

COMMUNITY PROMISE

DESCRIPTION

Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) is a community-level intervention model that can be implemented with any high-risk population in which there are established social networks. Community PROMISE focuses on the influencing risk factors that put members of a specific population at risk for HIV. These are persons or groups who practice HIV risk behaviors (e.g., injection drug users and their sex partners, people living with HIV, sex workers, men who have sex with men but do not identify themselves as gay, youth.) The intervention will not be effective for use in a general population in which the risk behaviors are varied. For example, a population of heterosexual women would be too broad to work with compared with a population of African American women, 18 to 25 years of age, who are partners of injection drug users in Chelsea, Manhattan. In turn, men who have sex with men but do not identify themselves as gay will require a separate project than will men who do identify themselves as gay. For Community PROMISE to be effective, members of the target population must be able to identify with one another and openly communicate about risk factors. Trying to focus on 2 groups within 1 project may cause either group to become fearful of being identified with the other. The same consideration must be taken into account when targeting groups of HIV-infected persons versus groups of HIV-negative persons. Understanding how to identify populations, understanding their risk behaviors and influencing factors, and designing Community PROMISE accordingly points to the importance of gathering this type of information during the community identification (CID) process.

To conduct Community PROMISE, the CBO must have ties to the community and access to the target population. An existing outreach program will speed efforts to get this intervention up and running. In addition, experienced outreach workers who have earned trust from the community will save months of time up front in launching the program because they would be able to recruit peer and business advocates with ease.

Community PROMISE has been packaged by CDC's Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

Community PROMISE aims to increase condom use, condom carrying, bleach use, and drug-related risk-reduction behaviors.

How It Works

Community PROMISE uses messages in role model stories to change behavior by influencing attitudes, beliefs, and norms throughout social networks. Peer advocates

distribute role model stories containing messages that address the prevention needs of different populations. Besides reducing risk behaviors, the prevention messages can be used to encourage peers to seek HIV counseling and testing services, partner counseling and referral services, and other prevention and treatment services.

Theories behind the Intervention

Community PROMISE is grounded in several behavioral theories, including the stages of change model. Its effects extend beyond the persons who are involved in the intervention, thereby changing social norms and behavior within social networks in a community.

Research Findings

Results from a 3-year cross-sectional study in 5 cities across the United States showed Community PROMISE to be effective in promoting consistent HIV risk reduction throughout the involved communities. Specific results were increased consistent condom use with main and other partners and increased condom carrying among participants in the intervention compared with those in comparison communities. In addition, participants in the intervention group scored higher on the stages-of-change scale for use of condoms and bleach than did those in the comparison group.^{1,2}

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

Community PROMISE has the following 4 core elements:

- Conduct community identification.
- Write and distribute role model stories.
- Recruit and train peer advocates to reinforce the messages in the role model stories.
- Perform evaluation, to ensure integrity of intervention.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Community PROMISE has the following key characteristics:

- Discuss with stakeholders the appropriateness of the intervention and necessary program resources.
- Network with other agencies and community organizations to avoid duplicating efforts, to elicit support and cooperation, and to find referral sources.

- Form a Community Advisory Board to foster community commitment to the project and to develop a plan for accessing community members who are at risk.
- Begin the community identification (CID) process.
 - to develop a clear understanding of the composition of the target population
 - to identify specific risk behaviors and the contexts in which they occur
 - to discover the meaning of risk practices to the target population
 - to learn what risk-reduction messages the members of the target population believe are appropriate and relevant
- Review recent epidemiologic data.
- Interview CBO staff and members of populations at risk.
- Begin creating a map of the community (streets and populations) and conducting focus groups specifically for CID.
- Identify the most prevalent stage(s) of change for various risk-reduction practices among populations at risk.
- Review the CID data and prepare a comprehensive report to document the CID process.
- Use CID information to decide on a specific risk-reduction behavior.
- Recruit members of the target population (e.g., current or former commercial sex workers) or credible outreach staff to be peer advocates.
- Train peer advocates for 1 to 3 hours with regard to program goals, HIV/AIDS, and use of role model stories.
- Establish a system for maintaining commitment from peer advocates.
- Recruit, screen, and interview members of the local target population who are performing behaviors to avoid HIV; use their decisions to have safer sex as the basis for role model stories.
- Write and pretest role model stories locally. Stories should be brief (400 words or less), should address the target population's risk behavior, and can be based on examples available in the intervention kit. Stories should be relevant and realistic. They should include the person's initial stage of change, motivator, action step, resolved challenge, and positive consequences of making the behavior change.
- Have peer advocates distribute stage-appropriate stories to their peers and reinforce the stories' messages in conversation.
- Have peer advocates distribute condoms, lubricants, and bleach kits, as appropriate, along with the role model stories
- Have each peer advocate distribute these stories and supplies to 10 to 20 peers each week.
- Have program presence at community events (e.g., street fairs, Pridefests) to promote program recognition and community buy-in.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and activities.

