Preventing the Spread of HIV From Unprotected Sex and Intravenous Drug Use Among Black Women Through Community-Based Intervention and Education

Dashiel Geyen, Ed.D., M.P.H.; Ingrid Fisk-Holmes, M.P.H.
H. Mark Guidry, M.D., M.P.H. & Janice M. Beal, Ed.D.

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There are many popular, yet erroneous, beliefs about HIV/AIDS held by some women from the Black community. Such attitudes only complicate their confusion surrounding the origin and fatality of the disease.

The disproportionate number of Blacks who test positive for the Human Immunodeficiency Virus (HIV) give reason to devote attention to this segment of society. Blacks are 12 percent of the national population (Selik, Castro, & Pappaioanou, 1988) and yet in September of 1990 an estimated 28 percent of the reported Acquired Immune Deficiency Syndrome (AIDS) cases in the United States affected Black people (Center for Disease Control [CDC], 1990). In October, 1992, the HIV/AIDS Surveillance Report from the Center for Disease Control reported 71,984 cases of AIDS among the Black population. This number represented 30% of the AIDS cases in the United States. The report further showed that Black adolescent/adult males are 26 percent (56,081) of males with AIDS, and that females formed 53% of the adolescent/adult female population with AIDS. HIV/AIDS is rapidly growing and affecting many Blacks. More recently in 1996 Blacks represented 41% of the adolescent/adult population who reported having AIDS. This was the first time in the history of the AIDS epidemic that this group exceeded Anglos (CDC, 1996).

According to the Center for Disease Control (1986), AIDS may be defined as a set of symptoms occurring at the cumulative stages of a human immunodeficiency virus infection. Moreover, it is characterized by a loss of immunity against an otherwise nonthreatening disease. The virus infects certain cells of the immune system and can also affect the brain. Infected people remain in relatively good health for several months to years before the illness develops. Infected people who are in good health are classified as HIV positive, but without the illness.

Once the symptoms develop, the severity of illness varies from mild infections to life threatening infections called Acquired Immune Deficiency Syndrome. Most infected people eventuality deteorate from a state of good health to severe disease.

HIV is spread by sexual contact, needle sharing, blood, blood products, or organ donation. The virus can also be transmitted from an infected mother to an infant during pregnancy, at birth, or shortly after birth (possibly through breast milk). There have also been a few reported cases of transmission by an infected (HIV positive) health care professional to the patient. While the research toward the biomedical effects of this disease is vital, it is equally important to address the psychosocial related behaviors that perpetuate the transmission of HIV/AIDS throughout this population. According to the National Institutes of Health (1997), the pharmacologic treatment of HIV positive individuals may increase the longevity, but is unknown how successfully treated individuals will alter their recreational drug use or sexual behavior.

The Prevalence of HIV/AIDS Among Black Women

More women are testing positive for HIV. According to Mays and Cochran (1988) the incidence of HIV infection among women is growing at a proportionately faster rate than any other specific minority group. AIDS is now the eighth leading cause of death among women 15 to 44 years of age (Jenkins, Lamar, & Thompson-Crumble, 1993). Even women who are incarcerated have most reported HIV/AIDS cases. AIDS has become a leading cause of death among female inmates (Brewer & Derrickson, 1992).

The U.S. Department of Health and Human Services (1992) reported that the rate of HIV infection among women in ten selected U.S. jails, federal and state prisons increased from 3.2% to 14.7% in 1991. They compared these numbers with male cohorts that reported an increase from 2.3% to 7.8% at the same locations during the same year.

As the number of AIDS cases among women continues to rise, the disease bares no preference. It cuts across all ethnic, cultural, and socioeconomic groups. One group that draws much concern is adolescent and adult Black females. More specifically, the groups that may be greatly affected are the lower income Black and Latino women who are exposed to HIV through sexual contact and drug use (Pettit, 1997). However, the number of AIDS cases continues to grow most rapidly among Black women. Black women diagnosed with HIV/AIDS are disproportionately over represented among females with AIDS cases (Wingood, Hunter-Gambles, & Di Clemente, 1993). Deaths resulting from AIDS among Black women in 1987 totaled 739 and had increased to 995 in 1988 (Jenkins, Lamar, & Thompson-Crumble, 1993). During 1994 there were a reported 4,166 deaths caused by AIDS, the following year the number had increased to 4,313 deaths among adult Black females. Bakeman (1987) suggested that cumulative incidence of AIDS among Black women is 12 times higher than that of White women.

