PROMISE for High-Impact Prevention Implementation Manual

ACKNOWLEDGMENTS

The Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) training curriculum was based on the research conducted for the AIDS Community Demonstration Projects funded by the Centers for Disease Control and Prevention (CDC). The curriculum evolved into the current blended format of an online overview and a two-day course. This implementation manual reflects the current PROMISE for High-Impact Prevention curriculum and is designed to support agency implementation following training.

JSI Research & Training Institute, Inc. (JSI) developed this PROMISE for High-Impact Prevention Implementation Manual as part of JSI's Capacity Building Assistance project, CBA@JSI, funded by CDC, under grant number NU65PS004406. Special thanks to the principle writers and trainers Juli Powers and Arman Lorz. Holley Silirie and Michelle Samplin-Salgado provided creative direction and design. Maria Alvarez, Partnerships Team Lead, Capacity Building Branch (CBB), Division of HIV/AIDS Prevention (DHAP), CDC, and Program Consultants Mari Brown and CDR Shwana Coleman provided the necessary CBA coordination and support throughout the process. Dr. Jonny F. Andia of CBB provided leadership in the conceptualization and development of this document. Additional thanks to Dr. Charles Collins for his contributions to the final product. Additional thanks to Dr. Charles Collins for his contributions to the final product, and to Terry Stewart, Consultant with the Denver Prevention Training Center, for his review and feedback.

Many people contributed to the ultimate creation of this manual: the original principal investigators and their creative staff, CDC researchers and behavioral science consultants, community members who participated in the research project, trainers from the Capacity Building Assistance system and their directors, former Prevention Training Center (PTC) trainers and their directors, all who who have believed so wholeheartedly in Community PROMISE, agency staff who have implemented Community PROMISE throughout the years, and community members who have benefited from those programs. We thank them all.

TABLE OF CONTENTS

HOW TO USE THIS MANUAL

This implementation manual contains information and resources to help agencies decide if PROMISE for High-Impact Prevention is right for them and to guide agencies in planning, implementing, and evaluating the intervention.

This section provides an overview of the content and format of the manual.

The manual is composed of six modules, each addressing a major component of PROMISE for High-Impact Prevention.

Module 1
Introduction provides an overview of the HIV care continuum and High Impact Prevention in the United States. The module describes the theoretical basis for the intervention and introduces the four core elements: community identification process, role model stories, peer advocates and evaluation. This module also provides guidance for deciding if the intervention is right for your agency and describes the necessary resources and skills for implementation.

Module 2
Community Identification Process discusses why and how agencies should become familiar with the community's needs and issues to inform implementation of the intervention. This module discusses the key assessment tools and techniques to conduct the community identification process, as well as some optional tools and resources to enhance the assessment process if time and resources allow.

Module 3
Role Model Stories presents the key components and procedures for identifying possible role models, conducting interviews, and writing and producing role model stories.

Module 4
Peer Advocates contains information on the methods for identifying, recruiting, training, and supervising peer advocates to distribute role model stories and intervention materials.

Module 5
Evaluation discusses why and how to conduct ongoing evaluation activities and offers practical guidelines and tools for conducting process monitoring and evaluation and outcome monitoring.

Module 6
Management provides an overview in managing the human resources, finances, materials, and process of planning for and implementing the intervention.

Throughout the manual, a resource  icon indicates helpful tools and resources to support implementation activities. These sample tools and templates are included in the Appendices at the end of the manual. Additionally, a tip icon  indicates helpful hints throughout the manual.

ACRONYMS

ART	Antiretroviral therapy
CBA	Capacity Building Assistance
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
CID	Community identification process
HIP	High-Impact Prevention
HIV	Human immunodeficiency virus
LGBT	Lesbian, gay, bisexual, transgender
MOA	Memorandum of agreement
MOU	Memorandum of understanding
MSM	Men who have sex with men
PWH	Persons with HIV
PrEP	Pre-exposure prophylaxis
PROMISE	Peers Reaching Out and Modeling Intervention Strategies
PWID	People who inject drugs
RMS	Role model story
SMART	Specific, measurable, attainable, relevant, time-bound
STD	Sexually transmitted disease
VL	Viral load

PROMISE FOR HIGH-IMPACT PREVENTION IMPLEMENTATION MANUAL

MODULE 1: INTRODUCTION

THE HIV CARE CONTINUUM:

KNOW YOUR STATUS

CONNECT TO CARE

START HIV TREATMENT

STAY IN CARE

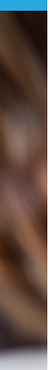
KEEP THE VIRUS UNDER CONTROL

MODULE 1: INTRODUCTION
WHAT IS HIGH-IMPACT PREVENTION?

BACKGROUND

While the overall number of new HIV infections in the United States is declining, progress among all groups remains uneven. A range of social, economic, and demographic factors affect some Americans' risk for HIV, such as knowledge, lack of self-efficacy, risk-related group norms, stigma, discrimination, income, education, and geographic region. To address these challenges and maximize the effectiveness of current HIV prevention methods, the Centers for Disease Control and Prevention (CDC) and its partners, are pursuing a high-impact approach to HIV prevention, which aims to achieve the greatest possible reduction in HIV infections by making sure that resources go to the regions, populations, and prevention strategies where they will have the greatest impact.[1]

Scientific advances have shown that antiretroviral therapy (ART) not only preserves the health of people living with HIV, but also dramatically lowers their risk of transmitting HIV to others by reducing the amount of virus in the body.[2] These developments have transformed the nation's approach to HIV prevention. By ensuring that everyone with HIV is aware of their infection and receiving the treatment they need, we can sharply reduce new infections in the United States. This vision is a core focus of CDC's High-Impact Prevention (HIP) strategy. To help gauge progress towards national goals and direct HIV prevention resources most effectively, CDC tracks data along the HIV care continuum.



WHAT IS THE HIV CARE CONTINUUM?

The HIV care continuum is the series of steps from the time a person receives a diagnosis of HIV through the successful treatment of their infection with HIV medications to achieve viral suppression, meaning the amount of HIV in the body is very low or undetectable.[3] Achieving viral suppression is important for persons with HIV (PWH) in order to stay healthy, live longer, and reduce their chances of passing HIV to others.

Specifically, CDC tracks each of the following stages:

- Diagnosed
- Linked to care, meaning they visited a health care provider within one month (30 days) after learning they were HIV positive
- Received medical care for HIV infection (defined as having received at least one CD4 or viral load [VL] test in the calendar year) or were retained in continuous medical care (defined as having at least two CD4 and VL tests at least three months apart tests in the calendar year)
- Viral suppression, meaning that their HIV viral load – the amount of HIV in the blood – was at a very low level (defined as <200 copies/mL on the most recent VL test)

This manual will guide you through the implementation of Community PROMISE in the era of HIP - or PROMISE for HIP. Previously, Community PROMISE largely focused on behavioral change in terms of condom use. PROMISE for HIP promotes pre-exposure prophylaxis (PrEP) and goal behaviors along the HIV care continuum including HIV testing, linkage to care, retention in care, and medication adherence.

WHAT IS PROMISE FOR HIP?

PROGRAM OVERVIEW

"PROMISE" is an acronym for "Peers Reaching Out and Modeling Intervention Strategies." PROMISE for HIP is an effective community-level HIV/sexually transmitted disease (STD) prevention intervention that relies on role model stories and peer advocates to promote healthy behaviors and change social norms related to the HIV care continuum. PROMISE for HIP evolved from Community PROMISE, which was based on the AIDS Community Demonstration Project,[4] Funded by CDC, the project found Community PROMISE to be effective in five cities across the United States in reducing risk behaviors related to HIV transmission and acquisition.

COMMUNITY – A GROUP OF PEOPLE LIVING OR SHARING A PARTICULAR AREA OR PLACE AND HAVING CHARACTERISTICS IN COMMON LIKE ATTRIBUTES, RESOURCES, BEHAVIORS, AND PREFERENCES.

PROMISE for HIP, like other community-level interventions, comes from the community and works with the community. A community can be defined as a group of people living or sharing a particular area or place and having characteristics in common, such as attributes, resources, behaviors, and preferences. PROMISE for HIP assumes that individuals acquire skills and practice behaviors within their social networks. It can serve any population since the messages come from and are communicated within the community. The intervention has been implemented with many groups including gay, bisexual, and other men who have sex with men (MSM); people who inject drugs (PWID); sex workers; heterosexual women and men; transgender women and men; young people; and diverse racial and ethnic communities.

PROMISE for HIP focuses on activities along the HIV care continuum. Community members generate the specific intervention content from their own experiences. Through their stories, they model strategies for goal behaviors related to HIV testing, PrEP, HIV status disclosure, linkage to care, retention in care, or adherence to ART for friends and community members. PROMISE for HIP then depends on peer advocates to distribute the stories within their communities and discuss them with peers. Role model story messages move through social networks to influence social norms, attitudes, and behaviors.

CORE ELEMENTS

Core elements refer to the features of an intervention that are responsible for its effectiveness. They are elements of the intervention that must be maintained in order for the intervention to remain effective and produce the expected outcomes.

The four core elements of PROMISE for HIP are:

1. **Community identification process**
2. **Role model stories**
3. **Peer advocates**
4. **Evaluation**

A brief description of each core element follows. More detailed information on implementing the core elements is found in module 2 (community identification process), module 3 (role model stories), module 4 (peer advocates), and module 5 (evaluation).

Core Element 1: Community Identification Process (CID)

Effective interventions begin with a community assessment. The CID is the process by which program staff will assess the intervention population to determine what issues are prevalent in the community. The main focus of the CID is to learn more about the population and community where you will be implementing the intervention. When conducted effectively, the CID provides information about attitudes and behaviors along the HIV care continuum that you are seeking to influence, and helps you identify what stage of change the community is in with respect to identified goal behaviors. This process also provides foundational information that will help you develop a plan to guide the intervention population forward from their current stage of change for a particular behavior toward a more desirable outcome.

The CID involves a brainstorming session with internal staff to capture what they know about the intervention population; individual interviews with systems people, or those who have formal and/or professional relationships with the intervention population; and individual interviews with key members of the intervention population. Intervention population interviews are the best source for getting accurate and current information about the population to understand what may prevent them for adopting goal behaviors and what may be putting them at risk for HIV transmission or acquisition.

Core Element 2: Role Model Stories

Role model stories are the heart of PROMISE for HIP. They are short narratives that depict personal accounts from individuals in the intervention population who have made or are planning to make positive changes. Role model stories depict the stage of change above that of the community for a specific behavior and tap into the HIV care continuum. Depending on which populations they are meant to reach and what behaviors they are trying to influence, the stories may include examples of people taking PrEP consistently, avoiding sharing needles and other injection equipment, or seeking treatment following a positive HIV test result, among others.

Role models are frequently identified during the CID process. In the stories, role models - often depicted by a fictional character to maintain confidentiality - explain how and why they took steps to change a behavior toward a more positive outcome, and the positive effect it has had on their lives. The role models are not required to demonstrate perfect behavior, but they must show some action or movement toward adopting healthy behaviors and reducing HIV transmission or acquisition risk, such as getting tested for HIV, beginning PrEP, or disclosing their HIV status to a partner.

Core Element 3: Peer Advocates

The messages in the role model stores are reinforced by interpersonal communication with trained peer advocates. Peer advocates are volunteers from the intervention population who help distribute the role model stories and other materials. Peer advocate recruitment, training, retention, and roles are discussed in detail in module 4. In their interactions with the intervention population, peer advocates encourage individuals in their social networks to read and talk about the stories. By doing so, peer advocates assist their peers to relate to the story content and help encourage them to engage in healthier behaviors.

Prevention materials may also be distributed by the peer advocates to help achieve intervention goals. The type of materials distributed depends on the intervention population and the behaviors the intervention is trying to change. If the goal is to increase access to PrEP, up-to-date information related to obtaining PrEP assistance and education should be readily available. If the goal is safe injection among PWID, information regarding syringe services programs would be appropriate for distribution. Often, programs package condoms with their role model stories. The intervention population informs the mix of distribution methods that work best for them, and this information is often revealed during the CID process.

Core Element 4: Evaluation

Evaluation is a continuation of the CID process and is intended to monitor changes in behavioral and social determinants of health that influence behaviors, discover new social networks, and measure progress in the stages of change. Ongoing evaluation as part of PROMISE for HIP should take place at least every six months. Programs assess attitudes and behaviors among the intervention population to determine if any stage of change movement had occurred for particular behaviors since the last assessment, and if the initial issues that needed to be addressed are still relevant.

Additionally, evaluation is an important program management tool. As an "effective intervention," PROMISE for HIP is understood to be effective in achieving a set of goals for your community. However, programs should also conduct evaluation activities to ensure the intervention is being delivered as intended and to identify where changes may need to be made.

These four core elements build on the behavioral theories behind PROMISE for HIP to together achieve the intervention goals.

UNDERSTANDING THE BEHAVIORAL THEORIES BEHIND PROMISE FOR HIP

An intervention is theoretically-based if its activities are consistent with a particular set of systematic assumptions about cause and effect. One advantage of using theoretically-based interventions is that theories are supported by reason and logical hypotheses. In addition, many theories about behavior have been supported by findings from experiments designed to test whether the theory can apply to many situations.

Behavioral theories suggest how and why individuals behave as they do. The behavioral theories behind PROMISE for HIP tell us that an individual's behavior is influenced by a variety of factors. We refer to these influencing factors as behavioral and social determinants. Effective behavioral interventions work by addressing a set of determinants.

BEHAVIORAL DETERMINANTS

Behavioral determinants are factors at the individual level that are capable of influencing behavior change. One must change the behavioral determinants first in order to be able to change behaviors.

PROMISE for HIP leverages the following behavioral determinants to influence behavior change:

- **Knowledge:** What a person knows about the behavior and the health problem.
- **Attitudes and beliefs:** What a person believes and thinks about the behavior and the health problem. It also encompasses pros and cons of the new behavior, including feasibility and effectiveness.
- **Intentions:** Willingness to try to change the behavior.
- **Values:** How a person sees him or herself as an individual, what they believe in, and what is OK and what is not OK for them to do. This relates to how the behavior fits in with how they see themselves.
- **Skills:** The actual capacity a person has to do the behavior.
- **Self-efficacy:** The feeling of confidence that a person has related to their ability to change the behavior.
- **Perception of risk:** The awareness a person has that a health problem exists.
- **Perceived susceptibility:** The belief an individual has of being personally vulnerable to the health condition.
- **Perceived severity:** A person's belief that harm can be done by the health condition.
- **Social norms:** The implicit or explicit rules a group uses to determine appropriate and inappropriate values, beliefs, attitudes, and behaviors.
- **Subjective/Perceived norms:** An individual's interpretation of what others think, approve, wish, and hope for the person about performing the behavior.
- **Social support:** An individual's perception and the actuality that they are cared for, have assistance available from other people, and that they are part of a greater social network.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are a complex and integrated set of overlapping social structures and economic systems. They include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world. Many social determinants of health are outside our control and would be difficult to influence with a behavioral intervention.

There are some social determinants that PROMISE for HIP may influence through role model stories. These include:

- **Access:** The ability or right to approach, enter, exit, communicate with, or make use of programs and services. Access can be related to structural issues, such as transportation or hours of service, or social issues such as support groups or advocacy.

- **Stigma:** The real, perceived, or imagined fear of societal attitudes regarding a particular condition.

STIGMA – THE REAL, PERCEIVED, OR IMAGINED FEAR OF SOCIETAL ATTITUDES REGARDING A PARTICULAR CONDITION.

BEHAVIORAL THEORIES THAT SUPPORT PROMISE FOR HIP

PROMISE for HIP is based on established models and theories of behavior change. No single theory adequately describes the complexity of sex- and drug-related behaviors or ways to motivate change among groups of individuals living with or vulnerable to HIV infection. Therefore, PROMISE for HIP incorporates five behavioral theories, which are described below:

Health Belief Model [5]

According to the Health Belief Model, two key components must be in place to influence behavior change:

1. Individuals must think they are personally at risk and there are severe consequences. *"I may get HIV if I have unprotected sex after I drink too much."*

2. They must believe that the new behavior will be effective in improving their health or reducing their risk, and that the benefits of that change outweigh its perceived costs. *"Taking PrEP every day will protect me from getting HIV from my partner."*

Theory of Reasoned Action [6]

The Theory of Reasoned Action suggests that a person must have the intention to change. Intentions are influenced by:

1. An individual's attitude toward performing the behavior based on his or her beliefs about its consequences. *"If I use a condom, I will lose my erection."* (negative outcome - behavior will not change)

2. A person's perception of the social pressure put upon him or her to perform the behavior. This theory suggests that people change behaviors if they believe that others who are important to them think that they should adopt a particular behavior. These are known as subjective norms. *"My friends think that using a condom is a smart thing to do."* (strong subjective norm - supports behavior change)

Social Cognitive Theory [7]

The Social Cognitive Theory states that behaviors are learned either through direct experience or by modeling the behavior of others. The likelihood of these behaviors being repeated depend on three factors:

1. Individuals must have confidence in their ability to perform the behavior. This is known as self-efficacy. *"I am confident that I can adhere to my HIV medications."*

2. They must believe that the benefits of the new behavior will outweigh its costs. *"I could get really sick if I don't take my HIV medications every day."*

3. There must be reinforcement of positive behavior changes from persons who are important to them. *"My friends remind me to take my meds when I have forgotten."*

Diffusion of Innovations Theory [8]

Diffusion of Innovations Theory refers to the process by which an innovation (idea, practice, technology) is communicated through certain channels over time through members of a social network. This theory suggests that behaviors along the HIV care continuum, when viewed as innovations, will be successful or adopted by individuals when the innovation is diffused or distributed through communities. These may include spreading prevention messages through social media, or friends sharing information about their own goal behaviors.

Transtheoretical Model [9]

The Transtheoretical Model - or Stages of Change Model - describes the stages individuals go through when changing any behavior. The stages are described below:

1. Pre-contemplation is when an individual has no intention of adopting a recommended protective behavior in the near future. This lack of intention could be because an individual does not have all information, is unaware of their risk, or because the person has no desire to make the change and therefore is not even thinking of changing their current behavior.

2. Contemplation is the stage at which an individual is thinking about choosing the new behavior, but has not yet begun to perform that behavior. It is a passive stage involving only their wish to change, but there is not yet a commitment to act.

3. Preparation is when there is a firm intention to change in the immediate future. During preparation, the intention becomes active and a person makes some plans that will help them initiate the change. There is a real commitment to change.

4. Action occurs when the new behavior is being performed consistently, but not for more than six months. Action is when the person modifies their behavior and environment to achieve their goal behavior firmly believing in obtaining the expected results. It implies visible conduct changes and a great deal of commitment, time, and energy.

5. Maintenance occurs when the behavior adopted during action becomes a habit and more natural. The person collects the benefits resulting from the change and works to prevent relapse. The maintenance stage begins when someone has been performing the behavior for six months.

6. Relapse is not a stage of change but it is also an important element in this theory and may occur at any stage. The stages of change are cyclical, rather than linear, and a person can cycle through them in various combinations and multiple times before reaching maintenance and remaining in maintenance.

According to this model, different intervention activities are needed depending on the stage of change for a particular behavior.

In PROMISE for HIP, role model stories will always portray movement through only one stage of change. That is:

from **precontemplation** to **contemplation,**
from **contemplation** to **preparation,**
from **preparation** to **action,** or
from **action** to **maintenance.**

Below is a summary of the behavioral theories and how they appear in the intervention:
1. People change their behaviors gradually, in stages, over time. PROMISE for HIP highlights people in various stages of change in the role model stories, and also periodically measures participants' stage of change in order to assess the community and our progress (Transtheoretical Model).

2. People change behaviors when they have skills to perform the new behavior. PROMISE for HIP shows role models developing and using these skills, such as disclosing their HIV status or taking PrEP consistently (Social Cognitive Theory).

3. People change their behavior when they are clear about a specific behavioral goal. PROMISE for HIP shows only one, clearly expressed behavioral goal in each role model story, and expresses the role model's attitudes and beliefs about performing the specific behavior (Theory of Reasoned Action).

4. People change behavior and learn how to perform a new behavior when they see others like themselves adopting those behaviors. Through the role model stories, PROMISE for HIP shows people from the intervention population overcoming obstacles to changing their behavior and emphasizes modeling, vicarious learning, and relevance in their lives (Social Cognitive Theory).

5. People change behaviors if they see others like them or close to them changing those behaviors creating a perception of social norms, and if people who are important to them think that they should adopt a particular behavior (subjective norms). PROMISE for HIP shows people becoming aware of important norms and learning what someone important to them wants them to do (Theory of Reasoned Action).

6. People tend to adopt behaviors if they are reinforced or rewarded for doing so by their peers. PROMISE for HIP tells the positive outcomes of adopting the behavior, such as feeling good about oneself, believing that you can perform the behavior, or being praised by others (Social Cognitive Theory).

7. People change their behaviors depending on their beliefs about the behaviors or about the consequences of the behaviors (Theory of Reasoned Action). These beliefs fall into several categories:

a. Perceived susceptibility – the belief that they are at risk for acquiring a certain disease. PROMISE for HIP has role models identify or become aware of their risk (Health Belief Model).

b. Perceived severity – the belief that HIV is a serious disease with serious consequences (Health Belief Model).

c. Self-efficacy – the belief that they can adopt the behavior despite the obstacles they might encounter. PROMISE for HIP shows how people overcome these obstacles (Social Cognitive Theory).

d. Response efficacy – the belief that taking the recommended action will work to protect oneself from disease (Social Cognitive Theory).

8. People also change behavior based on the attitudes that they have about the behavior and its consequences, and those attitudes – positive or negative – come from their beliefs (Theory of Reasoned Action). Individuals also conduct their own cost-benefit analyses to determine if the outcome of the behavior change is worth the cost (Health Belief Model).

9. People are more likely to change behavior if they have an intention to do so. PROMISE for HIP shows what people go through to develop an intention to change behavior (Theory of Reasoned Action).

10. These messages gain credibility if they are diffused throughout the intervention community by appropriate peers or respected members of that community. PROMISE for HIP relies on peer advocates to distribute and discuss the role model stores within their own social networks (Diffusion of Innovation).

As this summary suggests, these theoretical concepts form the heart of PROMISE for HIP and guide implementation of the intervention.

DECIDING IF PROMISE FOR HIP IS RIGHT FOR YOU

In making a decision about whether or not PROMISE for HIP is right for your agency, consider the following.

PROMISE for HIP is right for you if:

1. You have an outreach component in your program. PROMISE for HIP requires outreach into the community. At the core of the intervention are peer advocates - who may be working along with outreach workers - and who distribute the role model stores to members of the intervention population.

2. You can maintain the confidentiality of the people you interview and interact with in the community. Role model stores are the experiences of real people. If you are unable to maintain the confidentiality of the individuals you interview, you would be violating the trust necessary to implement PROMISE for HIP. For example, if your agency requires you to report illegal activities - such as substance use - to authorities, or prohibits you from working with someone who is actively using drugs, then you will not be able to offer the confidentiality necessary to get the complete true-life story. Such constraints will limit the success of PROMISE for HIP.

3. You can be specific about the population and goal behavior you are working with. PROMISE for HIP was developed to address specific populations and goal behaviors that reduce the likelihood of HIV transmission or acquisition. The intervention will not be effective for use in a general population where characteristics and behaviors vary greatly. Rather, programs must focus their efforts on specific groups and specific behaviors, for instance daily PrEP use among young, Black gay and bisexual men ages 18-22 who attend XYZ college.

4. You are working with other services like HIV testing, linkage to care, navigation services, and PrEP. As the goal behaviors featured in PROMISE for HIP role model stories support movement along the HIV care continuum, programs must ensure that they can connect community members to appropriate services to help meet client needs and program goals, whether HIV testing, beginning PrEP, linkage to care, retention in care, or medication adherence. It is also important that programs are connected to other support services that may help address barriers for community members in initiating behavior change, such as mental health or substance use services, housing, etc.

WHAT DOES AN AGENCY NEED TO MAKE THIS PROGRAM WORK?

If your agency meets the following six conditions, your chance of success with PROMISE for HIP will be much greater.

1. Access to the intervention population. To collect the preliminary information needed to develop the intervention effectively, you must have access to the intervention population. This means you must have some idea where to reach them, what their issues are, and what makes them vulnerable to HIV transmission or acquisition or not engaging in HIV medical care. Your agency must be able to overcome obstacles to reaching the intervention population.

2. Right intervention staff (e.g, one program manager, two outreach workers, one staff to write role model stories, support staff). There are multiple components to PROMISE for HIP that require diverse staff skills, oversight, and trust in the community for effective implementation. Staff are needed to oversee program implementation; conduct the CID process, including conducting interviews and drafting a CID report; recruit and interview role models; draft role model stories; recruit, train, and supervise peer advocates; conduct ongoing evaluation activities; and document all program activities.

3. Existing HIV prevention program collaboration agreements with clinical settings and other community-based organziatons (CBOs). Partnerships and collaboration are key to successfully supporting clients' needs for HIV prevention, care, and treatment; comorbidities (e.g., viral hepatitis, mental health, substance use); as well as those that address the larger scope of social determinants of health (e.g., housing, food, employment, education, etc.). Even if your program is part of a larger organization that offers a "one-stop shop" for prevention, case management, and care services, it is essential that systems are in place to facilitate client navigation between services. For external services, programs should establish a memorandum of agreement or understanding (MOA/MOU) with each clinical and service provider to outline responsibilities; the mechanism for follow-up, including data sharing; and points of contact.

4. Commitment to conduct a preliminary CID process. This program will be effective only if it is tailored to the specific population whose behavior is being addressed. Your agency must make a commitment to learn about the community and resist the tendency to think you know everything you need to know about the intervention population. Although staff and volunteers may already be associated with the intervention population through social contact, cultural or ethnic ties, current or past behavioral association, sexual orientation, or a combination of these, they should never assume that those associations provide all the knowledge needed about the population in order to implement PROMISE for HIP (or any other prevention intervention). The preliminary CID process allows for a much better understanding of the structural, environmental, behavioral, and psychological facilitators and barriers to HIV risk reduction in your community.

5. Talent and motivation to write the role model stores. This does not mean that you have to hire professional writers. Training and technical assistance are available through CDC's Capacity Building Assistance (CBA) Provider Network to help develop the skills necessary to draft effective role model stories. Though the stories will come from structured interviews, it is important that the writer understand the behavioral theories supporting the intervention. The writer must not only be able to condense a long interview into an interesting short story, but must also have a firm understanding of the purpose and intent of the stories.

6. Resources to publish the stories. Programs must consider the cost of producing materials in their PROMISE for HIP budget. Print publications can be duplicated on the office copier, printed in four-color

slick brochures, or anything in between. Adding artwork—photos, drawings, or other graphics—will give life to the publication but will require additional resources if you don't already have access to them. In addition, developing digital publications will help expose your role model stories on digital platforms. Someone with design experience will be useful in the publication of the role model stores, and having someone with experience in creating digital publications will help your PROMISE for HIP program gain traction on social media.

AN IMPORTANT NOTE ABOUT FIDELITY AND ADAPTATION

Reminder: Maintain fidelity to the Four Core Elements of PROMISE for HIP:

1 Community identification process
2 Role model stories
3 Peer advocates
4 Evaluation

As a community-level intervention, PROMISE for HIP is naturally tailored to each unique community environment to best fit the community's needs, culture, etc. In addition, agency resources will determine how the intervention is implemented and what modifications, if any, need to be made to fit within budget limits. Resources may permit production of glossy color stories in one agency, black and white photocopies in another, or high-quality videos to post online at another.

However, there are limits to how the intervention can be modified. In order for your program to see the expected outcomes, the four core elements of PROMISE for HIP must be implemented with fidelity. Fidelity refers to how faithfully and accurately you implement the four core elements of the intervention as they are outlined in this manual. For questions related to adaptation and fidelity, you should seek technical assistance. Consult your CDC Project Officer or state health department representative for assistance requesting CBA.

SUMMARY

This introductory module provided an overview of PROMISE for HIP, the role of theory in the intervention, the four core elements, and factors to consider for implementation. Each of the subsequent modules will provide detailed information about implementation of the four core elements in PROMISE for HIP.

ENDNOTES

[1] CDC. “High-impact HIV prevention: CDC's approach to reducing hiv infections in the united states.” Updated Aug 2017. Accessed Dec 21, 2017. Retrieved from: https://www.CDC.gov/hiv/policies/hip/hip.html

[2] Centers for Disease Control and Prevention. Dear colleague letter. Sept 27, 2017. Accessed March https://www.CDC.gov/hiv/library/dcl/dcl/092717.html

[3] CDC, “Understanding the HIV care continuum.” July 2017. AccessedDec 21, 2017. Retrieved from: https://www.CDC.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf

[4] The CDC AIDS Community Demonstration Projects Research Group. (1999). Community-level HIV intervention in 5 cities: Final outcome data from the CDC AIDS Community Demonstration Projects. American Journal of Public Health 89, 336-345. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1508588/pdf/amjph00003-0058.pdf

[5] Becker, M. H. (1974). The health belief model and personal health behavior. *Health Education Monographs*, 2, 324-508; Janz, N. K., & Becker, M. H. (1984). The Health Belief Model: A decade later. *Health Education Quarterly*, 11(1), 1-47.

[6] Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention and behavior: An introduction to theory and research.* Reading, MA: Addison-Wesley; Ajzen, I., & Fishbein, M. (1980). U*nderstanding attitudes and predicting social behavior.* Englewood Cliffs, NJ: Prentice-Hall.

[7] Bandura, A. (1986). *Social foundations of thought and action: A social coqnitive theory.* Englewood Cliffs, NJ: Prentice-Hall; Bandura, A. (1991). Social cognitive theory of self-regulation. *Orqanizational Behavior & Human Decision Processes*, 50(2), 248-287.

[8] Rogers, E.M. (1995). *Diffusion of Innovations, Fourth Edition.* New York: Free Press.

[9] Prochaska, J. 0., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 3-27). New York: Plenum Press; Prochaska, J. 0., & DiClemente, C. C. (1992). Stages of change in the modification of problem behaviors. In M. Hersen, P.M. Miller & R. Eisler (Eds.), *Progress in behavior modification* (Vol. 28, pp. 184-218). New York: Wadsworth Publishing Company.

PROMISE FOR HIGH-IMPACT PREVENTION IMPLEMENTATION MANUAL

MODULE 2: COMMUNITY IDENTIFICATION PROCESS

MODULE 2: COMMUNITY IDENTIFICATION PROCESS (CID)

GOALS OF CID PROCESS

The purpose of the CID process is to learn more about your intervention population and community where you will be implementing the intervention. Additionally, through the CID process, your program staff will:

1. Gain access and build trust with the intervention population
2. Develop a big picture that tells you about issues in the community and in the intervention population, as well as a clear understanding of the composition of its subpopulations
3. Identify specific behaviors, the contexts in which they occur, and barriers that may put the intervention population at risk for STD/HIV infection or transmission
4. Recruit key players in the community to help create and distribute key messages through role model stories
5. Build referral networks

WHO AND WHAT ARE INVOLVED IN THE CID PROCESS?

There are multiple components to PROMISE for HIP that require diverse staff skills, oversight, and trust in the community for effective implementation. Key staff responsibilities during the CID process include:

- **Facilitate internal staff brainstorm.** Plan and conduct a brainstorming activity with staff to gather information about what staff collectively know about the intervention population, the local systems serving the intervention population, key individuals within those systems, and key members of the intervention population.
- **Engage and oversee community advisory group.** Identify potential members, form an advisory group, and request input on potential interview sources (systems interviews, intervention population interviews). The advisory group may also review the final CID report.
- **Develop a general plan for peer advocate recruitment, training, and supervision**. Describe plan in the CID report.
- **Conduct interviews**.
  - **Systems interviews.** Schedule and interview key individuals who have a formal or professional relationship with the intervention population and who can provide valuable information to inform implementation.
  - **Intervention population interviews.** Plan and interview members of the intervention population to learn about factors affecting their behaviors.
- **Review and summarize data.** Collect, compile, review, and summarize all data to stage community and plan CID report.
- **Draft the CID report.** Summarize findings from the CID process and plans for implementation.

CID PROCESS TOOLS AND RESOURCES

There are a number of tools in this guide that may help you implement activities throughout the CID process. Throughout the module, you will see this icon  where one of these tools is used. All the tools are found in the appendices at the end of this manual.

- 2-1 Community Identification Process (CID) Planning Worksheet
- 2-2 Staff Brainstorm Worksheet
- 2-3 Systems Interview Tool*
- 2-4 Safety Guidelines for Field Staff
- 2-5 Intervention Population Interview Tool*
- 2-6 CID Report Template*
- 2-7 Advisory Group Notes
- 2-8 Focus Group Checklist
- 2-9 Preparation of Focus Group Discussion Outline
- 2-10 Focus Group Guide and Questions

** Tool also provided during PROMISE for HIP training*

Community identification (CID) is a formative evaluation process to gather helpful information for the planning of a service and its delivery to a particular group of people. In the context of PROMISE for HIP, CID is important for identifying and describing structural, environmental, behavioral, and psychological factors that can facilitate or act as barriers to HIV risk-reduction, and for accessing and understanding the intervention population.

CONDUCT THE CID PROCESS

A critical first step in any STD/HIV prevention program is understanding the contextual factors and specific behaviors in the intervention population that may make them vulnerable to infection. When supporting people living with HIV, it is important to understand what barriers prevent engagement and retention in care. A program will be effective only if it is tailored to the specific population for which it is intended and if it addresses their unique needs. Although staff may already be familiar with the intervention population through social or professional contact, community ties, and/or lived experience, you should not assume that you already have all the information you need. Engaging the community and understanding diverse perspectives is essential. As every subpopulation has similarities and differences, the CID process helps you gain a clear understanding of the general and specific characteristics of the intervention population and the specific subpopulations with which you will be working.

To successfully conduct PROMISE for HIP, you must understand the intervention population, its subpopulations, and their behaviors from their perspective. It is important to note that if your organization is planning to implement PROMISE for HIP with two or more populations, such as HIV-negative MSM, individuals living with HIV, transgender persons, etc., you must conduct a CID process for each intervention population you wish to reach.

USE THE CID PLANNING WORKSHEET (2-1) FOR EACH INTERVENTION POPULATION YOU WISH TO REACH.

DEFINE INTERVENTION POPULATION AND SUBPOPULATION(S)

The CID process can help you define and learn more about your intervention population. There may be multiple subpopulations within an intervention population and it is important to define and prioritize these subgroups to best target your message.

Examples of intervention populations:

	CLINICAL SETTING	COMMUNITY SETTING
Intervention population	Persons with HIV (PWH)	African American MSM at increased risk for HIV
Potential subpopulations	▪ Newly diagnosed on ART ▪ In an HIV discordant relationship ▪ In the workforce	▪ Use substances ▪ In an HIV discordant relationship ▪ College students ▪ Find partners through dating apps

To define your intervention population and subpopulations, first take into account the stages of the HIV care continuum. You may also consider multiple descriptors such as race, ethnicity, gender, age, language, education level, employment status, geographic setting, organizational setting, among others. You should also learn about the population's sexual behaviors, substance use, and factors influencing behaviors including those that may hinder as well as foster positive behavior change.

For example, an organization that is funded to deliver PROMISE for HIP to young African American gay, bisexual, and MSM may identify multiple subpopulations within the overall population such as those who are:

- Attending school
- Working
- In the military
- Openly gay
- In a stable relationship
- Actively using substances

Review existing data

The first step to help your program define the intervention population and subpopulations more clearly is to review available data. The main goal of reviewing the existing data is to have an educated estimate in terms of how many people from the intervention population you will work with and include in the implementation of your intervention. Census data, epidemiological profiles, and internal needs assessment data may all provide unique insights into the intervention population.

