# A Model of Community Mobilization for the Prevention of HIV in Women and Infants

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*SYNOPSIS*

**THE PREVENTION OF HIV IN WOMEN AND INFANTS Demonstration Projects use a conceptual model for maximizing broad community participation for HIV prevention called the Community Mobilization Framework. The projects' comprehensive approach attempts to bring about changes on a community level using a model which encourages community-wide participation of persons with various roles and relationships in the community. The Community Mobilization Framework is one way to systematically conceptualize the organization of the community for the purpose of mobilizing the maximum number of community members around a common health initiative. A community becomes mobilized around an issue by endorsing health-enhancing attitudes, behaviors, and projects supporting positive health outcomes. This mobilization is expressed through the promotion, support, and delivery of motivational and informational health messages which convey consistent ideas, themes, and images.**

**There are two fundamental bases of the Community Mobilization Framework. The first is its characterization of the variety of individual, social, and organizational roles and relationships in the community that might be used in a concerted campaign for HIV prevention for women. The second basis of the model is the description of the nature and extent of the involvement, which includes a continuum of involvement, ranging from simple endorsement to building active coalitions around a health initiative. The paper discusses practical methods of applying these principles, with the Women and Infants Demonstration Projects providing concrete examples.**

In 1990, the Centers for Disease Control and Prevention (CDC) funded the Prevention of HIV in Women and Infants Demonstration Projects (WIDP) *(1)*. These projects implement and evaluate community-level behavioral interventions that promote behavior changes to prevent sexually transmitted disease (STD) and HIV infection among women in five collaborating cities—Alameda County, CA; San Francisco, CA; Portland, OR; Pittsburgh, PA; and Philadelphia, PA.

The WIDP are designed to change women's HIV risk behaviors, as well as community norms, that is, community-approved attitudes and behaviors relevant to HIV risk. The WIDP aims to undertake these changes by developing

an environment supportive of safer sexual behaviors, a social awareness throughout the community that HIV prevention activities are valuable, and a social context for HIV prevention activities that is in keeping with other prominent issues of concern to women of the community. WIDP may influence community norms when credible, trusted people who play a variety of roles in the women's lives contact the women with WIDP information. Community residents and organizations are part of the audience being served by the WIDP interventions, but also are part of the strategy to reach people who engage in risky behaviors and to diffuse the WIDP messages.

A fundamental premise of the WIDP is that effective and sustainable community-level HIV prevention projects need to involve many and diverse community residents, businesses, and institutions. To implement this premise, WIDP required a systematic approach to identify community members and associations, determine roles and relationships among them, and develop multiple partnerships with them. We have termed this the Community Mobilization Framework (CMF).

The Community Mobilization Framework is one way to systematically conceptualize the organization of the community for the purpose of mobilizing the maximum number of community members around a common health initiative.

This strategy is still undergoing a test in the area of HIV prevention. However, the intent of this paper is to describe the CMF, the advantages it may confer, and the process that brought it about. The goal of the CMF is to mutually reinforce individual-level and community-level changes. This goal is seen in other studies. For example, the Institute of Medicine concluded that "...community organization may not only be an efficient conduit for the provision of information to a broader group, but may also serve as an agent of change and a source of inspiration, pride, and identification for individual members" *(2)*. In another study, Bracht and his colleagues described the context for community-oriented approaches, noting that they are "distinguished by their focus on whole populations and communities as major social aggregates that link members of a population in a network of relationships" *(3)*. However, broad community participation in the development and implementation of systematic HIV prevention strategies is still in its infancy. For example, Quimby and Friedman described the difficulties in mobilizing African-American communities in New York City around HIV prevention throughout the 1980s *(4)*. Therefore, a more detailed and formal description of community mobilization is in order.

## The Community Mobilization Framework (CMF)

For WIDP, the objective of community mobilization is an intermediate, or process, objective that contributes to the goal of reduced STD- and HIV-related morbidity and mortality. We suggest that a community becomes mobilized around an issue such as protecting women from infection with STDs and HIV by endorsing health-enhancing attitudes, behaviors, and activities that support positive health outcomes. Figure 1, the CMF, depicts how WIDP identified community members, groups, organizations, and agencies, and elicited their involvement in the prevention effort. Once the community partners were identified, CMF served as a guide to design and implement comprehensive strategies for HIV prevention among women. These strategies included a community feedback process to modify prevention activities if needed.

