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WHAT'S COMMUNITY GOT TO DO WITH IT? IMPLEMENTATION MODELS OF SYRINGE EXCHANGE PROGRAMS

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Abstract

Syringe exchange programs (SEPs) have been shown to be highly effective in reducing HIV transmission among injection drug users (IDUs). Despite this evidence, SEPs have not been implemented in many communities experiencing HIV epidemics among IDUs. We interviewed 17 key informants in nine U.S. cities to identify factors and conditions that facilitated or deterred the adoption of SEPs. Cities were selected to represent diversity in size, geographic location, AIDS incidence rates, and SEP implementation. Key informants included HIV prevention providers, political leaders, community activists, substance use and AIDS researchers, and health department directors. SEPs were established by one or more of three types of implementation models: (a) broad community coalition support, (b) community activist initiative, and (c) top-down decision making by government authorities. In each model, coalition building and community consultation were critical steps for the acceptance and sustainability of SEPs. When others were not prepared to act, community activists spearheaded SEP development, taking risks in the face of opposition, but often lacked the resources to sustain their efforts. Leadership from politicians and public health officials provided needed authority, clout, and access to resources. Researchers and scientific findings lent force and legitimacy to the effort. Rather than adopting adversarial positions, successful SEP implementers worked with or avoided the opposition. Fear of repercussions and lack of leadership were the greatest barriers to implementing SEPs. Communities that successfully implemented SEPs were those with activists willing to push the agenda, public officials willing to exercise leadership,

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researchers able to present authoritative findings, and proponents who effectively mobilized resources and worked to build community coalitions, using persistent but nonadversarial advocacy.

To avoid acquiring and transmitting bloodborne diseases, persons who inject drugs need access to sterile injection equipment. Syringe exchange programs (SEPs) have been shown to be effective in reducing the sharing of syringes and the transmission of bloodborne infections among drug users without increasing drug use (Des Jarlais & Friedman, 1998; Normand, Vlahov, & Moses, 1995; Ruiz, 2001; Strathdee & Vlahov, 2001; Watters, Estilo, Clark, & Lorvick, 1994).

There are currently 209 SEPs in the United States operating in 36 states, Puerto Rico, and the District of Columbia (D. Purchase, director, North American Syringe Exchange Network, personal communication, October 17, 2002). Nonetheless, communities have varied widely in the extent to which they have implemented SEPs. Many still do not have SEPs that effectively provide syringe access to drug users in their areas.

There is often a lag between the emergence of research findings and the implementation of interventions in practice. Reasons include delays in the dissemination of research findings, lack of prioritization, lack of resources, and organizational and structural barriers. The National Institutes of Health (NIH) established the Consensus Development Program to overcome the lag in dissemination of new research findings. In 1997, the NIH Consensus Development Conference reviewed evidence of the effectiveness of HIV prevention programs and recommended three types of programs for IDUs: community—ased outreach, expanded syringe access (including SEPs and pharmacy sales), and expanded treatment for substance use (NIH, 1997). We undertook a study of 13 U.S. communities to better understand why some adopted these prevention programs and some did not. This article summarizes our findings from nine communities on their efforts to implement SEPs specifically, or their decision not to, and factors and conditions that contributed to the success or failure of SEP implementation.

METHODS

SAMPLING PLAN

From a larger study of HIV prevention interventions for IDUs in 13 cities, we selected nine cities that were diverse in size, geographic location, AIDS incidence rates, and adoption or lack of adoption of SEPs. We could not include all 13 cities in this analysis due to lack of data about their SEPs. The nine selected cities were Baltimore, Boston, Detroit, Honolulu, Nashville, Oakland, Seattle, Miami, and Newark. New York and Chicago were not included because the large size and volume of these exchanges are not typical of the majority of U.S. exchanges. The first seven cities listed successfully implemented SEPs, the last two did not. Key informants in each city included public health officials, HIV prevention and drug treatment providers, researchers, policy makers, staff of community—ased organizations (CBOs), and activists. We attempted to interview opponents of SEPs, but despite many attempted contacts we were not successful.

