The protective effects of community involvement for HIV risk behavior: a conceptual framework

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Abstract

This paper presents a conceptual framework of the protective effects of community involvement in HIV/AIDS-related groups and organizations for HIV sexual risk behavior among gay and bisexual men. The framework delineates hypotheses for future research, and provides a guide for prevention programs based on the active and direct involvement of participants, particularly communities of color. The framework (1) argues that community involvement moderates the association between three socio-structural risk factors (i.e. poverty, homophobia and racism) and sexual risk behavior; (2) posits that community involvement in HIV/AIDS reduces sexual risk behavior via its effects on four mediating factors (i.e. peer norms, self-efficacy, positive self-identity and alienation); (3) proposes five socio-cultural barriers to and facilitators of community involvement in HIV/AIDS (i.e. motives for participation, poverty, acculturation, stigma and perceived opportunities); and (4) addresses burnout as one potential negative consequence of community involvement in HIV/AIDS-related organizations and groups. The conceptual framework advances the understanding of HIV sexual risk behavior by integrating both its socio-structural risk and protective factors. It contributes to health education by specifying how interventions based on collective action (e.g. community involvement) for social change may be effective in generating healthy behaviors at individual and community levels.

Introduction

Community involvement has played a central role in the fight against HIV/AIDS since the beginning of the epidemic in generating individual and social change. Volunteers and activists led the first educational, prevention and care activities, and created community-based organizations in the most affected populations (Arno, 1986; Kobasa, 1990; Perrow and Guillen, 1990; Chambre, 1991). They created a culture of safer sex in their communities. Furthermore, in the process of mobilizing, volunteers and activists transformed themselves. They became educated about the risks and prevention measures for HIV/AIDS; developed a sense of community and a positive self-identity in spite of the stigma associated with being gay men in the times of AIDS; and mobilized their social networks and social support to cope with their individual and community stressors. Thus, individuals’ community involvement may have critical public health implications. First, through their involvement in HIV/AIDS-related organizations and efforts, individuals develop and maintain a positive sense of themselves, and become educated and conscious of HIV/AIDS risks and preventive behaviors. Second, via this involvement individuals affect change in their communities and make health interventions culturally appropriate and sustainable (Snyder and Omoto, 1992; Omoto et al., 1993; Coates et al., 1995; Zimmerman et al., 1997; Kelly, 1999). Yet, research and prevention programs
have overlooked community involvement as a mechanism to reduce HIV sexual risk behavior, particularly among minority gay and bisexual men. The aim of this paper is to present a conceptual framework of the protective effects of community involvement in HIV/AIDS-related groups and organizations for HIV/AIDS sexual risk behavior among gay or bisexual men. This is the first attempt to integrate research from several fields and the specific variables affecting minority gay and bisexual men’s HIV risk behavior and community involvement in HIV/AIDS. Although there is a rich literature on activism and volunteerism [e.g. (McAdam, 1989; Abrahams, 1996; Putnam, 2000)], and particularly around other health-related issues [e.g. (Brown and Mikkelsen, 1990; Boehmer, 2000)], it does not speak directly to the HIV/AIDS context and the lives of gay and bisexual men. Furthermore, this literature cannot be easily translated into prevention programs. The major premise of this conceptual framework is that the promotion of community involvement, such as activism and volunteering, is an effective prevention strategy because individuals learn by doing while generating social change (Freire, 1970). The framework delineates hypotheses for future research and provides a guide for prevention programs based on the active and direct involvement of participants, particularly communities of color.

In the following sections, I start by discussing the state of research on community involvement in HIV/AIDS and define the concept of community involvement. Next, I present the framework of the protective effects of community involvement in HIV/AIDS among gay and bisexual men. First, I argue that community involvement moderates the association between three socio-structural risk factors (i.e. poverty, homophobia and racism) and sexual risk behavior. Second, I propose that community involvement in HIV/AIDS reduces sexual risk behavior via its effects on four mediating factors (i.e. peer norms, self-efficacy, positive self-identity and alienation). Third, I discuss five socio-cultural barriers to and facilitators of community involvement in HIV/AIDS (i.e. motives for participation, poverty, acculturation, stigma and perceived opportunities). Finally, I address burnout as one of the potential negative consequences of community involvement in HIV/AIDS-related organizations and groups.

