The Community Psychologist

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CHILDREN AND YOUTH:
The Children and Youth interest group facilitates the interests of child and adolescent development in high risk contexts, especially the effect of urban poverty and community structures on child and family development
Chair: Mark Aber, (217) 333-6999, maber@s.psych.uiuc.edu

COMMUNITY ACTION:
The Community Action interest group explores the roles and contributions of people working in applied community psychology settings
Chair: Paul Speer, (908) 932-0512, pspeer@rci.rutgers.edu

COMMUNITY HEALTH:
The Community Health interest group focuses on health promotion, disease prevention, and health care service delivery issues as they relate to the community
Chair: Steve Godin, (570) 422-3562, sgodin@po-box.esu.edu

DISABILITIES:
The Disabilities interest group promotes understanding of the depth and diversity of disabilities issues in the community that are ready for research and action; and influences community psychologists' involvement in policy and practices that enhance self-determination, personal choice, and full inclusion in the community for people with disabilities
Chair: Esther Onaga, (517) 355-0166, onaga@pilot.msu.edu

LESBIAN/GAY/BISEXUAL/TRANSGENDER (LGBT):
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The Prevention and Promotion interest group seeks to enhance development of prevention and promotion research, foster active dialogue about critical conceptual and methodological action and implementation issues, and promote rapid dissemination and discussion of new developments and findings in the field
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The School Intervention interest group addresses theories, methods knowledge base, and setting factors pertaining to prevention and health promotion in school
Chair: Nadia Ward, Nadia.Ward@yale.edu.

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The Self-Help/Mutual Support interest group is an international organization of researchers, self-help leaders, and policy makers that promotes research and action related to self-help group and organizations
Chair: Eric Mankowski, mankowskie@pdx.edu

STRESS AND COPING:
The Stress and Coping interest group aims to preserve the Society's ties to a historically important area of research and to facilitate communication among researchers in this area and with other community psychologists
Chair: Krys Kaniasty, (724) 357-5559, kaniasty@grove.iup.edu

UNDERGRADUATE AWARENESS:
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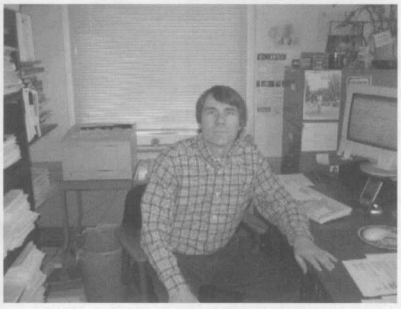
Editor's Column

Editor's Column
Paul A. Toro, Wayne State University, Detroit, Michigan



In addition to a large Special Feature, this issue of TCP has a range of columns (Policy, Students', Prevention and Promotion, and 2 Book Reviews), plus a listing of SCRA's program for the upcoming APA Convention in Toronto.

Special Feature: HIV/AIDS in Asia and among Asian Americans. Frank Wong and Rich Jenkins have collected an intriguing set of nine papers, some on the HIV/AIDS epidemic in Asia and others on HIV/AIDS issues in Asians and Pacific Islanders living in the US. I think these papers show how a community psychology perspective can be very useful in addressing such major social issues.

Hoping to see you all at the Biennial in New Mexico! You should all receive this issue of TCP well in advance of the Biennial. There's still time to register for the Biennial, if you haven't already. You can register by mailing in the blue registration form in the last (Winter) issue of TCP or you can register on-line at www.nmhu.edu/scrabiennial/. I'm very excited about this Biennial, which I suspect will have a very different "feel" as compared to prior Biennials. Not only will it take place in a small city in a rural area of the Southwest, but it will occur in a setting where a majority of the population speaks a language other than English. Having reviewed the program (now available on the Biennial web site), I have also noticed that a very large number (over 90) of the presenters are from outside of the US (including many from Latin America). There promises to be a very strong "international flavor" to this Biennial. The program is a very rich one in many respects. I encourage you to peruse it on the web and attend the Biennial (June 4-7).

Plans for the Summer issue of TCP. In what will be my last issue as TCP Editor, I would like to invite all of you who attend the Biennial in New Mexico to submit "reflections" and photos from the event to be included in this issue. I have extended the deadline for receipt of material for this summer issue to **June 23**, which will give you a full 2 weeks after the Biennial to send in such material. Remember that, after the Summer issue, the new TCP Editors will be Joy Kaufmann and Nadia Ward. You can contact them at: The Consultation Center, Yale University School of Medicine, 389 Whitney Ave., New Haven CT 06511, e-mail joy.kaufman@yale.edu, nadia.ward@yale.edu.

Also hoping to see you all at APA in Toronto! Jack Tebes, this year's APA Program Chair, just sent me, "hot off the press," SCRA's program and it looks great! The program is reproduced in this issue of TCP. I hope it will encourage you to also attend the APA Convention (August 7-10) in Toronto (one of my favorite cities in North America). The hotels in Toronto tend to fill fast, so register soon! You can register by mail (the materials appeared in the March issue of the Monitor on Psychology) or on APA's web site (www.apa.org).

