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Review article

Reducing AIDS risk among inner-city women: a review of the Collectivist Empowerment AIDS Prevention (CE-AP) Program

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Abstract

We discuss the process underlying our HIV-prevention project for young inner-city women. Health interventions are almost uniformly based on individualistic models of health and behavior. In contrast, AIDS and AIDS prevention, by their very social nature, may require more collectivist principles of disease, health, and intervention. We conducted a behavioral intervention, the Collectivist Empowerment AIDS Prevention (CE-AP) Program, with young, inner-city women to deal with this critical health issue. Our primary intervention goal was to promote women's sense of owning and making healthy choices about their bodies. We attempted to accomplish this by emphasizing the concepts of empowerment, collectivism (as opposed to individualism), and culturally sensitive skill building. Collectivism is emphasized to encourage women to involve others in their behavioral health decisions and to gain power through social joining and coalition building. A woman's behavioral decisions affect many others in her life. Thus, involving others in decision making emphasizes the connection between an individual's actions and their impact on interpersonal relationships. CE-AP was found to be effective in changing safer-sex behavior and we review our findings and future directions.

Keywords: AIDS; HIV; Inner-city women; Women; Safer-sex

1. Introduction

Human immunodeficiency virus (HIV) risk among women has received increasing attention in recent years as their rate of infection continues to rise, especially among ethnic minority women [1,2]. Subsequently, HIV-prevention projects targeting women at risk have been constructed and implemented to curb infection rates. Although empirical findings from intervention studies are beginning to emerge [3,4] and relevant conceptual models have been proposed in the literature [5], what is lacking are contextual accounts that detail how relevant issues for women are put into actual real-life practice in successful empirical prevention projects.

In this paper, we present an overview of the Collectivist Empowerment AIDS Prevention (CE-AP) Program, including a theoretical basis for implementing an HIV-prevention project among inner-city women. Specifically, the CE-AP Program strives to promote safer-sex among women with few economic resources and generally low empowerment, using principles derived from both collectivism and empowerment theory. We also explain how the CE-AP project builds on prior attempts to decrease HIV risk by taking those aspects of HIV prevention that have

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proven successful, such as assertiveness training, and incorporating such skill building into a communal context by emphasizing negotiation and mutual social support. We provide a brief contextual account of our recent project, including the specific methods we utilize within the group intervention to reduce women's AIDS risk. Specifically, we describe in detail the techniques employed within the group sessions, such as cognitive rehearsal and guided imagery. Finally, we discuss our findings, any program modifications over time, and make some overall statements regarding HIV prevention efforts with inner-city women.

2. The CE-AP Program

Our NIMH sponsored behavioral intervention with young inner city women has been implemented and has evolved since August, 1990. The intervention project randomly recruited women from inner-city clinics, serving primarily low-income women in a medium sized, Midwestern city. Women, who agreed to participate, were randomly assigned to one of three types of treatment: an AIDS prevention intervention, a general health intervention control condition, or a control condition with no intervention. All three groups were administered Pre-intervention questionnaires by interview. The questionnaires address issues, such as AIDS knowledge, perceived AIDS risk, social support, acute and chronic stressors, and safe sex practices (e.g. condom use). The women assigned to the AIDS Prevention or Health Promotion groups then attended six 90-min group sessions over a period of approximately 3 months. The AIDS Prevention group addressed AIDS and HIV prevention, whereas the Health Promotion group addressed general health concerns like drinking, smoking, and exercise. The two intervention groups were as closely linked in format as possible, with comparable use of role-play, cognitive rehearsal, and video stimulus material. In this way, we were able to isolate the effects of skills and AIDS specific knowledge to some degree for the first time in any AIDS prevention program. Upon completion of the six sessions, all three groups were administered Post-intervention questionnaires and were asked to return once more 6 months later to complete a follow-up questionnaire to assess the long-term effects of the intervention. Involvement in the project for each woman averaged about a year, although this participation was spread over time as described.

