INTRODUCTION

PROVISIONAL PROCEDURAL GUIDANCE FOR COMMUNITY-BASED ORGANIZATIONS

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ABOUT THE PROCEDURAL GUIDANCE

From the beginning of the HIV/AIDS epidemic, the Centers for Disease Control and Prevention (CDC) has worked with its partners to help stop the spread of HIV. Staff members have worked tirelessly on national, state, and local levels and have had much success. Today, HIV treatments can help improve the lives of those with the disease, and more information is available on how to help prevent the spread of HIV.

The number of new HIV diagnoses went down until the 1990s. Since then, the number has stayed at about 40,000 each year. Data from 33 states from 2001 through 2004 show that overall, except among men who have sex with men, the number of new HIV diagnoses is remaining stable. However, studies show that some people are putting themselves and others at risk by not taking steps to reduce their risk of getting HIV. In 2000 and 2001, the number of cases of syphilis went up, after 10 years of fewer cases.

In April 2003, CDC launched Advancing HIV Prevention: New Strategies for a Changing Epidemic (AHP). AHP supports HIV prevention work being done now, but also brings new tools (such as rapid HIV testing) and methods to meet the needs of persons living with HIV. The goals of AHP are to increase the number of persons living with HIV who know that they are infected and to give them and persons at high risk for HIV infection the best tools we have for staying healthy and reducing the chance of giving HIV to others or getting the disease.

AHP is designed to

- increase early diagnosis
- improve referral to prevention services, medical care, and treatment
- put programs in place to help persons living with HIV

The interventions and strategies in this guide give you information on programs that can help your community-based organization (CBO) provide services under the recommendations of AHP.

Why Was the Guidance Written?
The Procedural Guidance (the Guidance) gives information to help CBOs come up with a plan for delivering interventions.

It will help you design prevention programs and recruitment strategies to promote counseling and testing, health education and risk reduction, and other prevention services; counseling, testing, and referral strategies; and interventions to help prevent the spread of HIV to meet the needs of persons living with HIV, their partners, and other persons who are not HIV infected but are at very high risk for HIV.

The Guidance does not give all of the information you would need to design, deliver, and monitor the interventions. CDC will help you with more training and technical assistance. Information about the interventions is available at www.effectiveinterventions.org. Other information is being developed. If your CBO cannot handle an intervention by itself, you can ask another CBO to partner with you.

The Guidance and intervention kits produced by the Replicating Effective Programs (REP) project and distributed by the Diffusion of Effective Behavioral Interventions (DEBI) project are the best science we have today to improve HIV prevention efforts.

REP helps make HIV prevention interventions that have been shown to work more accessible. They use everyday language and are packaged in a user-friendly way.

DEBI is CDC's national project that provides training and technical assistance for health departments and CBO staff who are conducting evidence-based interventions to prevent HIV, viral hepatitis, and sexually transmitted diseases.

How is the Guidance Organized?
Each intervention is organized under the following subheadings:

- Description
- Core Elements, Key Characteristics, and Procedures
- Adapting
- Resource Requirements
- Recruitment
- Policies and Standards
- Quality Assurance
- Monitoring and Evaluation
- Key Articles and Resources
- References

MAKING THE INTERVENTIONS WORK FOR YOUR CBO (ADAPTING)

When HIV was first identified, ways in which the disease was spread were also identified. Since that time, much effort has been made to develop interventions to prevent others from getting the disease. These efforts led to the development of a number of evidence-based interventions for persons who do not have HIV or whose HIV serostatus is unknown. Interventions are now offered for a variety of populations and settings. Because of this, more persons who have HIV are receiving their diagnosis earlier in their infection. As a result of better treatments, these persons are living longer and healthier lives. This has increased the prevention needs of persons living with HIV and the attention given to these needs. A number of interventions that have been shown to work are available to address the strategies of AHP; others are being tested.

The interventions in the Guidance are based on theories of behavior change that can be applied to many behaviors and populations. Because of this, interventions can be adapted to meet the specific needs of groups that were not part of the studies done so far. Adapting these interventions will show success if changes made are based on the known needs and special conditions of the population with whom the work is to be done. When adapting, you can modify key characteristics (**but not core elements**) to meet the needs of your CBO or target population. Core elements and key characteristics are explained for each intervention.