- **Census data** provide information about the members of a given population collected through a government census. Census data include population count, ethnicity breakdown, income, and housing values for a geographic location. This information can provide you insight regarding the concentration of your intervention population and relevant social conditions.
- **Epidemiological profiles** describe the burden of HIV on the population of an area in terms of sociodemographic, geographic, behavioral, and clinical characteristics of persons with HIV. The profile is a valuable tool that is used at the state and local levels by those who make recommendations for allocating HIV prevention and care resources, planning programs, and evaluating programs and policies.
- **Internal needs assessments** may include client feedback and satisfaction survey data in which clients express needs yet to be met, affirm available resources in meeting their needs, and note gaps in services and resources.

STAFF BRAINSTORM WORKSHEET (2-2)

Conduct brainstorming activity with internal staff

The goal of conducting a brainstorming activity with your own staff is to document what you already know about the intervention population, while also developing a list of contacts outside of your agency who interact with the intervention population and may provide additional insight. Internal staff includes program staff (e.g., program manager, outreach workers, support staff, other PROMISE for HIP staff who will be involved in conducting interviews and role model story development, etc.), as well as agency staff who may not work directly on the project (such as administrators, HIV testing staff, peer navigators, etc.).

The task for internal staff is to brainstorm and document everything they know about the intervention population. It is important to understand where the intervention population lives and/or hangs out. Staff may have this information about the intervention population from other outreach activities, but some degree of community observation should also be incorporated early in the CID process. The list should include, but not be limited to race, ethnicity, gender, age range, language, trends, educational levels, employment status, clothing styles, geographic settings, risk behaviors, slang related to risk behaviors, where and how to access the population (this includes not only physical locations, but also virtual locations - dating sites and apps), barriers to access, ways to overcome or eliminate barriers, perceived risk, actual risk, factors that influence risk, people who are gatekeepers, informal networks within the population, internal resources, and other outside groups serving the population.Note names and contact information of people you know who are part of, have access to, or work with the population. The brainstorming activity will enrich your knowledge base before you begin conducting interviews and you may identify staff resources you didn't know you had.

Tip: You may consider conducting in-depth community observations or mapping prior to beginning interviews, particularly if staff do not have significant experience with the intervention population. See page 31 for more details on in-depth community observations.

From the information you have collected, you can revise the intervention population and systems interview guides. Based on emerging data, you may always revise the interview questions to reflect new types of information you wish to obtain.

SYSTEMS INTERVIEW TOOL (2-3)

Conduct systems interviews

As part of the CID process, it is important to speak with individuals who have a formal or professional relationship with the intervention population and who can provide valuable information to inform implementation. These individuals are known as systems people and may include clinicians and other health care providers, case managers, health department staff, patient navigators, substance use treatment providers, mental health counselors, parole officers, legal representatives, social service agency staff, and staff from other community-based organizations.

Systems interviews may help you further define subpopulations and identify potential strategies for reaching members of the intervention population. Often, external sources are able to identify specific locations where intervention population members may be found, and they can assist in identifying potential barriers to HIV prevention among intervention population members. Additionally, systems interviews may help establish relationships with other community providers and agencies and identify additional resources and referrals to help the intervention population with whom you and your staff interact.

Tip: If you identify a number of people at a given agency who are familiar with the intervention population, you may wish to conduct a group interview.

Plan to conduct between five and 10 systems interviews; you may stop if you are only being referred to people with whom you have already spoken or you are only getting answers you have already heard. The interviews may be conducted in person or via telephone.

Systems interviews should help answer questions about the intervention population, including:

- Existence, size, and description of subpopulations
- Understanding of HIV prevention, care, and treatment, including PrEP
- Sexual behaviors and substance use among the subpopulations
- Other behaviors that contribute to risk of HIV acquisition or transmission
- Locations and strategies to reach the population
- Potential barriers to accessing population members
- Literacy level
- Names and contact information for others who could be interviewed, with permission to use the name of the person who supplied the contact

Conduct intervention population interviews

The intervention population interviews will help your program identify the needs of the specific subpopulations to address through PROMISE for HIP role model stories. You should interview individuals from the area in which you will implement the intervention. Interviews with selected members of the subpopulation can tell you about their lives, how they view their vulnerability to HIV, and what they have done about it, all from the insider perspective. Through the intervention population interviews, you will identify: 1) the stage of change the community is in with respect to specific goal behaviors; and 2) potential barriers to adopting specific goal behaviors. It is this insider perspective that will help you understand the factors that influence behaviors for the particular population, identify appropriate role models, and plan appropriate and relevant role model stories.

Tip: If implementing PROMISE for HIP in a clinical setting, individuals selected for the intervention population interviews should access services at that clinic.

The Intervention Population Interview Tool is intended to help facilitate a discussion between the interviewer (a member of your staff) and the participant (a member of the intervention subpopulation). While the interviews are guided by a set of structured questions, spontaneous questions can and should also be asked to follow up on key points and to provide participants the freedom to describe their experiences in their own way. The interview tool is not a written document to be completed by the participant. Follow your agency protocols to obtain consent prior to the interview, specifically obtaining consent to record the interview as appropriate.

INTERVENTION POPULATION INTERVIEW TOOL (2-5)

Intervention population interviews should be conducted in person. Prior to conducting the interview, you should screen prospective interviewees to ensure membership in the intervention population. Depending on your program goals, you may plan to interview nine (or more depending on your program requirements and goals) individuals from each subpopulation or until you reach saturation (you start to hear the same responses from participants) - whichever comes first. This will provide you with enough information to identify the stage of change in the subpopulation for a particular behavior and some of the challenges faced by members of the intervention population.

One way to do these interviews is to record the audio and transcribe the interview so that the interviewer can concentrate his or her attention on having a discussion with the person, rather than documenting their responses. If audio recording is not possible, and in some cases these interviews will be done on the street where audio recording is impractical, take careful notes following the structured interview guide and review them immediately after the interview to make additions and corrections. These interviews are very important, so take the time and effort to do them well.

Identify the community's stage of change for selected goal behaviors

Responses to questions in the Intervention Population Interview Tool can help you stage the community for particular goal behaviors. For example, your program may have a goal of promoting PrEP use among your intervention population. Once you determine that the participants are not currently on PrEP, you would want to determine the stage of change for the subpopulation related to starting PrEP (goal behavior) by asking: *Do you intend to access and begin taking PrEP in the near future?*

Compile responses to determine the stage of change for the subpopulation for the given behavior.

If they respond….	Then they would be in this stage of change….
No	Pre-contemplation
Probably not	Pre-contemplation
Probably will	Contemplation
Yes	Contemplation OR Preparation

In this case, if they responded "yes," you would want to probe with additional questions to see what steps they have taken to most accurately determine whether they are actually in contemplation (thinking about it but haven't taken any steps) or if they are in preparation (taken steps toward the goal behavior, such as finding out where PrEP is offered or making an appointment with a health care provider).

Tip: You can substitute other behaviors and modify questions as needed to determine the stage of change for other behaviors along the HIV care continuum, such as HIV testing.

Identify potential role models and peer advocates

Agency staff, such as outreach workers or community health workers, may help identify potential role models or peer advocates through their interactions in the community. Additionally, conducting interviews with members of the intervention population also provides you with the opportunity to identify other key individuals in the community who are taking steps to reduce their risk for STDs/HIV or improve their health. They may provide you a wealth of information during additional interviews to develop your role model stories and/or may potentially serve as peer advocates.

Debrief and summarize data

Program staff should meet to discuss and process the CID experience. During this debriefing session:

- Identify intervention population(s) and focused subpopulation(s)
- Identify goal behaviors to address
- Identify behavioral determinants
- Stage intervention population for selected goal behaviors

Summarize CID notes, transcripts, and other data to present in a written report. The CID report documents the activities you conducted, as well as what you learned from the community. It also provides an important rationale and justification for the intervention activities you undertake. You will also be able to identify where information is incomplete or missing and whether additional identification work is needed.

Develop the CID Report

CID REPORT TEMPLATE (2-6)

Discuss expectations for the CID report with your project officer or contract monitor and confirm any requirements for review and submission. A CID report may contain the following sections:

1. Introduction (half page)
   a. Introduction to PROMISE for HIP
      i. Why are you doing PROMISE for HIP?
      ii. What is the perceived need for PROMISE for HIP in your community?
   b. Funding source
   c. Expected outcomes
2. Description of CID process and results (two-three pages)
   a. Selection of implementation site
   b. Brief summary of number of each type of discussion/interview conducted
      i. Internal staff discussion/brainstorm
      ii. System interviews
      iii. Intervention population interviews
   c. PROMISE for HIP population selection
      i. Intervention population
      ii. Subpopulations—demographics and other characteristics
      iii. Process of prioritization
      iv. Selection of intervention population—description and justification
   d. Intervention population risk behaviors, risk factors, behavioral determinants
      i. Risk behaviors
      ii. Risk factors
      iii. Behavioral determinants of risk or influencing factors
   e. Barriers and methods to overcome behaviors
   f. Methods to establish presence and trust
   g. Acceptable and unacceptable messages and means of access
   h. Estimate of intervention population and plans to access the 15 percent
      i. Develop a plan for accessing intervention population based on 15-percent criteria
      ii. Estimation of subpopulation size
   i. Community partners and referral networks

3. Community staging results (half page)
4. Initial role model stories (one page)
   a. Brief description of each initial role model story based on eight key components
      i. Risk behavior, goal behavior, stage of change, behavioral determinant and barrier to change method to overcome, characterization, membership, positive outcome
      ii. Risk factors using the HIV care continuum indicators you want to use
      iii. Results from initial role model story pilot with community advisory group
5. Peer advocate plans (one page)
   a. Plans for recruitment of peer advocates
   b. Training plans for peer advocates
   c. Retention plans for peer advocates
6. Plans for ongoing evaluation (plan for revisiting CID data every 3, 6, or 9 months) (half page)
7. Appendices
   a. Include final examples of initial role model stories
   b. Include specific tools used (especially if they have been adapted)
   c. Timeline for full implementation

Ongoing CID

CID does not end when the intervention begins. The process of interviewing members of the intervention population needs to continue throughout the intervention to keep current the information on language, key messages, behaviors, and movement in the community's stage of change since these are key factors for each round of role model story development. To assess community movement in terms of stages of change, conduct staging interviews every six months.

If the majority of the community starts in the contemplative stage for a particular behavior, you will be developing stories that show a movement to preparation. As the community moves to preparation, the stories need to switch to show a movement to action. Ongoing CID efforts provide this information. CID can also assist in some of the process evaluation efforts, particularly whether or not the community members are reading the materials.

Tip: More information about ongoing CID efforts are described in Module 5: Evaluation.

SUMMARY

The CID process is a critical element in preparing to conduct PROMISE for HIP. This module discussed the key steps and issues in the process, which provides an understanding of the practices that make a community vulnerable to HIV infection or transmission, the meaning of those practices to population members, and the context in which the behaviors occur.

The following section provides some additional optional activities to gain further insight into the intervention population. The next module introduces role model stories and discusses how to conduct interviews and develop stories from those interviews.

*OPTIONAL

Opportunities to collect additional information about the intervention population

The major activities described above (i.e., internal staff brainstorm, systems interviews, intervention population interviews) are the minimum activities needed to complete the CID process. If your agency or clinic has the resources, you may also consider additional activities to gather information about the intervention population. These activities were part of the original Community PROMISE implementation and include community observations, community and micro-site mapping, gatekeeper interviews, and focus groups. Each of these activities is described in the section that follows.

Conduct in-depth observations

Throughout the CID process, you can gather valuable information through field observations at the sites where outreach may take place. Conducting in-depth field observations allows you to document the characteristics and activities of intervention population members such as how a commercial sex worker solicits a date, or how people who use drugs interact with each other. Observations tell you about the community, such as the physical layout, the relationships of people in and moving through the area, the activities occurring that you can see, and the general "feel" of the area. Field observations establish the presence of outreach staff members, which earns the trust of the intervention population. They also help you identify the sites where the largest number of intervention population members can be reached, so you can plan the best locations for outreach and distribution of role model stories. Conducting community observations can also be an ongoing activity, which will allow you to be aware of changes in the type of activities in the area, law enforcement efforts, new people in the community, etc.

Although useful in producing rich and varied data, observation can be affected by a number of factors:

- The observer's interests, experience, and expectations
- An observer jumping to conclusions
- The length of time an observer waits until compiling notes—the longer he or she waits to complete a write-up, the less likely these notes are to be accurate and perceptive
- Being observed may lead to individuals changing their normal pattern of behavior

In order to provide a complete picture of the activity that takes place at a certain site, observations should be done at all times of day and every day of the week. Although as an observer you will be noticed, you

should try to fit in as much as possible by assuming a casual approach and dressing similarly to the specific group being observed. At first, observers may want to limit or avoid interaction with the individuals present, keeping conversations low-key in order to allow people to get used to their presence. If asked, be honest about what you are doing and your organization. This allows trust to form. Carry identification but little or no money or jewelry. A list of safety guidelines for field staff is included in Appendix 2-4. These guidelines are also useful for conducting intervention population interviews and any time you and your staff are in the field.

SAFETY GUIDELINES FOR FIELD STAFF (2-4)

What is observation?

The most natural and obvious way to collect information is to simply watch, listen, and record what is happening. Observation is unlike other methods that rely on self-reported behavior or other data sources. Instead, it allows the observer to gain first-hand experience of the meanings, relationships, and contexts of behavior. The observer learns by being present; by seeing what people do and how they interact; by listening to what they say; and noticing the sounds, smells, and seemingly insignificant details of the environment.

Community observation can be conducted throughout the entire CID process, and as an ongoing PROMISE for HIP activity.

At an early stage of the CID process, observations may be used to:

- Highlight areas for materials distribution, map key areas, establish means of accessing the intervention population, identify key informants
- Gain an understanding of local behaviors, vocabulary, and customs

During the middle stage of the CID process, observations may be used to:

- Confirm findings from other methods and data sources
- Explore specific topics or behaviors further

At the ongoing stage of the CID process, observations may be used to:

- Confirm findings from other methods and data sources
- Assess the representative nature of the your findings (this could be through repeating observations with different groups in different areas)
- Outline potential problems and possible solutions for recruiting peer advocates and distributing materials

What can be observed?

Almost anything can be observed during community observations. However, this does not mean that observers should conduct observations that observe everything. An inexperienced observer may make the mistake of trying to record or remember every detail of a situation because he or she is worried that something important will be missed or is unsure what is actually of interest.

Rather, observers should concentrate their observations on specific aspects of a situation. To help ensure that observations are undertaken systematically and consistently among observers, the following elements should be considered.

Elements of Observation	
Settings	Where does the observation take place? When? What is the physical layout? What kinds of physical characteristics are present?
People	Who is present? Numbers? Gender, age, race, ethnicity?
Activities	What is going on? What activities are the people involved in?
Signs	Are there any clues that provide evidence about meanings and behaviors?
Acts	What are people doing?
Events	Is this a regular occurrence? Or is it a event such as a meeting?
Time	In what order do things happen? Is there a reason for this?
Goals	What are people trying to accomplish?
Connections	How do the people know one another? Is their relationship social or organized on a commercial basis? Does the relationship change over time?

Not all of these elements can or should be observed at one time. Where observers feel that there are an overwhelming number of aspects that could be observed, they should:

- Prioritize each element in terms of its importance to the CID process and deal with these in turn. This is normally done when a situation is unlikely to be repeated or could end at any moment.
- Ask co-workers to help. This is only possible when the situation under observation would not be disturbed or interrupted by additional observers.
- Observe a limited number of aspects and try to repeat the observation at a later date. This can be useful where a situation is frequently repeated such as interactions at a needle exchange program.

Where and when should observations be conducted?

Observers should try to conduct observations where the most important behaviors and activities are likely to occur. This may involve gaining access to "difficult to reach" populations. Sometimes the observer may accidentally come across interesting situations, but it is better to anticipate when and where relevant behaviors and events are likely to occur.

- Observation can aid and improve knowledge through mapping the community and listing items/events observed.
- Knowledge from such mapping and listing exercises can benefit further observations. This is particularly useful for distinguishing between regular and unusual events.

Where and when should observation not be conducted?

Some observers may wish to observe all kinds of behaviors and events. However, some of these might be better investigated using other methods. There are also certain times and places when observations should not be used. These include situations where an observer may place themselves, participants being observed, or the larger CID process in a vulnerable or compromised position.

Community mapping

Maps are one product of community observations. You may create maps that are both physical elements of the areas in which you will be working, as well as locations where different subpopulations seem to cluster. You may later use the maps to mark locations where peer advocates are located, where they are distributing materials, where you have established condom distribution points with partners, etc. These maps give you a quick and visual snapshot of the area in which you are working and the work you are doing. Maps are useful as they can provide graphic representations of often complex information. Mapping is a continual process. New locations and areas of interest will arise during the CID process and these can also be mapped. See figure A below for a sample map. There are three main steps in mapping an area.

1. Obtain an up-to date map of the locality. If a map is not available, draw your own. This need not be drawn to scale. However, it should be large enough to allow sufficient details to be recorded. Note all streets, alleys, buildings, other landmarks.

2. Walk through the area a number of times. You should note important features, check the layout, make rough sketches, and add detail to the map. Add names of businesses, locations of high activity, gathering spots, social service agencies, faith-based organizations, etc.

3. Talk through the area. As you talk with **interactors** and **gatekeepers** you can add to the information on your maps. You will learn of new gathering spots, new social networks, and potential peer advocates.

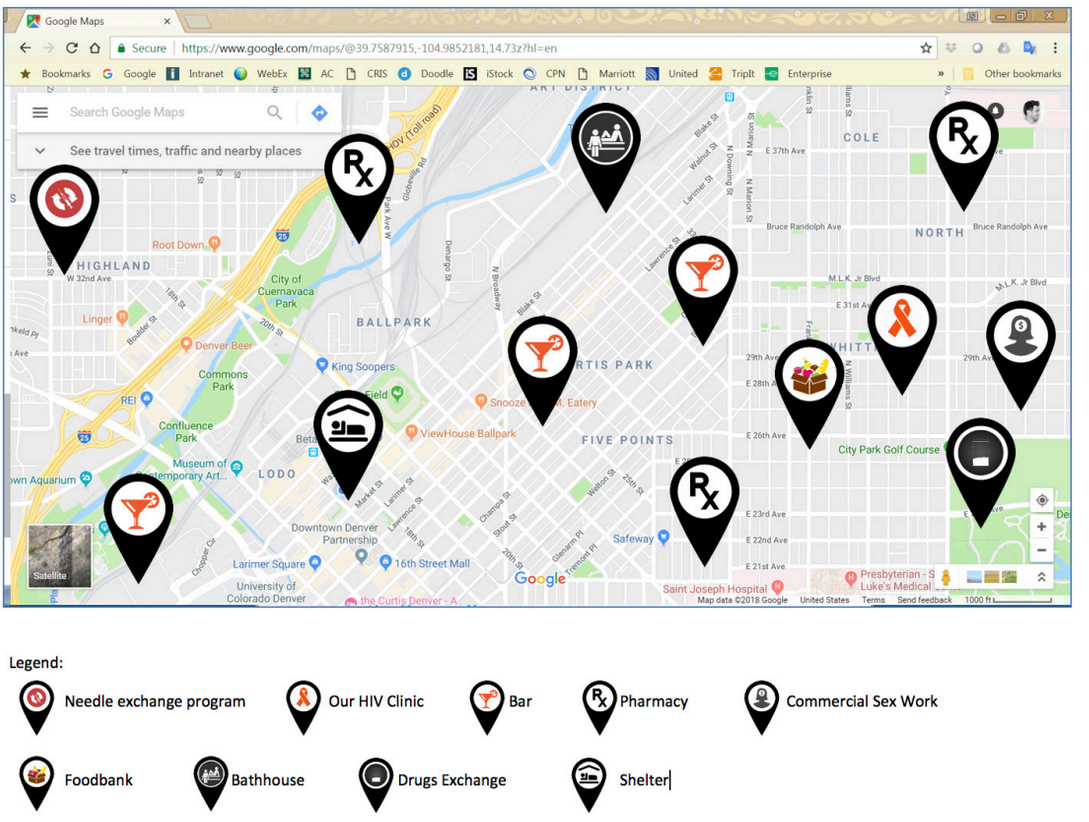


Figure A, Sample PROMISE Map

Interactors - people who engage with the intervention population but are not members of either the formal system (such as the legal or social service system) or of the intervention population. Examples: shopkeepers, taxi drivers, hairdressers, park attendants, bus drivers, motel clerks, bartenders, liquor and convenience store clerks, former intervention population members.

Gatekeepers - Individuals within a given intervention population who can allow or prevent an outsider's entrance into a community. They are often informal leaders who are respected or admired.

Conduct Gatekeeper Interviews

Gatekeepers are individuals within a given intervention population who can allow or prevent an outsider's entrance into a community. They are often informal leaders who are respected or admired. Their endorsement can facilitate the acceptance of staff members who are not part of the intervention population. The purposes of gatekeeper interviews are: (1) to gain access to intervention population members; (2) to learn more about the HIV risk and perceptions of the intervention population; and (3) to introduce PROMISE for HIP to the population through its highly regarded members.

As you conduct the CID process, create a list of people who are perceived as gatekeepers in the intervention community. You will be able to contact them and say that you have been referred to them by a person you have already interviewed, someone with whom the gatekeeper has an established relationship of trust. This referral process will greatly increase the chances that the gatekeeper will be willing to speak with you about your project. A well-connected gatekeeper will already know that you are in the community. Be sure to send your best people to see gatekeepers – staff who can clearly speak about the purposes and activities of the project, the role for the gatekeeper, and the importance of working with the community. These gatekeepers can make significant contributions to the success of your program or cause its failure.

Gatekeeper interviews take place following the internal staff brainstorm and systems interviews, but usually before intervention population interviews or focus groups. During the internal staff brainstorm, some gatekeepers will likely be identified. These individuals can be approached and, after the project and its purpose are explained, asked for an interview. It is important to familiarize them with your program and its goals before meeting with gatekeepers; gaining their trust and respect is essential. Let them know they are an important part of the program.

Gatekeeper interviews are typically conducted in field settings. Often, gatekeepers introduce staff members to the places frequented by the intervention population and the people they know in the area. Gatekeepers can also help to identify members of the intervention population to interview. Gatekeepers can be among the most valuable advocates for the program by spreading program awareness and helping to secure more participants. Gatekeepers can become advisory group members, recruit peer advocates, and identify initial role models.

Focus Groups

Focus groups are group interviews where a moderator raises topics while a small group of participants discusses them in comfortable terms. Ideally, focus groups are composed of six to 10 individuals who come from similar backgrounds. One or two well-trained and experienced moderators work from a predetermined set of discussion topics. The interview is usually recorded on audio and/or video, and note-takers may be assigned to record observations.

Focus groups are extremely important because they create lines of communication among the participants. Just as important, however, are the lines of communication that connect the program staff with the participants. First, program staff determine what they need to learn from the participants. Second, the moderator facilitates a focused conversation among the participants. Third, the moderator and members of the team summarize what they have learned from the participants. If you do not have staff in-house with focus group expertise, you should seek external resources.

There are four basic steps for designing a successful focus group. A checklist to help prepare the day of the focus group is included in Appendix 2-8.

FOCUS GROUP CHECKLIST (2-8)
PREPARATION OF FOCUS GROUP DISCUSSION OUTLINE (2-9)
FOCUS GROUP GUIDE AND QUESTIONS (2-10)

Planning

- Determine what information is needed with a clear, specific list of objectives.
- Determine how to divide groups. Sometimes it may be appropriate to divide participants of different genders, racial/ethnic backgrounds, and educational levels into separate groups.
- Determine how many focus groups you want to conduct. As a general rule, conduct at least one group interview with each subpopulation.
- If the intervention group is spread out over a wide area, consider conducting focus groups in multiple locations.
- Determine the duration of the focus group. 1 ½ to 2 ½ hours is usual.
- Determine how many moderators will be necessary given the number of groups you will be conducting. Also, moderators should have similar backgrounds to the population being interviewed. At the very least, they should be comfortable interacting with them.
- Prepare a realistic timeline. For example, if you have not recruited for a focus group before, or if you are relying on other organizations to assist in recruiting, allow yourself at least three weeks for the recruiting phase.
- Budget appropriately. While you want to leverage available free space and existing resources, costs for each focus group may include transportation, rental fees, food, incentives, and transcription, among others.

Recruiting

- Develop eligibility and exclusion criteria for individual participants.
- Develop the screening specifications, including how many participants to screen and invite to the groups and the demographics of each group.
- Develop a screening questionnaire for help in determining which individuals meet the eligibility criteria.
- Develop a one-page flyer explaining the program and promoting participation.

- Determine a recruitment strategy. Will you rely on the program staff's own networks? Will the program staff get assistance from outside referrals but do all the screening themselves? Will program staff delegate some screening to outside referral sources, such as volunteers or another agency (not recommended; try to avoid if you can)?
- Once the strategy has been determined, complete the recruitment plan.
    - Identify where and when to contact the intervention population.
    - If appropriate, identify outside referral sources for possible assistance.
- Allow at least two to three weeks for recruiting.
    - Be aware that posters, leaflets, and announcements are likely to be insufficient for recruiting focus group participants. People who respond to them may be unqualified for the group in some fashion, may develop fake qualifications to make themselves seem eligible for the incentive, or may have a personal characteristic that you would have screened out had you interviewed them in advance.
    - Contact prospective participants who have responded to the posters and announcements individually. They should be screened and invited to participate once it appears they meet the qualifications (for instance, sufficiently verbal but not uncontrollably verbose, willing to discuss intimate topics, etc).
    - Once an eligible individual agrees to participate, a confirmation letter/email should be sent (if possible and appropriate) and reminder calls/texts can be made.

Throughout recruitment, assess how recruiting is going so problems can be quickly identified and solved. One problem you will face is participants failing to show up to the focus group. Over-recruiting will minimize this. If you are looking for eight people in each group, it is wise to recruit 15 to 16. Anticipate barriers to attendance and ways to overcome those barriers, such as providing childcare or transportation. If more than the needed number of people present for the group, thank those who arrive last, pay them the incentive for coming, and invite them to attend a future group, if appropriate.

Moderating

FOCUS GROUP GUIDE AND DISCUSSIONS (2-9)

Included in Appendix 2-9 is an outline to assist the moderator in preparing for the focus group discussion and sample focus group questions.

- Listen carefully and use active listening techniques. Be interested in the participants and show positive regard.
- Be a moderator, not a participant. Do not express your own opinions.
- Control your reactions and never evaluate responses, not even in facial expression or body language.
- Use words to reward thoughtful, relevant responses.
- Encourage group cohesion and interaction in the first 15-20 minutes of the group:
    - Pose provocative questions that ask for people's opinions.
    - Pose questions to the group, not individuals.
    - Use silence to signal that group interaction is wanted.
    - Avoid eye contact with participants who persist in interacting with the moderator in a one-on-one fashion.
    - Get nonparticipating group members to speak through the use of eye contact or by calling on them directly.

- Discourage individuals from interrupting each other by saying, "Let's let ___ finish."
- Discourage side conversations.
- Watch time carefully. Constantly monitor the discussion for relevance.
- Be flexible. If one question doesn't work, try another.
- Probe for both clarification and motivation; probing should be simple and specific.
- Ask for feelings directly if you want to discuss them. Participants may be reluctant to offer their feelings without being asked.
- Intervene as gently and as infrequently as possible as a general rule.
- Never answer substantive questions or play the role of the expert. If the discussion depends on a minimum level of participant knowledge, introduce the information through written materials.
- Avoid taking notes.

Analysis

The data from the focus group are analyzed to obtain the information needed to develop the program. It is not very helpful to have a focus group report that contains only raw data (i.e., transcripts that present the exact statements of focus group participants as they responded to specific questions or topics). Summarize participant comments and group as themes, including common or insightful quotes to illustrate themes and note how often comments were made. From the summary, you may generate ideas regarding future courses of action. Depending on the information provided by the focus group participants, recommendations might be made regarding the topic area—for example, where and how should recruitment of the intervention population take place, or what beliefs about HIV risk-reduction should be addressed in the intervention.

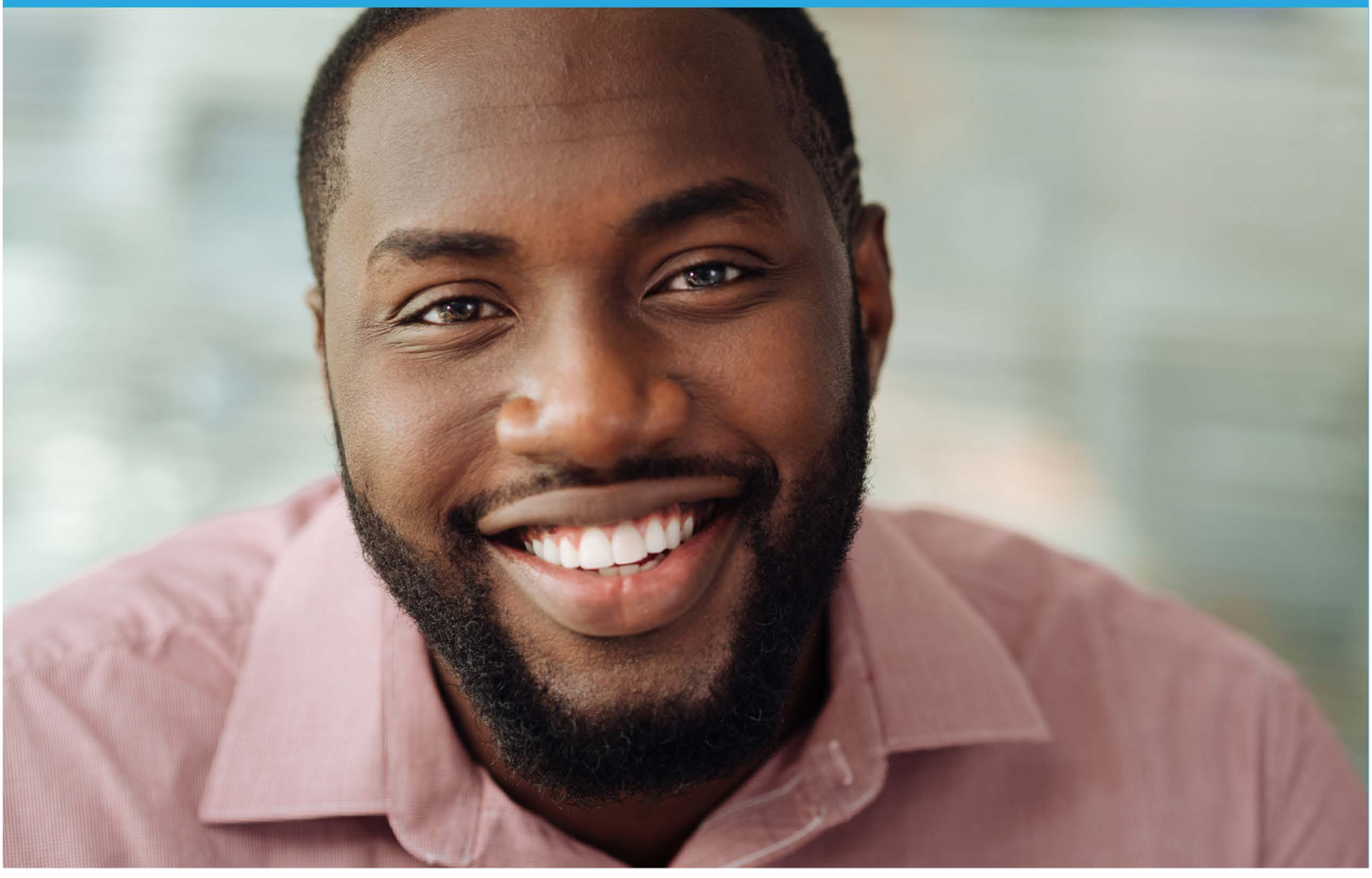
Debrief and summarize data

Program staff should also meet to discuss and process any additional data collected through observations, mapping, interviews, and focus groups. During this debriefing session:

- Identify what new and additional information you learned.
- Note important gatekeepers with whom you want to maintain a relationship or revisit at a later point.
- Make any additional entries on the maps to indicate points of access, places to recruit advocates, etc.
- Identify any gaps in knowledge that remain, which can then be addressed in later surveys.

PROMISE for High-Impact Prevention Implementation Manual

MODULE 3: Role Model Stories



MODULE 3: ROLE MODEL STORIES

ROLE MODEL STORIES (RMS)

Role model stories (RMS) are short narratives (~200-400 words) that depict personal accounts from individuals in the intervention population who have made or are planning to make positive behavior changes. RMS are based on actual experiences of members of the community and illustrate the positive outcome of making a particular behavior change.

Tip: RMS only show movement from one stage of change to the next for a specific behavior.

GOALS OF RMS

1. Provide a genuine, acceptable, and engaging depiction of a role model's real life experience
2. Illustrate how the role model overcame an obstacle when moving from one stage of change (for a specific behavior) to the next stage
3. Motivate movement toward the desired goal behavior

Role models are frequently identified during the CID process. The role models are not required to demonstrate perfect behavior, but they must show some action or movement toward adopting healthy behaviors and reducing their risk of HIV transmission or acquisition. Depending on the specific populations they are intending to reach and the behaviors they are trying to influence, RMS may focus on various HIV prevention strategies and behaviors across the HIV care continuum, however each RMS only focuses on one behavioral goal. The stories are distributed and reinforced by trained **peer advocates** from the intervention population.

Tip: See Module 4 for information on peer advocates.

PROMISE for HIP RMS may highlight:

- Condom use
- Consistent PrEP use
- Avoiding sharing needles and other injection equipment or using clean injection equipment
- HIV testing
- Linking to care following a positive HIV test result
- Retention in medical care
- Adherence to HIV medication

The best RMS are based on stories from individuals in the intervention population. Depending on your agency's resources and what you learned in the CID process, there are some additional options to help you begin rapidly developing and disseminating stories. These options are described below as good, better, or best options:

Good - Use a generic RMS that has no local references. You may also recycle or repackage RMS in the CDC PROMISE for HIP compendium or those used by other agencies. You may also choose to develop a story from popular media sources (e.g., magazines, videos) or your own experiences based on CID results.

Better - Use a generic RMS and add local references or flavor. Add references to known parts of town, events, hangouts, local bars, etc. Remember to pre-test your materials to ensure that local references are acceptable.

Best - Develop your own RMS with local references or flavor using the experiences of real people from your intervention population.

Following are two RMS examples:

RMS Example #1: "Party and PrEP"

PNP? Yeah, man. I've partied and played with guys. Some are poz and others are neg. And my buddies here in the hood do it too, man. The thing is, when I've done drugs, I've done it bare too. I know I should use rubbers. It just ain't easy to think of it when I'm high. Last year, one of bros told me about him being on PrEP and I thought it could work for me too. I went to the clinic on Main Street and started PrEP and started popping the pill every night to not get the bug. I felt I was taking care of myself and let my tricks know that by seeing it too, you know? It worked well until a few times when guys saw me taking the pill. The dudes just freaked out and left. I didn't know what to do. I even skipped PrEP a couple of times so guys wouldn't judge.

I'm smart, you know? I want to stay HIV free by not skipping a pill but I don't have to take the pill in front of anyone. So about three months ago I started to pop the pill before partying. It might seem like not a big deal now but even when I forgot to take PrEP before a trick, I'd just go to the bathroom, pop the pill in private, and I'm ready for the action. I'm prepared and I don't have to prove it. I'm taking my pill every time. Even when I PNP, I call it Party and PrEP.

