

PROVIDING INFORMATION IS NOT ENOUGH:

**HIV prevention programming
at the
AIDS Committee of Toronto:**

Looking back and moving forward.



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Background:

This document outlines the evolution of HIV prevention approaches from the onset of the epidemic in the early 1980s to today. It is based on an examination of HIV prevention approaches undertaken by the AIDS Committee of Toronto (ACT), other community-based AIDS service organizations (ASOs), and through an examination of literature that examines best practices related to HIV prevention programming. This document should be viewed as a guide to developing effective HIV prevention initiatives targeted to diverse communities at risk for HIV infection, as well as people living with HIV/AIDS (PHAs).

A Look Back:

Providing information is not enough.

In the earliest stages of the epidemic, it was recognized that HIV was a “behaviourally transmitted disease.” Thus, early conceptions of HIV prevention were built around changing individual behaviour. In the early days, a naïve belief existed that merely informing people about the presence of a deadly disease, how it was/was not transmitted, and how to protect themselves from it would be sufficient to change behaviour. At the time, there were no effective treatments for people with HIV/AIDS; HIV quickly progressed to AIDS, and death from HIV/AIDS was imminent. HIV/AIDS work (including HIV prevention) was often done in “crisis” mode. HIV prevention messages were uniformly targeted at the uninfected. Early prevention efforts built around this model unfortunately failed, producing little or no significant and sustainable behavioural change.

Understanding environmental and contextual factors is critical to enabling people to change behaviour.

Over the next decade, organizations and activists began to recognize that a number of other factors influenced the effectiveness of prevention efforts. In particular, it was recognized that the individual often does not control his or her own behaviour. Original models of HIV behaviour change put far too much emphasis on individualistic approaches and failed to consider the social, cultural and economic contexts in which behaviours occurred. They assumed that individuals could always make informed decisions based on the information provided to them and then act on those decisions. What we have learned – both through experience and through research – is that these approaches are also limited, as they assume that each individual is equally able to make healthy, informed choices.

Moving Forward:

A more realistic model of behaviour change — addressing risk AND vulnerability.

The lessons learned over the first two decades of HIV/AIDS in Canada have led to a more realistic model of HIV prevention. In the real world, individuals make decisions about risk behaviour not only in response to information provided, but also in response

to a variety of other factors. In this model, even once individuals have made a decision to take protective measures (such as to use a condom or not share needles/works) a number of other factors may stand in the way. Many of these external factors are part of the local environment in which risk behaviours occur or the context in which the risk behaviours are undertaken. These factors can influence an individual's vulnerability to HIV infection or transmission.

The first environmental and contextual issue that must be addressed is whether the individual has *access* to the means of prevention (for example, access to condoms). A number of barriers may stand in the way of gaining access: many people may not be able to afford condoms (economic barrier). Others may be too ashamed to walk into a pharmacy and purchase condoms (social barrier). And sometimes condoms just aren't available when sex takes place, because it's late at night, because the individual is unwilling to carry a condom because of peer pressure, etc. Over the years, ACT has tried to address these barriers by increasing access to free condoms: Condoms and lubricant are available in ACT's Access Centre, in a location where individuals do not have to ask to receive them. Outreach staff and volunteers regularly provide condoms (often packaged in small, plastic bags containing culturally-appropriate HIV/AIDS information) during outreach to at-risk communities. Within the gay community, ACT has installed condom-dispenser units in gay bars and other venues (these are restocked weekly by volunteers) to increase community access to condoms.

However, once the condom is obtained, the next question to be addressed is whether the individual possesses the *skills* to use the condom with his or her partner. Again a number of barriers may arise. Young people often receive no skills training in use of condoms because schools and youth organizations may refuse to allow discussion of condoms, distribution of skills building materials, or demonstration of a condom's use. Using a condom is not just a matter of mechanical skills (i.e. how to open the package and put it on); it also requires negotiation and decision-making skills with partners, something often omitted from sexual health curricula not designed by those with HIV prevention experience. For young gay and bisexual men, there are even less opportunities for them to discuss their sexuality and sexual health needs.

ACT has tried to address the skills barrier by working with organizations that serve gay men, women, youth and Portuguese-speaking communities to encourage them to integrate HIV prevention education (including discussions of condom use) within their programming, providing in-service training to staff to do this work, as well as providing workshops on HIV/AIDS, sexually transmitted infections (STIs), condom use, and safer sex negotiation skills at agencies. Additionally, ACT has developed HIV prevention campaigns and materials that seek to provide individuals with the information needed to build their skills.