Methods of HIV/AIDS Exposure

Among women heterosexual contact and injecting drug use account for 40 % and 34% of cases reported in 1996 (CDC, 1996). However, most of the Black women who are exposed to an HIV infection contract it via unprotected heterosexual activity, illegal drug use behavior, or a combination of both. The exposure categories for AIDS may vary by gender for Blacks. Nevertheless researchers who study Black adult females showed that the virus is primarily contracted through needle sharing for drugs and heterosexual contact (Belgrave & Randolph, 1993). Higher rates of infection among Black women are the result of higher rates of intravenous drug abuse and higher rates of infection among their drug using sexual partners (Jenkins, Lamar, & Thompson-Crumble, 1993).

The relative risk of intravenous drug abuse related AIDS has been consistently higher among Black women than with White women since 1982 (Selik, Castro, & Pappaionmoare, 1988). Therefore, researchers hypothesize that the greater proportion of Black women who abuse intravenous drugs in the Black community accounts for many differences in the distribution of AIDS cases by ethnicity.

Despite HIV/AIDS messages directed toward injectable drug users (IDUs), needle sharing continues to occur. Poor IDUs who are unable to obtain needles and syringes may use ìshooting galleriesî where needle sharing is common (Jue & Kain, 1989). Shooting galleries are usually abandoned and condemned buildings or houses where people can hide and inject drugs into their veins. According to Friedman (1990) and Inciardi (1992) a shooting gallery may be the most significant factor in the drug related transmission of HIV, because an HIV infected person may pass the infection onto other patrons of the shooting gallery.

Some women engage in unprotected heterosexual behavior in exchange for illegal drugs. Others participate in unlawful sexual activity to get money to purchase illegal drugs, and there are women who believe that ìgetting highî before having sex make the activity a more pleasurable experience. These actions contribute to greater exposure to HIV/AIDS among Black women. It is estimated that Black women represent about one third of female AIDS cases in the United States whose primary HIV risk was sex with a bisexual male (CDC, 1993).

Moreover the research shows that higher HIV infection rates among female inmates may be attributed to the prevalence of substance abuse, exchanging sex for money or drugs, and the greater efficiency of male to female HIV transmission (CDC1989; Graham & Wish, 1994; Van Hoeven, Stoneburner, & Rooney, 1991; Weisfuse, Greenburg, Back, Makki, Thomos, Rooney, & Rautenberg, 1991).

Socio-Cultural Dimensions and Self Efficacy

The cultural norms within many Black communities hold significance for addressing HIV/AIDS among Black women. Important social and biological contexts and co-factors can increase or decrease the likelihood of risk behaviors. Moreover many behavioral risk factors are quite well known but the contextual risk factors are only beginning to be understood (National Institutes of Health [NIH], 1997). AIDS education and prevention efforts have previously lagged in the development and implementation of gender and cultural specific programs that can help Black women in incorporating general AIDS knowledge into safer sex behaviors (Dalton, 1989; Mays & Cochran, 1988; Peterson & Marin, 1988). An understanding of the African American culture is important for educating Black women who exhibit risky behaviors.

A major concern for many Black women is how to deal with role strain produced by ìcultural conflict.î Cultural conflict occurs when some peeople stick to the status of their own culture and fail to assimilate to the norms of the dominate culture. For Black women this may mean they are often expected to adhere to certain behaviors that have been put into place in Anglo-male western civilization. Cultural conflict causes a great deal of stress for these women (Aponte, Rivers, & Whohl 1995). Cultural conflict may lead to sex role conflict such as identity crisis, feelings of isolation, alienation, or depression.