Community involvement in HIV/AIDS

What we know about the antecedents, processes and consequences of community involvement in HIV/AIDS has come from anecdotal data, testimonials and a handful of studies among white volunteers and activists, mainly gay and bisexual men [e.g. (Kobasa, 1990; Valentgas et al., 1990; Chambre, 1991; Bebbington and Gatter, 1994; Omoto and Snyder, 1995; Ouellette et al., 1995; Stewart and Weinstein, 1997; Boehmer, 2000)]. The value of these studies has been in documenting the grassroots efforts of gay and bisexual men, and in suggesting that community involvement in HIV/AIDS has positive effects on participants’ safer sex practices, social acceptance and self-identity. There is, however, no systematic research or theory to support those observations and to explicate how community involvement affects safer sex behavior.

One of the limitations of those studies is their reliance on the concepts of volunteerism and activism to describe gay and bisexual men’s participation in HIV/AIDS-related organizations. Volunteerism, activism or community involvement are rarely defined in the literature and they are usually measured by a single dichotomous variable (e.g. volunteer, yes/no) or a list of volunteering-related activities, overlooking other dimensions, such as the frequency and length of involvement and the meaning (or importance) individuals attach to their participation. Furthermore, concepts such as volunteering and activism (or even organizational membership) fall short in capturing the ways and extent to which minority gay and bisexual men work (unpaid) for others in HIV/AIDS-related issues. Among Latino gay and bisexual men, for instance, community involvement takes different modalities, which include informal helping behaviors and activism in non-gay/bisexual organizations. Also, for some of these men,
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particularly those of working class origin, volunteering may be a foreign idea because it denotes the middle and upper class notion of ‘giving back’ (Abrahams, 1996; Boehmer, 2000). Thus, I propose the concept of community involvement and define it as a construct indicating individuals’ unpaid work on behalf of others or a collective good and in the context of a formal or semi-formal organization and social networks, i.e. outside the home and the family (Schondel et al., 1992; Smith, 1997; Wilson and Musik, 1997). The concept also has several dimensions including type and number of activities, frequency, length of involvement and participation and perceived importance. It implies that community involvement is not a dichotomous variable but a continuous construct, and that variations along that continuum (or along the above dimensions) may have varying positive effects on individuals’ behaviors. The modalities and dimensions of community involvement, however, need further exploration to fully develop the concept of community involvement in the context of HIV/AIDS. A construct such as this one may be a point of departure because it captures better the complexity of unpaid work on behalf of a public good such as HIV/AIDS prevention and care.

A second limitation of the existing literature is the lack of inclusion of minority gay and bisexual men (Ouellette et al., 1995). The findings and models put forward in the literature, hence, may not be applicable to minority gay and bisexual men. This is particularly relevant because they constitute the group most affected in the second decade of the HIV/AIDS epidemic (Marin, 1995; Klevens, 1999; Centers for Disease Control, 2000). As Arno has noted, while HIV/AIDS continues to be a pressing problem among minority communities and as treatments become available extending life expectancy, our society will need to provide more services to these communities (Arno, 1988). A considerable proportion of these services will be provided by community members and their organizations. Yet, the current pools of community volunteers and activists may not be able to adequately meet the needs of individuals of color, for they are comprised of mostly white, middle-class gay and bisexual men. The existing community-based organizations may have little knowledge and experience with the needs and resources of minority gay and bisexual men. In addition, the few minority HIV/AIDS community-based organizations have sparse resources and experience to generate and maintain community involvement. These organizations need to develop broader and stronger community-based efforts to address HIV/AIDS in a social class and culturally appropriate ways. Thus, it is necessary to build culturally sensitive knowledge about the processes of community involvement in HIV/AIDS among minority gay and bisexual men.

A related shortcoming is that this line of research, while focusing on psychological antecedents of community involvement, has overlooked the effects of social class, acculturation and stigma of homosexuality and AIDS on the levels of community involvement, specifically among communities of color. Finally, most of the research on community involvement in HIV/AIDS has been conducted among participants (e.g. volunteers and activists) only. The lack of inclusion of non-participants has hindered conclusions regarding the effects of community involvement on individuals’ behaviors.

