quite resource-intensive. However, the results are expected to be greater and more sustainable than conventional research approaches.[64] Various approaches to engaging those with practice-based and lived expertise may help teams balance goals, resource constraints, interests of multiple parties and other considerations.[65] There may also be opportunities to leverage the talents of intermediaries, such as knowledge brokers, to connect developers and implementers of evidence-based campaigns.[66] Alternatively, translational intermediaries, such as clinical translational science centres, may be important for supporting the creation and execution of ongoing dissemination activities. Future work should explore the types and attributes of dissemination products that successfully meet these goals and opportunities to use co-design processes to improve the dissemination of evidence-based health communication campaigns. Additionally, such a work must examine the impact of suggested changes on CBOs and the communities they serve.

We present our findings in the context of a set of limitations. First, we grounded the data collection in descriptions of materials related to one project focused on young adult sexual minority women. The emphasis on this group may have shaped some of the responses, but we attempted to overcome this limitation with probes that delved into applications related to other LGBTQ+ groups. Second, we focused narrowly on a specific type of CBO, but the rigour of the analysis supports the transferability of findings to CBOs addressing the needs of other marginalised communities. At the same time, a series of strengths outweigh these limitations. Collecting these data as part of a community-engaged study that privileged the expertise of LGBTQ+ community members and CBO practitioners offered credibility and value alignment between the research team and participants. Furthermore, we increased the rigour of the analysis through deep engagement in relevant practice settings, incorporating diverse perspectives in the analysis and using a reflexive analytic process. Lastly, the study offers insights into how a ‘designing for dissemination’ lens can support the development of products and processes that reflect campaign particulars and the needs of intended audiences.

CONCLUSIONS

This work highlights the need to develop dissemination products that offer rich detail so CBOs serving LGBTQ+ communities can examine campaigns regarding underlying values, expected mechanisms and impact and connection to broader community goals. Through CBO engagement, there is an important opportunity to bridge some of the gaps between campaign materials and the types of tailoring required for increasing relevance and impact. The study also emphasises the need for user-centred processes to support the adaptation of evidence-based campaigns, particularly in over-burdened organisations. With more relevant and appropriate dissemination of products and processes, CBOs can better leverage available research evidence to address tobacco and other health inequities among LGBTQ+ populations.

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Contributors SR and MS conceptualised the study. SR, MS, JR, JC, EH and AT analysed the data, with support for interpretation from JMA, RG, AMM and NFN. SR, MS, JR, JC, EH, AT, JP and MH contributed to the initial drafts. All authors read and approved the final version of the manuscript. SR accepts full responsibility for the finished work, had access to the data and controlled the decision to publish.

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