The CMF provided WIDP a structure by which to elicit the involvement of active community partners, influence communities' norms, and develop and promote a supportive environment for attempts to change. Community structures varied among the WIDP sites; this affected the pattern of community mobilization. Other projects should expect such variation as well. Coates and Greenblatt *(5)* noted that the community provides the context for individual-level HIV intervention; the CMF describes the community context as it relates to individual HIV-relevant behaviors.

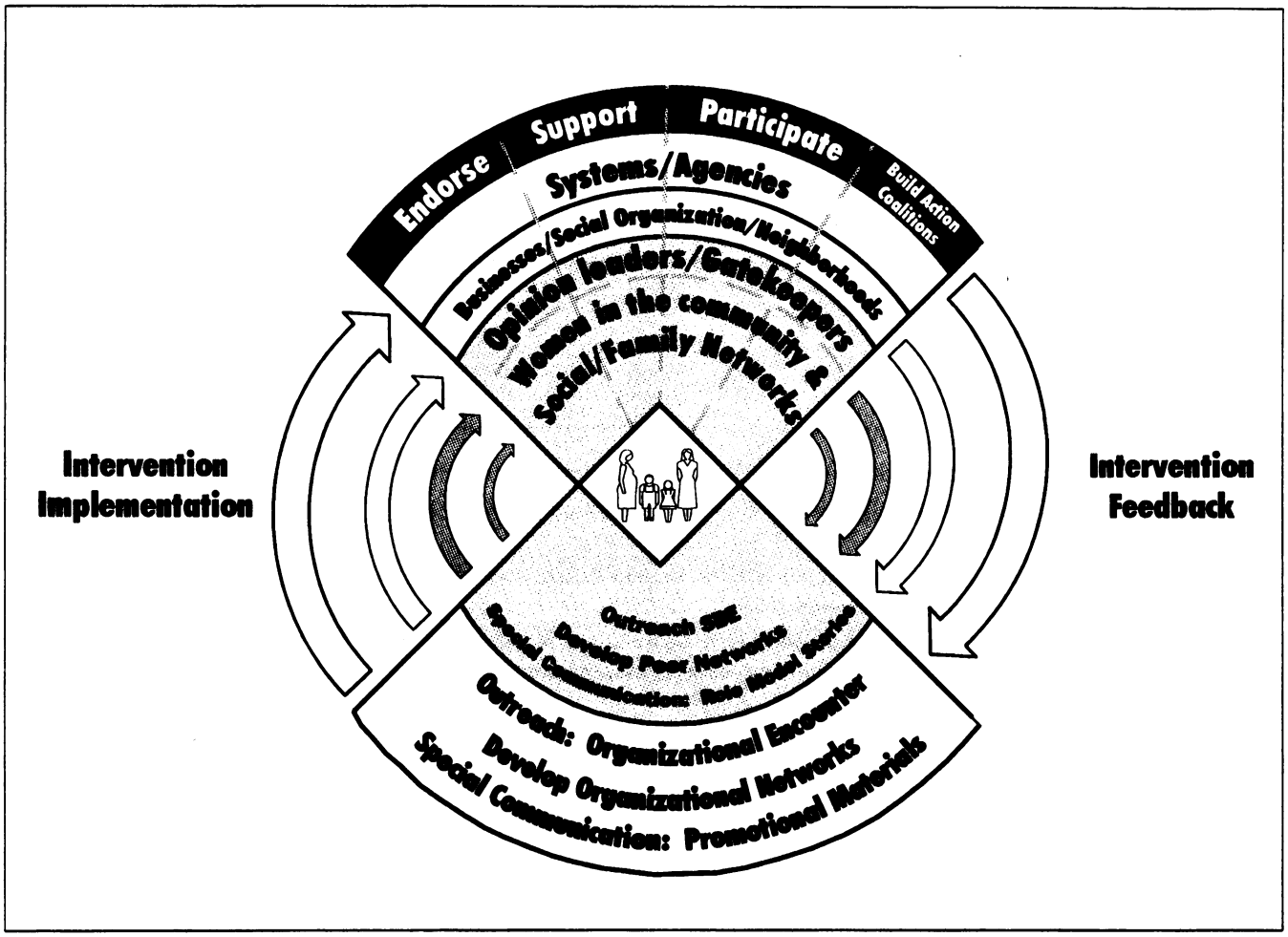
For individuals, the CMF assisted the WIDP in promoting:

(a) Attention to local norms, attitudes, and values so that people could become aware of them and assess them.
(b) Skills and strategies for safer behavior.
(c) Individual involvement in, and ownership of, the prevention effort.

