WHAT WORKS

IN HIV PREVENTION for women of color

until it's over
AIDS ACTION

What Works in HIV Prevention for Women of Color is a product of AIDS Action.

What Works in HIV Prevention for Women of Color is the fourth in a series of prevention guides. Others in the series include what works guides for gay men, substance users, youth, and incarcerated populations.

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AIDS Action is the national voice on AIDS. We are committed to advocating for people affected by HIV/AIDS "Until It's Over" — until no more people become infected with HIV, until people living with HIV have the care and support they need, and until a cure is found.

For additional copies please contact

AIDS Action
1906 Sunderland Place, NW
Washington, DC 20036
Phone: (202) 530-8030
Fax: (202) 530-8031
E-mail: network@aidsaction.org
www.aidsaction.org

WHAT WORKS IN HIV PREVENTION for women of color

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chapter 1

INTRODUCTION

The demographic profile of the AIDS epidemic has steadily changed over time, and HIV prevention messages must keep pace with these evolving trends. HIV and AIDS cases continue to rise among women of color. The Surgeon General projects that 80 percent of women newly infected with HIV will be African-American or Latina. These sobering figures suggest a disconnect between existing HIV prevention efforts and women of color at-risk for HIV. A variety of cultural, economic, biological, and political variables shape women's experiences, and a comprehensive understanding of these complicated factors is necessary to stem the rising tide of HIV infections among women, especially among women of color. Acknowledging complex social issues in comprehensive HIV prevention programs for women of color requires careful attention to stereotypes about HIV and women. Women do not respond uniformly to gender-based prevention messages, as gender is one issue for women to consider in addition to social, cultural, and economic factors. Even so, women of the same race or ethnicity may respond to prevention messages differently based on their country of origin, socioeconomic status, sexual orientation, and other personal factors.

This guide is intended as a resource for community-based organizations (CBOs) hoping to expand or improve their HIV prevention services to women of color. It describes the theoretical foundations of targeted HIV prevention interventions as well as the practical experiences of organizations successfully fighting HIV infection among women of color. The CBOs described in this guide have developed and utilized effective HIV prevention strategies for women of color. These programs provide examples for other organizations seeking to prevent HIV infections among women of color.

Chapter Two discusses the epidemiology of HIV and AIDS among women of color in the U.S. today. Subsequent chapters examine factors that may contribute to the increasing number of HIV infections among women of color and look at critical modifications to prevailing HIV prevention theories. Finally, Chapter Four describes community-based programs tailored to the HIV prevention needs of women of color and provides contact information for the profiled community-based organizations.