SCRA WEB PAGE
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The **SCRA Women's Listserv** enables SCRA members and others to access the best source of information and comment relative to women in SCRA. It is also the main source of communication about issues relating to the SCRA Committee on Women. To subscribe, send your e-mail to: LISTSERV@LISTS..APA ORG. Leave the subject area blank, and in your message area type:
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The **SCRA Student Listserv** is student initiated, run and maintained and has "social coordinators," who will implement special events on the listserv, like having a "guest of the month," to elicit Q&A, etc. To subscribe, send your e-mail to: LISTSERV@LISTS.APA.ORG. Leave the subject area blank, and in your message area type:
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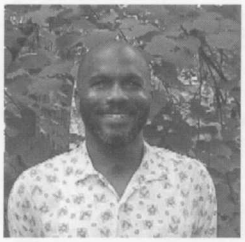
President's Column

by Mel Wilson, University of Virginia



The current furor over Affirmative Action has mainly focused on concerns of the individual access to societal opportunities and benefits including jobs and employment opportunities, and education and training opportunities. In the most recent example of Affirmative Action furor, the Supreme Court is considering whether or not Affirmation Action policies at the University of Michigan discriminate against qualified white applicants. This focus has been on individual and group representation. In contrast, current Affirmative Action challenges have not acknowledged the societal needs for an open and diverse society. In a large way Affirmative Action policy represents rules that encourage, endorse, and foster cultural diversity within our society. Interestingly, however, we have not calculated the positive role of cultural diversity or noted its function as a tremendous resource to our society. In order to understand the contribution of cultural diversity, we must analyze not only the outcomes in terms of individual gains and losses, but also analyze the outcomes in terms of societal gains and losses. Affirmative Action policies possess benefits for individuals and society. Individually, citizens gain opportunity of access to social benefits and resources while society gains added value of strengths and resources that the individual contributes. I have been suggesting within these presidential columns that a culturally diverse group can serve as an immense advantage in addressing system level problems and issues. It is often the case that when we are attempting to resolve pressing community issues we repeatedly and mistakenly attempt the same strategy or tactic. Because a culturally diverse group represents many different perspectives, the group can tackle concerns from alternative angles. As an example I return to the demonstration project called Valuing Diversity Project (VDP), which was sponsored jointly by the Board for the Advancement of Psychology in the Public Interest, SCRA and Association for the Study and Development of Community (ASDC). The VDP was created several years ago to enhance the capacity of professional psychology to assist communities in addressing issues related to diversity. VDP's three objectives include a) assembling a database of relevant psychological literature and model programs that can assist communities in addressing issues related to diversity; b) assisting two communities in the adoption and adaptation of model efforts to improve inter-group relations and to promote diversity; and c) disseminating the lessons learned and resources developed through this project to communities across the country as well as intermediary organizations, foundations, and government agencies. ASDC's David Chavis and Kien Lee led this effort. The underlying principle within the VDP was the notion that diverse representatives within a community working together could create solutions to pressing community problems. By using an alternative perspective we reduce the barriers to change and acknowledge the contribution of all people. Thus, rather than merely clashing over limited community resources, the community reframed the problem such that the groups began working together to solve conflict. In one instance of community reframing, a community created a valuable cultural fair and in another the community launched an accurate news and media program that decreased negative images of minorities by reporting on white crimes as well as black crimes.

The Valuing Diversity Project was a demonstration of the increased capacity for problem solving within a community or neighborhood. A cultural diversity perspective represents the variety of relevant meanings and understandings that exist within the group. Because community psychology assumes that intervention and research necessarily involve work with contextually relevant diverse groups, it is important to assess meaning, activity, situation, and consequences of human contexts. Incorporating a cultural diverse perspective means that the relevant diverse peoples within a society have an opportunity to contribute their perspective to our world's pressing problems.

Indeed, failure to ensure the congruence between the values implicit in a proposed program and the cultural beliefs and practices of people who are directly affected by the efforts, may result in harm to the very population intended to help. Cultural diversity is a valued aspect of humanity. Its social implications are dramatic and far-reaching in that the key to viable solutions may lie in the diversity of our peoples. Society must be encourage to protect its naturally occurring culturally diversity in the same way that society is encouraged to preserve endangered species, natural habitats and environments.

Notice - In memoriam

Judy Primavera is the Regional Network Coordinator and a member of the SCRA Executive Committee. Judy's daughter, Jamie A. Hulley, passed away soon after returning from studying in Italy. At the time of her death, Jamie was only 20 years old and about to begin her senior year at Wesleyan University where she was a double major in studio art and creative writing. Judy and her family have established a non-profit fund that honors the memory of Jamie by providing awards and scholarships to deserving students of the arts. I have talked with Judy about this and have her permission to solicit your support. I am sharing information about the Jamie A. Hulley Fund with hope that you would honor the memory of Jamie by donating to fund. Send donations to: Jamie A. Hulley Trust Fund, Webster Bank, c/o Rosemarie Sheehy, 500 New Haven Ave., Orange-Derby Shopping Center, Derby, CT 06418.

Social Policy Column

Edited by

Diane Costello

Kathy Hogan Bruen

Alison Martin

Social Policy and Mental Health in England's Tertiary Education: Where is community psychology's response?

