

Implementation and Long-Term Outcomes of Two HIV Intervention Programs for Latinas

Despite the disproportionate effect of HIV/AIDS on Latinas in the United States, only a few studies of HIV prevention programs have focused on this priority population. In the meantime, public health practitioners have needed to develop and implement programs that contribute to the reduction of HIV sexual risk among women in Latino communities. This article reports on a joint effort of a state health department, community advocates, and researchers to develop and test the effectiveness of two 12-week interventions, an Intensive HIV Prevention Program and a Women's Health Program. The authors present the short-term and longer term outcomes of both programs, assess their strengths and weaknesses, and finally consider the broader implications of their findings for HIV prevention programs for Latinas nationwide.

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In spite of recent trends demonstrating a reduction in HIV rates among certain groups in the United States, the Centers for Disease Control and Prevention (CDC) reported that HIV/AIDS rates among racial/ethnic minorities remain high (2001). Latinas are among the groups that have been disproportionately affected by this epidemic. Latinas constitute approximately 12.5% of the U.S. population (U.S. Census Bureau, 2000), yet they represented 18.3% of the country's AIDS cases reported through 2000 (CDC, 2001). Analysis of AIDS deaths by race/ethnicity through 2000 indicates that Latinas with AIDS were twice as likely to die by age 29 as were Whites with AIDS (CDC, 2001). Latinas account for 19.8% of adult/adolescent female AIDS cases and for 18% of all new HIV infections among women (CDC, 2001). Furthermore, Latinas have an AIDS case rate that is sixfold higher than that of non-Hispanic White women (13.2 vs. 2.2). Yet, few HIV prevention programs have been

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directed toward Latinas, and fewer still have been shown to be effective with this population.

The HIV Prevention Program Archive (HAPPA) identified 18 programs that were judged by a panel of experts to have had a salutary effect on behaviors that increase HIV risk (Card, Benner, Shields, & Feinstein, 2001). Of those, only one program targeted Latinas, and this program required English fluency as a criterion for inclusion (Shain et al., 1999). Similarly, the CDC *Compendium of HIV Prevention Interventions With Evidence of Effectiveness* (1999) revealed a lack of effective programs for Latinas (Amaro, Vega, & Valencia, 2001). The lack of Spanish-based programs for Latinos is particularly astounding, as almost half of the Latino population is foreign born (U.S. Census Bureau, 2000) and 65% of Latinos diagnosed with AIDS in 2000 was foreign born (CDC, 2001). Clearly, Spanish-based programs are needed to reach this priority population.

This article describes a joint effort of the Massachusetts Department of Public Health (MDPH), the Massachusetts HIV/AIDS Prevention Planning Group, community advocates, and researchers to provide evidence-based HIV prevention programs to Latinas in Massachusetts. Two Spanish-based, culturally tailored HIV prevention programs were designed to promote sexual risk reduction in women with a male partner. Sexual risk was the focus because the majority of Latinas in the United States most often become infected with HIV through sex with an infected male partner (CDC, 2001).

BACKGROUND

HIV Risk Factors for Latinas

Most of the research and literature on risk factors for HIV among Latinas has focused on lower income, urban women. Studies of Latinas have shown (a) limited knowledge of HIV transmission and prevention (Amaro & Gornemann, 1992; Kalichman, Kelly, & Hunter, 1992), (b) a self-perception of being at low risk for HIV and negative attitudes toward safer sex practice (Catania et al., 1992), (c) a perception that condoms make sex less pleasurable and that condom use implies male infidelity or female distrust (Carovano, 1991), (d) a belief that condoms do not need to be used within the context of an intimate relationship with a steady partner (Catania et al., 1994; Marin, Tschann, Gomez, & Gregorich, 1998), (e) a belief that sex without a condom is an expression of deep love (Pivnick, 1993), and

(f) a willingness among some Latinas to engage in unprotected sex with their partner even if they knew their partner was infected with HIV—because of their perception that unprotected sex was equated with love and intimacy (Harrison et al., 1991; Yeakley & Gant, 1997; Yep, 1992). Some of these findings have been shown to be associated with acculturation (Marks, Cantero, & Simoni, 1998; Nyamathi, Bennet, Leake, Lewis, & Flaskerud, 1993) and/or education (Aruffo, Coverdale, & Vallbona, 1991; McCaig, Hardy, & Winn, 1991).