Cultural attitudes influence the Black communityís experiences with AIDS and seeking health care for HIV/AIDS (Broman, 1987). Many Black people within lower socioeconomic strata are confronted with high unemployment, poverty, and disproportionately high incidences of morbidity and mortality. There are other Blacks who view AIDS as relatively unimportant when compared to other more immediate problems such as paying rent and feeding their families (Icard, Schilling, El Bassel, & Young, 1992) According to research, Black women may have to confront pressing social problems such as poverty,

racism, unemployment, inadequate education and crime that make AIDS are far less urgent (Freudenberg, Lee, & Germain, 1994).

There are many popular yet erroneous beliefs about HIV/AIDS held by some women from the Black community. Such attitudes only complicate their confusion surrounding the origin and fatality of the disease. For example there is a myth that HIV/AIDS is the disease of White middle class homosexual males. This notion may stem from reports presented by the Center for Disease Control (1996) which reported that in 1981 five-healthy White males with a history of having sex with men were diagnosed with pneumocystis pneumonia. Their condition was later called Acquired Immune Deficiency Syndrome (AIDS), and also became associated with being White, middle to upper middle class, homosexual, and male.

There are also certain traditional beliefs perpetuated within much of the Black community. However, these beliefs are sometimes misunderstood by members of the community. That is, they may engage in risky behaviors based upon mores. For example, one traditional philosophical concept emphasizes an extended kinship among people of similar culture and ethnicity. This concept may involve certain communal group practices. Given the notion that as a group they are all ìsisters and brothersî (extended kinship), then sharing needle within the ìfamilyî is probably safe.
Moreover, Mays and Cochran (1988) noted that sharing ìworksî sometimes denotes bonding among ìbuddiesî who use drugs. Those IDUs who are most in need of social validation may be more likely to engage in this form of behavior. The practice of needle and syringe sharing should never occur.

Black women IDUs may face stressors stemming from racial discrimination, poverty, and deprivation. Ascribing to a ìsubcultureî status, many Black women IDUs may perceive that there is limited access to the same resources made available to White women. They may experience feelings of alienation and reach out for any opportunity to use an available needle and syringe. Research has suggested that Black and Hispanic IDUs are more likely to share syringes than White IDUs (Des Jareais, Friedman, & Hopkins, 1985)

Many Black women maintain a poor self concept and often perceive themselves in a less than favorable manner. They may develop a sense of helplessness and inclinations toward victimization from a system that fosters dependence. As such, these women exhibit greater risk behaviors that would expose them to people who are HIV positive. They may subconsciously place small value on the integrity of life by putting themselves in hazardous situations. The women often feel trapped by an environment that only offers to them oppression. This experience usually results in manifestations of internal emotional dissatisfaction.

Black women often lack an internal locus of control. They believe that they are unable to take the responsibility for the direction of their lives. According to Sue and Sue (1990) an internal locus of control refers to a personís belief that lifeís affirming reinforcements are contingent upon their own actions, and that a person can shape her own fate. Many Black women from this group may not possess self confidence in their own ability to decide. They often become the victims of circumstance and fail at any attempt at controlling their own destiny. In essence, these women do not feel good about whom they are, their means of maintaining survival, and the environment in which they exist.

Intervention, Prevention, and Educational Programs

There is a consensus in much of the literature that many Black women who test positive for HIV contracted the virus through unprotected heterosexual contact and illegal drug use behavior. Local and community outreach programs have been established throughout the country to address the treatment and

prevention of HIV/AIDS. According to the National Institutes of Health (1997), community workers have developed many innovative and promising programs. There is a great need for the programs to work with researchers to further HIV/AIDS risk behavior intervention through scientific analysis.

Researchers suggest that many programs that are currently in existence fail to meet the needs of Black women. This is primarily among those women who are educationally disenfranchised from the lower socioeconomic strata. The weaknesses in the programs may be attributed to format and design. Quimby (1993) suggested that appropriateness of content, methods, and personnel have been questioned. He noted that the major funded efforts are generally top down actions organized by professional elites and aimed at their constituencies rather than neighborhoods. These programs are useful for some, but they are inappropriate and lack authenticity for certain ethnic and gender groups.

