

Prevention of Sexually Transmitted Infections in Inner-City Mexican- and African-American Women

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- **Have a relevant theoretical model: provides structure and coherence**
- **Know your community: ethnography**
- **Integrate qualitative data with theory to design intervention**
- **Pretest 'till it hurts'**
- **Randomized trial to test efficacy**

Stages of AIDS Risk Reduction Model (ARRM)

- 1. Recognizing one's risk**
- 2. Making a commitment to reduce risk**
- 3. Following through on commitment by seeking and enacting solutions**

Factors Important to Stage 1 (Recognizing One's Risk)

- 1. Recognition of personal susceptibility**
- 2. Knowledge of disease transmission**
- 3. Social support**

Factors Important to Stage 2 (Committing to Reduce Risk)

- 1. Knowing what works to reduce risk**
- 2. Knowing ways to increase enjoyment from low-risk activities**
- 3. Recognizing barriers to change**
- 4. Recognizing benefits to change**
- 5. Self-efficacy – confidence in ability to change**
- 6. Social support**

Factors Important to Stage 3 (Following Through on Commitment)

1. **Social skills attainment (primarily sexual communication)**
2. **Condom application skills**
Partner selection
3. **Social support**

KNOW YOUR COMMUNITY

- **Design the intervention so that its content and presentation are consistent with and relevant to clients' belief systems, values, behaviors, language, and lifestyles (their reality)**
- **Extend existing belief patterns to new behaviors.**

- **25 Focus Groups**
- **102 In-depth Interviews**
- **31 Short Interviews**
- **Community Observation**

Ethnographic Data

- **Life Conditions/Lifestyles**
- **Sexual Behavior**
- **Knowledge/Concern about STDs/AIDS**
- **Risk Perception**
- **Male-Female Relationships**
- **Drug/Alcohol Use Patterns**
- **Use/Attitudes Toward Condoms**
- **Motivation to Reduce Risk**
- **Strategies to Increase Motivation**
- **Logistics of Intervention**

Recognition of Own Risk

- **Low prevalence of AIDS in SA**
- **Contracting STD least of problems**
- **Diseases most familiar with have been readily curable**
- **Douching an important hygienic practice to African-Americans**
- **Little knowledge of serious consequences of symptomless STDs**

Recognition of Own Risk (continued)

- **Limited understanding of transmission process – partners' other partners**
- **Tendency to blame partner instead of assuming responsibility**
- **God's will**
- **Believe can judge who is safe**

“To find a decent woman that I can make love to? I go to nice clubs. Mingle. I talk to her. I find out all about her: Where is she from? Where she works, if she works? What does she like to do? Does she have any children? If she takes care of her family, herself, and you see her appearance, and then you don’t see her everywhere, here, there, unless she’s working, mostly between two points, to work and back. She’s gonna have some fun in between. She’s not out there all the time. She socializes with very few people.”

“Because some people think like this, they see a fine broad, they say, she don’t have it, she clean, I figure if you go to the ugly one you be better off, but that might be the one that really be givin’ it to you, nobody be looking at her, she happy for anybody to come to her.”

Triggers to Motivate Behavior Change

Mexican-Americans:

Great need to protect family (parents, partner, children, future children) from disease or unhappiness

Strong identity with Hispanic people

African-Americans:

Survival by wits/intelligence

Strong emphasis on cleanliness and disease prevention: not sharing eating/drinking utensils

Strong identity with African-American people

L: “Basically, when you are drinking behind somebody, you’re sharing. Suppose the individual have teeth removed or whatever and had oral sex with a man or female and that individual had got burned (i.e., infected with an STD) or whatever. And, there is some kind of discharge or whatever or some type of cut from the mouth or whatever. And that blood is being transmitted. Or, have a busted lip, a busted lip from smoking (crack) too much.”

T: “We don’t like to share. If you have your own cup, we’ll give you a drink, but we won’t let you drink out of the same cup and the same bottle.”

L: “See, just like them, like that, it just happened. (He refers to a news item being presented on the television.) That day they got stabbed over a beer. They were drinking out of a bottle. It happens. It shows. (He gestures to indicate that an individual does not drink from another’s beer bottle.)”

R: “That’s interesting because on the one hand people don’t drink behind each other, but yet they may share the same guy or the same woman.”

T: “That’s what the matter here.”