Male partner-related factors can also have an effect on women's risk-reduction practices. Such factors include men's negative perceptions of condom use and their belief that condoms are associated with disease (Amaro & Raj, 2000; Catania et al., 1992; Weeks, Schensul, Williams, Singer, & Grier, 1995). Deren, Shedlin, and Beardsley (1996) found that even when Latinas have concerns about HIV and discuss them with partners, their rates of condom use remain low. Some women fear male abandonment or violence as a result of condom negotiation (Weeks et al., 1995). Mays and Cochran (1988) identified Latinas who were, in fact, physically or verbally assaulted in response to their requests for partners to use condoms.

Male control over decision making regarding condom use can be attributed directly to culturally prescribed gender roles that reinforce male promiscuity and sexual passivity among women. Women are expected to serve as "gatekeepers" to sexual activity (Erickson, 1998). A Latina who carries condoms may be viewed as "prepared for sex" and thus considered promiscuous and undesirable (Mays & Cochran, 1988; Weeks et al., 1995). This gender- and culture-based script for sexual relations places Latinas, regardless of their knowledge and skills, at increased risk for HIV in situations where their partners are unwilling to use condoms (Flaskerud, Uman, Lara, Romero, & Taka, 1996). Pulerwitz, Gortmaker, and DeJong (2000) looked at culturally determined power imbalances in Latino heterosexual relationships and found that women with the least decision-making power in their relationships were the least likely to report condom use.

Interventions With Latinas

Only two studies involving Latinas have demonstrated significant sexual risk behavior reductions. The first was a randomized, controlled trial with English-speaking Mexican Americans and African Americans that compared a cognitive-behavioral small-group

program that included three sessions (3 to 4 hours per session) to a single standard counseling session lasting about 15 minutes (Shain et al., 1999). Findings indicated significantly lower sexually transmitted disease (STD) rates in the intervention group, as compared to the control group, during 12 months of follow-up. Although these findings were dramatic, the lack of inclusion of non-English-speaking Latinas limits the intervention's generalizability to immigrant Latinas who lack English fluency.

The second study reported effects for the intervention described in this article (Raj et al., in press). The study used a quasi-experimental design to compare an HIV-Intensive Prevention (HIV-IP) program, a Women's Health Program (WHP), and a wait-list control group that received literature and referrals for HIV prevention (Raj et al., in press). Both intervention programs lasted 12 weeks and were offered in Spanish to a group of predominantly Dominican (55%) and Puerto Rican (13%) women. Participants in both intervention programs were significantly more likely than those in the wait-list group to report increased condom use baseline to posttest and at a 3-month follow-up. However, only the HIV-IP resulted in a significant increase in safer sex communication, whereas only the WHP resulted in significant increases in HIV testing. Although these findings indicate the utility of both programs, longer term effects of the two programs were unknown. The purpose of the current article is to (a) present findings from the 15-month follow-up of this study and (b) present lessons learned in the implementation of the HIV-IP and the WHP, assessing the two interventions' strengths and weaknesses.

PROGRAM IMPLEMENTATION

Curricula

A team composed of staff from the MDPH HIV/AIDS Bureau and various community agencies, curriculum writers, and researchers developed curricula for both programs. The HIV section of the WHP was based on existing HIV-prevention programs at many community-based organizations (CBOs) throughout the state. The HIV-IP was a new curriculum. Both the HIV-IP and WHP were delivered over 12 sessions (1.5 to 2 hours each) and tailored to women whose primary risk for HIV infection was via unprotected sex with male main partners. Both programs were Spanish-based and facilitated by two trained bi-

lingual community health educators. The primary facilitators were respected community leaders experienced in HIV education and trained in the program curriculum. The secondary facilitators were primarily responsible for the logistics of the program, for example, arranging for child care, transportation, and food provided during the sessions. Facilitators were allotted \$50 per group to provide small presents for the participants.