DATA COLLECTION

In the larger study from which these data are drawn, we conducted 49 qualitative telephone interviews about syringe exchange, community—ased outreach, and expanded substance use treatment with key informants in the 13 cities, from June 2000 through September 2001. Interviewers had extensive experience in qualitative interviewing and research methods. Interviews were tape—recorded and transcribed verbatim. Informants provided written consent before the interviews. In addition, existing archival data were collected on drug use, HIV prevalence, local HIV prevention plans, and news reports about SEPs in each city. Our goal

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was to identify factors that influenced whether a city initiated HIV prevention interventions for IDUs and whether their communities accepted or rejected them. For this report we analyzed 17 interviews from nine cities that focused substantively on syringe exchange.

DATA ANALYSIS

We used a grounded theory approach to analyze our data (Strauss & Corbin, 1990). The research team met regularly during data collection and analysis to review the audiotapes and develop an SEP narrative for each city. Through an iterative process of reading the data, creating theoretical memos, and rereading the data, we developed case studies describing the implementation of both successful and unsuccessful SEPs in each city (Stake, 1995). From these case studies we identified emergent themes in each city and across cities. We then compared and contrasted these findings to expand, clarify, and refine emergent findings. We integrated our themes to derive a more complete and accurate interpretation of the findings (Fielding & Fielding, 1986).

RESULTS

IMPLEMENTATION MODELS

We identified three SEP implementation models. SEPs were established by (a) community coalitions, (b) community activists, or (c) top down by government authorities. Establishing a successful SEP sometimes involved movement between different models at different times.

SEPs Established by Community Coalitions. SEPs were often instituted by coalitions of groups and individuals with similar goals who worked together to develop an SEP and to subsequently implement it with community support and official approval. Coalitions were created based on the premise that by combining efforts, resources, expertise, influence, and constituencies, SEPs could be sustained over a longer period of time. Coalitions were formed by political action groups, CBO staff, or public health officials and included a wide variety of health and social service agencies, community and church groups, neighborhood associations, and sometimes local political leaders and researchers. Although often a long and difficult process, coalition building allowed organizers to win support and approval from diverse organizations and individuals. Coalition building involved compromises that might have diluted the original intentions of the group but that resulted in wider community acceptance. Furthermore, coalitions typically had access to a greater variety of resources that could shore up SEPs and increase their sustainability. The community coalition model was characteristic of programs that were set up in Detroit and Seattle.

SEPs Established by Community Activists. Community activists played a part in all the implementation models, but in some cities they established SEPs independently. The illegal status of syringe exchange often served as an impetus for such groups rather than a deterrent. Several SEPs were started by AIDS activists from political groups motivated to challenge the treatment and marginalization of IDUs. Typically, community activist SEPs operated on a smaller scale and without any official approval from local authorities. Community activists were willing to be arrested, go against “the system” and confront public opposition. Because they had limited access to resources, power, and public legitimacy, activist SEPs were often vulnerable to criminal prosecution. Their strengths were a willingness to act when other groups would not and the ability to do so quickly. By contrast, action through broad community coalitions and government authorities was more protracted. SEPs in Boston, Detroit, Honolulu, Miami, Nashville, Newark, Oakland, and Seattle were all started by community activists. Efforts in Miami and Newark failed to get off the ground or to expand beyond a one—person operation serving a handful of clients. SEPs in Boston, Detroit, Honolulu, and Seattle were initiated by activists but quickly evolved into other models.

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SEPs Established Top Down by Government Authorities. State and local officials have the authority to develop policy, affect law enforcement, and fund, implement, and expand programs. SEPs established by elected officials or public health authorities had more access to political power and financial resources than did coalition— or activist—led SEPs. These officials often relied on the expert knowledge of researchers, which could further solidify the legitimacy of the SEP. Weaknesses of a top—down government—initiated model include the inability to quickly respond or to change due to the nature of large bureaucratic systems and susceptibility to pressure from community criticism.

SEP implementation in Baltimore, Boston, and Honolulu were characteristic of this model, and in all three locations SEPs remain viable and effective, continuing to expand and enjoy community support. Although they were sometimes hampered by their bureaucracies, that did not prevent them from becoming successful and finally winning community acceptance.

CRITICAL STRATEGIES AND RESOURCES FOR SUCCESSFUL SEP IMPLEMENTATION

We identified six key strategies and resources that characterize successful SEP implementation, regardless of which models were used: (a) staging the debate with sensitivity to political and cultural norms, (b) coalition building and community involvement, (c) leadership, (d) access to resources, (e) use of researchers and research findings, and (f) resisting fear of repercussions and political hostility. Effective knowledge and use of these, along with the ability to move from one model to another, contributed to the success or failure of syringe exchange in the cities we investigated. While some of these strategies and resources were integral to establishing SEPs, others were vital to sustaining effective programs.