We have adapted and expanded the original work in a more comprehensive model and intervention study that is identified by the acronym CE-AP for Collectivist Empowerment AIDS Prevention (pronounced 'SEE-AP'). The CE-AP program represents the first published, case controlled group trial concerning AIDS prevention among women [6]. The primary intervention goal has been to promote women's sense of owning and making healthy choices about their bodies [7]. The program utilizes women's strength and resources within an acceptable cultural context. This is attempted by emphasizing empowerment, collectivism, and culturally sensitive skill building. We have recently completed data collection with women recruited within the last 4 years of the project.

3. Philosophy behind the CE-AP Program

Theoretically, our intervention was based on Bandura's [8] social learning theory and Hobfoll's [9,10] conservation of resources (COR) theory. COR theory asserts that the threat of AIDS is an additional stressor facing women who are already overburdened in their coping efforts. An inner-city woman's decision to negotiate safer-sex alternatives is based on her perceptions of the costs and benefits to the particular relationship and the partner's role in her economic, social, and physical survival, as well as goals [11]. Poor women are more constrained in their choices about relationships and living situations, so they may not feel the freedom and comfort to negotiate their sexual practices or leave their partners [12]. Immediate concerns of food, shelter, and child-care may overshadow remote worries about AIDS [13]. Such realistic concerns may cause discomfort in suggesting condom use, as such discussion could potentially put relationships that provide emotional, as well as economic support, at risk.

COR theory postulates that in such situations, an intervention must increase both women's personal and social resources in concert with one another in order to combat against increased threat [6]. Further,

COR theory suggests that target groups must see the intervention as not only adding new resources, but also building on their current resource strengths, particularly their shared strengths as members of dyads, families, and social groups. Thus, women will adopt safer sex practices if they see themselves at risk for HIV infection and if they do not risk losing other valued resources that are tied to connections with others [14]. To the extent they do not perceive themselves at risk or to the extent they may lose or risk other resources, they will not adopt safer sex practices [13]. 'The key to poor women's response to AIDS is their perception of its danger relative to the hierarchy of other risks present in their lives and the existence of resources available to act differently' [13].

Within social learning theory, the emphasis is placed on the use of modeling to increase specific feelings of efficacy around targeted behaviors. It has been postulated that one must have perceived self-efficacy and effective skills to negotiate safe sex [15]. However, if the woman does not have such self perception, she may feel uncomfortable initiating or engaging in safe sex negotiation. The empowerment of women is especially important because of the unequal power status that women often hold in male-female relationships. Women are at a disadvantage to effectively decrease risk behavior because the major HIV prevention method available, condom use, requires men's cooperation [2]. If a woman feels unequal 'bargaining power' within the relationship, she may not feel comfortable negotiating safe sex [16]. Thus, by helping women to achieve a sense of empowerment, the hope is that women will feel more able to promote safer sex behavior with their partners.

In contrast, most health interventions are uniformly based on individualistic models of health behavior. However, models of health-related behaviors based on individualistic conceptualizations of risk may be inadequate when examining sexual behavior. Sexual behavior is inherently social in nature, whereas individual models assume that one's behavior is controlled by the individual [2,17]. AIDS and AIDS prevention are social issues that require more collectivist notions of health and intervention. Subsequently, another focus within our intervention, consistent with COR theory, is on communal mindedness. We felt that this emphasis was relevant to women in general [18,19] because women tend to make better use of social support than do men [6]. A similar emphasis has been asserted within studies of the psychology of women [20] and it was believed that such a communal orientation would be better fitted to women of color, in particular.

The communal emphasis that was incorporated into our intervention focuses on the need for women to support each other, their families, and the health of their community [6]. It is our contention that people need to develop skills relevant to the proposed behavioral change, need to feel that change is in fact possible and beneficial for them, and need to feel that the change is not only approved, but supported by others in their lives [5,7,21]. It is proposed that a group-based intervention provides a way to encourage such change in many at a time [22]. In fact, such a group setting has often been found to be effective in AIDS prevention when working with women [3,4].

Collectivism is emphasized to encourage women to involve others in their behavioral health decisions and to gain power through social joining and coalition building. The behavioral decisions a woman makes impact many others in her life, including her partner, her children, those who rely on her for support, and those whom she relies on to provide support. By involving others in the decision-making process, the focus is on the connection between one's actions and their impact on various interpersonal relationships. Women can be supported by others in their decisions and learn how to rely on others. Recognizing cultural diversity demands that we centrally incorporate elements of the target group's culture, and collectivism represents key elements of these women's social space.