The HIV-IP was based on social cognitive theory (SCT) (Bandura, 1977, 1989) and utilized an empowerment approach (EM) (Wallerstein & Bernstein, 1994) composed of Freirian concepts (Freire, 1970), self-in-relation theory (Amaro, 1995; Miller, 1986; Surrey, 1991), and the theory of gender and power (Connell, 1987). This program differed from traditional psychoeducational models of HIV prevention by including participatory education strategies such as critical reflection, codification and theme generation, root cause identification, and social action. The curriculum included more than 16 hours of content related to HIV and STD transmission and prevention, sexual and reproductive health, substance use, partner violence, body image, and the relationship of sociostructural health risk factors (e.g., economics and oppression) to HIV risk. The program was administered by a CBO that regularly provided social services to Latinas.

The WHP used a small-group format with a health education/psychoeducational approach that relied largely on didactic education and skills training exercises. This program was based on concepts from SCT, the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), and the health belief model (Becker, 1974; Becker & Joseph, 1988; Rosenstock, 1974). The WHP did not consider sociostructural factors. About 6 to 9 hours were devoted to educational sessions on HIV transmission and prevention, STDs, sexual and reproductive anatomy, and condom practice and negotiation skills. The remaining sessions focused on general women's health topics deemed relevant by program participants. The program was implemented by a CBO that serves a predominantly Latino population.

Recruitment of Participants

Facilitators recruited participants at housing projects, community service agencies, and clinics. Ultimately, 170 women were enrolled (HIV-IP, $n = 44$; WHP, $n = 56$; wait-list control, $n = 70$). Enrollment was

based on the following criteria: (a) Spanish-speaking Latina, (b) aged 18 to 35, (c) had not used condoms or had been inconsistent in their use with a steady male partner in the past 3 months, (d) had not engaged in injection drug use or sex trade in the past 6 months, and (e) had no plan to relocate from her Boston-based community in the next year.

The primary HIV-IP facilitator reported that only slightly more than half (55%) of the women she approached for recruitment into the program were both interested and eligible. Common reasons for disinterest by eligible women were the length of the program and feeling saturated with HIV information already. Of the women approached for the WHP, 90% were both interested and eligible. The main reason for program ineligibility was not having a steady relationship with a male sex partner.

In the final sample, fewer than half of the women (47%) were employed. Three fourths of the women (74%) reported an income of \$800 or less per month, and 50% reported being on government assistance. More than one fourth of the participants (29%) held less than a high school degree. All participants gave written informed consent and were compensated for partaking in the study. Eight women were dropped from the data analyses because they did not meet the criteria at baseline testing, they demonstrated cognitive impairment at the time of testing, and/or they were HIV positive.

Measurement Tools

A 45-minute, self-administered survey was used to assess participants' frequency of condom use, safer sex efficacy communication with partner (Wingood & DiClemente, 1998), and history of HIV testing in the previous 3 months, as well as their demographic characteristics at baseline, posttest (i.e., 12 weeks following baseline), 3-month follow-up, and 15-month follow-up. Surveys were conducted in the participants' preferred language (Spanish or English). All participants received \$15 for participation in the baseline survey, \$20 for participation in the posttest, and \$25 for each subsequent follow-up.

Information on program implementation and participants' experiences of the intervention were collected through participant interviews ($n = 8$), focus groups ($n = 28$ women), and surveys ($n = 100$), as well as facilitator interviews and reviews of facilitator session records, which documented attendance rates, program content and strategies, and contact with participants outside of the group sessions.