Conceptual framework of the protective effects of community involvement for HIV risk behavior

The proposed conceptual framework is depicted in Figure 1 and its presentation is organized according to the major paths (1–4).

Community involvement, poverty, homophobia and racism

Experiences of poverty, homophobia and racism are underlying socio-structural factors associated with sexual risk behavior among gay and bisexual men, particularly gay men of color (Carballo-Dieguez and Dolezal, 1996; Ramirez-Valles et al., 1998a; Stokes and Peterson, 1998; Diaz et al., 1999a; Kraft et al., 2000; Williamson, 2000). For instance, in the largest HIV/AIDS study conducted
among Latino gay and bisexual men in the US, Diaz et al. found that poverty, homophobia and racism were significantly associated with higher sexual risk and substance use (Diaz et al., 1999b). These findings concur with previous research on discrimination [e.g. (Krieger, 1990; Meyer, 1995; Kessler et al., 1999)] and further support the hypothesis that discrimination, e.g. gender or race based, has negative health effects.

Poverty and racism have been identified as risk factors for sexual risk behavior, substance use and other health outcomes among ethnic minorities (Williams et al., 1994; Allen and Mitchell, 1996; Krieger, 1999). Homophobia (e.g. negative feelings and reactions towards homosexuality) has been found to be associated with sexual risk behavior and psychological well-being among white gay and bisexual men (Turner et al., 1993; Meyer, 1995; Frabel, 1997; Williamson, 2000). Previous studies, however, have not explained why some individuals initiate and maintain safer sex behaviors despite facing poverty, homophobia and racism.

Research among white and African-American groups suggests that involvement in social service, neighborhood and community-based organizations buffers the negative effects of poverty, homophobia and racism on individuals’ well-being (Chambre, 1991; Weitz, 1991; Wilson, 1991; Brown et al., 1992; Brown, 1997; Smith, 1997). Here I propose that community involvement in HIV/AIDS-related organizations and groups may operate as one protective factor on the association between poverty, homophobia and racism and HIV/AIDS sexual risk behavior (see Path 1 in Figure 1).

The theoretical and empirical work of Garmezy et al., Rutter and Brook et al. on protective factors (also known as risk/protective factors) and resiliency, provide the theoretical foundation to hypothesize the protective effects of community involvement.
involvement (Garmezy et al., 1984; Rutter, 1987; Brook et al., 1990, 1991, 1992). These authors posit that there are social and psychological factors that help individuals cope favorably with adverse circumstances. These factors work by moderating the relationship between two other constructs (e.g. poverty and sexual risk behavior), i.e. they function as protective variables. This thesis, applied to gay and bisexual men’s sexual risk behavior, suggests that community involvement in HIV/AIDS may compensate for the negative effects that poverty, homophobia and racism have on HIV/AIDS sexual behavior.

The model in Figure 1 also assumes that community involvement encompasses type of activity (e.g. organizing meetings, providing support), frequency (e.g. weekly, monthly), length (e.g. 1 year, 3 years) and importance (e.g. very important to me, not important to me). To understand further how community involvement in HIV/AIDS works and to translate it into interventions; however, it is necessary to consider the mediating mechanisms between community involvement and sexual risk behavior.

**Mediating mechanisms of community involvement**

Although it has not been empirically and systematically tested, researchers, HIV/AIDS workers and volunteers/activists suggest that involvement in HIV/AIDS organizations provides individuals with a sense of personal growth and community and increases knowledge about HIV/AIDS and safer sex behavior, at the same time that it provides invaluable public health and financial benefits for their communities (Snyder and Omoto, 1992; Omoto et al., 1993). A study on New York City’s Gay Men’s Health Crisis notes, ‘Participation in AIDS voluntary associations offers an opportunity for empowerment and personal development through social action. Volunteering encourages people to respond successfully to the serious stressors...’ [(Kobasa, 1991, pp. 173–174); my italics]. Building from psychosocial theories and research findings, Path 2 postulates the mediating mechanisms by which community involvement in HIV/AIDS may reduce sexual risk behavior for HIV.

