Building Sustainable Networks to Provide Preconception Care and Reduce Health Disparity:

Strategies to Prevent HIV/STDs

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A Program of Research That Seeks To:

• Elucidate the social and psychological factors that underlie HIV/STD and risk-associated sexual behavior.

• Identify the particular conceptual variables that are most important to achieving intervention-induced sexual behavior change.

• Identify theory-based, culture-sensitive, developmentally appropriate strategies to reduce HIV/STD and risk-associated sexual behaviors.
A Program of Research That Seeks To: (cont’d)

• Answer practical questions about the most effective way to implement HIV/STD and risk-reduction interventions with ethnic minority youth

• Test the effectiveness of such interventions using scientifically rigorous methodologies and experimental designs

• Tailor and disseminate effective research-based behavioral interventions to nongovernmental organizations, schools, churches, clinics, etc
CO-INVESTIGATORS

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- M. Kathy Hutchinson, PhD, RN School of Nursing
- Larry Icard, Ph.D. School of Social Administration
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FUNDING SOURCES

National Institute of Nursing Research

National Institute of Mental Health

National Institute of Child Health and Human Development
What are Examples Health Disparities Issues?

- HIV/AIDS & STDs
- Low birth weight, pre-term birth, & other negative pregnancy outcomes
- Cardiovascular disease
- Obesity
- Cancer
- Diabetes
- Lack of breast feeding

- Chronic health problems
- Poor mental health
- Immunizations
- Asthma
- Abuse & neglect
- Violence & violence-related injury
- Higher morbidity/mortality
Health Disparities Are Related To...

- Lifestyle issues/Behaviors People Do
- Immigration and acculturation issues
- Poverty/Environment
- Poor family comm.
- Language/reading
- Heavy family and caregiver burden
- Lack of education
- Lack of trust

- Poor provider patient relationships
- Lack of culturally competent treatment
- Access to care
- Healthcare treatment issues
- Insurance issues
- Bias, racism & marginalization
What Do We Know about HIV/STDs?

- HIV/STD incidence is a national concern and teens have high rates of sexually transmitted diseases.
- AIDS cases are increasing among young adults 20 to 29 years of age.
- HIV infection is increasing among people 13 to 24 years of age.
- Adolescents feel invulnerable, are resistance to abstinence messages, have negative beliefs about safer-sex practices, and inadequate confidence to negotiate safer sex.
- Adolescents have sporadic sex and fail to use condoms
Disempowered
Low Self-Esteem

Attitudes Beliefs

Family Gender Roles Societal Norms

Culture Tradition Customs

Religious Beliefs

Language

Partner Power & Abuse

Lack of Knowledge

Poverty

Denial Invulnerable

Discrimination & Stigma

Lack of Knowledge

Parent Child Sex Talk
What Can We Do About It?
We Can Design Theory-Based, Culturally Specific, Developmentally Appropriate HIV/STD Risk-Reduction Interventions
Who Has the Answers?
.....the community

We Can Partner with the Community to Design, Evaluate and Translate Culturally Appropriate Evidenced-Based HIV/STD and Risk Reduction Interventions
WE CAN ANSWER KEY RESEARCH QUESTIONS FOR ADOLESCENTS

• Can the behavior of high-risk youth be changed?

• Can culture-sensitive programs be effective when implemented by facilitators who do not share the ethnicity of participants?

• Can abstinence-based interventions be effective?

• How effective are peer educators?

• Can evidenced-based practices be disseminated and evaluated when implemented by end users?
HOW DO WE CONDUCT OUR RESEARCH?
THE SIX PHASES OF RESEARCH

1. Elicitation (*Focus Groups … Code of the Street*)
2. Questionnaire Development
3. Design Culturally Appropriate Intervention
4. Pilot Intervention
5. Evaluation
6. Dissemination
THEORETICAL MODELS

• **Social Cognitive Theory**
  Self-efficacy, Outcome Expectancy, (Hedonistic, Partner Reaction, Prevention Beliefs) and Skills.

