Standard Operating Procedures: Community Mobilization
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I. Introduction

A. Purpose of this Manual

The purpose of this manual is to describe the plan for conducting community mobilization activities for NIMH Project Accept at all five international sites. Community Mobilization is one of three components of the community-based VCT intervention. The other two components of the intervention are 1) provision of mobile VCT and 2) provision of HIV post-test support services (PTSS) for all community members who have participated in VCT.

The three components of the intervention are designed to function together interdependently. Therefore, this manual should be read together with the manuals that describe the mobile VCT and post-test service components of the intervention.

As a multi-site study, it is vitally important that all sites implement intervention activities that conform to common standards and procedures. We do recognize, however, that the social context in each site is unique and may require adaptations of what is presented in this manual. In those cases, adaptations are welcome; however, they should be submitted to and approved by the intervention subcommittee prior to being implemented.

B. Working with the Project Accept Intervention Subcommitteee

The Intervention Subcommitteee is tasked with overseeing all aspects of the Project Accept intervention. It is chaired by Stephen F. Morin, PhD, of the University of California San Francisco (UCSF) and comprises members from each of the five project sites. The duties of the subcommitteee are to:

1. develop the intervention concept
2. coordinate the writing of manuals of operation that will guide the conduct of the intervention
3. coordinate the writing of training manuals for each intervention component
4. monitor the implementation of the intervention to ensure that all sites are carrying out the intervention according to common standards and procedures set out in the operations manuals
5. develop and conduct regular quality assurance activities

The subcommitteee also produced the Project Accept Staff Orientation Manual, which provides detail on the project's rationale, objectives, governance mechanisms, and procedures and may be utilized/adapted by sites as they wish.

C. How this Manual Is Organized

This manual is organized into seven sections. Following this introductory section, Section II examines the specifics of Community Mobilization, providing definition of terms and the specific aims of this component of the intervention. In Section III, we discuss the foundation of the community mobilization strategy in Diffusion of Innovation Theory and in Section IV we specifically look at how we will apply DOI theory in creating our community mobilization plan. In Section V, we look at the roles and responsibilities of the Community Mobilization Team of staff and volunteers, as well as related training requirements. Section VI provides a
step-by-step guide for initiating and implementing the community mobilization plan. In Section VII, we address quality assurance procedures we can use to ensure this aspect of our intervention consistently meets the highest standards.

To ensure this manual is maximally useful to study PIs and staff, please read it carefully and direct suggestions for improvement and revision to Katherine Fritz (kfritz@telkomsa.net).
II. Introduction to the Community Mobilization Component of the Intervention

A. Definition of Terms

What is community mobilization?
To mobilize a community around any issue or problem, such as the HIV epidemic, is to raise the community’s consciousness about that issue through education, support the community to think about how the issue affects them, and to nurture the will and commitment of community members develop constructive responses. The Community Mobilization activities for Project Accept aim to 1) create awareness about and an open dialogue around HIV/AIDS in communities, 2) enhance the communities’ understanding of, participation in, and enthusiasm for VCT and PTSS, 3) to foster understanding and acceptance of HIV positive members of the community (stigma reduction), 4) to promote HIV risk reduction among all community members, and 5) to ensure that steps 1-4 continually reinforce one another.

Who are community mobilizers?
In Project Accept, each community will have a team of community mobilizers made up of study staff (outreach worker/drivers) and community-based outreach volunteers (CBOVs). The CBOVs will include 1) opinion leaders who become early adopters of mobile VCT or post-test services who can speak from personal experience about the benefits of knowing (and disclosing) one’s HIV status, 2) members of the communities’ CWGs who become early adopters of VCT or PTSS and are interested in being CBOVs, 3) other community members who hold strategic positions within community social networks and who are interested in being CBOVs, and 4) community members who possess specific attributes that have been identified as enhancing community mobilization efforts (see Section VI.D below).

How is community mobilization different from community preparedness/involvement?
Community preparedness/involvement describes the process through which researchers gain entry into study communities, identify community stakeholders, establish rapport with stakeholders and community members, educate community members about the aims and procedures of the study, negotiate “buy-in” among community members, prepare community members to participate as partners in the research activities, and work to maintain that involvement in the research process over the entire course of the study. Community preparedness/involvement activities continue throughout the study period in both intervention and comparison communities and revolve around the work of the Community Working Groups, which have the responsibility of representing community members’ interests and ensuring that the research study as a whole serves community interests. In addition, as new social networks become involved in Project Accept over the study period, community preparedness activities will be undertaken with them. Therefore, it is difficult to state that community preparedness ends at an exact point at which community mobilization begins. Rather, we should view community preparedness as an ongoing process within both control and intervention communities.

Community mobilization, however, is a component of the intervention that occurs only after randomization of communities and only within those communities randomized to receive the intervention. The Community Mobilization activities are aimed specifically to create awareness
about and an open dialogue around HIV/AIDS in communities, enhance the communities’ understanding of, participation in, and enthusiasm for VCT, to foster understanding and acceptance of HIV positive members of the community (stigma reduction), and to promote knowledge and practice of HIV risk reduction among all community members.

**What is the role of CWGs in control communities?** The role of CWGs in control communities (CCs) will be more limited than that of CWGs in intervention communities. However, CWGs in CCs will still be crucial and their role must be carefully defined, as must the type, intensity, and frequency of the community mobilization coordinator's engagement with them.

Among the key issues to consider in crafting these roles and developing terms of references for CWGs in control communities are:

The CM coordinator must ensure that he/she does not spend an inordinate amount of time dealing with CWGs in CCs, both to avoid contamination and to ensure sufficient time allocation to CWGs in intervention communities.

1. He/she must interact with the CWGs often enough so that:
   - Project Accept keeps the promises it made to CCs
   - Linkages to MoH/DoH services for CC members can be facilitated
   - CWGs are kept abreast of Project Accept developments, implementation, next steps, etc., and do not feel neglected
   - CWGs are able to express their concerns/grievances regarding the project to the coordinator
   - The coordinator can track new developments in CCs, including detecting any possible signs of contamination

A possible scenario is that the coordinator will convene formal meetings with CWGs in CCs every six months, but will undertake more informal check-ins with CCs on a bimonthly basis to determine if any problems or grievances have arisen and to check for signs of contamination.

**B. Aims of Community Mobilization**

The specific aims of Project Accept Community Mobilization are to:

1. create awareness about and an open dialogue around HIV/AIDS in communities
2. enhance the communities’ understanding of, participation in, and enthusiasm for VCT
3. foster understanding and acceptance of HIV positive members of the community (stigma reduction)
4. promote HIV risk reduction among all community members
III. Foundation of Community Mobilization Strategy in Diffusion of Innovation Theory

Diffusion of Innovation theory (DOI) is the behavioral theory that will guide our community mobilization activities. DOI provides us with a detailed model of how innovative ideas, practices, or technologies “catch on” or spread from person to person until they eventually become the norm within social systems. The following synthesis of DOI theory is drawn from Everett Rogers’ *Diffusion of Innovations*, 5th Edition, New York: Free Press, 2003. This book is also recommended reading for all Project Accept Community Mobilization staff members.

A. What is an innovation?

An innovation is simply something new. It can be an idea, a practice, or a thing. Most innovations are improvements on an existing idea, practice, or technology that is already familiar. For example, cell phones were an innovation of the 1990s that improved on the existing technology of telecommunications. The idea of using a phone to communicate wasn’t new but using a phone that was completely mobile and free from the constraints of cables and wires was very new. Cell phones turned out to be a very attractive innovation and it didn’t take long for people to adopt them and for their use to become quite normal throughout society.

B. What qualities make an innovation likely to be adopted?

Diffusion of Innovation theory describes 5 qualities that make it likely an innovation will be adopted. These are:

1. **Relative Advantage.** This is the degree to which an innovation is perceived as better than what it replaces. For example, it is easy to see how people perceived cell phones to be a better option than conventional phones. The advantages were clear, especially to those who previously did not have or could not have conventional phones and lines. For many around the world, the cell phone revolution meant they could now have a phone. For those who did already have conventional phones, cell phone technology meant that for the first time, the could be available for communication 24 hours a day, 7 days a week.

2. **Compatibility.** This is the degree to which an innovation is perceived as being consistent with existing values, past experiences, and the needs of potential adopters. Was the cell phone innovation compatible with existing values, past experiences, and needs of potential adopters? People value personal communication in most societies and the faster and more efficient the better. In addition, there was a vast pent up demand for access to phones around the world. Many people had never had a phone and wanted one. The cell phone revolution has allowed more people to have phones than ever before. It was an innovation that was very compatible with people’s needs and did not go against values.

3. **Complexity.** This is the degree to which an innovation is perceived as difficult to understand and use. Innovations that are simple to understand and easy to use are more
likely to be adopted than complex innovations. Are cell phones difficult to understand and use? They do not seem to be prohibitively complex. Some people quickly learn to master all of the complex functions and tools a cell phone offers while others choose to learn just the basics. Cell phone designers have tried to offer a technology that serves both types of people.

4. **Trialability.** This is the degree to which an innovation may be experimented with on a limited basis. If you are not sure you want to use a cell phone for the rest of your life, can you try one out for a while to see if you like it? Sure. You can buy or borrow one and see how it goes, then make a final decision.

5. **Observability.** This is the degree to which the results of an innovation are visible to others. Can you easily observe people using cell phones and benefiting from that use? Definitely. Every time you see someone make a call to gain information, further a business deal, get help in an emergency, or just check in with a friend or relative, you can observe how the innovation serves people’s interests.

DOI theory calls particular attention to the first two characteristics: Relative Advantage and Compatibility as the most important in determining the rate at which an innovation is adopted.

**C. How do individuals decide to adopt an innovation?**

People react differently when faced with a new idea. You have probably observed among your own friends and relatives that some were eager to adopt cell phone use straight away when it was introduced while others took more time warming up to the idea. Even today, you probably know people who are always buying the newest cell phone technology as soon as it becomes available while other people you know still don’t like the idea of cell phones, use them reluctantly, or complain about other people’s use of cell phones. There is always a continuum of responses to an innovation. Diffusion of Innovation theory gives us a model for understanding the stages an individual passes through as she decides whether or not to adopt an innovation. The stages are:

1. **Knowledge.** An individual learns of the innovation’s existence and gains some understanding of how it functions. The individual seeks information to answer the questions “What is this innovation?” “How does it work?” and “Why does it work?”

