Behavioral Interventions for STD/HIV Prevention

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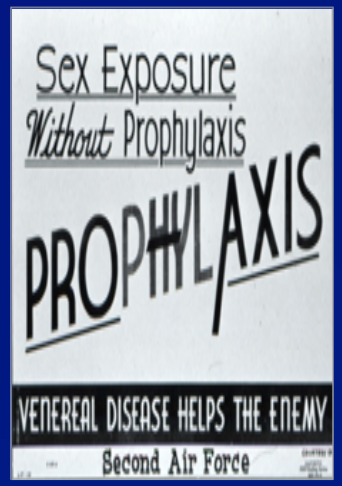
Division of STD Prevention

Relevance of HIV Prevention Interventions for STD Prevention and Vice-Versa

- **HIV is an STD & other STDs may enhance the transmission of HIV – biological connection**
- **Similar behavioral goals**
  - Sexual behavior change
    - Reduce number of partners
    - Condom use
  - Getting tested & getting partner(s) tested
  - Treatment & treatment adherence
- **Many interventions developed for HIV prevention impact STD outcomes, e.g.,**
  - Condom use
  - Mutual monogamy with HIV & STD tested-negative partner
  - Healthcare seeking, including HIV & STD routine testing

Behavioral Science-based Interventions for STD/HIV Prevention

- **Historical Perspective**
- **Behavioral Intervention – Levels**
  - Individual-level approaches – one client at a time
  - Group-level approaches – small groups of people with similar life experiences & circumstances
  - Community-level approaches – neighborhoods, cities, schools – broadly reaching persons with similar life experiences & circumstances



www.cdc.gov

- **Structural Interventions – another type of community-wide approach – addresses components of behaviors that could affect public health**
  - Availability,
  - Accessibility
  - Acceptability

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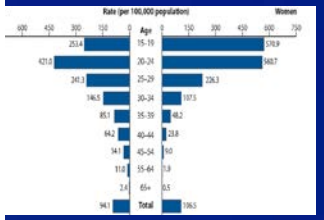
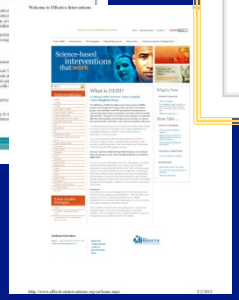
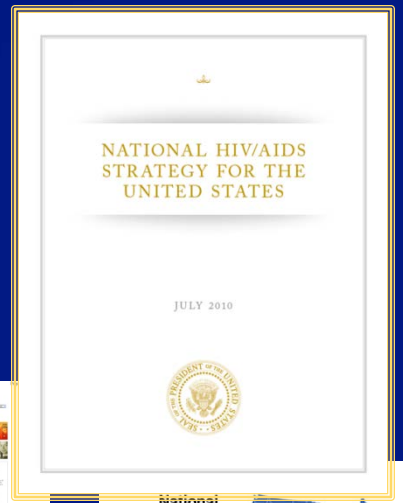
* Blankenship, KM et al. (2006). *Journal of Urban Health: Bulletin of NY Academy of Medicine, 83* (1)
* Charania, MR et al. (2010). *AIDS Behavior, DOI 10.1007/s10461-010-9812-y.*
* McGough, LJ & Handsfield, HH, in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*

Behavioral Science-based Interventions for STD/HIV Prevention

- **National HIV/AIDS Strategy (NHAS)**
  - Includes biomedical, behavioral, & structural approaches
- **Resources – information about**
  - Training
  - Technical Assistance
  - Tools for working with clients & communities
  - Behavioral Interventions
  - Epidemiology

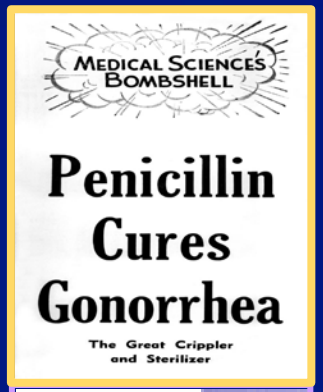






* www.effectiveinterventions.org
* www.cdc.gov
* www.cdcnpin.org

Historical Perspective



- **Before HIV**
  - Main focus was identification & treatment of bacterial STDs – ***secondary & tertiary prevention*** – which also helped reduce spread – ***primary prevention***
  - Prevention messages were given as an "add-on" in the form of education & even "orders"
  - Partner services
- **After HIV – initially – education & later – other behavioral influences**
  - Increased emphasis on behavioral interventions to prevent acquisition of (incurable) infections – ***primary prevention***
    - Approaches were based in giving knowledge in hope of leading to safer & healthier behavior
    - Later – it was recognized that social & behavioral science-based interventions addressed much more than knowledge alone ~ & ~ they were effective

