Advancing HIV/AIDS Prevention Among American Indians Through Capacity Building and the Community Readiness Model

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Although HIV/AIDS prevention has presented challenges over the past 25 years, prevention does work! To be most effective, however, prevention must be specific to the culture and the nature of the community. Building the capacity of a community for prevention efforts is not an easy process. If capacity is to be sustained, it must be practical and utilize the resources that already exist in the community. Attitudes vary across communities; resources vary, political climates are constantly varied and changing. Communities are fluid—always changing, adapting, growing. They are "ready" for different things at different times. Readiness is a key issue! This article presents a model that has experienced a high level of success in building community capacity for effective prevention/intervention for HIV/AIDS and offers case studies for review. The Community Readiness Model provides both quantitative and qualitative information in a user-friendly structure that guides a community through the process of understanding the importance of the measure of readiness. The model identifies readiness-appropriate strategies, provides readiness scores for evaluation, and most important, involves community stakeholders in the process. The article will demonstrate the importance of developing strategies consistent with readiness levels for more cost-effective and successful prevention efforts.

KEY WORDS: **American Indian, capacity building, community readiness, HIV/AIDS, prevention**

What we have learned in the past 25 years is that prevention works! However, for prevention to be most effective, it must be specific to the needs of the population of focus.[1,2] In an effort to provide the necessary resources to ensure efficacy, the Centers for Disease Control's (CDC's) Capacity Building Branch works to strengthen the capabilities of the HIV prevention workforce by ensuring the availability of evidence-based and culturally appropriate Capacity Building Assistance (CBA). The intent of this article is to familiarize the reader with the Community Readiness Model (CRM) and its utility for development of effective prevention and social marketing related to HIV/AIDS. Specifically, the article offers a very brief discussion of American Indians and HIV/AIDS and then an in-depth description of the CRM, followed by lessons learned and case studies.

American Indians and HIV/AIDS

The history of HIV/AIDS among American Indians continues in a silent and steady growth pattern. American Indians were diagnosed with AIDS early in the onset of the disease (1987–1988) but it was not until 1989 that Indian Health Service was funded to specifically address these needs. At that time, HIV/AIDS was not identified as a health priority but rather one of a myriad of health concerns.[3] Although less than 1 percent of

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cumulative AIDS cases in the United States are among American Indians, the numbers continue to climb. The reported statistics are held highly suspect and the actual numbers are believed to be higher because of misclassification and data collection problems.[4–6] In contrast to the low numbers of HIV/AIDS relative to other subpopulations, American Indians rank third when one examines rates of AIDS cases among all races: 56.4 per 100,000 in the African American population, 18.6 in the Hispanic population, 7.9 in the American Indian population, 6.0 in the White population, and 3.7 in the Asian/Pacific population.[7] As for HIV reporting, 25 states have shown that the rate of diagnosed HIV infection reported among tribal people living in those states averaged 16.4 per 100,000 persons—approximately 1.5 times the average rate for whites.[8] When we consider the "low" numbers of reported AIDS cases (third among all races), the rate of diagnosed HIV infection, and the many documented risk factors, it is imperative that American Indians be educated about this issue so that they may be diligent in identifying and utilizing effective intervention/prevention methods in their promotion of HIV testing and early diagnosis.

It is important to note that American Indians are considered at great risk for contracting HIV *not* because of their race, but because of their socioeconomic status and health conditions. It is also important to remember that the impact of these factors will vary from community to community. The factors that place American Indians at risk and present barriers to prevention include poverty, high rates of sexually transmitted diseases, substance abuse, violence, stigma, denial, and concern about confidentiality in smaller reservation and rural communities.[3,8–11]

Capacity Building Assistance for American Indians

Despite national efforts to reduce HIV/AIDS infection, there are many American Indian communities that do not have programs or resources to effectively address HIV/AIDS, nor do they have adequate culturally specific prevention or intervention materials/programs for their communities. In fact, many organizations lack the resources to develop competitive proposal applications and they have limited access to culturally normed evaluation tools and knowledge of the necessary Capacity Building Assistance (CBA) to assist them in their prevention endeavors. Feasible, effective, practical, and culturally specific approaches are needed for CBA to be effective and for it to sustain the efforts. Mobilizing a community is essential in the face of limited resources. If a community does not believe an issue is important, they will not mobilize and any efforts initiated will meet with apathy, resistance or even failure. By increasing the level of awareness and, thus, community involvement and interest, there is also an increase in availability of resources, demand for culturally competent services and support from various related sectors of the community. By engaging as many of those sectors as possible, the potential for an effective community-wide prevention effort is increased. Prevention efforts must have the support and commitment of its members in order to build the needed resources to implement effective prevention, especially on a topic as complex as HIV/AIDS.

