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National Alliance of State and Territorial AIDS Directors

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Women and HIV/AIDS: A Focus on Women of Color

1997 marked the year of NASTAD's first *HIV Prevention Bulletin* dedicated to women and HIV/AIDS. Over the years, many aspects of the HIV epidemic and its impact on women have been explored, however, in recent years, the focus has been on women of color, who now represent a significant portion of the female epidemic in the U.S. According to the U.S. Centers for Disease Control and Prevention (CDC), women with HIV and AIDS comprise an increasing part of the epidemic. At the end of 2004, women represented approximately 27 percent of the estimated 455,983 adults/adolescents living with HIV/AIDS. ¹ In 2004, approximately 9,874 cases of HIV infection were reported among female adults and adolescents, and closer examination of the data reveals that the HIV/AIDS epidemic is continuing to disproportionately impact women of color. ¹ African American and Hispanic women alone comprised over 81 percent of the reported female adult and adolescent cases of HIV infection in 2004. ¹

What is driving the HIV/AIDS epidemic among women, in particular women of color? The CDC cites six categories of "Risk Factors and Barriers to Prevention" for women:

- 1) young age;
- 2) lack of recognition of partner's risk;
- 3) sexual inequality in relationships with men;
- 4) biologic vulnerability and sexually transmitted diseases;
- 5) substance abuse; and
- 6) low socioeconomic status and other societal factors. ²

"Sexual Inequality in Relationships with Men" is one area of particular concern when explaining the disproportionate impact of HIV/AIDS on women of color. One CDC study of teenaged girls found that more than one-third of African American and Hispanic teenaged girls experienced their first sexual encounter with an older man.² Older male partners represent a greater HIV transmission risk when compared to adolescent males,³ since they are more likely to have had a greater number of sexual partners, to have experimented with drugs, or be HIV infected. The teenage girls in this study also tended to be younger in age at first sexual intercourse and were less likely to have used a condom during their first and most recent act of sexual intercourse, or were less likely to report consistent condom use.²

Women of color experience higher rates of sexually transmitted diseases (STDs) such as gonorrhea and syphilis, and the presence of an STD has been shown to greatly increase the likelihood of acquiring (or transmitting) HIV infection.² Additionally, several socioeconomic and societal factors including poverty, higher levels of substance abuse, and limited access to quality health care may directly or indirectly impact the HIV risk for women of color. Women of color are more likely to encounter a series of financial, institutional, and cultural barriers to obtaining health care when compared to white women.³ Latinas, in particular, may face cultural barriers to consistent condom use such as *machismo*, a term used to describe a cultural expectation to respect males and be submissive, and religious beliefs that may oppose the use of birth control.³

Thus, HIV/AIDS continues to pose a serious health threat to women, especially African American women and Latinas. In its article "*What Works in HIV Prevention for Women of Color*," the AIDS Action Council says the staggering rates of HIV infection among women of color suggest a "disconnect between existing HIV prevention efforts and women of color at-risk for HIV." The article further states that "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 infection among women, especially among women of color."⁴

This month's *HIV Prevention Bulletin* highlights health department and community-based initiatives targeting women and youth of color and explores the impact of domestic violence on HIV risk among women. Important information on research and development of an effective microbicide for women is also included.

¹ Centers for Disease Control and Prevention. (2004). HIV/AIDS Surveillance Report, 16. Atlanta: U. S. Department of Health and Human Services, Centers for Disease Control and Prevention. Also available at: <http://www.cdc.gov/hiv/stats/hasrlink.htm>.

² Centers for Disease Control and Prevention. (2004). HIV/AIDS Among Women [Fact Sheet]. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Also available at: <http://www.cdc.gov/hiv/pubs/facts/women.htm>.

³ Advocates for Youth. (2003). Young Women of Color and the HIV Epidemic [Fact Sheet]. Also available at: <http://www.advocatesforyouth.org/publications/factsheet/fsyngwom.pdf>.

⁴ AIDS Action Council (2001). *What Works in HIV Prevention for Women of Color*. Retrieved December 23, 2005 from <http://www.thebody.com/aac/woc/contents.html>.

HIV/AIDS and Intimate Partner Violence

Nearly 5.3 million incidents of intimate partner violence (IPV) are reported by U.S. women each year,¹ and studies suggest that up to one-third of all women in the U.S. will be physically assaulted by a partner or ex-partner at some point during their lifetime. Furthermore, roughly 3.2 million incidents of IPV occur among men in the U.S. each year and more than 800,000 men are raped or physically assaulted by an intimate partner.² IPV accounts for nearly 2 million injuries and 1,300 deaths each year,¹ and the health-related costs associated with IPV exceeds \$5.8 billion each year.³ Although most assaults are categorized as

“relatively minor” and involve acts such as pushing and shoving, IPV can also include more serious offenses such as violent physical assault or forced sex. ¹