• **Theory of Reasoned Action**
  Attitudes, Beliefs, Subjective Norms and Intentions.

• **Theory of Planned Behavior**
  Perceived Behavioral Control and Control Beliefs
The Theory of Planned Behavior

Behavioral Beliefs

Normative Beliefs

Intention

Behavior

Behavioral Intervention

Other External Variables

Control Beliefs

THEMES:
(FAMILY, COMMUNITY, CULTURE & PRIDE)

• “Respect Yourself, Protect Yourself...Because You Are Worth It”

• “Let’s Work Together to Save Our People & Community.”

• “Be Proud, Be Responsible...Respect Yourself, Protect Yourself!”
WHAT DO OUR INTERVENTIONS INVOLVE?

• Small Group Discussion
• Culturally Appropriate Themes & Strategies
• Developmentally Appropriate Strategies
• Interactive Activities
• Audiovisuals

• Knowledge
• Self-efficacy
• Attitudes/Beliefs
• Goals & Dreams
• Technical Skill Building
• Role Playing
• Practice and Feedback
We Partnered With The Community to Design & Implement Interventions On Three Levels: Individual Family/Community International
Individual Level Interventions:

Adolescents in School and Community Settings
JEMMOTT, JEMMOTT, & FONG (1992, AJPH)--DESIGN

- Randomized controlled trial
- 157 African American male adolescents at a weekend program
- Mean age was 14.6 years
- 83% reported ever having sexual intercourse

- Five hour cognitive-behavioral small group intervention
- Facilitator gender
- 96% 3-month follow-up return rate
JEMMOTT, JEMMOTT, & FONG
(1992, AJPH)--RESULTS

• Reduced HIV/STD and risk-associated sexual behavior
• Reduced frequency of sexual intercourse
• Reduced unprotected sexual intercourse
• Fewer sexual partners
• No consistent effect of gender of facilitator
• Self-reported sexual behavior change unrelated to social desirability bias
JEMMOTT, JEMMOTT, FONG & MCCAFFREE (1999 AJCP) --DESIGN

- Randomized controlled trial
- 496 African American adolescents at a weekend program
- Mean age was 13.1 years
- 54% were female
- 55% reported ever having sexual intercourse

- 5-hour cognitive-behavioral small group intervention
- Facilitator race, facilitator gender, and group gender composition
- 96% 3-month follow-up return rate; 93% 6-month follow-up return rate
JEMMOTT, JEMMOTT, FONG & MCCAFFREE (1999 AJCP) --RESULTS

- Reduced HIV/STD and risk-associated sexual behavior
- Reduced unprotected sexual intercourse
- Self-reported sexual behavior change unrelated to social desirability bias
- Intervention effects were the same irrespective of race of facilitator, gender of facilitator, and the gender composition of the group
Randomized controlled trial

659 African American adolescents at a weekend program

Mean age was 11.8 years

53% were female

25% reported ever having sexual intercourse

8-hour abstinence-based, safer-sex, or general health promotion intervention

Adult facilitator or peer co-facilitators

96% 3-month follow-up return rate
JEMMOTT, JEMMOTT, & FONG
(1998, JAMA)-- RESULTS

• Abstinence intervention reduced the frequency of coitus and, in virgins, delayed initiation of coitus.
• Safer-sex intervention increased condom use.
• Safer-sex intervention reduced unprotected coitus.
• Adult and peer facilitators equally effective.
• Self-reported sexual behavior change unrelated to social desirability bias.
HOW DO EFFECTIVE INTERVENTIONS GET DISSEMINATED TO END USERS, SUCH AS SCHOOLS, COMMUNITY BASED ORGANIZATIONS, OR HEALTH CLINICS?
CDC'S DISSEMINATION PROJECT
"RESEARCH TO CLASSROOMS: PROGRAMS THAT WORK"

• Scientifically valid evidence of effectiveness

• User-friendly

• Dissemination to educators and other advocates for youth across the nation

• "Be Proud! Be Responsible! Strategies to Empower Youth to Prevent AIDS" (Jemmott, et al, 1994)
THE JEMMOTT INTERVENTION
BE PROUD! BE RESPONSIBLE!