Barriers to Safer Sex: Condom Use

Convinced partner is against use

Means acknowledging lack of trust

Dislike – does not feel natural

**Problems with use – breakage, lodge inside,
halfway placement**

Difficult when high on drugs/alcohol

Difficult – heat of moment

**Do not realize effectiveness dependent on
consistent use**

Barriers to Safer Sex: Comfort with Sexuality and Self-Efficacy

Mexican-American Women:

Uncomfortable with many aspects of sexuality

Perceive men dislike the “macha” (the sexually aggressive woman)

Most women do not know how to ask for condom use, let alone apply one

Mexican-American Men:

Some lack condom placement skills; embarrassment

Fear of fumbling

Acquiescing to woman’s request may threaten sense of control

Some concern for erection loss

ME: If you learned something (from the workshop), how do you plan to apply it in your life?

MR: It's been about three weeks since my boyfriend went to jail, to Louisiana, and before he left he wanted to have sex...I took out a condom, it was my first time. I had never used one, never. He didn't get mad or angry. I was afraid cause this was the last time he'd see me, right and I wasn't going to see him for about two years, but I took it out, and I was scared! But he didn't question it or anything. He used it! He put it on...He didn't get mad, and still told me he loved me before he left.

Barriers to Safer Sex: Multiple Partners

Mexican-American Community:

Tacit assumption that men may be unfaithful; accepted if kept hidden

Women often feel “owned” by husband

Feel they cannot show sexual enjoyment in fear of being perceived as “whores”

Women may seek lovers (Sanchos) for self-expression

Barriers to Safer Sex: Multiple Partners

African-American Community:

Marriage is not the norm; fluidity of relationships

Male unemployment – obtain income from female sexual partners

Women perceive shortage of available men.

Tolerate infidelity and unemployment for affection; blame infidelity on “tramps” who enticed him

Belief – males have a weakness for women – difficult to overcome

Seeking of Health Care

Delay care until it hurts

do not want to be seen at STD Clinic

feel put down

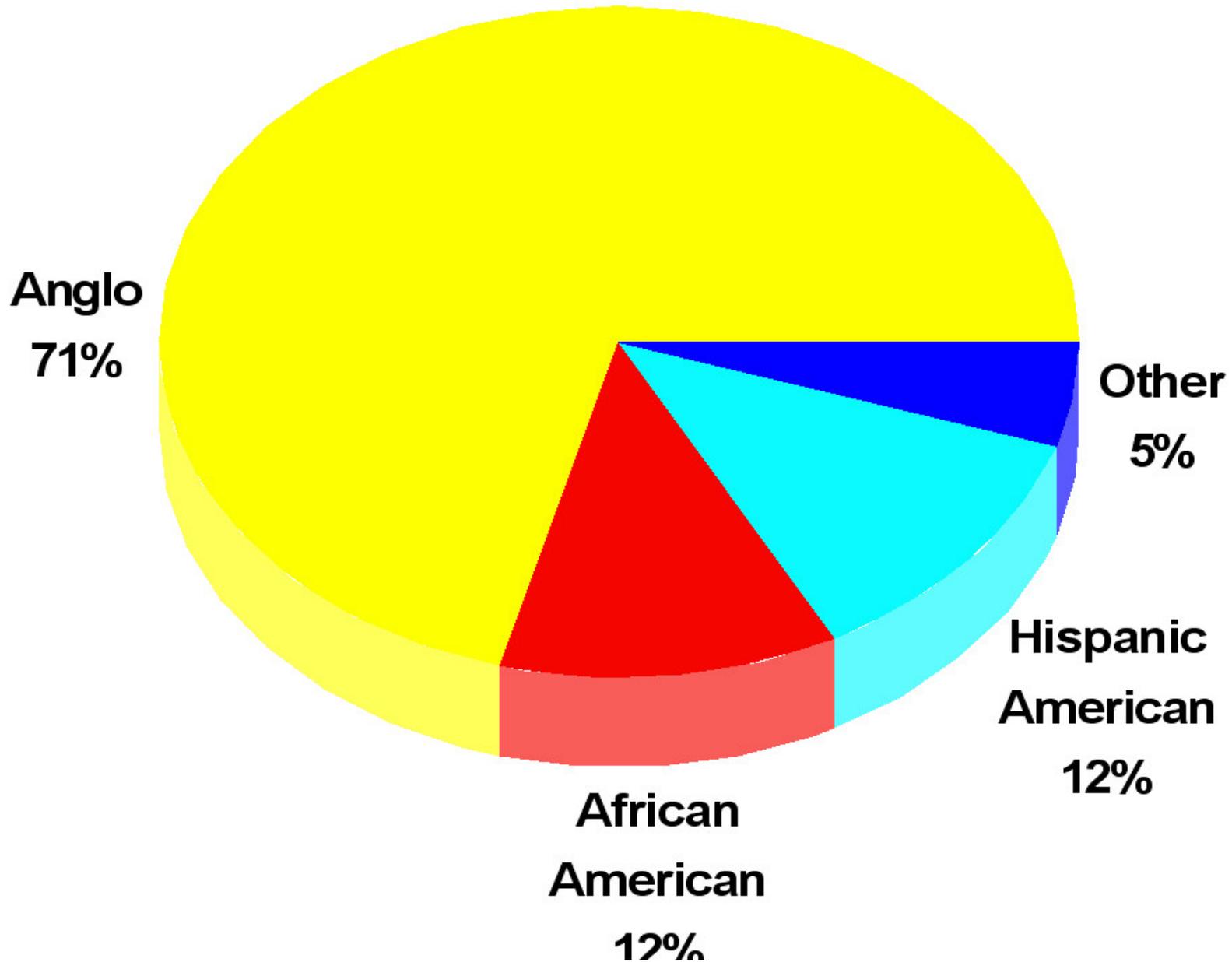
Share medication when symptoms disappear