Path 2 in Figure 1 hypothesizes that community involvement reduces instances of sexual risk behavior because it (1) increases peer norms towards safer sex, (2) increases self-efficacy towards condom use, (3) increases positive self-identity and (4) decreases social alienation. The four constructs are not only the most salient and proximal factors that may put gay and bisexual men at risk for HIV/AIDS (Carballo-Dieguez and Dolezal, 1996; National Institutes of Health, 1997; Diaz, 1998; Stokes and Peterson, 1998), but they also are theoretically and culturally relevant.

**Peer norms towards safer sex**

The positive effects of community involvement are partly deduced from Social Control Theory. This theory posits that individuals’ behaviors, such as sex practices and substance use, are regulated through participation and bonding to organizations and groups, such as community-based organizations, religious groups and those with cultural and political ends, i.e. through groups promoting norms and actions against those behaviors (Hirschi, 1969; Catalano et al., 1996). Individuals who participate in an organization become socialized in its norms and develop a social bonding with the organization and its members; hence, they tend to act in conformity with the organization’s norms. The organization’s agenda and culture, as well as the bonding the participant feels, create a pressure to act according to the group or organization’s norms and expectations (Fine and Holyfield, 1996). The organization’s or group’s norms are used as a point of reference by members to monitor each others’ behaviors (Smith, 1994), so that social control is exercised through the peers that the individual comes in contact, and interacts, with in the organization. Thus, community involvement in HIV/AIDS-related organizations may reduce risk behaviors for HIV/AIDS because it provides a set of peer norms linked to the good the organization promotes (e.g. safer sex) and because the individual feels bonded to those peers (Barbour, 1994; Hodgkinson, 1995; Omoto and Snyder, 1995;
Individuals who do not participate or feel any bonding to these organizations may not feel compelled to act according to organizations’ and members’ norms (Smith, 1997). They may have little reason to commit to safer sex.

Social Control Theory has been extensively tested on youth sexual risk behavior and substance use. Research done with white and African-American youth has found that involvement in community-based organizations, youth programs and church-related activities is negatively correlated to sexual risk behavior and drug use (Donovan and Jessor, 1978; Jessor et al., 1983; Wilson, 1987; Bingham et al., 1990; Maton, 1990; Zimmerman and Maton, 1992; Catalano et al., 1996). A study by Ramirez-Valles et al. among African-American and white youth, for instance, found that involvement in community-based organizations and extra-curricular activities is associated with less sexual risk behavior, while controlling for race, gender, family structure, social class, parental involvement and neighborhood poverty (Ramirez-Valles et al., 1998b). This line of research, therefore, indicates that sexual behavior is influenced by involvement in positive socializing agents (e.g. service organizations).

Self-efficacy towards condom use
Community involvement has been found to be positively associated with self-efficacy in general (Moen and Fields, 1999). Theories of action-oriented learning (also referred to as adult, popular or empowerment education) (Freire, 1970; Minkler and Cox, 1980; Minkler, 1985; Wilson, 1987; Wallerstein and Bernstein, 1988; Wallerstein, 1992; Zimmerman et al., 1997) and Social Cognitive Theory (Bandura, 1986) predict that involvement in HIV/AIDS-related organizations increases self-efficacy towards condom use, hence reducing instances of risk behavior. Learning and behavioral change may occur through community involvement in HIV/AIDS-related organizations because participants acquire knowledge and awareness while conducting actions directed to HIV/AIDS (Freire, 1970; Smith, 1997; Stewart and Weinstein, 1997; Zimmerman, et al., 1997). Action-oriented learning theories propose that individuals increase their self-efficacy and change their behaviors if learning takes place in a group and is based on the interconnection between development of awareness and action (Freire, 1970; Rappaport, 1984; Cornell Empowerment Group, 1989; Zimmerman et al., 1992). Through involvement in collective action, individuals increase their understanding of the agents that facilitate or inhibit the capacity to be proactive in their efforts to change their own health and the health of their community (Zimmerman, 1995). In addition, individuals produce their own knowledge and incorporate it into their own realities.