Findings

HIV-IP. Participants in the HIV-IP had a 69% attendance rate of six or more sessions. Interviews with women who dropped out of the HIV-IP indicated that they had enjoyed the program but had to leave owing to difficulties obtaining childcare and transportation, personal illness, family responsibilities, scheduling conflicts, or the need to travel out of the country.

Facilitators adhered well to the curriculum content on topics related to HIV risk, gender-specific topics (e.g., body image, violence against women), and culture-specific topics (e.g., Latino culture, immigration). However, they were not as consistent in adhering to the curriculum in the identification of class- and race-based issues that are at the root of HIV risk in Latino communities. Nor did they fully implement several of the key participatory strategies originally proposed, including problem posing and social action development.

Facilitators and participants alike reported logistical challenges. These were in large part due to a lack of staff control over things like scheduling and the location of group meetings and insufficient time and resources for arranging for transportation, childcare, and outside contact with participants. Only 14 HIV-IP participants contacted facilitators outside the program. These contacts were primarily for additional health education, job training information, referrals for housing, food and transportation needs, and contraceptive concerns.

WHP. This intervention group had 92% attendance for six or more sessions. Like their counterparts in the HIV-IP, those who left the WHP group indicated that they had enjoyed the program. Their main reason for leaving was scheduling conflicts, primarily with their jobs.

The program was implemented as originally designed, with four standard HIV sessions and eight additional non-HIV health sessions (which included topics such as mental health and depression, cervical cancer, non-HIV-related partner communication, diabetes and nutrition, partner violence, and oppression and social justice). Consistent with the curriculum, the facilitators primarily relied on psychoeducational strategies, utilizing lectures and skill-building games considerably more often than group discussion. Whereas the WHP staff and the participants reported fewer problems with logistics than did their counterparts in the HIV-IP, the WHP staff noted that they spent significant time deal-

ing with transportation and baby-sitting issues as well as seeing participants outside of groups.

Participants in the WHP made more than 100 contacts with the facilitators outside the program. These contacts were usually for support or referrals that pertained to personal issues (e.g., substance use, domestic violence, mental health), social service needs (e.g., housing, legal help, immigration matters), or employment (e.g., job training).

Satisfaction with the program. Data from satisfaction surveys, interviews, and focus groups indicated that participants in the HIV-IP and the WHP were highly satisfied with the programs (see Table 1). Virtually all women in both intervention groups said that they would recommend the program to their friends and women in other communities.

Safety in the group and connection to other women. Focus group’s findings revealed that one reason for the high level of satisfaction was that those in both groups felt safe and comfortable sharing their thoughts and feelings. The sense of connection and confidentiality was clearly important.

They gave us the opportunity to listen to one another and that was the best.¹

To have more trust among ourselves, to lose the fear and be able to speak, to ask questions . . . to be able to share our experiences, I think that is a very positive thing it [the program] gave us.

We get to cry, we get to share personal things with one another, and I know we, we help each other at that particular moment.

We shared like a family. And what was said there stayed there, it did not go outside. We shared like sisters.

Women also reported continuing their discussions after meetings and connecting outside the program.

We usually, after the meetings, we usually talk about what we liked, you know, how interesting it was and how comfortable we felt talking about it . . . we [were] just discussing between us. It became very confident, very comfortable, for everyone to share even out of the program.

We gave the phone numbers and things like that so we could call each other.

TABLE 1
Satisfaction of Participants With Two Interventions: HIV-IP (n = 44) and WHP (n = 56) (in percentages)

Satisfaction Rating	Very		Not Very
	Much	Somewhat	Much/Not At All
Enjoyed program			
HIV-IP	75	25	0
WHP	85	15	0
Fulfilled needs related to HIV/AIDS			
HIV-IP	77	23	0
WHP ^a	75	23	0
Fulfilled general health needs			
HIV-IP	68	32	0
WHP	65	29	6
Fulfilled needs related to gender issues			
HIV-IP	83	17	0
WHP	73	19	8
Addressed cultural issues relevant to Latinas’ HIV risk			
HIV-IP	52	40	8
WHP	44	38	18

NOTE: HIV-IP = HIV-Intensive Prevention, WHP = Women’s Health Program.

a. 2% WHP participants did not answer this item.

