Project Eban: A Giant Step Forward

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Substantial progress has been made in the United States since the 1980s in the prevention and treatment of HIV/AIDS, but socially disadvantaged racial/ethnic populations are increasingly bearing a disproportionate share of the burden of this disease. The black or African American population, in particular, is losing ground in the battle against the HIV/AIDS pandemic. Blacks currently have the highest HIV/AIDS infection rate—a rate 8.5 times higher than that of whites. The problem is particularly salient among African American women among whom AIDS is one of the leading causes of death and where the majority have acquired their infection through heterosexual contact. Among persons diagnosed with AIDS, blacks have poorer survival than whites, Hispanics, or Asian Pacific Islanders. Although African Americans are only 13% of the US population, they are 51% of newly diagnosed cases, 65% of infants perinatally infected, 68% of children under 13 with an AIDS diagnosis, and 66% of all 13–19 year olds with AIDS. African Americans are similarly overrepresented in infections rates from other sexually transmitted infections (STIs) where they have the highest rates of Chlamydia, gonorrhea, and syphilis, and in 2008, nearly one half of all African American teenage girls aged 14–19 years were infected by an STI.

More research is needed to fully elucidate the determinants of excess risk among African Americans. Although it is clear that the patterns of HIV risk among African Americans are distinctive, much is yet to be understood regarding the ways in which the economic context of the black population combines with psychological, cultural, historical, and social factors to affect patterns of HIV transmission and risk. However, even more urgently, we need a new generation of HIV prevention interventions that are designed to reduce HIV/AIDS risks for African Americans. The prevention and intervention approaches that have led to reducing the spread of HIV among white homosexual males have been less successful among African Americans and Hispanics. There is thus an urgent need for HIV prevention interventions that are grounded in our current knowledge base and seek, in a more comprehensive and innovative fashion than most prior efforts, to effectively address HIV/AIDS prevention in the black community. This is exactly what Project Eban has attempted to do.

There are several aspects of this study that are noteworthy and relevant for the design of future interventions with socially stigmatized and disadvantaged populations across multiple racial/ethnic populations and health conditions. First, the Eban project was successfully implemented in a hard-to-reach population group that is difficult to follow over time. In general, serodiscordant couples’ studies are difficult to conduct, and given issues related to social marginalization, generally low income and education, and limited connections to health care and employment, conducting such a study among African Americans (the first of its kind) was particularly challenging. This population tends to be characterized by high levels of comorbidity of other illnesses and/or substance abuse and elevated exposure to a broad range of social stressors including being in and out of jail or prison. This is the type of target population that some researchers fail to study precisely because the task seems too difficult. The challenge of identifying and tracking participants despite their fragile living circumstances and social adversity is a difficult one, which taxed the organizational and financial resources of the study team. Nonetheless, the successful implementation of the intervention demonstrates that it is not an impossible task when both funders and researchers are committed and allocate the needed resources.
Second, the study was designed and implemented by a multidisciplinary group of researchers that was disproportionately made up of investigators who combined their research expertise of studying the African American population with their personal experience of being African Americans themselves. Third, and relatedly, the intervention was designed to be culturally congruent and incorporated the strengths of many aspects of African and African American cultural values as key building blocks. With creativity and sensitivity and an enormous amount of formative work, the curriculum addressed health disparities, racial and sexual minority discrimination, and misconceptions and stigma about HIV transmission. For example, in one group exercise, HIV-negative partners formed an inner circle with a facilitator and described what it was like to live with an infected person whereas the HIV-positive partners listened from an outer circle. The members of the circles then traded places so that each serodiscordant couple had the opportunity to hear what the other partner was experiencing without the feelings and concerns being individualized. Facilitators would then draw out the major points that were discussed. This allowed couples, who are often isolated and ostracized from their families, religious institutions, and communities, a unique opportunity for open and meaningful dialogue and understanding in a supportive context where they did not have to worry about hurting each others’ feelings.

Fourth, the Eban Project focused on couples in a committed relationship. In contrast, most behavioral interventions tend to focus on individual behavior and seek to modify individual risk. The couples recruited were in a relationship for at least 6 months. Given this, almost certainly the study recruited couples who were biased towards a willingness to change. Nevertheless, this allowed the intervention to focus on the context of risk for individuals who identify as committed to each other, but where one partner is infected and the other is not. The study of this group can also help to reshape some of the negative stereotypes of HIV-infected individuals and their partners. The study offered glimpses of stable and loving couples who are struggling with a chronic rather than life-threatening disease but who nonetheless attempt to maintain love, romance, health, and dignity. The study delivered a prevention message that was consistent with staying together and staying healthy.

Fifth, the study was conducted in 4 different cities, each with high seroprevalence rates but with variation in the most common pathway to infection. It provides a unique opportunity to monitor the success of the intervention across diverse communities. Finally, the intervention recognized that HIV prevention efforts must be understood within the context of elevated exposure to other STIs as well. An important component of the intervention was to teach couples how to prevent STIs and enhance their awareness of the importance of treating them. Couples were treated for 3 STIs (Chlamydia, gonorrhea, and trichomoniasis) that were also monitored as study outcomes.

Project Eban was not a perfect study. Its findings will not be generalizable to all infected individuals or couples, but it broke new ground in many important ways and raises a high bar for future efforts that seek to effectively address disparities in HIV/AIDS and a broad range of other health outcomes in socially disadvantaged populations. It is also fertile ground for a new set of research questions. How can the core ideas here be adapted to other vulnerable subgroups within the African American and other populations?

Most importantly, however, at this point we are only certain that Project Eban was implemented successfully and that the chance of a positive effect seems high. However, the results are not in. Once they are, we can consider which components of the intervention are most effective and which aspects of cultural adaptation, if any, are necessary for the success of the intervention. There is much that we still need to learn about the optimal components of successful interventions and the conditions under which they are more or less likely to have maximal effects.

REFERENCES