Community involvement may have a direct positive effect on self-efficacy because it provides opportunities for vicarious learning and verbal persuasion. Social Cognitive Theory proposes that behavioral change and maintenance is a function of (1) expectations that one’s actions can lead to a desired outcome (outcome expectations) and (2) expectations about one’s ability to enact a behavior to produce the desired outcome (self-efficacy) (Bandura, 1986; Strecher et al., 1986; Rosentock et al., 1988). These expectations may be enhanced through vicarious learning, which involves observing others’ actions, and verbal persuasion, which entails exhortations from others. Through community involvement in HIV/AIDS, individuals vicariously learn about safer sex and its negotiation from other participants and from individuals the organization works for; and they may also be exhorted by other members to maintain safer sex practices (Riessman, 1965; Schondel et al., 1992). Moreover, involvement may increase self-efficacy because individuals develop a greater commitment to the program or agenda of the organization; they are exposed to diverse opportunities to acquire and maintain behaviors and skills; and they may make public commitments to behavioral change and maintenance (Wandersman, 1981; Stewart and Weinstein, 1997; Altman et al., 1998).

Positive self-identity
Community involvement may create a positive self-identity because participants interact with
supporting peers, and because working toward the good of others provides participants with an identity of a caring and good person, and with feelings of self-worth (Hunter and Linn, 1981; Cutler, 1982; Holland and Andre, 1987; Marsh, 1992; Bellah et al., 1996; Wilson and Musick, 1997; Youniss and Yates, 1997; Moen and Fields, 1999). Peers provide information, feedback, and a point of reference to evaluate the self and construct and maintain a self-identity (Frable et al., 1997).

Although research on community involvement in HIV/AIDS is scarce (particularly among gay and bisexual men), the available studies show that participation is associated with self-acceptance and positive self-identity (Kobasa, 1990; Ouellette et al., 1995). For instance, Schondel et al. found that AIDS volunteers reported higher personal satisfaction and self-esteem than non-volunteers (Schondel et al., 1992). Among ACT UP members, Wolfe observed that some gay members ‘came out of the closet’ and acquired a sense of self-affirmation through their participation (Wolfe, 1994). Community involvement has unique positive effects on psychological well-being, beyond the effects of social support and mastery that may be gained through participating (Rietschlin, 1998). Findings from this body of research may also be true for HIV-positive individuals and those with AIDS. Weitz found that people living with AIDS cope with social stigma, create a positive self-identity and find a positive meaning for their lives through participating in community-based organizations (Weitz, 1991).

Among gay men, it has been suggested that community involvement reduces sexual risk behavior through its positive effects on self-acceptance (Waldo et al., 1998). Association with a network of gay men has positive effects on gay identity and self-perceptions (Turner et al., 1993; Frable et al., 1997). In minority groups, participation in organizations furnishes opportunities for self-expression and validation (Chambre, 1991; Brown et al., 1992; Brown, 1997; Smith, 1997). For minority gay and bisexual men this is particularly relevant because their ethnic and sexual identities are frequently conflicting (Stokes and Peterson, 1998; Kraft et al., 2000). They experience difficulty in developing and maintaining a positive ethnic and gay identity. Individuals who do not accept their gay and bisexual identity or feel shame about their homosexual desires are at risk of HIV/AIDS because they have difficulty talking about their own sexuality, and tend to engage in sex under the influence of alcohol and with anonymous partners (Diaz, 1998). Thus, to the extent that community involvement of gay and bisexual men entails interaction with both ethnic (in the case of men of color) and gay men and working with their communities, it may positively affect self-identity, which in turn may reduce episodes of sexual risk behavior.

**Alienation**

Community involvement also may decrease sexual risk behavior because it reduces feelings of alienation, especially among minority gay and bisexual men. In their classic work, ‘Habits of the Heart’, Bellah et al. argue that participation, volunteering and activism in religious, civic associations and local organizations are the means for individuals to connect to their larger society (Bellah et al., 1996). Several studies suggest that involvement in community-based organizations increases social interactions and face-to-face communication, creates social networks, and develops a sense of community, hence reducing alienation (McAdam, 1989; Smith, 1994, 1997; Stewart and Weinstein, 1997; Wilson and Musick, 1997; Younis and Yates, 1997; Rietschlin, 1998; Ramirez-Valles, 1999). Among gay men, community involvement has been found to be associated with greater social support (Waldo et al., 1998). In addition, taking action to address individual and community-level problems is associated with greater sense of community (Altman et al., 1998).