The sexual exploitation of females has been described as “one of the most extended forms of gender violence” ⁴ and the physical and emotional consequences for women can be devastating. According to the American Foundation for AIDS Research (amfAR), sexual abuse and forced or coercive sex against women can include rape within marriage or in dating situations, rape by a stranger, forced marriage, forced prostitution, and the denial of one's right to use contraceptive or other measures to protect against STDs. ⁵ IPV, including sexual assault, can lead to many serious physical and psychological consequences for women, including depression, low self-esteem, gynecological disorders, pregnancy difficulties, and STDs. ¹ Several studies have shown that women with a history of IPV are more likely to display behaviors that pose further health risks, and IPV has been associated with a variety of negative health behaviors for the victim that include unprotected sex, early sexual initiation, decreased condom use, multiple sex partners, and trading sex for money. ¹

Physical violence, threats of violence, and fear of abandonment are considered to be “powerful factors that prevent women from talking about fidelity, sex and condom use, or leaving relationships that might put them at risk for HIV infection”. ⁶ Several studies have highlighted the connection between IPV and increased HIV/AIDS risk among women. Studies conducted both in the U.S. and in areas of sub-Saharan Africa and the Caribbean not only show an increased risk of HIV/AIDS among female victims of IPV, but also show that HIV-positive serostatus is a risk factor for violence against women. ⁴ One study conducted in Latin America and the Caribbean profiling domestic violence, showed a positive association between domestic violence and HIV/AIDS. ⁴ Another study, conducted in the U.S., revealed that 20.5 percent of HIV-positive women reported a history of physical abuse. ⁴ Sex workers also report an increase in violence against them by HIV-positive clients who blame them for their HIV infection. ⁴ Violence against women is considered to be both a “cause and consequence of HIV/AIDS infection,” however the two issues are seldom part of the same health, political, or legal agendas. ⁶

Several factors may put women in violent situations at increased risk for HIV and STD transmission. These include:

Biological Factors

During acts of forced sexual intercourse, bleeding or tearing in the vaginal or rectal area can occur, creating a path of entry for HIV to enter the bloodstream.

Psychological Factors

Victims of sexual abuse may engage in more risky behaviors and may be less able to refuse sexually aggressive partners.

Economic Factors

A woman's economic dependency on a partner because of lack of access to fair-wage jobs, lack of education, and discrimination, may render her unable to leave a violent partner or negotiate condom use. This economic dependency also impacts a woman's ability to seek legal protection from the abuse and to seek health care.

Cultural Factors

In many cultures, women are taught to regard their bodies as the property of men, thus women often have little to no control over when, how, and under what circumstances sex occurs. ⁷

Women involved in situations of IPV continue to struggle to maintain control over their safety and their health. Addressing HIV/AIDS within the context of IPV requires a focused examination of many complex

factors, including gender-based inequality, cultural and societal views of sex and sexuality, stigma, blame, and denial that often impact these women. In an article written for the Consortium on Violence Against Women,⁷ several important points are deemed key to addressing HIV/AIDS among women in domestic violence situations. First, the views of women infected and affected by HIV/AIDS should inform the development of programmatic interventions. Secondly, there must be heightened awareness regarding the intersection between IPV and HIV/AIDS. Health care providers must be educated and trained to identify the HIV/AIDS related risk of women in situations of IPV, and finally, there must be a global paradigm shift affirming a woman's fundamental human and socioeconomic rights.

¹ Centers for Disease Control and Prevention. (2005). Intimate Partner Violence [Fact Sheet]. Also Available at <http://www.cdc.gov/ncipc/factsheets/ipvfacts.htm>.

² Cohen, C., Deamant, C., Barkan, S., Richardson, J., Young, M., Holman, S., Anastos, K., Cohen, J., & Melnick, S. (2000). Domestic Violence and Childhood Sexual Abuse in HIV-Infected Women and Women at Risk for HIV. *American Journal of Public Health*, 90 (4), 560-565.

³ American Institute on Domestic Violence (2001). Domestic Violence in the Workplace Statistics. Retrieved January 3, 2006 from <http://www.aidv-usa.com/Statistics.htm>.

⁴ American Foundation for AIDS Research (amfAR). (2005). Gender-Based Violence and HIV Among Women: Assessing the Evidence [Issue Brief]. Also Available at www.amfar.org.

⁵ Pan American Health Organization (PAHO). Gender Based Violence and HIV/AIDS [Fact Sheet]. Also available at <http://www.paho.org/genderandhealth/>

⁶ Jacobs, T. (2003). Domestic Violence and HIV/AIDS: An Area for Urgent Intervention (Institute of Criminology, University of Cape Town, South African).

⁷ Global Campaign for Microbicides (2004). Violence and HIV [Fact Sheet]. Retrieved December 15, 2005 from <http://www.global-campaign.org/violence.htm>.

New York State Responds to HIV/AIDS and Domestic Violence

In New York, HIV and Domestic Violence (DV) have been described as "invisible public health epidemics affecting some of the most vulnerable persons in the state." Historically, HIV and domestic violence service providers have had little interaction. However, due to factors such as new state legislation requiring HIV service providers to screen all newly diagnosed HIV-positive clients for domestic violence, it became clear that several opportunities have existed for collaboration between the two entities.

