

African American Prevention Intervention Network

SANKOFA FACT SHEET

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Adaptation of HIV Prevention Programs

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. 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. 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.

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. 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. 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. 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. 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.

What are some examples?

The STOP AIDS project in San Francisco, Calif. has served as a model for HIV prevention across the country. 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, Calif.; West Palm Beach, Fla.; Phoenix, Ariz.; and Chicago, Ill. 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, Calif., 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. 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

Source: <http://www.caps.ucsf.edu/adapttext.html>; Centers for AIDS Prevention Studies, University of California at San Francisco

For more information, call the technical assistance analyst at the Mississippi Urban Research Center, 1-866-JSU-MURC (578-6872).