Characterization: Latino man who has sex with men
Membership: Uses drugs and is on PrEP
Risk behavior: Skipping PrEP doses
Goal behavior: Consistent PrEP use
Stage of change: Preparation to action
Behavioral determinant: Perception of risk
Barrier and method to overcome barrier: Did not want to take in front of others; takes pill in bathroom privately
Positive outcome: Taking PrEP as prescribed

RMS Example #2: "Afraid to Tell"

I've been in New York City less than a year now pursuing my nursing degree. Meeting people hasn't been so easy since my boyfriend and I split and I tested positive for HIV. Physically, I feel strong and healthy, but emotionally I feel alone and depressed. How can an intelligent nursing degree major be HIV positive? I am embarrassed and ashamed; I should know better. I am afraid to tell the world, especially my parents who live in Atlanta. They know about my sexual identity and they are supportive. Most importantly, they told me to take care of myself. I have let them down. See, this can't be happening to me. Yesterday, in class my teacher, whom I admire and respect, told us about new HIV treatments and the progress science is making with respect to treating HIV infection. "HIV doesn't have to be a death sentence anymore," he mentioned. After class, I thought about my life, my family, and my situation. I am thinking I should get into care as soon as possible since my professor says that early antiretroviral therapy can really fight the virus pretty well. I know that my life changed when I learned about testing positive, but I have been postponing this for the last 6 months or so. Also, I am afraid to tell my parents; they don't deserve this, but it is what it is….Tomorrow, I will go to the hospital to talk with the doctor about my options, and of course call my parents. That is what they would like me to do.

Characterization: Gay man living in NYC, nursing student
Membership: Living with HIV but has put off getting into care
Risk behavior: Not in care/not on antiretroviral therapy
Goal behavior: Linkage to care
Stage of change: Contemplation to preparation
Behavioral determinant: Knowledge
Barrier and method to overcome barrier: Fear of disclosure; made a plan to call his parents
Positive outcome: Planning to go to the doctor the next day to talk about treatment options

WHO AND WHAT ARE INVOLVED IN THE DEVELOPMENT OF RMS?

There are multiple components to PROMISE for HIP that require diverse staff skills, oversight, and trust in the community for effective implementation. Key staff responsibilities during the development of RMS include:

1. **Conduct role model interviews.** Schedule and interview key individuals who are part of the intervention population and have made or are in the process of making positive changes related to the goal behavior identified in the CID process.

2. **Transcribe interviews.** Review interviews and plan RMS development.

3. **Draft the RMS.** Draft the RMS to include all PROMISE for HIP RMS components.

4. **Design RMS for print and/or digital publication.**

5. **Coordinate RMS promotion and/or dissemination via social media.** Develop PROMISE for HIP social media protocols (following CDC social media and agency guidelines) and develop promotion and dissemination plan.

6. **Review and pilot RMS.** Engage the community advisory group, peer advocates, and other staff to review and provide feedback on RMS.

RMS TOOLS AND RESOURCES

There are a number of tools in this guide that may help you implement activities throughout the RMS development. Throughout the module, you will see this icon where one of these tools is used. All the tools are found in the appendices at the end of this manual.

- 3-1 Consent to be Interviewed Template
- 3-2 Consent to be Photographed Template
- 3-3 Role Model Story Interview Tool
- 3-4 Planning your Role Model Stories
- 3-5 Behavioral and Social Determinants
- 3-6 Eight Key Components of a Role Model Story
- 3-7 Role Model Story Content Worksheet
- 3-8 RMS Pre-Test Worksheet

DEVELOPING RMS

Step 1: Gather information

Specify a subpopulation and behavior

As described in Module 2, the CID process provides you with information about your intervention population, the behavior(s) you are planning to target, and the stage of change the population is in for that particular behavior. The first step in developing a RMS is to narrow – or segment - your intervention population and identify both the subpopulation and behavior you will address through your RMS.

Example

Your PROMISE for HIP program is funded to promote PrEP use among gay and bisexual men of color in South Carolina. During your CID process you identified that Black men in college who live in metro Columbia, SC and identify as gay find most of their sexual encounters through mobile apps and dating sites – and most of these young men are not on PrEP.

You determine that to best address the PrEP needs of this community, you will focus your RMS on Black gay men ages 18-24 who go to college in Columbia, SC and find their sexual partners online or from dating apps.

Each RMS should focus on **only one behavior**. If you identified through your CID process that the identified subpopulation engages in various behaviors, such as condomless anal sex with multiple sex partners and are resistant to condom use, but have considered the suggestion of taking PrEP, then you might want to focus your initial efforts on increasing the use of PrEP among this community.

Recruit role models

The CID process also is helpful to identify potential role models. To be credible, RMS must contain elements of racial, cultural, and socioeconomic experiences common to individuals in the subpopulation. For this reason, it is very important to elicit stories from actual members of the specific population in geographic areas in which the stories will be distributed.

Good role models do not have to practice the target behavior perfectly. A good role model is someone from the identified subpopulation who has made a positive change regarding the specific behavior to be modeled. For example, role models are not just the individuals who have been using PrEP all the time as prescribed, but also those who have only started using PrEP.

Other program or clinic staff may also refer or recruit potential role models. Outreach workers may recruit the role model by using established, trusted contacts in the community.

Screening potential role models

Outreach workers should screen potential role models to make sure the individuals are part of the intervention population. Good rapport and a trusting relationship between the outreach worker and potential role model will help to ensure that the role model will be willing to speak openly to the person conducting the interview. Your agency can decide whether or not to provide incentives to role models to participate in interviews and share their stories (e.g., gift cards, transportation, program materials T-shirts, water bottles. etc.).

During the screening, consider the following:

- Does the role model's experience fit with the target goals of the RMS (e.g., appropriate stage of change of the goal behavior)?
- Does the role model practice (or to what degree is there an intention to practice) risk-reducing behaviors in order to prevent the spread of HIV and other STDs?
- Is the role model able to recall and describe specific details about past and present risk and goal behaviors?
- Is the role model willing to share detailed personal experiences about relevant, intimate aspects of his or her life, including sex- and drug-related behaviors?
- Does the role model understand how the information will be used and that the interview will be recorded?
- Does the role model agree to give the time needed for the interview?

Prior to the final selection, the interviewer should personally screen the potential role models to assess whether the individuals can provide worthwhile material for the stories.

ROLE MODEL INTERVIEWS CAPTURE THE ELEMENTS NEEDED FOR THE STORY AND RECORD THE PERSON'S OWN WORDS DESCRIBING THEIR EXPERIENCE AND THE CIRCUMSTANCES SURROUNDING THE BEHAVIOR CHANGE.

Interview role models

Because the outreach worker and the role model have established a relationship, the role model may not want to disappoint or shock the outreach worker; therefore, he or she may be less truthful about the story. Likewise, the role model may want to impress the outreach worker. To minimize the possibility of the role model altering his or her story, someone other than the outreach worker may conduct the role model's interview. This person could be the program coordinator or other staff. However, if your agency has limited staff resources, an outreach worker may conduct the interview.

Where to conduct the interview

Ideally, the interview should be conducted in a private room. However, other settings may be used if a private space is not available. Community locations that offer some privacy are options. The key is to provide a safe environment with minimal distraction, where the role model feels comfortable disclosing personal information, and where you can record the interview with minimal background noise.

How to conduct the interview

It is best if the interview is recorded. Recording and transcribing the interview will provide the writer of the RMS with exact words and expressions, and allow the interviewer to focus on the interview instead of taking comprehensive notes. The recording will also allow the interviewer to review the session repeatedly and at a comfortable pace.

If a digital recorder is not available or appropriate, the interviewer can take notes during the interview. However if taking notes, it may be more difficult to capture the role model's own words, remain engaged in the discussion, and record all the details they share.

Obtain consent

Before the interview, obtain consent from the individual to be interviewed and recorded. If you do not currently have a consent form specific to PROMISE for HIP, it is a good idea to develop one. A sample, to be adapted as necessary, can be found in Appendix 3-1. Review the consent form verbally with the potential role model before you begin the actual interview. The role model should sign the form and be given a copy to keep. Also, remember to record the role model's name if they choose to disclose it, and any nicknames they may have when you conduct the interview. If they want to remain anonymous in the story, the real name and any nicknames are kept confidential.

CONSENT TO BE INTERVIEWED TEMPLATE (3-1)

Show the role model an example of a RMS or the publication in which the story will appear. This allows the role model to understand how their story will be used and feel comfortable with the process. You should not reveal their true identity unless they have given explicit permission to do so. You should also obtain consent for any photography of role models or others, to be used in RMS publications. A sample consent form for photography is in Appendix 3-2.

CONSENT TO BE PHOTOGRAPHED TEMPLATE (3-2)

Conduct the interview

During the interview with the role model, pose questions clearly and concisely using simple words and phrases. The interview questions should be designed to elicit responses that will make up the elements of a RMS (discussed in Step 2). When asking questions, it is important that the interviewer not lead the role model in a certain direction by communicating his or her own ideas.

ROLE MODEL STORY INTERVIEW TOOL (3-3)

The interviewer must not attempt to counsel the role model or provide feedback during the interview. After the interview is completed, the interviewer should correct any misinformation the role model gives, furnish information about STDs and HIV, and provide referrals if needed.

Tip: Ask open-ended questions that allow the role model to tell his or her own story and share relevant details.

Often, a single interview can yield enough information for several RMS. It may be possible to create a series of stories that follows one individual through his or her own behavior change process. This series may chronicle the individual's initial reluctance to change, his or her development of a commitment to change, the first attempts at change, and eventual consistent adoption of the new goal behavior.

Tip: Each story depicts movement through one stage of change.

You may also find the need to make minor tweaks to the story to fit the needs of the intervention and the required RMS components. The final RMS may look a little different than the way it was initially told. Ensure that you are following agency guidelines and communicate to the role model the potential for modifications in the final story when you obtain consent prior to the interview. It is not appropriate to look for consent to alter the story after the interview has been conducted.

Transcribe the interview

Once you have completed the interview, transcribe the recording before beginning to develop the RMS. This provides you with a written account of the role model's story in their own words. As you develop the RMS, you will want to refer back to the transcript to incorporate their language and descriptions as appropriate.

Step 2: Write the RMS

After you conduct and transcribe the interview, draft one story at a time, and pilot test with a sample of the intervention population. Make any edits and turn it into a draft publication. Ask staff, your community advisory group, peer advocates, and the materials review committee if applicable to review the draft RMS and make final edits before production and dissemination. We will discuss how to conduct all these activities in the sections that follow.

There are eight key components of a RMS. They can appear in any order, however they generally follow the order in the list below as the story develops and builds.

1) Characterization
2) Membership in intervention population
3) Risk behavior (i.e., behavior to address)
4) Goal behavior
5) Stage of change movement
6) Behavioral determinant
7) Barrier to change and method to overcome it
8) Positive outcome

PLANNING YOUR ROLE MODEL STORY (3-4)

Tip: Remember – if your RMS does not include all eight components, it may be a good story, but it is not a PROMISE for HIP RMS.

A well-written RMS should be no more than 200-400 words. We want to get the message out in a clear, concise, and easy-to-read manner. Begin developing the story using the role model's own words as appropriate to illustrate each of the eight RMS components. A well-developed story will also have graphics to help convey the message.

Component 1: Characterization is a short description about the role model and the circumstances of their life. It ranges from one or two sentences to not more than a short paragraph. The characterization makes the role model real, adds credibility to their experience, and brings the story to life.

Component 2: Membership in the intervention population helps the reader identify with the role model. This short description indicates that the role model belongs to a particular subpopulation (e.g., young openly gay Black man living in and attending college in Columbia, SC). The language and any images used in the story may help illustrate membership in the subpopulation.

Component 3: Risk behavior. Many individuals have more than one risk behavior, but the RMS should focus on one behavior. It is important that the behavior to address is central to the story and clear to the reader. Risk behaviors in PROMISE RMS may include condomless sex with an individual of unknown HIV status (without PrEP); sharing injection equipment; and a number of behaviors along the HIV care continuum: refusal to be tested for HIV – unknown HIV status; failure to access care when diagnosed with HIV; missing doses of ART or PrEP; and not attending medical appointments as recommended.

Component 4: Goal behavior. Each story should contain only one goal behavior. The goal must also be specific. For example, while "reducing HIV risk" is not a specific goal, "taking PrEP every day as prescribed" or "not sharing injection equipment" are more specific goals.

Component 5: Stage of change. The story should illustrate movement from one stage of behavior change to the next stage. The story should not illustrate movement of more than one stage. Do not skip stages!

Examples of goals:

- HIV testing
- Initiating PrEP
- Linkage to care
- Medication adherence
- Retention in care
- Using a clean needle and works

It is important to note that not every individual in the intervention population is at the same stage of change. Most of your RMS will reflect the stage of change of the majority of the target population – as determined in the CID process.

There are only three shifts (from one stage to the next) that you can show in a RMS:

from **precontemplation** to **contemplation**

from **contemplation** to **preparation**

from **preparation** to **action**

Tip: The stage of change in the story should end one stage above where the community is for that particular behavior.

The last shift possible in the stages of change model, action to maintenance, does not make a good story because the only difference between these two stages is the passage of time. Also, if your population is already in action for a particular behavior, you probably should be focusing on a different goal behavior. The reality of relapse should be addressed if relevant to the story. Relapse can occur at any stage and can move an individual back one or several stages.

Reviewing the Stages of Change Model

Pre-contemplation: The individual has no intention of adopting a new behavior and is not thinking of changing their current behavior.

Contemplation: The individual is thinking about choosing the new behavior but has not yet begun to perform the new behavior.

Preparation: The individual takes steps toward the new behavior, but has not yet begun to perform the new behavior; this is accompanied by a firm intention to accomplish change in the immediate future.

Action: The individual is performing the new behavior consistently.

Maintenance: the individual is practicing the new behavior for a period of six months or more.

Component 6: Behavioral determinant. It is important to remember that PROMISE for HIP works in part by addressing behavioral and social determinants of risk. They influence how someone thinks about engaging in risk behaviors or healthier behaviors. In PROMISE for HIP, we identify the relevant behavioral and social determinants of risk through the intervention population interviews and then use RMS to describe how behavioral determinants motivate individuals to make a change.

Each RMS should describe only one or two factors that influences the role model to change their behavior. These factors have an impact on the way a person thinks or feels about HIV risk or performing a specific behavior. The behavioral determinant is what motivates the role model to develop an intention to modify his or her risk behavior, adopt a new behavior, or continue with a practice that has already been adopted.

Examples of behavioral determinants:

BEHAVIORAL AND SOCIAL DETERMINANTS (3-5)

- Knowledge
- Attitudes and beliefs
- Perception of risk/susceptibility
- Perceived severity
- Intentions
- Self-efficacy
- Values
- Skills
- Perceived norms
- Social norms
- Social support

Component 7: Barriers to change and methods of overcoming them. Each story should describe a specific barrier that the role model encountered when adopting the new goal behavior. For example, forgetting to take medication is clearly a barrier to medication adherence. The story should address this issue and describe the method used to overcome the barrier, such as setting an alarm in the morning as a reminder to take their pill.

Component 8: Positive outcome. Finally, the RMS should include the positive outcome that reinforces the adoption or the intention to adopt the desired behavior. For example, the positive outcome may be that the individual found out where they could get PrEP and made an appointment. Even in situations where the goal was not achieved (such as starting PrEP), a positive outcome must be included (such as taking a step by finding out where PrEP is available and making an appointment).

Personal experience: Writing RMS

"One of the difficulties I had in writing a RMS is showing how the person had difficulties that they had to overcome. This is especially hard when you're interviewing people who have been successful. Often times they gloss over the hard times they have experienced because, naturally, they want to talk about all of their successes. They may even say something like, 'Oh, I woke up one day, and just did it.' As a result, they can seem to go from the first stage to the last stage very quickly. They want to be perceived in a good light."

Review and edit

Staff members who are not involved in the development of the story should review the RMS draft and provide feedback.

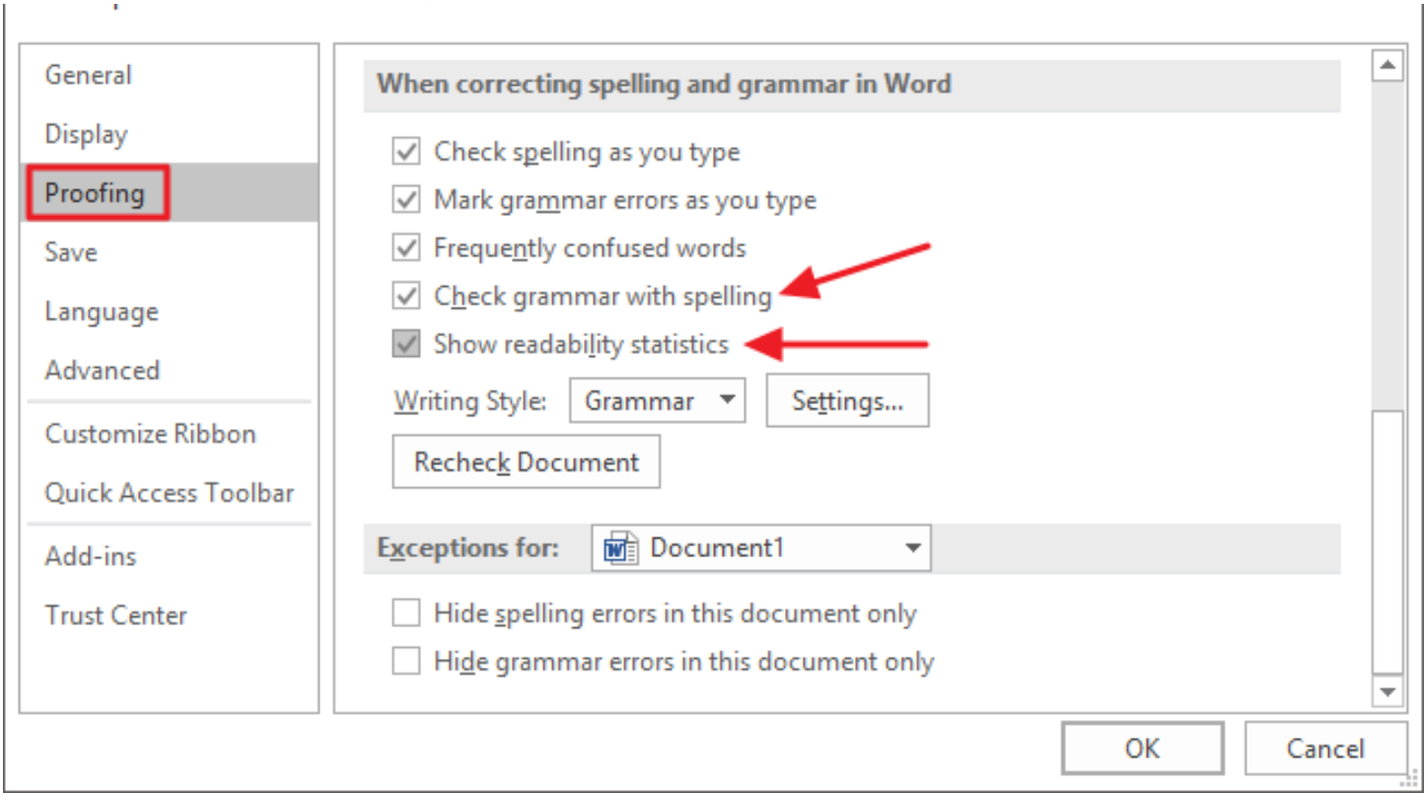
The key messages in the story should be easily understood by others including the:

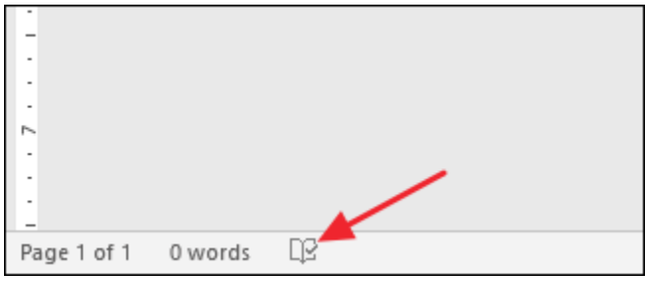
- Behavior to address (risk behavior)
- Goal behavior
- Movement from the beginning of the story to the end (stage of change movement)
- Barrier to change and method to overcome it
- Main factor influencing the change (behavioral determinant)

Tip: Have reviewers pick out each of the eight RMS components using the Role Model

ROLE MODEL STORY CONTENT WORKSHEET (3-7)

This is also the time to do a reading level check. You want to make sure that the story is at the appropriate reading level for your intervention population. If you have typed your story in Microsoft Word you can go to File – Options – Proofing and then check "Show readability statistics." It will tell you the reading level of your text. Other software programs also have this feature.





Once you have enabled readability statistics, run a spell and grammar check to determine reading level. You can select specific text to check, or make sure nothing is selected to check the whole document. Select F7 or click the "proofing" icon in the status bar at the bottom of the window.

After the spelling and grammar check run, a pop-up window will appear with some basic information about your document including the Flesch-Kincaid Grade Level. This scale tells you the readability of text based on U.S. school grade levels. A score of 4.0 means that the writing can be understood by a fourth grader.

Tip: Your RMS should generally be at a 6th grade reading level or lower.

After reviewing the literacy level, make any additional necessary edits to the RMS text to make sure the language is appropriate, relevant, and approachable, and that the story contains all eight components.

Step 3: Produce the RMS

Format

RMS should be appealing, relevant, and generate conversations among the intervention population. When deciding what formats to use, always consider the role peer advocates have in engaging their peers in conversations focused on the RMS. As you prepare to produce the story, you will also need to consider the best formats to reach your intervention population most effectively (i.e., print, video, through social media, or a combination of these). In addition, plan to include any accompanying prevention materials as appropriate (e.g., condoms, information about PrEP, safer injection equipment, etc.).

Print

RMS may be developed as short stories, fotonovelas, cartoons, or newspaper articles. The print publication itself may be a magazine, flyer, brochure, poster, or trading card – or even presented electronically on a tablet. The story format should be selected with the intervention population in mind. Do they spend a lot of time reading? Would they like a pocket-sized publication, or something larger? Would they be more likely to read a story if the peer advocate presented it on a tablet? Consider these questions in any focus groups and pre-testing. The RMS should be relatively brief, somewhere between one and six paragraphs (200-400 words).

A FOTONOVELA OR PHOTONOVELLA IS A SERIES OF CAPTIONED PHOTOGRAPHS THAT TELL A STORY

Papers and colors. Once you have chosen the print media for the publication, consider paper types – weight, texture, and color - and ink color. Glossy paper, although more visibly appealing, may not be the choice of your audience. For example, in one demonstration site, individuals preferred non-glossy paper because glossy paper is difficult to write on and they liked to make notes, such as recording telephone numbers, on the RMS.

Artwork. Illustrations may include photographs of models, actual pictures of the role models if they agree and sign a photo release form, pictures or advocates from the community, drawings, cartoons, or original art. If role models interviewed are interested in being photographed for this purpose, it

is important to thoroughly explain the context in which the photographs will be used and obtain written consent. Photographic models may be offered incentives, such as free photographs, in exchange for their participation. Drawings or illustrations may also be obtained from the population members or through local art classes. A small fee or a certificate of appreciation may be offered to those whose artwork is used in the publication.

Layout. Ensure that the materials are clear and attractive to your audience, but they need not be overly slick or professional. Design a layout that is easy to read and appealing to the eye.

Editing. Make any additional edits to the RMS after layout as needed. Pre-testing and additional edits are discussed later in this module.

Video

RMS may also be developed as short video stories, to be uploaded on YouTube, published on your website, played at the local places where your intervention population socializes, shared during personal interactions on a tablet, and presented in any other way you find appropriate. The video should be relatively brief – like a TV commercial: concise, realistic, and to the point. To develop a video, you will need to draft the story as a script; determine if you will use real people or animation, and if using real people if the role model will appear as him/herself in the video; and plan the recording, editing, and feedback process.

Script. When developing the script for the video, consider using language with which your intervention population will identify. In addition, make sure that all RMS components are clearly presented in the script. Remember that a person will be delivering the script and it should sound natural and conversational - not forced. Lastly, once you have a final draft of the script, request that other staff members review the RMS script to ensure the key messages are clear.

Layout. Once you have a final script, work on developing a layout for your video. Include how the scene will begin, what information will be spoken, and what text or images will appear on the screen.

Editing. As you plan the video, consider the desired length of the final video. Keep in mind that videos must be concise and to the point to keep your intervention population engaged, but must still include the eight required RMS components. Ask other staff to view the video and provide feedback. Your video editors must remember the purpose of the video; this will help them stay on track and keep the video focused. Invite the community advisory group to provide feedback, pre-test the video with peer advocates and/or a small group of community members, and be open for recommendations for improvement.

Social media

RMS may be featured in social media and liked, tagged, linked, and shared. If you are planning on incorporating a social media aspect, consider CDC's social media guidelines, policies, and best practices. It is a good practice to consult with your project officer to ensure they support your efforts.

Platforms. Social media can be useful to promote and distribute RMS. If you plan to distribute RMS through social media, you should consider in advance which platform(s) you will use. Revisit information collected during the CID process to determine what online platforms your intervention population prefers. Not all social media platforms are appropriate for all audiences, nor do they

replace the crucial role peer advocates play in engaging others in discussions about the RMS. Also consider that each platform will require various levels of effort and may present unique limitations.

Visuals. Similar to the artwork that you must consider for print media, you will have to decide on what the RMS will look like. The appearance of your stories is important to get the attention of your intervention population while they are online. In addition to using photos, drawings, or art as part of your RMS intended for distribution through social media, consider the use of infographics. Be strategic when using visuals and ensure the visuals you choose align with the goal of your RMS. If you decide to incorporate hashtags in your stories, make sure they are consistent with the RMS and program goals.

Produce RMS

The manner in which you print, record, design, and reproduce the RMS depends on your agency's resources. You will have to budget for publication and distribution costs, which will depend on the format. Remember that there are many affordable online sites that can reproduce your printed RMS. Some organizations tap into local graphic design, printing, or other expertise in the communities they serve, including individuals who are willing to volunteer their time and skills.

In addition to the RMS, you will want to identify and secure accompanying materials to distribute with the stories as appropriate (e.g., condoms, PrEP resources, safer injection materials). Additional materials or referrals should be based on input from the intervention population through focus groups and interviews, staff interviews, and program resources. Finally, materials accompanying the RMS should be tailored to the needs of the specific population and subpopulation for which the publication has been developed. For example, if your intervention is geared toward persons living with HIV who are out of care, packets could include information and resources to access care, clinic hours, condoms, lubricant, instructions for correct condom use, etc.

RMS PRE-TEST WORKSHEET (3-8)

Pre-test RMS and make revisions as needed

Once you have developed the RMS, it is important to test it with the intervention population and community advisory group. Through focus groups or brief individual interviews with members of the intervention population and outreach staff, you will be able to:

- Gather information regarding their preferences for different styles and presentation formats
- Identify attention grabbing features in the messages and stories
- Determine acceptability of local references in your stories
- Get reactions about the comprehension, credibility, and perceived relevance of the RMS

When pre-testing a particular RMS, show it to the participants. After giving sufficient time for review, facilitate a group discussion asking questions, such as:

- What is the story trying to say?
- What is the message in the story?
- What is the point of the story?
- What words or phrases might people not understand?
- What might upset people about the story?
- Do you believe this story? Why or why not?

- What makes the story interesting? Or why is it not interesting?
- What action does the story suggest?
- How will people like you respond to the story?
- How could we make this stronger, better, more effective, etc.?

Use the responses obtained from these conversations to fine-tune the story. When you have a nearly final version, present your story to your materials review panel and any funder required review for approval.

Market program through RMS distribution

An organization that is implementing PROMISE for HIP for the first time in their community may benefit from inviting members of the intervention population to be involved in the creation and selection of a name and logo for the program. You may engage the population in formal discussions, implement surveys among those involved in the CID process, or hold a contest to solicit artwork to be used as a logo.

Building your program identity will help members of the intervention population to recognize the program, and may help you recruit and retain peer advocates. The use of the logo on t-shirts, caps, posters, bags, or other items used by staff members and peer advocates will assist in creating visibility for your program. Through the development of RMS you have the opportunity to not only increase the visibility of your program by adding its name and logo, but you also promote your programs and the services provided by your organization. The repeated use of a program logo or publication name will reinforce that your program is active and vital.

Step 4: Determine reach of RMS distribution to mobilize behavior change in the community

Number of interviews needed to develop RMS

As you plan your PROMISE for HIP activities, consider the number of RMS interviews you will need to conduct to provide you with enough information for your stories. Some organizations identify and interview various role models and develop one RMS per interview. Others are able to interview fewer role models and develop multiple stories from one interview.

Example

During your CID process, you stage your intervention population in contemplation for PrEP use - they are just thinking about starting PrEP. You identify a role model, Marcus, who has been successfully taking PrEP every day as prescribed for some time. During your interview, Marcus describes and provides details about his journey. He talks about what made him consider starting PrEP, what steps he had to take before he could begin, and his early struggles taking every dose every day as prescribed.

In this case, your role model shares his complete story through the stages of change. This interview will provide you with plenty of material to develop one initial story moving from contemplation to preparation (one stage above the community for starting PrEP), as well as an additional story that takes him from preparation to action. If you see that the population has moved to preparation when you conduct your ongoing evaluation, you will be able to use your additional story reflecting movement from preparation to action.

ONGOING EVALUATION IS DISCUSSED IN MODULE 5

Number of stories to develop

When you are planning the number of stories to produce for a period of time consider all the variables in your community and the intervention population, such as your resources, outings planned, size of your intervention population (specifically the subpopulation you will address with the story you are developing), etc. In addition, consider the stage of change for the specified goal behavior. Communities in pre-contemplation may take more time to move to the next stage in comparison to those who are in preparation. In these situations, you might want to produce various concurrent RMS portraying characters moving from pre-contemplation to contemplation and strategically distribute them either at the same time or at different intervals.

CDC recommends to produce one new RMS per month or 12 per year per subpopulation. If your organization is planning on reaching two or more subpopulations within the same intervention population, then it is recommended to develop one new story per subpopulation each month.

Number of RMS to be distributed

Behavioral theory tells us that 15% of a given population should adopt a new innovation in order for it to become a new norm. In PROMISE for HIP, you want to ensure that you are reaching at least 15% of your subpopulation with the RMS. To determine how many stories you need to distribute, you need to take into account the size of your subpopulation (determined during the CID process). You will also want to take into account the number of outings you plan on conducting and the number of venues your peer advocates will visit. Similarly, you must determine the number of peer advocates you will need to reach your distribution goal. The role of peer advocates will be discussed in detail in the next module.

SUMMARY

This module introduced you to the eight components of the RMS and provided a step-by-step guide to developing the stories from the interview to the production. The next module discusses the role of peer advocates in distributing the stories.

Example: Number of Stories Needed

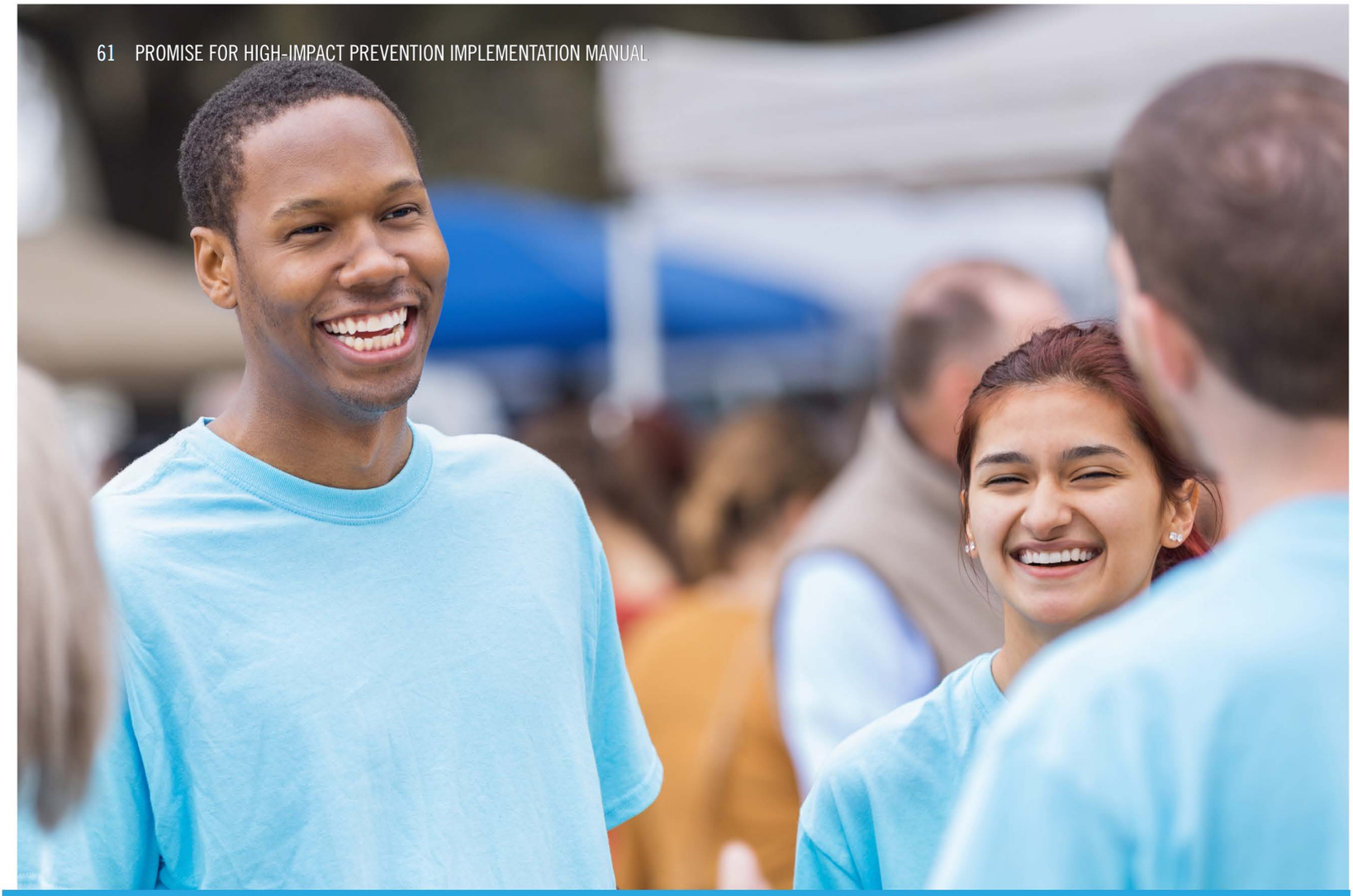
- The clinic estimated that it saw 160 African American gay and bisexual men ages 21-35 who engage in anal and oral condomless sex with casual partners.
- 160 X 15% = 24
- The clinic and their funder determine that a reasonable distribution period will be every two weeks.
- The clinic staff plan to have their peer advocates distribute 24 copies of a RMS every two weeks.

ENDNOTES

[1] https://www.howtogeek.com/247921/how-to-test-the-readability-of-your-writing-in-microsoft-word-or-outlook/hiv/pdf/ library/factsheets/cdc-hiv-care-continuum.pdf

PROMISE for High-Impact Prevention Implementation Manual

MODULE 4: Peer Advocates



MODULE 4: PEER ADVOCATES

The success of PROMISE for HIP depends on focused and frequent distribution of role model stories by peer advocates to members of the intervention population. As discussed in module 3, these RMS, often packaged with prevention materials (e.g. condoms, PrEP information, safer injection kits, medication adherence tips, etc.), encourage individuals to adopt and practice healthier behaviors.

Peer advocates are volunteers who are reflective of the intervention population and who have been recruited and trained by your staff to help distribute PROMISE for HIP RMS and model new behaviors and norms within the intervention population. Peer advocates are chosen because of their influence within their social and interpersonal networks and their ability to reinforce and model the messages in RMS to their peers. Modeling is important in conveying norms, which communicate the idea that "everyone is doing it." Social networks, or subpopulations within the intervention population, may be based on geography and/or intervention population demographics. These subpopulations, as well as potential peer advocates, are identified through the CID process.