1. Staging the Debate with Sensitivity to Political and Cultural Norms—Successful SEP proponents in our sample carefully considered the political and cultural norms in their communities when deciding whether and how to take their arguments for syringe exchange to the public. Different strategies were required in different cities to accommodate local sensibilities shaping the terms of public debate on substance use. In some cities, compassion for drug users was an accepted norm in public debate, whereas in others vilification was the only acceptable public attitude toward drug users. Even where community norms precluded public support for syringe exchange, however, SEP supporters who kept the debate out of the public realm could often accomplish a great deal. Often critical support could be obtained from policymakers if they were not forced to take a public stand in favor of syringe exchange. On the other hand, in places where concern about HIV transmission was the predominant community value, public sympathies could be used effectively to move syringe exchange forward. Strategies in different locations included (a) tailoring specific messages for different audiences, (b) debating the pros and cons of syringe exchange in an atmosphere of courtesy and respect toward all viewpoints, (c) tapping the support of a city's progressive political views, and (d) making use of behind—the—scenes support for syringe exchange from public figures who could not take a public stand on the issue. These widely divergent strategies were used successfully in different communities because they were adapted to fit the needs and norms of each particular city.

Custom—Designed Messages and Appropriate Messengers. The strategies used to advance syringe exchange in one successful city were shaped and controlled by a mayor who was not deterred by an earlier failed attempt to legalize syringe exchange. The mayor and the health commissioner were determined to legalize syringe exchange in their state. They identified their opposition early on, and they positioned syringe exchange in a way that addressed the different concerns of diverse groups, using language that spoke to the core values of each group. For law enforcement, they framed syringe exchange as a crime reduction measure. For state legislators, it was offered as a cost—saving measure. When making presentations to religious

groups, they used the language of the church and stressed the need to help the less fortunate. When the SEP legislation was sent to the state legislature, it passed on the first vote.

In addition to crafting carefully tailored messages, employing culturally sensitive and acceptable messengers was key. In another city that secured the backing of public leaders, the syringe exchange coalition flew in a council member of a distant city. This councilperson had initially been opposed to SEP but had “seen the light” and was invited to speak to the local city council as it weighed the issue. By contrast, in another city, an “out-of-town” AIDS activist organization attempted to launch a public education campaign to build awareness about syringe exchange. Although the organization worked with the community to get local resolutions passed approving syringe exchange, the effort was ultimately unsuccessful. The out—of—state activists made a presentation to a local city council, and though they gained the support of a few council members, they also faced criticism.

They weren't the right people for the job. They came in with their own agenda. What the agenda should have been was to educate people to make up their own minds, and letting people see what their own prejudices, preconceptions, etc. are...They had a forum and it didn't work because they didn't understand the local culture. They had a White guy from [anothercity]...and you can't do that [here], it doesn't work...you have to be very sensitive to what the issues are locally.

Open and Respectful Debate. In another effort, SEP strategists used community debates to deal with potential opponents. They organized community meetings to give community members time to air their concerns. SEP proponents made it a point to hear the concerns of the opponents respectfully and never discount or dismiss them. When concerned community leaders realized they would be heard and their needs would be addressed, their opposition was assuaged.

Tapping Progressive Community Norms. One group of activists used their city's politically progressive reputation as a starting point for the syringe exchange debate. Activists worked closely with health department officials, pushing them whenever the SEP became mired in the bureaucratic or collaborative process. Activists managed press coverage so that syringe exchange would be favorably presented to various communities. The health department had many supporters, including HIV prevention providers, the substance use treatment community, and local public health researchers, which enabled them to pass legislation legalizing syringe exchange with little political opposition. The city was able to maintain and expand SEP services and weave them into enhanced substance use treatment programs that were considered some of the most progressive in the United States.

Behind—the—Scenes Support From Public Officials. Another program had to take a very different approach. One SEP was started by an African American church using its own funds and existing HIV outreach services. The church had strong ties to the community and a long—standing reputation for serving marginalized populations. Their reputation as a community—ased service provider lent credibility to the program. They worked closely with local faith communities to gain popular support. They purposefully did not represent syringe exchange as a political issue, nor did they seek political approval or look for active collaborations with other organizations. Although there were some supporters on the city council, when an SEP funding matter came before the council for a vote, the measure was pulled for fear that it would be rejected and cause other members of the council, city health officials, and law enforcement to take a public stand for or against SEPs. The SEP proponents knew they would be able to gain tacit approval and a “gentlemen's agreement to look the other way” from various city officials, so they did not force these officials to take a public position.