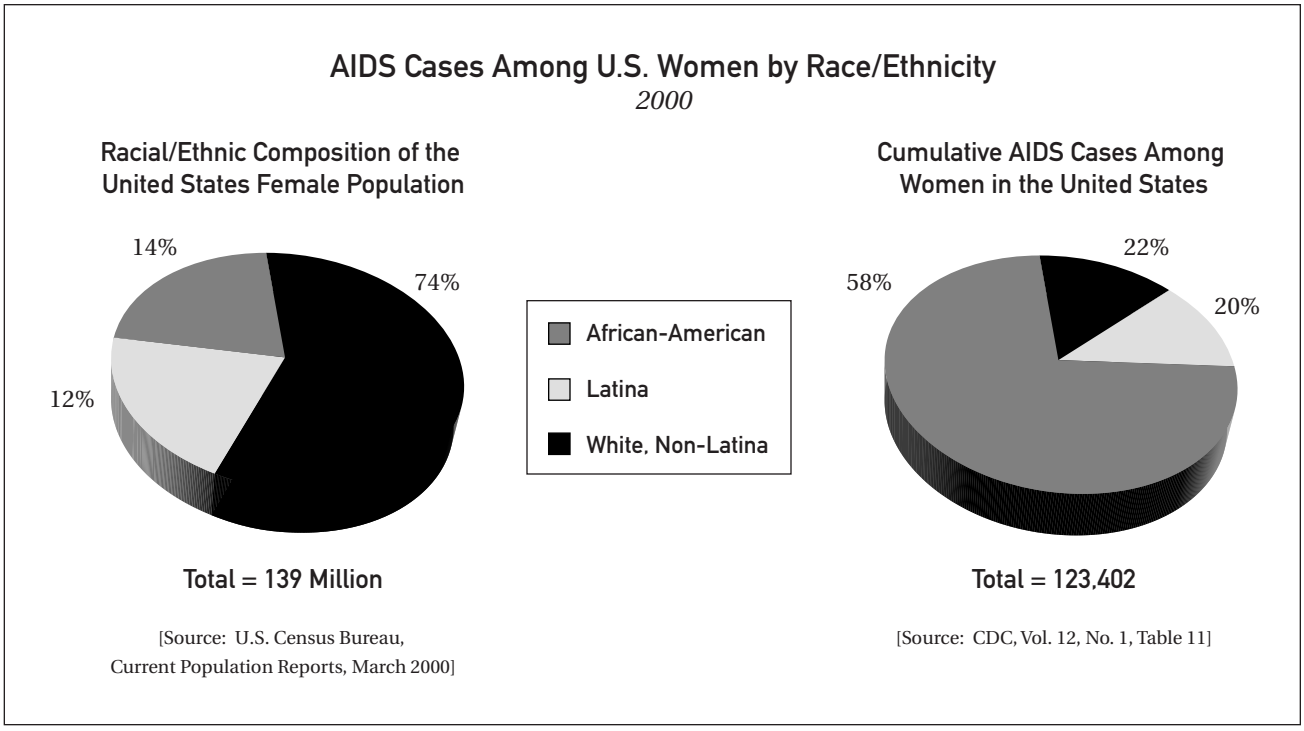
chapter 2

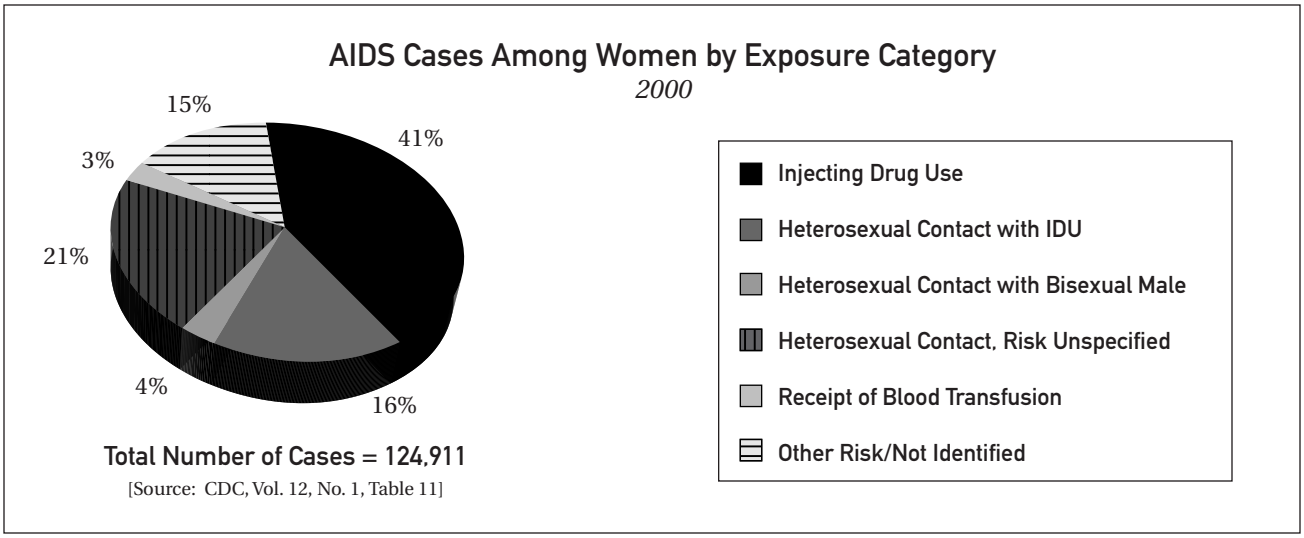
HIV/AIDS AMONG WOMEN OF COLOR

Addressing the HIV prevention needs of women of color in a sustained, targeted fashion is long overdue, given HIV infection data and trends that highlight the disproportionate burden of infection found among women of color. Women of all races and ethnicities share certain vulnerabilities to HIV infection relative to men, as transmission of the virus is biologically more efficient from men to women. Even so, women of color are disproportionately at risk. In 1999, an estimated 23 percent of new AIDS cases were identified in women, and women now account for 18 percent of total AIDS cases, almost three times the prevalence rate identified by the Centers for Disease Control and Prevention (CDC) fifteen years ago (Hader et al., 2001). In addition, disproportionate rates of HIV infection are found among those with common cultural backgrounds, socioeconomic status, age, or geographic locale. All of these factors must be accounted for in the development and delivery of HIV prevention messages that resonate with women of color.

The Relative Impact of HIV

AIDS was the fifth leading cause of death for all women age 25 to 44 in 1998 (Hader et al., 2001). Among African-American women in the same age group, however, AIDS was the third leading cause of death. The disproportionate number of AIDS cases among women of color as compared to their representation in the female population of the United States is compelling evidence of the scope of the problem.