By Paul Duckett, Manchester Metropolitan University, England

Rationale

As a community psychologist I am concerned with identifying structural causes for poor mental health and facilitating systemic changes that promote positive mental health. As an academic community psychologist working in a Tertiary Education (TE) environment I am also concerned with identifying structural factors that lead to poor and positive mental health in TE institutions. In this short paper I reflect upon TE social policy in England and contextualise this within the growing concern over the mental health profile of staff and students. I conclude by positioning community psychology into such concerns and ask that academic community psychologists spend more time focusing on the factors that promote and demote mental health in the universities and colleges in which they work.

The changing face of Tertiary Education in England

Tertiary Education (TE) is the term used in the UK that refers to all post-compulsory education (including further education colleges and higher education universities). TE has undergone significant change in England following the Further and Higher Education Act 1992, the report of the Dearing Committee in 1997 and the Labour government's unfolding Lifelong Learning and Active Citizenship agendas. Further changes are anticipated through the government's plans to introduce "top-up" tuition fees (where universities in England will be given discretion over how high they set the tuition fees they charge students in England) and a re-classification and re-financing of universities into either research or teaching institutions.

TE social policy reforms are evident in other countries where change has been underway for more than a decade. Common themes behind these reforms are ensuring taxpayer 'value for money', graduate 'employability', and industry 'relevance' and 'accountability' within an education culture that increasingly emphasizes value for money and economic frugality. There are also global changes in the participation rates in TE, with widening access and equitable access featuring high in HE policy initiatives internationally. Such policies seek to redress the social exclusion from TE of non-dominant groups, though their efficacy is debatable (Duckett, in press).

England's TE sector in particular is becoming increasingly densely populated through widening access initiatives. England's government has set their sights on a 50% participation rate for 18 to 30 year olds by 2010. At present they have attained a 43% participation rate.

Throughout this period of restructuring, concern has turned to the effects these new cultural and political features of the TE environment have on students and staff. Such concern has focused particularly on students' and staffs' psychosocial well being - though these concerns have predated the most recent changes to the TE sector.

Concern for the mental health of TE students

In England there has been a growing concern over the high incidence of suicide and para-suicide among the TE student population (AUCC, 1999) and surveys report increasing numbers of students experiencing serious mental health problems (Phippen, 1995; ULEDSC, 1998). Concern over high student suicide rates gained particular veracity in the 1950s and 1960s following the suicide of nine Oxford University students (Schwartz & Whitaker, 1990). This burgeoned a large body of subsequent research into the issue of student suicide rates both in England and the US, but most noticeably in the US (e.g. Slimack, 1990; Westefeld, et al., 1990). The literature suggests US students who have thought of committing suicide range from 6% (Wright, 1985) to 65% (Grayson, 1994) and between 4% (Westefeld and Furr, 1987) and 15% (Mishara, et al. 1976) have actually attempted suicide. Several commentators confer that suicide is the second leading cause of death in US colleges and universities (Slimak, 1990). Still in England there has been no comprehensive survey of student suicide rates (Stanley & Manthorpe, 2001). Considerable attention has, understandably, focused on suicide. It is a dramatic behavioural marker for poor mental health. However, this is only the tip of the iceberg. Westefeld and Furr (1987) report that 81% of US students experience depression since beginning college.

The TE sector has changed dramatically over the past decade. Few if any academics will have the experiential knowledge of what it means to be a student in the present socio-political and economic climate. It is important to be aware of the cultural gap that may lie between tutors and students in TE. Among the economic, political and cultural changes to the circumstances of students in England are: increasing levels of poverty and pressures to secure paid employment as a result of the abolition of grants and introduction of course fees (Kular & Winn, 1998, Fisher 1998; McLaughlin, 1985); a demand-led labour market hostile to graduates where numbers of prospective employees outstrips availability of good quality employment

(Duckett, 1998); a powerful ideology of heightened competitive individualism, and neo-liberalist citizenship (where the citizen's responsibilities overshadow the citizen's rights); and, increasing vocationalisation of TE degrees wedded to a political climate where employability is transplanting the concept of personal growth as a motivation to engage in a TE learning environment (Duckett, 2002).

Concern for the mental health of academic staff

The TE environment is very different for those who are now entering as teachers and researchers compared to those who entered in previous decades. Structural changes in TE throughout the 1990s have been implicated in increasing the workload, job stress and insecurity of academics (Knight & Trowler, 2000). Such changes in England include: modularisation of degree programs; shrinking academic budgets (Lafferty & Fleming, 2000); increased student intake (Bett Report, 1999); a culture of publish or perish burgeoned from the Research Assessment Exercise - part of the quality assessment exercise in England - (Baty, 2000); a heightened level of managerialism (Bessant, 1995); and, an increasing replacement of academic tenure with fixed and short term contracts (Barnes & O'Hara, 1999). Low staff morale and staff burnout have been reported outcomes of high workloads (Goddard, 1998), inadequate social support (Adeoye, 1991), and poor pay and conditions (Bett Report, 1999). Concern is increasing over the general mental health of academics (Fisher, 1994; Ruskin, 2000).