Facilitators as role models and teachers. In survey responses, participants revealed a high level of satisfaction with the facilitators, whom they praised for their commitment to the program, their ability to educate them and to give them the “power” to voice their opinions, feelings, and ideas. In focus groups, women in the HIV-IP stated,

As directors, they did not think of themselves, they did not act selfishly. With them, who are not even family, you could count on them, they have been wonderful people.

The main advantage was the power we had as participants to . . . be able to communicate with the person instructing us.

Participants further credited the facilitators with creating a safe environment that supported female bonding and discussion. One WHP participant said,

When I got to know her [lead facilitator] I said, "This one knows what she is doing"—in the way in which she presents herself, the way in which she expresses herself, she is a complete woman.

Learning HIV risk-reduction skills. Participants were pleased with the skills they gained, especially in terms of condom negotiation with their partner.

One always has a bit of psychologist inside . . . if you know how to manage him, you can use it the same way, very creative, and it's something he'll enjoy. It is finding the right way to reach him and say, "Check this out."

I got more alert because of the program. . . I used to say, "OK, we don't have a condom; we can do it without a condom." But now I say, "Nope, no condoms, no sex."

Women took pride in being a resource for their families. They discussed their own childhood misconceptions and lack of accurate information about sex and resolved not to let the same thing happen with their children.

And now my daughters know. When they need to know something or something changes inside them, they now know who to go to where there is information that may be useful to them.

In these times, as women, we need to be well-informed about our health because it is very easy . . . there are many things . . . many relations outside of our home and that are bringing many problems to our homes and they not only affect us (women) but also our children.

Yet, in both programs, discussions about condom negotiation often focused on the use of condoms in hypothetical extramarital affairs or unanticipated encounters rather than within the context of participants' steady relationships. A great deal of risk-reduction "talk" in both programs pivoted on HIV risk via infidelity and the need to ask partners to protect themselves. Often, however, the discussion did not involve any articulation of a desire for the partner to change his behavior.

I . . . anyway . . . my partner is going to go out. Regardless, I give him a condom. And he says, "Girl, what's the matter with you? What are you saying? You are a *cabrona*." "*Cabrona*? No, my friend. I value myself a lot. . . . When you leave that door and enter the streets, I have no clue who you might meet."

Topics of most value. Topics that participants in both groups considered most helpful were those related to reproductive health, domestic violence, and alcohol and drugs.

The violence topic was pretty good . . . you know, I've never gone through that and I've never thought that I would probably stay with a man who hits me. I don't know, it hasn't happened, but I definitely know what to do and where I can go in case that happens you know to talk about it, just to get away from that relationship.

In the program . . . they also gave us awareness about alcohol . . . we gained a broader understanding of dangers that come with alcohol, the abuses that come about through alcohol . . . in that session we gained much awareness and I have been able to practice it with men.

Participant Suggestions

Participants from both programs suggested a few changes in the curricula. One was that more materials be given out, such as information sheets and pamphlets, and that more visuals be used, such as videos featuring people with HIV/AIDS. They also thought a similar program should be offered to men. One woman wished that the latest AIDS research and medications had been covered; she also noted that if there had been more handouts, she would not have needed to take as many notes and therefore would have been able to participate more freely in discussions.

15 Month Follow-Up Outcomes

A series of logistic regression analyses were conducted to test for group by interaction effects on major HIV-risk behavior outcomes from baseline to 15 = month follow-up. While we had found significant program effects at a 3-month follow-up (Raj et al., in press), these effects were not maintained at the 15-month follow-up for frequency of condom use, safer sex communication, and HIV testing (see Table 2).