The New York State Department of Health (NYS DOH) AIDS Institute and the NYS Office for the Prevention of Domestic Violence (OPDV) have worked together to implement regional needs assessments to determine service gaps and training needs. The NYS DOH AIDS Institute and OPDV have funded community coalitions to foster grass-roots collaboration between HIV and DV providers and as a result, a seven-step DV screening protocol has been developed for use in HIV counseling, testing, referral, and partner notification (CTRPN) settings. The NYS DOH AIDS Institute also currently offers three DV focused trainings: *Basic Information About Domestic Violence*, *Practicing the NYS Domestic Violence Screening Protocol*, and *Domestic Violence in Lesbian, Gay, Transgender & Bisexual Communities*.

- ***Basic Information About Domestic Violence*** is a one-day training that provides an overview of the interrelationships between adult domestic violence and HIV/AIDS.
- ***Practicing the NYS Domestic Violence Screening Protocol*** is a half-day training for new and

experienced HIV testing and counseling providers that provides opportunity for practice of the skills needed to implement DV protocols and to provide the appropriate referrals to domestic violence services.

- ***Domestic Violence in Lesbian, Gay, Transgender & Bisexual Communities*** is a one-day training where participants examine beliefs, values, and attitudes that can impact their ability to respond to lesbian, gay, transgender and bisexual victims of domestic violence.

Since 1998 over 2,335 HIV providers have received basic training on DV. Evaluation data from the training programs consistently demonstrates that 85-90 percent of participants feel "strongly" or "very strongly" that the information they learned was meaningful and resulted in a moderate to substantial amount of new information or skills. The success of the trainings also show that when provided a forum, HIV and DV providers are willing to work together in order to meet the needs of an often invisible public health concern.

For more information, contact Rachel Iverson (518) 474-3045. A comprehensive list of trainings, including DV-related trainings offered through the NYS DOH, is available at <http://www.health.state.ny.us/diseases/aids/training/index.htm>.

Health Departments and Community-Based Organizations Respond to the HIV Prevention and Care Needs of African American Women and Latinas

The following profiles were submitted by state health departments and community-based organizations working to address HIV/AIDS among African American women and Latinas.

California

The California Department of Health Services Office of AIDS administers the Early Intervention Program (EIP) in 34 sites. Two of these sites are funded to provide services primarily for women. At WomensCare West, 94 percent of the total caseload of 140 clients is female. Thirty-one percent of the caseload is African American and 69 percent is Latina. WomensCare East serves a caseload of 86 clients. Eighty-eight percent are female, 23 percent are African American and 70 percent are Latina.¹ Like all EIP sites, the two WomensCare sites offer an array of HIV/AIDS services including medical care, psychosocial, transmission risk reduction counseling, health and treatment education, and case management and benefits services.

WomensCare staff believe that to adequately serve HIV-positive women of color requires not only an understanding of their medical needs, but also an understanding and respect for their varying backgrounds, customs, values, and beliefs. WomensCare services are offered in both Spanish and English and because access to child care is one of the most fundamental barriers to health care access for women, WomensCare sites provide on-site child care. Assistance with reproductive health is also offered for those women wanting to have children. Transportation is another significant barrier to health care for women, so WomensCare helps with transportation to and from medical and social services appointments. In recognition of the fact that many women neglect their own needs as they struggle to provide for family members, WomensCare also offers access to shampoo, soaps, lotions, infant care items, and clothing. Finally, WomensCare provides adjunctive support to family members and assistance with enrolling in low-cost or no-cost insurance programs, as well as facilitating access to complete general medicine, geriatrics, family medicine, and pediatric services, because women are more likely to maintain their own health care when they know that family health care needs are being met.

For more information, contact Lupe Carreon (323) 662-7420.

¹ (Data through April 21, 2005)

Florida

Submitted by Alberto M. Santana, Statewide Latino AIDS Coordinator, Florida Department of Health

Ethnically, Miami-Dade County's population can be described as a minority majority. Fifty-seven percent of the county's population is Latino, 21 percent are white and 20 percent are Black. Within these three major categories there is great ethnic, cultural and linguistic diversity which create many challenges for delivering effective HIV prevention interventions for those most at risk. Addressing these challenges becomes even more difficult when relatively few HIV prevention interventions are specifically designed to meet the needs of Black and Latino communities. Therefore, HIV prevention providers are faced with adapting and tailoring proven effective interventions as an attempt to make them culturally and linguistically appropriate. To address this challenge within Miami-Dade County, the Miami-Dade County Health Department (MDCHD) is undertaking various initiatives that include developing HIV prevention interventions, increasing training capacity of providers, and adapting and tailoring proven effective interventions. One of these initiatives includes addressing HIV prevention among Latinas residing in Miami-Dade County through the development of a group-level intervention that includes an HIV counseling and testing component.

Conversaciones Intimas Entre Mujeres (Intimate Conversations among Women) is an HIV prevention intervention targeting Latina women, produced by MDCHD staff. Initially the development of this intervention was funded through local county resources, however today it is also supported for replication in other counties through the Florida Department of Health, Bureau of HIV/AIDS. This HIV prevention intervention is aimed at increasing HIV risk awareness and encourages HIV testing for early detection and linkage to care.