Gay and bisexual men of color frequently experience alienation because of racism, poverty and low levels of acculturation (Diaz, 1998; Kraft et al., 2000). Mainstream gay and bisexual groups typically exclude non-English speakers and gay and bisexual men of color. Alienation can lead to sexual risk behavior because it creates feelings of low self-worth. This can be counterbalanced by
involvement in HIV/AIDS-related organizations if this involvement provides face-to-face interactions, a network of peers and opportunities to work for their communities.

The four potential mediating mechanisms (e.g. peer norms, self-efficacy, self-identity and alienation) by which community involvement may decrease instances of sexual risk behavior are important for two reasons. First, they help disentangle the documented association between community involvement in HIV/AIDS-related organizations and safer sex practices. Second, they can be used to target specific areas to enhance the experience of participants, such as proving channels of communication among peers. Yet, to extend the positive impact of community involvement to larger segments of the population and to design interventions is necessary to identify the barriers and facilitators for community involvement.

**Socio-cultural barriers to and facilitators of community involvement**

The process, extent and consequences of community involvement in HIV/AIDS-related organizations are linked to cultural and social-specific factors that work as barriers and facilitators for community involvement. Based on previous research, I have identified five factors that may influence community involvement in HIV/AIDS (see Path 3 in Figure 1), motives for community involvement, poverty, acculturation, the stigma of homosexuality and HIV/AIDS, and perceived opportunities to participate. These factors have not been systematically studied in the context of community involvement in HIV/AIDS among gay and bisexual men. The understanding of how these factors facilitate or inhibit community involvement in HIV/AIDS is vital to inform future research and interventions among gay and bisexual men and HIV/AIDS-related organizations.

**Motives for community involvement**

Motives are psychosocial and cultural factors which partly determine levels of community involvement (Knoke and Woods, 1981; Omoto and Snyder, 1995; Ramirez-Valles, 2002). The levels and types of community involvement may depend on the levels of motivation and the types of motives individuals have for participation. Research on participation in community-based, neighborhood and service organizations has identified categories of motives for involvement (e.g. concern for one’s community, moral values, understanding others, coping with one’s troubles and helping others) (Knoke and Woods, 1981; Jenner, 1982; Wandersman and Alderman, 1986; Clary et al., 1992; Snyder and Omoto, 1992; Bebbington and Gatter, 1994; Smith, 1994; Gabard, 1995; Hodgkinson, 1995; Omoto and Snyder, 1995; Ouellette et al., 1995; Stewart and Weinstein, 1997). The types of motives found do not differ greatly across studies. What appears to be different are the types of motives identified as most salient (Knoke and Woods, 1981; Jenner, 1982; Hodgkinson, 1995; Omoto and Snyder, 1995; Stewart and Weinstein, 1997). For instance, Omoto and Snyder found overall motivation positively associated with length of time as an HIV/AIDS volunteer, but self-oriented motives (e.g. personal development) were better predictors of length of service than community-oriented motives (e.g. community concern) (Omoto and Snyder, 1995).

Research on motives, however, has been conducted primarily among participants who are white, middle class and relatively well educated. This limits its application to minority gay and bisexual men, because motives are shaped by the social and cultural context (Stewart and Weinstein, 1997; Ramirez-Valles, 2001). Motives for participation in HIV/AIDS-related organizations have not been studied among gay and bisexual men of color, who may have other motives or may express their motivations with a different cultural vocabulary. Future research, thus, is needed to identify motives for community involvement in HIV/AIDS among minority gay and bisexual men, and to examine whether motivation levels are associated with levels of community involvement and which motives are associated with greater community involvement.
Poverty and acculturation