Furthermore, the use of drugs or alcohol may prevent the individual with skills from applying those skills in a particular setting or situation. Given the history of gay community development (often centred on the gay bar), and the role of 'party' drugs within certain gay 'scenes,' ACT integrated harm reduction messages into its HIV prevention programming for gay men. This has included the development of on-line resources (www.torontovibe.com, www.himynameistina.com), printed resources, integrated harm and HIV risk reduction outreach at gay community venues, parties and events where substance use is likely to occur, training for service providers who may work with gay men on substance use, and community forums that address the impact of

substance use on HIV risk-taking (for example community forums that have explored the impact of crystal methamphetamine use within Toronto's gay community).

Finally, there is also the question of whether a sexual partner is *willing* to use a condom. Again, this is often ignored in ineffective prevention programs. Societal gender imbalances may also serve as a major barrier. In few societies can a woman ask her male partner to use a condom, even if she knows he has been engaging in higher risk sexual or injecting drug behaviours. Societal norms or cultural beliefs can also stand in the way of condom use, especially where use of a condom is considered a sign of character weakness by macho peers or is felt to interfere with proper sexual functioning. False perceptions of risk (i.e. assumptions about a partner's HIV status), power imbalances due to race, language, culture, or age, or perceptions of self-worth¹ can also impede one's ability to use — or insist on the use of — condoms. ACT's "Handy Dandy How-to Handbooks" developed for gay men and drawing on community-based research that sought to better understand HIV risk-taking amongst gay men in Toronto, to address issues related to condom use skills, negotiating safer sex within the context of relationships, and provide information to gay men who are seeking sexual partners in a variety of venues (bars, clubs, parties, on-line, etc) so that they understand, in advance, the etiquette and the health and safety (including sexual safety) concerns of the various venues².

All of the above have led to the realization that individually targeted prevention efforts alone are insufficient to produce sustained behaviour change.

Effective HIV prevention programs must address the multitude of factors which interfere with an individual's ability to protect him/her and his/her sexual/drug using partners. That is, they must not only address risk, they must also address vulnerability.

Several recent initiatives have been undertaken to address the multiple factors that place individuals and communities at increased risk of HIV transmission. ACT has participated in the development of a number of these innovative provincial strategies including the formation of the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), which was developed out of a provincial working group created to examine high rates of HIV infection within African and Caribbean communities in the province. This initial work (under the name of the Endemic Task Force³) resulted in the creation of targeted interventions (including the development of a social marketing campaign, enhanced resources for community-based ASOs working with these communities) and the creation of ACCHO as an umbrella organization to oversee this work provincially.

¹ Adam B, Husbands W, Murray J, Maxwell J. (2003) Renewing HIV Prevention for gay and bisexual men. Report available on-line at:
<http://www.atoronto.org/website/research.nsf/pages/renewinghivprevention>

² See Handy Dandy How-To Handbooks, available on-line at: <http://www.handydandy.ca/>

³ Remis RS, Whittingham EP.(November 1999) [The HIV/AIDS epidemic among persons from HIV-endemic countries in Ontario, 1981-98: Situation report.](#) 62 pp. Department of Public Health Sciences, University of Toronto,

The recent development of culturally specific HIV prevention guidelines⁴ for African and Caribbean communities acknowledge that systemic, structural and individual factors converge to create situations and circumstances that facilitate HIV transmission. Systemic and structural issues such as gender inequity, sexism, heterosexism, homophobia and racism limit peoples' ability to make choices that promote and sustain good health.

Similarly, ACT has been involved in the development of the Ontario Gay Men's HIV Prevention Strategy. Although as yet not as fully developed as the work with African and Caribbean communities, this strategy also seeks to locate HIV prevention within the broader factors that influence risk and vulnerability:

There are a broad range of social determinants of health that impact on the sexual behaviour of gay and other MSM. These include race/ethnicity and culture, HIV-status, sexual orientation and identity, gender identity, socio-economic class, age, ability and geographic location, mental health and immigration status. These factors can influence a man's risk for HIV transmission and his capacity to access HIV-related services. A perspective that is inclusive of the social determinants of health is consistent with *Ontario's HIV/AIDS Strategy to 2008*, as developed by the Ontario Advisory Committee on HIV/AIDS. It is important to articulate a vision for Ontario's HIV prevention work with gay and other MSM that accounts for the impact of a diversity of experiences on risk for the transmission of HIV and other sexually transmitted infections.⁵

One of the first outputs of the Ontario Gay Men's HIV Prevention Strategy was the development of an Ontario-wide HIV awareness campaign targeting gay men, titled "Be Real." This campaign, for the first time, sought to address the complex reasons why gay men may not always use condoms. The campaign addressed issues faced by HIV-positive men, men who are new to Canada or are non-white, and men who may feel that they are somehow not valued due to their age, looks, or their identification (or lack thereof) to community norms⁶.