For communities, CMF helped to define specific types of involvement that could be elicited from community members. WIDP recognized that:

(a) All members of a community are potential change agents as well as potential members of the intended audience for intervention.

Figure 1. Community Mobilization Framework




(b) Community-wide changes in norms and behaviors take a long time to develop.

(c) Changes in individuals need to be reinforced constantly once they are made.

(d) Community-based prevention needs to access new community members, who will cycle into higher risk behaviors as they become older and face risky situations, as they change lifestyles and make other behavioral choices, or as social and political situations change over time.

## Integration of Behavior Change Principles in the CMF

We believe that a strategy to affect community norms and values must build upon behavior change principles along with community mobilization principles. These principles were found to be critical to success in mobilizing for HIV prevention in earlier studies *(6)*. The first principle is that behavior change does not occur rapidly; therefore, intervention efforts must endure in the community over an extended period. WIDP investigators decided that such long-term investments in behavior change require both grass-roots involvement by individuals and small groups as well as more formal community organizations and institutions. The second principle of behavior change is that many exposures to information and sources of motivation are needed to increase behavior change among a community's women. The report of the National Research Council noted that influencing norms and behaviors for HIV prevention would require efforts by individuals, schools, churches, health care providers, media, and other venues for interaction *(7)*. Moreover, these efforts should be integrated in an overall campaign or program. Consistent themes, messages, and images at various points of exposure will enhance the effort.

Not only does this approach facilitate clear communication about HIV prevention, it also helps to rally community members. WIDP seeks to involve nontraditional sources of influence in communities, as well as the traditional service providers and those directly affected by HIV or AIDS. This strategy is similar to the one used by the National Cancer Institute's COMMIT program, a community approach to smoking cessation *(8)*.

Like other HIV prevention researchers, we expected that behavior change would be more likely when HIV prevention was designed to complement, not compete with, women's other social and health concerns *(9)*. To ensure relevance to these other concerns, CMF draws on the Blended

**Figure 2. Systems and agencies**

| *HIV/AIDS agencies* | *Health care providers* | *Social service agencies* | *Criminal justice & police* |
|---|---|---|---|
| CBOs<br>Meal providers<br>Treatment providers<br>C&T facilities<br>NAPWA affiliates<br>Support groups | Family planning<br>Drug treatment<br>Tuberculosis control<br>Primary care clinics<br>Community mental health hospitals | United Way | Courts<br>Probation<br>Jails/Prisons<br>Legal services |
| *Public (financial) assistance agencies* | *Residential assistance agencies* | *Other private, non-profit agencies* | *Other city, state, or federal agencies* |
| WIC<br>Food stamps<br>Welfare<br>AFDC | Homeless shelters<br>Battered-spouse shelters<br>Public housing<br>Tenants' associations | | |

**Endorsement - Meals-on-Wheels puts project stockers on vans or their meal trays.**

**Support - Tenant Housing Association gives your project meeting space free or at reduced cost.**

**Participation- Community Health Center nurses hand out and discuss your materials when they talk to women about HIV prevention.**

**Coalition Building - Planned Parenthood invites you to be a regular resource for them concerning HIV prevention.They ask you to come in monthly and address their clients.**

**Figure 3. Businessess, social organizations, and neighborhoods**

| *Businesses* | *Religious organizations* | *Social organizations* | *Neighborhood organizations* | *Media organiztions* |
|---|---|---|---|---|
| Laundry<br>Grocers<br>Restaurants<br>Printer<br>Hairdressers<br>Nail shop<br>Liquor stores | Churches<br>Mosques<br>Synagogues | 100 Black Men<br>Lions/Kiwanis/etc.<br>Boys/Girls Clubs<br>YMCA/YWCA | Neighborhood Watch<br>Tenants' associations | Weekly newspapers and magazines<br>Local television<br>Local television affiliates<br>Daily newspapers |

**Endorsement - The liquor store owner tells prostitutes who frequent her store that the project outreach staff are "O.K." to talk to.**

**Support - Sandwish chop provides lunch for volunteers. Grocer provides gift certificates for use as incentives.**

**Participation - Church develops a team of volunteers to can vass the neighborhood with project materials.**

**Coalition Building - Five different community organizations who have been working with your project come together to lobby the city council for a needle exchange**

Model of Community Involvement *(10)*. In this model, public health providers and local community leaders share the determination of goals and strategies. The intervention-specific objective (HIV prevention) remains the highest priority, and the model does not promise more than a project can realistically deliver. Wherever possible, however, the model integrates prevention objectives with related concerns identified by community members (for example, drug abuse, teen pregnancy, infant mortality).