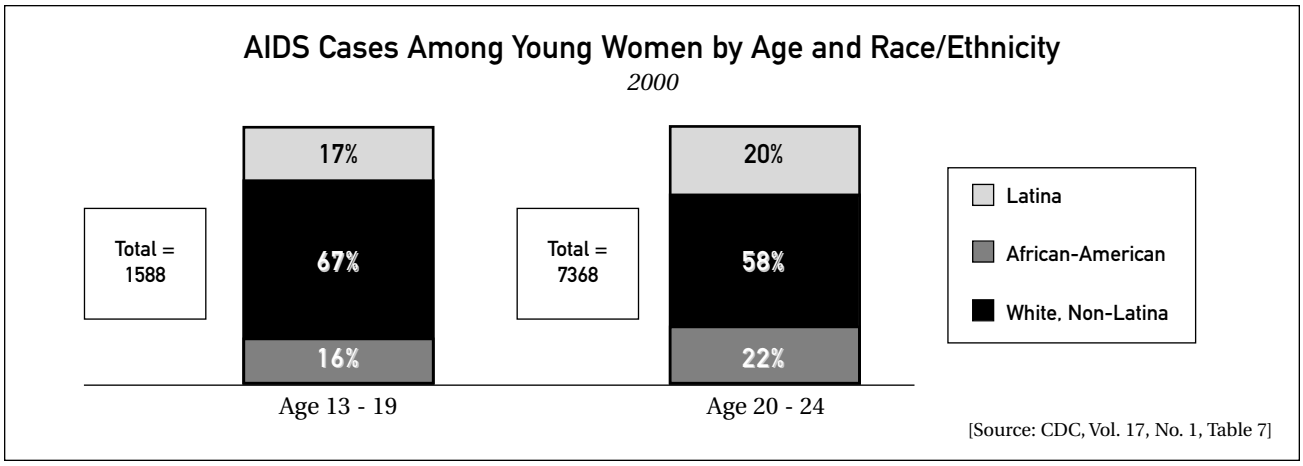
While African-American women represent 14 percent of the U.S. female population, they account for 58 percent of cumulative AIDS cases. Between 1998 and 1999, 63 percent of new AIDS cases among women were identified in African-American women. A similar imbalance holds true for Latina women who represent 20 percent of cumulative AIDS cases, yet comprise only 12 percent of the female population. These racial and ethnic disparities parallel broader disparities in health status by race and ethnicity in the U.S. that have been widely documented.

Risk Factors for Women Living with HIV and AIDS

By and large, it is heterosexual contact and injection drug use that put women of any race or ethnicity at risk of HIV infection. Since 1995, heterosexual encounters have led to more infections among women than injection drug use. The CDC estimates that 54 percent of newly reported AIDS cases among women in 1998 were related to sex with an infected partner. At least half of women with unknown risk factors are believed to have been infected through heterosexual contact (Hader et al., 2001)

Young Women of Color

Among young women age 13 to 24, African-American and Latina women represent three-fourths of new HIV infections reported through June 2000 (CDC, 2000). As with older women, unprotected heterosexual contact accounts for the highest number of these new HIV infections. Researchers believe that many of the younger women among the 25 to 44 year old demographic diagnosed with AIDS acquired the virus as teenagers or in their early 20s (Neal, 1997).



Geography

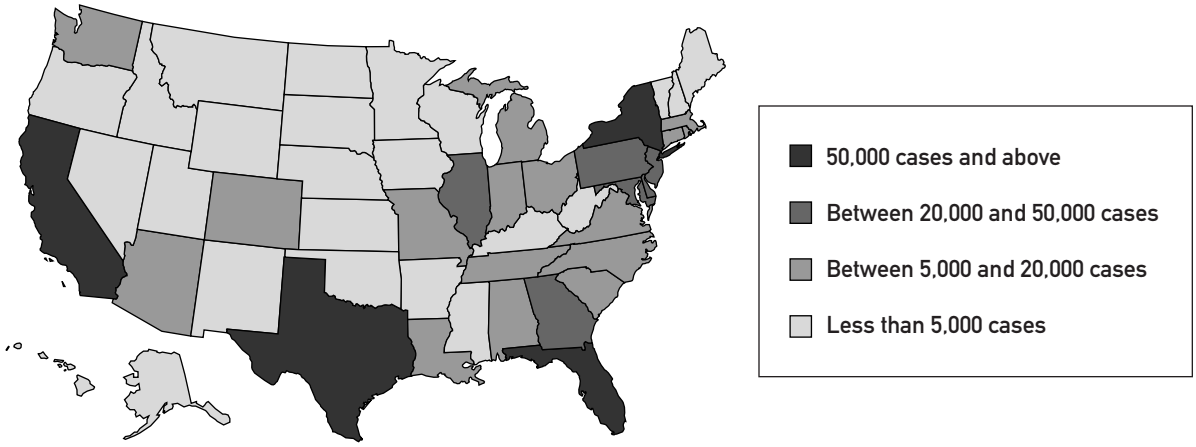
While anyone may engage in risky behavior, geographic location and corresponding HIV prevalence rates may minimize or increase the risk of HIV infection. New AIDS cases among women are increasingly concentrated in the South (41 percent) where sexually transmitted diseases are also more common (Hader et al., 2001). This trend among women is a notable shift from the AIDS epidemic's beginnings in the urban Northeast.

Why Men Matter

Men continue to outnumber women in HIV and AIDS statistics. The CDC (2001) reports that men account for nearly five times as many cumulative AIDS cases as women through June 2000. A smaller distinction between genders is found in HIV infection data where men account for two and a half times more HIV infections than women. This data indicates that the AIDS epidemic now affects women at disproportionately greater rates.

Trends in HIV transmission among men suggest risk factors for women as well. Men who have sex with men continue to dominate U.S. reported AIDS cases overall, but the risk factors for African-American and Latino men tend to be more evenly distributed between injection drug users and men who have sex with men. As a result of the racial and ethnic differences in sexual behavior among men living with HIV/AIDS, African-American and Latina women may be more likely than white, non-Latina women to have a sexual partner who is living with HIV.