The JEMMOTT Intervention

In the absence of a vaccine or a cure for AIDS, the only effective weapon against this invariably fatal disease is prevention. But knowledge alone is not enough to change a risky behavior — witness the tens of millions of people who continue to smoke despite the overwhelming link to lung cancer and heart disease.

People must be persuaded and empowered to change. Evidence suggests that the Jemmott Intervention, a multidisciplinary educational and skill-building curriculum, can do just that. This innovative intervention was recently selected as a nationwide model by the Centers for Disease Control and Prevention.

In February, the day health officials announced some encouraging news about AIDS — the number of new cases among homosexuals in San Francisco is actually falling — Dr. James B. Jemmott, of the School of Nursing at Columbia University, was predictably elated.

"It's great news," explained Dr. Jemmott, director of the School of Nursing's new Center for AIDS Research. "It's a relief. But there are many middle-class gay men out there who are changing their behavior. They are the ones who fought hard to get America's attention on the AIDS crisis. They fought for AIDS education, prevention, and treatment, and they have lost a lot of friends and relatives. They want to live more suburban lives. They want to be normal."

Dr. Jemmott is also worried about young urban minorities, particularly black youth, who are among the first to be infected with AIDS and who have the least access to political or social services to help them change their behavior.

One reason the intervention works is that it is a "hook." Messages are delivered through a variety of interactive activities, including videos, role playing, and comic strip demonstrations. Messages last from 15 to 20 minutes. One particularly effective activity, a role play game, was called "Don't Just Do It." Participants are asked to discuss issues about healthy behaviors.

Teachers can learn how to present the curriculum through 16 to 24 hours of training.

Be Proud! Be Responsible!

Schools and community-based organizations throughout the country will soon be implementing the Jemmott Intervention, which has been selected for inclusion in "Research to Classroom," a new CDC project that identifies and disseminates interventions that affect health risk behaviors among youth.

The Jemmott curriculum, to be distributed under the name "Be Proud! Be Responsible: Strategies to Reduce Youth Risk for AIDS," is intended for inner-city schools and community-based programs that serve minorities between the ages of 13 and 16. The first year of the program will begin in the fall of 1987.

In the meantime, the CDC announced last week a $6.2 million grant to the University of California at San Francisco to study the interventions being developed by the Jemmott Intervention Project. The project, called "Health Care Network," will provide technical assistance to health care providers in low-income communities to help them implement the Jemmott Intervention.

In addition, the CDC is funding a study at the University of California at Berkeley to evaluate the effectiveness of the Jemmott Intervention Project. The study will compare the effectiveness of the Jemmott Intervention Project with other existing programs in reducing health risk behaviors among youth.

The Jemmott Intervention Project has been selected as a model for other school systems to use in their efforts to reduce health risk behaviors among youth. The project has already received funding from the Centers for Disease Control and Prevention, the United States Department of Health and Human Services, and the National Institutes of Health.

"Making Proud Choices! A Safer Sex Approach to Prevent HIV/STD." (Jemmott, et al., 2001)
CDC selected 7 HIV/STD risk reduction curricula for dissemination and translation to schools and CBOs across the nation.

3 of the 7 were designed by my team, the only nurse-led research team.
WHY DOES OUR INTERVENTIONS WORK?