There are, however, those intervention and prevention programs that show gender, cultural, and socioeconomic sensitivity that are helping many women of color. Community-based organizations contribute a great deal of effort to control the HIV/AIDS epidemic. There are programs with components that provide an ongoing and intimate relationship which constituents an understanding of relevant cultural values, beliefs, familiarity with relevant channels of communication, and commitment to safeguard the well being of their neighborhoods (Singer; 1991; Freudenberg & Trinidad, 1992)

Other projects that have met with a large degree of success are those that include training on self management and interpersonal management skills. Kelly and colleagues (1989) discovered that training in self management skills that consist of personal awareness, problem solving, and coping skills tended to enhance the perception of risk and to increase motivation toward risk reduction behavior. In addition, teaching individuals to identify high risk circumstances and to recognize prospective situations that are likely to lead to unsafe sex and illegal drug use is vital. Moreover, some programs stress the significance of working through high-problem areas by developing and maintaining alternative coping behaviors. Enhancing interpersonal skills helps to reduce a partnerís opposing reactions, and to maintain a mutual relationship that is supportive of safe sex.

Research has demonstrated the importance of having social support and social networks in community based and culturally-oriented prevention programs. Belonging to and keeping social connections may become an integral aspect of living with HIV. Many ethnic minority groups extol the family as a primary social unit and a necessary means for support (Aponte, River, & Wohl, 1995). However, Rhoads (1983) suggested that those women who use drugs tend to lack the support systems that have been traditionally made available to men. Many women who are substance abusers lack social support from family and friends who do not abuse drugs.

In recent years, the Association of Black Psychologists addressed the issue of culturally appropriate education to help in preventing the spread of HIV/AIDS within the Black community. The Association of Black Psychologists, in consultation with Progressive Life Center, designed and carried out an Afrocentric model to train psychologists to deliver culturally competent AIDS education, prevention programs, and psychological services in the Black communities nationwide. The Center for Disease Control funded this project for six programs years beginning in 1988 and ending in 1993 (Foster, Phillips, Belgrave, Randolf, & Braithwaite,1993). According to the organizations, their effort to reduce the spread of HIV among the Black community has been successful.

Addressing High Risk Behaviors

The Public Health Department of Beaumont, Texas, reported in 1995 and 1996 an increase in the number of Black women who tested positive for HIV. It was believed that the increase was attributed to high-risk

behaviors that contribute to the spread of HIV. Unprotected heterosexual contact and illegal drug use behavior may be the salient concern regarding this population. According to the city Public Health Departmentís demographic data report, in 1995, 26 cases were reported as HIV positive; of the 26 cases, 27% were females and 73% were males. Within ethnic parameters, 8% were Hispanic, 27% were Anglo, and 65% were Black (Beaumont Public Health Department [BPHD], 1995).

The following year the Public Health Department reported 32 positive cases of HIV. Among this group, 47% were males and 53% were females. Nine percent of this group were Hispanics, 31% were Anglos, and 59% were Black (BPHD, 1996). The Public Health Department has identified this epidemic as an extremely critical concern. The number of positive HIV cases in Beaumont is increasing within the Black community especially among its female population. Therefore, it becomes imperative to address the concerns and implement prevention measures for those Black women at risk.

Womenís Empowerment Program

The Beaumont Public Health Department has an extensive, innovative, and culturally sensitive Womenís Empowerment Program for the large population of HIV at-risk, ethnic minority women that live within the metropolis. More specifically, the targeted population is women who receive drugs or money for sex, is the sex partner of men who are intravenous drug users, ones that may be actively abusing drugs, and those that presented a history of illegal drug use.

Blacks represent more than 80 % of the clients that regularly visit the two clinics. The clinics serve a metropolitan area of a twenty-five-mile radius. The at risk women are also identified through other local, county and state-supported organizations with which the public health department has collaborative agreements for HIV prevention education programs.