Over 40% of all academic teachers and 93% of all academic researchers in UK TE are on temporary contracts (AAEU et al., 1998; Bett Report, 1999) creating a new underclass of academics in Higher Education (Barnes & O'Hara, 1999) populated mostly by women due to institutionalized sexism within the academy (Bett Report, 1999; Lafferty & Fleming, 2000; Reay, 2000). There is considerable empirical and theoretical work to suggest that such insecure employment can be as damaging to psychosocial well being as some forms of unemployment (Fryer, 1999).

The mental health of non-academic staff

There has been a general failure in the research literature to fully address the excessive psychological strain experienced by non-academic staff working in TE. Indeed, there is a dearth of literature focusing on university personnel working in accommodation, administration, catering, cleaning, and grounds work. University porters, security guards, secretaries, technicians and shop workers certainly have contact with students many of whom we know will be experiencing excessive psychological strain. Indeed, the quality and quantity of this contact between such staff and students may be equal or in excess of the contact between academic staff and students. This may be particularly so for bar staff, porters, wardens, security staff, and cleaners in university halls of residence. Such staff may have a wealth of experience on the mental health of students. There is also reason to believe that non-academic staff are as equally at risk of psychological strain as students and academic staff. For example, those who may be particularly vulnerable to psychological strain are part-time cleaning staff who are often juggling multiple part-time insecure jobs. The recent review of pay and conditions in UK TE (Bett Report, 1999) highlighted the poor working conditions of many such staff. As with academic staff, increasing numbers of non-academic staff are on insecure employment contracts. The structural changes to TE have also affected non-academic staff. For example, increasing student enrolments lead to more intensive use of TE buildings, resulting in increased work for cleaning and maintenance staff, and placing extra demand on catering, retail and administrative workers. Increasing strain is being placed on the infrastructures of TE institutions and this is being transferred onto the personnel that maintain these infrastructures.

It has been a serious omission not to consider the effects of the restructuring of TE on the 'ancillary' staff that work in TE whose working conditions may have suffered as much if not more deterioration than academic staff. Such staff may also have less organizational power to resist encroachments onto their pay and working conditions.

The response of community psychology so far

> To help students make connections between micro, meso, and macro levels of analyses … we must also attend to social justice issues within our own graduate programs. We cannot focus on social justice issues "out there" while ignoring injustices and power imbalances in our own institutions. (Prilleltensky & Nelson, 1997:182)

Despite community psychology having a sophisticated understanding of social systems (e.g. Kelly et al. 2000), seldom do the reflections of academic community psychologists turn in on the health demoting conditions of the educational systems they are embedded in (at least such reflections seldom reach peer review publication). Community psychologists in academia are at particular risk of helping to get everyone else's houses into order while forgetting to sort out their own - notable in the way that the organization of some academic community psychology conferences leave hierarchical power inequalities within academia not only intact but reified (re: Duckett, 2001). Furthermore, many undergraduate and postgraduate courses in community psychology are structured within deeply bureaucratic and steeply hierarchical academic institutions where didactic teaching and strict systems of student surveillance and regulation persist.

Most undergraduate and postgraduate community psychology texts do not deal with student stress. This is surprising given such texts are explicitly targeted at a student readership and given the discipline's emphasis on personal empowerment through socio-political self-awareness (Zimmerman, 2000) or what Paulo Freire termed 'conscientisation' (Freire, 1972). It becomes even more surprising given what we know of the poor mental health epidemic in the TE student population.

To date the pathways between psychosocial well being of staff and students and the changing cultural and political climate of TE have been relatively unexplored. Time is ripe for more empirical and political venturing from community psychologists into unraveling the psychosocial pathways between the mental health of staff and students and the changing social, cultural, economic and political landscape of TE and an exploration of the spaces staff and students occupy in this fast changing TE environment.

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References

Adeoye, E.A. (1991). Correlates of job stress among university professors in Nigeria. Nigerian Journal of Guidance and Counselling, 4,1-2, 117-126.

Association for University and College Counselling. (1999). Degree of Disturbance: The New Agenda - the impact of increasing levels of psychological disturbance amongst students in higher education. Rugby: British Association for Counselling.

Barnes, N., & O'Hara, S. (1999). Managing academics on short term contracts. Higher Education Quarterly, 53,3, 229-239.

Baty, P. (2000). Mass campaign threat over performance related pay. Times Higher Education Supplement, June 02.

Bett, M. (1999). Independent Review of Higher Education Pay and Conditions. HMSO: London.

Bessant, B. (1995). Corporate management and its penetration of the university administration and government. Australian Universities' Review, 38,1, 59-62.

Duckett, P.S. (1998). Disabled at Interview: a community psychologist in and amid action. PhD Thesis, Stirling University, Scotland.

Duckett, P.S. (2001). A crisis of conscience or a crisis of conference? Subjective reflections on academic conference stimulated by attendance at the European Community Psychology Conference, (Bergen 2000). The Community Psychologist, 34, 2, 14-15.

Duckett, P.S. (2002a). Community Psychology, Millennium Volunteers and UK Higher Education: A disruptive triptych? Journal of Community and Applied Social Psychology, 12, 2, 1-14.

Duckett, P.S. (in press). Celebrating diversity as an academic community psychologist: tackling social exclusion and oppression operating within the tertiary education sector. Network: The official journal of the Australian Psychology Society College of Community Psychologists.