Session 1 - Motivate Clients to Recognize Risk and Begin to Commit to Risk Reduction

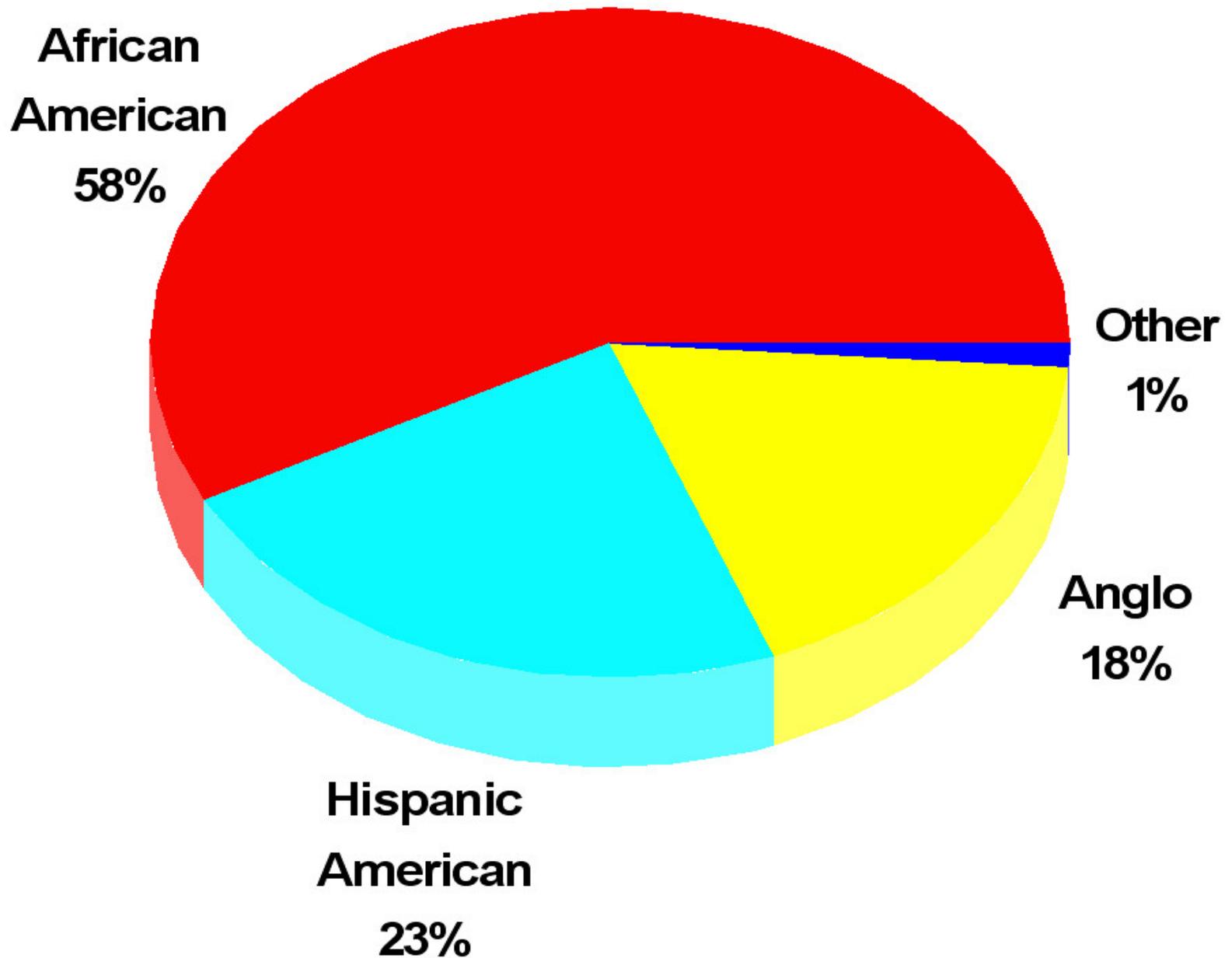
Disassociate disease from being “dirty”

