

can HIV prevention programs be adapted?

why adapt?

We know that many HIV prevention interventions have made a difference, and that prevention efforts have helped to lower rates of HIV infection in many different populations.¹ But as the HIV epidemic changes, so too do the number and groups of people at risk for HIV. Adapting interventions allows us to use principles we know are effective to address the needs of those newly at risk, who may not have been studied yet.

Developing new interventions is expensive and time consuming, and it makes good sense to adapt programs that have been demonstrated to be effective.² Using existing tools and theories of successful programs can save time and money. In an age when money for prevention is limited, adapting interventions can be cost-effective.

aren't all populations different?

Yes and no. While each community or population is unique, there are many similarities between populations and their social, political and emotional environments. While injecting drug users in Chicago, IL may have very different needs than young gay men in Eugene, OR, both may benefit from similar aspects of programs. For example, using peer educators to help spread the message and change community norms can be effective for both groups.^{3,4}

HIV prevention is more than simply teaching safer sex and safe drug use nuts and bolts. Prevention programs need to take into account the life context in which a person applies safer sex, and the relationship to the HIV epidemic of the person. Prevention programs need to be tailored to these different situations, not reinvented entirely.

what helps with adaptation?

Program planners can choose from a variety of elements of prevention programs that can address their own local population, setting or intervention needs. Staff training and technical assistance to understand and effectively implement programs is key for successful adaptation.

Understanding the community is integral to adapting programs.⁵ Service organizations often know their populations best, whether through outreach or needs assessment. Before adapting an intervention, it is essential to understand the characteristics of the original program and its audience, and how they are different or similar to the new environment.

Theory gives a background for behavior change, and may also be useful in assessing whether an intervention is appropriate for a different target group. For example, the Social Cognitive theory of behavior calls for learning through interactions with other people and using physical and social environments to produce change.⁶ Role playing, community building, interactive videos and job training can all be components of a program using this theory.

Peer education has been an important element of prevention programs and serves as a powerful motivator especially for disenfranchised people. Such programs recruit peer educators who are at high risk, and teach them how to educate and help save the lives of their friends and colleagues.⁷ This recognizes that people in their own communities have tremendous power of persuasion and can be effective agents of change.

Another successful prevention element involves addressing notions of family, community and ethnic pride.⁸ For example, offering parenting and communicating classes often attracts more participation from parents than offering classes specifically about HIV. Appealing to protecting and supporting the community or family-children, spouses, relatives-can be more encouraging than simply protecting oneself.

Says who?

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what are some examples?

The STOP AIDS project in San Francisco, CA, has served as a model for HIV prevention across the country.⁹ The model, based on community mobilization and outreach and small group meetings, has been adapted and used for gay men across the country. The STOP AIDS model has been used in Los Angeles, CA, West Palm Beach, FL, Phoenix, AZ and Chicago, IL, among other cities. In San Francisco, clients have been recruited on the streets and at bars, while in Chicago, the program has gone into schools. They have found that HIV prevention programs work better when high levels of local commitment are established in a city.

Healthy Oakland Teens (HOT), a peer-based sex education program at a junior high school in Oakland, CA, trained ninth graders to lead classes on sexuality and HIV/AIDS to seventh graders. After one year, students in the program were less likely to initiate activities such as deep kissing, genital touching, and sexual intercourse.¹⁰ HOT was then adapted to address Balinese youth who were perceived at risk for HIV due to increasing HIV seroprevalence and an extensive tourist and sex industry in Bali.

In Bali, researchers found that among members of traditional Balinese youth groups, only 14% of those who were sexually active had used condoms. Although most still lived at home, only 33% reported feeling comfortable discussing sexuality with their parents, while 75% felt comfortable discussing it with their peers. The HOT model of peer education was therefore seen to be appropriate, and the setting was changed from public schools to traditional Balinese youth groups which reach all Balinese youth regardless of socioeconomic status or educational level.¹¹

One successful prevention program for gay men in small cities recruited popular opinion leaders from bars, and trained them to deliver and model prevention messages to their peers.¹² This program was then adapted to address minority women in inner city housing developments. However, the program didn't work there. The reason? Women didn't know their neighbors, and because of high crime rates in the housing developments, were reluctant to open their doors to someone they didn't know.

This program was then reworked, starting by helping women in the housing developments establish a sense of community through potluck dinners and music festivals. As a result, not only did the women increase condom use and communication, but the community began to tackle other issues besides HIV such as drugs and violence in the housing development.¹³

what needs to be done?

Service organizations need to commit time and resources to training staff in effective use of prevention programs, including using theory, conducting needs assessments and reaching out to researchers and other organizations to find out what interventions have been shown to be effective.

Community planning groups (CPGs) need to facilitate better communication and stable relationships between researchers, community based organizations and Health Departments. CPG Program Coordinators can help link CPGs with local researchers to help community-based prevention planners determine the best adaptations to make.

Researchers need to move from small scale efficacy studies to wide scale field trials. Many interventions are effective in what can be a very controlled research environment (clients often receive payment, staff is well paid and often have advanced degrees). These interventions then need to be tested in the "real world" to see how they may need to be adapted or modified to ensure effectiveness under different conditions and with different populations.

Funders need to commit funds to adaptation and pilot testing new programs at the community level. A comprehensive HIV prevention strategy uses many elements to protect as many people at risk for HIV as possible. Adapting existing interventions can be a money-saving and effective prevention strategy.

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