Once the women have been identified for being at risk, they are interviewed and recruited to the Beaumont Public Health Departmentís Womenís Empowerment Program (WEP). The women participate in and complete the HIV prevention education program as a component of WEP. The program has joined HIV prevention with education on building self esteem and developing responsible decision making skills related to sexuality and drug abuse. The curriculum is presented by a full-time WEP coordinator who trains WEP peer educators to provide on-going information and support to other women (and men) of color who are at-risk for contracting HIV. The peer educator who is also part of the at risk group serves as an essential component to assure cultural and lifestyle sensitivities.

The Public Health Department acknowledges that WEP peer educators need support and encouragement for circulating information to friends in their community and maintaining their own low risk behaviors. Therefore, support groups are provided for WEP peer educators to advocate maintenance of low risk behaviors for HIV transmission.

Method

Subjects

The subjects for this investigation consisted of 28 adult females (peer educators). They were referred to the day long program by the public health departmentís outpatientsí clinic and from local organizations that have collaborative agreements with the cityís public health department for HIV prevention education.

The subjectsí ages ranged from 20 to 47 years of age. They were 71% Black, 21% White, 4% Hispanic, and 4% Native Americans. The sample consisted of 68% who earned less than $ 10,000 a year. Fourteen

percent of the subjects earned between $10,000 and $15,000 annually. Among the sample, 4% had yearly incomes ranging from $15,001 to $20,000, and another 4% earned between $20,001 and $25,000 dollars. Seven percent of the sample group had an annual income of more than $25,000 a year.

The marital status consisted of 50% single women and 14% divorced. Fourteen percent of the subjects said they were married, and 18% reported married but not living with their husbands. Four percent of the sample indicated a mutual cohabitation arrangement. Fifty-four percent of the sample were mothers of two or fewer children. Within the same sample 25% had four or fewer children. Eleven percent reported having six or fewer children, and 11% of the subjects had no children.

Within the realm of education, 39% of the subjects said they had completed high school. Thirty-two percent indicated a limited college education. Fourteen percent of the sample had gone beyond the ninth grade, and only 4% indicated having graduated from a four-year college. Among the sample, 96% reported having never tested positive for the HIV infection. Four percent indicated a positive HIV infection test result.

Instrument

The HIV/AIDS Attitude and Awareness Inventory for Unprotected Sex and Drug Use - Form F (Geyen, 1997) was used in this investigation. The instrument is newly developed and continues to undergo field testing and evaluation. Its objective is to assess the womenís attitude toward and awareness of risky behaviors that may lead to contracting the HIV infection. Furthermore, the instrument is designed with three components: (a) question demographic data, (b) unprotected heterosexual activity, and (c) illegal drug use behavior.

The instrument suggests that higher response scores represent a greater awareness of risky behaviors leading to HIV/AIDS. Conversely, lower response scores suggest a lesser awareness of risky behaviors leading to HIV/AIDS. In the initial test analysis of internal consistency on the twenty-eight subjects of this investigation, the instrument yielded a reliability coefficient of .83.

The sections of the instrument that assessed unprotected heterosexual activity and illegal drug use behavior were constructed to be gender appropriate and culturally sensitive. The instrument is geared toward the population from which the subjects originated. It should be emphasized that the content of the instrument is not intended in any way to pass judgment, categorize, or negatively stereotype and depict the participants in this investigation.

Data Collection and Procedure

Twenty-eight women, majority Black, took part in the investigation. Subjects were given a written informed consent form to read and endorse before their actual participation in the study. The women were then administered the HIV/AIDS Attitude and Awareness Inventory for Unprotected Sex and Drug Use. This segment of the investigation took place in the morning before the women took part in the program. The program was divided into two sessions, the first focused on education and prevention of HIV/AIDS, and the second session involved developing self-efficacy.

Representatives from both the cityís Public Health Department and the university facilitated the program sessions. The facilitators were majority Black women. Although there was an array of important information delivered by the facilitators, the format of each session centered on the subjects. This style allowed for a relaxed, comfortable, and homogeneous environment suitable to address the participantís personal issues related to HIV. The language, behavior, mode of dress, and context of information presented and discussed was informal. This arrangement was perceived as appropriate and productive for

the subjects.