Fisher, C.M. (1998). Resource Allocation in the Public Sector. London: Department of Health.

Fisher, S. (1994). Stress in Academic Life. Buckingham: Open University.

Freire, P. (1972). Pedagogy of the Oppressed. Middlesex: Penguin.

Fryer, D. (1999). Strukturwandel der Arbeitslosigkeit und psychische Gesundheit. In H.G. Zilian, & J. Flecker, (eds), Soziale Sicherheit und Strukturwandel der Arbeitslosigkeit, Berlin: Sigma.

Goddard, A. (1998). AUT slams work hours law for excluding academics. Times Higher Education Supplement, Sept. 18.

Grayson, P. (1994). Campus suicide: a memoir. Journal of College Student Psychotherapy, 9,1, 57-68.

Kelly, J.G., Ryan, A.M., Altman, B.E., & Stelzner, S.P. (2000). Understanding and changing social systems: an ecological view. In Rappaport, J., & E. Seidman, (Eds), Handbook of Community Psychology, New York: Kluwer academic/Plenum Publishers.

Kular, R., & Winn, S. (1998). The Financial Situation of Students at the University of Brighton: the seventh report, 1997-98. University of Brighton: Health and Social Policy Research Centre.

Lafferty, G., & Fleming, J. (2000). The restructuring of academic work in Australia: power, management and gender. British Journal of Sociology of Education, 21,2, 257-267.

McLaughlin, M.C. (1985). Graduate school and families: Issues for academic departments and university mental health professionals. Journal of College Student Personnel, 26,6, 488-491.

Mishara, B., Baker, A., & Mishara, T. (1976). The frequency of suicide attempts: a retrospective approach applied to college students. American Journal of Psychiatry, 133, 841-844.

Phippen, M. (1995). The 1993/4 survey of counselling services in further and higher education. Newsletter of the Association for Student Counselling, Nov, 25-26.

Prilleltensky, I., & Nelson, G. (1997). Community psychology: reclaiming social justice. In D. Fox, & I. Prilleltensky, (eds), Critical Psychology: An introduction, Sage, London.

Reay, D. (2000). "Dim Dross": marginalised women both inside and outside the academy. Women's Studies International Forum, 23,1, 13-21.

Slimak, R.E. (1990). Suicide and the American college and university: a review of the literature. Journal of College Student Psychotherapy, 4,3-4, 5-24.

Schwartz, A.J., & Whitaker, L.C. (1990). Suicide among college students: Assessment, treatment, and intervention. In S.J. Blumenthal, D.J. Kupfer, et-al. (Eds.), Suicide Over the Life Cycle: Risk factors, assessment, and treatment of suicidal patients. (pp. 303-340). Washington, DC: American Psychiatric Press.

Stanley, N., & Manthorpe, J. (2001). Responding to student's mental health needs: impermeable systems and diverse users. Journal of Mental Health, 10,1, 41-52.

University of Leicester Educational Development and Support Centre. (1998). Student Psychological Health Project: project report 1997-1998. University of Leicester (UK).

Westefeld, J.S., & Furr, S.R. (1987). Suicide and depression among college students. Professional Psychology: Research and practice, 18, 119-123.

Westefeld, J.S., Witchard, K.A., & Range, L.M. (1990). College and university student suicide: trends and implications. The Counseling Psychologist, 18,3, 464-476.

Wright, L.L. (1985). Suicidal thoughts and their relationship to family stress and personal problems among high school seniors and college undergraduates. Adolescence, 20, 575-580.

Zimmerman, M. (2000). Empowerment theory: psychological, organisational and community levels of analysis. In Rappaport, J., & E. Seidman, (Eds), Handbook of Community Psychology, New York: Kluwer academic/Plenum Publishers.

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Prevention & Promotion

Edited by Rich Wolitski

We often forget the very basic health problems that challenge much of the world—limited access to clean water, inadequate supplies of nutritious food, and an inability to afford even the least expensive medical treatments that we take for granted. In this issue, Sandra Wright-Fofanah provides a first-hand account of efforts to mobilize community members in Ghana to prevent the spread of guinea worm. In this case, prevention efforts also brought about change in the structure of prevention services, creating opportunities for women in activities that were largely dominated by men. This report shows how recognizing and drawing on the inherent strengths of community members can bring about substantial changes in health and well-being. It is an important reminder that each one of us has the ability to make a significant difference in the lives of many other individuals. –Rich Wolitski

Guinea Worm Eradication Efforts in Ghana, West Africa

Sandra Wright-Fofanah, Centers for Disease Control and Prevention

As the world becomes smaller through the advent of frequent and relatively inexpensive air travel, the Internet and other technologies, the health concerns of the nations of the world become more global. One element common across the world, however, is the need to design and implement effective strategies to address health issues of concern to local communities. It is important for experienced public health professionals to be adequately prepared to provide assistance needed by resource poor nations to assist them in fighting some of the most challenging health issues of the modern era. In order to prepare them to meet countries' pressing public health needs, under conditions not encountered in typical work, the Centers for Disease Control and Prevention (CDC) provides training in international public health to interested public health professionals.