**Appeal to concerns about one's people
– minorities are disproportionately
affected by AIDS/STDs**

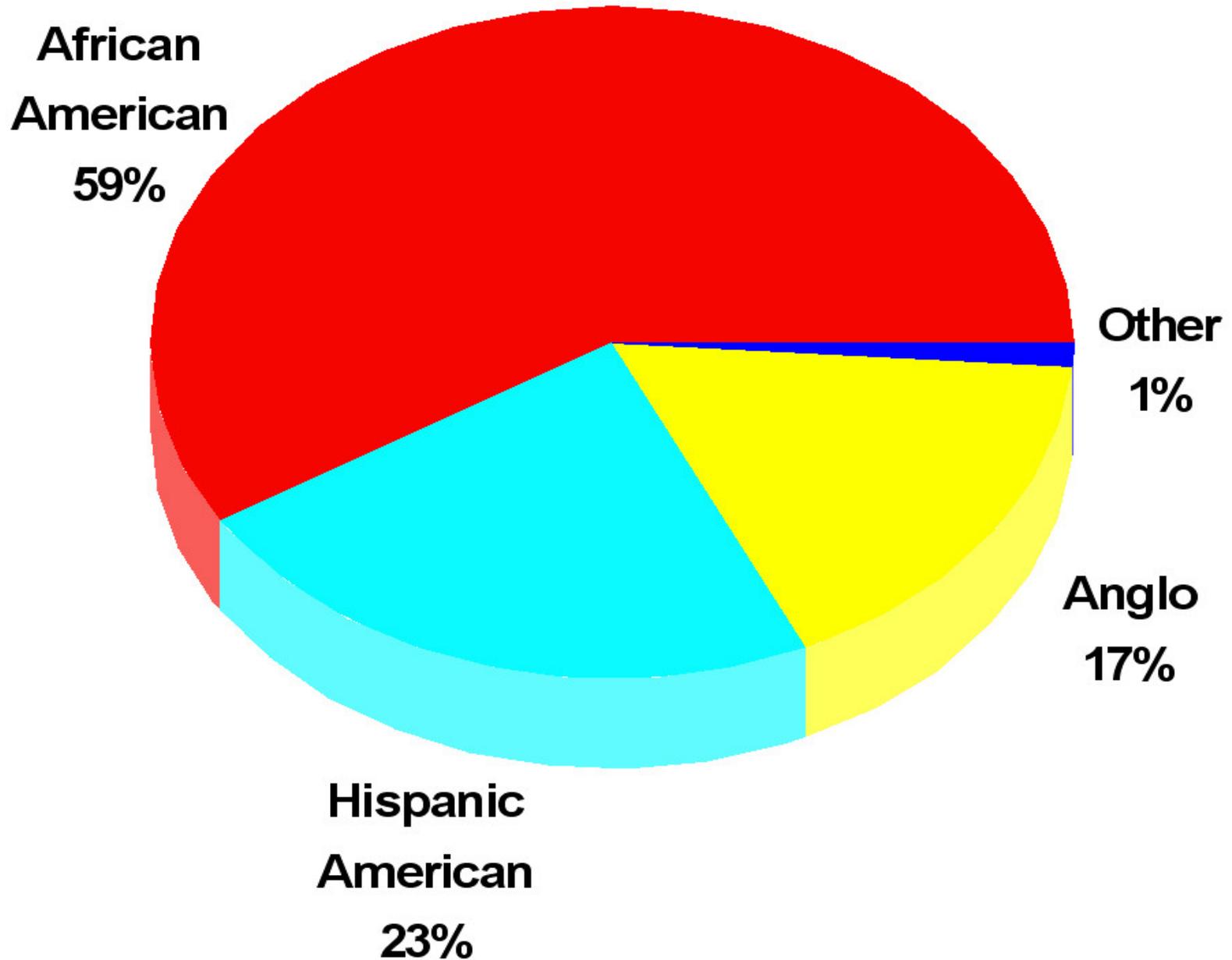
PEOPLE IN THE UNITED STATES



WOMEN WITH AIDS



CHILDREN WITH AIDS



**Increased risk not associated with
skin color but with poverty**

Low Income, Education, Self Esteem

PROBLEMS

- Health Insurance
- Transportation
- Money for Doctor
- Information for Free Care
- Fear/Put Down
- Not Going to Doctor till it Hurts
- Sharing Medicine--No One Gets Cured
- STDs Stay Around Longer & Infect More People
- Sores/Body Weak—Easier to Get Another STD if Exposed

- Sex for Economic/Social Support
- Drugs to Feel Good
- Prison/Share Needles
- Sex/Tattoos

AIDS

What Can We Do?

Session 1 (continued)

Dissipate myths

Is it God's will for a mother to die and leave her children or to pass on AIDS to the baby she's carrying?

Accept responsibility and protect yourself

**Understanding disease transmission –
define "sex"**

Session 1 (continued)

Discuss partner selection – who is safe – survival of the smartest

STDs – treatment issues – take all medicine – do not share

Show frightening pictures of symptoms in men and women

Discuss absence of symptoms and female vulnerability

Session 1 (continued)

Connect current STD to possibility of AIDS

Explain consequences of STDs/AIDS

STDs: focus on infertility and consequences to baby

AIDS: focus on what happens to family

Encourage clients to share information - children

Session 2

Commitment To Reduce Risk

Teach preventive methods:

abstinence, mutual monogamy

decrease rate of partner acquisition

avoid unprotected sex until in a long-term relationship

extend “not drinking behind” to not “having sex behind”

Is any man worth dying for?

consistent, correct condom use

avoid douching

avoid sex with incompletely treated partner

Session 2 (continued)