Procedures for Community PROMISE are as follows:

Conducting Community Identification

CID, the formative evaluation stage of Community PROMISE, is designed to assist in identifying, prioritizing, accessing, and understanding target populations. CID means having project staff get to know the community being prioritized for the intervention. It is a process that is ongoing throughout the life of the project, as role model stories need to be continuously updated in order to have meaning for the target population. One main reason for doing the CID process is to identify the influencing factors and risk behaviors of the target population. For example, lack of self-efficacy is an influencing factor for unprotected sex, a risk behavior. Understanding influencing factors and risk behaviors through extensive interviews conducted during the CID process is essential to understanding the target population and writing role model stories that will affect individual behaviors and community norms.

Community identification helps to

- accurately define problems and identify solutions
- reveal community norms and the community's stage(s) of change
- develop trust
- provide information for intervention approaches
- identify peers who can be involved in outreach

Because Community PROMISE is based on stages of changes and other theoretical models, you have to identify which stage your population is in. We call this "staging" the population. Then you write role model stories that describe behavior in the next stage. For example, if you find that 75% of the target population is in the contemplation stage, then you would write role model stories in which the main character demonstrates behavior in the planning stage. See Evaluation below for more information on this process.

This first step of CID is identifying which formative evaluation methods to use and developing or adapting the necessary instruments, such as

- interviews
- community observation protocol
- focus group script and materials
- informed consent forms
- field safety guidelines

The next step of CID is hiring staff or training current staff members to conduct the formative evaluation. Staff members make decisions and develop an implementation plan according to the findings. Then outreach workers recruit members of the target population for in-depth interviews; identify possible role models to be used in role model stories; and act as liaisons between peer volunteers, members of the target population, and other CBO staff. The primary duty of these staff outreach workers is to train and supervise the peer volunteers.

A key component of CID is mobilizing the community to support and participate in the intervention. For example, local shops can make available prevention and other materials related to the intervention.

The time it takes to conduct CID depends on the CBO's access to the community. A CBO that is well trusted and established within a community may plan on spending from 3 to 6 months on this process; whereas, a new CBO may need more time. CID can be conducted by many methods, such as

- interviewing CBO staff
- mapping the intervention areas
- observing venues and locations where the target population congregates
- interviewing community leaders and business owners
- interviewing the members of the target population (key participants)

CBOs must plan on giving incentives to key participants who agree to be interviewed. This is a trust-building process that will introduce the project, its staff, and its mission to the community. During this process, outreach staff will be meeting many people who will later become key stakeholders in the intervention. These stakeholders may become part of the project's advisory board, role model interviews, models for program materials, or peer advocates.

Producing Role Model Stories

Role model stories are real-life descriptions of a positive behavior change described in the words of members of the target population. The stories are developed from interviews conducted by outreach workers with target population members, and they explain how and why the role models took steps to reduce risk for HIV and the positive effect that this behavior has had. This is the *message* that Community PROMISE is sending to your target population. The stories may be in the form of brochures, newsletters, comic strips or fotonovelas (a series of pictures with a story, often in comic book format). Candidates for role model stories will be identified through the CID process, outreach, referrals from other agencies, or HIV counseling and testing centers. The role model must have a shared risk behavior with your target population and must have made some positive changes to avoid that risk. An incentive deemed appropriate through the CID should be offered to those who agree to be interviewed. A structured role model interview form is recommended for documenting all of the influencing factors described by your role model (See Community PROMISE implementation manual). Tape-recording the interview is very helpful in terms of providing direct quotations for the stories. Several stories can be derived from 1 interview. For example, if you are interviewing someone with both sexual and drug-using risk, you may construct a story that talks about reducing sexual risk and another about reducing needle-sharing behavior. After a format and layout for the story are developed, the product is reviewed and edited by staff. Sample stories are included in the intervention kit and can be used as models. Once approved, the stories are printed and combined with prevention materials, if used.