4. Reducing women's AIDS risk through social skill-building

A number of AIDS intervention programs have been successful by employing a shared emphasis on providing knowledge, increasing perceived risk for HIV infection, and most importantly, imparting behavioral skills. Although studies have shown the benefits of increasing knowledge and perceived risk [23], there is also evidence that this is not enough [17,24]. Having information on how HIV/AIDS is transmitted

must be combined with a feeling of personal risk, and learning the skills to prevent infection.

Therefore, in addition to providing general knowledge on the prevention and transmission of the disease and heightening perception of risk, we attempt to teach AIDS-specific and negotiation skills. In particular, we emphasize social skills that promote the *individual's health in a social context*. This approach is similar to other interventions that focus on skills training by practicing, for example, how to put a condom on correctly or say 'no' to unprotected sex. Although this type of skills training is a necessary component for change, without a collectivist orientation, the model remains individualistic and the social context of safe sex negotiation is negated. Hence, our focus is not solely on individual skills or decisions, but on how one's behavior and choices affect those around them. The emphasis is on what happens to the 'we' and not solely the 'I'. Assertiveness training emphasizes the 'I', but it is the next steps of negotiation that champion the 'we'. In assertiveness the self is center stage. In contrast, all parties must see themselves as gaining meaningfully if negotiation is to prove successful. We attempt to improve planning and negotiation skills by practicing safer sex communication within a group setting, which in turn can enable women to better persuade their partners of the importance of condom use, and help them identify his needs, desires, and dreams as well as her own.

In this light, there are certain skills that we focus on in our six group sessions. These groups are based on an interactive videotape based curriculum with a live group leader who facilitates discussion. The videotape stimulus occupies about 20–25 min of the 90-min sessions. We emphasize assertion in combination with building skills of communal planning and negotiation. Planning involves knowing your goal, thinking of ways to meet your goal and how to overcome likely obstacles. Additionally, we emphasize getting other ideas from those you trust and practicing role-playing situations with a friend. Assertion is an important skill for women to learn and involves knowing what you want and how much you are willing to compromise. One must make points clearly, but also listen to other's views. Whereas passivity is discouraged, so is aggressiveness. As group facilitators, we often observed that many misinterpret these terms. For instance, assertiveness is often confused with aggressiveness, including a disregard for one's partner's needs. We help women reformulate their definitions so that social joining is encouraged, rather than alienating others through aggression.

Another common misconception we have observed is that women view negotiation as giving in or failing. Within the groups, this negative connotation is discussed and revised. Women learn to 'sell' their position in order to protect their health, while at the same time acknowledging their partner's needs. Thus, one type of negotiation may involve a woman acquiescing to her partner. This notion of learning to give in is the opposite of individualism, which teaches that assertion does not include compromise. This approach may seem passive at first glance, but the woman is actively choosing to give in on what is not personally important in order to get what is important to her in the long run. So, a woman might acquiesce to go to the restaurant he likes or may on a more personal level agree to be more sexually uninhibited. Part of negotiation is learning how to choose your battlegrounds. Whereas some things are not worth fighting for, other things, like protecting self-esteem and sexual health are not to be compromised.

If a concern for others is negated, the results could include either the loss of a valued relationship, or yielding to unsafe sex. If one stops at assertion by standing up for one's beliefs without considering other's feelings, they may temporarily achieve safer sex promotion, but may risk their relationship in the process. Many interventions simplistically assume that women will choose assertion even if this means risking their relationship. The trick is to learn how to meet personal needs while simultaneously meeting a partner's needs.