Cumumlative AIDS Cases Among Adults/Adolescents per 100,000 Population by State
2000



Total = 745, 103

[Source: CDC, Vol. 12, No. 1, Table 2]

chapter 3

HIV PREVENTION STRATEGIES AND THEIR IMPLICATIONS FOR WOMEN OF COLOR

Current Theoretical Frameworks

Current HIV prevention efforts have relied heavily on psychological foundations to explain risk behavior and identify the best methods to bring about permanent change. Interventions designed to reflect these theoretical frameworks tend to emphasize the individual and the influence of immediate peer groups and social networks when seeking to identify and change social norms. Most HIV prevention programs incorporate elements of one or more of the following theories of behavior change.

Although these theories of behavior change have effectively been incorporated into HIV prevention programs, women of color have special needs and concerns regarding HIV and AIDS prevention and education. Programs that effectively address these missing pieces are more likely to reach a greater number of women.

Health Belief Model
Individual perception is central, because individual actions are held to be grounded in personal beliefs. Interventions based on this model attempt to address perceived susceptibility, severity of the illness and barriers to behavior change. (Rosenstock, Strecher, and Becker)

Theory of Reasoned Action
This cognitive model emphasizes social influence. Intention to act drives behavior change, and this intention is responsive to both individual and peer beliefs. (Fishbein and Middlestadt)

Social Learning Theory
Social learning theory holds that role modeling is highly influential. The belief that risk reduction strategies are effective that promotes the confidence to implement them is central. (Bandura)

AIDS Risk Reduction Model
The health belief model and social learning theory are combined in this model. High-risk behavior is identified, and a commitment is made to change it. Steps are then taken to follow through with the commitment, withstanding societal pressures, fear, or anxiety, which may make this transition difficult. (Catania, Kegeles, and Coates)

Stages of Change Model
Five stages of behavior change characterize this model although individuals do not necessarily pass through them sequentially. Behavior change is achieved through pre-contemplation, contemplation, preparation, action, and maintenance. (Prochaska, DiClemente, and Norcross)

Diffusion Theory
Diffusion theory borrows some elements from social learning theory because, according to its proponents, new ideas are communicated through a social network. This may mean peer educators or "opinion leaders" deliver information. (Rogers)

Missing Pieces: Gender and HIV Prevention

HIV prevention theory serves as an important starting point, but too often fails to account for "extra-individual" circumstances (Amaro, 1995). Amaro highlights the unique relationship women have with risk behavior — which is too often thought of as a corollary, rather than the central focus, of HIV prevention strategies — and criticizes the concept that sexual encounters are always within an individual's control. None of the existing HIV prevention models explicitly acknowledge the potential for an imbalance of power in relationships, and too often the decision to wear a condom is considered a shared responsibility between men and women when the reality may be quite different.

UNIQUE CONCERNS FOR WOMEN

Condom Use

For men, condom use is a personal decision, but for women protection must be negotiated. HIV prevention strategies that promote condom use must recognize that for some women:

- Power in the relationships may not be evenly distributed, which is pertinent since partner consultation and cooperation are essential when using condoms.
- Asking a partner to wear a condom may involve fear of rejection or violence.
- Requesting condom use may implicitly question individual fidelity and character as well as the integrity of the relationship.

Cash (1996) echoes the importance of considering gender in HIV prevention for women. She contends that current HIV prevention strategies have focused on increasing condom use and discouraging multiple partners without acknowledging the implicit issues associated with condom use for women. Negotiating condom use may seem to question fidelity, character, and the overall integrity of the relationship. Traditional HIV prevention models that ignore these dynamics assume that sexual risk behavior is motivated by the same factors, carried out in the same manner, and affected by the same strategies for both men and women.

Notably, Wingood and DiClemente have examined theories of gender and power as they relate to HIV exposure, risk factors, and effective interventions. Based on a theory of gender and power that identifies three major social structures that characterize gendered relationships between men and women – the sexual division of labor, the sexual division of power, and emotional energy – Wingood and DiClemente explored the relationship between power and gender among disadvantaged women. Examination of this relationship creates new data, poses new and larger questions with regards to women and HIV, and creates new opportunities for prevention (2000).

Concerning these power imbalances, Wingwood and DiClemente have also found that there is a correlation between rape among African-American women and the sexual, psychological, and social factors that may predispose survivors of rape to increased risk of HIV infection as well as other sexually transmitted diseases (STD) (1998). They also found similar results with victims of childhood sexual abuse. African-American women who experienced childhood sexual abuse were 1.5 times more likely to have had an abortion, 1.4 times more likely to have a STD, 2.4 times more likely to have more than one STD, 5.1 times as likely to have a partner who had been physically abusive in the past month, and 2.6 times as likely to have a partner who was physically abusive when asked to use condoms (Wingwood and DiClemente, 1997a). These power imbalances among women with regards to gender can lead to a heightened risk for HIV infection and should be addressed in comprehensive HIV prevention programs.

In addition to these interpersonal influences on women's risk behavior, research has identified additional psychosocial challenges for women. The Human Immunodeficiency Virus Research Study (HERS) began in 1991, and the Women's Interagency HIV Study (WIHS) started three years later in 1994, to examine and inform HIV prevention efforts, treatment, and care for women. These studies suggest that, for women, HIV risk reduction is secondary to basic and often urgent survival priorities such as food, clothing, housing, childcare, and transportation. High-risk activities such as substance use and sex work often occur simultaneously with psychological distress, risk of violence, family problems, and minimal social supports. A history of violence

as a child or as an adult was frequently reported among women living with HIV and AIDS in both the HERS and WIHS studies. Also, women often take on additional caregiver responsibilities: one third of HERS study participants had a family member suffering from HIV or AIDS.