Recruiting, Screening, and Training Peer Advocates

Peer advocates are recruited and trained to distribute role model stories. Peer advocates use conversation to reinforce the messages in the role model stories. They encourage other members of the target population to read and talk about the stories within their own social networks. By doing this, peer advocates help their peers relate more immediately to the content of the role model stories and encourage them to engage in risk-reduction or health-enhancing behaviors. For example, if the role model story demonstrates how the main character got tested for HIV, then the peer advocate encourages the member of the target population to think about getting tested. Peer advocates also distribute prevention materials such as condoms and bleach.

Once peer advocates are recruited, screened, and trained, they work with staff outreach workers and other staff to identify areas for distributing the role model stories and prevention materials. Peer advocates distribute materials to and interact with the target population at times and frequencies agreed upon with the outreach worker.

Enlisting members of your target population into a network of peer advocates is a core element of Community PROMISE. These people are the *messengers* of your program and will take the message to others in their social networks and encourage their peers to take risk-reduction measures. By using natural "change agents" from the community, your prevention efforts will reach a wide audience. These persons will be engaging in risk-reduction conversations and distributing the role model stories to people within their social networks who may never access other prevention programs. This is why Community PROMISE is an ideal intervention with "underground" or hard-to-reach populations. For example, a man who has sex with other men but for confidentiality reasons does not identify himself as gay or even bisexual may be reluctant to access prevention programs. However, this person is undoubtedly interacting socially with others who engage in the same risk behavior. If you are able to identify a peer advocate who socializes with this person, the peer advocate can deliver prevention messages and materials to him in a very natural and informal manner. It is recommended that you recruit peer advocates on a regular basis and have them meet at least monthly to pick up materials for distribution. Monetary and other incentives, such as t-shirts with the project logo, must be provided for the peer advocates.

ADAPTING

Because role model stories are based on experiences of the target population, Community PROMISE can be easily adapted to meet the needs of your target population. The ongoing CID formative evaluation process will ensure that you are always keeping your finger on the pulse of the community and its attitudes, behaviors, and beliefs regarding the transmission or acquisition of sexually transmitted diseases, HIV, and viral hepatitis. Because community members and businesses are recruited to be actively involved in the intervention, you are more likely to have a program that is culturally appropriate. This holds true for any target population. In addition, the role model stories can be written to include prevention messages about very specific behaviors, and these stories can be formatted to reflect cultural differences. A good example of this is the use of fotonovelas for Latino populations.

RESOURCE REQUIREMENTS

People

Community PROMISE needs at least

- a program manager (1/4 time to full time)
- 1 or more full-time outreach workers
- staff members (half-time) to write and produce role model stories
- a support staff member (half-time)
- volunteer peer advocates

Space

Community PROMISE needs space for

- CID (stores, bars, on the street, in CBO offices)
- interviews (in CBO offices or other private places in the community)
- distribution of role model stories (at whatever locations CID identifies as appropriate)

Supplies

Community PROMISE needs

- a computer that can do word processing, desktop publishing, and data analysis
- a printer
- telephones, fax machine, and copier
- a digital camera or a photographer (to take pictures for role model stories) and scanner
- transportation for outreach workers
- incentives for peer advocates (e.g., hats, hygiene kits)
- prevention supplies (e.g., condoms, bleach)

RECRUITMENT

Populations recruited for Community PROMISE are CID participants, role models, peer advocates, and recipients of the role model stories.

CID Participants

First, persons are recruited to participate in CID. These persons are invited to share their knowledge of the target population in focus groups, interviews, or surveys.