About formative evaluation

Before adapting an intervention, you must first do what is called formative evaluation. This type of evaluation will help you know more about the group you are trying to reach, their culture, risk behaviors, and other factors that put them at risk for HIV infection.

Following the steps of a formative evaluation can help you find answers to questions about which population is most appropriate for the intervention, what location is best for the intervention, what message(s) you need to be giving, and how best to deliver the messages and time your intervention to have the best chance of reaching the target population.

You must find out whether risk determinants that were used in an intervention that has been shown to work apply to your new target population.

> **Example:** The SISTA intervention has shown that African American women must have open discussion with their male sex partners to get these partners to use condoms. To use SISTA to reach Hispanic women, you would have to assess whether this type of discussion with male sex partners makes sense in this population.

Steps of formative evaluation

1. Interview community gatekeepers and stakeholders.

a. Determine whether an intervention can be done successfully in the group you are trying to reach by talking with the community gatekeepers and stakeholders.

> **Example:** For Popular Opinion Leader (POL), an intervention with men who have sex with men, you might interview owners of gay bars to be sure that they agree with the intervention, will allow the intervention to take place in their bars, and will support their employees in helping to identify opinion leaders.
>
> **Example:** For SISTA, you might need to interview the managers and guards of county and city jails to make sure that they are comfortable with the intervention being done in their facility.

b. Check to be sure they believe the service is needed.

> **Example:** For Safety Counts, community leaders and those who have an interest in the program may ask, "We already have street outreach. Why do we need another intervention in our community for drug users?" Your staff could then explain, "Safety Counts is an intervention that works with injection drug and cocaine users to get them into prevention counseling, rapid testing, partner services, individual- and group-level interventions, medical services, and support-focused social events. Safety Counts is a specific outreach method with specific goals and is a new type of outreach and may not have been done before in your community."

2. Conduct focus groups to learn what issues are most important to members of your new target population and their community. If what you find is similar to what was found in the original evidence-based intervention, then the intervention may be the one to choose for adapting. The focus groups must also discuss all the core elements of the original evidence-based intervention. Several focus groups may be needed in order to look at each core element.

> **Example:** MPowerment, an intervention for young gay men, has 9 core elements, of which 5 are listed below and could be explored using focus groups.
>
> - Recruit and maintain a core group of 12 to 20 young gay and bisexual men to design and carry out project activities.
> - Conduct formal outreach, including educational activities and social events.
> - Conduct informal outreach to influence behavior change.
> - Convene peer-led, 1-time discussion groups (M-groups).
> - Conduct a publicity campaign about the project within the community.

Focus groups should find out whether each of the core elements of the evidence-based program is doable and appropriate for the new target population and settings.

3. Develop a logic model, a plan (often shown in a flow chart or table) that shows a sequence of activities that will be used to address a problem statement. These activities are then linked to measurable outcomes that show reduced HIV risk.

Your logic model should fully describe the core elements of an intervention or strategy and how these activities work together to help prevent HIV. All intervention activities, based on the core elements of the intervention, should address the problem statement and be linked to clearly stated and planned results of the activities.

Your logic model also needs information for each of the core elements of the intervention. This means that you need to find all of the resources you need to do an evidence-based intervention. Resources include

- Enough people involved (employees, managers, and volunteers)
- Supplies
- Costs for site to be used
- Travel costs
- Incentives
- Ability to develop materials

When putting together your logic model, look at the changes in behavior that happened as a result of the original research done on the intervention. Be sure that the activities in your adapted program are designed to get the same or better results.

> **Example:** Street Smart was able to get more homeless and runaway adolescents to use condoms after 8 intervention sessions. To get similar outcomes in an adapted program, you must be willing and able to provide a similar number of sessions (8 sessions) to your new target population.

4. Pretest your intervention materials with a Community Advisory Board. Pretesting ensures that the materials are right for the population and meet the needs of the population. Explore things such as

- reading level of the target population
- community values and norms
- attractiveness of materials
- whether the messages and instructions are understood and can be remembered by the new target audience

5. Pilot test to check how the intervention works in a small subgroup of the population you will serve. Pilot testing shows the usefulness of the adapted intervention.