5. Methods utilized within groups to facilitate social skill-building

Many of the skills highlighted above cannot be role-played because they involve private, sexual behavior. Hence, we helped women practice these skills through the use of cognitive rehearsal [25]. During a cognitive rehearsal, women were directed to close their eyes, to imagine themselves in a situation, and to work out how they would handle themselves in that situation. To facilitate the cognitive rehearsal,

segments of the videotape described particular difficult situations for the women to consider in terms of their own personal action plans. Thus, cognitive rehearsal involves the development of action plans to meet goals. A typical cognitive rehearsal might go like this:

> Group facilitator: What we are going to do now is practice a technique called cognitive rehearsal. It is a way of forming an action plan to protect ourselves by thinking through what we would do in a situation. Close your eyes. Take a slow, deep breath (Pause)
>
> Imagine that you and your partner are together. You are going to have sex. You have been kissing and caressing each other lovingly. You are getting more passionate with each other. It becomes obvious that he is getting ready to have intercourse without a condom.
>
> What will you do? What will you say to him?
>
> How do you think he will feel about your asking him to wear a condom?
>
> How will you convince him to wear one?
>
> Will you help to make condom use fun for your partner?
>
> (Pause for 2–3 min allowance for cognitive rehearsal)
>
> You can open your eyes. Now let's talk about what we just imagined.

Following such a cognitive rehearsal, the women talked about what they felt and how they imagined themselves handling the situation. They shared ideas, anticipated problems in their plans, and then problem-solved with each other for more solutions. The typical time-frame for cognitive rehearsal was approximately 5–10 min in length.

Role-play is employed to learn skills that can be practiced in group. We emphasize the importance of acquiring accurate knowledge and being clear in what you want before talking with a partner. We role-play the issues presented by the video, such as discussing condom use with one's partner. Women learn to express their wishes for condom use to their partner and how to explain the reasons for sticking to their goal. In so doing, women learn to emphasize the need for healthy behavior and how to suggest healthy choices for their partners. They also learn to respond to his potential reactions and to remain focused on finding a healthy solution. Negotiation is encouraged by practicing how to acknowledge their partner's feelings, wants and needs, without compromising their own. For instance, learning how to compromise may include saying:

> I know you want to feel me and I want to feel you too. Let's just try it with a condom this one time and I promise to make it feel really good for you. I can put it on for you and make it fun. I'll even give you that all over massage that you like so much. I know how much you care about me, so will you please try it for me this one time and if you don't like it we can talk about it again later?

The woman ultimately gets what she wants, safer sex, but also acknowledges her partner's wants (i.e. to feel pleasure), and gives him something he likes in return (e.g. a massage). Thus, she finds a way to meet both her needs and his needs through compromise and negotiation. Such role-plays were typically 1–5 min in length depending on the given content.

Guided imagery is another exercise we employ within the group. We included aversive-conditioning [26] segments in the videos to increase both a sense of vulnerability and mastery. Women are placed in a relaxed state and then asked to imagine a scene in which they practiced an unhealthy behavior and had an aversive outcome, such as becoming infected with HIV. If done correctly, the technique produces a deeply felt emotional and visceral reaction [6]. We added a secondary component consistent with this type of classical conditioning. Specifically, after the negative health scenario, we paired a healthy behavior with a positive outcome, such as having a healthy baby, and the joyful emotions in relation to this event. This addition was designed to increase a sense of mastery. Many interventions use scare tactics without combining this with feelings of mastery. Subsequently, fear is promoted, but ways to actively

combat the fear are negated. This results in feelings of helplessness, not empowerment. Guided imagery typically lasted 5–10 min in length.

6. CE-AP findings and modifications over time

We predicted that the AIDS-prevention group would be most effective in producing increases in knowledge about HIV/AIDS, and both the intent to adopt and actual adoption of safer sex behaviors. We further predicted that the health-promotion group would be more successful than the no-intervention control, because many of the same behaviors and attitudes that relate to being healthy generalize to adoption of safer sex behavior [6].