PEER ADVOCATE GOALS AND RESPONSIBILITIES

1. Distribute RMS and prevention materials to members of the intervention population.
2. Reinforce and model the acceptance of the stories and materials by discussing the stories, highlighting the key messages, and reinforcing positive behavior change.
3. Encourage peers to share RMS with others.
4. Identify peers to participate in ongoing interviews, as potential role models, or as peer advocates.

WHO AND WHAT ARE INVOLVED IN PEER ADVOCATE ACTIVITIES?

There are multiple components to PROMISE for HIP that require diverse staff skills, oversight, and trust in the community for effective implementation. Key staff responsibilities during the recruitment, training, and supervision of peer advocates include:

- **Recruit and screen** potential peer advocates.
- **Orient and train** peer advocates. Provide an overview of the responsibilities of peer advocates; organize and deliver training to build the capacity of peer advocates to effectively fulfill their role.
- **Determine the number of RMS** to be distributed in person and online (as appropriate).
- **Track distribution of RMS** and program supplies.
- **Supervise and support** peer advocates.
- **Monitor social media** engagement and RMS distribution through social media (as applicable).

PEER ADVOCATE TOOLS AND RESOURCES

In addition to the RMS, there are a few tools in this guide that may help you support activities related to peer advocates. Throughout the module, you will see this icon where one of these tools is used. All the tools are found in the appendices at the end of this manual.

- 4-1 Peer Advocate Contact Sheet
- 4-2 Distribution of RMS Guidelines
- 4-3 Peer Advocate Invitation to Training Template

Who are PROMISE for HIP peer advocate advocates?
Peer advocates are individuals who are representative of the intervention population and influential within their social network (e.g., MSM, a person who currently injects drugs, a person living with HIV) and/or hospital or clinic volunteers who work as peer navigators. It is important that you have peer advocates who represent each of the social networks in your intervention population. The CID process will assist staff in identifying networks and the first group of potential peer advocates.

Tip: If you are engaging former intervention population members as peer advocates, it is important to pay attention to the situations they may be put in by interacting with current intervention population members. For example, engaging in PROMISE for HIP activities with PWID may jeopardize the sobriety of an individual in recovery.

Not everyone from the intervention population will make a good peer advocate. Some characteristics to look for in PROMISE for HIP peer advocates include:

- *Culturally and socially aware of the intervention population* - When peer advocates recognize the needs of the intervention population, they will be able to understand the struggles peers might have and offer potential solutions. They will also be able to provide you with feedback throughout PROMISE for HIP implementation.

- *Believe in the prevention message in the RMS* - Peer advocates who believe the message portrayed in the RMS will be able to help peers understand it and how they may benefit when taking similar actions in their own lives. Peer advocates reinforce the message of the story not only by talking about it, but by learning from it and implementing changes in their own behavior.

- *Model the process of behavior change* - It is important that peer advocates strive to make positive behavior changes in their lives. Ideally, they should aim to reach the goal behavior portrayed in the RMS. RMS are presented as one stage above where the population is for a particular behavior. Peer advocates

Tip: Remember that peer advocates may be engaged in some of the same behaviors and face some of the same challenges as their peers.

may not have achieved behavior change, but may model the process of working toward it and are likely to understand the challenges in achieving the goal behavior.

- *Have access to the intervention population including those who are hard to reach* - It is crucial to find peer advocates who will help you reach your intervention population and subpopulations in order to mobilize behavior change among priority communities.

- *Sought out by community leaders* - The best peer advocates have credibility among their peers, other organizations, and your staff. In this role, they may influence peers considering or taking steps toward behavioral changes.

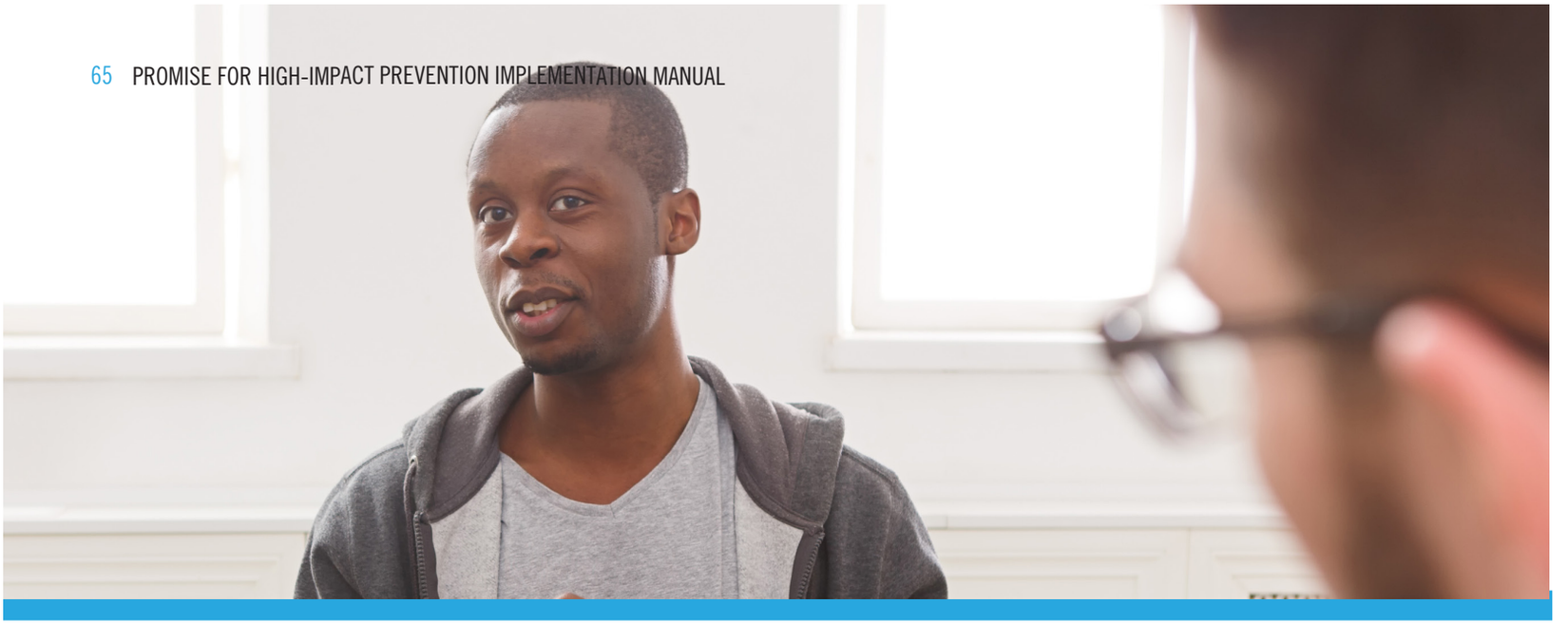
Tip: While they do not replace peer advocates, community champions, businesses, and clinical staff may also distribute RMS and materials. They may also prominently display posters or other prevention materials that support PROMISE for HIP goals. Their participation provides the intervention population with regular and consistent access to the prevention materials at a known location.

Peer advocate responsibilities

- *Distribute RMS and accompanying materials* - Peer advocates distribute RMS to the identified intervention subpopulation(s) and encourage the adoption of healthy behaviors. Peer advocates may also distribute additional materials related to the goal behavior portrayed in your RMS such as condoms; information on HIV testing, PrEP, or syringe services programs; and safer injection kits. In their conversations with peers, peer advocates encourage acceptance of the RMS, draw attention to the key message of the story, make the story more relevant to the person receiving it, and provide reinforcement for positive behavior change. The peer advocate's role is not to educate people or teach them facts about HIV. RMS distribution should occur largely within the peer advocate's own social network among the people they already know who may be at increased risk for HIV transmission or acquisition.

Tip: When the peer advocate gives the story to a peer and says, "I think you'll really like this story; you should check it out," the peer advocate is encouraging acceptance of the story. The peer advocate reinforces progress toward adopting healthier practices by asking peers if they have tried the behavior (depending on the RMS behavioral goal) and making a positive comment. For example, "It's great that you found out where to get PrEP. It's important to protect yourself."

- *Encourage peers to share RMS with others* - In their discussions with peers, peer advocates also encourage them to share the RMS with others and talk about their own experience reflecting on the message in the RMS. Peer advocates may encourage their peers to take a copy or two of the story and have a conversation with friends who may be in a similar situation as the RMS character.



- *Identify individuals in the intervention population to participate in PROMISE for HIP activities* - Since peer advocates interact directly with members of the intervention population, they are able to identify other members within the community who may be interviewed as part of your CID and evaluation efforts. Peer advocates may also identify potential role models for future RMS and potential peer advocates.

Tip: Outreach workers are invaluable in gaining access to the community and establishing the presence of your program since they conduct the CID process. They may also help conduct ongoing evaluation activities.

Peer advocates vs. outreach workers

The success of peer advocates relies on how well they are able to interact and communicate with their peers when distributing RMS. They are seen as regular members of the community and have better access to the intervention population than staff do. Many organizations have outreach workers as part of their HIV/STD prevention efforts who engage with community members, share information, and distribute program materials. However, PROMISE for HIP recognizes that programs benefit when carefully chosen and well-trained peer advocates from the intervention population distribute PROMISE for HIP RMS.

- Peer advocates often have immediate credibility with members of the intervention — credibility that typically would be earned more slowly by program staff.
- Peer advocates can distribute RMS and prevention materials at times when outreach workers may not be available or in clinical settings when clients are waiting for appointments.
- Peer advocates are often present in the places where the risk behaviors occur.
- Peer advocates expand the reach of your program, enabling a larger number of individuals to be contacted than could be reached by paid staff alone.
- Peer advocates will allow your program to reach individuals who might not otherwise access information provided by people who are identified as being part of an organization or governmental institution.
- Peer advocates teach us about the intervention population.

STAFF WHO HAVE REGULAR, DIRECT CONTACT WITH MEMBERS OF THE INTERVENTION POPULATION ALSO PLAY AN IMPORTANT ROLE IN PROMISE FOR HIP. WHILE STAFF MAY NOT SERVE AS PEER ADVOCATES, THEY MAY SERVE AS IMPORTANT CHAMPIONS. CASE MANAGERS, NURSES, FRONT-DESK STAFF, AND OTHERS MAY SUPPORT PROMISE FOR HIP GOALS BY ENGAGING CLIENTS IN CONVERSATIONS ABOUT RMS.

Peer advocates are volunteers or may receive a stipend, but are not paid employees. Many organizations already use volunteers in various roles and they may support outreach activities in the community or provide staff support at the organization. The peer advocate role is more specific. Although their role is also voluntary, peer advocates are members of the intervention population and are seen as leaders among their peers.**Comparing responsibilities of outreach workers and PROMISE for HIP peer advocates:**

OUTREACH WORKERS	PEER ADVOCATES
▪ Gain access and establish presence in the community ▪ Identify potential peer advocates ▪ Help recruit and train advocates ▪ Reinforce the efforts of peer advocates ▪ Distribute materials	▪ Distribute RMS ▪ Encourage others to read RMS ▪ Encourage others to share the RMS with their own peers ▪ Refer others who possibly could become peer advocates

Recruit peer advocates

Soon after you begin implementing PROMISE for HIP, you will need to begin recruiting peer advocates. The initial recruitment of peer advocates is one of the most challenging and important steps in the intervention. You are more likely to be successful in your recruitment efforts when you establish a community presence and identify recruitment areas prior to beginning recruitment. The CID process is helpful to establish a community presence and identify potential peer advocates.

- **Determine the number of peer advocates you will need** to effectively implement the program in your community. The number of peer advocates will vary depending on your organization and funding requirements. CDC suggests having eight to 10 peer advocates engaged in PROMISE for HIP activities at any time.
- **Document responsibilities and expectations** to share with potential peer advocates during the recruitment process. By clearly communicating with your peer advocates from the beginning, you foster a mutually respectful relationship and help ensure you understand each other's expectations. It will also help to think about and anticipate potential challenges that you both might face and plan accordingly.
- **Identify potential peer advocates** beginning with the CID process. During the brainstorming activity, it is common to hear staff identify individuals who may be beneficial to PROMISE for HIP. You may also compile a list of potential peer advocates from the systems interviews. And you will be able to identify more candidates while conducting the intervention population interviews. Potential peer advocates may

also be identified during the role model interviews and even role models could become peer advocates. You may also find peer advocates through your outreach workers, stakeholders, clients, and through your current peer advocates.

- **Identify desired peer advocate characteristics** for recruitment. Not every member of the intervention population is appropriate to serve as a peer advocate. It is important that individuals who are selected to be peer advocates do not impose their own agenda on the individuals they encounter and remain non-judgmental. Willingness to participate and distribute RMS should only be a small part of the criteria to be a peer advocate. Therefore, it is important to identify the characteristics you are looking for in peer advocates before you begin recruiting. Peer advocate characteristics may include:
  - Have spent time or lived in the local community for more than six months with plans to remain in the area for the next year - This will ensure that they have strong connections with intervention population members and will minimize peer advocate turnover.
  - Demonstrate strong communication skills - Since peer advocates will primarily interact and engage others in conversations, it is important that advocates possess good communication, observation, and listening skills.
  - Believe in the goal behavior - Peer advocates do not have to consistently engage in risk-reduction activities, but to be credible to others they do need to believe in the importance of protecting themselves from acquiring or transmitting HIV, and at least be working toward healthier practices. For example, if an advocate is known by his peers as someone who refuses to use condoms, then it is likely that he will not be an effective condom promotion advocate.
  - Possess leadership characteristics - Peer advocates must be viewed as a credible source of information by his or her peers. Those who demonstrate leadership qualities are more likely to engage peers in conversations and motivate others to taking actual steps toward healthier behaviors.

  It is important to be mindful of the geographic areas and social networks from which you have recruited peer advocates. You want to reach 15% of the intervention population with your RMS, but you do not want to oversaturate an area or network and miss the opportunity to distribute stories throughout the intervention population.
- **Identify mechanism for recruitment**. Use information gathered during the CID process to inform and plan appropriate recruitment strategies. While you may identify individuals as potential peer advocates through the internal staff brainstorm and various interviews, you will likely need to engage in additional recruitment activities, which may include:
  - **Referrals** - Seek referrals from the advisory group, other stakeholders, informal community leaders, staff, other programs, and current volunteers or peers.
  - **Venue-based recruitment** - The best locations for successfully recruiting advocates will depend on the intervention population. The CID process will tell you where to begin. Areas where population members naturally congregate — such as lesbian, gay, bisexual, or transgender (LGBT) community centers, clinics, or coffee shops — can be good places to initiate recruitment efforts.
  - **Social media and advertisements** - Leverage existing social media platforms to connect with followers

Tip: Do not rely entirely on referrals from existing peer advocates to identify new advocates. Friends of current peer advocates often move in the same social networks and may duplicate, rather than enhance existing efforts.

and consider placing ads online and/or in other publications read by your intervention population - such as school newspapers to reach youth, or local gay-oriented magazines to reach MSM. You may also consider posting flyers in areas where your intervention population hangs out or seeks services such as laundromats, bars, stores, or other health and social service agencies.

When recruiting, the staff (recruiter) should introduce themself and the program. The goal of the initial contact is to gain the individual's interest in the program. Some individuals may express interest in becoming a peer advocate immediately, but others may need more time or information before making a commitment. Ideally, the recruiter should observe the potential advocate and his or her interactions with peers.

In describing the program, the recruiter may want to stress the opportunity to do something good for the community and the importance of what peer advocates do (e.g., saving lives, reaching people who may not otherwise learn how to access PrEP, etc.) as well as any incentives provided for participating as a peer advocate.

When the recruiter has determined that the individual has a genuine interest in becoming a peer advocate, they should collect contact information and either screen the candidate or schedule a follow-up screening and summarize the next steps.

- **Screen and interview potential peer advocates** to make sure they are a good fit for the role. To determine whether the individual will be able to contribute to the program as a peer advocate, you may consider assessing the degree to which they:
  - Are connected with and have access to the intervention population
  - Are seen as credible in the community and among peers
  - Have a position of influence within their peer groups
  - Support your organization and program
  - Have faith in prevention and believe in the PROMISE for HIP prevention messages
  - Are interested in becoming involved and helping their community, as well as serving as a peer advocate

During the screening process, provide a brief explanation of PROMISE for HIP, a clear description of the role of the peer advocate, and expectations – and let them know that if selected, they will receive much more information during training. Extend an invitation to those individuals who meet the selection criteria discussed above to the peer advocate training sessions. Consider offering transportation to training as needed.

- **Orient peer advocates** prior to the formal training. Orientation may take place as part of the screening process or you may deliver a brief peer advocate orientation to individuals or small groups to confirm their interest in the program. Briefly describe the PROMISE for HIP program and the role of peer advocates noting:
  - Responsibilities of peer advocates
  - Time commitment and duration of commitment
  - Support available to peer advocates, including incentives
  - How they as peer advocates will support HIV prevention efforts in their community
  - Training expectations and support

PEER ADVOCATE INVITATION TO TRAINING TEMPLATE (4-3)

Tip: Develop written invitations for peer advocate training detailing the date, time, and location. Make reminder calls or send text messages prior to training.

Train peer advocates

Effective PROMISE for HIP peer advocate training will reinforce program expectations, deliver relevant and clear information, demonstrate how knowledge and skills they learn will be applied, and provide opportunities for the peer advocates to practice. When developing training content, prioritize topics most relevant to your PROMISE for HIP program, goal behaviors, implementation population, and peer advocate activities. Supplemental information and continuing education may be delivered in regular group sessions following training.

- **Logistics and planning**
  A group training for potential peer advocates should last at least one hour, but not more than three hours. Consider holding the training at a location that is convenient and easily accessible to the intervention population. Answer the following questions to help plan your peer advocate training:
  - Who is responsible for:
    - Coordination - room reservation, equipment (computer/projector, easel and easel pad, markers, etc.), set-up; meal/snacks and beverages; communicating with participants; data collection?
    - Developing and producing materials - agenda, presentation, handouts?
    - Delivering the training?
  - Who else from your agency should attend and support the training?
  - When and where will training be held (date, time, duration, location)? Ensure the training date does not conflict with other internal or external events.

PEER ADVOCATE CONTACT SHEET (4-1)

- **Training materials**
  - Training folder for each peer advocate
  - Agenda
  - Samples of RMS
  - Map of the implementation area
  - Worksheets
  - Blank paper
  - Data collection forms (e.g., Peer Advocate Contact Sheet, peer advocate agreement, etc.)
  - Training evaluation
  - Schedule and agency contacts
  - Pen/pencil

- **Training outline**
  - **Introduction** - The facilitator begins by introducing him or herself and welcoming participants to the peer advocate training session. Introduce any staff present and ask participants to introduce themselves. Consider asking participants why they are interested in becoming a peer advocate and any experience they have conducting outreach. Briefly explain that the training will focus on delivering relevant and clear information, demonstrating how knowledge and skills they learn will be applied, and providing opportunities for them to practice. Review the training materials, including the agenda for the session, peer advocate agreement form, etc.

- **Description of the program** - Provide a brief summary of how the program is structured and the goal it aims to reach. Describe the specific population and subpopulations your PROMISE for HIP program focuses on and how their involvement as peer advocates reinforces the purpose of the program.
- **Roles and responsibilities** - Discuss how they are key to successfully helping their community stay healthy and emphasize that they as leaders in their community have credibly among the intervention population. Individuals are more likely to listen to those they already know and respect than they are to persons working for an organization.
    - Explain that their success relies on how well they are able to interact and communicate with their peers when distributing RMS. Discuss boundaries and challenges they may face, including rejection.
    - Point out that they will distribute copies of the RMS along with other relevant materials (e.g., information on HIV testing, PrEP, or syringe services programs; or safer sex or injection kits) – depending on the goal behavior).
    - Note that they should encourage their peers to take a copy or two of the story and have a conversation with friends who may be in a similar situation as the RMS character.

Tip: The number of RMS distributed may not be the same number of individuals reached. If a peer advocate distributes two RMS to one community member, then they will count two RMS distributed.

    - Explain that because they interact directly with the intervention population, they can help you identify potential candidates to participate in your evaluation, potential role models to interview, and even new potential peer advocates.
    - Stress that they will reinforce the message of the story not only by talking about it, but by the opportunity they have to learn from it and implement changes in their own behavior.
- **Time commitment** - Acknowledging that peer advocate involvement is voluntary, discuss how long they will remain in their role (i.e., based on time or on number of stories distributed).

Tip: A good rule of thumb is that peer advocates will spend one to two hours a week disseminating RMS and talking with members of the intervention population. Agency staff however may spend four to eight hours a week accompanying peer advocates in the community as they may accompany multiple groups of peer advocates each week.

- **HIV/STD information** - Depending on the needs of the group, provide relevant information regarding HIV and other STDs. Topics may include HIV and Hepatitis C, PrEP, medication adherence and the HIV care continuum, condom use, etc. Keep in mind that you may also choose to provide education on these topics during booster sessions and not necessarily during the training.
- **Findings from CID process** - It will be useful to share the findings from the CID process to help peer advocates understand the program focus.
    - Location - Describe specific geographic areas identified for the intervention.
    - Intervention population - Discuss how you identified the subpopulations and their risk behaviors.

- Goal behaviors and behavioral determinants – Share in terms that peer advocates will understand, the most influential behavioral determinant(s) identified during the intervention population interviews, as well as where the community is with respect to the goal behavior (current stage of change).

- **Review RMS** - When you are ready to introduce the RMS, make sure to read the story out loud. Let your peer advocates know that the RMS are an honest reflection of the reality of the selected population and that they are stories based on actual members of the population.
  - **Identify key messages**. Review the key components depicted in the story with the peer advocates in their own language.
  - **Discuss movement toward goal behavior.** Clearly discuss where the character in the story is at the beginning of the story, what the character does that moves them toward the behavioral goal, and where the character is at the end of the story.
  - **Identify factors affecting movement toward goal behavior.** Discuss the influencing aspects that affect the character's decision to move toward the behavioral goal.
  - **Describe the barrier and method to overcome it.** Ask peer advocates to identify the barrier to the new behavior and describe how the character overcame the barrier. This highlights the importance of talking about the stories with their peers from a realistic point of view with real obstacles.
- **Demonstrate RMS distributio**n - Before the demonstration, review the Distribution of Role Model Story Guidelines tool (Appendix 4-2) with your peer advocates. Facilitate a conversation about the different venues and social norms in these venues (e.g., approaching someone drinking at a bar or dancing at a club to discuss a story might be unwelcome, but an individual socializing at a park may be more receptive to having a conversation). Demonstrate approaching a person in an open, friendly, non-threatening way and establishing a comfortable conversation.

Before the training, master your demonstration. During the demonstration present a realistic scenario, make sure you stay in character, and focus attention on discussion of the key messages. Make sure you use the RMS guidelines tool; by seeing this, participants will also be more comfortable using the tool until they are comfortable with the process. Demonstrate how to present the story, how to engage the peers, how to ask the questions, and how to respond to the peers' reactions.

Tips for discussing RMS distribution:

DISTRIBUTION OF ROLE MODEL STORY GUIDELINES TOOL (4-2)

- When sharing the RMS with the intervention population, peer advocates should encourage them to read the story and discuss STD/HIV prevention. Some people may not be able to or may not have the time to read the publication, so peer advocates need to be sure to tell recipients a little about the stories. Other people may not want to take the RMS at first. If a peer says, "I don't need this," peer advocates can respond by saying, "Maybe you know someone who does."

- Emphasize encouragement or positive reinforcement for individuals to begin or continue positive behavior change. It is hard for people to change their behaviors, so it is good for peer advocates to let them know that they are doing a good job by saying something positive. The facilitator should give specific examples of positive reinforcement, such as: "It's great that you're concerned about protecting yourself from HIV." "You're doing the right thing by thinking about starting PrEP." "More and more people are thinking that way and have started PrEP too." Or even when the person they are talking with has refused to look at or take the RMS, the peer advocate can say, "Well, maybe next time. Have a good day!"

When you finish, debrief by asking what they observed that worked well. Ask participants to focus on how you asked the questions, and what responses the questions provoked. Ask if anyone would do anything different, address any challenges, and answer any questions they might have. Encourage peer advocates to follow-up with the people to whom they have given the RMS. When re-contacting someone, the advocate may say something as simple as, "How did you like that story I gave you?" This kind of follow-up reinforces reading and practicing the behaviors illustrated in the stories.

RMS distribution - online - Many organizations have opted to deliver services virtually. Some peer advocates may be comfortable having virtual conversations, however CDC strongly recommends not involving peer advocates in the use of social media to interact with the intervention population. CDC recommends that skilled staff interact with the intervention population through social media. Peer advocates may support online distribution by promoting the PROMISE for HIP webpage among the intervention population. Clearly delineate the role of peer advocates and spend time during training discussing how staff and peer advocates will support and reinforce each other's efforts.

The following are program considerations for the use of social media in PROMISE for HIP, which may also be noted during training as appropriate:

- Selection of most conducive platforms - Selecting an online platform to conduct PROMISE for HIP activities requires understanding the audience each platform reaches, the features that will support PROMISE for HIP exercises, as well as the features that hinder the program efforts.

Tip: Request technical assistance to help design a PROMISE for HIP program that leverages online distribution of RMS.

- Social media guidelines - Staff should be familiar with their funder's recommended guidelines for online engagement, as well as organizational protocols on social media and online interaction. Review and revise/adapt social media guidelines as needed for the PROMISE for HIP program.

- Methods to engage members of the intervention population - Review various approaches you and your staff have identified to effectively approach and engage members of the intervention population online in conversations that will lead to discussions around the RMS messages.

Tip: Remember that not all social media is appropriate, nor does it replace peer advocates and their crucial role engaging others in discussions about RMS.

- Strategies to reinforce messages online - Point out the different processes to ensure online engagement with peers focus on reinforcing the PROMISE for HIP RMS messages. If considering use of social media to support PROMISE for HIP implementation, CDC strongly recommends to implement a hybrid PROMISE for HIP model in which social media is used in combination with face-to-face interactions with peers. Online interactions align with and reinforce the messages of the RMS distributed in person.

- Monitor engagement - Plan in advance how to measure and monitor the engagement conducted through social media. Think about how you will evaluate these efforts (if it will be through "likes" "reposts" "comments," etc.).

- **Practice engaging with peers and distributing RMS** - While your peer advocates have the demonstration fresh in their minds, give them the time to practice a similar scenario. Reinforce any information at this point, provide the scenario, and let them practice. Quietly observe the practice, noting opportunities for improvement and where they excel. Debrief with the group and discuss what went well and what they would do differently the next time. Provide positive feedback and suggestions for improvement based on your observation. Be clear and specific when providing feedback, and as appropriate, allow for additional practice to polish their skills. The goal is to get all the individuals in the training session to participate in at least one skills-building practice activity.

- **Follow-up and other activities -** Once your peer advocates feel ready to conduct the RMS distribution and engagement activities, provide information about how you will support their efforts. Let them know you want them to be successful. Explain data reporting requirements and share the RMS schedule and supply pick-up. Distribute materials and incentives as appropriate. Discuss additional scheduled trainings and monthly gatherings, as well as any planned field visits for staff to view them in action.

At the end of the training, remind participants what is expected of peer advocates. Also remind peer advocates that they are serving as volunteers and may decide to discontinue their service at any point. Similarly, if they do not meet program expectations or follow guidelines, they may be dismissed. Upon successful completion of training, participants should sign a peer advocate agreement and be welcomed

as official PROMISE for HIP peer advocates. Thank participants for their participation in the training and their support of the program, reminding them that peer advocates are an essential component of PROMISE for HIP.

Support, supervise, and retain peer advocates

Training and managing advocates is labor-intensive, but it is crucial to retaining a dedicated group of peer advocates. It is important to be available for your peer advocates and it may involve meeting with them in the community. Make sure you meet regularly with peer advocates to provide them with additional support and distribution materials when needed.

Tip: If peer advocates are in one geographic area, you may designate a standing time and location for them to check in, for example at a local LGBT community center on Thursdays from 1-4 pm.

To ensure you are able to maintain contact with and adequately support peer advocates:

- **Maintain records of peer advocate contact information -** including telephone numbers, email addresses, and home addresses or other places where they hang out.

- **Obtain contact information for a relative, friend, other agency staff, or authority** - such as a parole officer - who is in regular contact with the peer advocate.

- **Develop a schedule for RMS and supply pick-up** - You may schedule group meetings for all peer advocates or opportunities for individual pick-up. Schedule pick-ups based on your plan for publishing and disseminating new RMS. Collect any outdated RMS and distribute additional or new RMS to peer advocates. During these meetings, you may also distribute other necessary materials peer advocates may need as well as incentives.

- **Plan monthly peer advocate meetings -** Monthly support group meetings, sessions to review materials and information, or informational workshops can be conducted to provide additional support and reinforcement for the peer advocates' activities. These activities give them the opportunity to meet and share their experiences with program staff and each other. In addition, peer advocates can describe their perceptions of the barriers to behavior change in the intervention population and discuss solutions to overcome these barriers.

Group activities also enable staff members to solicit information from peer advocates about a number of issues: (1) the intervention population's interest in the intervention materials, (2) specific sites where outreach currently is needed, and (3) when distribution is not going well in the intervention area. These meetings also provide an important opportunity for staff to reinforce the role of the peer advocates in the project by offering additional skills practice. Finally, peer advocate meetings may include guest speakers who discuss other health-related topics of interest to the peer advocates.

Other ways to motivate, encourage, and retain peer advocates include:

- **Social gatherings and community events** - Picnics, barbeques, Pride events, parade participation, and other appreciation events serve as incentives for peer advocate participation. They also provide a method of recruiting new peer advocates, provide additional opportunities to reinforce peer advocates' efforts, and provide social reinforcement for risk-reduction and health enhancing behaviors. Events such as participation in parades may also increase program visibility as well as provide an opportunity for the peer advocates to participate in positive social interactions with peers and staff. Peer advocates have the opportunity to bring a guest to the event.

Tip: When planning incentives, consult your peer advocates and/or advisory board - do not assume you know what people want even if you have been working with the population for a number of years.

- **Incentives -** Incentives for peer advocates should be small rewards that indicate to participants that their hard work is appreciated. Suggested incentives may include T-shirts with the program logo, water bottles, sunglasses, hygiene kits, coffee mugs, tote bags, or backpacks. Other incentives may include movie tickets, rideshare gift cards, restaurant gift cards, groceries or grocery vouchers, and other entertainment or gift cards. Plan the schedule and qualifications to receive incentives in advance and communicate expectations to peer advocates.

- **Cards and letters -** Sending birthday cards to advocates from staff members expressing appreciation for their hard work and effort provides an incentive to continue advocate activities. Letters and cards containing current intervention materials may also be motivating while the peer advocate is in the hospital, jail, or prison. Peer advocates have responded positively to all these additional social incentives, particularly the letters while in prison and jail because often this is the only correspondence they receive the entire time they are incarcerated. Peer advocates may also need letters verifying their activities for court appearances, job references, and for their parole officers.

Personal experience: Incentives

"Incentives are usually not the reason why peer advocates volunteer their time. While they definitely enjoy and appreciate the incentives, some bigger rewards for them are: the prestige and respect they get in the community, the good feelings they get about themselves from volunteering, which is often times simply the praise they get from staff, and going to all of the parties, meetings, and other activities associated with being a peer advocate."

Printed on letterhead, a letter may be very useful to peer advocates seeking employment or documenting their community activities.

- **A program newsletter -** A paper or electronic program newsletter (depending on population) may also be distributed among peer advocates to provide local information about HIV, program updates, referrals to local services, and acknowledgments of exceptional and new peer advocates. Calendars listing the program activities for the month may be included to remind peer advocates of upcoming project and community events.

- **Non-tangible motivators are also important -** Other than the advocate's own altruistic motives, attention from staff members is often the most important factor. Providing a positive contribution to the community is also a predominate reason for participating as a peer advocate. A sense of belonging and contributing to a community effort is vital; therefore, fostering this feeling is very important. Giving concrete symbols of peer advocates' connection to the group—such as badges or T-shirts with the program logo—is an important aspect of the peer advocate effort.

- **Other opportunities -** Peer advocates may express interest in becoming involved with additional opportunities to support agency activities and serve as a volunteer in other capacities. They may become candidates for the advisory committee. They may gain tangible experience for potential employment opportunities with other organizations. Additionally, peer advocates may be interested in other skills-building opportunities, such as resume development, presentation skills training, computer classes, other workforce development programs, etc.

SUMMARY

This module reinforced the role and importance of peer advocates in distributing PROMISE for HIP RMS and sharing the key messages with members of the intervention population. To successfully engage peer advocates, you must adequately screen, orient, train, support, and motivate them throughout program implementation.

PROMISE for High-Impact Prevention Implementation Manual

MODULE 5: Evaluation

MODULE 5: EVALUATION

Evaluation is the fourth core element in PROMISE for HIP and is also an important program management tool. This module presents an overview of evaluation terminology and techniques, and provides tools to assist you in monitoring and evaluating PROMISE for HIP implementation.

WHO AND WHAT ARE INVOLVED IN EVALUATION ACTIVITIES?

There are multiple components to PROMISE for HIP that require diverse staff skills, oversight, and trust in the community for effective implementation. Key staff responsibilities during the recruitment, training, and supervision of peer advocates include:

- Monitor the agency's PROMISE for HIP implementation plan
- Draft a PROMISE for HIP evaluation plan
  - Oversee data collection and management
  - Compile implementation data: RMS development, RMS distribution, peer advocate recruitment, peer advocate training
  - Develop social media evaluation plan and compile social media metrics (optional activity – only if relevant)
- Summarize data for CID report
- Update CID report
- Work with program staff to assess need for additional RMS and interviews

EVALUATION TOOLS AND RESOURCES

In addition to the interview guides discussed in previous modules and the CID report, there are a few tools in this guide that may help you support activities related to evaluation. Throughout the module, you will see this icon  where one of these tools is used. All the tools are found in the appendices at the end of this manual.

- 5-1 Peer Advocate Recruitment Report Template
- 5-2 Role Model Story Quarterly Production Report Template
- 5-3 Peer Advocate RMS Distribution Template
- 5-4 Quarterly Peer Advocate Activity Summary Template

EVALUATION OVERVIEW

Evaluation can be defined as "the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming."[1]

As an "effective intervention," the original Community PROMISE intervention is already understood to be effective in achieving behavior change in a community. To achieve the expected results, you will need to ensure that you are implementing the intervention as intended. The monitoring and evaluation activities

your organization conducts for PROMISE for HIP can show that: 1) your program achieved your objectives with your intervention population; 2) you maintained fidelity to the core elements of PROMISE for HIP; and 3) you saw movement in the stage of change related to behaviors, attitudes, and/or community norms in support of reducing HIV risk or improving health outcomes along the HIV care continuum.

Evaluation activities also support accountability, program improvement, and knowledge development.