UNIQUE CONCERNS FOR WOMEN

Competing Priorities

HIV prevention messages may get lost in the competing demands and pressures women face daily. Although all women are technically at risk for HIV infection, many of the women engaging in high-risk behavior:

- Have immediate, fundamental needs for childcare or housing;
- Experience psychological distress associated with family problems; and
- Often must assume additional caregiver roles for family members.

HIV Prevention: Identifying Misconceptions about Women

In developing HIV prevention efforts targeted towards women of color it is important not to oversimplify social situations or foster complacency among various communities. Hogan (1998) cautions against the portrayal of women as caretakers or maternal surrogates, since being a mother or wife alone is not sufficient to protect against HIV infection. Ogur (1998) suggests that women are defined categorically, as either good or bad, signifying an innocent victim or a deserving vector of disease. Roberts (1999) calls for more ethnographic studies to deconstruct this restrictive definition of women at risk for HIV infection. She emphasizes the importance of analyses that "challenge prevailing images of [women of color] as developmentally or psychologically bent towards adolescent pregnancy, sexual promiscuity, educational failure, and welfare dependency."

UNIQUE CONCERNS FOR WOMEN

Representations

Too often women are one-dimensional characters when the story of the AIDS epidemic is told. As unsuspecting victims or carriers of disease, the important factors that put women at risk are never fully explored. More importantly, the inherent strength of women, perhaps the most productive method of encouraging HIV prevention, is underemphasized or ignored.

Racial and ethnic issues must be included in HIV prevention programs as well as the unique challenges posed by gender. Highlighting the strengths and challenges that exist where gender and race intersect may prove useful in the design of HIV prevention efforts for women of color. A new model of HIV prevention that enables women of color to influence public health, science, and political debate could be a major factor in stemming the tide of HIV infections. While a feminist movement in the conventional sense may seem unrelated to HIV prevention, ignoring the political implications underscores the limited amount of thoughtful attention that has been given to the HIV prevention needs of women of color.

Missing Pieces: Race and Ethnicity in HIV Prevention

The shared experience of women in the AIDS epidemic does not obscure the diversity among women in terms of race, ethnicity, social class, and sexual orientation. HIV prevention strategies designed for women must continually evaluate the most appropriate point of reference for interventions for women of varying cultural backgrounds and socioeconomic status. Variations in race, ethnicity, and social status will determine whether one form of discrimination is felt more acutely than another, and thus will affect both risk behavior and successful prevention efforts. HIV prevention programs must be sensitive to all of these factors and the way they shape the experiences of communities of color.

For example, Marin and Gomez (1994) have found that acculturation influences sexual behavior, as does ethnicity. Their work on HIV prevention in Latino men and women indicates that Latino married men may behave differently than their white, non-Latino counterparts. There was also some degree of variation among groups of Latino men themselves. While this is only one example, other studies underscore the different values and behaviors found among diverse communities. These variations should be incorporated into HIV prevention efforts while ensuring that these concepts are not used to generalize or stereotype communities.

Examples of Successful HIV Prevention Interventions for Women of Color

There has been limited success in extending HIV prevention messages to women of color. In 1995, DiClemente and Wingood found that African-American women who participated in small group interventions to discuss consistent use of condoms were significantly more likely than women in a comparison group to report consistent condom use with their partners, better skills in negotiating condom use, and choosing not having sex when a condom was not available. Wingood and DiClemente also believe that using women living with HIV and training them as facilitators to deliver secondary HIV prevention messages to other women living with HIV increases the effectiveness of secondary prevention interventions. Women living with HIV, especially women of color, serve as powerful opinion leaders for other women who are living with HIV to enhance their coping skills and to reduce their STD-related sexual risks (1997b).

UNDERSTANDING THE OVERALL CONTEXT FOR HIV PREVENTION AMONG WOMEN OF COLOR

Comprehensive programs should focus on:

- Societal attitudes towards gender norms
- Historical and current experiences with racism and discrimination
- Physical, emotional, and social characteristics of the immediate neighborhood
- Access to and use of pre- existing services
- Societal and structural inequalities that perpetuate poor health outcomes

Moving Forward: Suggestions for HIV Prevention for Women of Color

Roberts (1999) suggests moving beyond risk taking to incorporate social factors. She contends that focusing on risk behavior and risk factors overemphasizes an individual's poor decision making and neglects other conditions that motivate behavior; specifically, society's attitudes towards gender and historical and current experiences of racism and discrimination. The physical, social, and economic conditions of the immediate neighborhood and limited access to community resources are relevant to the successful delivery and influence of HIV prevention programs. Efforts to improve self-esteem as a means of preventing HIV infection should be broadened to examine structural inequities within resource poor settings that contribute not only to a higher incidence of HIV infections, but also to other health disparities as well. Roberts also suggests that health promotion strategies that integrate social justice themes may improve overall outcomes. The former seeks to alter individual behavior; the latter encourages collective action to challenge the social causes of health inequities.

chapter 4

MODELS OF EFFECTIVE PROGRAMS

The programs described below have helped thousands of people reduce their risk for HIV infection and lead healthier lives. The HIV prevention models and the CBO programs that are presented provide examples for other organizations hoping to expand or enhance their HIV prevention strategies. This is by no means a comprehensive list of programs, but rather highlights innovative approaches that may be useful. Contact information is provided for each CBO program.