2. **Persuasion.** An individual forms a favorable or unfavorable attitude or “feeling” toward the innovation. At this stage, the individual is uncertain about the consequences of the innovation and needs answers to the questions “Will the innovation be advantageous to me in my particular situation?” “How might it improve the quality of my life?” “How does the innovation compare with my other options?” “Is it easy to use?” “Are other people like me using it?” “Does it fit with my values and past experiences?” At this stage, the individual also needs to decide if she trusts the information she is receiving about the innovation as well as the people who are giving her the information about the innovation—are they credible sources? Is the information credible?
It is important to note that many people never move beyond this phase of the decision process. That is, even though they form a generally positive impression of the innovation, they never adopt it. This is especially true for innovations that focus on prevention of some unwanted consequence in the future. The lag time between adoption of the preventive innovation now and reaping the reward from that innovation in the future creates uncertainty in the mind of the potential adopter about its relative advantage. Take for example the preventive behavior of eating a low-fat diet when you are 40 years old to prevent having a heart attack at age 60. Most people say it’s a very good idea, yet the innovation is rarely adopted. It is not until one has a heart attack that the innovation starts to look extremely advantageous in preventing a second heart attack. In this example, having a heart attack is a “cue-to-action” event. Cues-to-action are special events in a person’s life that help motivate them to adopt innovative preventive behavior. Seeing a brother or sister die of lung cancer, for example, can be a cue-to-action to stop smoking. Going to repeated funerals of individuals who have died of AIDS can be a cue-to-action to adopt risk reduction behaviors.

3. Decision. An individual engages in activities that lead to a choice to adopt or reject the innovation. A very important part of this phase is trying the innovation out to see how you like it. Most people do not adopt an innovation without trying it out on a small scale first to see if it suits them and their situation. Innovations that can be divided into a trial component are more rapidly adopted. This is why advertisers and marketers offer trial subscriptions, demonstrations, or sample packages of new products. People who try new things often become adopters. People who are reluctant to try an innovation themselves, can also be influenced by watching someone else do it first. This is called “trial by others” in which a potential adopter gets to see someone similar to him try the innovation in a demonstration setting. This is especially effective if the person in the demonstration is an opinion leader in the social system.

4. Implementation. An individual puts an innovation into use. Up to this point, the decision-making process has been mental. Now it becomes physical as the adopter takes steps to implement the innovation in her life. At this stage, an individual still has some uncertainty, however. They need answers to the questions “Where can I obtain the innovation?” “How do I use it?” and “What kinds of operational problems might I encounter in using it?” The individual may need technical assistance to put the innovation into practice. It is also in this stage that individuals may “re-invent” the innovation. This means that individuals find ways of altering the innovation to better serve their needs. Re-invention is a very positive force and can both increase the rate of adoption of an innovation and improve the innovation’s sustainability.

5. Confirmation. An individual seeks reinforcement of their decision to adopt the innovation. At this stage, an individual is often seeking confirmation that they made the “right” decision in adopting the innovation. If the adopter is exposed to conflicting messages about the innovation at this stage, she may reverse her previous decision and discontinue the innovation. Discontinuance of an innovation after adoption is quite common. There are two types of discontinuance: replacement and disenchantment. Replacement happens when a person discontinues one innovation to replace it with a better one. Disenchantment is when a person discontinues an innovation because of
dissatisfaction with its performance. This may be a result of the innovation being inappropriate for the adopter’s situation or the innovation being misused by the adopter because of lack of understanding. Discontinuance is more likely with innovations that have a slow rate of adoption. Adopters who are likely to discontinue tend to have less formal education, lower socio-economic status, and have less contact with those promoting the innovation.

Figure 5-1 shows a diagram of the model of the decision stages.
D. When do people adopt an innovation?

Some people pass through the 5 stages of the innovation-decision process very quickly and adopt the innovation seemingly without any problem. Others take longer to pass through the stages or never complete their trip through the stages at all and thus never adopt the innovation. Diffusion of Innovation Theory classifies people into one of 5 groups based on how quickly they adopt an innovation.

1. **Innovators.** These people are venturesome. They love new ideas and seek them out or even develop innovations themselves. They are risk-takers, information-seekers, and often have financial capital to push their innovations into the public realm and absorb losses. They have a high tolerance for uncertainty when they adopt an innovation. They are not “typical” members of the social system in which they live. They do not stick to a local circle of friends but branch out in many directions beyond the boundaries of their home community. Their community views them as unusual, perhaps even eccentric and therefore innovators do not serve as role-models for others. Innovators are a small group, accounting for just 2.5% of a social system.

2. **Early Adopters.** Early adopters are innovative in their thinking and are enthusiastic to integrate innovations into their lifestyle. Unlike innovators, however, early adopters are very well rooted and respected in their communities. They are ahead of most people in their communities in terms of their innovativeness but not so far ahead of the pack that they seem highly unusual or eccentric. It is among early adopters that you are most likely to find people called “opinion leaders.” Opinion leaders typically serve as role models and are respected for their successful and careful adoption of new ideas. They are seen as the people to “check with” before adopting an innovation. The early adopter decreases uncertainty about an innovation by using the innovation himself and then talking to his peers about what he thinks of it. Early adopters also tend to have very large interpersonal networks, which amplify the effect of their position as role model. Their social connections also extend beyond the boundaries of their own local system. It is also interesting to note that early adopters tend to have more formal education, be literate, be wealthier, have more occupational prestige and be more upwardly socially mobile than people who are later adopters. Early adopters account for 13.5% of the population in a social system.

3. **Early Majority.** These are deliberate people who adopt new ideas just before the average member of a community. They take their time to think about an innovation before making a decision to adopt. They don’t want to be the last to adopt but they don’t want to be the first, either. They follow the lead of the early adopters. They interact with other members of their social system frequently but do not typically act as opinion leaders. They are numerous and make up 34% of all members of a system.

4. **Late Majority.** These are skeptical people who adopt ideas just after the average member of a community. For these people, the pressure of peers or economic necessity is necessary to motivate them to adopt an innovation. The late majority will wait until the social norms have definitely swung in favor of the innovation before they adopt. They often have scarce resources and will not adopt until all uncertainty about the
innovation has been removed and they feel it is economically safe to adopt the innovation. They are also numerous and account for 34% of the members of a system.

5. **Laggards.** These are the traditionalists in society. They are conservative toward change and are the last to adopt an innovation. The pay little attention to the opinions of others. They also tend to be the most vulnerable group socio-economically and often feel they cannot afford to take chances on new ideas. Their point of reference is what has worked for them in the past and they are reluctant to change those practices. They interact with others who are in similar conditions or have the same outlook. They are suspicious of those who promote an innovation. Laggards account for 16% of the social system membership.

DOI theory also points to an interesting paradox in the timing of when certain people adopt innovations. It is called the Innovativeness/Needs Paradox. The paradox lies in the reality that early adopters (who tend to be wealthier and more educated) are usually those who least need the benefits of an innovation yet adopt it first while those who most need the benefits of an innovation (the less wealthy and less educated) tend to be among the last to adopt an innovation (the laggards). This paradox tends to widen the socioeconomic disparities within society—early adopters gain advantage after advantage from each innovation they adopt while laggards rarely reap the benefits of innovations and are thus kept in a vulnerable condition. An example is family planning initiatives. Elite men and women with already small families tend to be the first to adopt family planning while poor men and women with the least resources for raising families tend to not adopt the innovation of family planning. Aggravating this paradox is that in promoting innovations, organizers often favor the strategy of least resistance and target those populations with the highest probability of adopting the innovation—those with higher socioeconomic status. An alternative strategy would be to concentrate effort toward reaching sub-populations with the least likelihood of adoption—those of low socio-economic status who comprise the “late majority” and “laggards.” This approach would assist in reducing the disparities kept in play by the Innovativeness/Needs Paradox.
D. What is diffusion?

Diffusion is what happens when members of a social system communicate about an innovation over time. Successful diffusion ends when most community members have adopted the innovation and incorporated it into their daily lives and values. Successful diffusion results in social change within a social system. An innovation typically moves slowly through a group of early adopters when it is first introduced (the “take-off period”). Then, as the number of adopters increases, the diffusion moves at a much faster rate. DOI theory shows that most diffusion of innovations follows an “S” shaped curve. The diagram below shows three different innovations and their diffusion over time. Innovation I has an extremely fast take off, which results in a fast diffusion process. Innovation II takes longer to take off and its diffusion through the social system is moderate. Innovation III has an even longer take off and the rate of diffusion is slow but steady.

As we’ve pointed out, much of the success of an innovation depends on the inherent characteristics of the innovation—it’s relative advantage, compatibility, complexity, trialability, and observability. But there is another part of the equation we must consider: how people communicate with each other about the innovation thus leading to the innovation’s diffusion. Diffusion of Innovation theory gives us direction regarding how this communication can be most effective.

**Principle 1: Diffusion is a Social Process**

Communication about an innovation can happen in many different ways. Mass media, such as radio, television, and newspapers can be used to rapidly inform a community about the existence of an innovation. However, interpersonal communication is really the key to successful diffusion of an innovation. Interpersonal communication involves a face-to-face exchange between two or more individuals. Few people are persuaded to adopt an innovation by seeing television commercials. But when your best friend adopts an innovation and tells you the benefits she’s gotten from it, you are much more likely to consider adopting the innovation.
yourself. When you see that most of your social network is using the innovation, it becomes nearly impossible to resist adopting it yourself. In deciding whether or not to adopt an innovation, people rely on the opinions of people like themselves who have already adopted the innovation. Diffusion occurs best when adopters model the new behavior and members of their social network imitate that behavior. In this way, diffusion is a very social process that hinges on interpersonal communication that travels along social networks.

**Principle 2: Effective Diffusion Requires the Work of Change Agents**

Change agents are an essential part of the diffusion process. In DOI theory, change agents come in two types. The first type of change agent is the “professional” change agent. This person has great expertise with the innovation and is employed (typically) to promote it. Examples of professional change agents are agricultural extension workers and community health workers or nurses. The second type of change agent is the “community-based” change agent. These are members of the community who are recruited by the professional change agents to assist in the promotion of the innovation but who are not necessarily employed to do so in a professional sense. The community-based change agent’s level of expertise regarding the innovation is typically less developed than that of the professional change agent, however, their position as a member of the community often makes them more effective promoters of the innovation than the professional change agents. Examples of community-based change agents include peer educators, opinion leaders, and any community member who is trained to help promote an innovation. In the case of Project Accept’s Community Mobilization team, the staff members are the professional change agents and the CBOVs are the community-based change agents.

One of the most crucial roles any change agent plays (professional or community-based) is providing a communication bridge between the designers/initiators of the innovation and the clients who are the potential adopters of the innovation. This bridge is a two-way communication flow. Technical information and expertise about the innovation travels from the designers through the change agents to the target community. But feedback also flows from the community back through the change agents then back to the designers. It is vitally important for the change agents to feed information back to the designers/initiators on how the clients perceive the innovation (for example, does it meet their needs?) and where challenges are cropping up in adoption and diffusion. This feedback allows for changes to be made to bring the innovation in line with client needs and ensure its adoption/diffusion is successful.