Unlike most intervention projects that rely solely on self-report measures, data was gathered from many different sources, both self-report and more objective measures. Findings from the CE-AP program indicate that the AIDS-prevention group produced moderate, consistent increases in knowledge and safer sex behaviors in comparison with either the health-promotion or no-intervention group (see Figs. 1 and 2)[1]. Most of the data was collected through a series of three structured interviews: pre-intervention, post-intervention, and 6-month follow-up. These interviews revealed that women in the AIDS Prevention group expressed more intentions to purchase condoms and spermicide than women in the two other groups. Additionally, the

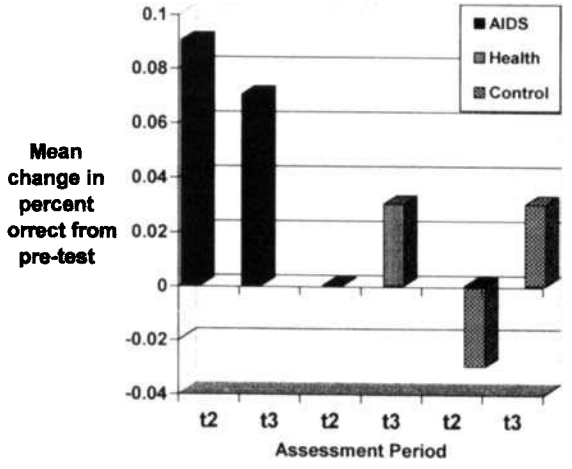

Fig. 1. Changes in AIDS knowledge: post-intervention (t2) and 6-month follow-up (t3).

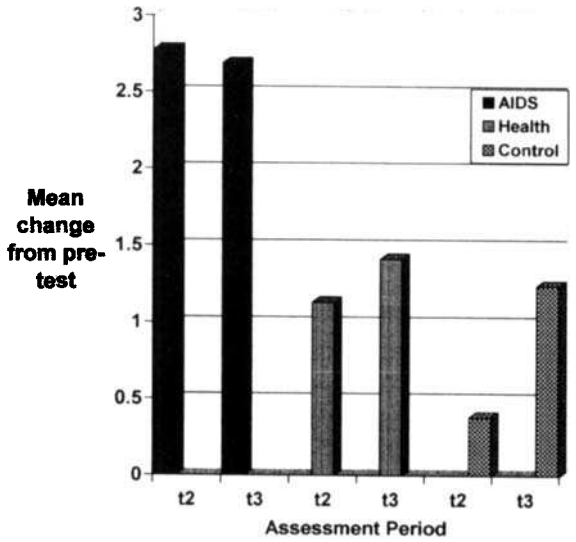

Fig. 2. Changes in safer sex intentions and behaviours at post-intervention (t2) and 6-month follow-up (t3).

AIDS Prevention group reported more condom and spermicide acquisition and frequency of use during sex than women in the no-intervention group. Women in the Health group also acquired significantly more condoms than the control group (see Fig. 3).

Two additional sources of data allowed for other ways to gauge the success of the intervention. The first was through the distribution of 'condom credit cards' to our participants at the time of recruitment. Because these photo identification cards were numbered without names, they allowed the women to anonymously obtain free condoms and spermicide through two local pharmacies for a period of 1 year. Purchase records for these cards allowed for a more objective assessment of condom and spermicide usage. Records revealed that more women from the AIDS Prevention group purchased condoms with the credit card in comparison to the no-intervention group. A second behavioral measure, which was included in the current program, was an audiotape made at the time of the follow-up interview. Trained interviewers engaged in role-plays of safer sex behavior with the women that

[1] Statistical analyses are reported in full in Hobfoll et al. (1994) [6]. Analyses were based on MANACOVAS using Time-1 outcomes as the covariate, with *P*-values established at 0.05.

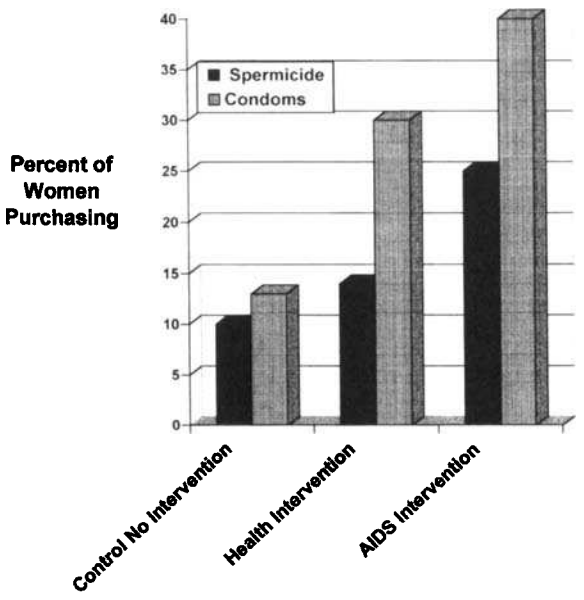

Fig. 3. Condom and spermicide usage by intervention condition.