Behavior change in WIDP is also based on the principle that HIV prevention activities must be relevant and acceptable to community women. To identify community-appropriate messages and acceptable means to disseminate those messages, WIDP used both qualitative and quantitative research before developing the intervention. This research involved many segments of the community that were related to, or involved with, community women: women with high-risk behaviors, opinion leaders, community leaders, and agencies. By soliciting people's information and experience, WIDP generated initial interest in the project, developed collaborative relationships, and gained ongoing involvement from diverse community members.

## Description of the CMF

There are four primary components of the Community Mobilization Framework: (a) community structure, (b) nature and extent of community members' involvement, (c) community and project partnership, and (d) specific intervention activities.

**Community Structure.** During planning for the WIDP, community residents, groups, organizations, and agencies were first characterized by their roles and activities, and then ordered according to the likely proximity and intensity of their interactions with the women who engage in risky behaviors. We define the layers of this ordering as community strata. The strata, shown in figure 1, are (a) women who engage in risky behaviors; (b) family and social networks of these women; (c) community gatekeepers and opinion leaders; (d) business, religious, and social organizations; and (e) health, social service, and other agencies and systems. Figure 1 depicts women in greatest need of HIV prevention messages and activities as the central focus of the WIDP projects.

The community strata serve as a guide to identifying potential HIV prevention partners whose involvement can be solicited by project personnel. This approach allows for

continuing monitoring of the changing relationships of all the identified partners with the prevention project, as their involvement waxes and wanes. The approach may also assist in identifying gaps in prevention activities.

The central stratum of figure 1 represents women whose sexual and drug-using practices place them at increased risk of HIV infection. A myriad of social, economic, and gender-based factors influence these practices. The WIDP study specifically targets women who do not use condoms during intercourse with sex partners who may be HIV-infected or at risk for HIV infection. Many women who smoke crack cocaine have various forms of sex with many men to get drugs to satisfy their addiction. The larger number of sex partners increases a woman's risk for HIV and other STDs. In the same way, women who trade sex for money and do not use condoms increase their potential for exposure to HIV. Some women use injection drugs and share their equipment or do not clean others' equipment before they use it. Finally, in communities with high rates of HIV, women having sexual intercourse without a condom may be at risk for infection.

The families and social networks of targeted women are represented in the next stratum, the level closest to the women at risk. They are the groups most likely to have an immediate impact on women's beliefs about norms and behavior. Many women with otherwise chaotic lives have an extended family with whom they maintain contact. Family members are often a primary source of continuing support and may also be influential advisors. In some cultures, the family often includes people other than those related directly by blood.

The various social networks, in contrast, are defined by characteristics such as proximity, shared interests, cultural and ethnic heritage, risky behaviors in common, occupation, and religious affiliation. Some networks may consist of peer groups, while others reflect a person's role in a hierarchy (boss-employee; teacher-student; pimp-prostitute). Social networks for WIDP projects can include men and women at lower risk of HIV, as well as those at higher risk.

Gatekeepers and opinion leaders, located within or involved with the community, form the stratum next removed from the women. Opinion leaders and gatekeepers either have direct or indirect contact with women at risk, or they have significant social influence over community members' ideas, values, or behaviors. A grandmother may be an opinion leader if an extended family turns to her for information and direction. An opinion leader may indirectly influence the women at risk through their social networks; for example, a minister may affect the family members of women even if the women themselves do not attend church. Opinion leaders and gatekeepers can be a primary source of information for the project. They can provide implicit or explicit approval for community members to interact with project staff and volunteers, and to adopt the changes the project staff suggest.

Business, social, and religious organizations constitute the next stratum, and are important potential community partners. Many of these organizations participate regularly in civic and philanthropic activities; the health of women in their community is likely to be a particularly strong issue for them to rally around. Social organizations also gain credibility and good will by supporting and participating in activities that benefit the community as a whole.