In addressing the needs of American Indians, Alaska Natives, and Native Hawaiians, the CDC has funded, through 2009, the National Native American AIDS Prevention Center (NNAAPC), Center for Applied Studies in American Ethnicity (CASAE: Advancing HIV/AIDS Prevention in Native Communities), and Inter Tribal Council of Arizona (ITCA) to assist in the prevention of HIV/AIDS by offering CBA for community-based organizations, health departments, and organization/tribes serving Native people. All services are free and easily accessible through the CASAE Web site (http://www. colostate.edu/Depts/CASAE/). This CDC-funded initiative is making significant impacts toward advancing HIV/AIDS prevention in Native communities. CASAE provides Community Readiness[12–17] CBA to strengthen community access to and utilization of HIV prevention services.

Community Readiness Model

The Community Readiness Model is an innovative method for assessing the readiness of a community to develop and implement prevention efforts. Although it was originally developed to address community alcohol and drug abuse prevention efforts, it was quickly discovered, by communities that used it, that it has a much broader utility of assessing readiness for a gamut of problems, ranging from health and nutritional issues such as sexually transmitted diseases, heart disease, and diet to environmental issues such as water and air quality, litter and recycling, to other social issues such as poverty, homelessness, and violence. The model identifies specific characteristics related to different levels of problem awareness and readiness for change. To stand a chance of success, interventions introduced in a community must be consistent with their awareness of the problem and their readiness for change. Essentially, the purpose of *Community Readiness* is to provide communities with a user-friendly "diagnostic tool" that identifies multidimensional stages of readiness that support the development of strategies that are *more successful and cost-effective*.

The Community Readiness Model is a nine-stage, multidimensional model that facilitates community- or organization-based change and prepares the group for better integration of an intervention. Perhaps its greatest strength is that it is issue- *and* community-specific and applying the model builds capacity, investment, and cooperation among systems and individuals. The model matches the intensity of prevention/intervention efforts to a community's level of readiness, which is *critical* for success. By applying the strategies appropriate to the readiness stage for each dimension, the efforts are more consistent with what a community or organization is able to accept, thus increasing the potential for success and offering a very cost-effective and resource-rich foundation on which to initiate a change in community norms. It serves as an accurate community diagnostic and offers a step-by-step structured and easily evaluated change process. General strategies have been identified consistent with each stage so that the user knows exactly what level of intensity to apply to avoid wasting resources and utilizing the resources at hand.

Community Readiness Stages and Dimensions

The nine stages of readiness adapted for HIV/AIDS are as follows: (1) *No Awareness*. There is no awareness within the community or organization that HIV/AIDS is an issue that needs to be addressed. (2) *Denial/Resistance*. HIV/AIDS is recognized as something that may need attention, but "it's not our problem," or "we can't (or don't want to) do anything about that." The community may even actively resist doing anything. Leadership would not support efforts to do something about the problem. (3) *Vague Awareness*. Although HIV/AIDS is seen as an issue to be dealt with, there is little motivation to address it. There may be enough interest among a small number of community members for a team of volunteers to be recruited and trained, but the community at large and the leadership lacks motivation to initiate efforts. (4) *Preplanning*. Identifiable leaders may indicate that prevention or positive change is needed and would be valuable for the community. Community climate would support doing something about prevention but focus may still be lacking for both the leadership and the community at large. (5) *Preparation*. There is focus in the planning process, decisions are being made, practical details resolved, training programs are being discussed and people are being identified, possibly even recruited to serve in different functions. The planning group is energetic and active. Community climate is beginning to acknowledge the need to do something about HIV/AIDS prevention. Existing data are being gathered. (6) *Initiation*. Enough data and information is available to justify action, and action is underway, but programs may still be new and/or untested. Decisions are made about what will be done and who will do it and leaders are supportive of efforts. (7) *Stabilization*. Programs are running and supported by most leadership. Programs are viewed as stable, ongoing, and necessary. Some evaluation may be occurring. Community climate is generally supportive. (8) *Confirmation/Expansion*. There is now continuous evaluation; the program is consumer-driven and evaluation feedback maintains quality of the effort. Community support is constantly tracked and the program is enhanced where needed, perhaps even in related areas. (9) *Community Ownership*. Prevention activities continue at a high level of effectiveness and are constantly evaluated and modified as needed. All dimensions of community readiness can be monitored regularly and action taken to maintain readiness levels.