PREVENTION MODEL - PEER EDUCATION AND OUTREACH

Peer education and outreach programs have long been a mainstay of HIV prevention efforts. They tend to incorporate a number of traditional behavioral theories and models in one form or another. "AIDS 101" information is often delivered in peer interventions using the health belief model to raise awareness of HIV and AIDS. Peer models also borrow elements from the theory of reasoned action and social learning theory, which emphasize the importance of peer groups and role modeling. Finally, the importance of social networks in determining behavior change modeled by diffusion theory suggests an important role for peer educators in encouraging behavior change.

Although these programs incorporate proven methods, it is important to examine the degree to which peer educators are effective in their delivery of HIV prevention messages. Shared identity and common experience create an important foundation for communication, but the successful transfer of ideas is equally, if not more, important. Transfer of information using a peer education model involves walking a tightrope between biology and ideology. Although having a peer deliver an HIV prevention message may engage an individual, the appropriateness and accuracy of the ideological content of the message is critical to ensure that HIV prevention strategies are understood and incorporated. The converse, in which an educator in no way resembles the intended audience, may fall short of expectations as well.

CBO PROGRAM - ASIAN PACIFIC ISLANDER COALITION ON HIV AND AIDS (APICHA)

The Asian Pacific Islander Coalition on HIV and AIDS Women's Peer Education Program recruits and trains peer educators to inform women about the risks of HIV infection.

Six Japanese-American women founded the Asian Pacific Islander Coalition on HIV and AIDS (APICHA) in 1989 after being inspired by the people of color AIDS conference that took place that fall. The founding members were concerned about the lack of attention paid to the needs of Asian Pacific Islanders in the design, implementation, and evaluation of HIV prevention programs. Even at the most basic statistical level, Asian Pacific Islanders failed to be counted in the AIDS epidemic. [At that time, Asian Pacific Islanders and Native-Americans were combined in the "other" category of AIDS cases, and APICHA and other organizations began advocating for recognition in the epidemic.] Initially, APICHA was run by volunteers, but grants allowed the organization to expand and hire staff, and it currently has two offices in the New York City area.

The women's project at APICHA trains approximately ten paid peer educators and additional community volunteers to do outreach and HIV education in Asian Pacific Islander communities. Paid peer educators are expected to attend monthly

trainings that cover basic AIDS information, current trends of HIV infections, and community resources available to both HIV-positive and negative women.

APICHA's peer education efforts were evaluated internally in 1999. Focus groups were conducted with peer educators from all of APICHA's outreach programs. These efforts were undertaken to address the lack of theory and principle guiding HIV prevention and education in Asian Pacific Islander communities. The groups sought to identify current outreach strategies, highlight success stories, and build upon these lessons to improve prevention efforts. Each project conducted focus groups with six to twelve peer educators about their experiences, and the women's project conducted groups in two languages: one in English and the other in Bengali.

Focus groups indicated that targeting social networks and communities was the most effective way to deliver HIV prevention messages that addressed the ways in which immigration, acculturation, and cultural norms exacerbate HIV risk factors. Efforts to cultivate popular opinion leaders among women in various Asian Pacific Islander communities have been developed that integrate lessons about HIV prevention into everyday conversation. For example, some south Asian women immigrate to the U.S. at a date later than their husbands. Bringing these women together to discuss this common experience offers an opportunity to incorporate HIV risk reduction strategies into a larger context of life experiences.

Networking among grocery store owners in Bangladeshi neighborhoods also was successful in disseminating HIV education and prevention information to women in a neutral setting. Peer educators indicated that they were more comfortable presenting HIV education materials in neutral settings.

RESOURCES REQUIRED:

- HIV education material to be distributed in multiple languages
- Training booklets for paid/unpaid peer educators
- Meeting space
- Focus group questions to facilitate the evaluation of peer outreach

CONTACT: Javida Syed
Asian Pacific Islander Coalition on HIV and AIDS (APICHA)
275 Seventh Ave., Suite 1204
New York, NY 10001-6708
Phone: (212) 620-7287

PREVENTION MODEL - COMPREHENSIVE WOMEN'S HEALTH PROMOTION MODEL

> *"…Emphasis should also be placed on applying existing knowledge about HIV prevention and treatment in women by enhancing use of available health services and including greater use of antiretroviral therapy options, treating depression and drug use, facilitating educational efforts, and providing social support to reduce competing needs that prevent women from taking control of HIV prevention and treatment."*
>
> – Hader et al., March 2001, pp.1191.

The comprehensive women's health promotion model focuses on individual risk and behavior change, not unlike the peer education model previously outlined. This program, however, incorporates broader health and social themes and provides support above and beyond the delivery of HIV prevention information. The model focuses on overall health and wellness and attempts to mitigate some of the "extra-individual" factors that make protection against HIV and other sexually transmitted diseases difficult for women. These factors include: the fact that women are often underinsured compared to their male counterparts and that their caregiver responsibilities may make access to health services and information more difficult (Hader et al., 2001).