The group level intervention also includes a video presentation produced by MDCHD Staff. In Spanish with English subtitles, the video features four women discussing their encounters with HIV/AIDS. In their discussions, the women also share their perspectives and experiences as persons living with or affected by HIV disease. The women discuss a multitude of issues that impact their lives, including the variety of roles they play in society, both at home and as a member of a Latino family.

Following the video, a group facilitator provides participants with HIV education and information and leads the group into interactive discussions about risk behaviors and the importance of HIV prevention. The women are also offered on-site HIV counseling and testing. The emotional and powerful video leads most of the participants to be tested for HIV and to participate in the group discussion. Following this session, the women are invited to a second session that addresses issues of self esteem, values, communication, safer sex negotiation skills, etc. During this session, the women also learn the results of their HIV tests and are linked to services if needed.

Recently, a facilitator's manual was completed and the video has been mass-produced for circulation within Florida. Prior to obtaining the video and facilitators manual, MDCHD staff provided training to prospective group facilitators. The Bureau of HIV/AIDS continues to support this effort as part of their training and technical assistance strategies.

For more information, contact [Zaida Castillo](#) (305) 470-6999.

Kansas

HERS (Health, Empowerment, Resources, and Support), a component of the Topeka AIDS Project, is a women's support group geared to meet the needs of African American women, specifically those who could be at risk for acquiring HIV. Jerry Finney, Deputy Director, Topeka AIDS Project, designed the HERS support group to reach women of color, women living in poverty, and sex workers. The goal of HERS is to empower women to make safe choices for themselves and to reduce the rate of HIV transmission. The Empowerment Theory is used as a part of this intervention, and HERS provides a forum in which women can come together to share experiences, understand social and cultural influences, and be supportive of each other. The group discusses educational topics along with topics that focus on dating, single parenting, and other issues of interest for these women.

For more information, contact Jerry Finney (785) 232-3100.

Louisiana

Integrating African American Red Cross proverbs, Project AYA (Allowing Yourself Acceptance), was designed by African American women for African American women. AYA is an Adinkra symbol from the West African

culture and the Adinkra symbolism is a visual representation of African social thought relating to history, philosophy and religious beliefs. The curriculum involves culturally appropriate activities that are designed to build group cohesion and enhance the learning experience. AYA is designed as a six-week, two-hour session curriculum, broken into six modules targeting HIV-infected women. HIV prevention education includes initiating and maintaining healthy behaviors, increasing knowledge and understanding of the disease process, identifying self defeating attitudes and behaviors, improving self-esteem and self-awareness, enhancing communication skills, teaching skills building, and acknowledging decision-making about social and sexual behavior. These activities empower women to take control of their lives. Through group interaction and participation, participants learn to maintain healthy decision-making and understand risky behavior and its consequences.

NOTE: AYA was developed and implemented by Children's Hospital Family Advocacy, Care, and Educational Services (FACES) in New Orleans, LA. HAP funds this project in New Orleans and Baton Rouge, Louisiana.

For more information, contact [Jacky Bickham](#) (504) 568-5512.

Michigan

African American communities are the most HIV-impacted population in Michigan, making up 60 percent of all those living with HIV/AIDS but only 14 percent of the state's general population. Among women with HIV/AIDS, African Americans account for 56 percent of all cases and it is estimated that one out of every 280 African American women in Michigan has HIV. To address these disparities, the Michigan Department of Community Health (MDCH) provides funding to community-based providers with demonstrated success in accessing and serving-target populations; supports only evidence-based and culturally competent HIV prevention interventions; and concentrates prevention efforts into the highest prevalence areas of the state. Peer-based outreach and education, targeted to high-risk African American women, is provided by community-based providers in venues as diverse as shelters, low-income residential settings, correctional facilities (both short and long-term), nail and beauty salons, and "on the street". *SISTA (Sisters Informing Sisters About Topics on AIDS)*, a CDC-endorsed prevention intervention, has been particularly successful. One CBO has successfully tailored SISTA for incarcerated women, while another has adapted the intervention for adolescent girls, replacing poetry readings with rap music lyrics. Using the Personalized Nursing LIGHT Model, another agency has implemented an intervention targeting African American women who are sex workers. This intervention combines individual-level prevention counseling with group-level skills building around the negotiation of safer sex and the use of condoms.

For more information, contact [Deb Szwejda](#) (517) 241-5905.

New Jersey

From June-August 2004, the New Jersey Department of Health and Senior Services, Division of HIV/AIDS Services (NJDHSS/DHAS), utilizing a \$2 million budget, launched the first public information campaign designed to encourage African American women of childbearing age to be tested for HIV infection, using the rapid HIV test. This message was selected because African American women infected sexually are accounting for a growing proportion of individuals infected with HIV in New Jersey. Based on lessons learned from the first media campaign, a second one, modified to target both African American women and Latinas, was implemented from February-June 2005, and appeared in venues such as beauty shops. From the overwhelming success of these previous campaigns, NJDHSS/DHAS will announce its third campaign on February 7 (National Black HIV/AIDS Awareness Day) encouraging all adult African Americans and Latinos to be tested for HIV infection using the rapid HIV test.