(continued)

* Bolan GA et al (2012) *NEJM, 366* (6)
* (1996) *Public Health Reports, III* (S1) Entire Issue
* www.cdc.gov

Historical Perspective
From Orders to Education-Alone to Behavioral

- **Traditional STD prevention messages were "orders" – just do not have sexual contact ~ or ~ use a condom**
  - Intuitively a good thing to do – "An ounce of prevention is better than a pound of cure"
- **HIV – during 1980s – there was urgency & fear –**
  - Most of the prevention response came from affected communities
  - Delivered in the form of educational messages, e.g.,
    - Reduce the number of partners
    - Use condoms
- **HIV & other STDs – during 1990s & 2000s**
  - Scientific evidence supports behavior science-based interventions
  - Community involvement continued & there was an embrace of the behavioral science-based approaches – researchers & communities joined forces, including study of "homegrown" interventions

* McGough, LJ & Handsfield, HH, in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*

Behavioral Interventions for STD/HIV Prevention

- **Behavioral science-based interventions with other health behaviors had shown effectiveness**
- **Due to this experience & a recognition that STD/HIV prevention needed to improve – application of behavioral science to STD/HIV prevention & behavior change was recommended by the CDC, NIH, & others – for nearly 20 years ***
- **Cost-benefit analyses have had variable results**
  - D Cohen et al (RAND)
  - D Holtgrave et al has conducted many of these studies

(continued)

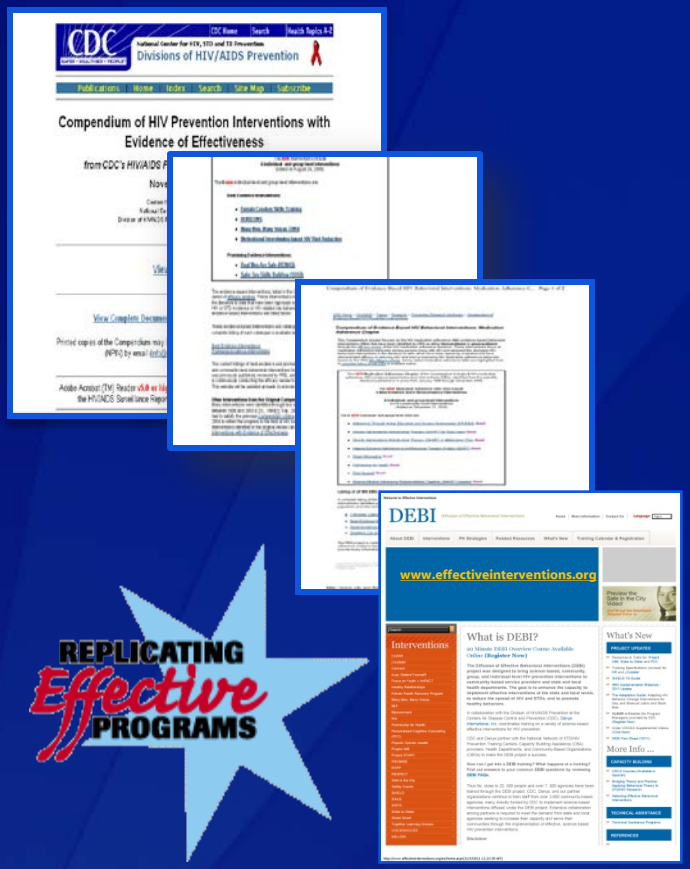
* NIH-IOM (1997). *The Hidden Epidemic: Confronting STDs.;* NIH (1997). *Consensus Statement Report*
* CDC (1993, 1998, 2002, 2006, 2010). MMWR – STD Treatment Guidelines – multiple editions
* CDC (2001, 2006). MMWR – HIV CTR Guidelines
* Cohen, D et al. (2005). *Health Affairs, 24* (4)
* Holtgrave, DR et al. (1994). *Archives of Internal Medicine , 153* (10), p 1225-30