**Figure 4. Opinion lleaders and gatekeepers**

Gang leaders
Respected police officer
Pimps
Influential elders
Drug dealers
Business owners respected by community residents
Lay religious leaders
Ex-prostitutes
Other project outreach staff
Lay heal advisors

**Endorsement - Police officer allows project to work with the intended audience without hassle.**
**Support - Crack house owner leaves project material at front door.**
**Participation - Ex-prostitutes volunteer to be networkers.**
**Coalition building - Your agency convenes a meeting twice per year for influential community members to discuss issues related to project goals.**

The specific organizations that enter a partnership with the project will vary by community. For example, in one neighborhood a particular barber shop or bar may be an important gathering place, while in another it has little special significance. It is imperative to identify and involve organizations with high credibility among community members. For example, although a homeless shelter may be favorably recognized among community leaders, the attitudes of staff members may be known among women in the community to be particularly demeaning. The organization will not be very helpful as a prevention partner, although it may still provide a setting in which more credible staff and community volunteers can access the women. Some organizations (such as an urban grocery store) may be sanctioned by society at large, while not being sanctioned by the community served. Other organizations (such as gangs) may have credibility among only some subgroups within a community. WIDP sites take care to select a mix of various groups, organizations, and small businesses to maximize the likelihood of contacting and influencing women at risk.

The church is often a pivotal contact in a community. A variety of denominations and organizations have been included in prevention activities at the WIDP sites. In many communities the church remains an active spiritual, cultural, and social center. Even women who are otherwise socially disenfranchised may attend church with some regularity or may be influenced by strong church networks. Family members, friends, and other members of the women's social network often attend, making churches productive sites for

**Figure 5. Women in the community and their social and family networks**

| *Community women* | *Social networks* | *Family networks* |
|---|---|---|
| Women engaging in risky behaviors<br><br>Women at lower risk than intended audience | Friendship networks<br>Recreational networks (e.g., sports teams)<br>Co-workers<br>Drug-using networks | Immediate family<br>Extended family<br>Nontraditional families<br>Child-care networks |

**Endorsement - Women tell their friends about the project.**
**Support - Grandmother who cares for several neighborhood children puts a project poster on her bulletin board.**
**Participation - Women on softball team recruits her team members as peer networkers.**
**Coalition building - Neighborhood women who have been working on your project use their new group cohesiveness to lobby their local government to keep community policing in their housing development.**

recruiting volunteers to interact with the women about HIV prevention in a structured way. The churches may also provide more organized support, including sponsorship of health fairs, lectures, and discussion groups.

Businesses in communities with WIDP interventions can expose a considerable number of residents to print material containing project messages. Business owners and employees can convey project-relevant information personally. They can offer social reinforcement of healthful attitudes, intentions, and behaviors. They can improve the credibility of the project by endorsing its efforts.

The stratum of the CMF that is farthest removed from women at risk consists of public and private systems for health and social services, criminal justice, and other community services. Health departments and other state and local government agencies provide an array of services that address the many needs of community residents who may be at risk of HIV infection. A variety of private organizations (both not-for-profit and for-profit) complement the work of government agencies, including facilities for family planning and reproductive health care, STD and HIV services, tuberculosis control and treatment, primary care, and drug treatment. Other systems and agencies with which women in the community may interact include mental health, financial assistance (WIC, food stamps, AFDC, public assistance), criminal justice (courts, probation offices, jails and prisons, legal services), and residential assistance (public housing, shelters for people without homes or for battered spouses).

As well as providing assistance, local agencies can benefit from participation in CMF in several ways:

(a) Integrating efforts with WIDP and similar projects can help to extend agencies' limited existing resources for HIV and STD prevention, reproductive health, and related services.

(b) Collaboration can maximize exposure to prevention messages and activities of an agency.

(c) Agencies can build upon unique strengths and access channels to women in the community.

(d) Agencies can develop credible relationships with nontraditional community partners.