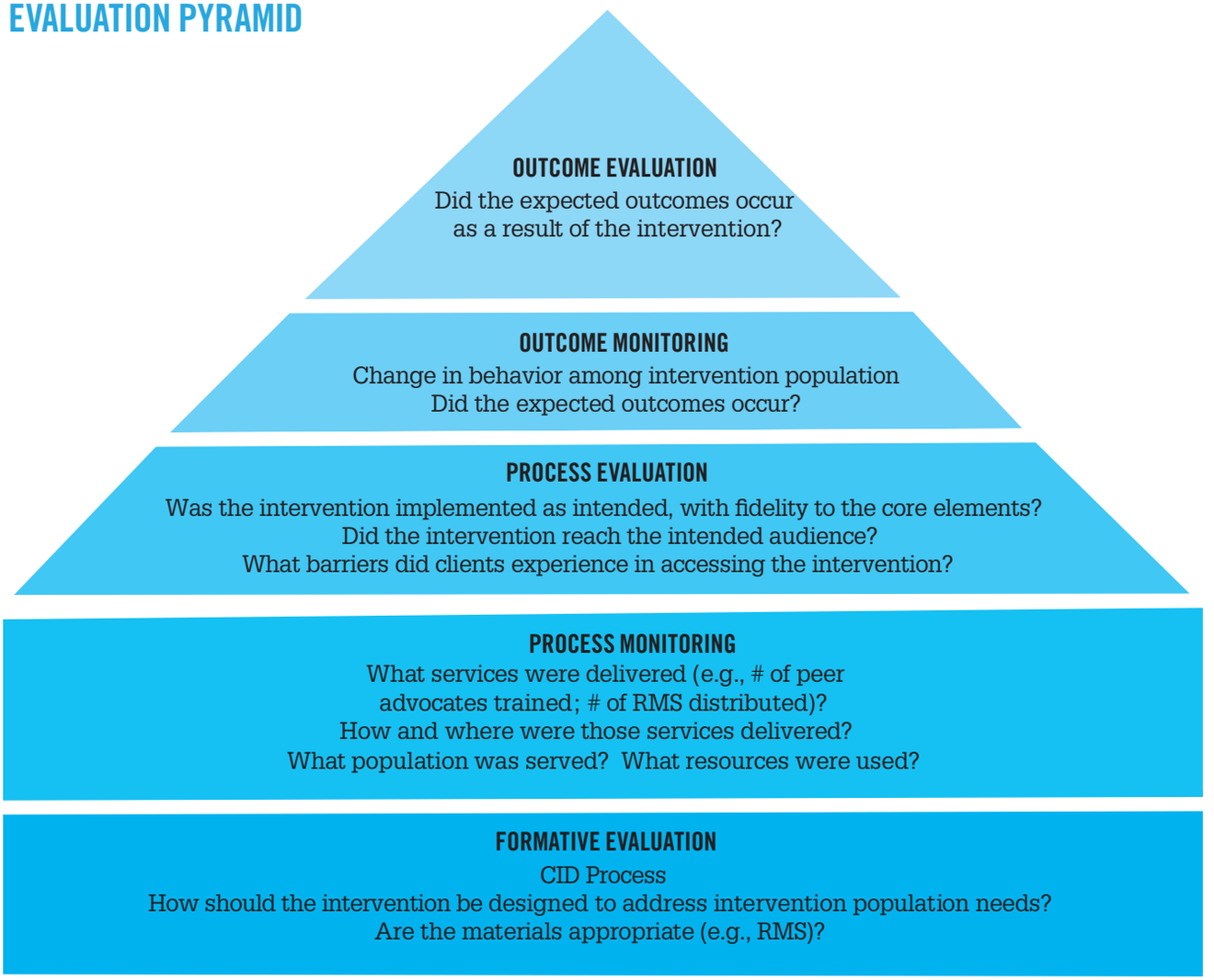
- **Accountability -** Information collected through evaluation activities may be useful for:
  - Organizational management to monitor program implementation and budgets
  - Program staff to show their work is making a difference
  - Funders to ensure their limited dollars are reaching the right populations with the right activities
  - HIV planning groups to make recommendations to funding agencies
  - Members of the community to show appropriate investments and movement toward improved health outcomes
  - Political bodies to support funding allocations
- **Program improvement -** Evaluation helps us to identify where changes may need to be made in implementation to improve existing programs.
- **Knowledge development -** Information gathered through evaluation activities helps to identify other areas of need - whether through changing demographics, behaviors, or new trends - and inform future programs.

Types of evaluation

There are multiple types of evaluation, which are briefly described below. Examples of each type of evaluation as they apply to PROMISE for HIP implementation are detailed in the sections that follow.

- **Formative Evaluation -** collects data describing the needs of the population and the factors that put them at risk, as well as factors that can help them reduce their risk and protect their health. In PROMISE for HIP, formative evaluation is accomplished through the CID process (Module 2).
- **Process Monitoring -** collects data describing the characteristics of the population served, the types of services provided, and the resources used to deliver those services. Process monitoring helps you make decisions and changes throughout implementation.
- **Process Evaluation -** collects detailed data to compare the implementation plan with the actual services delivered. Process evaluation looks at how the intervention was delivered, differences between the intended population and the population served, and access to the intervention.
- **Outcome Monitoring -** collects data about client outcomes before and after the intervention, such as knowledge, attitudes, skills, behaviors, or intentions for behavior change. In PROMISE for HIP, outcome monitoring takes place when you conduct additional interviews with the implementation population at least every six months as part of your ongoing evaluation efforts.

EVALUATION PYRAMID



- **Outcome Evaluation** collects data about outcomes before and after the intervention for clients, as well as with a similar group that did not participate in the intervention being evaluated, to show that the intervention is responsible for the observed changes. You are not required to conduct outcome evaluation activities as PROMISE for HIP is based on the original Community PROMISE research, which has already been tested.

EVALUATING PROMISE FOR HIP

Process monitoring and evaluation, as well as outcome monitoring, will be a part of PROMISE for HIP implementation. The steps below outline a general evaluation approach that you may apply to PROMISE for HIP.

Develop a PROMISE for HIP evaluation plan

It is useful to first develop a plan for your evaluation efforts to be sure that you have 1) outlined all the data you need to collect; 2) identified data sources; 3) described the resources to complete the planned work; and 4) developed a timeline for all evaluation activities. Table 1 below illustrates one way to organize your evaluation plan.

Table 1: Evaluation Plan Matrix

Evaluation Question:				
SMART Objective	**Measure/ Indicator**	**Data Source**	**Responsible Staff**	**Frequency**

SMART objectives

To be able to measure your objectives and determine whether you have successfully met your objectives, ensure that they meet the SMART criteria:

- **Specific -** detailed, clear, and precise
- **Measurable -** describes what success will look like in terms of quantity or quality
- **Attainable -** realistically achievable considering the time, resources, and support.
- **Relevant -** closely related to the overall program and what it needs to achieve
- **Time-bound -** specifying when the objective will be achieved or how often

Measures/indicators

An evaluation plan helps you organize and plan data collection activities. You do not want to get to the end of your first year of implementation and discover that you forgot to collect a piece of information that is vital to determining if you implemented PROMISE for HIP with fidelity to the core elements. Similarly, you do not want to collect data that you will never need or use.

It is critical that you establish measures that will help you track progress of your implementation efforts. Examples of measures include the number of RMS developed, the number of peer advocates trained, the number of engagements between peer advocates and members of your intervention population, and the number of additional materials distributed – condoms, safer sex kits, safer injection kits, etc.

Table 2: Sample Evaluation Plan

Evaluation Question: How many RMS were distributed to clinic patients?				
SMART Objective	**Measure/ Indicator**	**Data Source**	**Responsible Staff**	**Frequency**
Each month, PROMISE for HIP peer educators will disseminate 48 medication adherence RMS to African American gay and bisexual men ages 21-35 living with HIV getting their care at the Healthy Living clinic	# of medication adherence RMS distributed in the clinic # of medication adherence RMS disseminated to AA gay and bisexual men living with HIV ages 21-35 in the Healthy Living clinic	Peer Advocate RMS Distribution Form Monthly peer advocate summary sheet	Peer advocates PROMISE for HIP outreach worker program manager	Peers submit logs weekly Monthly summary
Evaluation Question: Did PrEP use change in the intervention population?				
SMART Objective	**Measure/ Indicator**	**Data Source**	**Responsible Staff**	**Frequency**
By [insert date - six months following completion of the CID process], PROMISE for HIP staff will interview [X number] African American gay men ages 18-24 to assess stage of change for PrEP use.	Date the CID process was completed Stage of change for PrEP use in original CID process Demographics of interviewees Overall stage of change for PrEP use six months following original CID process	Completed intervention population interviews (Intervention Population Interview Tool)	PROMISE for HIP interviewer program manager	Every six months

Develop a social media evaluation plan (optional – applies if agency will use social media to disseminate RMS) When using social media to support your PROMISE for HIP program, include additional metrics to monitor activities such as likes, reposts, sharing, comments, etc. depending on the platform you are using and your goals in using social media. Evaluation questions related to social media may include:

- Are we reaching our intended audience?
- How do we know our intended audience is engaged? Do people comment on posts, share posts, and share our videos?

- Is online engagement leading to offline activity?
- Are the time and resources we are investing in social media activities providing us with the outcomes we expect and a significant/ appropriate return on investment and/or insight?
- Are we reaching a significant number of people?

If needed, request technical assistance to support the development of an evaluation plan specifically for your social media activities.

Data collection and management

For each measure, you will want to indicate the data source where the information to calculate the measure can be found, as well as when, how, and who will be involved in collecting and managing the data. For example, you may want to specify peer advocate responsibilities in reporting RMS distribution each month and staff roles in tracking dissemination of RMS through social media. Additionally, you should plan how to review and ensure data quality, and how evaluation results will be shared.

Conduct evaluation activities

Table 3 lists sample methods, indicators, and tools to support your evaluation efforts. These resources are by no means comprehensive, and you may choose to seek additional technical assistance from CDC's CBA Provider Network as needed.

Formative evaluation

As noted previously, a program will be effective only if it is tailored to the specific population for which it is intended. In PROMISE for HIP, the CID process is a formative evaluation process to gather the necessary information to inform program implementation.

Process monitoring and evaluation

Process monitoring of PROMISE for HIP will identify if, when, how, and how many program activities were implemented. Examples of process monitoring indicators include: the number of systems interviews completed; number of intervention population interviews completed; number of peer advocates recruited; number of peer advocates trained; number of role model interviews conducted; and number of RMS developed, published, and distributed.

Tip: See Module 2 for details on the CID process and data collection activities.

Table 3: Sample Evaluation Methods, Indicators, and Tools

Evaluation Type	Methods	Sample Indicators	Sample Tools
Process Monitoring	Tracking forms Questionnaires Interviews	# of peer advocates recruited # of peer advocates trained # of RMS developed # of RMS published # of RMS distributed to the intervention population # of outreach conversations without distribution of RMS # of safer sex kits (or condoms) distributed # of safer injection kits distributed	Peer Advocate Recruitment Report Role Model Story Quarterly Production Report Outreach worksheets
Process Evaluation	Summary tracking forms Questionnaires Interviews	Was the goal achieved for # of peer advocates recruited or RMS developed? Did the RMS contain the eight key components? Did the intervention population receive the materials? Were peer advocates trained appropriately?	Peer Advocate Recruitment Report Role Model Story Quarterly Production Report Outreach worksheets
Outcome Monitoring	Interviews	Did behaviors change in the intervention population? Was there progression in the stage of change among the intervention population? Did attitudes or norms change?	Intervention Population Interview Tool

Process evaluation tells you if the intervention was implemented as intended and planned. In order to achieve the expected outcomes, it is important that PROMISE for HIP activities are implemented as designed – or with fidelity. Process evaluation data help determine whether the PROMISE for HIP core elements were implemented correctly (e.g., Were all the components of the CID process implemented? Did the RMS all contain the eight key components? Did peer advocates engage members of the intervention population in discussions about the RMS?).

Process evaluation may also help answer questions such as: Did we successfully recruit the number of peer advocates that were projected? What proportion of potential peer advocates completed peer advocate training? Did the organization produce the goal number of RMS in a specified time period? Examples of process evaluation for different aspects of PROMISE for HIP are described below.

Peer advocates recruited and trained

It is helpful to track peer advocate recruitment activities to tell you the level of effort necessary to recruit new peer advocates and help with future staffing plans. This may be a simple log that includes the person who referred him/her or the place recruited from, the dates, the type of contact, and the result, including future plans to follow-up if necessary.

PEER ADVOCATE RECRUITMENT REPORT TEMPLATE (5-1)

Maintain a record of each peer advocate training session to document:

- Number of potential peer advocates invited to and attending the training
- Membership in intervention population(s) and geographic area or social network to be accessed by each peer advocate
- Number and types of risk-reduction materials given to each peer advocate
- Description of the training session
- Incentives provided

This information is valuable for tracking training activities, monitoring the performance of trainers and advocates, and making decisions about future recruiting efforts.

Tip: Consider using a unique identifier to keep peer advocates' identities confidential, particularly in external reports or documents

RMS developed

It is important to track the number of role model interviews and the number and type of RMS developed from interviews. A simple form that is updated periodically and totaled at the end of the program period, such as the sample Role Model Story Quarterly Production Report Template, may support these efforts.

ROLE MODEL STORY QUARTERLY PRODUCTION REPORT TEMPLATE (5-2)

To ensure fidelity and quality, once a RMS has been developed, the agency should review the story to assess whether or not it contains all eight key RMS components as described in Module 3. The RMS Content Worksheet may be used to confirm that the story meets the PROMISE for HIP RMS criteria and the review activity should be documented as part of ongoing evaluation activities.

ROLE MODEL STORY CONTENT WORKSHEET (3-7)

Materials published and distributed

PROMISE for HIP programs should track the number of RMS produced and the story content, including characteristics of the role model, goal behavior presented, and the stage of change. At least quarterly, summarize and review the data to assess the mix of stories and the rate of story production. Tracking the mix of stories is useful in making sure that the stories depict a variety of situations and persons reflective of the intervention population(s) and that RMS have changed as the community moves through the stages of change as determined through ongoing evaluation efforts. It is recommended not to change the risk behavior or goal behavior in the RMS as they should be constant for a determined period of time (e.g., six or more months). RMS can depict different personalities or situations, but the goal behavior should be constant.

Program staff should also document contacts with peer advocates to document distribution of RMS and other materials, as well as to document challenges. During each contact, staff should also confirm peer advocate contact information to ensure it is kept current. In your evaluation plan, determine how frequently you will collect and summarize data from peer advocates.

PEER ADVOCATE RMS DISTRIBUTION TEMPLATE (5-3)

Tip: The Peer Advocate RMS Distribution Template may be adapted to collect information about peer advocate activities and distribution of RMS and other materials

A tool such as the Quarterly Peer Advocate Activity Summary Template may be used to summarize peer advocate activities (reported weekly), including the total number of materials distributed over time to each peer advocate and the total number of materials distributed by each peer advocate during the reporting period. Reviewing distribution data may be useful to recognize peer advocates with especially low or high distribution rates and identify the need to recruit new peer advocates to expand overall distribution and fully cover known social networks. The summary may also be used to compare the expected and actual number of materials distributed and the number of individuals reached.

QUARTERLY PEER ADVOCATE ACTIVITY SUMMARY TEMPLATE (5-4)

You may also consider interviewing your peer advocates to assess their understanding and perspective of the reach of your PROMISE for HIP activities. Consider the following in your discussions with peer advocates:

- How, to whom, and when the peer advocate distributes materials
- The proportion of persons contacted who have not been previously exposed to PROMISE for HIP RMS
- The reactions of those receiving the RMS
- Suggestions for improving PROMISE for HIP

Ensure that the interview is brief and that any information you collect guides evaluation efforts and informs program implementation.

Outcome monitoring

Outcome monitoring is a required activity in PROMISE for HIP implementation. Your ongoing evaluation efforts will help you determine what changes in behavior along the HIV care continuum have occurred in the intervention population. The outcomes that you are monitoring are dependent on your goal behaviors in your RMS and the goals of your PROMISE for HIP program with your particular intervention population. Such changes may include increased awareness of HIV status through regular HIV testing, decreased needle sharing, increased PrEP initiation, increased condom use, improved linkage to care after a positive test result, improved retention in care, increased adherence to ART, and increased rates of viral suppression.

You should conduct follow-up interviews with members of the intervention population at least every six months to assess any changes in perception, attitudes, or behaviors related to your RMS goal behaviors. Similar to the CID process, you should conduct up to nine intervention population interviews (or more depending on your program goals and requirements) and stage the population for the desired behavior. Adapt the intervention population interview guide as necessary to address your goal behavior(s). Once you have completed your interviews, summarize your findings, noting any movement in the stages of change, any behavioral changes, or any other relevant findings.

INTERVENTION POPULATION INTERVIEW TOOL (2-5)

Tip: Remember that if you are developing RMS and working with more than one subpopulation, you will have to conduct follow-up activities with members of each subpopulation.

Use the information you gather to plan the next round of role model interviews and RMS, update the CID report as appropriate, discuss the data with program staff to plan additional PROMISE for HIP activities or to make modifications as needed, and include in reports to stakeholders and funders.

Tip: Remember, the goal is to move the intervention population from one stage of change to the next.

SUMMARY

Evaluation is the fourth core element of PROMISE for HIP. Ongoing evaluation through intervention population interviews informs RMS development and program implementation. Evaluation is also an important program management tool that can provide highly valuable data to ensure you are implementing PROMISE for HIP as intended and to make improvements in program implementation.

ENDNOTES

[1] Patton, Q. M. (1997). Utilization Focused Evaluation: The New Century Text (3rd Ed.), London: Sage Publications.

PROMISE for High-Impact Prevention Implementation Manual

MODULE 6: Management

MODULE 6: MANAGEMENT

Implementing PROMISE for HIP requires engaging in multiple - and often simultaneous - planned activities, as illustrated throughout the previous modules. This module pulls together all the different components of PROMISE for HIP to describe and summarize the steps, resources, and staff necessary to support implementation and an active management approach.

GETTING STARTED

Pre-implementation activities

If you have decided that PROMISE for HIP is right for your agency, you will need to engage in several activities in preparation for its implementation. These pre-implementation activities include developing a timeline, marketing the program to stakeholders, networking with other agencies and community organizations, and forming a community advisory group if you do not already have one in place.

A description of these pre-implementation activities follows:

1. Develop a timeline - Planning all your implementation activities in advance helps you stay organized and accomplish all the necessary tasks, particularly when diverse activities are taking place simultaneously. After you have reviewed the steps described in this module, create a timeline for your work that will include initial program planning tasks, obtaining community support, conducting the CID process, identifying role models, recruiting and training peer advocates, developing and producing RMS, and implementation plans. See Table 1 to help you get started.

SAMPLE PROMISE FOR HIP IMPLEMENTATION TIMELINE (6-1)

2. Market PROMISE for HIP to stakeholders. The more support you have in implementing PROMISE for HIP, the more likely you are to be successful. It is helpful to get buy-in from your stakeholders prior to implementation. By stakeholders, we mean the decision-making board at your organization, your staff and potential peer advocates, members of the population you will focus on, and other community organizations and potential partners. In speaking with stakeholders, you want to talk about the basic elements of PROMISE for HIP, the appropriateness of the intervention for your agency and community, evidence of its effectiveness, and the resources necessary for implementation. Having these discussions early improves the chance that your stakeholders will be sufficiently informed to speak out on your behalf and will support your efforts.

3. Network with other agencies, community organizations, and or clinical staff. It is important to establish a network of community organizations or clinical leaders when implementing PROMISE for HIP in a community or clinical setting. Doing so will familiarize other clinical staff or agencies with your programs and services and is a necessary step in eliciting their cooperation or support. Clinical staff and staff members of other agencies working with your intervention population are valuable resources for information and experience and should be included in your CID process as part of the systems interviews. Networking also keeps you in touch with what others are doing in the community, thereby reducing the likelihood of duplicating efforts.

4. Form a community advisory group. Although it is not a requirement for implementing PROMISE for HIP, forming a community advisory group will be very helpful - and may otherwise be required by your funder. At a minimum, you will likely need to engage a materials review panel to sign off on all RMS and other materials for dissemination.

Table 1: Example of PROMISE for HIP Planning Schedule

Abbreviations:
CID = Community identification process RM = Role models OE = Ongoing evaluation (staging)
RMS = Role model stories PA = Peer advocates

Year One:

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Hire and train staff							
Begin CID including community staging	Write CID report						
	Recruit PA and RM						
	Train PA						
	Interview RM		Interview RM		Interview RM		Interview RM
		Develop and publish three RMS per quarter					
			OE		OE		
				Write Year One report			

Community involvement creates a sense of ownership and acceptance, and it results in a project that uniquely responds to the concerns of its population, and one that is more sustainable. The same is true if you are implementing PROMISE for HIP in a clinical setting, in which case an advisory group is also crucial. Ideally, an advisory group consists of community leaders (i.e., people who are recognized as leaders by your intervention population), individuals who work with the intervention population (e.g., social workers, law enforcement, health care workers, health educators, teachers), members of the intervention population, and others who can provide input into the planning and implementation of PROMISE for HIP. The advisory group may review materials and offer design and content ideas, as well as provide input on events and peer advocate incentives. You may identify new or additional advisory group members through the CID process.

Staffing considerations

To plan, implement, and evaluate PROMISE for HIP you need adequate staffing. Your resources and circumstances will dictate the size of the PROMISE for HIP program and staff required to implement it. For example, in large programs, responsibilities such as program management and coordination, conducting interviews, writing RMS, overseeing social media activities, evaluation, and support tasks may be divided among multiple staff. At the very least, implementing PROMISE for HIP will require two or three staff members to oversee major tasks as described below:

- One management-level staff person responsible for planning, organizing, supervising, providing quality assurance, and conducting process evaluation and outcome monitoring of program activities. This person should have experience with HIV prevention, implementing programs, and managing employees. They should also be capable of handling multiple program activities at the same time.

- Staff to interview role models, write RMS, and prepare publications for print.

Tip: When making staff assignments, take into consideration the number of different subpopulations, anticipated RMS schedule, and total RMS required.

- Outreach staff responsible for conducting the CID process, assessing the intervention population, recruiting peer advocates and role models, and supervising peer advocates. Assigned staff should have experience with the intervention population, be able to engage others in conversations easily, and be willing to work outside regular office hours.

- Support staff responsible for keeping records, typing interview transcripts (if done), maintaining correspondence, conducting reminder calls, and providing overall project support.

The table below lists the key personnel necessary to implement PROMISE for HIP, including the number and percentage of time for each position. In addition, the position responsibilities and required skills and knowledge are listed. This will assist you in estimating personnel needs and costs. Note that pay rates vary by community, so they have been omitted from the chart, but you must consider them when developing your budget.

Table 2: PROMISE for HIP Key Staff

Position	Number of Staff and Percentage Time	Responsibilities	Skills and Knowledge
Program manager	1 @ 25–100% (depending on size of program)	See that program integrity is maintained Supervise staff and debrief them daily Assure that supplies and publications are on hand when needed, ensure peer advocates are trained and supported Monitor data collection Request technical assistance as needed Explain program to stakeholders	Supervisory skills Excellent knowledge of program elements to be able to train and supervise staff Knowledge of outreach and local community Competent in all skills needed (CID process, RMS, peers advocates, basic evaluation)
Outreach workers	2 @ 25-50%	Make contacts in community Collect preliminary CID data Recruit and manage peer advocates Recruit role models Supervise peer advocates	Knowledge of community Comfort with intervention population Verbal communication skills Understanding of and commitment to project and its goals Completed PROMISE for HIP training
RMS staff	1 @ 25–50% (may be part of another staff member's job, if qualified)	In collaboration with program manager, identify and inform outreach workers about type of RMS needed Interview role models Write RMS Prepare RMS for publication	Interviewing skills Writing skills consistent with theory Desktop publishing Completed PROMISE for HIP training
Support staff	1 @ 50%	Maintain program records, including data records (CID, process, and outcome data) Order and follow up on materials and publications Keep notes of debrief meetings and peer advocate and staff trainings	Detail-oriented Good at record keeping and retrieval Can use agency databases and software programs Understands concepts related to project Has completed overview course at minimum

Budget considerations
Ensure that you have budgeted appropriately and have the resources to support program activities, including:

- Project staff
- Computer, printer, and software for word processing, desktop publishing, and data management and analysis
- Basic office supplies and equipment
- Digital camera (if you will be doing your own pictures for the publications), camera and scanner, or contract with photographer for RMS production; OR access to electronic art or an artist's services for drawings
- Production and printing resources and costs
- Transportation for staff
- Incentives for peer advocates - including any meals and materials for training
- Prevention materials to package with RMS (condoms, safer sex kits, information about PrEP or linkage to care, safer injection kits, etc.)
- Resources for peer advocate activities or events

RMS preparation for publication - If stories are prepared in-house, using your own desktop publishing capabilities, RMS will take staff time but additional costs are reduced. If you must purchase outside services, the cost will increase. Even if a community partner donates time to support the RMS design, you will incur costs with respect to staff time and materials. Printing costs will be dependent on design and colors. Your community advisory group and may help guide your choice as to design, photographs, or drawings.

Outreach support equipment - If you pay mileage to your outreach or other staff, calculate the costs of daily trips to the sites where peer advocates and intervention population members will be found, since your outreach staff are likely to be in the field more than in the office. Also budget for cellular phones or other necessary field equipment.

Incentives - As part of the initial and ongoing CID process, you will be interviewing members of the intervention population. Since these interviews are lengthy, you may decide to offer them an incentive for their time. Role models may also receive incentives for their time to be interviewed. Your advisory group may help determine the appropriate amount based on your community. You may also decide to provide non-monetary incentives to role models and peer advocates. These may include branded program giveaways (e.g., T-shirts, bags, hats) or gift cards (e.g., transportation, grocery stores, movie theater, etc.). To develop your budget, discuss incentives with your project officer or funding organization and then plan your incentives and determine a schedule for distribution.

Peer advocate events - You may decide to host social events for peer advocates to support engagement and retention. These may be barbecues in a park, indoor picnics in a local recreation center, or something similar, at which the peers may provide music, the staff may provide skits, and the program provides food, certificates, and small gifts of appreciation. Peer advocates may invite their immediate families. Other ideas include bake sales or garage sales where items are donated and then sold by peer advocates. Peer advocates who participate can then split the proceeds from the event as an incentive. This type of event teaches the peer advocates organizational skills and is very satisfying since the results are so tangible.

General costs - As with any intervention, you will have costs for overhead items: space, utilities, insurance, furniture, telephones and phone service, computers, internet, etc.

Implementation activities

PROMISE for HIP will be effective because it is tailored to the specific population whose behavior is being addressed. The tables that follow summarize the tasks required to implement PROMISE for HIP - as described in the previous modules - to aid your planning efforts.

Table 3: Conduct CID Process

Task	Capacity and Knowledge Needed
If not already on staff, recruit, hire, and train program staff.	Training and supervisory skills; knowledge of intervention activities and type of personnel needed
Market intervention to stakeholders.	Knowledge of intervention; marketing skills; ability to answer questions
Network with other agencies and community organizations.	Knowledge of intervention; marketing skills; ability to answer questions; knowledge of community and agencies that work with your community
Form and oversee a community advisory group to review materials and provide program input.	Knowledge of intervention; marketing skills; ability to answer questions; ability to establish connections with community persons; facilitation skills
Prepare for the CID process: gather and refine/ adapt the necessary materials: Systems Interview Tool (2-3) , Intervention Population Interview Tool (2-5), informed consent, and field safety guidelines.	Questionnaire/interview development skills; knowledge of internal agency protocols
Conduct an internal staff brainstorming activity.	Knowledge of people in your own organization who interact professionally with intervention population; ability to facilitate session

Conduct systems interviews.	Knowledge of and access to people who interact professionally with intervention population; ability to access them, create trust and elicit information; ability to explain your purpose; interviewing skills
Conduct intervention population interviews.	Ability to interact with strangers, create trust, and elicit information; ability to explain your purpose; interviewing skills
Conduct in-depth community observations. (optional)	Street knowledge; ability to interact with strangers, create trust, and elicit information; ability to explain your purpose; detail-oriented; observant
Conduct focus groups. (optional)	Experienced at conducting focus groups (not therapy groups); group facilitation skills
Make final decision regarding the intervention population and subpopulation(s).	Knowledge of intervention and agency; understanding of agency's priorities and mission; knowledge of CID results to determine intervention population and subpopulations' needs, stages of change, and influencing factors
Identify goal behavior.	Knowledge of intervention and agency; understanding of organization and funding agency's priorities and mission; knowledge of CID results to determine intervention population and subpopulations' needs, stages of change, and influencing factors
Compile data and identify key findings about the intervention population that will feed the components of RMS.	Skills in staff debriefing, qualitative data-analysis
Develop a general plan for peer advocate recruitment, training, and supervision to describe in the CID report.	Knowledge of intervention activities; training and supervision skills; knowledge of agency resources and existing peer programs
Develop CID report.	Knowledge of intervention; knowledge of CID components and results to determine intervention population and subpopulations' needs, stages of change and influencing factors; understanding of PROMISE for HIP implementation plans
Train staff and outreach team. Training issues include safety, conducting outreach, documentation, and the intervention.	Experienced in outreach, ability to engage intervention population; knowledgeable and committed to the intervention; knowledge of tasks required to implement PROMISE for HIP and forms to conduct evaluation; group facilitation skills
Select specific sites and means of accessing intervention population.	Knowledge of sites frequented by intervention population; ability to access them; ability to establish trust with sites
Contact community advisory group and members of the intervention population through surveys, informal discussions, or focus groups to identify preferred program name and materials.	Knowledge of intervention activities; group management skills
Prepare and train staff on the necessary PROMISE for HIP forms and procedures for implementation in your agency and community.	Data collection and management skills; knowledge of the intervention

Table 4: Recruit Role Models and Conduct RMS Interviews

Task	Capacity and Knowledge Needed
Recruit potential role models.	Knowledge of intervention, intervention population, and type of behavior and stage of change needed; skills to explain the program and purposes of story
Screen potential role models.	Knowledge of intervention, intervention population, and type of behavior and stage of change needed; skills to explain the program and purposes of story
Interview role models for stories.	Interviewing skills; familiarity with interview tool
Transcribe interviews.	Attention to detail; ability to put in writing (verbatim) what was said during the interview

Table 5: Develop RMS

Task	Capacity and Knowledge Needed
Write RMS from transcript or from interview notes and edit.	Knowledge of theory and required RMS components; practiced at writing RMS using worksheet; good understnding of purpose, intent of RMS; writing skills
Decide on platform for publication.	Knowledge of intervention population preferences; knowledge of agency resources
Decide on size, colors, types of paper, etc.	Knowledge of intervention population preferences; knowledge of agency resources
Decide on artwork: ▪ Illustrations - identify artist. ▪ Photographs - identify models and photographer or site for stock photos.	Knowledge of local resources and intervention population preferences; ability to communicate what is needed to photographer or artist; ability to facilitate discussions with advisory group
Develop mock-ups of role model publication.	Graphic design and desktop publishing skills
Produce RMS.	Knowledge of local resources and ability to negotiate or desktop publishing skills
Pre-test the story and the mock-up with community advisory group.	Must be able to describe purpose, theory behind intervention, required components; ability to engage advisory group; ability to facilitate a small group discussion, and ask open-ended questions

Revise story as necessary.	Knowledge of theory and required RMS components; practiced at writing RMS using worksheet; good understanding of purpose, intent of RMS; writing skills
Identify other information to be contained in publication (referrals, ads, etc.) and accompanying materials (e.g., condoms, safer injection kits, information about PrEP, etc.).	Knowledge of community as well as needs of intervention population
Pre-test RMS with members of the intervention population.	Must be able to describe purpose, theory behind intervention; ability to engage intervention population; ability to ask open-ended questions
Revise RMS as needed.	Knowledge of theory and required RMS components; practiced at writing RMS using worksheet; good understanding of purpose, intent of RMS; writing skills
Publish the RMS; reproduce each RMS publication in sufficient quantities for distribution.	Knowledge of agency's resources and distribution needs

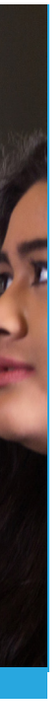
Table 6: Recruit, Orient, Train, and Supervise Peer Advocates

Task	Capacity and Knowledge Needed
Recruit peer advocates by establishing community presence, identifying recruitment contacts or areas, initiating recruitment, and engaging in follow-up activities. Recruit to cover intervention subpopulation. Screen potential peer advocates and invite them to PROMISE for HIP training.	Street knowledge and comfort in the community; access to intervention population and ability to engage the intervention population; skills to explain the program and the role in a way that makes it attractive to the potential peer advocate
Identify and pre-test peer advocate incentives.	Comfort with intervention population; knowledgeable about peer advocates' needs and preferences
Conduct peer advocate training. Provide initial materials and assign staff contact.	Training skills; comfort with population; ability to thoroughly explain the intervention and the advocates' role

Outline geographic area on a local map where materials distribution is to occur; place dot where each peer advocate works; recruit additional peer advocates to fill in gaps. Be aware of appropriate number of peer advocates to cover existing social networks (optional but recommended activity).	Knowledge of geographic area; familiarity with peer advocates and their social networks and areas of operation
Establish weekly peer advocate contact schedule to enhance communication with peer advocates and strengthen implementation efforts. Provide peer advocates with new materials. Document materials distributed by peer advocates (i.e., RMS as well as additional materials – condoms, safer injection kits, PrEP information, etc.).	Friendliness, comfort with intervention population; knowledge of how to use forms; knowledge of PROMISE for HIP

Table 7: Disseminate RMS

Task	Capacity and Knowledge Needed
Provide peer advocates with RMS and accompanying materials; provide documentation for tracking.	Knowledge of RMS distribution and documentation forms



Accompany peer advocates to distribute RMS.	Knowledge of PROMISE for HIP and RMS distribution; knowledge of geographic area; comfort with intervention population and peer advocates
Track RMS and materials (e.g., condoms, safer injection kits, educational materials) distribution.	Knowledge of RMS distribution and documentation forms; data collection and management skills; knowledge of the intervention
Contact peer advocates regularly. Support problem solving. Provide with supplementary materials, inquire about acceptance, field conditions, intervention population issues, and preferences. Document the content of the interaction and materials provided.	Ability to maintain positive relationship with peer advocates and elicit their cooperation; problem solving skills; motivational skills; knowledge of documentation forms
Provide incentives; annually poll peer advocates regarding what small gifts they would like as incentives for volunteering.	Friendliness, comfort with intervention population; knowledge of peer advocates' needs and preferences; creativity
Promote engagement of peer advocates through social events, cards, incentives, and skills building opportunities. Consider holding an appreciation event with food, certificates of appreciation, raffle, small door prizes or gifts, games, music, or other entertainment.	Friendliness, comfort with intervention population; knowledge of peer advocates' needs and preferences

Table 8: Conduct Ongoing Evaluation Activities

Task	Capacity and Knowledge Needed
Develop evaluation plan.	Knowledge of PROMISE for HIP and implementation plan; evaluation skills; understanding of process and outcome measures for PROMISE for HIP; knowledge of data collection instruments
Collect necessary evaluation forms.	Knowledge of PROMISE for HIP evaluation forms, purpose, intent, and usage; instrument design experience; ability to motivate staff to complete forms; ability to communicate need for evaluation to staff
Enter data; manage tracking spreadsheets and database as relevant.	Knowledge of data management techniques and software
Conduct intervention population interviews at least every six months and stage intervention population.	Understanding of PROMISE for HIP; ability to interact with strangers, create trust, and elicit information; ability to explain your purpose; interviewing skills; data analysis skills

Summarize, analyze, and report collected data.	Knowledge of analysis techniques; knowledge about how organization and funding agency defines success
Update CID report.	Knowledge of intervention; knowledge of ongoing evaluation results to inform needs, stages of change and influencing factors in intervention population, as well as changes since first CID process; understanding of PROMISE for HIP implementation plan

SUMMARY

Successful implementation of PROMISE for HIP requires effective management of staff and monitoring of peer advocates, finances, and other resources. This module provided a brief overview of managerial and administrative activities necessary to plan for and to implement PROMISE for HIP.

We encourage you to use the resources in this manual and those presented to you at the PROMISE for HIP training to support program implementation. Additionally, you may request technical assistance through CDC's CBA Provider Network project to support implementation of any of the PROMISE for HIP core elements as described in the previous modules.

We wish you successful implementation of your PROMISE for HIP program.