Role Models

Second, members of the target population are recruited by outreach workers to be interviewed for role model stories. These persons can be identified during CID or through referrals (by outreach workers, test site personnel, and other people who interact with members of the target population). Because you will be recruiting role models from the community you are targeting, they are sure to reflect the racial or ethnic make-up, age range, and identity of the target population.

Peer Advocates

Third, peer advocates are recruited either during CID (through interaction with target population and community members) or through street outreach (e.g., at local meeting places). Peer advocates who deliver the role model stories and reinforcing messages are also members of the target population.

Recipients of the Role Model Stories

Fourth, peers from the target population are recruited by peer advocates. Depending on the message in the role model story, peer advocates recruit peers into counseling, testing, and referral services and other prevention and treatment services. CID and the peer advocate's familiarity with the target population environment will identify the proper settings and methods for interactions and distribution of role model stories and materials. Community PROMISE, developed and mobilized by the community for the community, creates a sense of project ownership which can result in an intervention that is well received and respected by the target population.

POLICIES AND STANDARDS

Before a CBO attempts to implement Community PROMISE, the following policies and procedures should be in place to protect clients and the CBO:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see

Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Linkage of Services

Recruitment and health education and risk reduction must link clients whose HIV status is unknown to counseling, testing, and referral services and persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members were completed.

Personnel Policies

CBOs conducting outreach must establish a code of conduct. This code should include, but not be limited to, the following: do not use drugs or alcohol, do use appropriate behavior with clients, and do not loan or borrow money.

Safety

CBO policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance data, and the state or local HIV prevention plan created with input from state or local community planning groups.

Volunteers

The CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Community PROMISE:

CBOs

Implementation Plan

A strong component of quality assurance is preparing a plan to implement Community PROMISE. A comprehensive implementation plan will facilitate understanding and buy-in from staff and increase the likelihood that the intervention will run smoothly.

Leadership and Guidance

Someone from the CBO should provide hands-on leadership and guidance for the intervention, from planning through implementation. In addition, a decision maker from the CBO should provide higher-level support, including securing resources and advocating for Community PROMISE.

Fidelity to Core Elements

The technical assistance manual contains a quality assurance tool to check fidelity to the core elements. In addition, training on the intervention and supporting materials (such as the implementation manual and technical assistance manual) provide CBOs with quality assurance tools to monitor implementation and measure fidelity. For example, the implementation manual contains a table detailing each task from the planning stage to the evaluation stage and listing the resources, skills, and knowledge needed for tasks.

Evaluation

Evaluation is an important tool for program management and quality assurance. Community PROMISE focuses on formative evaluation in the community identification process, process monitoring and evaluation to assess the implementation process, and outcome monitoring to identify changes in the target population. The implementation manual in the intervention kit provides guidance and instruments such as interview guides, surveys, and tracking forms that can be adapted and used.

Clients

It is necessary to ensure that the intervention is meeting the needs of CBO clients and staff. Staff who are implementing Community PROMISE can develop their own quality assurance checklist to help staff identify, discuss, and solve problems.

MONITORING AND EVALUATION

Specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the procedural guidance will include the collection of standardized process and outcome measures. Specific data reporting requirements will be provided to agencies after notification of award. For their convenience, grantees may utilize PEMS software for data management and reporting. PEMS is a national data reporting system that includes a

standardized set of HIV prevention data variables, web-based software for data entry and management. CDC will also provide data collection and evaluation guidance and training and PEMS implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC by using PEMS or other software that transmits data to CDC according to data requirements. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies designed to assess the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

For more information on technical assistance or training for this intervention or to get your name on a list for a future training, please go to www.effectiveinterventions.org.

REFERENCES

1. The CDC AIDS Community Demonstration Projects Research Group. Community-level HIV intervention in 5 cities: final outcome data from the CDC AIDS Community Demonstration Projects. *American Journal of Public Health*.1999;89:336–345.
2. Corby NH, Wolitski RJ, eds. *Community HIV prevention: the Long Beach AIDS Community Demonstration Project*. Long Beach, Calif: The University Press, California State University, Long Beach; 1997.