I had the opportunity to gain some international public health exposure through my participation in the International Experience and Technical Assistance (IETA) Program at the CDC. IETA is a developmental training program for public health professionals employed by federal agencies to enhance their skills and apply them in an international setting through classroom work and a supervised, short-term international field assignment (IETA, 2002). I was assigned to work for three months with the Ghana Red Cross Society (GRCS) on a project to accelerate Guinea worm eradication by training female volunteers to bring about positive change in their communities.

There is a global effort to eradicate Guinea worm. This effort involves resources of the World Health Organization, the Carter Center, the CDC, and other organizations interested in ending the harm caused by this disease. Guinea worm disease is a painful and debilitating disease caused by a large (up to one meter long) nematode parasite whose effects reach beyond a single victim. Humans acquire the infection only by drinking water contaminated containing tiny fresh water crustaceans called copepods or "water fleas" that harbor the infective larval stage of the parasite. Once inside a person, the larvae take between ten months and one year to mature. Adult worms cause a painful (burning sensation) blister to form on the surface of the skin. The burning sensation can be so intense that it causes a person to immerse his affected limbs in water to relieve the pain. The skin over the blister sloughs off leaving a lesion that allows the worm to be exposed to the outside environment. This action causes the emerging worm to release more larvae in the water, starting the cycle over again. The lesions form usually on the lower limbs, but can appear on any part of the body. The pain associated with these lesions is exacerbated by the development of severe bacterial infections that usually ensue after the lesion is formed. On average persons with Guinea worm disease are incapacitated for 8 weeks, preventing the victims from carrying out the farm work, school work, and household chores necessary for daily living. While Guinea worm disease does not directly cause death, there is no medication that can be used to cure the infection. Some medications, such as aspirin or antibiotic ointment, may relieve the pain and reduce bacterial infections resulting from the emergence of the Guinea worm. Infected persons do not develop immunity against Guinea worm; a person can get the disease one year and get it again the next year.

Because of much work to eradicate Guinea worm since 1986, the rates of Guinea worm disease have been drastically reduced and the world is poised to eradicate this disease from the planet. In 1986, a total of 3.5 million cases were estimated to occur annually (Watts, 1987). In 2001, there were 63,609 cases of Guinea worm disease reported worldwide (WHO, 2002a), all confined to 13 countries in Africa. Almost 80% of these cases were reported in Sudan; Ghana's 4,738 cases represented about 7% of the total cases reported that year.

Preventing Guinea worm involves two fairly simple processes: 1) keeping persons infected with Guinea worm out of water sources and 2) not letting anyone drink unfiltered water. These seemingly simple prevention strategies are made more difficult because access to safe drinking water may be difficult or non-existent in some communities and community members may not believe Guinea worm disease is contracted through water. The keys to making the prevention strategies work are educating community members on the life cycle of the Guinea worm, motivating community members to adhere to the simple rules of prevention, and having communities advocate for better water sources as a result of increased knowledge.

Ghana, located in West Africa, is divided into 10 regions. The largest region in the country is the Northern region and it is subdivided into 10 districts. The region is largely rural in nature, with poor, unpaved roads and a traditional patriarchal society. This region is predominantly Muslim. The literacy rate in Ghana is estimated at 64.5% for the overall population and 53.5% for women (CIA, 2002). Currently, Ghana is the second most endemic country in the world for Guinea worm disease. About 70% of cases of Guinea worm in Ghana are confined to 15 endemic districts located mainly in the Northern and Brong-Ahafo regions (WHO, 2002b).

Women are the primary collectors and overseers of the collection and storage of water. Women may either collect water themselves or send their children to fetch water for them. They are very knowledgeable about the water sources available for their villages.

However, the Ghana Ministry of Health Guinea worm Eradication Programme (Ghana GWEP) employs mostly men to carry out the goals of eradicating Guinea worm in the country. At various points in this effort, women have been involved, but as funding for their activities ended, their involvement ceased. Officials at the Carter Center, CDC, and the Ghana GWEP thought it was important to re-ignite efforts to meet the ministry's goal to eradicate Guinea worm from the country by 2004. The plan devised by these partners included a proposal for funding a component to add female volunteers to assist with eradication efforts. The GRCS was chosen to implement this project because of its access to women through established Mothers Clubs throughout the country.

I was assigned to assist the GRCS in training female volunteers in active surveillance, filter distribution, and prevention of Guinea worm in 393 villages located in six districts in the Northern and Brong-Ahafo regions. This work involved coordinating training sessions for the volunteers, ensuring delivery of equipment and incentives for volunteers, developing systems for reporting activities and conducting site visits to the various districts to observe training, problem solve issues, and encourage volunteers. Together with the Ghana GWEP, GRCS was charged with training six female supervisors to oversee activities in each district, 78 coaches who were allotted to supervisors based on the number of endemic villages assigned to a district, and over 3900 women volunteers at the village level.

To be successful in implementing this project, it was important for all of the partners to work together collaboratively as well as include their perspectives on how best to make the project work. Strong collaboration between Ghana GWEP, GRCS, the Carter Center and the American Red Cross made possible the implementation of the project and facilitated obtaining the good will of affected communities. I, together with key staff at the GRCS, made decisions about day-to-day management of the project including monitoring activities, getting supplies and funds to the supervisors and volunteers, and tracking expenses.