For more information, contact [Clara Gregory](#) (609) 984-5874.

Oklahoma

Guiding Right, Inc. (GRI) is a minority community-based organization (CBO) that offers programs specifically designed for African American women infected and affected by HIV/AIDS. Currently GRI is the only CBO in the state of Oklahoma directly funded by the CDC and the Oklahoma State Department of

Health to provide targeted HIV prevention services to African American women. Sisters Who Care is a peer led support group for women of color infected with HIV or living with AIDS. The purpose of the support group is to bring women of color together in a safe environment to talk openly about the challenges that they face, and learn skills to make informed decisions and choices without the stigma and discrimination that is often associated with this disease. GRI also offers the SISTA intervention, a peer led group-level intervention program designed to prevent HIV/AIDS infection among African American young adult women. The SISTA Project consists of a total of ten hours (condensed into mini-sessions) that give participants knowledge, skills, and pride to actively protect themselves against HIV.

For more information, contact Theodore Noel (405) 733-0771.

Prevalences of HIV, STDs, and Hepatitis C, and Related Risk Behaviors Among Latinas on the San Diego/Tijuana Border Region

Submitted by Susan Gilbreath, PhD, Research Scientist, Epidemiologic Studies Section, California Department of Health Services, Office of AIDS

Latinos currently represent over 35 percent of California's population and are the fastest growing minority group in the state. With a prevalence of 2.9 cases per 10,000 women, Latinas represent 29 percent of reported HIV infections among women with HIV in California. A disproportionate number of HIV cases are in San Diego County, proximal to the U.S./Mexico border. The Transborder Latino Women's Health Study assessed the prevalence of HIV, STDs, hepatitis C, and related risk behaviors among Latinas living in the San Diego/Tijuana, Mexico border region. This investigation represented collaboration among the State of California, Department of Health Services, Office of AIDS; the County of San Diego Health and Human Services Department; and the community-based organization, Proyecto de Consejo y Apoyo Binacional (Bi-National AIDS Advocacy Project, PROCABI).

From July 2003-July 2004, 513 Latina women, ages 18-35, were recruited by trained community health workers from PROCABI. Women participated in an in-depth interview and provided specimens for HIV, STD, and hepatitis C testing. Test results, counseling, and referrals were provided to participants during follow-up visits. One hundred sixty-three women from San Diego and 350 women from Tijuana participated in this study. The prevalence of HIV was higher in San Diego than Tijuana (nearly 5 percent versus 0.3 percent). However, rates for STDs were higher among Tijuana than San Diego participants: syphilis, 2.0 percent versus 0.0 percent; gonorrhea, 1.4 percent versus 0.0 percent; and chlamydia, nearly 11 percent versus 5.0 percent. Rates for hepatitis C were 6.2 percent among women from San Diego and 6.0 percent among women from Tijuana.

Among the samples from both sides of the border, high acculturation into American society, history of homelessness, receipt of compensation for sex, multiple sex partners, and alcohol use were positively associated with engaging in risky behaviors such as unprotected sex. A majority (80 percent) of women in San Diego reported sexual partners from Mexico, with over half reporting only partners from Mexico, indicating a potential pathway of disease transmission across the border. The results from this study can assist in developing effective HIV/AIDS prevention and education programs targeting Latina women.

For more information, contact [Dr. Susan Gilbreath](#) (916) 449-5789.

Microbicides: Putting the Power of Prevention into Women's Hands

Submitted by Bindiya Patel, North American Coordinator, Global Campaign for Microbicides

Statistics reveal a growing trend – the burden of HIV is falling disproportionately on African American women. Two out of every three women newly diagnosed with AIDS are African American. ¹ HIV rates among African American women are 19 times higher than rates in white women. ² And most women with HIV, both in the U.S. and worldwide, became infected through sex with men. ³ Right now, condoms are an effective HIV prevention tool, but women are not always able to negotiate condom use with men – especially with their long-term partners. Microbicides, products that could prevent transmission of HIV when applied topically, offer women a way to protect themselves without requiring their partners' consent.

The research pipeline in 2006

Microbicides are not yet available. Scientists are currently testing dozens of products to determine if they help protect against HIV and/or other STDs. Of those, five are in large scale human trials around the world, where thousands of women are using the products to determine if they are effective against HIV. These five products (BufferGel, Carraguard, Cellulose Sulfate, PRO 2000, and Savvy) are developed by non-profit organizations or small biotech companies with public funding. If one of these five products currently in advanced clinical trials proves to be effective, a microbicide could be ready for distribution in a handful of countries in five to seven years. If the current set of products does not prove effective, the time horizon will be longer, waiting for the second-generation leads that are currently in the safety testing phase.