Learn what questions to ask partner

Check partner for symptoms

Men like women to apply condoms

Learn how to use condoms correctly

Learn how to enhance pleasure with condoms

Test 2 types of condoms

Openly discuss barriers to use

Discuss importance of self -- what one gets in relationship, what one wants, why settle

Teach/practice decision-making model:

list and write consequences of each decision

Session 3

Skills Acquisition

Sexual communication skills – talking can be erotic

Mexican-Americans – women tell partner turned on because of him, have more fun if talk, if allow expression

Reduce need for more partners

Session 3 (continued)

How to request condom use

Stress protection (positive aspect of machismo), can feel good, respect what I know, next time AIDS, not your first, still in charge

Males – share control

Role play to raise feelings of self-efficacy

Practice erotic application of condoms

The Intervention

- **Small groups**
- **Ethnicity matched facilitators**
- **3 weekly sessions, 3 hours each**
- **Active involvement of participants**
- **Standardized scripts**
- **SAFE 2: added support-group option (enhanced intervention)**

Synopsis of Objectives

- **Raise HIV risk awareness; inform about STD consequences and prevention and the importance of early treatment and full compliance**
- **Build feelings of self-efficacy and power to control one's life**
- **Raise consciousness regarding importance of self and awareness of what women want from a relationship and what they get**

Synopsis of Objectives

- Stress partner selectivity, mutual monogamy, condom use, and avoiding douching
- Increase sexual communication skills, particularly condom negotiation: role play
- Teach condom use and erotic placement
- (For Mexican-Americans) Facilitate recognition that sexual enjoyment is appropriate