Many activities that place someone at-risk of HIV infection are also associated with other health issues. Psychological distress and a lack of social support and stability frequently coincide with increased risk taking. By addressing more immediate as well as routine health concerns, the comprehensive women's health promotion model allows women to consider their susceptibility to HIV infec-

tion and develop strategies for HIV prevention in light of their total health. Programs emphasizing health and wellness increase individual knowledge and self-protection against HIV infection in addition to improving overall health outcomes.

CBO PROGRAM - WOMEN OF COLOR AIDS COUNCIL (WCAC)

The Women of Color AIDS Council (WCAC) was founded in the Boston area in 1992. The program is peer-led and peer-driven and was created by women in the community, five of whom were HIV-positive at the time. WCAC seeks to improve self-esteem among women of color. The organization offers a wide range of services to meet the needs of this population including: health workshops, counseling and case management, referrals, wellness groups, and a Drop-In Center.

The Drop-In Center is located in Dorchester, Massachusetts, in an area easily accessible to the target audience of women of color. The service population is women of color who are at risk primarily because of homelessness, substance use, or sex work. Fifteen paid employees and a number of volunteers staff the center. Funding comes from federal, state, and local governments.

The Drop-In Center was developed in response to a statewide survey on women's HIV prevention needs that found that women needed a place to go where they could feel comfortable. Since WCAC provides a wide range of services, not limited to HIV prevention and risk reduction, their outreach with women of color has been fairly successful. The Drop-In Center is not a shelter or emergency room. It is a neutral setting that helps increase women's comfort levels with their health status, including HIV risk reduction. In addition, the center has a nurse practitioner on-site so women can ask questions and address their non-urgent health needs in a safe environment. The Drop-In Center is also a good place to deliver messages about HIV risk reduction. Information is presented in a non-judgmental manner that attracts women into the center for support. The organization does some outreach work, but by and large women come by the Drop-In Center because they have heard about it through a friend.

RESOURCES

REQUIRED:
- Setting where both casual conversation and medical discussions can occur
- HIV prevention and education material
- Referral information
- Trained case managers and nurse practitioner

CONTACT:
Malkia Kendricks
Women of Color AIDS Council (WCAC)
409 Blue Hill Ave.
Dorchester, MA 02121
Phone: (617) 541-1050

PREVENTION MODEL - MULTIFACETED EMPOWERMENT MODEL FOR WOMEN

Much like the comprehensive health promotion model implemented by WCAC, the multifaceted empowerment model program expands the traditional notion of HIV prevention to incorporate a number of "extra-individual" factors that affect the lives of women of color although it does not include direct medical services. HIV prevention strategies that specifically address the historical position of women of color empower women politically and educationally. This concept is central to the multifaceted empowerment model.

By focusing on issues beyond HIV, this model enables women to address the social factors that may cause them to face competing demands that affect their attempts to minimize HIV risk behaviors. Individual feelings of powerlessness in relationships are addressed, but overall leadership, involvement, and activism are encouraged to reinforce individual behavior change. This program empowers women as architects of their own solutions rather than passive gatherers of information.

CBO PROGRAM - MUJERES UNIDAS Y ACTIVAS

In 1990, the Mujeres Unidas y Activas was created by Latina women for other Latinas in the Mission District of San Francisco. Five paid staff members currently serve 200 women, although volunteers ini-

tially ran the organization's programs. Mujeres' mission is to improve the economic, social, and political status of Latina women, irrespective of naturalization status.

Mujeres offers a variety of services. General meetings are larger and address a myriad of issues affecting Latinas and their health. Self-esteem support sessions and friendship circles are smaller versions of these meetings and often discuss more sensitive issues like domestic violence, substance use, and female sexual rights. HIV workshops are also offered that specifically address virus transmission, condom use negotiation, and HIV testing and counseling. In addition to these workshops, participants are encouraged to become involved in leadership and volunteer roles both within the Latina community and at Mujeres.

Mujeres does not specifically address HIV behaviors but rather presents HIV information in a larger health and empowerment context. Acknowledging broader socio-cultural issues is important for the Latina women in the program who face many challenges beyond the risk of HIV/AIDS. These include language barriers, lack of accurate information about HIV and AIDS, competing life priorities, and fear of accessing health services due to immigration status.

An evaluation of the program was developed in cooperation with the University of California at San Francisco Center for AIDS Prevention Studies. Women who agreed to participate in the evaluation were interviewed initially, after three months, and after six months. Their attendance at Mujeres workshops was documented. Researchers and staff correlated participation in program activities with changes in attitude using a survey/interview format.

Surveys and interviews found that women who participated in social and political activities at Mujeres in a volunteer or leadership role increased their level of comfort with sexual communication. This increase in comfort level was not observed in participants who attended smaller HIV and self-esteem workshops alone. Although condom use remained lower than desired, women who volunteered with Mujeres also seemed less likely to tolerate domestic violence and power imbalances in relationships.