APPENDICES

MODULE 2: CID TOOLS

2-1 Community Identification Process Planning Worksheet
2-2 Staff Brainstorm Worksheet
2-3 Systems Interview Tool*
2-4 Safety Guidelines for Field Staff
2-5 Intervention Population Interview Tool*
2-6 CID Report Template*
2-7 Advisory Group Notes
2-8 Focus Group Checklist
2-9 Preparation of Focus Group Discussion Outline
2-10 Focus Group Guide and Questions

MODULE 3: ROLE MODEL STORIES TOOLS

3-1 Consent to be Interviewed Template
3-2 Consent to be Photographed Template
3-3 Role Model Story Interview Tool*
3-4 Planning Your Role Model Stories
3-5 Behavioral and Social Determinants*
3-6 Eight Key Components of a Role Model Story*
3-7 Role Model Story Content Worksheet*
3-8 Role Model Story Pre-Test Worksheet

MODULE 4: PEER ADVOCATES TOOL

4-1 Peer Advocate Contact Sheet -
4-2 Distribution of RMS Guidelines
4-3 Peer Advocate Invitation to Training Template

MODULE 5: EVALUATION TOOLS

5-1 Peer Advocate Recruitment Report Template
5-2 Role Model Story Quarterly Production Report Template
5-3 Peer Advocate RMS Distribution Template
5-4 Quarterly Peer Advocate Activity Summary Template

MODULE 6: MANAGEMENT

6-1 Sample PROMISE for HIP Implementation Timeline

HISTORY OF COMMUNITY PROMISE

7-1 The AIDS Community Demonstration Projects
7-2 Intervention research article: "Community-Level HIV Intervention in 5 Cities: Final Outcome Data From the CDC AIDS Community Demonstration Projects"

* Tool also provided during PROMISE for HIP training

2-1 COMMUNITY IDENTIFICATION PROCESS PLANNING WORKSHEET

Community Identification Process (CID) Planning Worksheet

The CID is a core element of PROMISE for HIP and provides information about your intervention population. The CID process allows you to collect information and learn from the community. It helps you to understand:

- Why people engage in risk behaviors
- What barriers exist to changing behaviors
- What will encourage them to change behaviors
- Locations where members of the community may engage in risk behaviors
- Other key information about the population

The CID process also looks at the intervention population's stages of change related to specific risk behaviors.

The CID process involves discussions with internal staff to explore what they already know about the population, interviews with staff of agencies providing services to the population or people whose work puts them in close contact with the intervention population (external sources of information: systems people), and interviews with members of the intervention population.

Through the intervention population interviews, staff identify the behavioral determinants that are operating within the population (and that they hope to influence), risk behaviors, the stage of change for specific behaviors, and potential role models.

Identify a timeline and key staff involved in the CID process	
Timeline for CID process *~3 months*	
Who will…	
Facilitate internal staff brainstorm?	
Conduct systems interviews?	
Conduct intervention population interviews?	
Review and summarize data?	
Draft the CID report?	

Identify your intervention population and subpopulation	
Who is the intervention population?	
Who is the specific subpopulation for this PROMISE for HIP CID process?	
Review data *The main goal of reviewing the existing data is to have an educated estimate in terms of how many people from the intervention population you will work with and include in the implementation of your intervention.*	
List the data or reports you will review to inform PROMISE for HIP implementation. *e.g., census data, epidemiological profiles, local Integrated HIV Prevention and Care Plan, internal needs assessment data*	
Plan community observations	
In what areas or locations are staff able to observe the intervention population?	
Identify individuals for CID activities	
Enter the names or identities (job titles, location, contact information, etc.) of people you will initially recruit for each of the following types of CID data collection (if known).	
Internal staff brainstorm	
Systems interviews	
Intervention population interviews	

2-2 STAFF BRAINSTORM WORKSHEET

PROMISE for HIP Community Identification Process (CID) Staff Brainstorm Worksheet

The CID is a core element of PROMISE for HIP and provides information about your intervention population. The CID process allows you to collect information and learn from the community. It helps you to understand:

- Why people engage in risk behaviors
- What barriers exist to changing behaviors
- What will encourage them to change behaviors
- Locations where members of the community may engage in risk behaviors
- Other key information about the population

The CID process involves discussions with internal staff to explore what they already know about the population, interviews with staff of agencies providing services to the population or people whose work puts them in close contact with the intervention population (external sources of information: systems people), and interviews with members of the intervention population.

This worksheet is designed to help you facilitate the internal staff brainstorm to explore what staff know and understand about the intervention population.

PROMISE for HIP – CID Process
Staff Brainstorm Worksheet

Who is the intervention population and what do you know about them?

Who is the intervention population?	
What are the sub-populations within the larger identified intervention population? *Describe based on race, ethnicity, gender, age, language, trends, educational levels, employment status, clothing styles, geographic settings, risk behaviors, slang related to risk behaviors, etc.*	
What does the population think they are at risk for?	
What do you believe is the risk behavior for this population?	
Where can you access the population? *Where does the intervention population live or hang out? Can you access them virtually via specific platforms or applications?*	
What barriers could impede access to the population?	

How can you eliminate or overcome barriers? *Consider people who are gatekeepers, informal networks within the population, internal resources, and other outside groups serving the population.*	
Internal influences What are the internal individual-level factors that influence behavior (knowledge, attitudes, skills, values, etc.)? *What are their values and attitudes toward [insert goal behavior (e.g., HIV testing)]?*	
External influences External environmental factors that influence behavior (stigma, social norms, etc.) *What are the factors influencing [insert goal behavior (e.g., HIV testing)]?*	
Who else knows, has access to, or works with the population? *Note names, roles, agencies, contact information*	
Who are potential members of the intervention population who may be interviewed? *Note names, contact information or how to find them*	
Who else needs to be involved in PROMISE for HIP implementation?	

2-3 SYSTEMS INTERVIEW TOOL*

Systems Interview Tool

Person who referred you to them (complete before interview): _____

1. Position or title (if sensible to ask): _____
2. Sex: ❑ Male ❑ Female
   ❑ Transgender: Male to Female
   ❑ Transgender: Female to Male
3. Age: _____
4. Ethnicity (self-definition): _____
5. Language(s) spoken: _____
6. How long have you been in this position? (if sensible to ask) _____ years
7. We are interested in learning more about the (*intervention population*) in this community.

   When you think about the (*intervention population*) in your community, do you divide them into different groups such as males/females, older/younger, users of different drugs, or anything else? What are those groups?

   _____ _____

   _____ _____

   _____ _____

   _____ _____

   Which of these groups do you know the most about?

Now I am going to ask you questions only about the (*specific population group;* hereinafter *"specific group"*) you mentioned.

8. How do you have or have you had contact with (*specific group*)?

9. How would you approach (*specific group*) if you wanted to talk to them about HIV?

10. What barriers exist that would make it hard to talk to (*specific group)*?

11. What behaviors do (*specific group*) have that put them at risk for HIV infection and sexually transmitted diseases (S?

12. What do you think is motivating (*specific group*) to continue practicing these high-risk behaviors?

13. What do (*specific group*) think about their own risks for HIV transmission, acquisition, or STDs?

14. If you had to try to convince (*specific group*) to avoid high-risk behavior, how would you approach the problem? What specific suggestions do you have (programs, techniques, etc.) for getting (*specific group*) to reduce their risk of HIV?

15. What particular activities for (*specific group*) would not work or should be avoided in developing HIV prevention programs?

16. Who else would know about (*specific group*) in this community?

Name	Address	Telephone #	Can we use your name?

17. Who do (*specific group*) listen to, who influences their opinions and behaviors?

Name	Address	Telephone #	Can we use your name?

18. Do you know any (*specific group members*) with whom we might talk?

Name	Address	Telephone #	Can we use your name?

If respondent mentioned knowing about other specific groups from the intervention population,

THANK YOU VERY MUCH FOR YOUR ASSISTANCE!

2-4 SAFETY GUIDELINES FOR FIELD STAFF

Safety Guidelines for Field Staff

Safety guidelines apply to all staff at all times they are in the field, including at lunch or on a break.

Personal Appearance: Dress Accordingly

1. If your project provides clothing for staff to wear on the field (T-shirts, hats, tote bags, umbrellas, etc.), wear it. If not, do not dress to impress. Wear neutral clothing that does not attract undue attention. Do not wear clothing that will be considered seductive or revealing. Be aware of gangs and their colors; do not wear clothing or accessories that may suggest particular affiliations.

2. Employees should not carry a purse or a large amount of money while in the field. Jewelry should be limited to small costume jewelry.

3. When approaching others, identify yourself and tell people what you are doing and why. Consider wearing an identification badge where it is visible and can be easily produced.

Getting Along: Be Professional

4. Develop a friendly, professional relationship with clients you come into contact with, but remember your boundaries and do not interact with them socially, romantically, or financially.

5. Do not make assumptions, judgments, or generalizations about the intervention population members. Behave respectfully toward them and earn their trust and confidence. Avoid communication, through words or posture, which may convey arrogance or a judgmental attitude.

6. Do not touch participants. Friendly gestures may be threatening, welcomed, or misinterpreted on the street, and participants may react strongly to them.

7. Do not buy goods, or give or lend money to participants—it suggests favoritism to observers. Do not accept gifts, food, or merchandise from intervention population members or others on the street.

8. Do not play the role of therapist or counselor. Stay within your role of interviewer and provide referrals to community services as appropriate.

9. Always interview respondents one at a time to protect their confidentiality, even if they say it is okay for someone else to listen.

Safety Policy: On-the-Job Rules

10. Field work may be conducted only during specific times of day approved in advance by your supervisor and should be conducted with another staff member in view or in sight of the project office unless the area and circumstances have been approved by a supervisor for a staff member to enter on his or her own. Only conduct field work at night with your supervisor's permission and with at least one other person.

11. When carrying incentives or cash, limit the amount to what you will need during the day. Do not disclose the total amount of cash that you are carrying. Keep cash incentives in envelopes—one envelope per incentive—and only the number of cash or coupon incentives needed for half a day should be kept on your person. Return to the office or car to replenish your supply if needed.

12. When working in dangerous or questionable locations, inform police officers of your presence and purpose for being in the area.

13. Your supervisor is required to know where you are when you are out of the office. Do not depart from your agreed-upon schedule. Ensure that the office has your cell phone number and that colleagues know where you will be. If you must leave the assigned area for any reason, be sure to notify your supervisor.

Avoiding Trouble: Be Alert

14. Be aware of your surroundings at all times. You can avoid trouble by carefully observing the area around you before you leave your car or enter a new area.

15. Stay in view of other staff working with you as well as of street traffic whenever possible. Do not enter shrubbery, alleys, buildings, or other areas where you are not visible, unless you are accompanied by a partner and the area is known to be safe.

16. If you are working with a partner, never leave your partner in the field or fail to meet at a previously arranged site.

17. Do not carry weapons.

18. Avoid getting in the middle of the sale of drugs or sex. If a drug or sex deal is conducted near you, leave the area quickly and quietly, without drawing attention to yourself. Never take, touch, or sample any person's drugs or merchandise on the street.

19. If you do not feel comfortable entering certain areas, or if you have reason to believe that your safety has been compromised, do not enter the area and report to your supervisor immediately.

20. Make sure your know how to appropriately refer crime victims or someone who is in crisis to needed services (police, rape hotline, battered women's shelter, etc.).

21. You and your partner should establish a code word or action that means "leave immediately" so that you can warn each other of the need to move on.

If Trouble Occurs: Leave the Scene

22. If you are caught in a potentially dangerous position, stay calm and leave as soon as possible. In case of emergency, call 911.

23. Never yell or argue with anyone. If someone becomes angry or irritated at you, leave the area at once.

24. If someone is under the influence or otherwise behaving strangely or in a threatening manner, avoid him or her.

2-5 INTERVENTION POPULATION INTERVIEW TOOL

Intervention Population Interview Tool

Basic Information:

Age: _____
Ethnicity: _____
Gender: _____
Language(s) spoken:
_____
_____

Location:
_____
Date: _____ Time:
_____
HIV status:
_____
Interviewer:
_____

HIV Information (and some behavioral or social determinants)

SAY: Now I'd like to ask you some questions about HIV.

1. How do you think people become infected with HIV?

2. How likely do you think it is that you could give HIV to someone else (If HIV-negative, then get HIV from someone else)? What makes you think you could or could not?

3. What are you doing to protect yourself from giving HIV to someone else (If HIV-negative, then getting HIV from someone else)? If nothing, then what are some reasons?

4. What do you think is going on in your community that puts people at high risk for HIV infection?

5. What do you think makes it hard for people to avoid acquiring or transmitting HIV in your community?

Stage of Change Questions

Section 1: Sexual /Injection Drug Risk

6. Have you had vaginal sex or anal sex in the past 90 days?

❑ Yes ❑ No

7. Have you shared needles or works in the past 90 days?
   ❑ Yes ❑ No

Refer to each behavior in the next set of questions. If "no" behavior is reported and
be

SAY: For the next questions, we are going to concentrate on your experiences with vaginal or anal sex, and sharing drug equipment. Now think about your (sex/needle sharing) partners.

8. Do you have one main sex/sharing partner?
   ❑ Yes ❑ No

9. Do you have multiple sex/sharing partners?
   ❑ Yes ❑ No

SAY: I would like us to talk about (vaginal or anal sex/sharing drug equipment) with your (main/other partner(s)).

10. How often would you say you *<goal behavior> (goal behavior = use a condom/use a clean needle)* when *<insert context>*? *(Example: How often would you say you use a condom when you have anal sex?)*

    ❑ Every time → go directly to 10a

    ❑ Almost always → go directly to 10b

    ❑ Sometimes → go directly to 10b

    ❑ Almost never → go directly to 10c

    ❑ Never → go directly to 10c

10a. If "every time," then how long have you been doing this?

    ❑ If 6 months or more → MAINTENANCE STAGE

    ❑ If fewer than 6 months → ACTION STAGE

10b. If "almost always" or "sometimes," do you intend to <*goal behavior*> in the near future every time you <*context*>?

❑ No → PREPARATION STAGE without intent

❑ Probably not → PREPARATION STAGE without intent

❑ Probably will → PREPARATION STAGE with intent

❑ Yes → PREPARATION STAGE with intent

10c. If "almost never" or "never," then do you think you might begin to <*goal behavior*> in the near future when you <*context*>?

❑ No → PRECONTEMPLATION STAGE

❑ Probably not → PRECONTEMPLATION STAGE

❑ Probably will → CONTEMPLATION STAGE

❑ Yes → CONTEMPLATION STAGE

11. What would be some reasons you would <*goal behavior*> *(goal behavior = use a condom/use a clean needle)* when <*insert context*>? *(Example: What would be some reasons you would use a condom when you have anal sex?)*

12. What would be some reasons you would NOT<*goal behavior*> *(goal behavior = use a condom/use a clean needle)* when <*insert context*>? *(Example: What would be some reasons you would NOT use a condom when you have anal sex?)*

If HIV-negative, then skip to Section 3: PrEP (Question 23)

Section 2: Linkage to Care

13. Are you currently in medical care for HIV?

❑ Yes ❑ No

14. If yes, then how long have you been in care?

If no, then what are some reasons?

15. Since you have been in HIV care, how often would you say you go to all your HIV medical appointments?

- ❑ Every time → go directly to 15a
- ❑ Almost always → go directly to 15b
- ❑ Sometimes → go directly to 15b
- ❑ Almost never → go directly to 15c
- ❑ Never → go directly to 15c

15a. If "every time," then how long have you been doing this?
____ days/months/years (circle one)

- ❑ If 6 months or more → MAINTENANCE STAGE
- ❑ If fewer than 6 months → ACTION STAGE

15b. If "almost always" or "sometimes," then do you intend to go to all of your HIV medical appointments in the near future?

- ❑ No → PREPARATION STAGE without intent
- ❑ Probably not → PREPARATION STAGE without intent
- ❑ Probably will → PREPARATION STAGE with intent
- ❑ Yes → PREPARATION STAGE with intent

15c. If "almost never" or "never," then do you think you might begin to go to all your HIV medical appointments?

- ❑ No → PRECONTEMPLATION STAGE
- ❑ Probably not → PRECONTEMPLATION STAGE
- ❑ Probably will → CONTEMPLATION STAGE
- ❑ Yes → CONTEMPLATION STAGE

16. What would be some reasons you would go to all your HIV medical appointments?

17. What would be some reasons you would **not** go to all your HIV medical appointments?

Adherence to HIV Treatment

18. Are you currently taking medication to treat HIV?

❑ Yes ❑ No

19. If yes, then how long have you been taking HIV medication?

If no, then what are some reasons?

20. Since you have been taking HIV medications, how often would you say you take them as your doctor prescribes?

❑ Every time → go directly to 20a

❑ Almost always → go directly to 20b

❑ Sometimes → go directly to 20b

❑ Almost never → go directly to 20c

❑ Never → go directly to 20c

20a. If "every time," then how long have you been doing this?
____ days/months/years (circle one)

❑ If 6 months or more → MAINTENANCE STAGE

❑ If fewer than 6 months → ACTION STAGE

20b. If "almost always" or "sometimes," then do you intend to take your HIV medications the way your doctor prescribes in the near future?

❑ No → PREPARATION STAGE without intent

❑ Probably not → PREPARATION STAGE without intent

❑ Probably will → PREPARATION STAGE with intent

❑ Yes → PREPARATION STAGE with intent

20c. If "almost never" or "never," then do you think you might begin to take your HIV medications the way your doctor prescribes in the near future?

❑ No → PRECONTEMPLATION STAGE

❑ Probably not → PRECONTEMPLATION STAGE

❑ Probably will → CONTEMPLATION STAGE

❑ Yes → CONTEMPLATION STAGE

21. What would be some reasons you would take your HIV medications the way your doctor prescribes?

22. What would be some reasons you would **not** take your HIV medications the way your doctor prescribes?

Section 3: PrEP

23. Have you heard of PrEP?

❑ Yes ❑ No

24. If yes, then what are your thoughts about it as an HIV prevention technique?

25. Do you know anyone who currently is on or has ever taken PrEP?

❑ Yes ❑ No

The remaining questions are for HIV-negative people only.

26. Are you currently taking PrEP?

❑ Yes ❑ No

If yes, then the interviewer should let the respondent know that this concludes the i

27. Do you intend to access and begin taking PrEP in the near future?

- ❑ No → PRECONTEMPLATION STAGE
- ❑ Probably not → PRECONTEMPLATION STAGE
- ❑ Probably will → CONTEMPLATION STAGE
- ❑ Yes → PREPARATION STAGE with intent

28. What would be some reasons you might consider taking PrEP?

29. What would be some reasons you would **not** consider taking PrEP?

Let the respondent know that this concludes the interview, thank them for their time, and provide incentive if appropriate.

2-6 CID REPORT TEMPLATE

CID Report Template

1. Introduction—half page
    a. Introduction to Community PROMISE
        i. Why are you doing PROMISE?
        ii. What is the perceived need for PROMISE in your locality?
    b. Funding source
    c. Expected outcomes

2. Description of CID Process and Results—two to three pages
    a. Selection of implementation site (geographic area to do the intervention)
    b. Brief summary of number of each type of interview/focus group conducted
        i. Interviews (internal and external)
        ii. Focus groups
    c. Description of seven CID objectives—main results for each
        i. Interventions population, segments, prioritization, intervention population
            1. Intervention population
            2. Segments—demographics and other characteristics
            3. Process of prioritization
            4. Selection of intervention population—description and justification
        ii. Intervention population risk behaviors, risk factors, behavioral determinants
            1. Risk behaviors
            2. Risk factors
            3. Behavioral determinants of risk or influencing factors
        iii. Barriers and methods to overcome behaviors
            1. Access, cost, lack of information
            2. Other barriers
        iv. Establishing presence and trust
            1. How did you do it?
            2. How is it evidenced?
        v. Acceptable and unacceptable messages and means of access
        vi. Estimate of intervention population and plans to access the 15 percent
            1. Develop a plan for accessing intervention population based on 15-percent criteria
            2. Estimation of intervention population size (how many people from my intervention population are in my implementation site?)
            3. How did you gain access?
            4. Plan for utilizing access methods
        vii. Community partners: community advocates, referral networks
            1. Partnering
            2. Peer and community advocates
            3. Referral network members

3. Community Staging Results—half page

4. Initial Role Model Stories—one page
    a. Brief description of each initial role model story based on eight key components
        i. Risk behavior, goal behavior, stage of change, behavioral determinant and barrier to change/method to overcome, characterization, membership, positive outcome, OR
        ii. Risk factors using the HIV care continuum indicators you want to use
        iii. Results of piloting of initial role model stories with community advisory group for format

5. Peer Advocates Plans—one page
    a. Plans for recruitment of peer advocates
    b. Training plans for peer advocates
    c. Retention plans for peer advocates

6. Plans for Ongoing Evaluation (plan for revisiting CID data every 3, 6, or 9 months)—half page [just state here you want to stage every 3, 6, or 9 months so you will develop new role model stories]

7. Appendix
    a. Include final examples of initial role model stories
    b. Include specific tools used (especially if they have been adapted)
    c. Timeline for full implementation

2-7 ADVISORY GROUP NOTES

Advisory Group Notes

Meeting details	
Date	
Duration	
Location	
Facilitator	
Other staff present	
Advisory group members present:	
Type of input/feedback/recommendations:	○ CID process ○ CID contacts ○ CID report ○ Potential role models ○ Role model story design ○ Role model story content ○ Potential peer advocates ○ Events ○ Incentives ○ Advisory group members ○ Other:

Recommended contacts/contact information	
Systems interviews	
Intervention population interviews	
Role models	
Peer advocates	
Advisory group members	
Other	
Other ideas/suggestions	

Feedback on protocols/processes	
CID process	
Incentives (intervention population interviews, role model interviews, peer advocates)	
Peer advocate activities	
Online engagement of intervention population by PROMISE for HIP staff	
Other	
Other ideas/suggestions	
Feedback on content	
Priorities for intervention population (HIV prevention)	
Priorities for intervention population (health/social priorities)	
Other	
Other ideas/suggestions	
Feedback on materials	
CID report	
Role model story	
Promotional or marketing materials	

Other outreach materials	
Other	
Other ideas/suggestions	
Feedback on events	
Peer advocate activities	
Outreach events	
Peer advocate social events	
Other agency events	
Other	
Other ideas/suggestions	
Any other comments or recommendations not previously noted to improve PROMISE for HIP implementation?	

2-8 FOCUS GROUP CHECKLIST

Focus Group Checklist

- ✓ Arrive early at the site.
- ✓ Brief the staff on the anticipated duration of the focus group, procedures for signing people in and using registration and confidentiality forms, and how incentives will be distributed upon completion of the focus group.
- ✓ Arrange the room (table and chairs) in the desired style.
- ✓ Review and organize discussion aides, post-session handouts (referral information, HIV facts).
- ✓ Review discussion outline.
- ✓ Prepare incentives in advance. Divide incentives in individual envelopes for distribution to participants.
- ✓ Prepare a sign-in sheet, release forms, confidentiality forms, and any other tools that you may need to facilitate the discussion as part of the community identification process. In addition, identify who is responsible for ensuring participants complete the forms and collecting them.
- ✓ Prepare refreshments.
- ✓ Prepare the digital recorders. When you initiate the recording, state the purpose of the session, location, date, and time of the group discussion. At end of group, collect the audio- or video-recordings and label them for transcription or for future reference. Label files with information about city, date, and time of the focus group.

2-9 PREPARATION OF FOCUS GROUP DISCUSSION OUTLINE

Preparation of Focus Group Discussion Outline

1. Cover the following with participants:
    a. Welcome participants and introduce yourself; do not use professional titles
    b. Provide an explanation of project's purpose; be clear, concise, and do not be secretive
    c. Explain the process of a focus group
    d. Establish ground rules for interaction (these are similar to those in other counseling groups)
    e. Invite participants to introduce themselves

2. Promote group engagement and interaction by posing provocative opinion-based questions that encourage reflection.

3. Topics should go from broad to narrow. This provides a valuable context for participants, prepares them for discussion, and makes it easier to cover sensitive material.

4. Save the most sensitive items for when trust and rapport have been established.

5. The outline should consist of questions you plan to pose to the group. Whether you use them all or not, it is wise to specify follow-up probing questions.

6. Assign time to each topic. As part of your preparation, reduce the number of topics until you feel you have adequate time to cover each one.

7. Be flexible. Topics may emerge in the discussion before they appear on your outline, and unanticipated topics may come up that need to be explored.

8. When appropriate and/or necessary, use any of the following techniques:

    a. Free association
    b. Paraphrasing
    c. Posing hypothetical or previous real-life situations
    d. "If you had to choose" questions
    e. Playing devil's advocate
    f. Asking group whether they agree or disagree with certain statements
    g. Written or video materials
    h. Mini-surveys
    i. Setting group validation of generalizations you are drawing

9. Be sure to thank the group members for the information they provided to you, for their time, participation, and remind them to treat all the information shared by the other participants as sensitive and personal - to maintain confidentiality of what others shared during the discussion.

2-10 FOCUS GROUP GUIDE AND QUESTIONS

Focus Group Guide and Questions

Introduce facilitators.
Welcome, my name is <Your Name>. I will be facilitating this discussion geared toward learning more about the community and different groups within the community, and find out more about their concerns and successes in preventing HIV and staying healthy.

Define purpose of focus group.
Specifically, we want to learn more about the lives of <subpopulation> who use drugs, have sex, or both. So we will be talking today about sex, drugs, and HIV.

Introduce group participants.
To start things off, why don't you tell us your first name. Please use your first names only, but if you do not feel comfortable, you do not have to use your real name. Also - and if you wish - share your age, and how long you have lived in this area.

Acknowledge diversity and commonality among participants.
You may hang out in different parts of town or with different people, and when you were invited to participate in this discussion, you all mentioned that you have sex or use drugs in one form or another. It is possible that you may have similar concerns, questions, or may have had similar experiences.

Explain the reason the session will be recorded.
We are going to record our discussion today so that we can revisit the information after the session is over and pay closer attention to what was discussed. Afterward, we'll have someone type up a summary of what was said and might include relevant phrases verbatim. Your names will not be included, just what you shared. Once we get the recording typed up, we will delete the recordings.

Establish rules of confidentiality.
We ask you to keep what people say here confidential; it's going to be up to all of you to keep it that way.

Encourage participants to set limits.
Share only what you're comfortable sharing; you don't have to discuss every topic, and you don't have to talk about yourself or your own situation unless you want to.

Identify location of bathrooms.
If you need to use the bathroom, that's okay, but come back quickly because we need your input.

Allow participants to disagree.
Feel free to say what you think; we want to hear all of your ideas, even if you don't agree with each other. It's okay to disagree; you just need to respect each other's opinions. You can do this by stating that your experience has been different, and then share your opinion.

Confirm understanding of group participants.
Does anyone have any questions or concerns about what we are going to be doing today?

Turn on recorder and begin the questions.

1. Let's start off by talking about how <subpopulation> are learning about HIV here in <city/area>. So could you start out by giving us an idea of where <subpopulation> are getting their information about how to reduce risks from coming in contact with HIV?
    - Where would most <subpopulation> say they get the best information?
    - Whom do you think <subpopulation> usually turn to for information about HIV?
    - Is there anyone or anywhere else where <subpopulation> get their information from?
    - Tell us a little bit about these places and the different kinds of people who access information there.
    - What about within the <subpopulation> community? What can you tell us about how they get information about preventing the spread of HIV through connections within the community?
    - Do <subpopulation> ever talk about getting information from outreach workers?
    - Tell us about people who aren't connecting with outreach workers; what have you heard?
    - It sounds like some sources are better than others for getting information about HIV. What are your thought on this?

2. Tell us what <subpopulation> know and do to prevent getting or transmitting HIV. *[Facilitators: pay attention to (a) prioritization of responses and relevance to participants' risk behaviors; and (b) which prevention techniques are reported spontaneously, reported only in response to probing, and omitted.]*
    - What else do <subpopulation> know about preventing the spread of HIV?
        - What have you heard about ways that prevent the spread of HIV through sexual contact (such as using condoms, having fewer sex partners, taking PrEP, etc.)?
        - What have you heard about other ways to prevent the spread of HIV through using needles (such as using needle exchange programs; not sharing needles and works, etc.)?

3. We've talked a lot about what <subpopulation> know about preventing the spread of HIV. Let's talk about the kinds of situations that <subpopulation> get into where they don't use that information about how to prevent acquiring or transmitting HIV?
    - What are some situations where they would not use HIV prevention sex practices?
    - What kind of sex partners does that usually happen with?
    - What are some situations where they would not apply their HIV prevention knowledge to injection practices?
    - What kind of drug partners does that usually happen with?
    - Sometimes taking risks is closely related to drug use, what can you tell me about that?
    - What can you tell us about <subpopulation> who don't really know about HIV or just don't know the full story about how HIV is spread?
    - What are some of the misconceptions about HIV prevention that you have heard or noticed?

4. Based on your own experience, and also what you know about the drug scene and the sex scene, what do you think would be the best way to increase awareness, knowledge, and support for <subpopulation> for HIV prevention?
    - What would it look like?
    - What would be the best approach?
    - What kind of staff members do you think <subpopulation> would trust the most to give them information about HIV?
    - What other ways to approach <subpopulation> would work best?
    - What do you think about having people who formerly used drugs or who are living with HIV approaching their specific networks?
    - Are there other needs that people have that you'd like to include in this approach?
    - Is there anything else you can think of that would help make this approach really useful for you or <subpopulation>?

3-1 CONSENT TO BE INTERVIEWED TEMPLATE

Consent to be Interviewed Template

This interview is part of a program being conducted by <name of your organization>.

The purpose of this interview is to gather information about people's experiences in trying to reduce their risk of sexually transmitted diseases (STDs), including HIV. These experiences will be used to identify barriers and best practices to reduce the risk of acquiring or transmitting HIV and can help write stories that will be distributed to peers in order to help them reduce their risk.

This interview is anonymous. We will never identify your name or other personal information. During this interview, I will ask you personal questions about your sexual practices and drug use and hope your honesty will provide us with valuable information to improve our efforts.

The interview will be recorded, so please do not use your name or the names of other people you know while the recorder is turned on. If that occurs, we will not identify anyone in any way and we will delete the recording afterwards. Only staff participating in this program will listen to the tape recording.

In some cases, stories will be written based on the interview, and these stories may be published —without any identifying information—in STD and HIV prevention pamphlets and/or in social media platforms.

We would like for you to answer all the questions fully and provide as many details as possible, but you may choose not to answer anything you are not comfortable with.

I have been informed about the nature and purpose of this interview. I agree to be interviewed and to participate in this program under the conditions that have been described above.

_____ _____

Participant Signature Date

_____ _____

Staff Signature Date

3-2 CONSENT TO BE PHOTOGRAPHED TEMPLATE

Consent to be Photographed Template

I agree to be photographed by <Name of Your Organization> to appear in HIV prevention flyers and brochures.

I understand that these pictures will be published without actual names in a way that will keep me from being identified by name. These pictures may be published in educational flyers and stories for the prevention of HIV and promotion or health in the community of <City, State>.

I have been informed about the nature and purpose of these photographs. I agree to be photographed under the conditions described above.

_____ _____

Participant Signature Date

_____ _____

Staff Signature Date

3-3 ROLE MODEL STORY INTERVIEW TOOL

Role Model Story Interview Tool

Interviewer name: _____ Date: _____

Interviewee name or pseudonym: _____

Intervention population name: _____ Age range:_____

Gender: ❑ Male
❑ Female
❑ Transgender: Male to Female
❑ Transgender: Female to Male

Hispanic or Latino: ❑ Yes ❑ No ❑ Don't Know

Race (check all that apply): ❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Pacific Islander
❑ White

RISK BEHAVIOR, GOAL BEHAVIOR, AND STAGE OF CHANGE (*fill out after the interview is completed*)

- Current or past sex-related risk behavior (for example: sex without a condom, treatment, adherence) and goal behavior (for example: condom use, fewer sex partners, treatment, adherence)
  - Risk behavior (including type of sex and partner if applicable, out of care, not on treatment):
  - Goal behavior:
  - Current stage of change:

- If injection drug use is reported, then fill out the following for current or past drug-related risk behavior (for example, sharing drug-using materials) and goal behaviors (for example: cleaning needles or drug-using materials, using new needles)
  - Risk behavior:
  - Goal behavior:
  - Current stage of change:

INTRODUCTION AND BACKGROUND INFORMATION

Use this if person has been screened already.

Hello. My name is _____. I want to thank you for <*coming/meeting me*> today.

I believe that <*staff member who conducted screening*> has explained to you that we're interested in talking to people who are concerned about HIV or who have done something toward keeping themselves healthy or protecting others from becoming infected.

Use this if person has not been screened already.

Hello. My name is _____. I want to thank you for <*coming/meeting me*> today.

We are interested in talking to people who are concerned about HIV or who have done something toward keeping themselves healthy or protecting others from becoming infected. The first thing we need to do is to ask you some questions about yourself and what you do to control or prevent HIV, to determine if you are eligible for the complete interview. May I continue?

❑ Yes
❑ No → Thank person and discontinue interview

DESCRIPTION OF PROCESS

We want to know what people are doing about HIV prevention so we can write up their stories for others to see, like this one here [*show sample publication*]. I appreciate your willingness to share what you have done because your story will help others improve their sexual health.

You can decide if we can use your first name or identifying information in the final story. Before we begin, I need your permission to use the information you give me today to write a story that we will give to other people. I am going to ask you questions and take notes of your own words so the story will be in your words.

As you know, we will be giving you [*describe incentive*] at the end of the interview as a way of expressing our appreciation. You do not have to answer any specific questions to receive this—if any question makes you uncomfortable, then let me know and we'll go on to another question.

Do I have your permission to start the interview?

❑ Yes → Ask person to sign a role model story permission form (if your agency has one)
❑ No → Thank person and discontinue interview

READ THIS ONLY IF RECORDING THE INTERVIEW

As <*staff member who conducted screening*> explained to you earlier, I am going to record our conversation today so I don't have to worry about taking notes. I hope that's okay with you. We will erase the recording once we have transcribed our interview, and everything will be kept in locked files all the time, and will be seen only by staff who will be working with them—the transcriber, writer, and program

supervisor. In the story that is used, we will change your name and identifying

First, let me verify the information I have about you. You told <*staff member who conducted screening*> that you have <*risk behavior*; *for example, had vaginal sex or anal sex without a condom/shared drug equipment/missed medical appointments/not adhering to meds* >. You also said that you had a certain <*goal behavior; for example, used condoms/used clean or new needles/used PrEP/went to medical appointments/took your meds*> that you do <*every time/almost every time/sometimes/almost never/ never*>. Is that right?

Check to be sure that this matches with the screening information. If not, then go

CHARACTERIZATION AND MEMBERSHIP

1. Before we talk any more about what you have done or are planning to do to stop HIV, tell me a little about yourself, something about your background.

For example, a person might say that he is 24 years old, has lived in this neighborhood for 10 years, lives with his girlfriend and baby, and works part-time in a fast food place. He left school when he was 16 years old and hangs out with his buddies on the corner by the convenience store where he drinks alcohol and keeps an eye out for girls. [*You can alter this example to fit your intervention population*.]

BEHAVIOR QUESTIONS

2. Now let's go back to what you <*have done/are doing/are planning to do*> about HIV. [*choose phrase according to stage*] We are going to talk about <*goal behavior*>.

NOTES ABOUT HOW TO ASK THE QUESTIONS:

Ask the remaining questions in turn for each goal behavior appropriate for the interviewee. Obtain the information about one behavior before going on to the next. It is important that all individuals who are interviewed have a current stage of change no lower than Contemplation for at least one goal behavior.