## Nature and Extent of Community Involvement

Once individuals, groups, and organizations in the community have been identified within the CMF, they are asked to become involved with the HIV prevention effort for women. For the WIDP, community volunteers are a cornerstone of community mobilization. The amount of time and energy put forth for a project will vary greatly among participants approached about becoming involved with the project. The level of effort and involvement may change over time, depending on many factors. Ideally, the commitment to the project and the effort expended by any given individual, group, or organization will grow over time, even if there are periods during which efforts temporarily wane. With the goal of gaining involvement from a maximum number of community members, the WIDP approach values even minimal effort and interprets it as a willingness to support values that are consistent with building and maintaining a comprehensive community-level prevention project.

A World Health Organization Study Group interpreted participation in three ways: as contribution, as organization, and as empowerment *(11)*. Participation through organization refers to the development of structures and processes that facilitate community involvement. Contributive participation is the involvement of community members through labor or resources. Empowering entails assisting marginalized groups to have an effective voice in the services provided to them. As will be highlighted in this section, the CMF also promotes organizational, contributive, and empowering participation among community members by eliciting specific types of involvement (defined in this project as endorsement, support, participation, and coalition building).

Project staff actively seek out endorsement, support, participation, and potential coalition-building opportunities from all of their contacts with community members. Endorsing the project requires the least activity from a community member. **Endorsement** is generally defined as expressing approval or acceptance of or sanctioning a person or activity. Klandermans and Oegema assert that people who do not have minimally positive attitudes toward the goals and means of a movement will not consider participating in its activities *(12)*. Thus, the WIDP sites have defined a minimum criterion for involvement in the mobilization effort to be endorsement of the project's work by credible community members throughout all strata of the CMF.

Endorsement can take the form of telling others that

the project and its goals are valuable, acceptable, and worthy, or demonstrating approval by specific actions. Some examples of endorsement from the WIDP sites include a business allowing the project to put a project logo sticker in its store window, a man telling his friends that WIDP project staff or volunteers should not be hassled, a meals-on-wheels delivery woman wearing a button with the project logo on it, or a pimp who lets women working for him talk to project staff about HIV prevention activities. Community organizations and agencies may mention the project to women or refer them to the project staff. Organizations may even lend their name as endorsement to specific community activities that the project initiates, such as a women's health fair.

For some people or organizations, not being an obstacle to project goals or operations may be taken as a sign of endorsement. The WIDP sites continuously monitor their communities to identify any barriers that would prevent endorsement, the least involved level of taking part; if there are barriers at this level, more active involvement can hardly be expected.

**Support** is characterized as providing means or assistance or providing the basis for existence or maintenance. Support entails more active involvement than endorsement, such as providing in-kind support of services, resources, or providing distribution channels for project materials. Some community members may be willing to do more than voice their backing, but less than directly providing prevention activities or services.

Support activities may be of particular interest to many businesses or organizations. For instance, in some WIDP sites, a local printing company might give a discount on printing costs for project materials; a fast-food franchise can donate refreshments for a meeting of peer networkers; a local exotic dance bar may allow the dancers' dressing room to be a condom dropsite; a home-based day care center operator may allow project staff to work in front of her home to talk with young mothers as they pick up their children. Support can be a mechanism for developing community investors—people and organizations who can be called on to help sustain the project's activities, ideologically and materially. For instance, a community college graphics class at one WIDP site has donated time to develop a community-specific HIV prevention campaign for the project, providing an immediate financial support as well as helping develop local ownership of the activities.

Another critical aspect of support is serving as a drop point for project-produced materials and condoms. Many businesses may be willing to provide space for a display of project-produced motivational literature. WIDP sites have found that free HIV prevention materials are often a draw for customers to enter a store or an extra benefit for regular patrons. Using outlets as drop sites for materials increases the visibility of the project-produced materials and the coverage of project messages in the community. Both of these help to saturate the community with messages, thus increasing the likelihood of shifts in social norms.

**Participation** is used in the context of the CMF to denote taking part in an activity that is directly related to HIV prevention. Participation is the category that includes distribution of materials, personal contact with other community members, and other endeavors in which the participant works actively on behalf of the project. In contrast to support, participation requires a more active effort on the part of a community member and is aimed specifically at meeting the goals of the project (that is, direct provision of HIV prevention services). The most obvious example is the community member who networks in her community and distributes material through personal contact. Examples from the WIDP include a woman without a job who goes out and interacts with other women three times a week, or a cab driver who hands out prevention materials and discusses the project with all women who enter his cab. Other examples of participation within WIDP include female gang members who have attended peer education sessions with project staff and then given those sessions to male gang members, and an editor of a community-specific paper who solicited project-produced stories to run as a regular feature in his newspaper.