The products work in one of several ways, by killing or otherwise immobilizing pathogens, blocking infection by creating a barrier between the pathogen and its target cells, or preventing the infection from taking hold after it has entered the body. The first generation of microbicides is likely to reduce risk of transmission by no more than 40-60 percent. But even a "partially effective" microbicide can provide substantial protection from HIV, especially if used consistently. The goal is to incrementally improve both the effectiveness of microbicides and the range of sexually transmitted infections against which they are effective. Just as the first generation of anti-HIV therapies, such as AZT, were cumbersome and less than optimal, microbicides will likely become more effective, more "user-friendly," and cheaper over time. The future of prevention is in "combination microbicides" that are more effective when they combine two or more mechanisms of action.

Microbicides as one of many essential prevention strategies

Microbicides alone are not likely to be as effective as correctly-used condoms. They will, however, offer back-up protection for condom users. Most importantly, they offer a prevention alternative for people who are unable to use condoms. Clear messages about microbicides and condoms, and about multiple HIV prevention tools, must be conveyed.

In the end, we all know that no one technology or strategy will "solve" the AIDS pandemic. We must employ all existing prevention options, such as behavior change, voluntary counseling and testing, STD diagnosis and treatment, broad access to male and female condoms, and access to anti-retroviral drugs. Microbicides are a critical component of these strategies, especially for women. In fact, modeling studies conducted by the London School of Hygiene and Tropical Medicine estimate that a 60 percent effective microbicide could avert 2.5 million infections over three years, if introduced into 73 low-income nations.

The need for public funding

Microbicide research depends on government funding, because big pharmaceuticals are not investing in this research. Right now, barely two percent of the U.S. budget for HIV/AIDS research – only two cents of every dollar – is spent on efforts to find a safe, effective microbicide. The timeframe in which microbicides become available largely depends on how many people are demanding them. In order for microbicides to be a higher priority, policymakers need to hear from communities that microbicides are important.

In 2005, the Microbicide Development Act (MDA) was introduced with bipartisan support in both the Senate (S. 550) and the House (H.R. 3854). If passed in 2006, the MDA will help ensure that the U.S. government's commitment to microbicide research and development is increased substantially.

For more information, visit the [Global Campaign for Microbicides](#) website.

¹ CDC, HIV/AIDS Surveillance Report, Vol.16, 2005

² CDC. Diagnoses of HIV/AIDS—32 states, 2000–2003. MMWR 2004; 53: 1106–1110

³ CDC, HIV/AIDS Surveillance Report, Vol.16, 2005

Adolescent and School Based Health: African American and Latina Youth and HIV/AIDS

Black women and Latinas account for 79 percent of all reported HIV infections among 13-19 year old women and 75 percent of infections among 20-24 year-old women in the U.S., although together, they represent only two percent of U.S. women these ages. ¹ By the end of 2001, African Americans represented 68 percent of all new HIV diagnoses among 13 to 24 year-old girls and young women.² Poverty, involvement with older male partners, inconsistent use of condoms or the inability to negotiate the use of condoms, and cultural norms are just some of the factors putting many young women of color at-risk for HIV infection.

Young women of color need HIV/AIDS information framed within their specific cultural context, ³ gender-specific information and services that address their situation and pay attention to power imbalances in their relationships, ^{3,4} as well as interventions that enhance self-esteem, address depression and substance use, and give youth hope for the future.⁵ Furthermore, young women need programs that build their skills in communication, negotiation, and assertiveness. ^{3,4,5,6}

Following are profiles of two national organizations currently implementing programs for young women of color.

Advocates for Youth: Young Women of Color Initiatives

NASTAD interviewed Smita Varie, Manager, Internet Services, Advocates for Youth.

Background

Advocates currently has three programs dedicated to young women of color primarily focused on African Americans and Latinas. Advocates began implementing programs specifically targeting these populations when the disparity of HIV/AIDS among Young Women of Color (YWOC) became increasingly apparent.

The Young Women of Color Leadership Council was launched in 2002. The main purpose of the group is to promote HIV prevention among at-risk populations, and to empower participants as leaders and peer educators. The goals and mission of the group were developed by youth participants. The group started with eight participants, selected from external recommendations and young women who had previously served as Advocates interns and volunteers. The group has grown to twenty participants and their primary activities include participating in workshops and community forums, writing op ed pieces, and planning events around national awareness days, such as World AIDS Day. Participants come to Washington, D.C. once a year for intensive training on the current trends in HIV among YWOC and on conducting workshops, peer education skills, etc. Participants are encouraged to start a Young Women of Color Leadership Council (YWCLC) in their communities, which typically results in the formation of a group on a college campus. The first such group was formed at George Washington University and was active for approximately two years. There is currently a YWCLC at Spelman College in Atlanta, GA, and a group is being formed at the University of South Florida at Tampa. Younger school-aged youth have been difficult to engage, based on academic and independent travel constraints, so participants have typically been 17 years and older.

Another Advocates project targeted at YWOC is the MySistahs.org website, which was launched in 2000. This website focuses specifically on reproductive health issues impacting YWOC, through an offering of educational features and message boards, and serves as a mechanism through which youth can make informed decisions about their health. Currently, eleven peer educators write the articles for the site and respond to questions posted to the site, which averages between 16,000-18,000 visits per month. Visitors post questions which are answered by peer educators who are typically between the ages of 14-16.