Change agents should follow seven basic steps when introducing an innovation to a social system:

1. **Develop a need for change among the members of the social system.** A change agent initially helps people become aware of the need to alter their behavior (if they are not already aware of it). The change agent points out new alternatives to existing problems, dramatizes the importance of these problems, and may assure people they are capable of confronting these problems.

2. **Establish an information exchange relationship.** Once a need for change is created, a change agent must develop rapport with her clients. The change agent must be perceived as credible, competent, and trustworthy. The change agent must empathize with the client’s needs and problems and not be judgmental. Clients must often accept
the change agents before they will accept the innovation she is promoting. A change agent may need several weeks or months to get acquainted with a client before introducing the innovation and then need many more contacts to help the client move through the decision making process of accepting or rejecting the innovation.

3. **Diagnose problems.** The change agent is responsible for analyzing clients’ problems in order to determine why existing alternatives do not meet their needs. The change agent must view the situation from the client’s perspective completely.

4. **Create an intent to change in the client.** After a change agent explores various avenues of action the client might take to achieve their goals, the change agent seeks to motivate the client’s interest in the innovation.

5. **Translate intent into action.** A change agent seeks to influence a client’s behavior change with recommendations based on the client’s needs. Interpersonal network influences from peers are most important at the persuasion and decision stages in the decision making process. The professional change agent usually can operate only indirectly here, by working with opinion leaders to activate peer networks. Community-based change agents will be in a stronger position to influence the client directly or mobilize the influence of the client’s social network.

6. **Stabilize adoption and prevent discontinuance.** Change agents may effectively stabilize new behavior by reinforcing messages to clients who have adopted thus helping to make the new behavior permanent. This assistance is appropriate when a client is at the implementation or confirmation stage in the decision making process.

7. **Achieve a terminal relationship.** The goal for a change agent is to develop self-renewing behavior on the part of the client. The change agent should seek to put himself out of business by developing the client’s ability to be his/her own change agent. In other words, the goal is self-reliance. At the end of the relationship with the change agent, the client should have developed his own skills in evaluating innovations.

The following case study illustrates a failure among change agents to bring about ethical adoption of an innovation in Indonesia.
Coercion in Norplant Diffusion Safaris in Indonesia*

The main criterion for judging the relative success of diffusion interventions is usually the rate of adoption of an innovation that they achieve. In some cases, however, this measure of change agency effectiveness needs to be seriously questioned. The quality of adoption decisions resulting from a diffusion campaign may be more important than just the number of adoptions achieved. An example of this crucial point is provided by the introduction of a new contraceptive, Norplant, in Indonesia. By the usual criterion of effectiveness, Norplant diffusion was a huge success. Indonesia in 1998 had 3.6 million Norplant adopters, more than any other country in the world. Officials from some eighty-six other nations visited Indonesia, and utilized its family-planning program as a model for their own approaches.

But a careful look at the microlevel process of how Norplant adoption was achieved in Indonesia discloses a rather different story. A certain degree of coercion was used to achieve the high rate of adoption, the change agents who provided this contraceptive gave little explanation or counseling to women at their time of their adoption, and discontinuance of the contraceptive by women who experienced side effects was actively discouraged. As a result, the quality of the Norplant innovation-decisions in Indonesia was far from perfect by any standard, raising ethical and moral questions about the Norplant diffusion campaign and posing threats to its long-term sustainability.

When Norplant initially became available in the mid-1980s, it was the first important advance in contraceptive technology since the intrauterine device (IUD) and the oral contraceptive pill in the early 1960s. The international family planning community was enthusiastic about Norplant, hailing it as the perfect contraceptive for women in developing countries. A woman adopts Norplant by having six small plastic tubelets inserted with a needle on the underside of one forearm. The tubelets, each about one inch long, slowly leak progesterin, a sex hormone, into the woman’s bloodstream. Pregnancy is thus prevented for a five-year period. The Norplant tubelets can be removed by health providers any time that the woman wishes to discontinue. The Food and Drug Administration (FDA) approved Norplant for use in the United States in 1991 on the basis of extensive clinical trials showing that the contraceptive was safe and efficacious.

This rather ideal picture of Norplant contrasts with the reality of its diffusion and adoption in Indonesia. First, Norplant was diffused through

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*This case illustration is based on Tuladhar, Donaldson, and Noble (1998).
intensive local campaigns called safaris in which policemen, local political leaders, and military forces participated in an all-out effort to gain adopters of the new contraceptive in each community in Indonesia. The safaris were based on the Indonesian minister of population's concept of "guided democracy," in which certain women were encouraged by providers to adopt a particular contraceptive, although a full cafeteria of family-planning methods were made available. Surveys showed that 73 percent of the Norplant adopters in West Java adopted during a safari. Justification for the safari approach by change agents was based on the notion that health providers knew more about the different contraceptives than did potential adopters. This top-down, coercive approach contradicts several of the recommended change agent rules described in the previous section.

Because Norplant was provided to a large number of women in a community in a relatively short period of time during a safari (which usually lasted for six weeks or so), individual counseling and provision of how-to knowledge and principles knowledge was shortchanged. Norplant adopters were not adequately informed about the possible side effects of the contraceptive, such as prolonged bleeding, that might accompany adoption. Many women were not told that the Norplant tubeblets could be removed if they wished to discontinue. In fact, Norplant discontinuation rates were only one fourth those for IUDs and oral contraceptive pills in Indonesia. A diffusion survey showed that discontinuance was much lower for women who did not know that discontinuance was possible. Women could not discontinue without the assistance of health providers, and many requests for discontinuance were denied. Of the women who were able to discontinue, many had to demand removal of their Norplant tubeblets two or three times.

Clearly, the Indonesian family-planning program officials were superenthusiasts for Norplant adoption, rather than showing concern for improving the quality of contraceptive services for their clients. These zealous innovation champions were not counterbalanced by consumer advocates, like women's organizations, who were too weak in Indonesia to have much influence in questioning the safari campaigns. International family-planning agencies operating in Indonesia might have intervened on behalf of the rights of women adopting Norplant, but the potentially most influential agency, the Population Council (a U.S.-based organization supported by the Rockefeller Foundation), had originally developed Norplant. The Population Council acted in Indonesia as an innovation champion, rather than as a change agency concerned with high-quality diffusion and adoption.

This case illustration demonstrates the tradeoff between the number of adopters of an innovation versus the quality of the adoption-decisions, a choice ultimately faced by every change agent and every change agency. The case of Norplant in Indonesia also suggests the need for microlevel investigations of change agent-client interaction at the time of adoption, a type of research discussed in a later section of this chapter.
The success of change agents is related to the following factors:

1. **Change Agent Effort.**
   The success of securing adoption of innovations by clients is closely related to the amount of effort change agents put forth in contacting clients. When we talk of change agent effort, we are talking about both the quantity and the quality of contact with clients. Sheer quantity may not be effective, as we saw with the Indonesian norplant case study where many people adopted but quality was clearly lacking. Change agents need to focus on process as well as end results. In the end, diffusion may be more effective when change agents put much effort into achieving a smaller number of very high-quality adoptions. These high-quality adopters may be more satisfied and therefore more likely to pass on a favorable recommendation of the innovation to others in their social network.

2. **Being Oriented toward the Client**
   Change agents who are “client oriented” are more successful in encouraging clients to adopt an innovation. To be client oriented means the change agent is focused on her relationship with her clients and is attendant to their needs. The aim of a client oriented change agent is not simply to “get them” to adopt the innovation but to assist the client to improve his skills in evaluating the innovation and making an informed decision as to whether it is right for them. Client oriented change agents are more feedback-minded, have closer rapport with their clients, enjoy higher credibility, and base their diffusion activities primarily on clients’ needs. Professional change agents who identify themselves too closely with the designers/initiators of the innovation tend to never achieve adequate client orientation. Likewise, community-based change agents who identify themselves too closely or try to emulate the “professional” change agents tend to distance themselves from the clients and also lose their client orientation. In short, change agents who are more concerned with displaying their own expertise than with listening and responding to clients needs will never be effective.

3. **Change Agent Empathy**
   Empathy is putting oneself into the role of another. A change agent’s success is directly related to her empathy with clients. Adoption of innovations is greatly facilitated when the change agent has excellent interpersonal skills including listening, friendliness, being non-judgmental and understanding.

4. **Change Agent Homophily**
   Communication between people who are socially similar (homophily) tends to be much more effective in promoting an innovation. Change agents are also more effective when they talk to those who are most like themselves. This can be a challenge for professional change agents, who by virtue of their advanced training and expertise with the innovation are often very unlike the clients they wish to persuade to adopt the innovation. This is where community-based change agents become very important. Community-based change agents should primarily target community members who are most like themselves rather than attempting to enter social networks that are very different. Therefore, the complement of community-based change agents needs to include representatives from a variety of segments of the community.
5. **Change Agent Credibility**
   In order to be effective, change agents must be credible with their clients. Clients will ask questions such as “What is this person’s motivation for trying to persuade me to adopt the innovation?” If the client believes the change agent is “selling” the innovation for their own personal gain (for example, in order to receive a commission on the “sale”) then the change agent’s credibility is severely undermined. Persuasive credibility comes from change agents who are perceived to have nothing to gain personally from promoting the innovation.

**Principle 3: Effective Diffusion Requires the Involvement of Opinion Leaders**
Opinion leaders play a very important role in the diffusion of innovations and must be included among the community-based change agents. Opinion leadership is the degree to which an individual is able to influence (informally) other individuals’ attitudes or overt behavior in a desired way with relative frequency. As we pointed out earlier, opinion leaders tend to be the type of people who are early adopters of an innovation and thus play an important role in modeling the innovative behavior to their followers and in doing so reduce uncertainty about the innovation. Successful diffusion of an innovation requires the involvement of opinion leaders as community-based change agents.

How do you know when you’ve found an opinion leader? Here are the common characteristics of opinion leaders:

1. Opinion leaders have greater exposure to the larger world than do their followers. Their networks are not confined to the local and their lives cross the boundaries of their own social system. They have an expansive social network that includes many weak ties. Their exposure to the larger world and their broad network makes opinion leaders conduits for new ideas to enter the local community. The opinion leader’s access to the larger world may be through mass media, the internet, or through his or her networks of colleagues and peers. Opinion leaders are positioned to broker between the outside and the local. They carry information across boundaries and between groups.