Upon completion of both sessions in the afternoon, the same subjects were administered the HIV/ AIDS Attitude and Awareness Inventory for Unprotected Sex and Drug Use. Data were collected and recorded from both sittings.

Analysis and Results

The mean score for the first administration of the HIV/AIDS Attitude and Awareness Inventory for Unprotected Sex and Drug Use was 128.0. The mean score for the second was 135.3. The womenís scores ranged from 95 to 154 on the HIV/AIDS instrument before the workshop sessions. Following the workshop sessions, the subjectís scores on the HIV/AIDS Attitude and Awareness Inventory for Unprotected Sex and Drug Use ranged from 111 to 155. The mean scores for both administrations of the HIV/AIDS Attitude and Awareness Inventory for Unprotected Sex and Drug use was compared using the two-tailed t-test for paired samples. There was no statistically significant difference found in scores at the .05 probability level. (t= 4.89, df 27, P>.05).

The statistics suggested no significant difference in the mean scores. More specifically, a seven-point increase from the mean score of the first sitting compared to the mean score of the second sitting. This increment of change in scores may suggest that, on the average, participants enhanced their awareness of HIV/AIDS; therefore, the increment of change in scores is clinically significant. Preventing the contact of HIV to even one person could extend or even save a life.

Discussion and Observations

This was a pilot study to address HIV prevention among Black women. Research investigations such as this one may take certain ìscientific research liberties.î The nature of some variables like the sample size, a newly developed instrument, and the subjectsí understanding of research are similar to confounding variables that are found in much of this type of research. Future research within this area should attempt to constitute greater control. However close and systematic observation of subjects during the session showed they actively engaged in the sessionís activities.

Many subjects in this study voiced their enlightenment on information regarding behaviors that spread HIV/AIDS. Subjects expressed interest in future sessions. Several subjects indicated their wanting to share the knowledge learned from the sessions with friends, relatives, boyfriends, and husbands. Subjects acknowledged their own counterproductive behaviors and vowed to change their life styles.

The applications of culturally appropriate strategies demand ethnographic or naturalistic research to understand values, attitudes, behaviors, and factors, such as socioeconomic status in different communities. Cultural factors may affect the ability of individuals to change behavior. Researchers from different ethnic or cultural backgrounds may help to address this issue. Language and other cultural barriers to the delivery of interventions must be addressed with special consideration for individuals whose physical or other impairments limit access to most prevention and intervention programs.

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Dr. Dashiel J. Geyen, Ed., M.P.H., is a behavioral scientist and clinical practitioner. He serves on the graduate counseling faculty at Sam Houston State University. Dr. Geyen is also an adjunct psychology professor at the University of Houston. He has completed research fellowships at the National Institute on Drug Abuse and the National Institutes of Health. Dr. Geyen had researched, published and presented works on youth-at-risk, chemical dependency, and mental health. E-Mail: edu_djg@shsu.edu.

Ingrid Fisk-Holmes, M.P.H., is the Public Health Director of the Beaumont Public Health Department. She has held positions of Director of Health Education, Executive Assistant to the City Manager, and Public Health Administrator. Ms. Fisk-Holmes is responsible for the initiation and development of the Peer Empowerment Program designed to work with at-risk women to reduce the spread of HIV.

H. Mark Guidry, M.D., M.P.H., is a Regional Health Director for the State of Texas. He has served as Public Health Directory and Health Authority for the City of Beaumont. His professional career experience also includes Associate Medical Director and Family Physician for a Beaumont area manage care practice. Dr. Guidry has researched and published articles on HIV/AIDS and other communicable diseases.

Janice M. Beal, Ed.D., is an assistant professor and coordinator of the psychology program at Prairie View A & M University in Prairie View, TX. She is also a clinician in private practice specializing in mental health issues that impacts women and children. Dr. Beal has published and presented research on drug addiction and mental illness at a number of national and international meetings.

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