were scored for the women's assertiveness and negotiation skills in potentially unsafe situations. Preliminary inspection of these audiotapes reveals that women in both the AIDS Prevention group and the Health group display more assertiveness and negotiation skills in comparison to the no-intervention group.

Both self-report and objective changes were sustained 6 months after the intervention for both African-American and European-American women. Most group differences were between the AIDS Prevention and no-intervention conditions which seems to suggest that skills in assertiveness, planning, and negotiation alone are not sufficient in producing meaningful behavioral change. Instead, a combination of AIDS-specific knowledge and appropriate skills is required [6].

The intervention's philosophy of collectivism and its importance in health promotion was emphasized even more during the last 4 years of the project when further changes were introduced. One such change involved inviting a random half of the women in the intervention conditions to bring a 'significant other' of their choosing to group sessions with them. They may bring their partner, a family member or friend. In other words, of the women assigned to the two intervention groups (health versus AIDS prevention), a random half of these women are assigned to a 'significant other' condition and can bring someone with them to groups if they choose to do so, whereas the other half are assigned to a 'women only' condition and instead attend group sessions alone. Unlike the typical strategies seen in other intervention projects, the unique purpose behind this is to involve others in the women's lives and in the process of making healthy life choices. Our medical delivery system seldom involves significant others in health promotion and the potential effects of such an initiative remain unknown.

Another way to compare an individualistic versus communal focus within health promotion involves how we structured the intervention's last two out of six sessions. These two sessions focus more intensively on personal skill building, not only giving women additional opportunities to work on skills, but also allowing for more attention on personal life issues and needs in a more individualistic way. For only these two final sessions, half of the women were randomly assigned to attend them in a group format, whereas the other half would work on a one-on-one basis with the intervention facilitator. Thus, besides random assignment to the type of intervention group (health vs. AIDS prevention), and to either a significant other or women only condition, women were also assigned to a group or individual condition for their last two sessions. Significant others also attended these skill-building sessions for women in the significant other condition. This construction allowed us to test whether individualized attention facilitates group effort. Whereas most interventions are either individual or group in focus, our intervention attempted to implement a mixed intervention to investigate this combined approach. For these new innovations we hope to soon have publishable findings, but preliminary reports are encouraging.

Objective data on women's sexual history was obtained during the last 4 years of the study by encouraging participants to be tested for sexually transmitted diseases as part of their involvement with the project. They were asked to do this at the time of recruitment and at the time of the 6-month follow-up interview. The project paid for all testing that was not part of women's medical care. This testing provided more objective data on sexual history and also encouraged women to take a more active

and empowered role in maintaining their own sexual health. We hope to soon report these new findings as well, but preliminary analyses indicate the program's effectiveness when applied to non-pregnant women and women at different levels of risk [27].

7. Conclusion

Several key components have been identified as important for the CE-AP program's ongoing success. These include: (1) the integration of real life issues into the intervention program; (2) utilizing the group format which encourages cohesiveness and support among the participants; (3) engaging group facilitators which promote a sense of mutuality and equality; and (4) promoting ongoing and authentic relationships among the participants and staff members [7].

An important and unique aspect of our intervention program is its responsivity to the participants' needs and issues. The program is designed to integrate aspects of the women's lives into the group's content and to facilitate the integration of intervention material into their lives. In addition, the structure and content of the intervention was responsive to the economic, gender and ethnic realities of the women involved in the study. Also, the use of a culturally diverse staff provided role models with whom participants could identify and relate. Another strength of this intervention is that it allows people of different cultures to learn about and interact with each other. In that process, women can realize that they share common issues and concerns. Further, they can work together through social joining to develop solutions for themselves and the significant others in their lives.

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