Evaluation of Efficacy

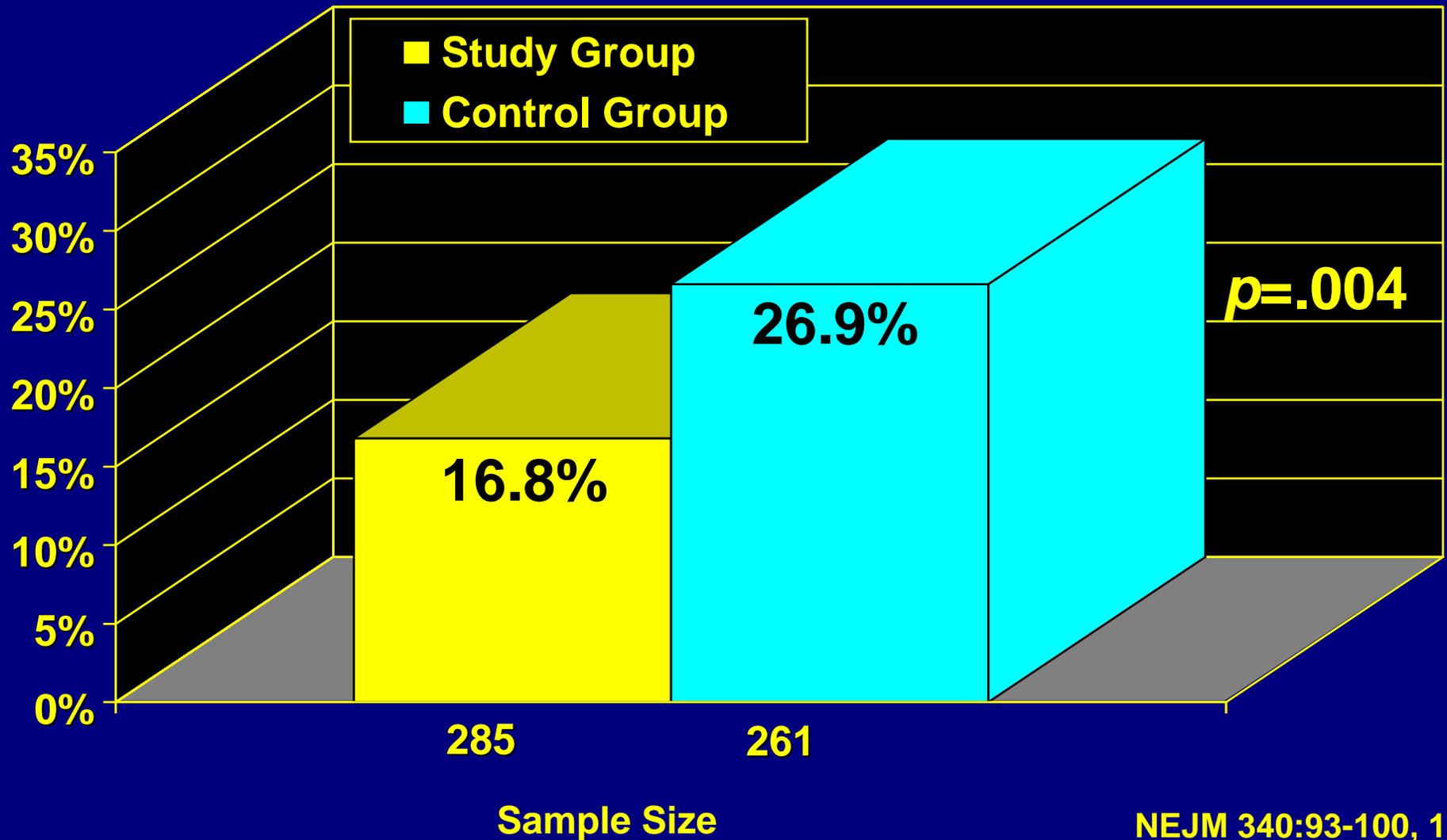
- **Controlled randomized trial**
- **Mexican- and African-American women**
- **Current curable STD**
- **SAFE Trial: 6 and 12 months' follow-up**
- **SAFE 2 Trial: 5 follow-up years; 2 years analyzed**

Evaluation of Efficacy (continued)

- **Primary outcome: Reinfection with gonorrhea or chlamydia, confirmed by lab**
- **Secondary outcomes: changes in sexual behaviors**
- **Analysis: Intent to treat**

SAFE (1991-1995)

