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CDC's dissemination of evidence-based behavioral HIV prevention interventions

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Abstract

The Division of HIV/AIDS Prevention at the National Center for HIV, Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention seeks to make evidence-based behavioral HIV prevention interventions (EBIs) accessible to HIV prevention providers through a systematic process of identification, packaging, and dissemination. This update synthesizes that process and describes recent efforts to expand the use of EBIs internationally through partnerships between the CDC's Global AIDS Program, academic research centers, and other international and US agencies.

Keywords

HIV, AIDS, Behavioral interventions, Dissemination, Diffusion, International, Evidence based, Global AIDS, Technology transfer, Translation

The Division of HIV/AIDS Prevention (DHAP) at the National Center for HIV, Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC) seeks to make evidence-based behavioral HIV prevention interventions (EBIs) accessible to HIV prevention providers through a systematic process of identification, packaging, and dissemination. This update synthesizes that process and describes recent efforts to expand the use of EBIs internationally through partnerships between the CDC's Global AIDS Program, academic research centers, and other international and US agencies.

This process of expansion relies on three interrelated projects: the Prevention Research Synthesis (PRS) Project, the Replicating Effective Programs (REP) Project, and the Diffusing Effective Behavioral Intervention (DEBI) Project. PRS identifies interventions that have been rigorously tested and have demonstrated efficacy in reducing HIV risk [1]. To date, more than 25,000 HIV research publications have been reviewed, yielding 69 interventions that meet DHAP's efficacy criteria: (1) strong evidence of efficacy in reducing risk behaviors for HIV and (2) evidence of effects lasting 30 days or longer to be considered a "promising-evidence intervention" and 90 days or longer to be considered a "best-evidence intervention" [2].

This commentary/editorial informs practitioners, policy makers, and researchers in the areas of HIV prevention, technology transfer, and dissemination science about the CDC's dissemination of evidence-based intervention in the USA and the diffusion of these interventions into international settings.

A subset of interventions drawn from promising- and best-evidence interventions was selected to develop user-friendly materials–including implementation manuals, evaluation materials, and training curricula–through the REP Project [3]. The DEBI Project was designed to move behavioral intervention packages into full-scale practice [4], through marketing, training, technical assistance, and capacity-building activities in partnership with a broad range of funders, trainers, capacity builders, and implementers. The 27 interventions disseminated [5] through this process are designed to reach various HIV risk groups including men who have sex with men, high-risk heterosexuals, drug users, and high-risk youth, with emphasis on subpopulations that have experienced disproportionate impact from HIV/AIDS.

The disease burden of HIV remains large in international settings with an estimated 33 million people living with HIV worldwide, 2.7 million people newly infected in 2007, and two million deaths due to consequences of AIDS in 2007 [6].

The DEBI project is aimed at building the capacity of domestic US HIV prevention providers to implement EBIs; the resulting materials can also be shared with international agencies and partners. Dr. Kevin Fenton, NCHHSTP Center Director, has encouraged international HIV prevention agencies and their funders to consider the CDC's menu of EBIs when selecting interventions for their local prevention needs [7]. An underlying assumption of this transfer is that EBIs tested in industrial developed countries may be applicable, with adaptation, to the HIV epidemic in developing countries.

Over the last 4 years, a range of potential international adopters and funders have contacted DEBI project staff, requesting assistance around evidence-based behavioral HIV interventions.

Requests have been made for intervention materials, training, technical assistance, capacity building around evidence-based prevention practice, and assistance in selecting prevention interventions to meet the needs of individual communities. The DEBI project makes intervention materials available free to domestic US HIV prevention providers, and these materials have been downloaded from the DEBI website by prevention providers in over 67 countries [5]. We have been able to link agencies who provide training and technical assistance on EBIs in the USA with many international providers and funders. For example, the Community Wellness Project in St. Louis, which provided EBI training and technical assistance to agencies serving young sexually active women, was linked with a group in St. Kitts, which was funded by grants from the British Health Ministry. Consultations have also taken place to help foreign health ministries and various US agencies select appropriate interventions for targeting particular epidemiological risk profiles. For example, the CDC's Global AIDS Program sponsored a consultation in the Dominican Republic with representatives of community-based providers, substance abuse treatment providers, and correctional medical services which resulted in selection of several EBIs that may be adapted for the Dominican Republic. Training on these selected EBIs began in February 2011.

In addition to training on specific EBIs, training and capacity building around bridging theory to practice, selecting an appropriate EBI, and developing a continuum of prevention services are found to be useful among US prevention providers and are typically suggested when EBIs are being considered for international implementation. The CDC's Global AIDS Program has used these training courses in a nine-country Southern Africa initiative to prepare providers and funders for movement toward evidence-based HIV prevention.

The sharing of behavioral intervention technology is intended to be a two-way street. When we have shared intervention materials and training curricula for use in international settings, we often ask to receive culturally and linguistically translated materials for use with local immigrants from that country.

Some intervention activities that are appropriate for US populations must be adapted for international settings. The DEBI project encourages adaptation of EBIs for local communities in the USA; use in international contexts usually requires more extensive adaptation.

Interventions developed in the USA and adapted for international settings and populations require evaluation to inform program improvement. Formative evaluation is required to adapt the intervention, process evaluation is required to determine reach of the program, and outcome monitoring is required to determine whether desired outcomes were obtained.

Through a partnership between the DEBI project and the CDC's Global AIDS Program and other international funders, many DEBI interventions are being implemented in Angola, the Bahamas, Botswana, Brazil, Canada, Dominican Republic, Ethiopia, Ivory Coast, Kenya, Mexico, Montserrat, Mozambique, Namibia, St.Kitts, South Africa, Tanzania, Uganda, Zimbabwe, and Zambia.

Conflicts of interest: The findings and conclusions in this report are those of the author and do not necessarily represent the views of the Centers for Disease Control and Prevention.

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