2. Opinion leaders have extensive interpersonal networks and are have more active social participation than their followers. They are members of more civic organizations, clubs, and groups than their followers and are always trying to broaden their base of contacts. They are extroverted and crave social contact.

3. Opinion leaders tend to have higher socioeconomic status than their followers.

4. Opinion leaders are more innovative than their followers but they are not necessarily innovators. Innovators are too “cutting-edge” to be realistic role models.

5. When a social system’s norms favor change, opinion leaders are more innovative but when the systems’ norms do not favor change, opinion leaders are not especially innovative. In very conservative social systems, opinion leaders will support the status quo rather than advocate for innovations. In very conservative social systems, the opinion leaders tend to be older, less educated, and less well-connected to the outside world.
One of the most important things to remember about opinion leaders is that their relationship with their followers is very delicate. If they are too eager to adopt an innovation, their followers will begin to question their judgment. If they become too innovative they will lose their following. Opinion leaders must always be considerate of how their social system regards an innovation. By showing careful judgment in adopting innovations, the opinion leader remains an effective role model.

It is also important to not mistake innovators for opinion leaders. Opinion leaders have followers and are respected for their views. Innovators are not.

Table 8-2 describes international research conducted to date on the effects of opinion leaders in the diffusion of innovation process.
<table>
<thead>
<tr>
<th>Investigators, Research Design</th>
<th>Method of Identifying Opinion Leaders</th>
<th>Objectives of the Diffusion Program</th>
<th>Effects of the Opinion Leader Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Castro et al. (1995), Randomized controlled trial over 3 years.</td>
<td>Key informants (priests/ministers in seven churches in Phoenix, Arizona)</td>
<td>Opinion leaders in each church who had successfully battled breast cancer encouraged church members in cancer prevention (cancer screening, nutrition, etc.)</td>
<td>None reported, as the project was still under way</td>
</tr>
<tr>
<td>Celentano et al. (2000), randomized controlled trial over 21 months.</td>
<td>Key informants and sociometric (Thai Royal Army draftees)</td>
<td>To decrease the high rate of STD and HIV infection among 450 men in the Thai Army</td>
<td>Robust effects on STD and HIV prevention</td>
</tr>
<tr>
<td>Earp et al. (2002), randomized controlled trial over 3 years.</td>
<td>Key informants (170 opinion leaders in 5 North Carolina counties)</td>
<td>To promote mammography breast cancer screening among African American women through presentations at beauty parlors, churches, etc.</td>
<td>Mammography rates increased by 7 percent over 5 comparison counties</td>
</tr>
<tr>
<td>Kelly et al. (1992), randomized controlled trial over 6 months.</td>
<td>Observation and key informants in gay bars (bartenders in 3 cities identified 45 opinion leaders)</td>
<td>To decrease rates of HIV infection among customers of gay bars by decreasing high-risk behaviors</td>
<td>15 to 29 percent reduction of unprotected anal intercourse</td>
</tr>
<tr>
<td>Kelly et al. (1997), randomized controlled trial over 1 year</td>
<td>Observation and key informants (bartenders in gay bars in 4 cities)</td>
<td>To decrease rates of HIV infection among 1,136 customers of gay bars by decreasing high-risk behavior</td>
<td>Decrease in unprotected anal intercourse and increased use of condoms</td>
</tr>
<tr>
<td>Lomas et al. (1991), randomized controlled trial over 2 years.</td>
<td>Sociometric nomination of 4 opinion leaders by doctors in 4 Ontario hospitals</td>
<td>To decrease birth by cesarean delivery for 3,552 pregnant women</td>
<td>A major reduction in the rate of cesarean birth deliveries only in the hospitals with opinion leader doctors</td>
</tr>
</tbody>
</table>
Table 8.2. Effects of Opinion Leaders (continued)

Experiments show that the effects of opinion leaders in diffusion programs are robust.

<table>
<thead>
<tr>
<th>Investigators, Research Design</th>
<th>Method of Identifying Opinion Leaders</th>
<th>Objectives of the Diffusion Program</th>
<th>Effects of the Opinion Leader Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miller et al. (1998), randomized controlled trial with data collected at 5 points in time over 8 months.</td>
<td>Observation and key informants (bartenders in hustler bars in New York City)</td>
<td>To decrease the risk of HIV infection among 1,862 male prostitutes and other patrons in hustler bars</td>
<td>Twenty trained opinion leaders influenced men to decrease high-risk behaviors by 3 to 25 percent</td>
</tr>
<tr>
<td>Purka et al. (1998), field experiment over 4 years.</td>
<td>805 opinion leaders, 2 in each village identified by key informants in North Kaeilja County, Finland</td>
<td>To reduce heart disease risk factors in a system characterized by very high cardiovascular disease</td>
<td>A reduction in smoking and an increase in healthy nutrition</td>
</tr>
<tr>
<td>Tessaro et al. (2000), field experiment over 18 months.</td>
<td>Key informants in 4 worksites recruited 104 female opinion leaders</td>
<td>To improve health behavior of all employees in the 4 work organizations</td>
<td>Opinion leaders distributed printed health materials, conducted health meetings, diffused health information through informal networks</td>
</tr>
<tr>
<td>Valente et al. (2002), randomized controlled trial over 3 months.</td>
<td>Key informants (teachers), sociometric methods (survey) and network methods (1,960 ninth-graders in 16 California schools)</td>
<td>To compare rates of smoking prevention resulting from training by teachers, opinion leaders, or by network partners</td>
<td>None reported, as the project is still under way</td>
</tr>
</tbody>
</table>
**Principle 4: Homophily Assists Diffusion but Heterophily is also Important**

We are all drawn to talk to people who are similar to us in beliefs, education, socioeconomic status, language, values, background, and so forth. Homophily is the degree to which two or more individuals who interact are similar in certain attributes. Heterophily is the opposite—the degree to which individuals are different. Communication is most effective when those communicating are similar because they share common meanings, a mutual language, and are alike in personal and social characteristics. In communication between people who have many similarities, the exchange of new ideas is likely to have greater effects in terms of knowledge gain, attitude and change, and overt behavior change. When homophily is present, communication is also likely to be rewarding to both participants. Diffusion requires this type of communication in order for people to be persuaded to adopt an innovation.

It is important to note, however, that if communication about an innovation occurs **only** between people who are alike, the process of diffusion is actually slowed down. After all, if people only talk to those who are most like them within a social network of people who are all mostly alike, how does the innovation spread into other networks that are socially different? Somewhere along the line, people must reach outside of their own comfortable social network to communicate with people who are more socially distant. “Strength of the Weak Tie” theory explains how and why it is important for people to occasionally reach outside of their own social network. Weak ties are basically social relationships that are not deeply rooted. They are acquaintances, accidental relationships, people you come to know of through a friend of a friend. These weak ties are often enormously useful, however, in gaining new information that one would not have gained from talking only to members of one’s own social clique. An example of the power of weak ties is job seeking. Very few people find jobs through close friends or relatives. Why? Because your close friends often don’t have much more information than you do about opportunities. If your clique is extremely close knit and interlocked, it becomes a very poor resource for finding new information. Your weak ties are actually more productive sources of new information because they provide a wider net in which information gets captured. Communication between people with weak ties is thus an important part of diffusion of innovation—especially in spreading the word that the innovation exists. Weak ties are not as efficient in persuading people to adopt an innovation, however. That type of persuasion requires communication between people who are similar. Fortunately, opinion leaders are often masters of weak tie communication and can play an important role in bridging diverse social networks and thus allowing diffusion to penetrate all corners of a social system.

**Principle 5: Well-Designed Communication Campaigns can Facilitate Diffusion**

As we stated in Principle 1, diffusion is primarily a process that involves interpersonal communication between individuals who are connected through a social network. Campaigns are not a substitute for this but when planned and executed well, organized communication campaigns can help speed the process of diffusion along. What is a campaign? A campaign is a purposive communication strategy aimed to bring about certain specific effects. A campaign is usually aimed at a large audience and is carried out in a specified time period (usually weeks or months). Finally, a campaign involves an organized set of activities and messages. Successful campaign strategies are made up of four elements:

1. Formative research to study the campaign’s audience and to inform the creation of effective messages.
2. Setting specific and achievable goals for the campaign.

3. Using audience segmentation to divide a heterogeneous group into segments that are relatively homogeneous and targeting campaign messages to those segments.

4. Designing campaign messages to trigger interpersonal network communication among members of the audience.

**Principle 6: Well-Designed Demonstrations can Assist Diffusion**

Well-designed demonstrations can speed the rate of adoption of an innovation by increasing its observability. Individuals who are evaluating whether to adopt an innovation may benefit from seeing how the innovation works in conditions similar to their own. Demonstration projects have long been effective elements of agricultural extension work, for example. Demonstrations should be conducted with high public visibility and the demonstrators should have an attitude of optimistic assurance about the innovation’s effectiveness. A demonstration’s effects can be amplified if the demonstrator is an opinion leader.
IV. How will we use Diffusion of Innovation Theory in Project Accept?

Diffusion of Innovation theory holds many lessons that we will apply in Project Accept to ensure our community mobilization activities are successful in promoting adoption and diffusion of the VCT innovation. In applying DOI theory to Project Accept Community Mobilization, we first have to think about the characteristics of our innovation, the characteristics of the individual adopters, and the characteristics of the communities we hope to mobilize to adopt the innovation.

A. What is our innovation?

Project Accept permits individuals to become aware of their HIV status, a feature that is also common to standard, facility-based VCT. However, Project Accept’s innovation is that it goes beyond individual awareness of one’s HIV status to facilitate a process that:

1. Makes HIV testing a community norm
2. Creates an enabling environment for disclosure of one’s HIV status
3. Reduces HIV/AIDS-related stigma
4. Increases acceptance of people living with HIV/AIDS

To achieve these four objectives, the disclosure process occurs at three key levels that continually reinforce one another:

1. During community mobilization, early adopters of VCT are trained to disclose that they have been tested for HIV
2. During post-test support services, individuals who have tested positive for HIV are taught to safely disclose their status to their family and friends
3. PTSS also provides training to early adopters of PTSS so that they become community change agents who disclose their HIV status publicly

B. What qualities make our innovation likely to be adopted?

How does our innovation rate in terms of the 5 characteristics that determine whether an innovation will likely be adopted?

1. Relative Advantage. Our VCT differs from standard, facility-based VCT in that it is:

   - Convenient (rapid testing, same-day result)
   - Community-based
     - Closer to people, taking the service to the community
     - Accessible
   - Cost-effective (free)
   - Time-saving
   - Designed to ensure participants' confidentiality and privacy
   - Based on an individualized risk reduction counseling model
   - Designed to provide easy links to post-test support services so that:
Those who test negative (about 70 percent of testers) will be provided with the support and tools to stay negative.