HIV prevention for people living with HIV/AIDS: a missing piece of the puzzle

Early HIV prevention programming almost exclusively focused on the uninfected, through the use of messages such as "protect yourself from HIV". These messages had the unintended effect of entrenching the notion that HIV prevention was something only of relevance to the uninfected. At the same time, support programming in ASOs for

⁴ James L. (July 2006) HIV Prevention Guidelines and Manual: A tool for service providers serving African and African Caribbean Communities living in Canada. Available on-line at: <http://accho.ca/?page=resources>

⁵ Ontario Gay Men's HIV Prevention Strategy Working Group (2005). Re-invigorating HIV Prevention for Ontario Gay, Bisexual and Other Men Who Have Sex with Men. Available on-line at: <http://www.ru4real.ca/pdfs/Ontarios-Gay-Mens.pdf>

⁶ See the Be Real website: <http://www.ru4real.ca/index.html>

PHAs was focused on helping people with HIV/AIDS to live as best as possible with a (largely fatal) disease. The advent of newer and more effective treatments for HIV/AIDS have dramatically reduced AIDS mortality rates, yet ASOs and others have been slow to address the unique HIV prevention needs of PHAs: while support programming has expanded to include programs to help PHAs return to work, manage side effects of treatment, build peer networks, and otherwise manage their health while living with a life-threatening disease, little if any acknowledgement of PHAs and their vulnerability to HIV transmission has taken place.

While HIV prevention messages at ACT have evolved to be inclusive of PHAs (for example: using statements such as “using condoms will help prevent you from getting, or passing on HIV”, and avoiding messages such as “assume all of your sexual partners are HIV-positive”), very little targeted programming has been developed to address the sexual health or other HIV prevention concerns of PHAs. Opportunities for the integration of HIV prevention programs within support services are evident: *counselling* and *case management* programs could include discussions of sexual and drug using risk reduction strategies. *Health promotion programs* for PHAs (including drop-ins, community forums, social support programs, and support groups for PHAs) could integrate sexual/drug using health information and skills-building strategies into their discussions.

The Ontario Gay Men’s HIV Prevention Strategy Working Group is currently developing specific recommendations and programming related to HIV prevention for HIV-positive gay and bisexual men. In addition, a grant application has been submitted to conduct research into best practices for HIV prevention for gay men living with HIV/AIDS.

Effective prevention works at multiple levels.

Sweat and Denison⁷, in discussing environmental and structural interventions, pointed out that addressing the factors influencing risk and vulnerability often requires multiple components working at several levels:

- **Superstructural:** These components address the large-scale social and political environments in which behaviour takes place. They may require, for example, addressing gender or social inequalities which contribute to elevated risk for women or for marginalized populations such as sex workers and gay and bisexual men and other men who have sex with men (MSM).
- **Structural:** Prevention components at the structural level address laws or policies at both national and institutional level that interfere with prevention efficacy, e.g., laws regarding drug paraphernalia or policies on condom advertising. They might also seek to address operational issues, such as failures to encourage condom use in brothels, or failure to apply universal precautions in medical settings.
- **Environmental:** These components address the factors in the local environment that lower the effectiveness of interventions or encourage risk behaviour. For example, in low- and middle-income countries they might encourage whole families to migrate together to worksites instead of encouraging male-only

⁷ Sweat M., Denison J. (1995). Reducing HIV in developing countries with structural and environmental interventions. AIDS, 9 (suppl A): S251-S257.

- migration. Or they might address lack of access to condoms or clean needles in a particular local setting. Or they might try to change social norms regarding condom use, or stigma related to living with HIV/AIDS.
- Individual: These components seek to influence the individual's decisions and skills regarding preventive measures. They are what most people think of when they hear the term "prevention," but by themselves they are insufficient to produce sustained behavioural change.

Lessons from the first two decades of HIV prevention.

A number of important conclusions flow out of the lessons of the first two decades in HIV prevention:

- ***Real HIV prevention is complex; there is no "magic bullet."*** This means there is no single HIV prevention approach or program that can work in every population. It also means that simplistic HIV prevention approaches, such as providing information alone, while easy to undertake, are likely to prove ineffective. Approaches that provide not only information, tools, skills, but address vulnerabilities must be implemented. Targeting HIV prevention efforts is extremely important as different communities (and sub-groups within those communities) will have unique issues and needs and will require unique approaches.

- ***Effective prevention takes time.***

Long-term behaviour change does not occur overnight. Putting the components into place to address the multiple factors influencing risk and vulnerability requires careful planning, time, effort and resources. To be effective, efforts must be sustained.