The model then applies these readiness stages to each of the following six dimensions of a community or organization: (1) *efforts currently in existence* (ie, current policies, programs, activities); (2) *community knowledge of efforts* (ie, what does the community actually know about the efforts that exist?); (3) *Leadership* (ie, what is the level of involvement and support of leaders, both formal and informal, for HIV/AIDS prevention/testing?); (4) *community climate* (ie, community energy, political issues that influence the issue, ability to address social problems, etc); (5) *knowledge of the issue* (ie, how much the community really knows about HIV/AIDS, where they can be tested, etc?). (6) *resources* (ie, availability of people, time, money, and space to apply to HIV/AIDS efforts, etc).

The Process of Community Readiness

The CRM process relies on community information to identify the readiness stage most appropriate for each dimension. Semistructured interviews are conducted with key respondents with the community. The interviewees are generally selected from a pool of roles and key positions within a community although community members at large are always included in the interview process. The interviews consist of approximately 34 questions that draw information specific to the six dimensions. The number of interviewees can vary from six to an unlimited number. The CASAE has learned from the experience of interviewing over 3000 respondents that, after six to eight interviews, the information is very consistent. These six to eight interviews can then be moved to the scoring process. However, some communities have ascertained, because of their political climates, that the

process is better accepted if more people are interviewed. If that is the case, then more interviews can be collected.

Once the interviews are complete, the scoring process is applied. Scoring utilizes anchored rating scales to score the responses of the key respondents on each of the six dimensions. Scoring is completed by two people. Each scorer independently reads through the interview completely, then scores each dimension. At that point, the two discuss the scores they have derived to make certain that all elements of the interview have been given thorough consideration. They reach a "consensus" score. Those scores are then recorded and averaged to reach an overall community readiness score.

The final scores are then presented to the community in an all-day workshop focused on building an action plan based on readiness levels. During the process of the workshop, the culture of the community is used to build the foundation on which the work will be done. Local resources and strengths are then identified and reframed and used to build and implement the strategies. The *Readiness Action Plans* are developed by first targeting the dimensions with lower stages of readiness and using strategies consistent with the intensity and readiness levels of each of the six dimensions. By implementing strategies that are consistent with readiness levels, more action is achieved, potential of successful intervention is increased, and cost-effectiveness and resource-effectiveness are put into motion. Readiness levels can easily be reassessed for evaluation purposes as well as for modification of action plans as readiness levels increase. CRM provides a built-in evaluation for gauging changes in readiness and in community norms related to HIV/AIDS or whatever topic is the focus.

Community Readiness Lessons Learned

Building the capacity of a community is not an easy process. If capacity is to be sustained, it must be practical and utilize the resources that exist in the community. Knowing the impact that CRM has had in our currently funded CBA project, we believe it to be essential in enhancing and increasing the potential of success of interventions. It is a key element in developing and introducing social marketing to encourage HIV testing and early detection. It is useful in the preparation of proposal applications and pursuit of grants. If a community can document the readiness stage and build their goals and objectives around that readiness level, they seem to experience a higher level of success.

No community, large or small, has an easy time when it comes to developing, implementing, and sustaining any kind of intervention. The reasons are many. Attitudes vary across communities; in one place a behavior can be recognized as a problem and in another the same behavior can be accepted as the way things are and have always been. Resources also vary from community to community: one group may be rich with volunteers and energy and another group may be struggling for input and attention. Political climates are constantly varying and changing—always a challenge when it comes to developing and implementing a new program of any sort. Even when programs do get up and running, all too often they meet with failure after a relatively short period of time. The general belief is because they are poorly planned or not potent enough to change the status quo of the community; people are insufficiently trained, or get bored waiting for results, or move on—leaving less motivated people behind. Money runs out. Frustration rises. Interest fades. Why did it work in the neighboring community, people want to know? Why didn't it work here? And yet, considering our country's vast array of ethnically, culturally, and geographically diverse communities, is it any wonder that what is effective in one community may not be even minimally effective in another? We have learned that communities are fluid—always changing, adapting, growing; *they are **ready** for different things at wholly different times*. Readiness is a key issue for creating positive change.

In an effort to shed light on the key issues and needs for rural minority and majority culture communities related to HIV/AIDS prevention, Barbara Plested examined Community Readiness across 30 ethnic communities. Respondents in all the communities, regardless of ethnic group, indicated that the topic of HIV/AIDS was generally not talked about in their communities, with some respondents characterizing it as "out of sight, out of mind." Furthermore, respondents across all of the ethnicities talked about prevalence of prejudice and lack of compassion for persons who have AIDS, particularly if how they contracted it is related to sexual preference or substance use. The need for education within the communities about HIV/AIDS was especially prominent in the responses of the participants.

This lesson is very important in the discussion of building capacity for prevention and intervention with and for American Indian communities. Those communities in Dr Plested's study noted that for an issue as sensitive as HIV/AIDS, the resources become highly politicized owing to stereotypes and, surprisingly, a general lack of education about transmission, the course of the disease, and conservative attitudes of community members. She found that community readiness, prior to introducing an intervention, increased the potential of success of the intervention and garnered improved support, mentoring, and networking.