Behavioral Interventions for STD/HIV Prevention

- **STD/HIV Prevention researchers base their studies in several behavioral science theories, e.g.,**
  - Health Belief Model
  - Social Cognitive Theory
  - Stage of Change/Transtheoretical Model of Behavior Change Theory
  - The HIV epidemic led to new models, e.g., Kelly's *AIDS Risk Reduction Model*, or Fisher & Fisher's *Information, Motivation, Behavior Model*
  - Many interventions use elements from various & different theoretical approaches, or combinations of different theories
- **Several meta-analyses have been conducted to determine utility, e.g.,**
  - R DiClemente et al
  - L Weinhardt et al
  - CM Obermyer & M Osborne
  - JS Lin et al

* DiClemente, RJ et al. (2005). *Seminars in Pediatric Infectious Diseases, 16* (3)
* Weinhardt, LS et al. (1999). *American Journal of Public Health, 89* (9)
* Obermeyer, CM & Osborne, M. (2007). *American Journal of Public Health, 97* (10)
* Lin, JS et al. (2008). *Annals of Internal Medicine, 149* (7)

CDC Efforts and Projects



- Prevention Research Synthesis Project
- Compendium of HIV Prevention Interventions with Evidence of Effectiveness
  - Original – 1999 (listed 24)
  - Updated – 2009 (listed > 70)
  - Newest Chapter – 2010 – Medication Adherence Interventions (currently lists 8)
- Replicating Effective Behavioral Programs Project – many of these interventions were replicated in "real world" settings by partnerships of researchers & community settings
- Diffusion of Effective Behavioral Interventions (training, materials, & technical assistance)

* www.cdc.gov/hiv/topics/research/prs/index.htm
* www.effectiveinterventions.org
* www.cdc.gov/hiv/topics/cba/index.htm
* www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* www.cdc.gov/hiv/topics/prev_prog/rep/resources/qa/

Behavioral Interventions – Individual Level

- **Client-centered, one-on-one intervention**
- **Science-based interventions with**
  - Research findings that show efficacy
  - Program evaluation that shows effectiveness in the "real world"
- **Individual Level Interventions (ILIs) should be evidence-based & if not, then science- or theory-based, e.g.,**
  - Stage of Change/Transtheoretical Model of Behavior Change Theory
  - Health Belief Model
  - Theory of Gender and Power
  - Theory of Reasoned Action
  - AIDS Risk Reduction Model
  - Information-Motivation-Behavioral Skills Model (IMB)

(continued)

* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*
* wwww.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* ww.effectiveinterventions.org

ILIs – Client-centered Counseling

- **These are client-centered, i.e., based on the client's individual circumstances & experiences**
  - Thus can be tailored to each person
- **This client-centered approach was recommended by the CDC for HIV pre- & post-test counseling to be**
  - *"Client-centered counseling refers to counseling conducted in an interactive manner responsive to individual client needs…"* This requires an *"understanding of the unique circumstances of the client …"* through *"the use of open-ended questions and active listening".* *
- **Since then, many ILIs have been developed, studied, & implemented**
  - Effectiveness has been shown with only have 1-2 sessions with the client, while others might include several sessions

(continued)

* CDC. (1997). *Prevention Case Management Guidance*, p 41

Elements of Client-Centered Counseling

- **Personalized risk assessment – thus useful for any/all target populations**
- **Facilitates & supports client-initiated behavior change**
- **Helps client recognize barriers to risk reduction**
- **Negotiates an acceptable & achievable risk-reduction plan – to identify a possible "first step" by the end of the counseling session; these could be simple or more involved, e.g.,**
  - "I'll start carrying condoms with me."
  - "I'll call the Drug Treatment Center for an appointment."
  - "I plan to talk with my partner about getting HIV/STD-tested – tonight."
- **Refer client to other specialized services, if needed**

* CDC. (2012). *Program Operations Guidelines for STD Prevention*
* CDC. (2009). *Procedural Guidance for Community Based Organizations*
* Kamb ML et al. (1998). *JAMA, 280 (13)*

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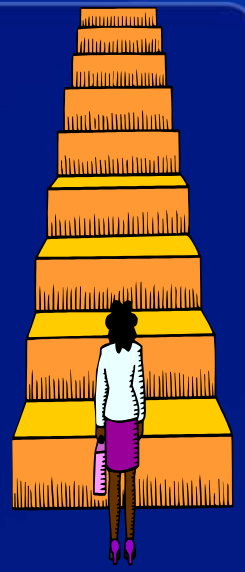
Client-Centered Counseling Challenges