- ***Prevention must take a long-term perspective.***

The HIV epidemic will be with us for the foreseeable future — no vaccines or cures are likely within the next decade. Thus, staying in a "crisis" mode which promotes "quick and dirty" but less effective prevention efforts, and ignores the need to undertake more comprehensive multisectoral/multilevel efforts to address other contributing factors, will result in far less effective future prevention efforts.

The following two examples outline some innovative strategies currently planned at ACT with respect to HIV prevention programming for at-risk communities. They incorporate the latest thinking about HIV prevention. While developed for specific populations and communities, these interventions can be adapted (as appropriate) for other at-risk communities.

1) Reinvigorating HIV prevention Programming for Gay Men:

NOTE: THIS PAPER WAS WRITTEN BY JASON ASSELIN, GAY MEN'S OUTREACH COORDINATOR AT ACT.

In the past two decades when health professionals addressed issues related to gay men's health (or wellness), these issues were most often framed in the lens of HIV and STI prevention. This ignores the diversity of the gay community and the diversity of the health and wellness issues endemic to it, many of which are intrinsically linked to one another. Just as these health and wellness issues are shown to be linked to one another, they have also been shown to be linked to increased risk of HIV. As such, many front-line HIV prevention programs, across the country and worldwide, have begun to shift to address the diversity of the gay community and its health and wellness through a Population Health framework. This discussion paper will aim to rationalize the shift of the AIDS Committee of Toronto's Gay Men's Outreach and Community Education programming towards a similar Population Health or "Gay Men's Wellness" model.

SOCIAL DETERMINANTS OF HEALTH VIS- À -VIS GAY MEN'S HEALTH

A Population Health framework draws heavily on the broad interdependent determinants of health recognized by Health Canada. Health Canada (1998a) defines them as "factors and conditions which have an influence on the health of individuals and communities. Critical to this definition is an understanding that the determinants of health do not act in isolation from each other." These determinants are acknowledged as unfixed and likely to evolve as knowledge in the area grows (Health Canada, 1998b). In their discussion paper, *Framing Gay Men's Health in a Population Health Discourse*, Ryan and Chervin (2000) present the determinants vis-à-vis gay men's health.

Those most of interest include:

- Social Support Networks
 - Gay men and youth often experience significant diminishment and exclusion within conventional social support networks, due to homophobia and heterosexism.
 - Isolation includes not only physical and social isolation but also cognitive isolation and emotional isolation.
 - Research indicates that high levels of social supports may moderate gay-identified stressors (Grossman & Kerner, 1998)
- Education
 - Most important to note is that generally schools are hostile environments for gay and bisexual youth. (Flynn Saulnier, 1998). Homophobia and heterosexism's presence in schools ranges from physical to verbal violence.
 - The effects of homophobia and heterosexism in school environments contribute to:

- High suicide rates and attempted suicide rates (Flynn Saulnier, 1998)
 - Internalized homophobia and low self-esteem (Otis et al., 1999)
- Social and Physical Environments
 - While gay men have challenged discriminatory social environments, many of these social environments such as bars and dance clubs may simultaneously be sources of concern because of the overwhelming presence of alcohol and substance use. Studies show that gay men experience alcoholism and drug abuse at a rate at least three times higher than the general population (Hellquist, 1996).
 - The effects of this altered state of mind may place individuals at causing themselves greater harm, including placing themselves at risk for HIV transmission.
- Personal Health Practices, Coping Skills, and Capacities for their Use
 - Unequal social power relations constructing interpersonal relations are seen to have profound eroding effect on the capacity of gay men, particularly of minority ethnic, cultural or racialized communities, to implement healthy practices and coping skills, particularly regarding HIV prevention (Sanitioso, 1999).
 - McInnis and Kong (1998) reinforce the importance of strengthening gay men's coping skills, especially when the effects of homophobia on their health are taken into consideration. Examples of such skills include: claiming one's gay identity, taking small steps toward health, practicing self-care, finding ways to get support and build community, fighting homophobia and heterosexism when possible, learning ways to express a range of emotions, as well as many others (McInnis and Kong, 1998)
- Healthy Child/Adolescent Development:
 - Social isolation (by family members, peers, teachers, and so on) experienced by many gay youth is named in the literature as a significant factor in the high suicide rate and suicide attempt rate among gay youth, as well as higher rates of alcohol and substance abuse (Grossman & Kerner, 1998).
 - Again, the effects of homophobia in the school environment contribute to internalized homophobia, shame and low self-esteem (Kaufman & Raphael, 1996).
- Conditions that Affirm Choices of Coming Out
 - Gay men who do not feel they are able to be open about their sexual orientation face increased risks for many health and social problems (Hellquist, 1996).

- The psychosocial stressors and challenges experience upon coming out compounded by cognitive, emotional, social and physical isolation, often lead to depression and suicidal ideation (Canadian Public Health Association, 1998).
- Health Services
 - Homophobia and heterosexism significantly affect the quality of care provided by health care providers within health services. Health practitioners appear insufficiently prepared for interacting effectively with gay clients (Ryan et al., 2000).