Dr Plested also found that people living with HIV/AIDS in rural communities are especially challenged in accessing healthcare, especially for anything

beyond basic health and wellness services. Distance to services for persons infected with HIV or AIDS were mentioned in all communities as a major challenge. Lack of education among community members about HIV/AIDS exacerbates the problem and reduces social support for those living with HIV/AIDS.

According to Plested's findings in her test of the CRM, it is clear that effective intervention must be based on involvement of multiple systems and utilization of within-community resources and strengths. Efforts must be culturally relevant and accepted as long-term and confidential in nature. The CRM takes these factors into account and provides a theory- and evidence-based tool that communities can easily use to focus and direct community efforts toward a desired result, maximizing their resources and minimizing discouraging failures.

To summarize our experiences in utilizing CRM within American Indian communities, we have learned a lot about the provision of CBA and have found that communities who used CRM as a foundation for utilizing the Diffused Effective Behavioral Interventions and Effective Behavioral Interventions had high levels of success of implementation and stakeholder involvement. It provides both quantitative and qualitative information in a user-friendly structure that guides a community through the process of selection of the best intervention, provides information on how the intervention must be tailored or adapted, and how it can serve as an evaluation tool. Community involvement in planning and decision making related to interventions introduced had a higher potential for success.[18,19]

During the past 2 years of providing CBA based on the CRM, several successful case studies have emerged.

Case Study 1. One urban agency serving Native high-risk adolescent boys utilized the CRM to examine the readiness of a very conservative community agency to introduce HIV/AIDS prevention, education, and testing concepts to young boys. Initially there was controversy about presenting information about sexual activity and HIV risk. However, many of these young boys had been sexually abused and were at high risk for HIV. None had been tested, however. HIV had not been a consideration at admission. Readiness scores pinpointed this concern as a topic that emerged throughout the interviews. Using readiness-stage strategies consistent with the vague awareness stage, and using one-on-one discussions with administration and the state departments, the agency actually quickly moved forward through two stages of readiness. Because they used the lower stages of readiness and utilized the one-on-one discussion, there was less resistance encountered. They were able to use the information they gathered from the interviews to prepare a proposal based on readiness theory and readiness scores (input from the community/organizational workers) to propose offering basic education and testing services. They were successful in their endeavor and have not only expanded their community outreach related to HIV/AIDS, but have now included HIV/AIDS education in their regular treatment curriculum. Furthermore, all new patients are now tested for HIV as part of the admissions process.

Case Study 2. An agency serving rural Native clients requested CRM assistance and provided the workshop to nine Native communities who wanted to introduce HIV/AIDS interventions. All of the communities were concerned about higher rates of STDs, although none of the communities were funded to specifically provide HIV education or prevention. All were very different and diverse in their resources and their culture. However, all nine implemented the interview process and using their readiness scores and their identified available resources, they were able to implement education and social marketing strategies that have resulted in an increased use of testing facilities and requests for information specific to HIV at their local clinics. Each community used strategies slightly different depending on their population to be served. Three of the communities utilized the church as their point of intervention, two used their school to introduce education through curriculum enhancement, and four used their local clinics as an avenue to distribute brochures and hang posters to encourage HIV testing.

Case Study 3. The tribe requesting CBA services serves a ten-county area. Their readiness assessment indicated very low readiness scores for HIV/AIDS prevention but a high concern about methamphetamine use. Although the tribal organization knew that HIV was rising, they also knew that the community would not be amenable to discussions about HIV. However, the group was very creative in that because they had completed readiness interviews, they were able to utilize the recurring theme of a concern about rising meth use that emerged from the interviews and offer methamphetamine education. In doing so, they also incorporated HIV/AIDS information related to intravenous needle use and other dangers associated to meth-amphetamine use. Their results have been very successful. They have been invited into schools, churches, and other hard-to-reach areas where previously the topic of HIV/AIDS would have resulted in closed doors. However, by addressing an issue the community was ready to address, they were able to introduce HIV/AIDS education and testing resources to many people.

Conclusion

Daniel Quinn suggests that "if the world is to be saved, it will be saved by people with changed minds,

people with a new vision—yet if the time isn't right for a new idea, it will fail. If however, the time is right, an idea can sweep the world like wildfire. The measures of change are not ease or difficulty, but readiness or unreadiness."[20] Certainly, we have learned and continue to learn that CRM is a very effective tool for building capacity. We offer the model in the hope that the movement of HIV infection will be limited, if not someday eradicated, and that those infected will have the access to care and quality treatment that they need.

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