- **Providing counseling that truly reaches the client**
  - History of risk behaviors as well as risk reduction successes
  - Knowledge and attitudes & beliefs about STDs, HIV, Viral Hepatitis, & the client's own sense of vulnerability to these infections
- **Identifying the best way to take that gathered information & using it to help the client work towards safer &/or healthier behavior by *letting the client do most of the talking***
  - Which is guided by the counselor's questions & comments – this often presents a challenge, since it is a shift from the traditional HIV/STD prevention educator approach
- **Assisting the client with identifying next steps that are reasonable & achievable**

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* CDC. (2012). *Program Operations Guidelines for STD Prevention*
* CDC. (2009). *Procedural Guidance for Community Based Organizations*
* Kamb ML et al. (1998). *JAMA, 280 (13)*

Client-centered Counseling – the Approach

- **Research has shown some common themes**
- **Use a combination of open-ended & close-ended questions**
  - Open-ended examples
    - Are STDs something you worry about for yourself?
    - What's been your experience with condoms?
    - What's the difference between the times you use condoms & the times you don't?
    - Who decided to introduce condoms the last time you used them?
    - What do you think you can do to reduce your risk for STDs?
  - Open-ended questions yield information about the client's risk & safety history as well as attitudes & beliefs related to his/her risk

(continued)

* Carey, MP et al (2009) *AIDS and Behavior, DOI 10.1007/s10461-009-9587-1*
* CDC. (2012). *Program Operations Guidelines for STD Prevention*
* CDC. (2009). *Procedural Guidance for Community Based Organizations*
* Kamb ML et al. (1998). *JAMA, 280 (13)*

Client-centered Counseling – the Approach

- **Use a combination of open-ended & close-ended questions**
  - Close-ended questions provide clarifications & specifics – used to get "the facts" besides the big picture
  - Close-ended examples
    - Are your partners males, females, or both?
    - How many partners would you say you've had over the past 3 months?
    - When was the last time you had sex?
    - When was the last time you had sex without a condom?
    - Have you &/or your partner been STD-tested? HIV-tested?
- **Use the principle of "Ask – Don't Tell!"**

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* Carey, MP et al (2009) *AIDS and Behavior, DOI 10.1007/s10461-009-9587-1*
* CDC. (2012). *Program Operations Guidelines for STD Prevention*
* CDC. (2009). *Procedural Guidance for Community Based Organizations*

Examples of Evidence-based ILIs

- **Project RESPECT** [1]
  - Studied & implemented in STD Clinics
  - In DEBI Project – for variable settings
- **Personalized Cognitive Counseling (PCC)** [2]
  - Studied MSM who with histories of repeat HIV testing – in publicly-funded Anonymous HIV CTR Programs
  - Recent addition to DEBI Project
- **Choosing Life: Empowerment! Action! Results!** [3]
  - Studied persons living with HIV & those at high risk with HIV – to reduce risk behaviors
  - In DEBI Project

1. Kamb ML et al. (1998). *JAMA, 280 (13)*
2. Dilley, JW et al. (2007). *JAIDS, 30 (2); 44* (5) – **2 citations**
3. Lightfoot, M et al. (2007). Behavior Modification, 31 (2)

Behavioral Interventions – Group Level

- **Most evaluated type of intervention (GLI)**
- **Because GLIs work with a group – typically 6-12 people/group – the group members need to have enough in common for the intervention to be relevant**
- **Have been shown to be effective in many risk groups**
  - Youth – Out-of-school & In-school
  - Men who have sex with men (MSM)
  - Injection drug users (IDUs)
  - STD clinic patients
  - Persons living with HIV
  - Heterosexual women & men (women more studied/implemented)

(continued)

* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*
* wwww.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* ww.effectiveinterventions.org

Behavioral Interventions – Group Level

- **As with the Individual, GLIs**
  - Focus on behavioral influencers such as knowledge, perceived risk, intentions, outcome expectancies, self- efficacy, perceived norms
  - Are behavioral science-based & theory-based, e.g.,
    - Social Cognitive Theory
    - SOC/TTM
    - Theory of Reasoned Action
    - Theory of Innovation
    - AIDS Risk Reduction Model
    - Information-Motivation-Behavioral Skills Model (IMB)