On the community level, GRCS District Committees worked very hard to make sure the project got off to a successful start. They talked positively about the project in their interactions with village members, assisted us with recruiting supervisors and other staff, and provided support for activities by either working directly with supervisors to train women or by being a resource for supervisors. Mothers Club Facilitators, members of the district committees charged with starting and maintaining mothers clubs in villages located in their respective districts, also contributed their efforts toward the project. Facilitators in three districts agreed to become supervisors for the project; in two other districts, these facilitators worked closely with the selected supervisor.

It was important to get buy-in from the Ghana GWEP and other entities for project activities because this project called for the re-introduction of women into a predominantly male program. In addition to the contribution to the original proposal (along with a key staff person from the Office of Global Health at CDC) made by the National Coordinator for the country's Guinea worm program in implementing the project, we also tried to involve Guinea worm staff as much as possible in the recruitment and training of the volunteers. Ghana GWEP regional staff worked very closely with us to plan the initial supervisor training and they facilitated the actual training.

Training sessions were held which provided instruction on the correct use of water filters, conducting active house-to-house visits to detect cases of Guinea worm disease, bandaging cases to keep them from exposing worms to water sources, and referring cases to clinics or case containment shelters for worm extraction. Supervisors and coaches received additional training on reporting requirements, recruiting new volunteers and retaining those already under their supervision. Ghana GWEP staffs at the district level were encouraged to attend all training with their GRCS female counterparts and received incentives given to female volunteers. Thus, these training also provided a refresher course for existing GWEP staff.

In my 11 weeks in country, the collaborative group was able to coordinate training for six female supervisors, 72 of 78 coaches, and 40% or 1572 of 3930 village volunteers. After my departure, the group was able to train the remaining village volunteers and coaches; all are currently working on eradication efforts. We conducted 15 site visits to all six districts to recruit women, introduce the project to various entities, observe training, deliver equipment, encourage women in their work, and problem solve issues that came up.

The Ghana GWEP, GRCS and the Carter Center Technical Advisors did an excellent job working collaboratively to get the project started. These partners, along with CDC and the American Red Cross, worked together to get funding for the project and pursue a consultant to help with initial project implementation. Supervisors worked very well with the women assigned to them and for the most part also worked well with the district health teams, especially the Guinea worm coordinators, to recruit and train women. In some districts, couples were able to work side by side to conduct eradication activities. This had been done informally for years, but this project afforded these couples a chance to do it legitimately.

The greatest impact of the project, however, was at the community or village level. Existing village volunteers, usually male, embraced the project and the extra ears and eyes that would be dedicated to eradication efforts. Often these volunteers were the only health workers in their villages, working on a variety of health issues (polio, birth and death registry, etc.) with little or no incentives. In some communities, there was an immediate impact in the detection of cases of Guinea worm disease with the addition of female volunteers. More importantly, women were not only willing to participate in the project, indeed there were more women volunteering than the project could use. A key reason for this was the engagement of village chiefs and elders as well as local Ghana GWEP staff in the recruitment of women leaders in the villages. One incredible example illustrates how the project was accepted in most communities: At one village training, there were 30 women scheduled to be trained. When the session was ready to begin, 76 women had shown up to be trained along with many curious members and children of the community. Community members wanted to stop Guinea worm from affecting their lives and showed up in support of an effort to make this happen.

There were some challenges encountered in implementing this project in the communities. Poor and washed-out roads prevented project staff from reaching all of the villages targeted for the project. There were minor problems with the distribution of equipment and incentives resulting in some delays in training women. Because communications systems in northern Ghana are very basic, it was not always possible to have open communications between supervisors and the regional office. In one district, a political attempt was made to shut down the project. By binding together, GRCS and Ghana

GWEP, and the Carter Center were able to intervene before the project was adversely affected. Despite these challenges, the collaborative group was able to implement the project in the majority of targeted villages.

My experience in Ghana reinforces my belief in the power of community in health promotion and prevention activities. In conducting prevention activities in communities, collaboration is important. Without the invitation and support from the Ghana GWEP and the CDC, the help of the GRCS district committees, the assistance of the technical assistants and advisors with the Carter Center, the financial support of the American Red Cross and the Carter Center, and the buy-in from communities through engaging the male staff of the Guinea worm program, the village chiefs and elders, and district health teams, the project would have had a more difficult time getting off the ground if at all. The need is great for eradicating this debilitating disease and with the active participation of the affected communities and their involvement in the major decisions about the implementation of the process for conducting activities was made easier. A project like this takes multiple efforts, but in the end can go a long way in solving issues of concern to communities if funded, planned, and implemented in a collaborative manner.

Reference List

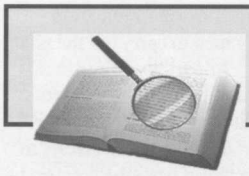
Centers for Disease Control and Prevention. (2002, August). International Experience and Technical Assistance Program. Retrieved December 16, 2002 from http://www.cdc.gov/nchstp/od/pso/ieta/default.htm .

Central Intelligence Agency. (2002). World Factbook. Retrieved December 16, 2002 from http://www.cia.gov/cia/publications/factbook/geos/gh.html.