As noted earlier, many ASOs, both in Canada and worldwide, have started shifting towards prevention programming that addresses a holistic approach to gay men's health.

One that deserves great attention is *Gayway of AIDS Vancouver*, whose mission is defined as "... a gay men's resource exchange that builds flourishing communities by providing supportive environments that encourage gay men to share knowledge, experience and resources." Using an assets-based approach, *Gayway* brings gay men together to build capacity within the gay community while providing programming that addresses their "three core determinants": Social Support Networks, Personal Health & Coping Skills, and Social and Physical Environments. Examples of such programming that has stemmed out from such an approach include social support drop-ins, education seminars, knitting groups, and much more.

Action Séro-Zéro in Montreal demonstrates another example of programming which addresses HIV prevention within a holistic gay men's health and wellness perspective. Touching on issues such as the coming out process, healthy relationships as well as the effects of homophobia on our community, they've begun breaking out of the condom-centered approach to HIV prevention.

There has been significant buy-in to this approach in the HIV-prevention movement, with various groups focusing their energies on ways to empower gay men to make healthy choices. Such examples include the National Gay Men's Health Networking Group, as well as the Canadian AIDS Society's National Gay Men's Health Steering Committee. Furthermore, the upcoming Provincial Gay Men's Campaign focuses on many of the determinants of health that impede gay men's health including discrimination (homophobia, racism, and stigma), social support and social environments.

Many HIV-negative gay men do not access services within ACT nor feel that they identify with the agency because it doesn't speak to their needs. This may be due to changes in HIV/AIDS mortality (dramatic reductions in HIV/AIDS deaths as a result of new treatment options) resulting in a (perhaps erroneous) belief that HIV/AIDS isn't an important health issue for gay men. Consequently, gay men are less likely to choose to come to workshops of discussions that focus solely on HIV/AIDS. By developing gay men's programming as one that ties to gay men's health in a holistic sense that includes HIV as one of *many* health concerns allows for a more inclusive environment, this perception can be changed.

Taking such an approach that is centred on empowering gay men allows our agency to reinvigorate and refine HIV prevention messaging so that it is something people can relate to, engaging gay men in issues that are important to them rather than telling them what they can and cannot do. This approach would give us greater flexibility in developing and planning activities centered around holistic gay men's health, that allow for both HIV-negative and HIV-positive gay men to reconnect with each other, and as such will not only help address stigma and discrimination around HIV, but will also help to build healthy social environment and social support networks thus reducing HIV transmission.

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2) From My Community: Activating Peer Networks for HIV

Prevention and Education among African, Caribbean, and

Aboriginal Women

Demographics of the Communities Served and Specific Needs

Gender plays a central role in shaping an individual's HIV prevention needs, and should be a critical consideration in developing, planning, and implementing HIV/AIDS initiatives. The female Canadian population is diverse, with a wide range of differing HIV prevention needs. To best meet those needs, we require community-based, tailored approaches to HIV prevention. HIV prevention programs have to acknowledge the multiple issues that women confront and that may serve as barriers to adopting HIV prevention practices, including abusive relationships, inequality, poverty, and responsibilities for the family, especially for children. In addition, for African, Caribbean and Aboriginal women, racism and specific cultural experiences are crucial factors in their lives that will determine whether or not HIV prevention programs are effective for them.

African and Caribbean women: The prevalence of HIV/AIDS in African and Caribbean communities has grown by 85% in the last 5 years, and 22-59% of these infections occurred after settlement in Ontario (Silent Voices of the HIV/AIDS Epidemic, p. 1). African and Caribbean people only make up approximately 4% of Ontario's population with 76% of them living in Toronto; however, 20% of AIDS diagnoses in 2001 and 2002 were attributed to the women of these communities. In 2004, 56% of new HIV diagnoses among women were from countries where HIV is endemic.

Aboriginal women: In those provinces where ethnicity data is captured, Aboriginal peoples represent 25.3% of positive HIV test reports. Of the Aboriginal HIV positive reports, Aboriginal women represent 44.6% of those reports. Among both women and men, Aboriginal persons living with HIV/AIDS are estimated to be infected at a younger age than in the general population (about 30% of Aboriginal people in Canada who tested positive for HIV between 1998 and June 2003 did so before the age of 30, compared to about 20% of the general population).

This information excludes Ontario and Quebec, for which ethnicity data is not captured. Ontario arguably has the highest population of people living with HIV/AIDS in the country and this probably includes Ontario Aboriginal people living with HIV/AIDS. The other way we capture this data is to say that at least one Aboriginal person per day is infected with HIV.

