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Researchers Adapt HIV Risk Prevention Program for African-American Women

Research  
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The HIV/AIDS epidemic has taken a disproportionate toll on racial and ethnic minority populations, especially women. In its surveillance report on the number of Americans living with HIV/AIDS in 2002, the Centers for Disease Control and Prevention estimates that among women with HIV/AIDS, non-Hispanic African-American women outnumbered non-Hispanic white women by three to one--a racial disparity not found among men.



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African-American drug-using women were addressed in two recent studies by NIDA-funded researchers in Atlanta. Dr. Claire E. Sterk of Emory University, Dr. Kirk W. Elifson of Georgia State University, and colleagues developed and tested gender-tailored, culturally specific adaptations of a standard NIDA HIV prevention intervention. They found that female African-American injecting drug users (IDUs) and crack cocaine users who received either of two targeted 4-week prevention programs reduced their risk behaviors related to drug taking and sex more than did women who received the standard intervention.

"These studies are examples of research that is responsive to community needs," says Dr. Dionne Jones of NIDA's Center on AIDS and Other Medical Consequences of Drug Abuse. "When it comes to designing a prevention program, it's not one-size-fits-all. You have to consider social context, be culturally sensitive and appropriate, and tailor your message to the group."

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Tailored Interventions Build on NIDA Intervention To Help Drug-Using Women Reduce HIV Risk

Behavior in Past 30 Days		NIDA Standard Intervention Group		Motivation Intervention Group		Negotiation Intervention Group	
		Baseline	Six-Month Followup	Baseline	Six-Month Followup	Baseline	Six-Month Followup
Injecting Drug Users	Number of days injected powder cocaine	8.2	3.1	6.4	0.1	4.7	0.2
	Number of days injected heroin	16.4	8.9	12.7	1.5	9.8	3.2
	Percentage who traded sex for drugs	70.4	40.7	50.0	20.0	42.9	10.0
Crack Cocaine Users	Mean number of days crack used	17.7	12.9	18.2	15.6	18.7	13.8
	Percentage who had vaginal sex with one or more paying partners	43.9	24.6	34.3	19.2	30.8	20.5

*African-American drug-using women in three intervention groups reduced behaviors that heightened their risk of HIV infection. However, women receiving the culturally specific, gender-tailored motivation and negotiation interventions generally reported greater reductions in risky behaviors after their participation than women in the NIDA standard intervention.*

The researchers' goal was to develop culturally appropriate programs grounded in the reality of the daily lives of women most at risk and the difficulties they face in their individual, social, family, and sexual relations and activities. "We worked hard to develop interventions with input from this target population, deliver the interventions in a setting where they feel comfortable, and involve them in planning, implementing, and evaluating the interventions," says Dr. Sterk.

Over 1 year, using one-on-one interviews and small focus groups, the researchers

sought to define the key issues in the women's lives and identify ways to address those issues, including such factors as gender dynamics, economic stressors, gender-specific norms and values, and power and control. Two interventions came out of this research phase. One, a motivation intervention, was designed to motivate the participants to change their behavior. The other, a negotiation intervention, recognized that women may fear verbal or physical abuse if they propose safer sex or safer needle use and thus sought to strengthen their negotiation and conflict-resolution skills.

"Our goal in the motivation intervention was to reduce risk based on what's realistic in the context of the participant's life," explains Dr. Sterk. "We worked with the women to set short- and long-term goals, celebrate successes, analyze failures, and identify and overcome barriers." The negotiation intervention recognizes that many of the women's challenges dealt with the need to resolve conflict and that negotiation skills are key to reducing risk.

Once the interventions were ready, more than 300 African-American women ages 18 to 59 years--68 IDUs and 265 crack cocaine users--were enrolled in the studies. All were HIV-negative and heterosexually active. The women were randomly assigned to one of the three interventions. The NIDA standard intervention was delivered in two one-on-one sessions; the motivation and negotiation interventions each involved four one-on-one sessions. (See [textbox](#), below, for descriptions of each intervention.) At the 6-month followup, both IDUs and crack cocaine users in all three groups reported lower levels of drug-using behavior and risky sexual behaviors than they had reported before receiving the interventions. Reductions were greater among women who received the tailored interventions.

**Injecting Drug Users.** The motivation and negotiation interventions were equally effective in reducing the incidence of needle and injection-works sharing. At 6 months, there was no sharing of drug injection paraphernalia in these groups; in the standard intervention group, 13 percent reported sharing needles and 18 percent reported sharing injection works. Although women in all intervention groups reduced their number of injections over time, only those in the tailored interventions reported statistically significant decreases. Participants in the motivation intervention were most likely to attend drug treatment, whereas women in the negotiation intervention reported more changes in their sexual behavior than did women in other interventions.

**Crack Cocaine Users.** All three interventions were associated with a drop in crack use in the 30 days preceding followup. About 40 percent of the women in each group reported no use during that period. Among those still abusing crack at followup, women in the motivation intervention were more likely to have reduced their use of crack in risky settings, such as outside or in a crack house, hotel room, or car. Women in the standard and motivation intervention groups significantly decreased the number of paying partners for vaginal sex and the frequency of sex with paying partners.