DISCUSSION

This study reports on the process evaluation and long-term outcomes of an HIV prevention program for Latinas. The interventions contained the content deemed critical for HIV prevention interventions (Kalichman, 1998; Kalichman, Carey, & Johnson, 1996; Wingood & DiClemente, 1996). Furthermore, the HIV-IP contained material on contextual issues

TABLE 2
Safer Sex Behavior at
Baseline (T1) and 15-Month Follow-Up (T2)

		T1	T2	P-value
Condom use (%)				
Never	HIV-IP	56.41	42.31	NS
	WHP	61.54	56.25	
	Control	68.75	55.00	
Always	HIV-IP	0	7.70	NS
	WHP	0	18.76	
	Control	0	10.00	
Safer sex communication (M)				
	HIV-IP	2.72	4.23	NS
	WHP	3.59	4.73	
	Control	2.87	4.33	
HIV testing in past 3 months (%)				
	HIV-IP	22.5	30.00	NS
	WHP	20.37	16.67	
	Control	30.30	31.91	

NOTE: HIV-IP = HIV-Intensive Prevention (N = 44), WHP = Women's Health Program (N = 56), Control = 70.

such as poverty, oppression, and so forth (Wingood & DiClemente, 1996). Both interventions were theoretically driven, culturally specific, and multisessional (Kalichman, 1998; Kalichman et al., 1996; Wingood & DiClemente, 1996).

Diminishing Effects of Interventions Over Time

Data from a 3-month postintervention follow-up of participants indicated significant reductions in risk behaviors for the two intervention groups, as compared to the control group (Raj et al., in press). However, data from a 15-month postintervention follow-up indicated that previously significant program effects were not maintained. Kalichman et al. (1996) demonstrated that the decrease of program effects over time is common in HIV prevention studies. In analyses of data from 12 HIV risk-reduction intervention studies, they found that "as the interval between the intervention and the assessment increased, intervention success tended to decrease" (p. 11). Diminished intervention effects during longer periods of time, in fact, are not unique to HIV prevention (Kalichman et al., 1996).

Although program effects were not evident at the 15-month follow-up, the significant behavior changes apparent at the 3-month follow-up (Raj et al., in press)

suggest that with some modifications of the programs, the effects might be prolonged. For example, a number of studies have documented that booster sessions—sessions to reinforce knowledge gained and key skills learned during the intervention period—have positive effects on the maintenance of various desirable behavior changes. These include parent literacy behaviors with children (Cronan, Brooks, Kilpatrick, Bigatti, & Tally, 1999), school-based drug-abuse prevention (Botvin, Baker, Dunsenbury, Botvin, & Diaz, 1995), adolescent problem behavior (Bry & Krinsley, 1992), and assertiveness training (Baggs & Spence, 1990). Hennessy et al. (1999) and el-Bassel and Schilling (1992) have recommended that HIV prevention programs incorporate the use of booster sessions. In fact, HIV interventions involving African American women (Dancy, Marcantonio, & Norr, 2000; el-Bassel et al., 1995; Harris, Bausell, Scott, Hetherington, & Kavanagh, 1998) and Latinas (Nyamathi, Flaskerud, Keenan, & Leake, 1998) that have reported maintenance of at least some program effects during long periods (e.g., 6 to 12 months) have employed booster sessions. However, Nyamathi's study with Latinas showed that even after booster sessions, reduced rates of unprotected sex and having multiple partners that were in evidence at 6 months' follow-up were not maintained at the 12-month follow-up.

Latino Men: A Critical Role

Although booster sessions may be important, they may not be sufficient for long-term maintenance of behaviors that are highly culturally embedded and involve the cooperation of male partners. Other interventions, such as ones focusing on Latino men and couples, may be needed to decrease the risk of HIV among Latinas. As noted previously, participants themselves voiced an interest in having HIV prevention education for their partners and for men in the community in general. Although there is significant evidence that male partners exert a crucial influence on condom use (Amaro & Raj, 2000), there is an absence of prevention strategies that specifically target Latino heterosexual male youth and adults (Amaro et al., 2001).