In addition, there will be a particular focus on prevention of secondary transmission for HIV positive women in these communities. Up to 1/3 of HIV positive women don't know their status, so encouraging women to get tested will be an essential aspect of this project. For women who are HIV positive, there is obviously a need for HIV prevention for their sexual partners, as well as protection from re-infection and other sexually transmitted infections, which can further weaken the immune system.

Specific needs:

The existing research agrees that culturally specific and gender specific prevention strategies are needed if women are to hear and heed HIV prevention messages. Of all the interventions that looked at both intrapersonal and interpersonal factors, gender, peer-led skills training that attempted to modify social norms were found to be the most consistently effective for women (cited in Ontario Women and HIV/AIDS Working Group, Literature Review: HIV Prevention and Women, Feb. 2006, p. 49).

While the research to date has identified the need for specifically tailored HIV prevention programs, there has not been much actually done in terms of implementation.

Information is not getting to where women are. The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) has developed a strategy to address issues related to HIV/AIDS faced by people in Ontario from countries where HIV is endemic. Among their recommended key directions and activities are:

- developing/piloting alternative modes of service/program delivery (e.g. off-site/mobile service delivery; assistance with basic needs such as housing, food, medical care, immigration; and peer support that is culturally competent);
- supporting community education and mobilization initiatives within African and Caribbean communities, and working with the informal support networks that exist in these communities;
- breaking the silence and creating a supportive environment for prevention work.

The Aboriginal Strategy on HIV/AIDS notes that poverty and discrimination keep many Aboriginal women from acting on traditional HIV/AIDS education messages. "For many Aboriginal women, poverty, violence, social exclusion and subordination are heightened due to the historical and continuing marginalization of Aboriginal communities" (Vectors, Vessels and Victims, p. ii).

Subordination inhibits women's capacity to protect themselves from exposure to HIV. It is obviously difficult for women to negotiate safer sex when they are not treated as equals in decision making around sexual practice; moreover, economic dependence can lead to a well-founded fear of abandonment or rejection that may prevent women from insisting on condom use, for example.

Program Objectives

If AIDS is going to be stopped, then we must reach women with HIV prevention campaigns that work. The objective of *From My Community* is to determine the most effective HIV prevention strategy and HIV education delivery system for women in the African, Caribbean, and Aboriginal communities of Toronto through a pilot project focused on real, tangible ways of getting to women in these communities. If this project proves to be successful, the long-term objective is for other communities in Ontario and across Canada to adopt it.

Program Scope of Work and Timeline

From My Community builds on existing research and experience. It is informed by Operation Hairspray, which was an Ottawa Public Health project that used hair salons as a distribution network for HIV education. This project also takes advantage of existing

research and materials already in development by Women's Health in Women's Hands and ACCHO. HIV prevention is most effective when the community it is aimed at is involved in program design and implementation. *From My Community* is a leading edge collaboration between the AIDS Committee of Toronto, 2-Spirited People of the First Nations, Women's Health in Women's Hands, and Voices of Positive Women. Finally, the approach recognizes that women's needs must be taken into account as a whole if HIV prevention is to succeed.

Outreach strategies: working as a collaboration of the AIDS Committee of Toronto, Women's Health in Women's Hands, Voices of Positive Women, and 2-Spirited People of the First Nations, *From My Community* will recruit and train a network of at least 40 peers to conduct HIV prevention education for African, Caribbean, and Aboriginal women in the Greater Toronto Area.

Service delivery activities: This project takes its title from a Ghanaian woman, quoted in *Silent Voices of the HIV/AIDS Epidemic*: "Church is where people find comfort and that is the only place where you can get women from my community." So a peer network trained by the participating organizations will be going to church--and to mosques, settlement agencies, ESL classes, outreach organizations (like Sistering), and wherever else women in the targeted communities can be found.

The ACCHO strategy identified in particular the need to develop alternate ways to reach people and communities, and to work with the informal support networks that exist within African and Caribbean communities. They cited a wide range of organizations that needed to be involved in prevention work: settlement services; health services; youth agencies; schools; community organizations for endemic communities; language training and job training programs; clinics; physicians' practices; community health centres; mosques; churches; expatriate national services (country specific); HIV/AIDS organizations; provincial AIDS Bureau; funders, universities and student associations. Women's Health in Women's Hands, 2-Spirited People of the First Nations and Voices of Positive Women will all contribute to identifying a list of places that will be targeted for reaching women in the African, Caribbean, and Aboriginal communities.