At one site, women in a correctional facility began writing their own personalized prevention materials and sharing them with others in prison and with the project to share broadly after receiving similar project materials from a woman in the WIDP community (see subsequent discussion of role-model stories). In another interesting example, a site has enlisted the involvement of four AmeriCorps volunteers to augment their other volunteer efforts (also discussed subsequently).

All levels of project involvement are rewarded by the project staff through a variety of incentives. Many community members, organizations, and businesses are highlighted in a quarterly newsletter and are acknowledged for their involvement in the women's HIV prevention project. Thank you cards, certificates, and awards are also given. Peer volunteer networkers are provided with project-identified handbags, T-shirts, calendars, and condom keychains. Other incentives may include small monetary incentives, shopping coupons, and condom vouchers.

**Coalition-building** is the formation of alliances, affiliations, or associations of distinct organizations, individuals, neighborhoods, and businesses around a common cause. This type of involvement often depends upon the range of involvement of community members in the other strata and the importance of the women's project among community members. The sustainability of a specific project and the larger goal of optimal HIV prevention ultimately requires the systematization of the participating members into groups who can take concerted social, legal, and political action towards a common goal.

We believe that these coalitions can be fostered and promoted within the system of prevention services reflected in the CMF. In some projects there will be opportunities to

develop both formal action coalitions (for example, organized neighborhood coalitions of businesses lobbying for legal needle exchanges) and informal ones (such as women talking to women to promote the retention of condoms in school clinics). In some WIDP sites, the women's project is now seen as a leader in community-level HIV prevention activities and has established new, permanent relationships with drug recovery centers, homeless shelters, and tenant housing associations. These partnerships have created new channels for reaching women. They have also created more opportunities for addressing and integrating the multiple concerns of women in the community, thus allowing for limited resources to be maximized. For example, a WIDP peer network decided to incorporate and apply for a nonprofit tax status to be able to expand the scope and sustainability of the women's project.

**Reciprocal Relationship Between the Community and the Prevention Effort.** The CMF, by the inclusion of multiple individuals, groups, and organizations in the prevention effort, fosters reciprocal relationships between the community and the organized prevention effort. As depicted by the arrows in figure 1, formal and informal channels of communication provide ongoing opportunities for community feedback concerning the salience, feasibility, and actual implementation of intervention activities and subsequent modification of them. Formal channels for feedback are established through Community Advisory Boards, Program Review Panels, and peer volunteer network debriefing sessions. Outreach specialists provide informal opportunities for gathering information about the community's response to the project activities. Within the WIDP sites, there are two additional formal evaluation-related methods for receiving feedback from the community—the annual cross-sectional outcome measures and process measures that track implementation and acceptance of specific program components. Such formal and informal feedback allows for ongoing revision of prevention activities throughout the life of the project.

## Using the CMF as a Guide for Implementing Community-Tailored Interventions

The first step in applying this framework is to use the strata characterizing the community (that is, the target audience, social and family networks, opinion leaders and gatekeepers, businesses and social organizations, and systems and agencies) as a guide for identifying potential partners within the community. Once a list of possible participants has been established, systematic efforts can be made to elicit their involvement in HIV prevention-related activities which complement and reinforce one another. Figures 2 through 5 are examples of templates that can be used to tailor these lists of potential participants to local communities.

The CMF characterizes two broad segments of the community—the individual and the organizational segments. For the WIDP, the **individual segment** (the shaded inner portion of figure 1) includes women at high risk for HIV infection or unintended pregnancies, their social and family networks, opinion leaders, and gatekeepers and receives the most resource-intensive, individually oriented interventions. The **organizational segment** (the nonshaded outer portion of figure 1) includes businesses, social and religious organizations, neighborhood organizations, health and social service agencies, and other public systems committed to HIV prevention and women's reproductive health. The intervention offered in this organizational segment is often characterized by informational, promotional, and invitational opportunities to become involved with the prevention effort. Although these segments are recognized to have distinct characteristics, their interventions have parallel implementation methods—outreach and networking. Within WIDP, critical prevention messages are promoted through stage-tailored, project-produced small media and personal communications.