Those who test positive will be provided with 1) support and tools to disclose their status safely and 2) links to care and treatment services.

Our innovative idea is to use VCT that has the above characteristics to create an enabling environment for:

- Knowing your HIV status
- Using this knowledge as 1) an entry point to prevention, care, treatment, and support services, and 2) focusing on individual, family, and community ways of reducing risk behaviors
- Encouraging open discussion about HIV/AIDS
- Choosing to disclose that you have been tested for HIV
- Choosing to disclose your HIV status (privately or publicly)

The question facing us is whether our innovative idea will be perceived as more beneficial than the alternatives of 1) not knowing your HIV status or 2) testing in a standard VCT facility but not being provided with the support and tools to disclose your status safely? This is an open question that we need to consider as we design and implement the community mobilization component of the intervention. It is likely that at the beginning, many community members will not perceive that knowing and disclosing their status has many advantages relative to the option of not knowing their HIV status. People may even feel the innovation has distinct disadvantages related to discrimination and stigma. Prior to beginning the intervention, it will be important to understand how community members see the advantages and disadvantages of testing so that the community mobilization team can develop messages and pursue mobilization strategies that will help persuade people that knowing and disclosing their HIV status has more advantages than not doing so.

2. **Compatibility.** Is our innovation sensitive to and compatible with the community's existing values and beliefs, local culture, indigenous customs, past experiences, and the needs of potential adopters? One of the challenges posed to the community mobilization team is to avoid making assumptions about communities but rather to find out how VCT is compatible with communities' existing values and beliefs and how we can draw attention to these compatibilities and tailor information, education, and communication (IEC) messages accordingly. Part of this process will involve working with CWGs to develop and tailor IEC materials that are relevant to and reach the various social networks within the community.

Likewise, it will be important to understand if and how VCT runs counter to existing values so that we can address community members’ concerns. It will also be important to ascertain whether community members feel that VCT meets a need. If there is no felt need for VCT, it will be up to the community mobilization team to develop strategies for building a sense of need among community members through education.
3. **Complexity.** Is our innovation easy to understand and to use? Yes. This innovation does not introduce technology that is complex to use or understand. HIV testing itself, including how the tests work and how the results are interpreted, will need to be explained in simple terms but it is not inherently difficult material to understand.

4. **Trialability.** Can our innovation been undertaken by someone on a trial basis so they can see if they like it? This is a bit tricky in the case of VCT. Choosing to be tested for HIV may seem like a point of no return for many people. If a person decides to be tested and has a positive result, he can’t then go back to the state of not having been tested if he feels the experience has not been good or useful for him. For someone who decides to test and their result is negative, they are in a position to decide if the experience was satisfactory and make a decision if they want to continue to be tested in the future. There may be other ways, however, that we can divide up the testing experience so that a partial trial is an option. For example:

   - A person could first participate in the HIV education that will be occurring around the caravan/mobile testing site.
   - Second, he could participate in pre-test counseling but not go through with the test. Their experience of the pre-test counseling trial may persuade them to later have the blood test or to decide not to.
   - The third option is to participate in pre-test counseling, testing, and post-testing counseling, including referral to PTSS.
   - For post-test support services, it is also possible for potential clients to try the services for a short time before making a decision about committing to participation. It is also possible for us to organize demonstrations of testing so that reluctant adopters can see a “trial by other” in substitute for trying it out themselves.

5. **Observability.** Can the benefits of our innovation be observed by others? One strength of our innovation is that the mobile VCT service (including the HIV educational activities and materials around the caravan) is very visible and can be observed by anyone who cares to take a look. If people see large numbers of people taking part in the mobile service (as well as Project Accept staff and volunteers), this observability could be very persuasive in convincing the late majority, for example, that social values have shifted strongly in favor of testing and therefore it is safe to adopt the innovation. (Note that PTSS sites and activities will also be observable.) However, the benefits of VCT to an individual are not physically observable in most cases. An exception might be someone who was ill, suspected he might have HIV, got tested, and through the experience of testing learned about how to maintain his health better. His improved health would be an observable benefit of having taken part in VCT. For most, however, whatever psychological or health benefits they reap from taking part in VCT will be invisible until they begin to talk about their experiences and tell people about the benefits they have gotten. Therefore, a large part of our community mobilization effort will need to be encouraging people to discuss these benefits with their peers in order to make the benefits of the innovation more easily observed by the larger community.
In looking at these five areas, there are clear challenges we face in the areas of Relative Advantage and Compatibility—the two areas DOI indicates are most crucial. We have additional challenges in the areas of Trialability and Observability. In the community mobilization component of the intervention, we will develop specific strategies for overcoming these challenges so that we can enhance community members’ positive perceptions of the innovation, thus making it more likely they will adopt.

C. How will individuals decide to adopt our innovation?
DOI theory tells us to expect individuals to pass through the five stages of decision-making (knowledge, persuasion, decision, implementation, and confirmation).

Our mobilization activities need to provide locally appropriate, sensitive, and relevant information and messages targeted for each stage of the process. These messages must be tailored to the various social networks within communities (for example, youth, traditional healers), bearing in mind that these social networks themselves are not homogenous and therefore we must further refine these messages to reach each segment within a social network. For example, for those in the knowledge phase, we need clear answers to the questions, “What is this innovation and how does it work?” For those in the persuasion phase, we need compelling answers to the questions, “How will this innovation benefit me in my particular situation?” “Is it easy to use?” “Does it fit in with my values and past experiences?” For those in the decision phase, we need to encourage them to try the innovation on a trial basis or we can organize a VCT demonstration so that people in the decision phase have a chance to “try” the innovation by watching someone else use it. For people in the implementation phase, we need to provide answers to the questions “Where can I find VCT?” “How do I use it” and “How can I overcome any operational problems I might encounter in using it?” Finally, for individuals in the confirmation stage, the community mobilization team members need to be ready to support adopters by helping them to feel they made the “right” decision to take part in VCT.

Individuals within communities obviously don’t move through the decision-making process in lock step. Therefore, the community mobilization team needs to be ready to speak to any individual or group of individuals in a way that is appropriate to where they are in the decision-making process. Ascertaining where a person or group is in the process is often as easy as asking them what questions they have—the types of questions they ask will alert us to the phase of decision-making they are in. Knowing where they are in the process will assist us to ensure our communication responds to their specific needs.

D. How long might it take for our innovation to diffuse?
DOI tells us we can expect to see an “S” shaped curve in the adoption of the innovation with innovators and early adopters being at the bottom of the curve in the initial uptake then the early majority leading the upward arc of the curve followed by the later majority near the top and finally the laggards at the top of the S curve. However, DOI theory does not tell us how long it may take for our particular innovation to reach the top curve of the “S” where most community members have adopted the innovation of using VCT. One clue DOI theory does gives us, however, is that innovations about prevention of an unwanted future event tend to be more difficult for people to adopt than other types of innovations that provide shorter-term benefits. Therefore, we should not expect for our VCT innovation to catch hold and diffuse
throughout the community very quickly. The community mobilization team should be aware its work will need to be intensive and sustained in order to succeed.

This also brings us to the important lesson of the Innovativeness/Needs Paradox, which DOI theory emphasizes. The paradox results because the so-called “laggards” are often the most difficult group to penetrate when an innovation is introduced and therefore is often ignored entirely. This is the group that is the most conservative, often because its members are the most socioeconomically disadvantaged and the least likely to take risks on new ideas. Because this group is difficult to penetrate, little effort is put into promoting the innovation with it, making it even more likely that this group will never adopt an innovation that could greatly benefit its members. Our community mobilization plan will include strategies for targeting the social networks of the late majority and laggards in order to promote the innovation of VCT with them and their specific interests and concerns in mind. This will also help to speed the diffusion process for the community as a whole because we will attempt to ensure that the innovation is “seeded” within diverse social networks throughout our research communities.

E. How will our innovation diffuse throughout the community?

There are many lessons we will draw from DOI theory to guide how we facilitate the diffusion of our innovation.

Perhaps the most important lesson DOI theory offers us is that diffusion is primarily a social process that occurs through interpersonal communication among members of social networks. Our community mobilization efforts will be organized around promoting interpersonal communication among people who are part of social networks.

We will recruit and train a team of change agents in each community receiving the intervention. Change agents will be both professional (our staff: outreach worker/drivers) and community-based outreach volunteers (CBOVs). The CBOVs will include 1) opinion leaders who become early adopters of mobile VCT or post-test services who can speak from personal experience about the benefits of knowing (and disclosing) one’s HIV status, 2) members of the communities’ CWGs who become early adopters of VCT (or PTSS) and are interested in being CBOVs, 3) other community members who hold strategic positions within community social networks and who are interested in being CBOVs, and 4) community members who possess specific attributes that have been identified as enhancing community mobilization efforts (see Section VI.D below). DOI theory tells us that early adopters, who are very often opinion leaders within their social networks, play a crucial role in ensuring that the diffusion process gains a solid foothold in the community and then “takes off”, meaning it spreads rapidly in many directions throughout the community. Diffusion of innovation requires adopters of an innovation do two things: 1) model the use of the innovation and 2) talk to their peers about the benefits they’ve received from it. We will develop strategies for assisting them to do this modeling and communication in effective ways. We will train our teams of change agents in concrete strategies for effective communication about innovations, how to introduce an innovation (the seven steps mentioned previously), how to communicate with individuals at each stage of the innovation-decision process and the keys to success for change agents: empathy, being client oriented, putting forth sufficient effort, establishing and maintaining credibility, and focusing on communication with people who are similar to oneself. The teams will also do formative research in their communities to understand the various sectors and
develop messages and communication strategies (including specific campaigns and demonstrations) appropriate for their target audiences. The teams of change agents will also be trained to act as conduits for information and feedback to flow between the innovation initiators (the research team) and community members.

Because diffusion occurs through the structures of social networks the community mobilization team will also be very knowledgeable about these networks. We will develop strategies for identifying, describing, and penetrating as many social networks as possible to ensure the innovation has the maximum opportunity to diffuse to all corners of the research communities.