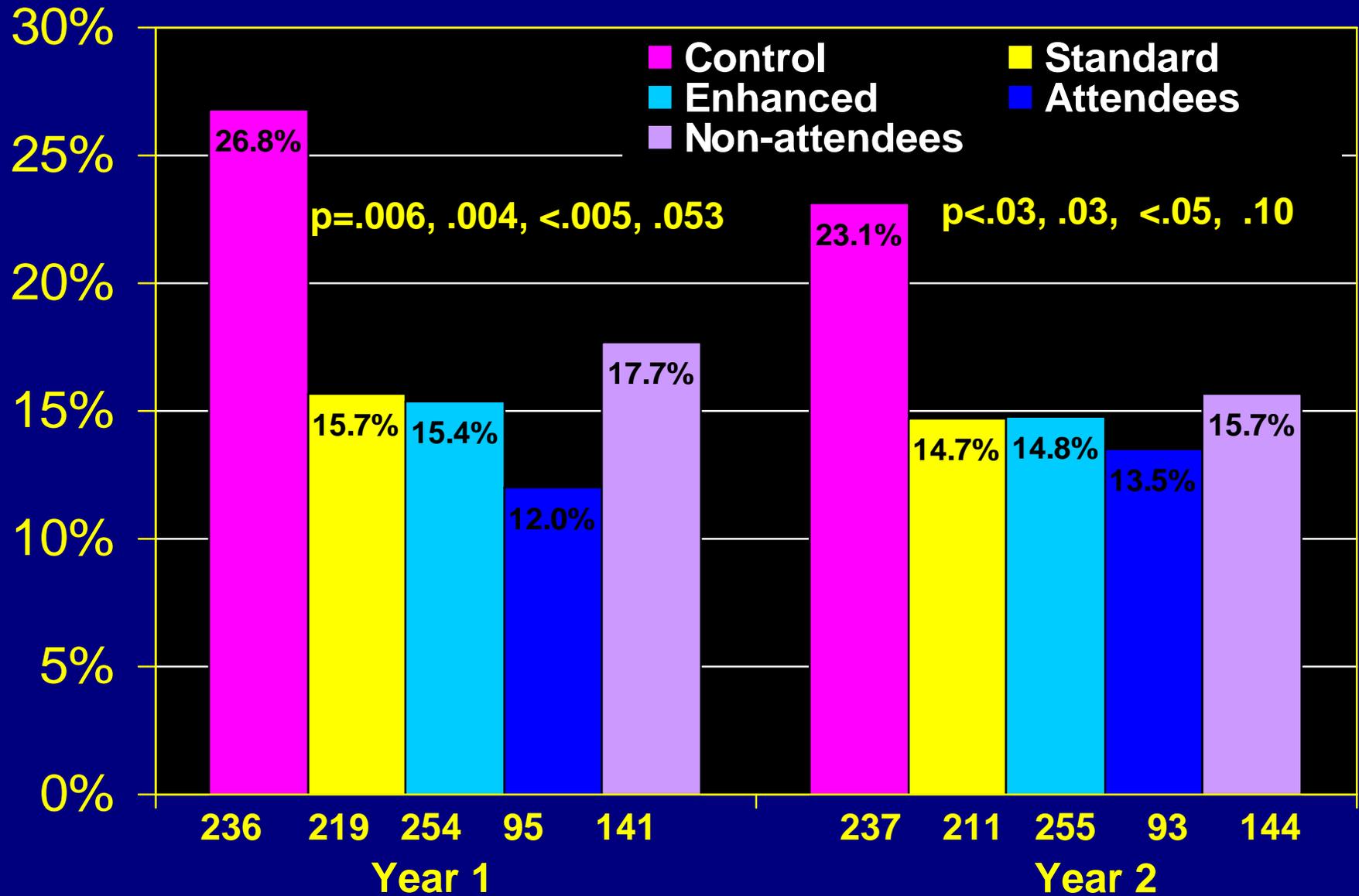
Cumulative 12-Month Reinfection Rates with Gonorrhea and/or Chlamydia