In the WIDP projects, each site initiated its community-wide intervention effort by identifying multiple partners within each of the community strata. Project staff generally approached specific contacts with specific types of involvement in mind, but remained flexible to accept the type or level of involvement that the individual or organization was willing to offer. The idea that all levels of involvement are valuable must be constantly kept at the forefront of the project staff's awareness. For instance, a community center director might be approached with the idea that the center might provide space for monthly meetings of volunteers (an example of support). During the discussion, however, the director may offer to provide the meeting space and also to distribute project materials to participants in their social and recreational projects (that is, a type of participation).

Careful planning and monitoring were essential when organizing this effort. Project staff identified and listed all known contacts and then solicited additional contacts from community members. Records are kept of all formal contacts made within each strata. Thus, community involvement is monitored through detailed process measures that record each partnership and the type and duration of involvement of individuals, groups, and organizations that collaborate with WIDP. In this way, changes in any participant's level of involvement can be tracked, as can additions to or removals from the group of participants. This type of monitoring is a critical management tool to help realize the goal of maximum involvement through feedback about implementation and progress. It can also identify shifting priorities of the community and allow for ongoing retooling of the intervention activities.

The organizational segment is solicited through organizational outreach and networking. Organizational networking requires WIDP staff to go out into the community and interact with staff from other systems, agencies, organiza-

tions, businesses, and religious groups. This community interaction is critical to building rapport and subsequent relationships with others interested in HIV prevention. Organizational outreach (a) provides an overview of WIDP goals and intervention activities, (b) shares project-produced materials, (c) invites organizations to become involved with the project, and (d) provides WIDP staff opportunities to stay abreast of other local HIV prevention activities (as well as the social and political climate in which they exist). All of these activities contribute to the functional goal of developing relationships for the purpose of coordinating complementary and systematic prevention activities.

The structure of the CMF provides a guide for HIV prevention providers interested in implementing strategic interventions which incorporate and integrate broad cross-sections of the community.

During an encounter with an organization, WIDP staff try to identify specific opportunities for collaboration and encourage members of the organization to commit to specific activities. At the same time, efforts are made to demonstrate how involvement in the project may directly benefit the new participant. For example, a project may find through street outreach that women are not utilizing STD clinics because the hours are too short. Having a network of organizations that can provide this type of feedback to STD clinic administrators is a concrete benefit of collaborative involvement.

The WIDP interventions for persons in the community are delivered through peer networking and stage-tailored outreach. Peer networkers are community residents recruited to promote the messages found in community-tailored small media produced by the project *(10, 12)*. The goal of the peer network is to permeate the community with messages, materials, and social reinforcement provided by people similar to the intended audience *(13)*. This similarity increases the credibility of the source and the trust placed in her or him, thus increasing the ease of relating to the message being conveyed *(14)*.

WIDP sites also employ project staff to provide outreach services to women within the inner strata of the CMF. The WIDP utilizes outreach staff trained to provide individually tailored encounters based on their assessment of a woman's readiness to adopt (or maintain) consistent condom use. These assessments and the tailored encounters are based on the Transtheoretical Model *(15, 16)* which incorporates attitudinal concepts from Theory of Reasoned Action *(17)*, efficacy constructs from Social Cognitive Theory *(18)*, and other theoretical bases. The outreach specialists' primary activity is to provide informational and motivational contacts on the street with women they reach there; they also provide appropriate referrals, provide other information as necessary, and recruit women to be part of the peer network.

## Discussion

The CMF was developed as part of the WIDP to conceptualize the range of participants within a community available for bringing about behavioral, attitudinal, and normative changes; the types of involvement they might contribute to the prevention effort; and systems of dynamic reciprocal communication. The structure of the CMF provides a guide for HIV prevention providers interested in implementing strategic interventions which incorporate and integrate broad cross-sections of the community.

Developing active community-level and community-wide participation in the five WIDP sites serves the goal of HIV prevention by (a) augmenting the resources available for providing prevention services, (b) creating a critical normative context for supporting healthy behaviors, and (c) supporting an underlying premise of sustainability—that a critical mass of community members must remain involved throughout the prevention effort to develop long-term investment.

Community-level HIV prevention efforts require the simultaneous modification of a complex set of factors including attitudes, behaviors, norms, and situational contexts. Mobilizing a community around HIV prevention is not a passive endeavor; it does not happen just because it is a good goal. The CMF offers one example of a systematic plan for structuring HIV prevention opportunities and the recruitment and retention of people to realize those opportunities.

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