Our community mobilization plan therefore includes the following steps:

1. Identify, learn about, and describe diverse social networks within the community.
2. Identify opinion leaders from each of the social networks.
3. Ensure opinion leaders gain a positive attitude toward the innovation and become early adopters of the innovation.
4. Recruit, train, and motivate early adopters as well as those who have not yet adopted any part of the innovation but who possess attributes that we believe crucial to effective community mobilization efforts to serve as change agents (CBOVs) who will educate and motivate their peers to adopt some or all parts of the innovation.
5. Monitor and supervise the CBOVs over time to ensure the intensity of the diffusion efforts are appropriate and the strategies are effective. Monitor attrition among the CBOVs.
6. Work with the CBOVs to expand the diffusion to all sectors of the community. Learn more about the community (identify more social networks that may have been overlooked previously including late majority and laggard networks and strategize how to reach out to them, recruit and train more CBOV change agents from these networks).
7. Re-train and re-fresh the ranks of the CBOVs as necessary.
V. Roles and Responsibilities of the Community Mobilization Team

A. Community Mobilization Coordinator
The Community Mobilization Coordinator is responsible for overseeing all aspects of the community mobilization work at the site. The coordinator supervises the outreach worker/drivers and assists them as needed in the field to accomplish their duties. The Coordinator reports to the Project Director. Among specific responsibilities:

1. Develop and implement a community mobilization workplan for the site, including objectives, strategies (see no. 3 below), activities, staff and volunteer responsibilities, and timeline
2. Maintain relationships with community leaders to keep them apprised of the project, including religious, government, traditional, and opinion leaders
3. Adapt the generic community mobilization strategies to the site; these will include identifying social networks and strategies for penetrating them
4. Facilitate a process to utilize the guidelines on IEC materials development and gather input from CWGs, OW/drivers, and CBOVs to create IEC materials appropriate for the community
5. Train, orient, coordinate the work of, supervise, and appraise the performance of outreach worker/drivers
6. Review and approve the CBOV candidates put forth by outreach worker/drivers

Community mobilization coordinators will be trained by site project directors; centralized and/or outsourced training may also occur. (For more detail on training for staff and volunteers, see training table below.)

B. Outreach Worker/Drivers (Staff)
The Outreach Worker/Drivers are responsible for carrying out the community mobilization strategy on the ground. This includes recruiting, training, supervising, and monitoring the Community-based Outreach Volunteers. The Outreach Worker/Driver reports to the Community Mobilization Coordinator.

1. Assist coordinator in designing and implementing site-specific community mobilization strategies
2. Work with coordinator in designing promotional and educational materials for use around the caravan/mobile testing site and for use by CBOVs as they penetrate social networks
3. Assist the coordinator in identifying social networks and strategies for penetrating them, identifying and engaging opinion leaders, and maintaining relationships with community leaders
4. Educate community members around the caravan/mobile testing site about HIV/AIDS and Project Accept
5. Identify CBOV candidates
6. Organize and conduct trainings and orientations for CBOVs
7. Coordinate work of CBOVs
8. Supervise and appraise the performance of CBOVs, using, among others, QC tools such as CBOVs' daily logs and diaries
C. Community-based Outreach Volunteers (CBOVs)

The CBOVs are volunteers. They are responsible for diffusing the innovation throughout their social networks and will require a high degree of specialized training to do so (see training table below). They will be supported in their efforts by the Outreach Workers.

1. Develop strategies for and implement the site's community mobilization strategy. Note that CBOVs will penetrate social networks in community venues (schools, churches, community meeting places, households/"door-to-door") and will not work/be situated around the caravan/mobile site
2. Steer and engage in both formal and informal discussions about HIV/AIDS and promote active participation of community members to embrace the concept of VCT at all community levels
3. Distribute educational materials on HIV/AIDS
4. Respond to questions and engage in discussions about HIV/AIDS
5. Liaise with peer groups and social clubs
6. Utilize QC tools such as daily logs and diaries to document all these discussions.

D. Core and Supplemental Training Requirements for Community Mobilization Staff and Volunteers

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<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
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</thead>
<tbody>
<tr>
<td><strong>Coordinator</strong></td>
<td></td>
</tr>
<tr>
<td>Overview of Project Accept (from Staff Orientation Manual)</td>
<td>General management/leadership</td>
</tr>
<tr>
<td>HIV/AIDS basics, including ART</td>
<td></td>
</tr>
<tr>
<td>HPTN and site-specific ethics training</td>
<td>Refresher/advanced team building skills (on the assumption that coordinators bring basic team building skills with them when they are hired)</td>
</tr>
<tr>
<td>HPTN and site-specific GCP training</td>
<td></td>
</tr>
<tr>
<td>Staff supervision and monitoring</td>
<td></td>
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<tr>
<td>Confidentiality</td>
<td></td>
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<tr>
<td>QA/QC</td>
<td></td>
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<tr>
<td>Utilization</td>
<td></td>
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<tr>
<td>Information and documentation systems</td>
<td></td>
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<tr>
<td>Data entry and management</td>
<td></td>
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<tr>
<td>CM training</td>
<td></td>
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<tr>
<td>CBOV training</td>
<td></td>
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<tr>
<td><strong>Outreach Worker/Driver</strong></td>
<td></td>
</tr>
<tr>
<td>Overview of Project Accept (from Staff Orientation Manual)</td>
<td>General management/leadership</td>
</tr>
<tr>
<td>HIV/AIDS basics, including ART</td>
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<td></td>
</tr>
<tr>
<td>Staff supervision and monitoring</td>
<td></td>
</tr>
</tbody>
</table>
| Confidentiality |                                                                              |```
Information and documentation systems
Data entry and management
QA/QC
CM training
CBOV training

CBOVs
Overview of Project Accept (from Staff Orientation Manual)
HIV/AIDS basics, including ART
Staff supervision and monitoring
Confidentiality
CBOV training

E. Negative Life Events, Adverse Events, and Incidents

Negative Life Events are detrimental social interactions experienced by study participants. During counseling, participants, particularly women, may report negative events associated with participating in the study. These may include breakup of a marriage or sexual relationship, physical abuse by a sexual partner, neglect by family, being disowned by family, rejection by peers, and being discriminated by health care providers or employers. We will also provide participants with a palm card containing information on how to contact the local research staff to report such events. Participants will be asked to return to the research site or otherwise contact research staff in order to make such reports as well as receive referrals to mitigate potential harm. Palm cards will not include identifying information about the study or references to HIV or HIV testing, so that the cards will not have the potential to jeopardize the confidentiality of participants.

Adverse Events, Serious Adverse Events, and Incidents are categories of occurrences that can occur during the course of the research. Broadly defined:

- An adverse event (AE) is any undesirable, unintended reaction or event (whether expected or unexpected) that results from study procedures or study interventions.
- A serious adverse event (SAEs) will be defined as a subset of AEs that are fatal, life threatening, require hospitalization or prolong existing hospitalization, or result in persistent or significant disability.
- Incidents are defined as a problem involving the conduct of the trial. Examples of incidents would include protocol violations (i.e., enrolling a participant who did not meet eligibility criteria), and other events (such as harassment of study staff) that do not qualify as AEs.

Detailed information on the documenting and reporting procedures for AEs, SAEs, and Incident can be found on the Administrative Forms section of the Project Accept website.
VI. Community Mobilization Activities and Strategies

A. Step 1: Identify and Describe Social Networks in the Community

The first step in our community mobilization process is for the community outreach workers and coordinator to learn as much as possible about how the communities are organized socially. The Qualitative Research Team may assist in this process. Much useful information will have already been collected during the community preparedness phase of the research and during the Phase I ethnography. All of this information can be applied to the task of identifying and describing social networks. CWG members, for example, will be excellent sources for information about social networks and without doubt, many CWG members will be influential members of several networks that they can tell us about. The participatory mapping exercises conducted by the qualitative research team will have also revealed interesting information about the social organization of the community and those data should also be examined.

What is a social network? One way to think about social networks is to imagine a group of individuals linked together in a web of relationships. These interconnected individuals form a clique of people who are linked, probably because they share common interests or background or goals. A network can be broad and loosely knit or it can be small and tightly knit. Networks are not mutually exclusive—they can and do overlap in many complex ways. Examples of networks we may find in our research communities include:

- networks of people who attend the same religious institution or share the same faith
- networks of parents whose children attend the same school (parent associations for example)
- networks of people who are involved in government (ward councillors, MPs)
- networks of people who are involved in community governance
- networks of traditional healers
- networks of people who play sports together or are fans of the same sport (members of a sports club, people who play in a league, fans of a particular team)
- networks of people who are committed to addressing community concerns (a crime watch group, volunteer health workers)
- networks of people who are members of the same mutual aid society (funeral societies, for example)
- networks of people who attend the same recreation venues (a bar or dance club that attracts a regular crowd of patrons every weekend)
- networks of people who share the same occupation or the same workplace (teachers, vendors, taxi drivers, sex workers, shop clerks, business owners, rotary club members, hair dressers to name just a few)
- networks of people who attend the same school, college, or university
- networks of people who live in the same housing complex
- networks of people who share a genealogy (members of a clan or other group who reckon common descent for example)

In identifying networks, it will also be important to cast the net widely, that is to say, attempt to identify networks that are not obvious and ensure we identify networks within all sectors of the population including adult women and men, youth, and marginalized or stigmatized
populations such as the very poor, homeless, migrants, intravenous drug users, sex workers, men who have sex with men or women who have sex with women.

We will want to ensure that we use a process of triangulation in identifying social networks, that is, we will not rely on only one source of information. Once we have identified a range of networks in the community, we need to recognize that a social network is not homogenous, but rather contains many "sub-networks." We therefore must delve more deeply into networks to identify the unique segments within them.

We then need to investigate them more deeply in order to determine whether they might be useful routes for the innovation to spread. Networks that are useful for diffusion are those that are rather large and somewhat diffuse and they must connect people who are socially similar. Networks that are small and tightly knit are not very suitable for diffusing innovations because the spread of the innovation quickly burns out. Networks that are far reaching and interact with other networks are the types we are looking for.

Having identified networks that seem suitable for diffusion, the next step is to get to know them. It’s important to answer the questions:

- Who are the typical members of this network?
- What common social characteristics do the members share?
- What common interests seem to bind this network?
- What are the values and norms of this network?
- Through what channels and how frequently do members of this network communicate?
- Does the network seem to have formal or informal leaders?
- What roles do the leaders play?
- How much influence do the leaders have?
- Can we identify opinion leaders with this network?
- How innovative or conservative does this network seem?

Answers to these questions will help us determine how easy or difficult it will be to introduce the innovation into them and at what rate the innovation is likely to diffuse. Knowing the composition and norms of each network will also help us identify messages that might be most compelling to the network members. For example, the type of message we use to introduce VCT to a network of parents of children who attend the same school would be quite different from the message we use to approach a network of young university students or a network of men who have sex with men.

We will also build into Step 1 a process for capturing and managing the data collected as we identify and describe social networks. This process may include the use of sociometric software and the creation of databases that can be consulted and updated over the study period. For all data collection activities, we will closely liaise with Project Accept's Utilization Subcommittee.