There is an understanding that as long as we are consistent with adhering to the protocols we have developed and shared with the powers that be, that we would be allowed to continue and

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not have to deal with any repercussions. But it is clear that there are very conservative people in the community who would turn it into a public issue that would impede our being able to do the work if it became highly visible. So we work hard at keeping it as low key as possible.

Similarly, strategists in another city garnered support at the state level to quietly lobby the governor without asking him to openly support syringe exchange. By not forcing a public position, SEP proponents ensured that the governor did not publicly oppose the SEP. The same was true in yet another city whose mayor supported the SEP behind the scenes. In these cases of successful SEPs, some public officials were never asked to take a visible stand.

We have to remember to do harm reduction for people, and run interference for people who could lose their jobs, like elected officials. And when I first said that, people were like, ″Hmm, I never thought about it that way.″ But we were really careful not to put the mayor in an untenable position, which would force him to not do the right thing...It was not just ″Get out there, you be the front person, and you get out there talking about syringes and all that.″ We were real careful not to put him in a position that would make people around him say, ″Fool, do you want to lose the election?″

2. Coalition Building and Community Involvement—Key informants from successful programs believed that their SEPs were accepted in their respective communities because they had consulted with community stake-holders in the implementation phase. In many cities, approval from African American community leaders was considered critical given the opposition some SEPs encountered in African American communities. SEPs had been criticized for facilitating drug use among African Americans and perpetuating genocide through drug addiction. Despite frustration over how long it took to obtain community buy—in, this was outweighed by the advantages of including potentially high—profile detractors in the SEP implementation process.

One program was implemented through a coalition of community activists, community service providers, researchers, health department staff, and key political figures. Although it took almost 5 years to legalize SEPs, the volunteer activist exchange continued to provide syringes every week during this time. The representatives from the local health department provided legitimacy by certifying organizations that wanted to run SEPs. The coalition held a series of meetings with opponents and proponents together. When asked what factor was most critical to their success, one public official replied:The incredible amount of positive momentum that could happen when you have different branches, disciplines, all working together doing what they do best. There were some things that the community did, that we probably would not have been able to accomplish, like getting the city council that fired up and motivated and all of that...Quite honestly, I don't think that the community group would have been able to cause the legal department to sit down and work day after day after day on getting that ordinance rewritten.Another health department in a different city involved community stakeholders in choosing new SEP sites. They conducted formative research with IDUs to help design the site, and they went to neighborhood and business association meetings. Some CBO staff were frustrated with the time it took to establish new sites:When the city has gone to a new site, I can't think of a site they've opened in less than a year. They go in and they talk to everybody, they talk to the barbershops, they talk to the restaurants, they talk to the bars, they talk to the neighbors. And what that's meant is that they've been able to open each new site with a relative minimum amount of controversy and no press.

Frequently, persons we interviewed discussed the importance of continuing to work with the opposition rather than taking an aggressive approach. Across successful cities, key informants believed the SEP was successful because of the attention given to the opposition's concerns. Importantly, successful SEP groups did not try to work with those whom they believed were

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unalterably opposed to syringe exchange. Instead, they worked carefully with “fence sitters” or individuals who, though perhaps personally opposed to SEP, could be convinced not to block it. They tried to avoid polarization at all costs. In some cities this required avoiding community consultation, operating an SEP underground, avoiding press coverage, and keeping a low profile so that they would not encourage public opposition.

It's one of these things where we were trying to avoid getting into a debate about whether there should be a needle exchange program with people who really didn't want it. You know, when you get in those kinds of conversations with people who really don't care about what you care about, you're not likely to experience much success. So, the idea was to stop it, not to stop, but to avoid a sort of community consultation process, and just start the program, and hope it could operate underneath their radar. And then, of course, the other piece of that is it's harder to stop something that's already started, than it is to stop something that hasn't started.

3. Leadership—Some respondents considered leadership a key facilitator in establishing SEPs. In successful cities, even one or two leaders with access to local power and resources could make implementing an SEP possible. In several cities political leaders found there was greater public support for syringe exchange than initially perceived. Others found the community response benign, and through coalition building and a willingness to listen to community members they could easily allay local concerns.