Make note of the respondent's stage for that behavior and alter the questions as below. For each stage, use these phrases or the appropriate variant of the phrase:

- Contemplation: thinking about the goal behavior
- Preparation/Ready for Action: planning to do, trying to do, sometimes doing the goal behavior
- Action: doing the goal behavior every time but for fewer than 6 months

- Maintenance: doing the goal behavior every time for 6 months or longer

Set the scene for the respondent by confirming again that he or she is [*insert the phrase from above with the goal behavior under discussion.*] Remind him or her that you want to talk about [*the type of behavior chosen in the earlier interview*].

Ask respondent to choose one of these behaviors to talk about for the story.

3. Please describe your experience with <*goal behavior*>.

4. How long you have you <*been doing goal behavior*>?

BEHAVIORAL AND SOCIAL DETERMINANTS

5. When you first started <*doing goal behavior*>, what made you think that you should?

6. What other things influenced your decision to begin <*doing goal behavior*>?

7. How effective do you think <*goal behavior*> is/would be in protecting you against exposing someone to HIV?

8. Of all the things you mentioned, which had the greatest impact on your decision to start <*doing goal behavior*>?

BARRIERS

9. What challenges did you have in <*doing goal behavior*>? What kept you from doing it earlier? What were the main disadvantages to <*goal behavior*>? What was hard about <*doing goal behavior*>?

OVERCOMING BARRIERS

10. How did you overcome these challenges? What helped? Who helped? What did you do?

POSITIVE OUTCOME

11. What benefits do you feel now that you are [*insert phrase and goal behavior*]?

If the respondent is at a stage of preparation/ready for action or above, then you can ask him or her questions to create a second role model story. Return to the behavior questions section and ask all the questions again for the earlier stage, first setting the stage for the respondent by making it clear that this is what you are doing and what the new phrase will be. It is helpful to have extra copies of the interview tool with you to make this process easier.

If there are additional goal behaviors to inquire about (listed on the screening section of this form), then return to the behavior questions section and ask about the new behavior. You do not have to repeat the introduction and background section. Again, it is helpful to have extra copies of the interview tool for this.

When you have completed the interview on all relevant behaviors, continue below.

CONCLUSION

If using the recorder, turn it off.

12. Thank you for your generosity to the community in participating and being so forthcoming. Would you like to have the story use your real first name and any identifying information or would you prefer the name or information changed?

    ❑ Use real first name

    ❑ Change first name to _____

    ❑ Change identifying information including:

Ask if he or she has any questions. Give the interviewee the incentive. Ask if he or she knows of others who might be willing to be interviewed. Give him or her any relevant referral information. Thank him or her again.

3-4 PLANNING YOUR ROLE MODEL STORIES

Planning your Role Model Stories

This tool is intended to help you develop your role model stories based on the information you obtained through the CID process and during the role model interview.

For a description of all the components needed to develop a RMS, please refer to the ***Eight Key Components of a Role Model Story*** handout.

1. **What is the *subpopulation* identified during the CID process you chose to focus on?** *(Membership in intervention population)*
   -

2. **What is the *risk behavior* identified during the CID process that you will address*?*** *(Risk behavior)*
   -

3. **What is the *desired behavior* related to the risk behavior you are aiming for them to do?** *(Goal)*
   -

4. **What is the *stage of change* for this particular behavior among the population identified during your CID process?** *(Stage of change)*
   -

   What is the *next stage*? *(Stage of change movement from one stage to the next)*
   -

5. **What *factor* identified during the CID process has the greatest influence on the population's ability to adopt a new behavior?** *(Determinant of risk)*
   -

6. **What could be one *challenge* that someone from the population could face that prevents them from moving toward the goal behavior?** *(Barriers to change)*
   -

   What options do they have to *overcome this challenge*? *(Methods to overcome barriers to change)*
   -

7. **What could be *realistic progress* related to the goal if the goal is not achieved?** *(Positive outcome)*
   -

8. **Other important *contextual* information about the individual:** *(Characterization)*
   -

3-5 BEHAVIORAL AND SOCIAL DETERMINANTS

Behavioral and Social Determinants

Behavioral determinants are things that have been proven to influence behavior change. Effective behavioral interventions work by addressing a set of determinants.

Remember: First the determinants change, then the behaviors change.

Definitions:

- ★ **Knowledge—**what we know about the behavior and the health problem.
- ★ **Attitudes and Beliefs—**what we think and believe about the behavior and the health problem, and how that may affect use of risk reduction, including beliefs about the effectiveness of the new behavior (response efficacy) and beliefs about the pros and cons of the behavior.
- ★ **Subjective Norms-**what significant others think about performing the behavior or motivation to perform behavior based on subjective norms.
- ★ **Perception of Risk-** the degree to which an individual perceives herself to be vulnerable to a [health] problem.
- ★ **Perceived Susceptibility—**the belief that one is personally vulnerable to the [health] condition.
- ★ **Perceived Severity—**believe that harm can be done by the [health] condition.
- ★ **Intentions—**willingness to try to change the behavior.
- ★ **Self-efficacy—**feeling confident that we have the capacity to change the behavior.
- ★ **Values—**how we see ourselves as individuals, what we believe in, what is OK and what is not OK for us to do. This relates to how the behavior fits in with how we see ourselves.
- ★ **Skills—**the actual ability to do the behavior.
- ★ **Perceived Norms—**an individual's interpretation of what significant others think about performing the behavior; and or motivation to perform behavior based on subjective norms.

- ★ **Social Norms—**the rules that a group uses to determine appropriate and inappropriate values, beliefs, attitudes, and behaviors. These rules may be implicit or explicit.
- ★ **Social Support—**Social support is the perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network.
- ★ **Access—**the ability or right to approach, enter, exit, communicate with, or make use of programs and services. Access can be related to structural issues, such as transportation or hours of service, or social issues such as discrimination.
- ★ **Stigma—**is the real, perceived or imagined fear of societal attitudes regarding a particular condition.

3-6 EIGHT KEY COMPONENTS OF A ROLE MODEL STORY

Eight Key Components of a Role Model Story

Component 1: Characterization is a short description about the role model and the circumstances of his or her life. It ranges from one or two sentences to not more than a short paragraph. The characterization makes the role model real, adds credibility to his or her experience, and brings the story to life.

Component 2: Membership in intervention population. Often, the characterization of the role model's life situation will identify clearly his or her membership in the intervention population. If it does not, then that membership should be made explicit early in the story since it helps the reader identify with the role model.

Component 3: Risk behavior. Many individuals have more than one risk behavior. It is important that the risk behavior central to the story is clear to the reader. The context in which the behavior occurs also should be included. If the target behavior is condom use, then an important factor in identifying the context is recognizing the type of sexual partner. An example of this would be: "I sell my body to guys on their way to work each morning, and I hardly ever asked them to use a rubber until…"

Component 4: Goal. Each story should contain only one goal. Since a single risk behavior could have a number of different goals, it is important that only one goal be selected and included in the story. That goal also must be precise. For example, while "reducing HIV risk" is not a precise goal, "not sharing injection equipment" or "using a condom during anal sex with a main partner" are more precise goals.

Component 5: Stage of change. The story also should illustrate movement from one stage of behavior change to another. There only should be movement from one stage to the next stage. The story should not illustrate movement of more than one stage. For example, the story should not show someone moving from Precontemplation (thinking about whether the behavior should be changed) to Action (practicing the new behavior). There are only three shifts (from one stage to the next) that you can show in a role model story:

- Precontemplation to Contemplation
- Contemplation to Preparation
- Preparation to Action

Component 6: Determinants. Each story should describe only one or two behavioral or social determinants that influenced the role model to change his or her behavior. They have an impact on the way a person thinks or feels about HIV risk or performing a target behavior. The determinant is what motivates the role model to develop an intention to modify his or her risk behavior, adopt a new behavior, or continue with a practice that has already been adopted.

Component 7: Barriers to change and methods of overcoming them. Each story should describe a specific barrier that the role model encountered when adopting the target behavior. For example, not having a condom available at the time of sex is clearly a barrier to condom use. The story should address this issue and describe the method used to overcome the barrier, such as carrying condoms or asking a date to stop by a store to buy them. Negative reactions or problems should be included, such as a partner becoming angry when asked to use a condom, but the resolution to this obstacle also must be presented.

Component 8: Positive outcome. Finally, the role model story should include the positive outcome that reinforces the adoption or the intention to adopt the desired behavior. For example, using a condom during sex may reduce the worry of contracting HIV, or it may give the role model a better self-image. Even in situations where the goal was not achieved (such as the role model asking a partner to use a condom but the partner refusing), a positive outcome must be included (such as the role model feeling good about trying and having developed a new strategy for overcoming the barrier in the future).

3-7 ROLE MODEL STORY CONTENT WORKSHEET

Role Model Story Content Worksheet

Ethnicity of Role Model:

Gender of Role Model:

Component 1: Characterization:

Component 2: Membership in intervention population:

Component 3: Risk behavior:

Component 4: Behavioral goal:

Component 5: Stage of change:

Component 6: Behavioral determinants:

Component 7: Barriers to change and methods of overcoming them:

Component 8: Positive outcome:

3-8 ROLE MODEL STORY PRE-TEST WORKSHEET

Role Model Story Pre-test Worksheet

- Introduce yourself and project.
- Explain the purpose of the feedback and worksheet.
- If applicable, inform reviewer of available incentives.
- Distribute the RMS (if various stories have been developed, distribute one at a time) and ask the person to read them and respond to questions.

Role Model Story Name:

What is the message or the main idea of this story?
What do you think this story is trying to say?
Personal relevance
How does the story relate to you and your friends?
What comes to mind when you read this story?
Believability
From your experience, are the changes described in the story believable? Why or why not?
Does the story sound like how you and your peers talk to each other?
How could the story be improved?
Acceptability
What did you like best about the story?

What did you like least about the story?
Is there anything offensive about the story?
What are your thoughts about the images in the story?
What should we consider if we decide to publish this story on social media platforms?
Production value
What catches your eye the most about the materials?
What would you do with the RMS if you were given a copy?
Access
Where would you place these materials (what physical locations) to reach <insert intervention subpopulation>? Would you pick this up?
On which social media platform(s) would you post the materials to reach <insert intervention subpopulation> ? Would you click on it?

4-1 PEER ADVOCATE CONTACT SHEET

Peer Advocate Contact Sheet

Peer advocate first name: _____Nickname:_____

Last name:_____Territory: _____

Address: _____ Phone: _____

Hangout/Location: _____ Message Phone: _____

Date	Publication ID	# of RMS provided	Comment	Staff

4-2 DISTRIBUTION OF ROLE MODEL STORY GUIDELINES

Distribution of Role Model Story Guidelines

1. Greet the person in a friendly manner.
2. Introduce yourself and what you're doing in the community.
3. Ask if they would be willing to let you share a story about someone in the neighborhood who's doing something to reduce their risk of HIV.
4. When they say yes, ask if you also can ask them a few questions afterward to make sure the story is clear.
5. When they say yes, tell them the story.
6. Ask them if they can tell you what the story is about (behavioral goal).
7. Ask them where the person in the story is in terms of doing what they talk about (stage of change) or what was the person doing at the start of the story and at the end.
8. Ask them why they think this person did what they did (behavioral determinant).
9. Ask them if this sounds like something in their own experience.
10. Ask them to tell you more about that.
11. Share a copy of the story with them.
12. Ask them if they would be willing to take a copy of the story to share with someone else.
13. If yes, give them an extra copy of the story.
14. Thank them for their time and let them know that they've been a great help.

4-3 PEER ADVOCATE INVITATION TO TRAINING TEMPLATE

Peer Advocate Invitation to Training Template

Dear (INSERT PEER ADVOCATE'S NAME HERE),

We wish to congratulate you on becoming a (INSERT NAME OF YOUR PROJECT) peer advocate as part of our PROMISE for HIP program! We could not be happier to have someone who cares about their community and wants to help guide the efforts of this project. Your involvement will truly make a difference in our organization and our community.

Your involvement as a peer advocate will consist of:

- Participating in a 1.5-hour training session to gain skills in approaching peers and engaging in focused conversations
- Distributing role model stories with peers during scheduled outings and other activities
- Engaging peers in conversations related to the role model story focusing on the positive behavioral change message
- Encourage peers to take a couple stories and engage their friends in similar conversations
- Amplifying the voice of the community by listening to them and sharing their needs, concerns, and successes with the project coordinator to enhance the design or improvement of (PROJECT NAME) events, programs, and services
- Providing input on and review role model stories and other educational and promotional materials for appropriateness, community relevance, acceptability, and accuracy
- Participating in or promotion of (PROJECT NAME) events in the community
- Taking an active role in improving their own overall health and that of their community members
- Participate in booster sessions or other activities as planned

Some of the benefits you will receive include:

- Strengthening network connections with community members
- Free access to social events hosted by (PROJECT NAME)
- Enhance skills and your resume
- Ability to make a difference in your community

As a reminder, our first meeting and training will be on (DATE), from (TIME FRAME), at (LOCATION). There will be light snacks and refreshments offered at our meeting.

We are excited to have you join us as a peer advocate and consider you an asset to help strengthen our program to eliminate HIV from our community. If you have any questions, please feel free to email us at (EMAIL ADDRESS), or call (PHONE NUMBER), prior to the meeting.

Sincerely,

(PROJECT COORDINATOR's NAME)
Project Coordinator

Peer Advocate Recruitment Report Template

Training date and location	
Number of participants	
Description of training	
Incentives provided (quantity and description)	

Name	ID #	Gender	Race/ethnicity	Peer advocate subpopulation	Population served	Area	# materials accepted

Role Model Story Quarterly Production Report Template

Months covered	J A N F E B M A R A P R M A Y J U N J U L A U G S E P T O C T N O V D E C
Year	

ROLE MODEL STORY INFORMATION				MAIN CHARACTER DETAILS			
Production date	**Title**	**Publication #**	**# produced**	**Intervention population**	**Goal behavior**	**Gender, race, ethnicity**	**Initial stage of change**

5-3 PEER ADVOCATE RMS DISTRIBUTION TEMPLATE

Peer Advocate RMS Distribution Template

Confirm peer advocate contact details and update as needed

Peer Advocate ID #	
First and last name	
Nickname	
Address	
Phone number	
Phone number to leave a message	
Hangout/where to locate	
Peer advocate territory	

Indicate number of RMS distributed and challenges conducting peer advocate activities.

ROLE MODEL STORY INFORMATION				
Date	**Publication ID #**		**Staff contact**	**Comments and any challenges identified**

Quarterly Peer Advocate Activity Summary Template

Months covered	J A N F E B M A R A P R M A Y J U N J U L A U G S E P T O C T N O V D E C
Year	

INCENTIVES					
1	2	3	4	5	6

Enter the RMS ID # in the header and then enter the number of stories distributed by each peer advocate.

ROLE MODEL STORY DISTRIBUTION										
		MONTH			MONTH			MONTH		
Peer advocate ID	Intervention population	RMS #	RMS #	Incentive #	RMS #	RMS #	Incentive #	RMS #	RMS #	Incentive #

Sample PROMISE for HIP Implementation Timeline

Abbreviations:

CID = Community identification process
OE = Ongoing evaluation (staging)
RM = Role models
RMS = Role model stories
PA = Peer advocates

YEAR ONE

1st Quarter	2nd Quarter		3rd Quarter	4th Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Hire and train staff								
Begin CID including community staging	Write CID report							
	Recruit PA and RM							
	Train PA							
	Interview RM			Interview RM		Interview RM		Interview RM
			Develop and publish three RMS per quarter					
				OE		OE		
					Write Year One report			

7-1 THE AIDS COMMUNITY DEMONSTRATION PROJECTS

History of Community PROMISE
The AIDS Community Demonstration Projects

The Centers for Disease Control and Prevention AIDS Community Demonstration Project was a multi-site collaboration. The intervention was developed collaboratively by investigators at the individual sites, CDC staff, and a team of nationally recognized experts who served as consultants. The institutions and individuals who contributed to the design and implementation of the intervention trial are listed below by the site at which they worked. Affiliations are given for the period during which staff persons collaborated on this research project and do not necessarily represent their current affiliations. Along with the principal investigators are listed key staff members who worked on the study at one time or another.

Dallas, TX. Anne Freeman, MSPH, Dallas County Health Department (principal investigator). Key staff: Suzi Berman, Curtis Jackson, Martin Krepcho, PhD, Elvin Magee, MS, and Jo Ann Valentine, MSW.

Denver, CO. David Cohn, MD, and Cornelis Rietmeijer, MD, MSPH, Denver Health and Hospitals (principal investigators). Key staff: Tim Davis, RN, Steve Kane, MS, Catherine Martindale Fischer, RN, Janet Morgan, RN, Diane Ortega, Patrick Piper, and Keith Yamaguchi.

Long Beach, CA. Nancy H. Corby, PhD, and Fen Rhodes, PhD, California State University, Long Beach, and Long Beach Department of Health and Human Services (principal investigators). Key staff: Susan Enguidanos, MPH, Robert DeLuna, Margaret Jamner, PhD, Suzanne Padilla, MA, Richard Wolitski, PhD, and Jefferson Wood.

New York, NY. Susan Tross, PhD, National Development and Research Institute (principal investigator). Key staff: Abu Abdul-Qadar, PhD, Beatrice Krauss, PhD, Martha Sanchez, and Paul Simons.

Seattle, WA. Robert Wood, MD, and Gary Goldbaum, MD, MPH, Seattle-King County Department of Public Health (principal investigators). Key staff: Karen Hartfield, MPH, Thomas Perdue, John Wiesman, MPH, and Tianji Yu, MPH.

Scientists from the CDC were associated with the original research AIDS Community Demonstration Project throughout its life. Project officers were Kevin O'Reilly, PhD, (1989-1992), Donna Higgins, PhD, (1992-1994), and Wayne D. Johnson, MSPH (1994-1995). Other CDC staff who made important contributions to the study include Carolyn Beeker, PhD, Christine Galavotti, PhD, Carolyn Guenther-Grey, MA, Linda Kay, MPH, and Daniel Schnell, PhD.

Scientific consultants also made major contributions to the development, design, and evaluation of the AIDS Community Demonstration Projects. These individuals include Martin Fishbein, PhD, Alfred McAlister, PhD, LeaVonne Pulley, PhD, James Prochaska, PhD, John Sheridan, Cathleen Crain, MA, and Nathaniel Tashina, PhD.

7-2 INTERVENTION RESEARCH ARTICLE: "COMMUNITY-LEVEL HIV INTERVENTION IN 5 CITIES: FINAL OUTCOME DATA FROM THE CDC AIDS COMMUNITY DEMONSTRATION PROJECTS"

Community-Level HIV Intervention in 5 Cities: Final Outcome Data From the CDC AIDS Community Demonstration Projects

The CDC AIDS Community Demonstration Projects Research Group

ABSTRACT

Objectives. This study evaluated a theory-based community-level intervention to promote progress toward consistent condom and bleach use among selected populations at increased risk for HIV infection in 5 US cities.

Methods. Role-model stories were distributed, along with condoms and bleach, by community members who encouraged behavior change among injection drug users, their female sex partners, sex workers, non–gay-identified men who have sex with men, high-risk youth, and residents in areas with high sexually transmitted disease rates. Over a 3-year period, cross-sectional interviews (n = 15 205) were conducted in 10 intervention and comparison community pairs. Outcomes were measured on a stage-of-change scale. Observed condom carrying and intervention exposure were also measured.

Results. At the community level, movement toward consistent condom use with main ($P < .05$) and nonmain ($P < .05$) partners, as well as increased condom carrying ($P < .0001$), was greater in intervention than in comparison communities. At the individual level, respondents recently exposed to the intervention were more likely to carry condoms and to have higher stage-of-change scores for condom and bleach use.

Conclusions. The intervention led to significant communitywide progress toward consistent HIV risk reduction. (*Am J Public Health.* 1999;89:336–345)

Community-level interventions represent a promising approach to prevention of HIV infection. They aim to change communitywide norms and practices in order to support individuals' efforts to change.[1,2] Since the 1970s, community-level interventions have addressed various health issues, including smoking cessation[3–5] and the control and prevention of coronary heart disease.[1,6–10] However, "the size of effects has been meager in relation to the effort expended."[11] In many studies, positive behavioral changes were seen in both the treatment and comparison areas, a result that seemed to be due in part to unexpectedly steep trends toward reducing unhealthy behaviors.[4,11–13]

Nevertheless, community-level interventions have had some success in prevention of HIV infection. Kelly and colleagues trained gay men to talk about prevention with their peers and to endorse behavior changes.[14] After the intervention, unprotected sexual intercourse decreased and condom use for anal intercourse increased. These trends continued for 3 years after the intervention,[15] and similar results were achieved when Kelly et al. replicated this study in 8 cities.[16] A community-level approach has also been used to reach young men who have sex with men.[17] Street outreach programs, mass media campaigns, and other forms of community-level interventions have been used extensively to reach injection drug users and other at-risk populations.[2,18–20]

Few studies have analyzed the degree to which community-level programs have led to behavioral changes at the community level. Rather, most have addressed changes among individuals. Here we describe the outcome evaluation results from the AIDS Community Demonstration Projects, an innovative 5-city trial to evaluate the effects of a community-level intervention for underserved populations at risk for HIV infection.[21–23]

Methods

The AIDS Community Demonstration Projects were conducted in Dallas, Tex; Denver, Colo; Long Beach, Calif; New York City; and Seattle, Wash. In each city, the project focused on members of 1 to 3 of the populations at increased risk for HIV infection: active injection drug users, female sex partners of male injection drug users, female commercial sex workers and other women who trade sex for money or drugs, youth in high-risk situations, non–gay-identified men who have sex with men, and residents of census tracts where rates of sexually transmitted diseases are high. A community was defined as an at-risk population in a specific geographic region. A total of 10 intervention–comparison community pairs were studied (Table 1).

The study design, data collection methods, and intervention activities have been described in detail elsewhere.[21–24] These activities were approved by human subjects review boards at each of the study sites.

Intervention Activities

All sites used a common intervention protocol that was based on behavioral theo-

A complete list of the members of the CDC AIDS Community Demonstration Projects Research Group appears in the Acknowledgments at the end of this article. The corresponding author is Richard J. Wolitski, MA, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention, 1600 Clifton Road, MS E-37, Atlanta, GA 30333 (e-mail: ryw1@cdc.gov).

Requests for reprints should be sent to the National Center for HIV, STD, and TB Prevention, Office of Communications, MS E-06, Centers for Disease Control and Prevention, Atlanta, GA 30333.

This paper was accepted September 2, 1998.

Editor's Note. See related editorial by Kelly (p 299) in this issue.

ries,[23–25] ethnographic research in the study communities,[26] and intervention strategies used in community-level trials.[5,10,27] The intervention had 3 key components: (1) mobilization of community members to distribute and verbally reinforce prevention messages and materials among their peers, (2) creation of small-media materials featuring theory-based prevention messages in the form of role-model stories, and (3) increased availability of condoms and bleach kits.

Persons from the targeted at-risk communities, other local residents, and persons from area businesses who had regular contact with the target population were recruited and trained to distribute the intervention materials in their community. These persons focused the recipients' attention on the HIV infection prevention messages in these materials and reinforced the recipients' attempts to adopt and maintain risk reduction practices.[28–31] From July 1991 to June 1994, nearly 1000 people were recruited and trained to distribute materials.

The small-media materials (e.g., community newsletters, pamphlets, baseball cards) contained authentic stories about people from the community that described how they were changing (or preparing to change) their HIV-related risk behaviors. The materials also contained basic AIDS information, instructions on the use of condoms, and other community-related information.[32,33] A total of 585 000 small-media materials were distributed across all sites.

Each story described the role model's progress toward the consistent practice of 1 of 5 risk reduction behaviors: condom use for (1) vaginal or (2) anal sex with a main partner (steady partner or spouse); condom use for (3) vaginal or (4) anal sex with nonmain partners (casual partners, one-time partners, paying partners); or (5) use of bleach to clean needles, syringes, and other equipment used to prepare or inject drugs. Because data on condom use during anal sex with nonmain partners were collected for only 1 population, we do not address condom use during anal sex in this report.

The messages, as well as the overall intervention strategy, were based on behavior change theory.[34–39] The role-model stories emphasized factors that behavioral theory associates with the adoption of reduced-risk practices (such as attitudes, perceived norms, and self-efficacy) and that were empirically associated with risk behavior in periodic analyses of data collected in each of the 10 intervention communities.[22,24,32]

The stories emphasized specific stages on a continuum of behavior change as specified by the transtheoretical model of behavior change. The primary goal of the intervention was to move people from precontemplation (no intention to adopt a given behavior) to contemplation (short-term or long-term intention to adopt the behavior) to preparation (short-term intention to adopt the behavior and some attempts to adopt the behavior) to action (adoption and consistent practice of the behavior for less than 6 months) and, finally, to maintenance (adoption and consistent practice of the behavior for 6 months or longer).[23,40–42]

The importance of environmental facilitation led to an early decision to distribute condoms and bleach kits along with the small-media materials.[22,24] Each site tailored the intervention to meet local needs. Details of the specific interventions in the participating cities are presented elsewhere.[22,30,31,43]

TABLE 1—Demographic and Risk Characteristics of the Intervention Group, the Comparison Group, and the Total Sample: CDC AIDS Community Demonstration Projects, 1991–1994

	Intervention Group (n = 8015), %	Comparison Group (n = 7190), %	Total Sample (n = 15205), %
Community pair			
Dallas–high STD pair 1	12.5	15.7	14.0
Dallas–high STD pair 2	7.7	10.0	8.8
Denver–IDU	12.3	8.8	10.6
Long Beach–CSW	13.6	16.6	15.0
Long Beach–FSP	5.1	5.5	5.3
Long Beach–IDU	14.4	8.6	11.7
New York–FSP	9.8	11.3	10.5
Seattle–CSW	9.5	7.5	8.5
Seattle–MSM	5.7	6.6	6.1
Seattle–youth	9.5	9.5	9.5
Sex			
Female	52.8	56.3	54.5
Male	47.2	43.7	45.5
Race/ethnicity**			
African American	55.6	52.9	54.3
White	22.3	21.8	22.0
Hispanic	16.8	20.6	18.6
Other	5.3	4.8	5.0
Age**			
11–29 y	33.1	38.0	35.4
30–39 y	40.4	39.0	39.7
40–87 y	26.5	23.0	24.9
Lifetime HIV risk			
Injection drug use**	57.5	47.7	52.9
Sex for money/drugs (women only)*	60.3	55.1	57.8
Same-sex contact (men only)**	21.4	20.8	21.1

Note. High STD = residents of census tracts having high rates of sexually transmitted diseases; CSW = commercial sex workers; FSP = female sex partners; IDUs = injection drug users; MSM = non–gay-identified men who have sex with men.
*$P < .05$ (Cochran-Mantel-Haenszel χ^2 stratified by community pair).
**$P < .001$ (Cochran-Mantel-Haenszel χ^2 stratified by community pair).

Study Design and Data Collection

The effects of the projects were evaluated by means of a nested cross-sectional design[9] with repeated sampling over time in matched intervention and comparison communities. The design was considered quasi-experimental because communities were randomly assigned (by coin toss) to treatment condition only in Dallas. In the other community pairs, assignment to intervention status was limited by resources such as office space for intervention activities. On the basis of formative research at each site, community pairs were matched by accessibility and density of at-risk target community members (e.g., observable sale and use of illicit drugs, presence of commercial sex workers), basic demographic characteristics (e.g., race/ethnicity, socioeconomic status), and the physical characteristics of interview locations (e.g., number and type of businesses, presence of residential housing).

In 2 instances, comparable intervention and comparison community pairs could not be found in a nearby community. For Seattle non–gay-identified men who have sex with men, a suitable comparison community was found in Long Beach. In Denver, extensive movement of injection drug users between the intervention and comparison communities was detected after data collection began.[44] Therefore, data collection at the

Denver comparison site was suspended and responses from the Long Beach comparison community of injection drug users were systematically divided into 2 groups to form a new Denver comparison group and a separate Long Beach comparison group.

To evaluate the effect of the intervention, anonymous field interviews were conducted in 10 cross-sectional waves from February 1991 through June 1994. The first 2 waves were completed before the implementation of intervention activities, and the remainder over the 32-month intervention period. Interviewers could not be blinded to the assignment of communities because project materials were observable in the intervention communities.

Sampling quotas were established for the specific risk behaviors targeted for intervention in each community (e.g., female sex partners of injection drug users who practiced vaginal intercourse with their main partners). In most communities, random number tables were used to select potential respondents. For Long Beach and for Seattle non–gay-identified men who have sex with men, the times and locations for interviews were randomized, and staff attempted to approach all potential respondents in an interview location. These methods are similar to those commonly used to recruit respondents in hard-to-reach communities.[45]

Potential respondents were approached on the street (non–gay-identified men who have sex with men were approached in adult bookstores or other public sex-related environments) and asked to complete a brief screening interview. The screening interview (typically lasting less than 5 minutes) provided basic data on demographics, membership in a targeted at-risk community, and HIV risk. Persons who met study eligibility criteria were asked to complete the standard interview (lasting, on average, an additional 10 minutes). Eligibility criteria for the standard interview were (1) membership in one of the at-risk communities targeted by the local site and (2) vaginal or anal intercourse in the 30 days before interview or sharing needles for drug injection in the 60 days before interview. Respondents were given small payments of cash or food coupons for participating.

Measures

The standard interview yielded basic information about HIV risk–related behaviors and behavioral determinants. For the behaviors of condom use with main and nonmain partners and bleach use, we used the Stages of Change continuum as our outcome measure. An increase in the mean stage-of-change score indicated progress toward the behavioral goal. The development and computation of the Stage of Change scale and the other measures have been described in detail elsewhere.[22,43,46]

Exposure to intervention. At the end of the interview, respondents were asked to describe anything they had seen or heard in the past 3 months "around here in the community" about how to protect themselves from HIV infection. Interviewers asked the source of this information to determine whether the information was associated with the AIDS Community Demonstration Projects intervention. Respondents who reported that they had talked with a project volunteer or staff person or had received project intervention materials were coded as having been exposed to the intervention.

Stage of change for condom use. For a given behavior, stage of change was defined by a 5-point ordinal scale ranging from precontemplation to maintenance. The scale for condom use was as follows:

1 = Precontemplation: has little or no intention to always use condoms in the future

2 = Contemplation: does not use condoms but intends to begin using them every time in the future

3 = Preparation: almost always or sometimes uses condoms *and* intends to use condoms every time in the future

4 = Action: has used condoms every time for less than 6 months

5 = Maintenance: has used condoms every time for 6 or more months

Responses to items regarding condom use frequency, history of condom use, and intention to use condoms consistently in the future were used to develop a stage-of-change score for each respondent who reported having vaginal sex in the past 30 days with a main or nonmain partner, according to an algorithm that was empirically derived for this study.[46]

Stage of change for bleach use. The stage of change for bleach use was computed by using the same approach as for condom use. Injection drug users were staged on bleach use only if they reported having shared needles in the past 60 days. Thus, injection drug users who had not shared injection equipment were excluded from analyses on stage of change for bleach use.

Condom carrying. All respondents were asked during the interview whether they were carrying a condom. All who answered yes were asked to show the condom to the interviewer. Respondents who produced a condom were coded as carrying condoms. Respondents who did not show a condom to the interviewer were coded as not carrying condoms.

Survey Respondents

As shown in Table 1, the sample was based on data from 15 205 interviews. A total of 51 235 screening interviews were conducted from February 1991 to June 1994 in the 10 matched community pairs. Of these, 16 311 longer interviews were initiated with persons who were eligible to participate, 16 134 (98.9%) of whom completed this interview. According to demographic information, 929 responses appeared to be repeats (i.e., a person interviewed more than once in a single wave); a coin was tossed to determine which of the completed interviews to retain for data analysis. Repeat standard interviews across different waves were not excluded. Thus, a person could be sampled in more than one wave but only once within one wave. The proportion of respondents who had been interviewed more than once did not differ significantly between the intervention and comparison communities.

Community-Level Analyses

Because the unit of treatment assignment for the AIDS Community Demonstration Projects was communities, we adapted the methods of Murray and colleagues[9,47] to generate community-level data based on individual observations from the interviews. We conducted a random-coefficients analysis, using a 2-stage hierarchical regression procedure to measure the effects of the intervention on each outcome variable at the community level. In the first stage, linear models were used to generate least squares adjusted means for each of the 10 intervention–comparison pairs for each data collection wave. These adjusted means were controlled for sex, race/ethnicity, age, and lifetime history of injection drug use, man-to-man sex, and, among women, trading sex for money or drugs. In the second step of the hierarchical regression process, the adjusted means for each community provided the observations for a mixed regression model to measure changes over time for each outcome variable of interest.

Because stage of change is ordinal rather than continuous, we originally developed a method using parameters from logistic models to generate "covariate-adjusted measures of central tendency" as the first step of the process described above. However, we subsequently observed that these values were almost indistinguishable from those based on linear parameters; therefore, we chose to employ the more familiar least

squares means for both the ordinal and dichotomous outcome variables. All analyses were replicated with unadjusted raw means; the results were the same as those from the analyses with adjusted means (i.e., the significant results remained significant), which took into account variations in the composition of the study sample between the treatment conditions and over time.

Independent variables for the mixed models were treatment (intervention or comparison) and time, which was analyzed as a continuous variable. Each data collection wave was represented in the model as the number of months elapsed since the intervention was initiated, divided by 32 (the midpoint of the final data collection wave). Thus, the 2 waves collected at baseline were coded as time 0 and the final wave was coded as time 1. Quadratic and cubed terms for time were included as appropriate. Community pair and appropriate interaction terms were included as random effects in the mixed models.

To evaluate the differential effect of the intervention across time, we added a treatment × time interaction term to each model. This term measures the extent to which changes from baseline to the end of the study in the intervention communities exceeded changes in the comparison communities.

A priori (planned) comparisons were conducted to aid in the interpretation of findings from the outcome analyses in which mean stage-of-change score was the outcome. These comparisons assessed the extent to which changes in mean scores were associated with movement between stages. Four dichotomous variables were computed to represent the communities' movement into successively higher stages of change. For example, the first dichotomous variable contrasted persons in the 4 higher stages with those in the precontemplation stage. Tests for changes over time in the intervention and comparison communities were evaluated separately for each of the dichotomous variables by means of the 2-stage approach already described.

Individual-Level Analyses

Since exposure to the intervention took place on the individual level, not the community level, analyses were conducted to determine the extent to which exposure to the intervention was associated with outcomes in the intervention communities. The effect of intervention exposure was tested by linear or logistic models in which a single independent variable represented recent exposure (exposed vs unexposed in past 3 months). The model was adjusted for data collection wave as well as for the demographic and risk history covariates already described.

The relationships between demographic variables and risk behaviors are elaborated on in other published articles.[24,44,48–51]

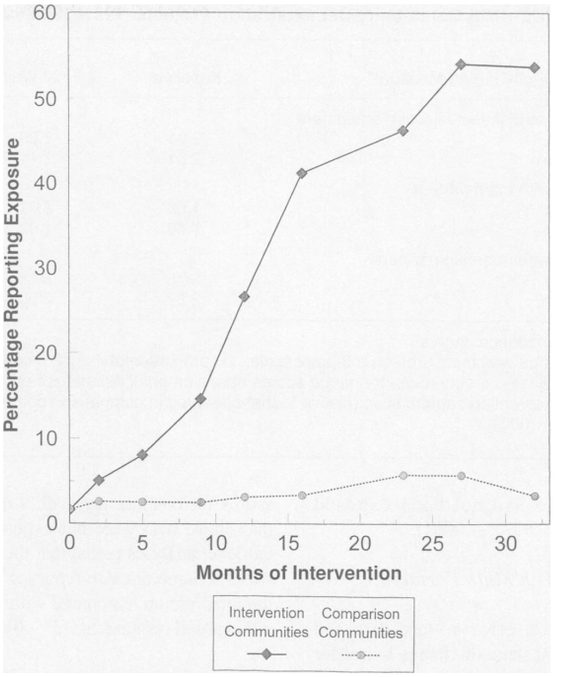


FIGURE 1—Percentage of respondents reporting exposure to the intervention over time: CDC AIDS Community Demonstration Projects, 1991–1994.