RESOURCES

REQUIRED:
- HIV prevention and education material
- Referral information
- Trained case managers and nurse practitioner

CONTACT:
Cynthia Gomez
Mujeres Unidas y Activas
74 New Montgomery Street
Suite 600
San Francisco, CA 94105
Phone: (415) 597-9267

PREVENTION MODEL - CULTURAL AFFIRMATION MODEL

Although it may not look like other HIV prevention models, the cultural affirmation model is quite comprehensive in its approach. This program does not focus exclusively on women: HIV infection is viewed in a larger context to encourage individuals to change their own behavior and to become active in improving their local environment. The cultural affirmation model is empowering through positive reinforcement, rather than focusing on risk behavior and implicitly assigning blame for poor health.

This model incorporates race and ethnicity in HIV prevention because these factors are relevant to everyday life. Targeting both men and women in HIV prevention efforts promotes the idea that men and women share responsibility for protection against HIV infection. While drawing upon common bonds among women, the model also emphasizes the diversity within the community. Open dialogue increases everyone's comfort level and makes HIV prevention more manageable for both men and women.

CBO PROGRAM - AMASSI CENTER OF LOS ANGELES

The Amassi Center of Los Angeles focuses on building self-esteem, teaching harm reduction, and providing social services. The center does not view itself as an organization designed to serve individuals already in crisis. It addresses broader issues of stigma and limited access to health care while serving a diverse sexual, social, and ethnic population. The

center was created to be a health and wellness promotion center that also conducts HIV/AIDS prevention rather than a traditional AIDS service organization. The founding members of Amassi believed that a crisis mentality hampers HIV prevention efforts.

The center serves mainly African-Americans and Latinos in Southern California and emphasizes the ways in which societal disparities and discrimination affect self-image. While many interventions focus on disease or sexual orientation, the Amassi Center seeks to highlight and affirm diversity within the African-American community as a means of preventing HIV infection. This strategy seeks to expand life options, self-respect, and cultural affirmation. Importantly, the center also is quick to point out that HIV is not just a poor person's disease, because such an attitude puts working class and middle class people of color at risk.

The center offers a wide range of services. Self-esteem workshops, math and English language tutoring, peer empowerment groups, and fitness classes all complement the center's HIV and AIDS programs. There are a number of groups specifically focusing on women, including Sustaining Our Sisterhood, The Black Women's Exchange, and the Female Rites of Passage Program.

Sustaining Our Sisterhood:

A bi-monthly meeting with a staff member who acts as a facilitator and engages the group of women in the discussion of a wide range of issues. Discussion is often loosely centered on relationships, nutrition, fitness, career, spiritual growth, love, and power. Women are able to express feelings, network, and explore changes in their lifestyle.

Black Women's Exchange:

A discussion group focusing on the needs, concerns and strengths of same-gender loving and bisexual women. The group meets twice a month, also in the evening, and facilitators guide conversation in the direction of family issues, health, intimate relationships, self-esteem, and coming out. Regular attendance goes a long way to build trust within the group, and more sensitive topics are discussed along with very practical career and financial concerns.

Rites of Passage Program:

A small group format with an intended audience of young women age 13-18. This program meets on weekend afternoons and deals with life, family, and career goals. The facilitator tends to take a more active role in steering discussion, and conversation also emphasizes empowerment and self-esteem.

The center also organizes an annual "Women in Jazz" benefit. The purpose of this event is two-fold. First, it seeks to display the talent of the artist as a means of furthering the organizational goal of cultural affirmation. Second, the artists and organizers use the forum to raise AIDS awareness in general in a positive environment. While this event specifically focuses on women, there are other fitness, tutoring, and creative expression programs that seek similar goals for the larger community.

RESOURCES

REQUIRED:
- Curriculum and distribution materials for all classes
- Trained facilitators to lead discussions, conduct neighborhood outreach
- Staff to arrange logistics for "Women in Jazz" benefit

CONTACT:

Cleo Manago
Amassi Center of Los Angeles
160 South LaBrea Ave.
Los Angeles, CA 90301
Phone: (310) 419-1969

chapter 5

TAILORING HIV PREVENTION PROGRAMS TO FIT YOUR NEEDS

Where HIV prevention is concerned, one size does not fit all. As community-based organizations seek to reduce the number of new HIV infections, it is important to tailor standardized prevention messages and specifically address communities considered hard to reach, especially women of color. Women respond to unique social, economic, and political pressures that must be incorporated into HIV prevention programs. Every approach may be different, but encouraging dialogue between community-based organizations, policy makers, and clients will go a long way to reducing HIV infections in increasingly diverse communities.

Evaluation is also an important part of the process. Internal and external reviews help community-based organization determine future needs and current strengths. Collaborative partnerships between CBOs, universities, and health departments mean that all those involved contribute to the overall investment in HIV prevention strategies that specifically target women of color.

Community-based organizations bring an expert knowledge of the communities they serve to HIV prevention work. CBOs can take the models presented here and shape them according to the culture of their communities, the available resources, and the strength and expertise of their staff. In addition, CBOs can ensure the effectiveness of their prevention efforts by seeking input from groups or individuals they plan to serve and conducting rigorous evaluations.

The challenge of meeting the constant demand for new, innovative, and successful HIV prevention strategies can only be addressed through the development of additional HIV prevention models for diverse communities. Prevention works. Each CBO should determine how and in what form HIV prevention can reach the people it serves.

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1906 Sunderland Place, NW, Washington, DC 20036
202.530.8030 P • 202.530.8031 F • www.aidsaction.org