B. Step 2: Identify Opinion Leaders from each Social Network

Having identified suitable networks and learned about them, the next step is to identify one or several opinion leaders from each network. There are four different approaches we can use to identify opinion leaders. All have been experimented with and all seem to be equally useful. Table 8-1 describes the methods along with the advantages and limitations of each.
Among the tools that we will use to identify opinion leaders are the interactions with communities that occurred during the community preparedness phase. Community preparedness involved identification of opinion leaders at a more general level; during community mobilization, identification of opinion leaders will be more specific and targeted.

Table 8-1. Advantages and Limitations of Four Methods of Measuring Opinion Leadership and Diffusion Networks

<table>
<thead>
<tr>
<th>Measurement Method</th>
<th>Description</th>
<th>Questions Asked</th>
<th>Advantages</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociometric method</td>
<td>Ask system members to whom they go for advice and information about an idea.</td>
<td>Who is your leader?</td>
<td>Sociometric questions are easy to administer and are adaptable to different types of settings and issues; highest validity</td>
<td>Analysis of sociometric data can be complex. Requires a large number of respondents to locate a small number of opinion leaders. Not applicable to sample designs where only a portion of the social system is interviewed.</td>
</tr>
<tr>
<td>Informants' ratings</td>
<td>Ask subjectively selected key informants in a system to designate opinion leaders</td>
<td>Who are leaders in this system?</td>
<td>A cost-saving and time-saving method as compared to the sociometric method</td>
<td>Each informant must be thoroughly familiar with the system.</td>
</tr>
<tr>
<td>Self-designating method</td>
<td>Ask each respondent a series of questions to determine the degree to which he/she perceives himself/herself to be an opinion leader</td>
<td>Are you a leader in this system?</td>
<td>Measures the individual's perceptions of his/her opinion leadership, which influence his/her behavior</td>
<td>Dependent upon the accuracy with which respondents can identify and report their self-images.</td>
</tr>
<tr>
<td>Observation</td>
<td>Identify and record communication network links as they occur</td>
<td>None</td>
<td>High validity</td>
<td>Obtrusive; works best in a very small system and may require much patience by the observer.</td>
</tr>
</tbody>
</table>
For our uses, a combination of informants’ ratings, the self-designating method, and observation will be adequate to identify opinion leaders. Although the sociometric method is probably the most rigorous, it is difficult to implement because it requires surveying all members of a social network. This type of exhaustive survey will not be realistic for us in most cases since it will be very difficult to adequately enumerate all members of a social network.

In many cases, CWG members are likely to be opinion leaders in one or more social networks. CWG members may also be excellent key informants and help us to identify opinion leaders in a variety of networks.

C. Step 3: Mobilize Opinion Leaders to become Early Adopters

In Project Accept, early adopters refer to individuals who are among the first groups of people in their particular community to have been tested for HIV at one of the project’s mobile VCT venues (and, later, among the first to have participated in PTSS). Having identified opinion leaders in the social networks, it’s now time to build rapport with them and encourage them to become early adopters of the innovation (note, however, that early adopters will include but will not be limited to opinion leaders; see below). For these opinion leaders, adopting the innovation involves having been tested for HIV, preferably but not necessarily at one of the project's mobile VCT venues (the "second wave" of early adopters will include those who have utilized PTSS). They can, of course, accept or decline any part of the innovation. It may be motivating for them to know, however, that they have been identified as potential CBOVs because of the leadership role they play within their social networks and we should talk to them about the special role we hope they will be willing to play in getting the diffusion of this innovation off to a strong start.

The process of rapport-building will be easiest with CWG members who have been identified as opinion leaders because they will have already been sensitized to the benefits of the innovation and we hope will be very willing to participate. The CWG/opinion leaders may also be very helpful in persuading other opinion leaders to adopt the innovation.

It is important to remember that while opinion leaders do tend to be early adopters of innovations, they still have to proceed through the decision making process starting with information and ending with confirmation. It is important not to rush them through this process—remember that quality adoption is much more valuable than quantity adoption, especially at this early phase in the diffusion process. These early adopters need to have very positive experiences with the innovation in order to become effective change agents in their social networks. If they have negative experiences or feel coerced to adopt the innovation, they may become powerful forces working against diffusion of the innovation in their communities. So it’s well worthwhile to pursue this process methodically and carefully.

It is also important to remember that some opinion leaders are conservative toward innovation. If a social network has very conservative norms, the opinion leaders tend to be conservative as well. Conservative opinion leaders will need special handling and communication approaches that are subtle and not overtly challenging.

The job of introducing the innovation to the opinion leaders and shepherding them through the decision making process will be in the hands of the community mobilization coordinator and outreach worker/drivers. This will be an excellent opportunity for the coordinator and staff to
hone their own skills as change agents as well as to develop and test messages about the innovation that will later be used in the mobilization activities with the wider community.

Before beginning their work with the opinion leaders, the staff will be thoroughly trained in all the skills they need to be effective change agents. These skills include how to develop a need for change among the members of the social system, how to establish an information exchange relationship, how to diagnose problems, how to create an intent to change in the client, how to translate intent into action, how to stabilize adoption and prevent discontinuance and how to achieve a terminal relationship. In the staff training, we will also develop messages appropriate to each stage of the client’s decision-making process.

In mobilizing opinion leaders to become early adopters we can use a number of strategies, as appropriate to the site setting. Options include (more than one strategy can be employed):

1. Individual one-on-one conversations between a staff member and the opinion leader.
2. Small group discussions between staff member(s) and several opinion leaders from one social network.
3. Larger group workshops that bring opinion leaders from various networks together.
4. Demonstration of the mobile VCT service to small or large group of opinion leaders.

**D. Step 4: Recruit and Train Early Adopters to become CBOVs**

Early adopters will have disclosed that they have been tested for HIV at a Project Accept mobile venue, but they need not have disclosed their HIV status. Only some early adopters will be invited to be CBOVs, depending on the specific criteria set by each site. Generally, however, when we talk about early adopters that we would like to recruit to become CBOVs, we are less concerned with "when" someone has tested than with one or more of the characteristics that this person possesses, namely:

- Influential within their communities
- Catalysts on issues within their communities
- Having an accurate knowledge of HIV/AIDS
- Motivated
- Passionate
- Enthusiastic
- Energetic

Note that we will not require that all CBOVs be literate; we will be flexible so that we are able to recruit those who still bring very strong personal characteristics and experiences and would therefore be tremendous assets to Project Accept's community mobilization efforts.

By this point in the process, a certain percentage of the opinion leaders we identified will have become early adopters. It’s now time to kick off the diffusion process by recruiting, training, and motivating them to become change agents in their social networks.
Recruiting the “First Wave” of CBOVs
The early adopters will comprise the “first wave” of CBOVs in the community mobilization programme (see below for discussion of non-adopter CBOVs). Later on down the road, we will recruit a “second wave” of CBOVs who have adopted testing as well as those who have also adopted PTSS (see Step 6: Refresh and Renew). For now, we want to build a well-motivated and well organized team of CBOVs that includes (but is not limited to) the very people we know are influential opinion leaders in the communities’ social networks. Recruitment of this first wave of CBOVs should be relatively straight-forward because it began when we started to mobilize the opinion leaders to become early adopters. We explained to them from the start that if they became an early adopter of the innovation, we would also like to consider them for recruitment as CBOVs who will be trained as change agents in their social networks. We hope that a majority of the opinion leaders who became early adopters will agree to become CBOVs.

Identification and recruitment processes will involve an oral invitation to consider becoming a CBOV, made by VCT (and PTSS) staff. We will develop procedures so that VCT (and PTSS staff) have the tools to identify and put forth candidates as CBOVs. The recruitment process will then involve educating candidates on the role of CBOVs and asking candidates how they would see themselves as CBOVs within their communities. Another process may involve having candidates undertake exchange visits with strong, highly functioning CBOV teams. The recruitment process will also ensure that CBOVs represent a range of ages, as well as gender, ethnic, and religious balance (as applicable), so that the widest range of social networks can be reached.

Ideally, each community will have a team of 10-20 CBOVs. Because the recruitment of CBOVs will be a highly charged political issue in some sites, we must ensure that we carefully explain our recruitment process, including the number of CBOVs we decide to recruit, to all Project Accept personnel as well as CWGs.

Members of CWGs will be eligible to become CBOVs, although we must inform CWGs that not every member of a CWG will be eligible to become a CBOV.

In addition, there are potential conflicts that could arise if a person is a CWG member and a CBOV at the same time. Therefore, sites will determine whether a CWG member who accepts the role of CBOV can still keep his/her membership in the CWG.

This section has described recruitment of early adopters to become CBOVs. However, CBOVs will also include people who have not yet adopted any part of the innovation but who possess attributes that we believe are crucial to effective community mobilization efforts; these were mentioned above and include:

- Influential within their communities
- Catalysts on issues within their communities
- Having an accurate knowledge of HIV/AIDS
- Motivated
- Passionate
- Enthusiastic
- Energetic
As mentioned above, we will not require that all CBOVs be literate; we will be flexible so that we are able to recruit those who still bring very strong personal characteristics and experiences and would therefore be tremendous assets to Project Accept's community mobilization activities.

**Training CBOVs**

See training table above for all CM staff and volunteers. The section below provides more detail on training for CBOVs.

CBOVs will be provided with an intensive 4-day training followed by a series of biweekly support sessions. Monthly support sessions will then be held for the duration of their involvement in community mobilization. The overall goals of the 4-day training and the ongoing support sessions are:

1. To promote a sense of collaboration and teamwork with the community outreach staff members.
2. Ensure CBOVs understand the goals of the community mobilization process.
3. Promote a sense of ownership in the CBOVs of the community mobilization process.
4. Ensure CBOVs understand the basic principles of Diffusion of Innovations theory.
5. Ensure CBOVs understand the role they will play as change agents in facilitating diffusion of the innovation.
6. Ensure CBOVs understand the process through which individuals decide to adopt or reject an innovation.
7. Ensure CBOVs understand the principles of effective communication with peers.
8. Assist CBOVs to overcome common barriers to communication with peers about HIV.
9. Ensure CBOVs are able to introduce the concept of VCT to their peers and speak about the benefits of adopting the innovation both for the individual and the community.
10. Ensure CBOVs are knowledgeable about how HIV is spread and how it can be prevented.
11. Ensure CBOVs are able to explain the role HIV testing plays in controlling the spread of the epidemic.
12. Ensure CBOVs are able to explain how a person can live with hope and dignity after testing positive for HIV.
13. Ensure CBOVs are able to articulate an accepting and supportive attitude toward HIV positive members of the community.