What common challenges have you faced implementing these programs?

Advocates has faced several challenges. Our participants are very passionate, committed, and motivated; however, they are typically involved in several other activities which potentially draw their attention away from the Advocates program with which they're involved. Our programs are voluntary and there is no stipend provided, which is often an issue since lack of income or generating income is a concern of many participants. We strive to cover issues for all women of color, but we continue to focus most of our

programming on African American and Latina youth. We would like to incorporate more participants and information from Native American and Asian Pacific Islander communities. Lastly, our program has typically drawn from youth who are in school, either high school or college. It has been difficult to tap into out-of-school and homeless youth.

What positive impacts, besides increased awareness about HIV prevention, do your programs have on participants?

Our programs offer many participants their first opportunity to become involved in a cause or purpose in which they are involved in the decision making process from start to finish. Ownership of the process builds commitment and leadership. Experiences such as writing articles and responding to questions on MySistahs.org, and making presentations at national HIV conferences have led to several participants choosing to pursue careers in women's health and HIV prevention.

What are some of the key lessons learned from your programs focused on young women of color?

The primary lesson learned is not specific to young women of color, but to any program with youth participants. There's often hesitation to let young people run programs. The bottom line, however, is that they are the ones that can do the most effective education among their peers. They are extremely enthusiastic, committed, and can teach us a lot about effective communication with youth.

What are some of your upcoming activities for 2006?

Advocates will launch a national campaign in February 2006, hopefully to coincide with National Black HIV Awareness Day. Another activity that we're proud of is having some of our YWOC participants present at the Ryan White Youth Conference.

For more information visit the Advocates for Youth website.

National Latina Health Network: Programs for Young Latinas

NASTAD interviewed Elizabeth Amaya-Fernandez, Director of Youth Initiatives, New Jersey Office.

Background

The Teatro AIDS Prevention Project (TAPP) combines traditional Latino theater, or teatro, with peer education to prevent HIV infection among Latino youth, especially young women ages 16-24, and encourages them to take responsibility for and make responsible decisions regarding their sexual health. The project was organized through a series of town meetings held in major urban cities with large Latino populations. The town meeting forum allowed for input and support from women's groups, local policy makers, community based organizations, business and community leaders, and public and private sector groups. Teatro performances are held in high schools and colleges, community organizations, churches, shelters, and any other venue where young Latinas come together. Depending on where the drama is performed, language and cultural modifications are made to ensure that the message is appropriate for the diverse range of Latino audiences.

The "Healthy Life CHOICES" (CHOICES) Project also incorporates elements of peer education and theater to engage participants. The program uses theater to motivate Latinas (ranging in age from 18-25), on college campuses, around health prevention strategies including HIV prevention. One of the primary activities of this project involves the partnering of students and campus and community leaders to convene campus-wide health forums.

The Latinas Educating Each Other (LEEO) project uses a community-centered approach to mobilize communities to become aware of the impact of HIV/AIDS. The LEEO project enhances HIV/AIDS service provider's capacity and in 2006 the project will begin recruiting young Latina participants between the ages of 18-24 to address HIV/AIDS issues in their communities.

How do you reach and retain program participants?

We reach participants through our local networks of Latina health professionals and through work with our state and national partners. We retain participants by ensuring that they are part of the planning process and by having them see the results of all their work and input. Those who have stayed with our projects the longest are those young people that have been part of our national youth advisory groups, those who have been able to present at national conferences such as the U.S. Conference on AIDS (USCA), and those who have attended national meetings. Some local networks provide monetary incentives to the peer educators in order to assist in retention.

What are some of the common challenges faced by your participants in protecting themselves from HIV?

Common challenges faced by participants in our HIV prevention projects are finding ways to assert themselves to their partners, since many lack empowerment strategies and communication skills. Also, HIV is not a main priority in their daily lives. They face other challenges and may not think about protecting themselves when they most need to.

What have been your successes and how do you measure success?

The most notable way that we are able to measure success is through the development and growth of our local and national networks. Our success is currently captured through qualitative feedback from participants. Based on the time frame of many of our youth projects, it is difficult to measure changes in behaviors, but we've been able to identify positive changes in attitude.

What are three lessons learned that you would share with other organizations trying to implement programs for Latina youth?

Partner with young people as much as you can throughout the project, in the planning, implementation, and evaluation of the project. Listen and demonstrate that you have listened by truly utilizing their input. The most effective programs are those that involve collaborative partners. Use national, state, local, and federal partners to strengthen your resources. Finally, continuously assess cultural competence at all levels.

What are some of your upcoming activities for 2006?

NLHN will be hold a National Latina Health Summit in September in Washington, D.C. The LEEO Project is accepting applications for the Latina HIV/AIDS Health Leadership Institute and will select 20 young Latinas to participate this year. Our local networks will be holding community health forums throughout the year.

For more information, visit the [National Latina Health Network](http://www.nationallatinahealthnetwork.org) website.