Results

Exposure to the Intervention

Recent exposure to the intervention increased in the intervention communities from 5% during month 2 to a peak of 54% during month 27 (Figure 1). Thus, by the end of the intervention, more than half of the target population had been reached at least once in the prior 3 months. A small amount of cross-contamination was observed: 3% to 6% of persons in comparison communities reported recent exposure to the intervention.

Use of Bleach to Clean Injection Equipment

Complete stage-of-change data for bleach use were obtained only from the following community pairs: commercial sex workers in Long Beach and injection drug users in Dallas, Denver, and Long Beach. A total of 3551 individual responses were used to compute the community-level means. At baseline, mean stage-of-change scores for bleach use indicated that most respondents in both conditions were in the preparation stage or a later stage. Over time, the mean scores did not change significantly in either condition; scores increased by 0.08 in the intervention communities but decreased by 0.10 in the comparison communities (Table 2). Examination of the dichotomous scores representing transitions into higher stages revealed no significant differential changes over time (Table 3). The only significant changes occurred in the comparison communities, reflecting a relapse from consistent bleach use (represented by the action and maintenance stages).

Examination of the effects of exposure to the intervention on individual-level data in the intervention communities revealed a significant association between exposure and stage-of-change scores for bleach use. Across all waves, respondents who had been exposed to the intervention had higher scores

TABLE 2—Change in Adjusted Mean Stage-of-Change Scores for Intervention and Comparison Communities Over Time: CDC AIDS Community Demonstration Projects, 1991–1994

Stage-of-Change Measure[a]	Baseline	Final Wave	Absolute Change[b] (95% CI)	Differential Change[c] (95% CI)
Use of bleach to disinfect injection equipment				
Intervention	2.91	2.99	0.08 (–0.12, 0.28)	0.19 (–0.10, 0.47)
Comparison	2.51	2.41	–0.10 (–0.3, 0.10)	
Condom use with main partner				
Intervention	1.66	2.07	0.41 (0.26, 0.56)**	0.19 (0.01, 0.38)*
Comparison	1.60	1.82	0.21 (0.07, 0.36)*	
Condom use with nonmain partners				
Intervention	2.76	3.18	0.42 (0.20, 0.64)**	0.34 (0.04, 0.63)*
Comparison	2.82	2.90	0.08 (–0.14, 0.30)	

Note. CI = Confidence interval.
[a]Stage of change was measured on a 5-point scale: 1 = precontemplation; 2 = contemplation; 3 = preparation; 4 = action; 5 = maintenance.
[b]Change in adjusted mean stage-of-change scores based on point estimates from all 10 waves of data.
[c]Change in intervention communities relative to that observed in comparison communities.
*$P < .05$; **$P < .0001$.

than those who had not been exposed (mean = 3.25 vs 2.93, $P < .0001$).

Condom Use With Main Partner

Intervention efforts were directed toward increasing stage-of-change scores for condom use during vaginal sex with a main partner in all 10 communities. Across all waves of data collection, 9457 individual responses were obtained on this measure. At baseline, scores indicated that most respondents in both the intervention and comparison communities were in the precontemplation stage (Table 2). By the final wave of data collection, scores had increased significantly in both conditions (Figure 2). As shown in Table 2, the increase in the intervention communities was significantly greater than the increase in the comparison communities—an absolute increase of 0.41 vs 0.21.

Comparisons of the dichotomous community-level scores revealed significant increases in stage of change for condom use with a main partner for the intervention communities across each of the 4 transitions (Table 3). The largest increase was in the first transition, representing movement from precontemplation into subsequent stages. This indicates that although the intervention was associated with positive movement across all stages of change, the only significant differential change was associated with movement out of the precontemplation stage. Changes observed in the comparison communities were also significant for 3 of the 4 transitions.

As was true of bleach use, respondents in the intervention communities who reported recent exposure to the intervention had, on average, higher stage-of-change scores for condom use with a main partner than those who were not exposed. Individual-level analyses reveal that the mean score was 1.97 among those reporting exposure to the intervention, compared with 1.83 among nonexposed respondents ($P < .01$).

Condom Use with Nonmain Partners

The intervention addressed condom use with nonmain partners in all of the intervention communities except for the 2 female-sex-partner community pairs. Across intervention waves, 7760 responses were obtained on stage of change for condom use during vaginal sex with nonmain partners. Mean scores show that most respondents were in the preparation stage or an earlier stage at baseline (Table 2). Over time, the mean stage-of-change score increased significantly in the intervention communities relative to the comparison communities (Figure 2). The increase in the intervention communities was 5 times that in the comparison communities.

For nonmain partners, as for main partners, comparisons of the dichotomous community-level scores revealed significant increases in the intervention communities across each of the 4 transitions (Table 3). The largest differential increases were for the later 2 transitions, representing movement from earlier stages during which condoms were not used (or were used inconsistently) to later stages in which respondents either had started using condoms consistently or had maintained consistent condom use for 6 months or longer. Significant differences were not observed in the comparison communities.

Recent exposure to the intervention was significantly associated with higher stage-of-change scores. Among intervention community respondents, those reporting recent exposure to the intervention had higher mean scores across data collection waves than nonexposed respondents (mean = 3.33 vs 3.01, $P < .0001$).

Observed Condom Carrying

Community-level data for condom carrying were obtained for all 10 community pairs; these data are based on 13 958 respondents who reported having had vaginal or anal intercourse in the past 30 days. The mean proportion of respondents carrying condoms in the intervention communities increased significantly over time (Figure 3). Relative to the baseline value of 17.4%, observed condom carrying increased by 73.6% in the intervention communities, to 30.2% by the end of the intervention (absolute increase = 12.8%, 95% confidence interval [CI] = 8.0%, 17.6%). Condom carrying increased only slightly in the comparison communities (from 18.5% at baseline to 18.9% at the end of the study; absolute increase = 0.4%, 95% CI = –4.4%, +5.2%). A differential increase of 12.4% occurred in the intervention communities (95% CI = 6.8%, 18.0%; $P < .0001$).

At the individual level, recent exposure to the intervention was strongly associated with observed condom carrying. Across the intervention period, 31.3% of exposed respondents were carrying a condom, compared with 19.8% of nonexposed respondents in the intervention communities ($P < .0001$).

Discussion

These findings indicate that the AIDS Community Demonstration Projects inter-

TABLE 3—Change in Percentage of Intervention and Comparison Community Respondents at Specific Stages in the Stage-of-Change Continuum Over Time: CDC AIDS Community Demonstration Projects, 1991–1994

Stage of Change	Baseline, %	Final Wave, %	Absolute Change, % (95% CI)	Differential Change, % (95% CI)
Bleach use to disinfect injection equipment				
Contemplation or higher				
Intervention	79.5	83.0	3.5 (–5.1, 12.2)	3.8 (–8.9, 16.6)
Comparison	69.8	69.5	–0.3 (–8.9, 8.4)	
Preparation or higher				
Intervention	65.1	72.1	6.9 (–0.6, 14.5)	–1.3 (–12.3, 9.7)
Comparison	51.7	59.9	8.2 (0.7, 15.8)*	
Action or higher				
Intervention	26.6	22.9	–3.7 (–10.7, 3.3)	6.5 (–3.5, 16.6)
Comparison	16.1	5.9	–10.2 (–17.2, –3.2)**	
Maintenance				
Intervention	19.8	21.2	1.4 (–6.0, 8.8)	9.5 (–1.0, 20.0)
Comparison	13.4	5.3	–8.1 (–15.5, –0.7)*	
Condom use with main partner				
Contemplation or higher				
Intervention	30.1	44.0	13.9 (8.5, 19.4)**	7.5 (1.1, 14.0)*
Comparison	26.8	33.2	6.4 (0.9, 11.8)*	
Preparation or higher				
Intervention	20.4	33.4	12.9 (8.3, 17.6)***	5.2 (–0.6, 11.1)
Comparison	17.7	25.4	7.7 (3.1, 12.3)**	
Action or higher				
Intervention	8.5	17.0	8.5 (4.7, 12.3)***	4.2 (–0.7, 9.1)
Comparison	9.1	13.4	4.3 (0.5, 8.1)*	
Maintenance				
Intervention	7.0	12.5	5.5 (2.1, 8.9)**	2.9 (–1.9, 7.6)
Comparison	7.2	9.8	2.6 (–0.8, 6.0)	
Condom use with nonmain partners				
Contemplation or higher				
Intervention	70.9	81.1	10.3 (4.2, 16.3)**	7.0 (–1.5, 15.5)
Comparison	70.2	73.5	3.3 (–2.8, 9.4)	
Preparation or higher				
Intervention	58.6	73.1	14.5 (7.6, 21.5)***	7.8 (–2.2, 17.8)
Comparison	58.4	65.1	6.8 (–0.2, 13.7)	
Action or higher				
Intervention	24.6	33.4	8.7 (2.2, 15.3)**	9.2 (0.7, 17.7)*
Comparison	27.4	27.0	–0.5 (–7.0, 6.1)	
Maintenance				
Intervention	21.7	30.2	8.5 (2.1, 14.9)**	9.4 (1.2, 17.7)*
Comparison	25.6	24.7	–0.9 (–7.3, 5.5)	

Note. CI = Confidence interval.
*$P < .05$; **$P < .01$; ***$P < .0001$.

vention reached the target population and motivated them toward adopting HIV risk-reduction behaviors. The significant increases in condom carrying and stage-of-change scores for condom use were observed not only among individuals reached directly by the intervention but across the study communities as a whole. The ability of the intervention to reach and motivate change in these geographically and demographically diverse communities suggests the potential usefulness of this approach to HIV prevention.

The participation of community members in delivering the intervention made it possible to reach many more persons than could have been reached by paid staff alone. Near the end of the intervention, slightly more than half of the persons interviewed in the intervention communities reported having been exposed to project prevention materials or volunteers in the past 3 months. This high level of community exposure may be attributed in part to the large number and type of community volunteers who disseminated prevention materials and role-model stories to their peers.[22,28,30] These volunteers reached community members who might otherwise not have participated in facility-based prevention programs. Furthermore, their presence may have served as a steady reminder of the risk reduction messages disseminated by the AIDS Community Demonstration Projects and provided ongoing reinforcement of behavior change efforts.

Because the intervention had multiple components, however, we cannot attribute outcomes to any one component. It is possible, for example, that condom distribution alone would have led to a significant increase in stage-of-change scores.

The intervention was most successful in promoting movement toward consistent condom use for vaginal sex with main and nonmain partners. This is reflected in significant changes at the community and individual levels of analysis. For vaginal intercourse with main partners, this change consisted primarily of the formation of intentions to adopt consistent condom use. At baseline, most of the persons interviewed expressed no intention of using condoms with their main sex

CDC Research Group

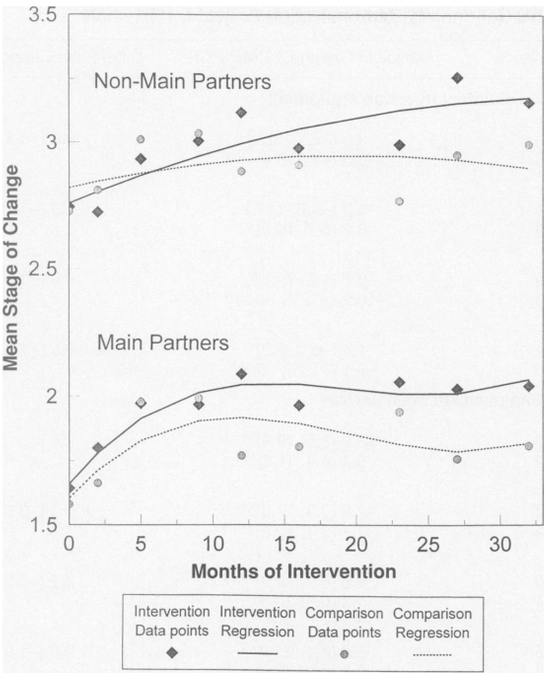


FIGURE 2—Mean stage-of-change scores for condom use with main and nonmain partners over time: CDC AIDS Community Demonstration Projects, 1991–1994.

partners. Accordingly, most of the role-model messages encouraged recipients to begin considering this behavior. For condom use with nonmain partners, however, the intervention effect was largely attributable to changes in consistent condom use (i.e., movement into the action and maintenance stages). The pattern of these findings is consistent with findings of studies indicating that people may be reluctant to use condoms with their main, but not their nonmain, partners.[52]

The increases in self-reported stage of change for condom use are substantiated by corresponding changes in observed condom carrying. A strong intervention effect was seen for condom carrying in the community- and individual-level analyses. In fact, condom carrying increased by 74% in the intervention communities. This change is not only a verification of the self-reported changes in condom use but is important in itself. Carrying condoms is an especially important step toward risk reduction for persons who are likely to engage in sexual activity in settings where condoms are not readily available, such as sex workers.

Given the consistently positive influence of the intervention on all measures of condom use, it is somewhat surprising that for bleach use a significant effect was observed only at the individual level, where recent exposure to the intervention was associated with stage-of-change scores. Statistical tests using the community as the unit of analysis, however, did not detect a significant intervention effect. This is primarily due to the fact that the bleach analysis was substantially underpowered. Statistical methods to determine power for community-level analyses have only recently been brought together by Murray.[47] As calculated by these methods, the post hoc estimate of power was 0.18. Thus, with 4 community pairs, we had only 18% power to reliably detect an intervention effect of 0.19 or larger.

In addition, changes in recommendations regarding the use of bleach that were announced during the study may have limited the magnitude of the intervention effect.[53] When the federal guidelines recommending a hierarchy of steps that placed less emphasis on bleach use were issued, the messages provided by the AIDS Community Demonstration Projects were changed accordingly. Given that needle exchange programs were rare at the project sites and that bleach use remained a viable prevention tool, bleach use was maintained as a primary outcome variable. The change in risk reduction messages, however, may have caused some injection drug users to adopt other risk reduction strategies that were not assessed as part of this study.

We believe that the use of the stages-of-change construct as a foundation of the intervention, as well as the outcome assessment, was critical to our success. As demonstrated in the baseline data, large proportions of the communities at risk were in the lower stages for consistent condom use with main and nonmain partners. With this information, we were able to develop and disseminate intervention messages that were more appropriate for facilitating movement from these early stages, for which "almost no meaningful interventions exist."[54] Also, by using the stage-of-change model to assess intervention effectiveness, we were able to assess change across all transitions in adopting risk reduction behaviors. Traditional dichotomous outcome measures measure change for only one transition: from preparation to action—the point at which the person actually changes behavior. The stages-of-change model allowed us to capture the nuances of change.

Changes in stage-of-change scores, however, are difficult to interpret with regard to their potential impact on HIV transmission in a community. It is easier to understand the importance of the changes observed in this study if we consider only changes in the proportion of individuals reporting consistent condom use (i.e., those in the action or maintenance stages). In this study, the percentage of individuals in the intervention communities who reported consistent condom use with their main partners doubled, increasing from 8.5% at baseline to 17.0% at the last wave (Table 3). The percentage using condoms with nonmain partners increased from 25% to 33%. The combined magnitude of these effects is consistent with the magnitude observed in scientifically rigorous studies included in a recent meta-analysis of individual- and community-level HIV interventions conducted in the United States.[55] More important, it is clear that an increase of this magnitude can have a significant public health impact when considered at the community level.

This study had several limitations. With 2 exceptions, the community pairs were not randomly assigned to intervention or comparison status. Data collection methods did not include probability sampling; however, strategies such as the use of random number lists to select potential respondents were used in an attempt to reduce selection bias. The study communities were not assumed, however, to

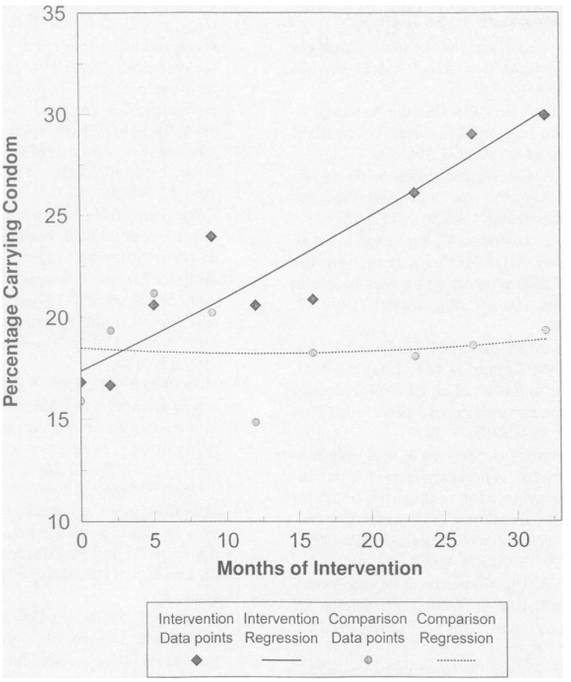


FIGURE 3—Percentage of respondents observed to be carrying a condom over time: CDC AIDS Community Demonstration Projects, 1991–1994.

be a representative sample of a larger set of communities or populations at risk for HIV infection. Therefore, these findings should be viewed as an indication of what *can* occur with this type of community-level intervention and not as an indication of what would *necessarily* occur in other communities.

Our reliance on self-reported data was necessary because sexual activity and drug use are private behaviors. However, changes in self-reported condom use corresponded with those in observed condom carrying. Finally, although these analyses include adjustments for demographics, city, and type of community, they represent only an overview of the results from the projects. The effects of the intervention differed somewhat among sites and populations. Recent publications of findings from individual AIDS Community Demonstration Projects sites provide further information about the success of specific implementations of the intervention.[44,56,57]

This study and others demonstrate that community-level interventions can modify HIV risk behaviors.[14,17,44,56–60] It is important to recognize, however, that no single intervention can be 100% effective. The challenge now faced by HIV prevention researchers and practitioners is to refine and integrate intervention efforts to optimize behavior change. Coordinating community-level interventions in a comprehensive HIV prevention plan with other, more intensive approaches, such as HIV counseling and testing and group interventions for skill building, may yield greater behavior change. Finally, community-level interventions may be enhanced by including structural factors that are indirectly related to HIV risk,[61,62] such as policies and laws regarding the availability of new syringes and needles;[63–66] opportunities for job training and placement (to provide financial alternatives to drug and sex trading); and solutions to broader social issues, such as discrimination and gender inequalities.[67] Unless society is willing to address these basic issues that sustain the HIV epidemic, most HIV prevention programs will achieve only limited success. □

Contributors

M. Fishbein, D. L. Higgins, C. Rietmeijer, and R. J. Wolitski contributed to the intervention and evaluation design and implementation. C. A. Guenther-Grey oversaw intervention implementation. W. D. Johnson analyzed the data. All authors contributed to data interpretation and the writing of the paper and are guarantors for the integrity of the research.

Acknowledgments

The Centers for Disease Control and Prevention AIDS Community Demonstration Projects were a multisite collaboration. The institutions and individuals who contributed to the design and implementation of the intervention trial are listed below. Affiliations are given for the period during which staff persons collaborated on this research project and do not necessarily represent their current affiliations. Members of the writing group for this paper are denoted by an asterisk.

Centers for Disease Control and Prevention
Carolyn Beeker, PhD
Christine Galavotti, PhD
Carolyn Guenther-Grey, MA*
Donna L. Higgins, PhD (Project Officer, 1992–1994)*
Wayne D. Johnson, MSPH (Project Officer, 1994–1995)*
Linda Kay, MPH
Kevin R. O'Reilly, PhD (Project Officer, 1989–1992)
Daniel Schnell, PhD

Dallas County Health Department, Dallas, Tex
Suzi Berman
Anne Freeman, MSPH (Principal Investigator)
Curtis Jackson
Martin Krepcho, PhD
Elvin Magee, MS
Jo Ann Valentine, MSW

Department of Public Health, Denver Health and Hospitals, Denver, Colo
David Cohn, MD (Principal Investigator)
Tim Davis, RN
Franklyn Judson, MD (Principal Investigator)
Steve Kane, MS
Catherine Martindal, RN
Janet Morgan, RN
Diane Ortega
Patrick Piper
Cornelis Rietmeijer, MD, MSPH*
Paul Simons

Long Beach Department of Health and Human Services and Center for Behavioral Research and Services, California State University, Long Beach, Calif
Nancy Corby, PhD (Principal Investigator)
Susan Enguidanos
Margaret Jamner, PhD
Fen Rhodes, PhD
Richard Wolitski, MA*
Jefferson Wood

National Development and Research Institute, New York, NY
Abu Abdul-Quader, PhD
Beatrice Krauss, PhD
Martha Sanchez
Paul Simons
Susan Tross, PhD (Principal Investigator)

Seattle–King County Department of Public Health, Seattle, Wash
Gary Goldbaum, MD, MPH
Karen Hartfield, MPH
Thomas Perdue
John Wiesman, MPH
Robert Wood, MD (Principal Investigator)
Tianji Yu, MPH

CDC Research Group

Project Consultants

John Sheridan (Conwal, Inc, McLean, Va)

Cathleen Crain, MA, and Nathaniel Tashima, PhD (LTG Associates, Tacoma Park, Md)

Martin Fishbein, PhD* (University of Illinois, Champaign, Ill)

James Prochaska, PhD (University of Rhode Island, Kingston, RI)

Alfred McAlister, PhD, and LeaVonne Pulley, PhD (University of Texas, School of Public Health, Houston, Tex)

The authors gratefully acknowledge the invaluable insights of Dr Lillian Lin (CDC) and Dr David Kleinbaum (Emory University) concerning the application of mixed models to this study, and they wish to thank Dr Russell Wolfinger (SAS Institute) for his recommendations on syntax in SAS Proc Mixed. They also thank Drs Phil Smith and Lynda Doll (CDC) and the journal reviewers for their careful and thoughtful reviews of the manuscript. Finally, the authors are indebted to the individuals in the communities who volunteered their time and energy to share HIV prevention information with their peers and encouraged them to reduce their risks. Without them, this project would not have been successful. The authors also thank the individuals in all communities who took the time to participate in the surveys.

References

1. Farquhar JW. The community-based model of life style intervention trials. *Am J Epidemiol.* 1978;108:103–111.
2. Holtgrave DR, Qualls NL, Curran JW, Valdiserri RO, Guinan ME, Parra WC. An overview of the effectiveness and efficiency of HIV prevention programs. *Public Health Rep.* 1995; 110:134–146.
3. The COMMIT Research Group. Community intervention trial for smoking cessation (COMMIT), I: cohort results from a four-year community intervention. *Am J Public Health.* 1995; 85:183–192.
4. The COMMIT Research Group. Community intervention trial for smoking cessation (COMMIT), II: changes in adult cigarette smoking prevalence. *Am J Public Health.* 1995;85: 193–200.
5. McAlister A, Puska P, Koskela K, Pallonen U, Maccoby N. Mass communication and community organization for public health education. *Am Psychol.* 1980;35:375–379.
6. Fortmann SP, Flora JA, Winkleby MA, Schooler C, Taylor CB, Farquhar JW. Community intervention trials: reflections on the Stanford Five-City Project. *Am J Epidemiol.* 1995;142:576–586.
7. Lando HA, Pechacek TF, Pirie PL, et al. Changes in adult cigarette smoking in the Minnesota Heart Health Program. *Am J Public Health.* 1995;85:201–208.
8. Luepker RV, Murray DM, Jacobs DR Jr, et al. Community education for cardiovascular disease prevention: risk factor changes in the Minnesota Heart Health Program. *Am J Public Health.* 1994;84:1383–1393.
9. Murray DM, Hannan PJ, Jacobs DR, et al. Assessing intervention effects in the Minnesota Heart Health Program. *Am J Epidemiol.* 1994;139:91–103.
10. Puska P, Nissinen A, Tuomilehto J, et al. The community-based strategy to prevent coronary heart disease: conclusions from the ten years of the North Karelia Project. *Annu Rev Public Health.* 1985;6:147–193.
11. Susser M. The tribulations of trials—intervention in communities. *Am J Public Health.* 1995;85:156–160.
12. Koepsell TD, Diehr PH, Cheadle A, Kristal A. Symposium on community intervention trials. *Am J Epidemiol.* 1995;142:594–599.
13. Fishbein M. Great expectations, or do we ask too much from community-level interventions? *Am J Public Health.* 1996;86:1075–1076.
14. Kelly JA, St. Lawrence JS, Stevenson LY, et al. Community AIDS/HIV risk reduction: the effects of endorsements by popular people in three cities. *Am J Public Health.* 1992;82: 1483–1489.
15. St. Lawrence JS, Brasfield TL, Diaz YE, Jefferson KW, Reynolds MT, Leonard MO. Three-year follow-up of an HIV risk-reduction intervention that used popular peers. *Am J Public Health.* 1994;84:2027–2028.
16. Kelly J, Murphy D, Sikkema K, et al. Randomized, controlled, community-level HIV-prevention intervention for sexual-risk behavior among homosexual men in US cities. Community HIV Prevention Research Collaborative. *Lancet.* 1997;350:1500–1505.
17. Kegeles SM. The Mpowerment Project: a community-level HIV prevention intervention for young gay men. *Am J Public Health.* 1996;86:1129–1136.
18. Booth RE, Watters JK. How effective are risk-reduction interventions targeting injecting drug users? *AIDS.* 1994;8:1515–1524.
19. Choi K, Coates TJ. Prevention of HIV infection. *AIDS.* 1994;8:1371–1389.
20. Dubois-Arber F, Jeannin A, Konings E, Paccaud F. Increased condom use without other major changes in sexual behavior among the general population in Switzerland. *Am J Public Health.* 1997;87:558–566.
21. Higgins DL, Galavotti C, O'Reilly K, Sheridan J, the AIDS Community Demonstration Projects. Evolution and development of the AIDS Community Demonstration Projects. In: Corby NH, Wolitski RJ, eds. *Community HIV Prevention: The Long Beach AIDS Community Demonstration Project.* Long Beach, Calif: The University Press, California State University; 1997:5–20.
22. Centers for Disease Control and Prevention. Community-level prevention of human immunodeficiency virus infection among high-risk populations: the AIDS Community Demonstration Projects. *MMWR Morb Mortal Wkly Rep.* 1996;45(RR-6).
23. O'Reilly K, Higgins DL. AIDS Community Demonstration Projects for HIV prevention among hard-to-reach groups. *Public Health Rep.* 1991;106:714–720.
24. Fishbein M, Guenther-Grey C, Johnson WD, et al. Using a theory-based community intervention to reduce AIDS risk behaviors: the CDC's AIDS Community Demonstration Projects. In: Oskamp S, Thompson SC, eds. *Understanding and Preventing HIV Risk Behavior: Safer Sex and Drug Use.* Thousand Oaks, Calif: Sage Publications; 1996:177–206.
25. Fishbein M, Rhodes F. Using behavioral theory in HIV prevention. In: Corby NH, Wolitski RJ, eds. *Community HIV Prevention: The Long Beach AIDS Community Demonstration Project.* Long Beach, Calif: The University Press, California State University; 1997:21–30.
26. Higgins DL, O'Reilly K, Tashima N, et al. Using formative research to lay the foundation for community-level HIV prevention efforts: an example from the AIDS Community Demonstration Projects. *Public Health Rep.* 1996;3(suppl 1):28–35. Special issue.
27. McAlister A. Population behavior change: a theory-based approach. *J Public Health Policy.* 1991;12:345–361.
28. Enguidanos SM. Enhancement of program effectiveness through meaningful involvement of community volunteers. In: Corby NH, Wolitski RJ, eds. *Community HIV Prevention: The Long Beach AIDS Community Demonstration Project.* Long Beach, Calif: The University Press, California State University; 1997:159–184.
29. Guenther-Grey C, Tross S, McAlister A, et al. AIDS Community Demonstration Projects: implementation of volunteer networks for HIV-prevention programs—selected sites, 1991–1992. *MMWR Morb Mortal Wkly Rep.* 1996;41:868–869, 875–876.
30. Guenther-Grey C, Noroian D, Fonseka J, Higgins D. Developing community networks to deliver HIV prevention interventions. *Public Health Rep.* 1996;3(suppl 1):41–49. Special issue.
31. Simons PZ, Rietmeijer CA, Kane MS, Guenther-Grey C, Higgins DL, Cohn DL. Building a peer network for a community-level HIV prevention program among injecting drug users in Denver. *Public Health Rep.* 1996;3(suppl 1): 50–53. Special issue.
32. Corby NH, Enguidanos SM, Kay LS. Development and use of role model stories in a community-level HIV risk reduction intervention. *Public Health Rep.* 1996;3(suppl 1):54–58. Special issue.
33. Corby NH, Enguidanos SM, Padilla S. Preparing culturally relevant HIV prevention materials: role model stories. In: Corby NH, Wolitski RJ, eds. *Community HIV Prevention: The Long Beach AIDS Community Demonstration Project.* Long Beach, Calif: The University Press, California State University; 1997: 135–158.
34. Ajzen I, Fishbein M. *Understanding Attitudes and Predicting Social Behavior.* Englewood Cliffs, NJ: Prentice Hall; 1980.
35. Bandura A. *Social Foundations of Thought and Action: A Social Cognitive Theory.* Englewood Cliffs, NJ: Prentice Hall; 1986.
36. Bandura A. Social cognitive theory and exercise of control over HIV infection. In: DiClemente RJ, Peterson JL, eds. *Preventing AIDS: Theories and Methods of Behavioral Interventions.* New York, NY: Plenum Press; 1994:25–60.
37. Becker M. The health belief model and personal health behavior. *Health Educ Monogr.* 1974;2:324–473.
38. Fishbein M, Middlestadt SE, Hitchcock PJ. Using information to change sexually transmitted disease–related behaviors: an analysis based on the theory of reasoned action. In: DiClemente RJ, Peterson JL, eds. *Preventing AIDS: Theories and Methods of Behavioral Interventions.* New York, NY: Plenum Press; 1994:61–78.
39. Rosenstock IM, Strecher VJ, Becker MJ. The health belief model and HIV risk behavior

change. In: DiClemente RJ, Peterson JL, eds. *Preventing AIDS: Theories and Methods of Behavioral Interventions*. New York, NY: Plenum Press; 1994:5–24.
40. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: applications to addictive behaviors. *Am Psychol*. 1992;47: 1102–1114.
41. Prochaska J, Velicer W. The transtheoretical model of health behavior change. *Am J Health Promotion*. 1997;12:38–48.
42. Schnell DJ, Magee E, Sheridan JR. A regression method for analyzing ordinal data from intervention trials. *Stat Med*. 1995;14: 1177–1189.
43. Corby NH, Wolitski RJ. *Community HIV Prevention: The Long Beach AIDS Community Demonstration Project*. Long Beach, Calif: The University Press, California State University; 1997.
44. Rietmeijer C, Kane M, Simons P, et al. Increasing the use of bleach and condoms among injection drug users in Denver: outcomes of a community-level HIV prevention program. *AIDS*. 1996;10:291–298.
45. Watters J, Biernacki P. Targeted sampling: options for the study of hidden populations. *Social Problems*. 1989;36:416–430.
46. Schnell DJ, Galavotti C, Fishbein M, Chan DK, the AIDS Community Demonstration Projects. Measuring the adoption of consistent use of condoms using the stages of change model. *Public Health Rep*. 1996;3(suppl 1):59–68. Special issue.
47. Murray DM. *Design and Analysis of Group-Randomized Trials*. New York, NY: Oxford University Press; 1998.
48. Jamner M, Corby N, Wolitski R. Bleaching injection equipment: influencing factors among IDUs who share. *Subst Use Misuse*. 1996;31: 1973–1993.
49. Wolitski RJ, Bensley L, Corby NH, Fishbein M, Galavotti C, the AIDS Community Demonstration Projects. Sources of AIDS information among low- and high-risk populations. *J Community Health*. 1996;21:239–310.
50. Goldbaum G, Perdue T, Wolitski R, et al. Differences in risk behavior and sources of AIDS information among gay, bisexual, and straight-identified men who have sex with men. *AIDS Behav*. 1998;2:13–21.
51. Krauss B, Wolitski R, Tross S, Corby N, Fishbein M, the AIDS Community Demonstration Projects. Getting the message: HIV information sources of women who have sex with injecting drug users—a two-site study. *Appl Psychol: Int Rev*. In press.
52. Misovich SJ, Fisher JD, Fisher WA. Close relationships and elevated HIV-risk behavior: evidence and possible underlying psychological processes. *Gen Psychol Rev*. 1997;1:72–107.
53. Curran J, Scheckel L, Millstein R. *CDC/CSAT/NIDA HIV/AIDS Prevention Bulletin*. Washington, DC: US Dept of Health and Human Services, Public Health Service; 1993.
54. Velicer W, Rossi J, Prochaska J, DiClemente C. A criterion measurement model for health behavior change. *Addict Behav*. 1996;21:555–584.
55. Sogolow E, Semaan S, Johnson WD, et al. Effects of US-based HIV interventions on safer sex: meta-analyses, overall and for populations, age groups, and settings. Paper presented at: 12th International Conference on AIDS; June 30, 1998; Geneva, Switzerland.
56. Schneider Jamner M, Wolitski RJ. Findings of the Long Beach AIDS Community Demonstration Project. In: Corby NH, Wolitski RJ, eds. *Community HIV Prevention: The Long Beach AIDS Community Demonstration Project*. Long Beach, Calif: The University Press, California State University; 1997:107–124.
57. Corby N, Wolitski R. Condom use with main and other sex partners among high-risk women: intervention outcomes and correlates of reduced risk. *Drugs Soc*. 1996;9(1/2):75–96.
58. Asamoah-Adu AWS, Pappoe M, Kanlisi N, Neequaye A, Lamptey P. Evaluation of a targeted AIDS prevention intervention to increase condom use among prostitutes in Ghana. *AIDS*. 1994;8:239–246.
59. Williams E, Lamson N, Efem S, Weir S, Lamptey P. Implementation of an AIDS prevention program among prostitutes in the Cross River state of Nigeria. *AIDS*. 1992;6:229–242.
60. Wilson D, Nyathi BNM, Lamson N, Weir S. *A Community-Level AIDS Prevention Programme Among Sexually Vulnerable Groups and the General Population in Bulwayo, Zimbabwe*. Harare, Zimbabwe: University of Zimbabwe; 1993.
61. Sweat MD, Denison JA. Reducing HIV incidence in developing countries with structural and environmental interventions. *AIDS*. 1995;9(suppl A):S251–S257.
62. Tawil O, Verster A, O'Reilly KR. Enabling approaches for HIV/AIDS prevention: can we modify the environment and minimize the risk? *AIDS*. 1995;9:1299–1306.
63. Gostin L, Lazzarini Z, Jones S, Flaherty K. Prevention of HIV/AIDS and other blood-borne diseases among injection drug users. *JAMA*. 1997;277:53–62.
64. Groseclose S, Weinstein B, Jones T, Valleroy L, Fehrs L, Kassler W. Impact of increased legal access to needles and syringes on practices of injecting-drug users and police officers—Connecticut, 1992–1993. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:82–89.
65. Lurie P, Sorensen J, Lane S, et al. The public health impact of needle exchange programs. In: Program and abstracts of the X International Conference on AIDS; August 7–12, 1994; Yokohama, Japan. Abstract 564C.
66. *Interventions to Prevent HIV Risk Behavior*. Bethesda, Md: National Institutes of Health; May 14, 1997. Consensus Development Conference Statement.
67. Farmer P, Conners M, Simmons J, eds. *Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence*. Monroe, Me: Common Courage Press; 1996.