(continued)

* Kelly, JA et al (1991). *AJPH, 81* (2)
* *PHR , III* (1999) Entire Issue
* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). Behavioral Interventions for Prevention and Control of STDs
* Valente, TW & Davis, RL. (1999). *Annals of the American Academy of Political & Social Science, 566* (1)(Si)

Behavioral Interventions – Group Level

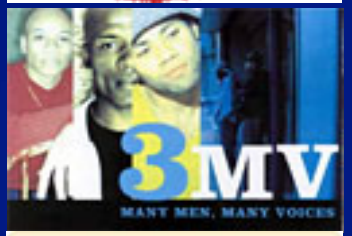
- **GLIs use the dynamics of a facilitated group to provide**
  - Modeling & practicing behavioral skills
  - On-going reinforcement
  - Instruction on social pressure
  - Reinforce clear values/norms regarding unprotected sex
- **Usually, these interventions involve multiple sessions – generally delivered over a few weeks to a few months – in various intervals, e.g.,**
  - Daily or weekly sessions
  - Follow-up sessions – weeks to months later

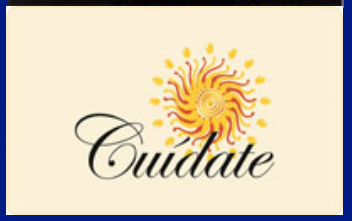
(continued)

* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). Behavioral Interventions for Prevention and Control of STDs

Examples of Evidence-based GLIs

- **Focus on Youth with Impact** [1]
  - Studied in youth – to reduce HIV/STD risk behaviors; also has parent-focused part
  - In DEBI Project
- **Many Men, Many Voices (3MV)** [2]
  - Studied Black MSM with STD/HIV risk behaviors
  - In DEBI Project
- ***¡Cuídate!*** **("Take Care of Yourself")** [3]
  - Studied 13-18 year-old Latino females – to reduce HIV/STD risk behaviors
  - In DEBI Project





1. Stanton, B et al.1(996 & 2004). *Archive of Pediatrics & Adolescent Medicine, 150* (4) & *158* (10) – 2 citations
2. Wilton, L et al. (2009). *AIDS Behavior, 13* (3)
3. Villarruel, AM (2006). *Archives of Pediatrics & Adolescent Medicine, 160* (8); Gallegos, EC et al. (2008). *Salud Publica de Mexico, 50* (1)

Behavioral Interventions – Community Level

- **Community is the target of the intervention, rather than the individual or a group**
  - Obviously, the reach is very extensive
- **Like with Group, CLIs must be directed to a specific target population so that the prevention is relevant**
- **Goals include changing community norms, reaching those that do not come into agencies/clinics for care, & empower community members, which are met through carefully designed strategies**

(continued)

* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). Behavioral Interventions for Prevention and Control of STDs
* wwww.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* ww.effectiveinterventions.org

Behavioral Interventions – Community Level

- **Reach & relevance is also accomplished by conducting these interventions through outreach using community members in venues/geographic areas where high-risk groups congregate**
- **Like Individual & Group, CLIs use concepts from a number of behavior change theories, particularly**
  - Diffusion of Innovation
  - Empowerment
  - SOC/TTM
  - Theory of Reasoned Action
- **It is essential to identify the Messenger & the Message**

(continued)

* Guenther-Grey, C et al. (1996). *Public Health Reports, 111* (S1)
* Kelly, JA (1991) *AJPH, 81* (2)
* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*
* *Valente, TW & Davis, RL (1999) ANNALS of the AAPSS, 566* (1)
* wwww.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* ww.effectiveinterventions.org

Behavioral Interventions – Community Level

- **Messengers – community members who**
  - Have full buy-in to the message & are fully prepared to pass on to others in community
  - Model the behavior change
  - Have access to community – particularly to the high-risk individuals who may be less likely to access prevention services
  - Have good connecting skills inside ~ & ~ outside of their own networks & are persuasive
  - Are recognized & respected as informal leaders who are "in the know" – they're credible & believed – opinion leaders
- **Message – content & "packaging" developed with**
  - Community input through formative research

* Guenther-Grey, C et al. (1996). *Public Health Reports, 111* (S1)
* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*
* Valente, TW & Davis, RL. (1999). *Annals of the American Academy of Political & Social Science, 566* (1)(Si)
* wwww.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* ww.effectiveinterventions.org