Dr. Sterk suggests that the study's results show it may be optimal to create an intervention that combines skills taught in both the negotiation and motivation

interventions. While participants in the negotiation intervention were generally more successful at reducing sexual risk behaviors, including decreasing the number of paying partners and increasing condom use with steady partners, participants in the motivation intervention had more success at changing drug-use behaviors.

Efforts were also made to assist program participants in their lives outside of the program, with success extending well beyond the study's parameters, notes Dr. Sterk. "A lot of the women who received the one-on-one support available through the tailored interventions said the program served as a re-entry into society. For example, they were encouraged to obtain a photo ID. Many reported that this simple act made them feel more connected to society again, part of the larger world." Program graduates returned to school, earned their GED, found jobs, joined the project to become counselors/interviewers, and stopped using drugs.

"Over and over, researchers are finding that we need to take a more holistic approach to intervention programs," says NIDA's Dr. Jones. "We can't just focus on drugs and sex. We must look at the big picture. It involves childcare, education, employment, housing, and job training. Community stakeholders need to develop programs that address multiple needs."

The project maintained a high retention rate--96 percent of the women enrolled in the studies completed the 6-month followup interview. Dr. Sterk attributes this success to the fact that the project was grounded in the community and to the value of involving community consultants--residents, both former drug users and others, who played key roles in recruiting, interviewing, and counseling participants.

In future research, Dr. Sterk intends to examine the cost-effectiveness of various intervention formats. "It appears that individual sessions may be more desirable and cost-effective," she predicts. Dr. Sterk would like to continue the research, assessing the long-term effects of specific interventions. She wants to develop an intervention that focuses on women's households, targeting both the woman and her main partner, and she is interested in capacity-building--translating her research into other settings and training people to develop similar programs in more communities.

## Sources

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[\[Abstract\]](#)

Sterk, C.E.; Theall, K.P.; Elifson, K.W.; and Kidder, D. HIV risk reduction among African-American women who inject drugs: A randomized controlled trial. *AIDS and Behavior* 7(1):73-86, 2003.

[\[Abstract\]](#)

### **Protocols for Standard, Motivation, and Negotiation Interventions**

All interventions include discussion of the local HIV epidemic, sex and drug-related risk behaviors, safer sex and drug use, and HIV risk-reduction strategies. The two tailored interventions also include a discussion of the impact of race and gender on HIV risk and protective behaviors.

**The NIDA standard intervention** is an HIV/AIDS education program that was developed in the early 1990s. It builds on standard HIV testing and counseling developed by CDC and adds discussion of the principles of HIV prevention for drug users and their sex partners. The intervention involves testing, counseling, and educating participants through use of cue cards on such topics as the definition of HIV/AIDS, who is at risk, and ways to reduce risk. Also offered are demonstrations on condom use and equipment-bleaching techniques for IDUs. Referrals to counseling and other services are provided.

**The motivation intervention** follows the format of the standard intervention for the first session but ends with asking participants to consider what they are motivated to change in their lives. During the second session, this list is reviewed and short- and long-term goals are set. The third and fourth sessions involve discussion of experiences with behavior change, including the woman's sense of control and feelings of ambivalence about behavior change. Risk-reduction messages tailored to the participant's level of readiness to change are also delivered in the fourth session.

**The negotiation/conflict-resolution intervention** also follows the NIDA standard intervention for the first session, but it ends with a discussion of intended behavior changes. The second session reviews the list of possible behavior changes and the level of control the participant believes she has and introduces general communication skills and strategies to develop assertiveness. Short-term goals are set for strengthening communication, gaining control, and developing assertiveness. Negotiation and conflict-resolution strategies are introduced during the third session and tailored to the individual during the final session.

### **Principles That Guide Format, Content of Interventions**

The interventions used by Dr. Sterk and her colleagues in this study are firmly based in theoretical research. The researchers conducted a series of one-on-one interviews and focus groups with the target population. These interviews yielded the following key principles that guided both the format and the content of the interventions.

- **Offer counseling sessions on an individual basis.** "It was very clear that women wanted to start with one-on-one sessions," says Dr. Sterk.

"HIV risk behaviors involve so many private, personal issues-- previous abuse experiences, actions to support their drug habits, things they'd never before discussed. They found it easier to discuss these experiences with one person, not a group."

- **Adopt a holistic approach.** Along with this research project, a clothing fair was conducted and clothes made available to program participants. Food for breakfast was provided; daycare was close by; and ongoing services, such as help preparing for job interviews, were provided.
- **Make programs community-based.** The project was headquartered in a house in the community, which was key to participants' convenience and comfort. Researchers also found it important for the women to link participation in this project to local social and health services, including local drug treatment, daycare centers, health services, and other community-based organizations. Community consultants played a key role in the project.
- **Address women's multiple social roles in the intervention.** Participants insisted that they didn't want to be labeled simply as drug users. Instead, they wanted the social context of their daily lives to be addressed, including their roles as mothers and steady partners.

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