Compared to their white peers, gay and bisexual men of color have been less involved in HIV/AIDS-related organizations and other collective prevention efforts (Perrow and Guillen, 1990; Chambre, 1991). The vast majority of participants in HIV/AIDS organizations are still white gay and bisexual men (Valentgas et al., 1990; Omoto and Snyder, 1995). Minority gay and bisexual men’s low rate of participation in HIV/AIDS-related organizations may be due to their overall poverty levels and low acculturation (for recent immigrants) into the mainstream culture. Generally, ethnic minorities seem to participate at lower rates in service, volunteer and community-based organizations than white populations (Smith, 1997). The available evidence, however, is inconclusive. In some studies, race participation differences disappear when social class is accounted for (Wilson and Musick, 1997), suggesting that minority’s low participation may be due to their higher poverty levels. National surveys and local studies have consistently found that individuals with higher education (e.g. college degree) and income are more likely to be recruited for volunteer positions (Wandersman and Alderman, 1986; Smith, 1994, 1997; Hodgkinson, 1995; Wilson and Musick, 1997). This excludes many minority gay and bisexual men, particularly those recent immigrants who do not speak English or who are less acculturated into the US mainstream culture. Other studies indicate that ethnic minorities do not participate less than white populations, but participate in different types of organizations (Portney et al., 1997). Communities of color may not be as involved in issue-oriented organizations (e.g. HIV/AIDS) as in neighborhood-level organizations (Schondel et al., 1992; Portney et al., 1997). Thus, poverty and low acculturation levels (for recent immigrants) appear to be significant barriers for community involvement in HIV/AIDS-related organizations.

Stigma of homosexuality and HIV/AIDS

Gay and bisexual men’s low rates of participation in HIV/AIDS-related organizations may also be due to the stigma of HIV/AIDS and homosexuality. The fear of being identified as homosexual or a ‘person with AIDS’ (PWA) by family, co-workers and friends may prevent individuals from becoming actively involved in HIV/AIDS-related organizations (Kayal, 1994; Gabard, 1995). Synder et al., for example, found that individuals who believe they will be stigmatized are less likely to become AIDS volunteers than those who do not perceive potential stigmatization (Synder et al., 1999). Moreover, family stigma against homosexuality has been found to be negatively associated with a positive gay identity (Turner et al., 1993; Frabel, 1997; Diaz, 1998). The stigma of homosexuality and HIV/AIDS is still widespread in many communities, organizations and families. Yet, the stigma of homosexuality and HIV/AIDS among gay and bisexual men has not been studied in the context of community involvement and sexual risk behavior, particularly among communities of color. Future research needs to examine whether stigma of homosexuality and HIV/AIDS is associated with lower levels of community involvement in HIV/AIDS.

Perceived opportunities

Studies on national and local civil and social service organizations indicate that participation may be largely determined by individuals’ perceptions of opportunities to participate (Snow et al., 1980; Williams and Ortega, 1986; Smith, 1994; Catalano et al., 1996). Individuals are likely to get involved if they know of the existence of organizations and opportunities to do so, and if they perceive those organizations and opportunities as accessible and accepting of them. There is, however, a need in the field to examine whether perceived opportunities to participate in HIV/AIDS-related organizations and activities is positively associated with actual community involvement.

Community involvement burnout

Community involvement in HIV/AIDS, however, may cause stress and burnout (see Path 4 in Figure 1). Activists, volunteers and other HIV/
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AIDS workers may experience physical and emotional fatigue, and depersonalization as a result of their work. Evidence of this effect is inconclusive, though (Guinan et al., 1991; Barbour, 1994). For instance, some research on ‘PWAs’ buddies’ suggests that feelings of stress are related to the time one works with a PWA (McKusick et al., 1986), while other research indicates that time helping a PWA is positively correlated with the helper’s mental health (Gilhooly, 1984). Moreover, it is not clear whether burnout is caused by the activity itself or by organizational factors (e.g. poor support and training). The available studies suggest that burnout may be due to organizational factors; that burnout associated with community involvement in HIV/AIDS may be compensated by its rewards (Guinan et al., 1991; Barbour, 1994); and that stress and burnout may not be generalizable to all HIV/AIDS-related activities, but to specific ones (e.g. being a PWA buddy).

Little is still known about community involvement in HIV/AIDS and burnout among gay and bisexual men and ethnic minority groups. Burnout effects among minority gay and bisexual men may be small, because the levels of involvement generally found in this population are not as high as to cause burnout. It is possible, however, that those gay and bisexual men of color who are involved experience burnout due to the extensive workload. Future research needs to explore whether community involvement is associated with burnout and what specific aspects of involvement (e.g. frequency, type of activity) are associated with greater burnout.

**Conclusion**

Community involvement is one of the most important means for individuals to feel part of their larger society (Bellah, et al., 1996). It also has an instrumental value beyond the individual level, as it provides a space for social action to address community-wide problems, such as HIV/AIDS (Patton, 1989; Smith, 1997). Through involvement in community-based organizations and action groups, individuals learn and create a sense of themselves while promoting social change.