- Teaches skills
- Emphasizes hedonistic beliefs
- Holds their attention
- Very interactive & fun
- Non judgmental, caring & supportive
- Culturally sensitive

- Videos are appropriate
- Excellent teacher-student interaction
- Age specific
- Good discussions
- Credible
- Promotes confidence
- Build pride/responsibility
Clinic-Based Interventions:

Reducing HIV Risk Behaviors Among African American Women in a Women’s Health Clinic
Sisters Saving Sisters: The Adolescent Female Health Promotion Project

• Is skills practice necessary to achieve behavior change?
• Can behavioral interventions reduce STD incidence among adolescent women?
Design

- Randomized controlled trial
- Adolescent medicine clinic
- 682 adolescent girls
- 68% Black
- 32% Latino
- 22% STD positive

- Skill-based intervention
- Information-based
- Health promotion
- 89% 12-month follow-up retention

Adjusted Mean Frequency of Unprotected Intercourse in the Previous 3 Months

Adjusted Mean Number of Sexual Partners in Previous 3 Months

Adjusted STD Incidence

Sister to Sister: The Black Young Women’s Health Promotion Project

• What type of HIV risk reduction intervention is best for AA women in a primary care setting? Group vs. individual? Information alone vs. skill based?

• Can a single, 20 minute, 1-on-1, skill-based intervention session reduce HIV risk-associated sexual behavior and the incidence of STDs?
Jemmott, Jemmott, & O’Leary Design

- Nurse-led randomized controlled trial
- 564 AA women attending a primary care clinic
- Mean age, 27 years
- Facilitators: 27 AA nurses
- 1 of 5 conditions
- 3-, 6-, 12-month follow-up
- Self-reported sexual behavior
- STD clinical examination
- 86.9% retained at 12-month follow-up

The 5 Interventions

- Contrasted 2 methods of delivery: group vs. individual
- Two kinds of intervention content: information vs. skill-building
- Health promotion control group
Did It Work?

• Did it work?

• Was it effective in changing behavior?

• Did it reduce STD incidence?
Results

- **Women in the skill building interventions**
  - Reduced HIV risk-associated sexual behavior
  - Reduced frequency of sexual intercourse
  - Reduced unprotected sexual intercourse
  - Fewer sex partners
  - Used condoms more often
  - Less unprotected sex
  - No effects on social desirability
Results (cont’d)

- Women in the skill-building interventions were less likely to have an STD at the 12-month follow-up than were those in the control group

Conclusion: The Results Suggest That

• Relatively brief but intensive culturally sensitive and developmentally appropriate HIV risk-reduction interventions can have significant impact on HIV risk behavior among AA women

• 1-to-1 and group skill-building interventions were equally effective in changing risk behavior and STD incidence.

• Nurses and other primary care providers can implement both types of interventions

Why Do Our Interventions Work?

• Teach skills
• Emphasize hedonistic beliefs
• Hold their attention
• Very interactive and fun
• Nonjudgmental, caring, and supportive
• Culturally sensitive
• Developed based on hearing their voices and the context of their lives

• Videos are appropriate
• Excellent teacher-student interaction
• Age specific
• Good discussions
• Credible
• Use culturally appropriate strategies (ie., storytelling)
• Promote confidence
• Build pride/responsibility
Dissemination and Translation of Sister to Sister

- CDC selected Sister to Sister for replication, dissemination, and translation to clinics in its program entitled, “Replication of Evidenced-Based Projects”

- CDC funded us to examine the feasibility of translating and tailoring this intervention for implementation in various Family Planning Clinics
Sister TO Sister

RESPECT YOURSELF! PROTECT YOURSELF!
BECAUSE YOU ARE WORTH IT!!!

Training Manual
An HIV/STI Risk-Reduction Program for Women

Includes a 20-Minute HIV Risk-Reduction Intervention for Women in Primary Health Care Clinics
Family/Community Level Interventions
Trained Housing Development Community Leaders to Train and Empower Single Mothers To Reduce HIV /STD Risk Behaviors Among Their Sons… Building on Their Strengths!
MOTHERS AND SONS HEALTH PROMOTION PROJECT

STRENGTHENING THE BOND
MOTHERS AND SONS HEALTH PROMOTION PROJECT

- Randomized controlled trial
- 42 housing developments in Philadelphia
- 16-hour cognitive-behavioral small group intervention over 4 Saturdays
- Homework assignments
- 630 single African American mothers and their sons ages 11-15
- Facilitators - 84 women residing in the housing developments
- Mother's sexual behavior
- Son's sexual behavior
- 24-month follow-up
Trained and Empowered Churches to Reduce HIV /STD Risk Behavior Among Their Members and Their Community… Focusing on Abstinence
CHURCH & FAMILY
HEALTH PROMOTION PROGRAM