Examples of Evidence-based CLIs

- **Mpowerment Project** [1]
  - Studied in young MSM (gay & bisexual) – to reduce HIV sexual risk behaviors; has a newer version for persons living with HIV
  - In DEBI Project
- **PROMISE** [2]
  - Studied in many communities with different target populations for STD/HIV risk behaviors
  - In DEBI Project
- **Popular Opinion Leader (POL)** [3]
  - Initially studied MSM in gay bars; has since been adapted to many other target populations – Black MSM: **d-up: DEFEND YOURSELF**
  - In DEBI Project

1. Kegeles, SM et al. (1996). *AJPH, 86* (8)
2. CDC AIDS Community Demonstration Projects Research Group. (1999). *AJPH, 89* (3)
3. Kelly, JA et al. (1991). *AJPH, 81* (2) ~ & ~ Jones, KT et al. (2008). *AJPH, 98* (6)

Structural Interventions

- **Health is promoted by working to change the social context in which STD/HIV risk activities occur, & this is accomplished by changing one or more of the following** (often in combination)
  - Changing laws , e.g., legalizing needle exchange
  - Changing physical environment, e.g., improving sidewalks, street lighting, & safety – to facilitate taking walks as exercise; or improving healthy & affordable food choices in neighborhood stores
  - Changing organizational structures, e.g., integration of HIV, STD, Viral Hepatitis, & TB services – to provide "one-stop shopping" that can facilitate & improve prevention & care of these overlapping infectious diseases & epidemics
  - Changing usual operating procedures, , e.g., having walk-in services rather than by appointment only – making it easier for the clientele to access services

* Blankenship, KM et al. (2006). *Journal of Urban Health: Bulletin of NY Academy of Medicine, 83* (1)
* Charania, MR et al. (2010). *AIDS Behavior, DOI 10.1007/s10461-010-9812-y.*
* McGough, LJ & Handsfield, HH, in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*

Example of Structural Intervention
Condom Distribution – Soon to Be Available

	Individual	Organizational	Environmental
Availability	• Condom bowls • Providing low cost condoms • Providing condom coupons	• 100% condom-use policies • Condoms in jails & prisons	• Increasing public funds for making condoms available
Acceptability	• Distributing promotional items (flyers to youth)	• PSAs • TV campaigns • Community mobilization	• Social Marking campaigns
Accessibility **Adapted from:**	• Wide-spread distribution of free condoms **Charania, MR et al, p 2**	• Development & production of female condoms • Expanding publicly – funded distribution (e.g., vans)	• Policy change

* Charania, MR et al. (2010). *AIDS Behavior, DOI 10.1007/s10461-010-9812-y*, p 2.

* See www.cdc.gov & www.effectiveinterventions.org

See www.effectiveinterventions.org

Behavioral Science-based Interventions for STD/HIV Prevention

- **While there are these various approaches – combining them has been shown to be even more effective**
  - Individual-level – working on the behaviors of individuals
  - Group-level – working with small numbers of individuals
  - Community-level – working with larger sectors of a community
  - Structural – working towards broad change
- **It is also clear that a variety of interventions can likewise have an even larger synergy**
  - Biomedical
  - Behavioral
  - Public Health Strategies

* Charania, MR et al. (2010). *AIDS Behavior, DOI 10.1007/s10461-010-9812-y*, p 2.
* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*
* McGough, LJ & Handsfield, HH, in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*

Newer Challenges – Viral STDs Including HIV

- **Bacterial STDs are curable – medicine can eradicate them**
  - However – some of the bacterial infections have become resistant to several antibiotics – particularly gonorrhea, as previously noted
- **Viral STDs are treatable – but not curable**
  - So, in addition to medical treatments – prevention of viral STDs involves behavior change, including
    - Protected sex
    - No sexual contact
  - This is true for all the viral sexually-transmitted infections
    - HIV
    - Viral Hepatitis (A, B, C)
    - Herpes Simplex Virus (HSV)
    - Human Papilloma Virus (HPV)
- **Some viral STDs are vaccine-preventable – these vaccines are both highly effective & safe**
  - Hepatitis A & Hepatitis B (HAV & HBV)
  - Human Papilloma Virus (HPV)

(continued)

