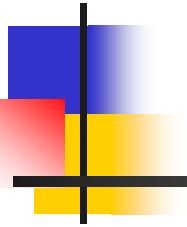
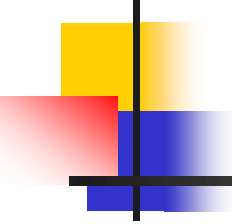


Some limitations of RCTs as the standard of evidence in HIV prevention research

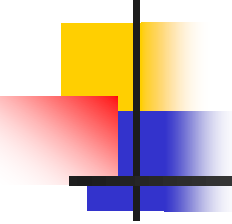


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Six Important Evaluation Questions (a brief reminder)

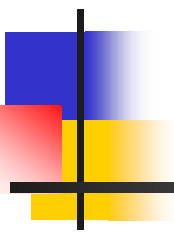
- Is it feasible and sustainable?
- Is it acceptable?
- Is there behavior change?
- Is change attributable to intervention?
- Mechanisms of change?
- For whom does it (or does not) work?



TWO MODELS OF HIV PREVENTION

- CHANGING “RISKY” BEHAVIOR
 - Risk is “within” the individual
 - Top-down, based on academic models of behavior change
 - Seeking a “conversion” experience, from risky to safe, sinner to saint
 - Short-term
 - Unprotected sex is risky sex
- SUSTAINING SAFE BEHAVIOR OVER TIME
 - Risk is a property of structurally produced contexts and situations
 - Community organizing approaches
 - Promoting access, connection, and participation in healthy contexts
 - Long-term
 - Protected sex over time is heroic and must be supported

DEBI: UNINTENDED CONSEQUENCES

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- *Applied problem: Privileging one model of prevention
 - *Scientific problem: Privileging internal over external/ecological validity
 - *Silencing community wisdom
 - *Good Workers = faithful to protocols
 - *Non-responsive to changing circumstances



Learning from long-standing reputationally-strong interventions

- *Hermanos de Luna y Sol (MNHC)*
- *Black Brothers Esteem (SFAF)*



Learning from long-standing reputationally-strong interventions

- Long-standing, slowly built trust
- Varied menu of possible activities
- Participant-driven choice of intervention modality and timing
- Peer-led, “our program”
- “Belonging” to an organization versus “participating” in a program
- One-stop shop/ takes into account other and more immediate life priorities
- Sustained presence over time
- Staff charisma is key