The 4-day training will cover the following material:

*Training Day 1*

- Session 1: Introduction to the Training, Trainers, and Participants
- Session 2: Hopes and Fears
- Session 3: Establishing Ground Rules
- Session 4: Basic Information on HIV/AIDS
- Session 5: How is HIV Transmitted and How can it be Prevented?

*Training Day 2*

- Session 6: What is VCT & how does HIV testing work?
- Session 7: What is PTSS & how does it work?
Training Day 3
Session 8: Our Community’s Response to HIV
Session 9: Stigma and Discrimination
Session 10: The Role of the CBOV

Training Day 4
Session 11: Devising Community Mobilization Strategies and Setting Goals
Session 12: Developing Messages for Promoting the Innovation
Session 13: Documenting Community Mobilization Activities

The biweekly and later monthly support meetings will provide an opportunity for the CBOVs to meet with each other and the staff to talk about how their diffusion efforts are going in the community and to receive emotional and technical support. The support meetings will also provide opportunities for the CBOVs and the staff to develop messages and devise communication strategies, strategize and plan activities they want to undertake together such as organizing workshops, communication campaigns, demonstrations, and other community mobilization activities. During support sessions, the team will also chart their progress toward their goals, revise, and set new goals as they proceed (see Step 5 below).

E. Step 5: Hold a Strategic Planning Workshop with the CBOVs

Once the CBOVs have been trained and initiated into the project as qualified change agents, it’s time to come up with an initial strategic plan for kicking off the diffusion of the innovation. CBOVs will have already begun talking to their peers within their social networks about the innovation. They will have a sense of how easy or difficult it is to promote this particular innovation. Given some of the negative or tepid responses they probably have received by now, they may be worried about whether they will ever be able to get the diffusion of this innovation off the ground. Now it is time to further develop the communication strategies, tailor the messages, target particular audiences, and set concrete goals to work toward. The staff must be very optimistic at this point and remind the CBOVs that fundamental community change is slow work but it can happen and their efforts are key. A well-organized Strategic Planning workshop at this phase of their work will also act as a motivator to the CBOVs because it will build their enthusiasm and sense of control over the process. The Strategic Planning Workshop should be held within one month the 3-day training.

Because our CBOVs represent a variety of social networks, it will be important to come up with a strategic plan for each of those networks. Strategies and messages that are appropriate for one network may be completely inappropriate for another. Moreover, as discussed above, networks themselves are not homogenous; therefore, strategies and messages may require further "segmentation" to reach a variety of network members.

The specific strategies the CBOVs and staff develop for each network will be context and site specific but the general guidelines for creating a strategic plan are:

1. The strategic planning process should occur every three months.
2. Characterize the network. Identify its norms, values, beliefs, age range, and other characteristics. What are the norms and values that will facilitate adoption and what are
the norms and values that will hinder adoption? How can we capitalize on the facilitators and minimize the barriers?

3. Identify which network members are the most innovative and open to new ideas. Target these members first.

4. Identifying what stage your target audience is in of the decision process (at this early point in the programme, most people will be in the Information stage).

5. Develop specific messages and scripts appropriate to the stage of the process. At this point, CBOVs will need to develop a script providing basic information about how VCT works and the role it plays in HIV prevention. They may also need to provide basic information about HIV in order to fill in knowledge gaps among their audience members.

6. Develop specific messages and scripts to help people progress on to the next stage of the decision making process: Persuasion. These messages and scripts need to get people thinking about how HIV affects them and their communities and what their HIV prevention needs are. The CBOV can then talk about how VCT is an important part of every person’s HIV prevention needs and emphasize its relative advantages. Messages also need to be developed that bring attention to compatibilities between the innovation and the networks existing norms and values.

7. Decide on communication channels. One-on-one personal chats between the CBOV and a peer can be a good way to start. Other options include informal group discussions, a series of discussions that could be organized on a weekly basis (for example among church goers who are willing to stay for an hour after church and talk), entertaining events aimed at making many people in a network aware of the existence of the innovation. CBOVs and staff should use their creativity to think of communication strategies, always remembering that the focus of our efforts is on interpersonal communication among people who are socially similar.

8. Make specific goals that are achievable by the end of the strategic plan period.

9. Agree on timetables and reporting procedures, including how CBOVs will report their daily activities.

10. Make a plan for another Strategic Planning Workshop to be held at the end of the period to review progress and create the next strategic plan.

F. Step 6: Motivate the CBOVs

Motivating CBOVs

Motivating volunteers to become involved and stay involved in any effort is a challenge and it is one we will certainly face in Project Accept. Specific motivation strategies will vary by site, but there are several general motivational strategies we will use with CBOVs:

1. Volunteers are more motivated when they perceive they are part of a well-organized, well-run, and professional operation with clear goals and strategies and in which the volunteer’s role is clearly defined. De-motivation quickly sets in when volunteers feel confused about their role and/or the mission of the organization. De-motivation also sets in when volunteers perceive their time is being wasted through in-efficient organization, or if the volunteers begin to question the technical expertise, credibility, or professionalism of the staff. Above all, volunteers need to feel they and their time are being respected and it will be important for the
community mobilization team to do everything it can to achieve this. For example, trainings, support sessions, and meetings must always have clear agendas, time frames, and objectives. The work of the CBOVs must also have clear time frames and objectives.

2. Volunteers are more motivated when they feel they have the adequate skills to perform their work. Volunteers working in the field of HIV prevention face particular challenges when they feel unprepared or unskilled in talking about sensitive topics having to do with sexuality. They may also feel unprepared or unskilled in handling community members’ negative reactions to the innovation. On-going and refresher training, skill building, debriefing sessions, monthly meetings, and invitations to community activity planning meetings will be an important part of the effort to keep CBOVs motivated and effective as community change agents.

3. Volunteers are more motivated when they sense congruence between their own values and goals and that of the organization they are volunteering with. In community-based projects, a volunteer’s sense of commitment to community improvement (based in their personal investment in the community as one of its members) must be reflected in the organization’s ethos and mission. Because Project Accept staff members are not members of the research community and the project as a whole is not a home-grown initiative, volunteers may feel skeptical about the true mission of the project. Staff members must therefore reflect back to CBOVs the same sense of commitment to community well-being and should promote a feeling of ownership among the CBOVs of the work they are doing.

4. Volunteers are more motivated when they work in an environment of consensual decision-making. Community-based volunteers, and especially opinion leaders, often have strong personalities and want to be part of decision-making rather than the objects of someone else’s decision-making. We need to make strong efforts to organize consensual decision making.

5. Volunteers are motivated when their work contributes to their own development as well as their community’s development. It is unrealistic to expect volunteers to be completely altruistic in their motivations to be a volunteer. It is important for the staff to find out what the CBOVs hope to gain from their involvement and try to make provision for that. For example, if a volunteer is looking for opportunities to network in the field of HIV prevention so that he may eventually find a job in the field, we may think of ways to ensure CBOVs have those networking opportunities.

6. Tokens of appreciation can also be powerful motivators. For example, a nicely printed and laminated certificate presented to at the end of a training can help a volunteer to feel they have achieved something important. Other tokens of appreciation such as t-shirts, hats, buttons, bags, pens, or other items the volunteer can wear or use and thus be identified with the project can also be helpful. It is important to remember, however, that client-orientation can be hampered when community-based change agents use these types of “uniform” items to feel separate from or superior to other community members. The strength of the community-
based change agent is that she is part of the social system, not separate from it. Other tools might include providing CBOVs with personal items such as soap, as well as access to project office space.

Whether CBOVs are provided with a stipend (and the amount of any stipend) will be decided by sites, depending on, among other factors, their site budgets. Sites will decide if they wish to provide any (or a combination) of the items below:

- a regular stipend
- specific stipends for participation in CBOV meetings, workshops, or trainings
- a monthly allowance
- reimbursement for incidental (unexpected) expenses
- reimbursement for cost of transportation

Sites may also wish to consider whether their CBOVs are eligible to participate in government-funded learnerships/internships, in which they would be "apprenticed" to Project Accept. Such learnerships carry a government-paid stipend and would also provide a certificate of completion and assistance with job placement after the learnership has ended (some recipients of learnerships are also eligible to receive higher education credit for their work). Learnerships would also provide an observable investment in the community.

G. Step 7: Re-train and Refresh the CBOVs

In the process of community mobilization over the first year or so, the staff and the first wave of CBOVs will be able to identify more opinion leaders who were not previously identified or networks that were not previously identified and need to be tapped into. There will be a need to refresh the corps of CBOVs with new recruits. There will also be the need to provide continuing refresher training to the existing CBOVs to keep them motivated and their skills sharp.

Recruitment of a “second wave” of CBOVs will probably be necessary after about six months into the intervention. The second wave of CBOVs will include:

1. Opinion leaders from previously un-identified networks whom we approach, encourage to adopt the innovation and then recruit to become CBOVs.
2. Additional opinion leaders from previously identified social networks.
3. Additional members of the community who have tested for HIV, as well as those who have participated in PTSS and who are eager to assist in the diffusion process.
4. Additional members of the community who have not adopted any component of the innovation but who possess attributes that we believe will facilitate effective community mobilization (as discussed above).
5. Individuals who demonstrate ability and willingness to challenge stigma and promote acceptance.

Recruitment of additional opinion leaders for the second wave of CBOVs will follow the same procedures as for the first wave.
VII Intervention Dose

Project Accept provides a standard intervention across all study sites. This means all sites offer the same amount of CM proportionate to community size. The Intervention Core developed dose guidelines for each site to assist in determining the number of hours that intervention should be available in each community. These calculations in turn determine the number of staff needed in order to make CM available for the prescribed number of hours.

Team Leaders and Coordinators: please see the QA/QC Manual and Utilization SOP for instruction on filling out dose and utilization forms. Dose is tracked using the Community Mobilization: Hours Log - Quality Control Evaluation Form, and the Community Mobilization CBOV Outreach - Support Meeting Quality Control Evaluation Form Utilization is tracked on the Community Outreach Log, CBOV Meeting Log, and the Community Outreach Activities form.

CM dose is proportionate to community size and is defined as 30 weekly hours (inclusive of CBOV and CM staff outreach) of CM per communities of 10,000.

The Intervention Core will provide the site intervention director with dose calculation figures for all intervention components. Sites should make every effort to achieve 100% of the dose hours listed. However, in certain circumstances it may be difficult to do so. Dose hours between 90% and 100% are permissible. Anticipated or actual dose hours less than 90% should be discussed with the Intervention Core.

Sample Calculation:

\[
\frac{30 \text{ weekly hours}}{10,000 \text{ people}} = .003 \times (\text{population 16 and older}) = \text{weekly hours CM.}
\]