* Bolan, GA et al. (2012). *NEJM, 366* (6) * CDC. (2010) STD Treatment Guidelines, *MMWR, 59* (RR-12)
* Curran, JW. (1996). & Satcher, D. (1996). *Public Health Reports, III* (S1) – **2 citations** * www.cdc.gov/vaccines/vpd-vac/default.htm
* St Lawrence, JS & Fortenberry, JD in Aral, SO & Douglas, JM (Eds). (2007). *Behavioral Interventions for Prevention and Control of STDs*

Newer Challenges – Viral STDs

- **In the past 10 years, rising concern about increased risk behaviors among persons with HIV have arisen**
  - Incident STDs (syphilis, gonorrhea) have increased among populations that also have high rates of HIV – many of whom were aware of their status – showing that the sexual risks have risen, which has contributed to increases in new HIV infections
    - This pattern has been seen in different populations, particularly MSM
  - The causes for these increases in STD rates have been attributed to various reasons, including
    - Compared to HIV, the perception of risk for STDs is generally much lower
    - Many STDs are perceived to be "curable" which means treatment is as simple as a "shot" or a "pill"
    - HIV Harm Reduction perspectives

* CDC. (2003). *MMWR,* 52 (15)
* CDC. (2007). *MMWR, 60* (11)
* Gilliam, PP & Straub, DM (2009) *JANAC, 20* (2)
* Janssen, RS et al. (2001). *American Journal of Public Health, 91* (7)
* West, GR et al (2007) *AIDS Education and Prevention, 19* (4)

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Newer Challenges – Viral STDs

- **Other causes for these increases in STD rates include**
  - The reduction in perception of risk or of the severity of HIV
  - Improved treatment & survival as well as quality of life for those living with HIV, related to
    - Antiretroviral medications (HAART) & less side effects,
    - Greater knowledge & technology for assessing patients (viral load & resistance testing, better understanding of immune status)
      - Undetectable Viral Load confusions
    - Those with HIV feel better than in past – life can continue including school, work, family, sex, &/or substance use
  - Prevention burn-out – often called "condom fatigue"

* CDC. (2003). *MMWR,* 52 (15)
* CDC. (2007). *MMWR, 60* (11)
* Gilliam, PP & Straub, DM (2009) *JANAC, 20* (2)
* Janssen, RS et al. (2001). *American Journal of Public Health, 91* (7)
* West, GR et al (2007) *AIDS Education and Prevention, 19* (4)

Newer Challenges – Viral STDs

- **Other causes for these increases in STD rates include**
  - Reluctance to disclose status – still associated with stigma, but is also associated with loss of relationships or sex
  - Perception that if a partner wanted condoms to be used – s/he would ask or insist
  - Younger at-risk individuals not being reached by old messages or the experiences of those in the early days of the HIV epidemic
- **There is an increased need for effective behavioral interventions for persons with HIV inside & outside the clinical care setting**

* CDC. (2003). *MMWR,* 52 (15)
* CDC. (2007). *MMWR, 60* (11)
* Gilliam, PP & Straub, DM (2009) *JANAC, 20* (2)
* Janssen, RS et al. (2001). *American Journal of Public Health, 91* (7)
* West, GR et al (2007) *AIDS Education and Prevention, 19* (4)

Newer Challenges – HIV "Prevention with Positives"

- **Several interventions for persons living with HIV have been developed & implemented – particularly for sexual risk reduction**
  - These interventions address these changes in risk perceptions associated with advances in HIV care
  - The focus on those with HIV is consistent with traditional public health infectious disease approach
- **DEBI menu now lists several for persons living with HIV**
  - Effective behavioral interventions – e.g., WiLLOW, CLEAR, Healthy Relationships, Partnership for Health
  - Public Health Strategies – e.g., CRCS, ARTAS
  - Several can be delivered to clients regardless of HIV status, e.g., Project START, SAFETY COUNTS

* www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm
* www.effectiveinterventions.org

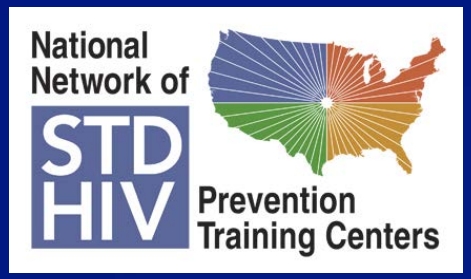
"Prevention with Positives" Examples All in the DEBI Project