In this paper a conceptual framework was presented to understand and disentangle the effects that community involvement in HIV/AIDS-related organizations and activities may have on individuals’ safer sex practices. The framework provides specific suggestions for future research to test how and to what extent community involvement affects individuals’ health, and to design health prevention programs based on the direct and active participation of affected communities.

The proposed framework presents significant contributions to HIV/AIDS, community involvement and health education literatures. It focuses on community involvement as a protective factor for HIV/AIDS risk behavior, while addressing socio-structural risk factors. Previous research on HIV/AIDS among gay and bisexual men has centered on finding predictors of and risk factors for HIV. While this has been important, little is known about why some individuals practise safer sex despite facing unfavorable circumstances, i.e. about protective factors for HIV. These protective factors may then be used to develop new interventions or to enhance existing ones that target risk factors solely. In addition, this framework advances the understanding of community involvement in HIV/AIDS, as well as its definition and association with sexual risk behavior. No previous research has directly addressed community involvement in HIV/AIDS and its effects on sexual risk behavior, especially among minority gay and bisexual men. Specifically, this framework argues for a comprehensive measure of community involvement in HIV/AIDS. It defines community involvement as a construct encompassing type of activities, length and frequency of involvement, and the meaning participants attach to their involvement. Moreover, this construct could be used, adapted and tested in other contexts, such as substance use, mental health and empowerment. It could also be tailored to other populations, such as Latino and African-American youth.

Regarding research on community involvement, several implications can be drawn from this framework. First, as mentioned above, community
involvement must be treated as a continuous or latent variable, instead of a dichotomous variable. In addition, it is necessary to assess the unique and combined effects of the various aspects of community involvement (e.g. length, frequency, type) on individuals’ behaviors. Second, studies should collect data from individuals with a range of levels of community involvement, not only from individuals who are at one extreme of involvement (e.g. volunteers and activists). Third, future research may benefit by collecting qualitative data (e.g. narratives, participant observation) from individuals and organizations to document the processes, trajectories and contexts of community involvement and further inform the models presented here. Fourth, longitudinal or experimental research designs need to be employed to assess causal effects and antecedents of community involvement. Finally, studies need to address the group-specific variables of non-white populations, such as Latino, Asian-Pacific and African-American gay and bisexual men, and modify this conceptual framework accordingly.

This framework also advances health education theory and practice by providing the basis for future interventions at community, organizational and individual levels. It delineates how interventions based on collective action (e.g. community involvement) for social change may be effective in generating healthy behaviors at individual and community levels. These types of interventions work as prevention strategies because individuals learn by doing while creating social change. For instance, if the hypotheses put forward here are correct, an intervention with HIV/AIDS-related organizations could be developed to (1) enhance community members’ involvement with organizations (e.g. creating satisfying activities and more interaction with peers) so that community involvement may affect participants’ peer norms, self-efficacy, positive self-identity and alienation; and (2) increase and improve outreach efforts for gay and bisexual men who live in poverty, are less acculturated and who feel stigmatized. At the community level, an educational intervention could be aimed at reducing stigma and increasing knowledge of community involvement opportunities among gay and bisexual men who are less likely to get involved (e.g. those who are less acculturated and live in poverty).

There are, however, some caveats that need to be considered when interpreting the conceptual framework presented here. The framework presumes one way causal relationships, which have not been empirically tested. For example, it is possible that those individuals who are practicing safer sex are more likely to volunteer in HIV/AIDS-related organizations. Nonetheless, the proposed relationships are consistent with theoretical expectations and previous research. Part of the agenda of future studies should be to assess the effects of community involvement on individual behavior over time. Likewise, the framework does not include variables that may have a significant impact on community involvement, such as health care and health policies. Access to health care, for instance, may influence who and how participates as volunteer or activist. Access to health care may also be a significant outcome of community involvement. Variables such as this one, however, add complexity to the framework presented here and deserve a detailed examination elsewhere. Moreover, although an effort was made to take into account the specific life experiences of minority gay and bisexual men, the framework does not fully represent the cultural diversity within this group. Future research would benefit by focusing only on a particular ethnic group to investigate whether there are ethnic-specific variations on community involvement and its precursors and consequences.

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Protective effects of community involvement


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