Individual- or group-level interventions can be divided into small pilot tests of each core element. Later, the entire intervention, including all core elements, can be pilot tested.

> **Example:** For SISTA, 1 group-level session addresses gender and ethnic pride for African American women. To adapt the

intervention for Hispanic women, you will need to test this session with a group of Hispanic women before carrying out the intervention on a larger scale.

Community-level interventions are hard to pilot test as a full intervention; however, core elements can be pilot tested.

> **Example:** For Community PROMISE, peer advocates hand out role model stories to members of the target audience. Before having all of these stories handed out in the community, you may want to pilot test them by having a small group of peer advocates hand out just 1 role model story. This will help you find out how best to do this activity on a larger scale.

Choosing an appropriate population is the first step to adapting an intervention. After that, messages and strategies can be changed to help persons change behaviors that put them at risk. Also**,** the setting for the intervention needs to be chosen. This will help you know how to deliver the intervention.

> **Example:** The Popular Opinion Leader intervention was first designed to reach gay men in bars. This intervention was changed successfully for use with African American women in an urban housing project.

> **Example:** VOICES/VOCES was first tested in sexually transmitted disease clinics but has been found to also work with persons in drug treatment settings.

ENSURING CULTURAL COMPETENCE

Individuals and groups can differ in ethnicity, gender, age, sexual orientation, and language. Their experiences may cause cultural variations that support these differences. It is important to look at the meaning of cultural variations when setting up and delivering your programs and services. Having an intervention delivered by a member of the target population does not mean it will be appropriate or successful. Reaching a population means understanding the culture of the population. Cultural competency is important for your intervention to be successful.

To make your intervention successful, you need to know the health needs of the persons you are trying to reach, as well as their cultural experience. This is a first step to a culturally competent program.

In 2001, the Office of Minority Health (OMH) in the Department of Health and Human Services published national standards for delivering services that reflect a group's culture and language. This is referred to as culturally and linguistically appropriate services (CLAS).

To be culturally competent, a person must

- value the differences between persons and groups
- understand any negative feelings against a group
- be aware of what happens when different cultures come together
- make the knowledge of a culture a part of oneself
- make changes as necessary guided by what is needed to reach diverse groups.

The Office of Minority Health began by defining cultural competence as follows:
A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.
Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ***Competence*** implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Office of Minority Health Standards for Measuring Cultural and Linguistic Competency

- Ensure that clients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural beliefs and practices and preferred language.

- Implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

- Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically *appropriate* service delivery.

- Offer and provide language assistance services, including bilingual staff and interpreters, at no cost to each client/consumer with limited English proficiency at all points of contact in a timely manner during all hours of operation.

- Provide to clients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

- Ensure the competence of language assistance provided to limited English proficient clients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the client/consumer).

- Make available easily understood, client-related materials, and post signage in the languages of the commonly encountered groups and/or groups represented within the service area.

- Develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically *appropriate* services.

- Conduct initial and ongoing organizational self-assessments of CLAS-related activities. [Organizations] are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

- Ensure that data on the individual client's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

- Maintain a current demographic cultural and epidemiologic profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area (the HIV prevention community plan and other sources of relevant information).

- Develop participatory, collaborative partnerships with communities, and utilize a variety of formal and informal mechanisms to facilitate community and client/consumer involvement in designing and implementing CLAS-related activities.

- Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by clients/consumers.

- Regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards, and provide public notice in (the organization's) communities about the availability of this information.

KEY ARTICLES AND RESOURCES

CDC. Advancing HIV prevention: new strategies for a changing epidemic. MMWR. 2003;52:329–332. Also available at: http://www.cdc.gov/hiv/partners/ahp.htm.

CDC. Diffusion of Effective Behavioral Interventions (DEBI) project. Available at: http://www.effectiveinterventions.org.

CDC. Replicating Effective Programs (REP) project. Available at: http://www.cdc.gov/hiv/projects/rep/default.htm.

US Department of Health and Human Services, Office of Minority Health. National standards for culturally and linguistically appropriate services in health care. Washington, DC: US

Department of Health and Human Services; 2001. Available at: http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.

US Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute, Office of Cancer Communications. Making health communication programs work: a planner's guide. Washington, DC: US Department of Health and Human Services; April 1992. NIH Publication No. 92-1493. Available at: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051.