TOGETHER WE CAN DO ALL THINGS
HOW DO WE DISSEMINATE INFORMATION TO TEENS NATIONALLY?
HOW DO WE CONDUCT OUR RESEARCH CROSS CULTURALLY AND INTERNATIONALLY?
STRATEGIES FOR TAILORING AND TRANSLATING EFFECTIVE PROGRAMS:

WE DO NOT HAVE TO RE-INVENT EVERYTHING

1. Elicitation (Focus Groups)
   
   Learn the code of their streets!!!

2. Questionnaire Development

3. Re-design & Tailor the Intervention –
   
   Keeping key components intact.

4. Pilot Intervention

5. Evaluation

6. Dissemination
THE 3 T’s of Effective Capacity Building and Designing Effective Interventions

Time
Trust
Team Building
Design

- Cluster Randomized Controlled Trial
- School as the unit of randomization
- 18 senior primary schools
- Urban and rural schools
- 1,057 or 94.5% of 1,118 eligible Grade 6 learners were enrolled
Structure of the Interventions

- Twelve 1-hour modules implemented over six 2-module sessions
- Extracurricular period
- Implemented in Xhosa
- Male and female adult co-facilitator pairs.
“PROTECT OUR FUTURE”
The South Africa Health Promotion Project
MY TEN COMMANDMENTS …

FOR BUILDING SUSTAINABLE NETWORKS IN COMMUNITIES TO PROVIDE PRECONCEPTION CARE AND REDUCE HEALTH DISPARITY IN MATERNAL CHILD HEALTH
THE TEN COMMANDMENTS FOR EFFECTIVE COMMUNITY BASED RESEARCH

• Thou must be truly committed to the community and committed to doing work that will make a difference for the residents of the community.

• Thou realize that the residents of the various urban communities have many burdens, yet are very resilient.
• Thou must respect various traditions and cultures of the various populations within thy community.

• Thou must know thy community and remember to give and take...not just take and treat them like thy truly care.

• Thou must listen to the voices of thy community...*Listen and learn the code of their streets*
THE TEN COMMANDMENTS FOR EFFECTIVE COMMUNITY BASED RESEARCH (CONTINUED)

• Thou must disseminate findings and material back to the community in a way that is understandable to them making sure that it culturally appropriate, gender specific, and reflects the learning needs, language, and style of the population.

• Thou must be committed to doing the 3 T's of building community partnerships and translating research into practice - Time, Trust, and Team Building. We, researchers and clinicians, do not have all of the answers. …Together we do.
THE TEN COMMANDMENTS FOR EFFECTIVE COMMUNITY BASED RESEARCH (CONTINUED)

- Thou must partner with the community to design, evaluate, tailor, and disseminate evidence-based strategies to save the lives of the children and tailor the messages to empower them not hurt them.

- Thou must develop linkages and partnerships with community leaders, organizations, and residents to build community capacity for sustaining effective research programs once the funding is over.
THE TEN COMMANDMENTS FOR DESIGNING AND TRANSLATING EFFECTIVE COMMUNITY BASED RESEARCH (CONTINUED)

• Thou shall not get discouraged. Be “the little red engine that could!”

• Thou shall have fun.
As we travel this road of trying to promote the health of women in the context of their daily lives....
It is Important to Remember…

Our Long term Goal is…

To save the lives of the young ladies…because they are our future.

Save her and we save our future!!!
“DIVIDED WE FAIL
UNITED WE FLOURISH”

So… Work Together…

• **Build New Partnerships,**
• **Listen to the Voices**…
• **Stay Focused**
• **Mentor & Value Each Other**
• **Design Culturally Competent, Collaborative, Compassionate Strategies to Promote Healthy Behaviors!!!**
THANK YOU