Clearly, it will be important to identify effective ways to engage Latino men in prevention efforts. Among other things, such interventions will need to focus on changing community norms regarding the acceptability of condom use in steady relationships by men.

Consideration of Future HIV Prevention Strategies for Latinas

Although the cohorts in our study were equivalent on a number of measures, we did not randomly assign women into study groups; therefore, less apparent variance in the groups may have affected outcomes. In addition, recruitment of women in part on the basis of condom use behavior may have mixed higher and lower risk individuals, who may have had different prevention needs. Furthermore, these findings may not be generalizable to women with a demographic and sexual-risk profile that differs from that of the study sample.

Despite these limitations, the consistent short-term effects achieved demonstrate the capacity for productive collaboration in applied HIV-prevention research among departments of public health, state HIV-prevention groups, CBOs, and academic researchers. Our study supported the feasibility of interventions for Latinas that involve multiple sessions.

Our study findings challenge stereotypes of poor, immigrant Latinas as passive or unwilling to discuss sex; participants in both intervention groups overwhelmingly appreciated the opportunity to carry on discussions of a very personal and sexual nature. The findings also imply that the content and process of more than one curriculum can be relied on to generate significant short-term reduction in risk behaviors among Latinas. If, with improvements in the structure and implementation of the programs, both curricula can be found to have longer lasting effects, then their different foci might appeal to different audiences of women and thereby increase their applied value.

These findings suggest that ongoing contact between program facilitators and intervention group participants would increase the chances that positive effects will be longer lasting. In theory, such follow-up contact should not be difficult for multiservice agencies that have an ongoing relationship with program participants through other services that the agencies provide. Kalichman (1998) showed that the inclusion of HIV-prevention programs within CBOs that offer other services are indeed effective. Such an approach benefits from the already established relationships, trust, and resources.

Our findings also highlight the importance of allocating resources for the ongoing training and supervision of facilitators to achieve high fidelity to the program models and curricula as well as appropriate preparation and

adaptation of curricula. Without this continuing guidance and oversight, the facilitators may not adhere to critical program components.

Finally, our evaluation found that CBOs are commonly faced with challenges in the implementation of HIV prevention. Whereas multisession models are more effective than briefer interventions, they are also more difficult to implement (Kalichman, 1998; Wingood & DiClemente, 1996). Although the provision of support services such as childcare and transportation is often cited as critical to women's attendance of health programs, those services are often considered too costly or staff intensive to include in community programs; thus, funding may not cover them. However, if HIV prevention programs are to reach and engage poor Latinas, then funding agencies need to promote the implementation of extended group interventions and allocate resources for support services.

NOTE

1. Quotations were translated from Spanish to English by a bilingual member of the research staff and checked for accuracy by another bilingual staff member.

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2002 SOPHE Awards

Deadline for nominations: July 31, 2002

Distinguished Fellow Award

This is SOPHE's highest form of recognition for a SOPHE member. This award recognizes person(s) who have made outstanding and lasting contributions to the field of health education.

Honorary Fellow Award

This is SOPHE's highest form of recognition for a NON-SOPHE member. This award recognizes a person who has made exemplary and lasting contributions to the field of health education and public health.

Program Excellence Award

This award recognizes outstanding contributions by a program (not an agency) in existence for at least three years to the practice of health education. Award recipients must demonstrate systematic application of the following components:

- Health education principles including provision of a planned, reinforcing series of educational experiences over time;
- Involvement of the target population in planning and implementation; and
- A well-defined evaluation component.

Health Education Mentor Award

This award recognizes individuals who have provided excellence in mentorship to health educators in preparation, performance, and practice in ways that have served to successfully bridge the rift between practice and research.

SOPHE Trophy

This award is given at the discretion of the SOPHE President to an individual who has performed exemplary service to the Society.

For more information or a nomination packet, www.sophe.org.