The Ontario Aboriginal HIV/AIDS Strategy has developed culturally specific HIV/AIDS programs and services for Aboriginal women. However, not all aboriginal women living with HIV/AIDS or those most at risk may come to the office and seek services. The Strategy cited the need to develop traditional services and programs such as craft classes, drumming and singing classes, nutritional programs, general health education, etc. where Aboriginal women can come and learn HIV information in a low-key and supportive environment almost as a secondary objective. For those Aboriginal women who do not come to the Strategy's office, there is a need to go to other Aboriginal and non-Aboriginal agencies and organizations that serve Aboriginal women and institute HIV programming. This will create a peer network of Aboriginal women who can share that information with other Aboriginal women.

In the first six months of the project, the emphasis will be on peer recruitment and training by staff of collaborating organizations in culturally appropriate, gender-sensitive and accessible HIV prevention, as well as education in secondary transmission prevention for HIV-positive women. An understanding of the roles of stigma and discrimination will be key aspects of the training, as well as how to encourage women to get tested. Peer training is clearly a critical activity if the project is to succeed. In order to avoid reinventing the wheel, Operation Hairspray is being approached to provide their

training materials. ACCHO and Women's Health in Women's Hands are also in the process of developing materials that will be extremely useful for informing the peer training: Women's Health is currently piloting an HIV prevention model aimed at African and Caribbean women, and ACCHO has nearly completed a manual for HIV/AIDS service providers to African and Caribbean people as well as a report on stigma and discrimination. In other words, there is already a great deal of significant work done that can and will be incorporated into this project.

HIV prevention for women has to be seen in the context of their lives as a whole. The peers will therefore be armed with an understanding of other services that respond to women's needs, and will be prepared to provide referrals (e.g. Community Health Centres offer health care to people without OHIP cards; identify programs/services that are relevant and accessible to African and Caribbean women; be prepared with the Assaulted Women's Helpline phone number, etc). The peers will especially need to be ready to discuss abuse and gender inequality as barriers that can prevent women from integrating HIV prevention into their lives. Once trained, 40 peers will spend the next 12 months (the bulk of the time on the project) visiting the sites identified. An average of four visits per month is envisioned, for a total of 1,920 site visits.

The work of the staff and peers in *From My Community* will be overseen by a steering committee consisting of representatives from the collaborating organizations. In addition, there will be community workshops held to inform the project, and to help with defining the training, recruiting peers, identifying the exact sites to visit, and participating in evaluation.

Staff roles and percentage of time allocation to this program: ACT has recently recruited a Women's Community Education Coordinator, who will participate in the project full-time, facilitating the steering committee activities and community workshops, and coordinating the activities of other staff and peers. At Women's Health in Women's Hands, Voices of Positive Women, and 2-Spirited People of the First Nations, there is already staff in place in half-time positions for community outreach. They will be increased to full-time so that 50% of their time will be allocated to the program. These staff will recruit peers, conduct training, supervise the schedule of site visits, provide support to peers, collect data and monitor results. The total time allocation for the period of the pilot will therefore be 1 full-time and 3 part-time staff.

Community involvement: The communities targeted will be involved in every facet of the project. The participating organizations are themselves representative of their communities. Other community organizations will be consulted through workshops. But most critical to the success of this project will be the network of peers, drawn from the communities that are the focus of the project.

Tracking and evaluation methods

We will conduct output evaluation, such as for Operation Hairspray, which used a log sheet filled in by the peers to capture data on information shared (prevention, condom use, explanation of HIV), testing (counselling on where to go, type of service available), referrals to agencies or elsewhere, type of discussion (one on one, group), language, support needed for follow up or issues to be dealt with, etc. Data will be collected on peers recruited and trained, information provided, service delivered, total contacts.

The process evaluation will highlight issues or concerns that might emerge in the development, implementation and delivery of the project. The project will be broken down into the various components and evaluated against implementation goals. For example, if the goal is to recruit 20 peers by October 31, the process evaluation will identify whether or not the goal was met, and if not, provide the reasons why.

The most important aspect of evaluation is measurement of outcomes. What we most need to know is if the program is effective; in other words, did it make a difference in the lives of the women concerning HIV prevention? Did they find the information they received useful, and were they able to act on it? On completion, the project, the project team will conduct two focus groups (6 – 10 participants per group) and follow-up interviews with 10 participants. The focus groups will discuss the above questions and others, but their overall purpose is to understand how participants interpret the benefits, challenges and outcomes of their involvement. The semi-structured personal interviews will discuss issues that are not necessarily amenable to group discussion (such as HIV testing and related issues). Group feedback will also be valuable in tailoring future program delivery and ultimately to determine if this type of HIV prevention program will move women to take action. We will also have a focus group with the peers who deliver HIV-related information to participants. This focus group will enable project partners to understand how peers conceptualized and implemented their role, the associated challenges, their views on the value and usefulness of the approach and their role, and their interpretation of the successes.