¹ Advocates for Youth. (2003). *The Facts: Young Women of Color and the HIV Epidemic*. Washington, DC: Advocates for Youth. Retrieved January 6, 2006 from <http://www.advocatesforyouth.org>

² CDC. "Patterns of new HIV/AIDS among adolescent and young adults in 25 states." Presented at 2005 National HIV prevention Conference, oral session. June 13, 2005: CDC. HIV/AIDS Surveillance report, v. 13, n. 2, table 8.

³ Weeks MR *et al.* AIDS prevention for African American and Latina women: building culturally and gender-appropriate intervention. *AIDS Educ Prev* 1995; 7:251-63.

⁴ CDC. *HIV/AIDS among U.S. Women: Minority and Young Women at Continuing Risk*. Atlanta, GA: The Centers, 2002.

⁵ University of California at San Francisco Center for AIDS Prevention Studies. *What Are Adolescents' HIV Prevention Needs?* San Francisco, CA: The Center, 1999.

⁶ Wyatt GE *et al.* Adapting a comprehensive approach to African American women's sexual risk taking. *J Health Educ* 1997; 28(6 Supp):S52-S59.

Perinatal HIV Prevention Resource

Four Sisters, Four Stories, a new educational booklet about preventing perinatal HIV infection, has been completed and distribution to HIV/STD service providers began in January. The primary target audience of this booklet is women of childbearing age with HIV infection or at risk for HIV infection. The stories in the booklet are based on interviews conducted with HIV-infected women of childbearing age in East Texas. The booklet also includes a list of frequently asked questions and other information about pregnancy, HIV, and other STDs. In December, a draft of the booklet was reviewed in one-on-one interviews with members of the target audience in Houston. Feedback was generally positive and the women expressed interest in sharing the review copies with other women they knew. The booklet was also reviewed and approved by the statewide Program Materials Review Panel (PMRP). A Spanish version of the booklet may be created in 2006 if funding permits.

For more information, contact [Greg Beets](mailto:Greg.Beets@ucsf.edu) (512) 533-3025.

Capacity Building Calendar

Information on CDC-sponsored Capacity Building Assistance trainings for [February-April](#) is now available.

Meeting and Planning Calendar

March 31-April 1, 2006

National HIV Testing Day Skills-Building Institute, Washington, D.C. For registration information, click [here](#). [En español](#).

April 30 – May 4, 2006

17th International Conference on the Reduction of Drug Related Harm, Vancouver, BC, Canada. For more information, visit the [conference website](#).

May 2-6, 2006

"Embracing Our Traditions, Values and Teaching: Native People of North America HIV/AIDS Conference," Anchorage, AK. Presented by Inter-Tribal Council of Michigan, Inc. Currently accepting abstracts on Research, Mental Health, Prevention, Special Populations and Stigma, Spiritual Issues and Leadership, and Treatment, Care and Support. For more information, visit the [conference website](#).

May 8–11, 2006

National STD Prevention Conference, Jacksonville, FL. "Beyond The Hidden Epidemic: Evolution or Revolution?" For more information, visit the [conference website](#).

May 19, 2006

National Asian and Pacific Islander HIV/AIDS Awareness Day. For more information, visit the [event website](#).

May 25-28, 2006

"HIV/AIDS 2006: The Social Work Response." Eighteenth Annual National Conference on Social Work and HIV/AIDS, Miami, FL. Sponsored by the Boston College Graduate School of Social Work. For more information, contact [Vincent Lynch](mailto:Vincent.Lynch@bc.edu) (617) 552-4038.

June 4-7, 2006

HIV Prevention Leadership Summit (HPLS), Dallas, TX. For more information, visit the [conference website](#).

June 27, 2006

National HIV Testing Day. Sponsored by the National Association of People With AIDS. For more information, visit the [event website](#).

August 13-18, 2006

XVI International AIDS Conference, Toronto, Canada. Abstract submissions due February 22, 2006. For more information, visit the [conference website](#).

September 12-14, 2006

CDC's 2006 National Health Promotion Conference: Innovations in Health Promotion: New Avenues for Collaboration, Atlanta, GA. For more information, visit the [conference website](#).

September 24-26, 2006

United States Conference on AIDS (USCA), Hollywood, CA. For more information, visit the [conference website](#).

November 4-8, 2006

"Public Health and Human Rights," American Public Health Association's 134th Annual Meeting, Boston, MA. For more information, visit the [conference website](#).

November 8 – 12, 2006

Sixth National Harm Reduction Conference, Oakland, CA. For more information, visit the [conference website](#).

If you have an idea or program relative to any of these topics that you would like to include in the *Bulletin*, please contact [Nyedra Booker](#) (202/434-8090). The NASTAD *HIV Prevention Bulletin* is written and edited by NASTAD staff and participants of community planning and prevention efforts around the country.

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Visit our Webpage! Electronic versions of the *Bulletin* are posted along with other information on both NASTAD's prevention and care projects.

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The logo for NASTAD, consisting of the word "NASTAD" in a bold, sans-serif font. To the left of the text is a vertical ellipsis (three dots) and a vertical line.

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