Conclusions: Project SAFE

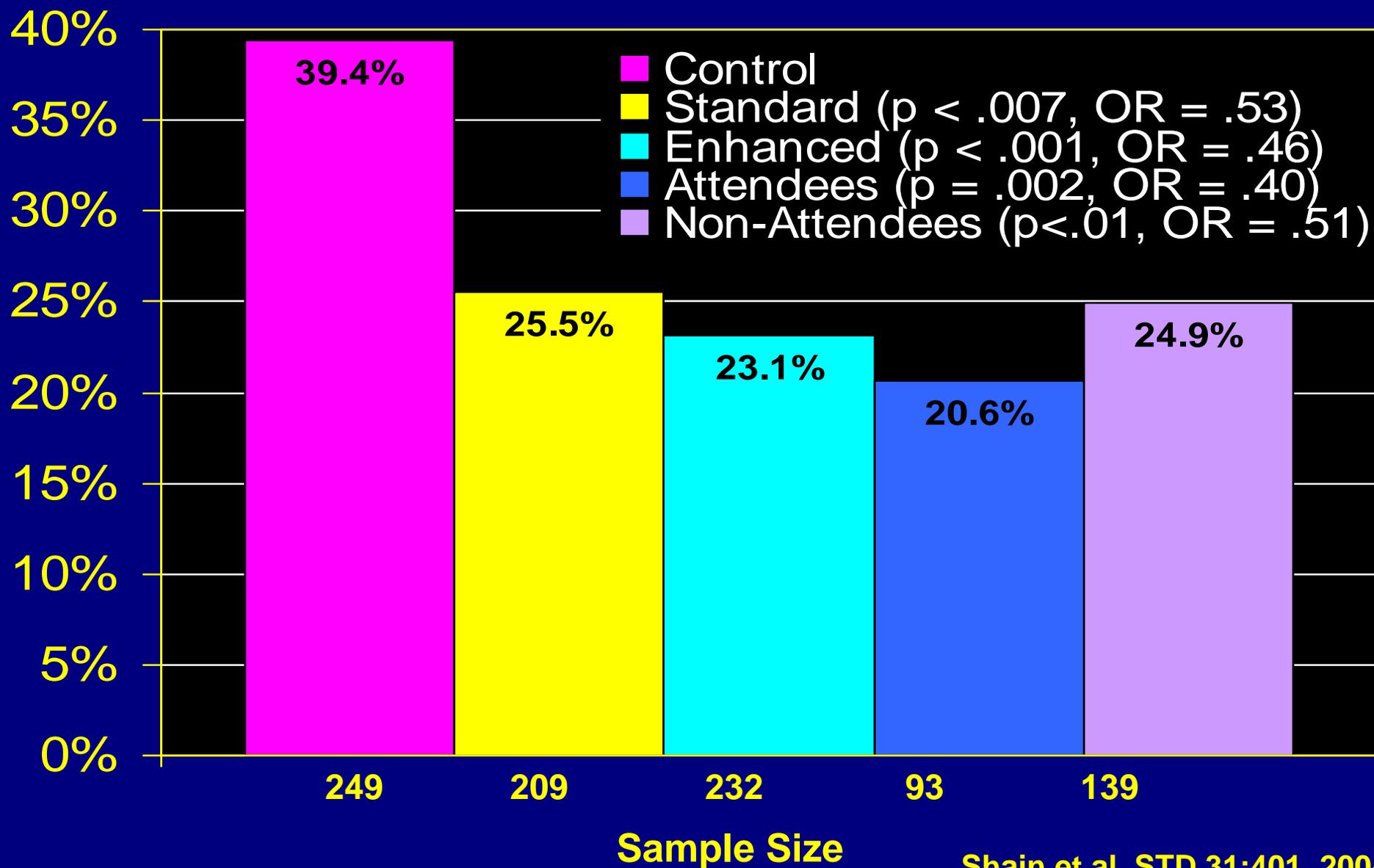
- A culture and gender specific behavioral intervention reduced rates of gonorrhea and/or chlamydia among Mexican- and African-American women at 0-6 months, 6-12 months, and 0-12 months. Respective effect sizes were 34%, 49% and 38%.

SAFE 2: Adjusted Percent of Women Infected Years 1 and 2



Shain et al, STD 31:401, 2004

Adjusted Percent of Women Infected at 0-2 Years



Conclusions: Project SAFE 2

- **Both arms of the behavioral intervention were significantly associated with reduced rates of GC/CT in the 2-year study period. Effect sizes were 42.5% & 41.4% in Yr. 1 and 36% in Yr. 2.**
- **Data suggest that non-attendees were similar to standard-intervention participants and that support-group attendance conferred some additional benefit and should be encouraged.**
- **Future research should include booster sessions and determine ways to increase support-group attendance.**