Another recent project, Infolink, was a community-based HIV outreach project in the beauty salons and barbershops along Eglinton Ave. West (Toronto) that targeted African Caribbean and Caribbean communities. It captured information about program non-participants, another useful means to help determine if the program is effective. Drawing on their evaluation approach, short (5-10 minute) face-to-face interviews will be administered by the peers or other trained community members with women who frequent community spaces in which the project is delivered in order to elicit their interpretation of the project and challenges that may have prevented them from participating or accessing the project. Where feasible, staff at community spaces (i.e. the staff or owner or a participating beauty salon) may also be interviewed to elicit their responses and challenges faced in participating in the program.

Conclusion: Moving Forward

Several major implications for effective HIV prevention programs can be gleaned from the literature and from a scan of “best practices” for HIV prevention:

- Effective prevention programs ***understand and address people’s behaviours***, the contexts in which they occur, and the factors influencing them to change or not change their behaviours.
- Effective prevention programs ***address not only risk, but also vulnerability***. Programs must include strategies targeted to both those at-risk of infection, and those living with HIV/AIDS.
- Effective prevention programs ***are evidence informed***. That is, the development of programs should involve an examination of the impact of similar programs, and a review of relevant literature.
- Effective prevention must ***involve and grow out of the community*** whose behaviours they seek to change. Only when those engaging in risk behaviour are involved in the design and implementation of prevention efforts are those efforts likely to adequately reflect an understanding of the local environment and context of risk and vulnerability.
- Effective prevention efforts must involve ***multiple partners and multiple prevention components*** to address the interconnection of environmental and contextual factors that influence risk and vulnerability. That is, they must be multisectoral in nature and involve multiple components working at multiple levels.

Examples of interventions that incorporate the above implications include (but are not limited to):

- **Small Group Discussions:**

Small group interventions (including “one-off” discussion groups, time-limited **support groups** for people with HIV/AIDS, drop in and/or social support events) that include discussions of sexual health, relationships, HIV and STI transmission should be implemented. Such groups provide opportunities for discussion about the complex nature of HIV-risk taking.

Today, the ACT/Gay West “**Java Knights**” group holds monthly events for gay men in the city’s west end. While focusing on a range of topics, ACT staff include discussions related to overall health (including sexual health).

In the past, ACT offered **semi-regular discussion groups** for gay men (called “One Night Stand” discussion groups) that were promoted in the community and dealt with a range of topics including ‘hooking up safely’, relationships, issues facing sero-discordant couples, issues facing HIV-positive men. Events such as the “**SEXploration**” week of events could be held on a monthly basis, in venues both within and outside of the gay village. These events (often developed in collaboration with gay social groups) provide opportunities for men to discuss issues related to sexual health including racism, homophobia, social inclusion/exclusion, dating and community.

ACT’s monthly “**Women’s Coffee Night**” is another example of a social-support initiative that can integrate discussions related to HIV prevention such as healthy relationships, building confidence, disclosure, and sexual health.

- **Health Promotion Programs:**

Community forums are another vehicle that could be used to increase awareness of, and stimulate discussion about HIV prevention. Our monthly Community Health Forums (targeting people living with HIV/AIDS and attended on average by 80 participants) could include topics for PHAs related to HIV prevention including relationships, negotiating safer sex, dealing with rejection from sexual partners. Similarly, community forums could be expanded to include forums for uninfected.

In addition, programs such as the **Hot Lunch** or **Women's Community Kitchen** might include discussions of sexual health relevant to attendees.

- **Counselling and Case Management:**

Counselling and case management services could integrate discussions of sexual health into conversations with clients. Taking a holistic approach to client needs would mean conversations (as appropriate) about sexual and drug-using risk reduction.

- **Skills-building/empowerment programs:**

Programs that seek to empower individuals (such as AIDS Vancouver's Gay Way programming, and ACT's "From My Community" project) help community members to build the skills necessary to protect themselves and their sexual partners from HIV and STI transmission. Numerous models of empowerment-type programs are in existence and could be adapted for particular communities.

- **Advocacy/public policy work:**

ACT's involvement in local, provincial, national and international working groups that seek to influence the development of public policies that reduce stigma, discrimination and marginalization for individuals at risk of HIV infection and for those living with HIV/AIDS, are ways in which our work can address both the superstructural and structural aspects of HIV prevention. ACT's work with ACCHO, the Gay Men's, and Women's HIV prevention strategies are concrete examples of this work, as they seek to address gender and social inequalities which contribute to elevated risk.

As HIV infections continue to impact more and more communities in the City of Toronto, it is important that HIV prevention programming at ACT incorporate best practices. ACT has a history of developing cutting-edge HIV prevention programs, and should continue this work as it moves forward.