- **Women Involved in Life Learning from Other Women (WiLLOW) [1]**
  - Studied women living with HIV – to improve support, coping skills, & to reduce sexual risk behaviors – a GLI
- **Healthy Relationships [2]**
  - Studied men (MSM & heterosexual) & women living with HIV – to improve coping & decision-making skills – GLI
- **Partnership for Health [3]**
  - Studied men (MSM & heterosexual) & women in HIV Care clinics – to reduce sexual risk behaviors – an ILI – to be delivered by medical providers

1. Wingood, GM. (2004). *Journal of Acquired Immune Deficiency Syndrome, 37* (S2)
2. Kalichman, S (2001). *American Journal of Preventive Medicine, 21* (2)
3. Richardson, JL et al. (2004). *AIDS, 18* (8)

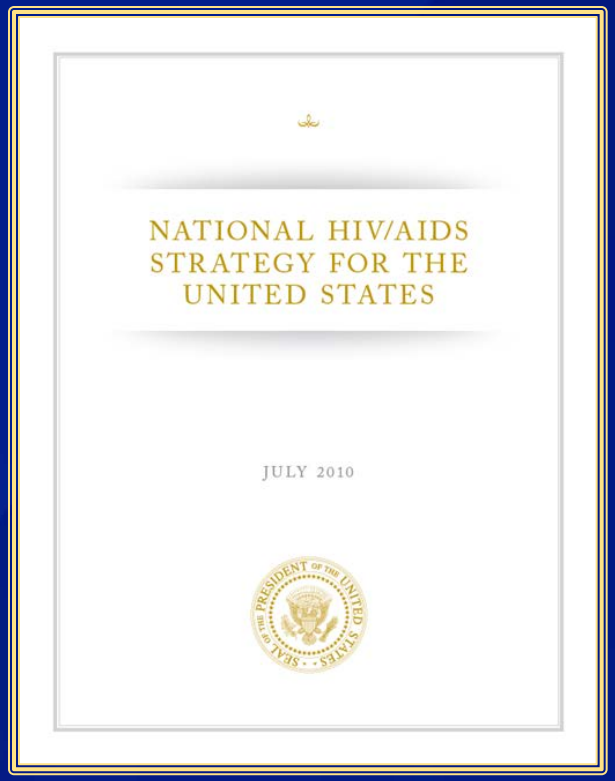
STD/HIV Prevention Behavioral Interventions

- **Proven effective behavioral interventions are available at Individual, Group, & Community Levels**
  - HIV & STD prevention
  - Healthcare seeking behaviors
  - Prevention for Persons Living with HIV



- **CDC continues the process of supporting the dissemination of selected interventions to clinical settings, community-based organizations, & other providers of prevention services, with increasing focus on working with those living with HIV**
- **Training offered by the NNPTC is part of this process**

* www.stdhivpreventiontraining.org



National HIV/AIDS Strategy for the United States

"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination." www.whitehouse.gov/onap

National HIV/AIDS Strategy

- **The National HIV/AIDS Strategy (NHAS) is an aggressive approach to changing the HIV epidemic – 4 goals**
  - Reducing New HIV Infections – by 25% by the year 2015
  - Increasing Access to Care and Improving Health Outcomes for People Living with HIV
  - Reducing HIV-Related Health Disparities
- **In order to achieve these goals – we need to work together in all service areas – NHAS objectives include**
  - Achieving a More Coordinated National Response to the HIV Epidemic in the United States
    - Integration of STD/HIV Care & Prevention is clearly a way to help reach this important goal – using combined behavioral, biomedical, & public health approaches

* www.whitehouse.gov/onap

Resources

- **Websites that can help you obtain more information about interventions & training, materials, & technical assistance (TA)**
  - CDC – general www.cdc.gov
    - National Network of Prevention Training Centers (NNPTCs) – www.STDHIVpreventiontraining.org
    - "DEBI Interventions" – www.effectiveinterventions.org, which also has information on training & TA
    - National Prevention Information Network (NPIN) – www.cdcnpin.org
  - HRSA – general www.hrsa.gov
    - HIV – http://hab.hrsa.gov/
    - AIDS Education & Training Centers (AETCs) – www.aidsetc.org
  - NIH – general www.nih.gov
    - AIDS Info – www.aidsinfo.org
  - White House – www.aids.gov