Activists in one location decided that the most effective strategy was to enlist the state legislature to legalize SEPs. Not only did they enlist their state lawmakers, they targeted the most conservative state senator to convince him to back enabling legislation.

They also tried to get the legislators involved...they tried to get the legislators on their side. And they actually wooed the legislator that they thought they would have the most difficulty with getting a syringe exchange passed. And once this—and he was of course, he was a Republican. And they got this guy on their side. They convinced him of the need to have a syringe exchange. And once he fell into place, all the other lawmakers fell into place. So they actually got the legislators to decide to have one of these needle exchanges. And it happened statewide.

In another city, where syringe exchange was backed by strong leadership at the highest level, the program became more acceptable to various constituencies. Conversely, in another case the governor's clear and express opposition was instrumental in preventing SEPs from operating in that state. The governor's firm stance intimidated other public leaders from taking on the issue.

4. Access to Resources—Some activist organizations not only lacked resources but also lacked access to resources. Generally, the greater the access to resources that activists had from the outset or were able to harness, and the more they were able to align with city institutions, the more successful they were. The importance of financial and staff support is highlighted by one state, where AIDS activists launched a large statewide campaign. Although it enjoyed some success, eventually the group ran out of funding to sustain their efforts and closed their office.

SEPs require substantial funds for syringes, other harm reduction supplies, and staffing. Once it is implemented, demand for the service can quickly outgrow the pool of available volunteers and donated materials. To overcome this, the activists who initiated the SEP in one city decided they had to work with the health department despite their concerns about co—optation because they had quickly exceeded their financial capacity to sustain and expand services.

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Nonmonetary resources included access to local and state policy makers, law enforcement agencies, and public health officials. The ability of community activists to influence or negotiate with these decision makers facilitated the operation of their SEPs and lent legitimacy to their programs, which in turn increased public support.

SEP activities in one area were run by independent activists who were not affiliated with community groups and had limited resources and ability to reach a significant number of IDUs. The most active provider in that area, exchanged about 300 syringes a month in 2001.

5. Researchers and Research Findings—Research played a role in initiating and legitimizing SEPs. In many cities proponents used research findings about the spread of HIV among IDUs and the effectiveness of SEPs to garner support or to defend SEPs. Some activist—initiated SEPs included research evaluations in their programs to gain legitimacy with local law enforcement, politicians, and services providers.

If you looked at the first 15 or 16 needle exchange programs, they were all in places, like 14 of them, or 13 of them, were in places that have had NIDA [National Institute on Drug Abuse] outreach work going on. Now, not all of these NIDA researchers were involved with the needle exchange, or even supported it. But, you know, I think it sort of raised the level of awareness.

In one program, local researchers joined the SEP coalition and used findings and information from other SEPs around the country to develop a plan to gain support from the city council. They brought in prominent researchers from other locations to present findings to the council. After that presentation, all of the council members supported the SEP.

One mayor gathered syringe exchange data, which convinced him that a program needed to be implemented in his city. The next year he found sponsors for legislation and the first syringe exchange bill was brought to committee. An evaluation was tied to the legislation, which was one of the reasons it was so easily passed in the legislature.

It's also extremely well evaluated...The legislation had certain evaluation requirements built in. It's probably the best evaluated needle exchange program in the world. Every syringe that went out was bar coded for the first 3 years. So we know where every syringe went. Where it came back. We have the gold standard. We've been able to actually track how HIV prevalence in our client population compared to a very closely matched group of drug addicts who don't use needle exchange. So it's been (a) very well supported by the city and (b) very well evaluated. And because of both those things, it's been institutionalized.″

6. Overcoming Fear of Repercussions and Political Hostility—Informants in cities that did not have SEPs expressed fear of negative public reactions to syringe exchange as a key barrier to implementation. Some persons we interviewed could only identify a general feeling of trepidation and a sense that “it could never be done here.” Fears were wide—ranging, some based in reality and others on speculation. Public health workers feared losing their jobs, elected officials feared losing elections, and activists feared being arrested or having their property seized. Many informants feared the loss of funding for other programs for drug users. Fundamentally, most feared the consequences of challenging what they perceived to be a strongly conservative political climate. These fears created obstacles to establishing SEPs that were often greater than any organized opposition.

In one unsuccessful city, employees of HIV research and prevention programs working with drug users were afraid that if they tried to organize an SEP they would lose their funding:One of the things you have to remember about our research community is we had kind of a long relationship with the state.... And at the time we were doing research, we also had other

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contracts for delivery of services. And so..we were pretty loath to irritate the state...what we attempted to do was to advocate the state to at least change its policy to allow some limited needle distribution in places...And it simply died in committee.The city's public health department had also not made efforts to promote SEP, reportedly because it was illegal. The local government was considered very conservative and not supportive of HIV prevention activities among drug users.

The effort to establish a syringe exchange in another city was abandoned because of fears of arrest and the perceived lack of political support. A CBO gave lengthy and careful consideration to distributing syringe kits but ultimately opted not to because of concerns over losing already tenuous funding.

Some programs overcame a pervasive sense of fear and hopelessness. In cities where public officials, CBOs, and health department staff were paralyzed by fear, community activists were often effective in overcoming those barriers and starting SEPs. Arrest was often a real threat. However, sometimes the knowledge that they were facing this threat in order to save lives enabled activists to go out week after week.

It's a pretty remarkable process. And it was one that, for me, it was one of the best experiences...I've had a lot of good experiences in my life. But it was a great experience for me. It was almost spiritual. Being able to pull off something so audacious but so needed.

DISCUSSION

The nine communities we studied faced numerous obstacles to implementing SEPs, and artful maneuvering was often required to be successful. Communities that successfully implemented SEPs were characterized by the presence of willing providers and the use of effective strategies and resources. Community coalitions, community activists, and government authorities all had the potential to establish SEPs. The optimal model in any given city depended on local obstacles and opportunities, and often a combination of models or transition from one model to another was necessary to sustain SEPs over time. Community activists overcame the fear inhibiting some local authorities; coalitions worked to reverse negative public opinion; and, where possible, those in authority facilitated SEP legalization and brought financial and other resources to SEPs.

Regardless of which model was used, successful implementers were sensitive to the political and cultural dynamics of their communities as they attempted to get SEPs started. Individuals or alliances that did not recognize and accommodate the concerns of their neighbors, colleagues, or opponents could face insurmountable obstacles to implementing and sustaining an SEP. At the same time, successful programs did not succumb to the fear of public opinion and repercussions. Strong leaders were able to develop plans to accommodate a wide range of public opinion as a strategy to overcome opposition to SEPs.

Coalition building with a variety of community and church groups, neighborhood associations, political organizations, and other types of health and social service agencies enhanced the acceptance of SEPs by specific constituencies. Developing a process for community input and feedback ensured that community members were included in the siting and development of SEPs in their neighborhoods. Where community norms precluded an open process, community sensibilities were accommodated implicitly by keeping everything out of the public eye.

Community activists played a critical role by challenging inertia in communities that were not taking action. They took action themselves, risking arrest to start SEPs when government and community coalitions were engaged in a process that would require years before an operative SEP was established. However, activist organizations were often hard pressed to sustain the

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SEPs, and the most successful ones were able to garner additional resources or connect with other organizations that could sustain their programs. Syringe exchange would not have become so widely accepted were it not for research, which validated the role of SEPs in reducing HIV risk behaviors. Many strategies were used to deal with community opposition, and SEP architects struggled to find those that were the most appropriate for their region.

There are limitations to this study. In cities where SEPs did not exist, it was not usually possible to find people to talk about why programs did not exist. On the other hand, in cities that responded early in the HIV epidemic, many cutting—edge SEPs were developed, and people were eager to discuss their programs. Thus, more data were available from successful cities than unsuccessful ones. Given the small sample size and geographic locations of data collection sites, our data might not be applicable to some locations where SEPs were not developed. Also, because the key informants interviewed were drawn from a range of different types of informants, the differences in position might account for some of the findings of differences across cities. Additionally, because this research was conducted in the U.S., conclusions may not be applicable in other settings abroad.

Despite these limitations, several findings emerged from our data. Successful efforts to implement SEPs brought community groups together to accommodate local sensibilities, elicit community input, and make collective change. Successful communities exploited access to available resources and made use of local researchers and research findings. Individual leaders were pivotal in the success of many communities. Overcoming the fear of repercussions and strongly opposed political attitudes was often difficult but necessary in order to take action.

There is no one way to establish and maintain SEPs, but program developers, researchers, and community members need to understand how these models and strategies work with local dynamics before they begin the process of developing an SEP.

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