Watts SJ. (1987). Dracunculiasis in Africa in 1986: its geographic extent, incidence, and at-risk population. American Journal of Tropical Medicine and Hygiene, Vol. 37, 119-125.

WHO Collaborating Center for Research, Training and Eradication of Dracunculiasis. (2002). Guinea Worm Wrap Up. (Number 121). Atlanta, GA: Author.

WHO Collaborating Center for Research, Training and Eradication of Dracunculiasis. (2002). Guinea Worm Wrap Up. (Number 123). Atlanta, GA: Author.



Book Reviews

Edited by Keith Humphries

Sense of Community Comes of Age: A Review of Psychological Sense of Community. Edited by Adrian Fisher, Christopher Sonn and Brian Bishop. Published by Plenum in the series on social/clinical psychology.

Reviewed by David W. McMillan

It has been 37 years since the Swampscott Conference and it has been 28 years since Sarason defined sense of community as the central organizing principle in the field. In 1974 I wrote my major area paper defining sense of community. This definition later found its way into the field in McMillan and Chavis (1986).

When we first offered a definition for sense of community, it was eagerly embraced. Finally the field had defined one thing that we could study. This edited volume by Adrian Fisher, Chris Sonn and Brian Bishop is symbolic of the coming of age of sense of community as a construct. It is past its conception stage as symbolized by Sarason's call to arms. It is also past its childhood when the idea developed an identity as represented by McMillan and Chavis (1986). Now it is well into its adolescence. Puberty has emerged and there is a great deal of contention and ferment about the construct.

Fisher et al have collected a representative set of articles in Psychological Sense of Community that make a variety of points related to sense of community. In the brilliant introductory chapter by Bess, Fisher, Sonn and Bishop, the authors serve as parents of this adolescent construct, defining what sense of community needs to do to cross the threshold into adulthood. It still must answer contentious questions of definition as well as methodological measurement issues that pit the logical positivists against the post modernists. Bess et al review the various debates in the field, e.g., are we defining sense of community too broadly or too narrowly? Is it a cognition, affective state, a behavior, an environmental condition or a spirit? Does it manifest itself differently in different contexts? Shouldn't we use phenomenology and hermeneutics to study it? And why aren't we? Does it have a dark side? Where is the study that models the differential impact of sense of community within varying segments of community? Bess et al suggest that the level of contention in the field can be described by the various abbreviations there are for sense of community. There is PSOC, SOC, and PSC.

The editors have selected and grouped together articles that view community from the individual to the macro level, from a thoughtful provocative, well written exploration of the meaning of psychological sense of home, to a focus on the correctional setting, the drug rehabilitation setting, the church and the school. The third section explores sense of community in relational communities, e.g., adolescents, immigrants, the internet and community issues related to an out-group (the aborigines in Australia) defined by a dominant culture.

The final section of articles attends to theoretical and methodological issues. The quantitative promise of hierarchical linear modeling is explored. The notion that SOC works similarly across all communities is challenged. And finally the theoretical issues of whether or not there are multiple senses of community with different valences are discussed.

All the articles were well written and well considered. The Bess et al article serves as an excellent statement of the current issues in the field. Bateman's article is an exemplary introduction to her collection of studies that explore sense of community in the classroom. She rediscovers the validity of the four elements introduced by McMillan and Chavis (1986). Her measure of sense of community in the classroom shows great promise for being the next standard for measuring sense of community. Hughey and Speer seem to be the best attempt yet at answering Bess et al's challenge to produce the study that models how sense of community works in a variety of settings from home, to neighborhood, to community center. This study demonstrates how a community psychology practitioner might ideally practice.

Studying communities in Australia challenges the notion that we can develop a simple one-size-fits-all model. Bishop et al demonstrate that SOC does not co-vary with other variables consistently across all communities. Rather, Bishop et al show that SOC varies in structure from community to community.

The book ends with perhaps its most theoretically intriguing contribution. Brodsky et al argue that we are attached to multiple communities. They suggest that we have multiple senses of community. While this rings in the readers ear with an "of course, why didn't I think of that," Brodsky et al go on to contend that SOC has a polarity that ranges from positive through neutral to negative. And further that SOC can sabotage individual development and well-being.

In 1995 I was asked to rewrite an updated version of the theory. I wrote the 1996 version from the perspective of a clinical psychologist who had been detached from community psychology and who wanted to speak clearly and directly without the constraints of academic language. My goal was to put soul in the theory, to add imagination, creativity, art, and spirit to the theory and to use ordinary words like "trade" (instead of "integration of needs") and "trust" (instead of "influence"). I also wanted to show how difficult it is to draw fine lines between the four constructs in the theory, how parts of the theory can jump back and forth among elements.

While soul might have been the strength of that article, scholarship was not. I wish I had read this book, Psychological Sense of Community, (particularly Bess et al) before writing that article. I would have had a great deal more to contribute to the conversation among community psychologists like Brodsky et al, who had incorporated the theory and moved on to other issues related to sense of community.

Psychological Sense of Community is a must have book for the serious student of Community Psychology. It will serve well as a supplementary text to introductory classes in community psychology or as a primary text for an advanced class on sense of community. If you are reading TCP, Psychological Sense of Community should be on your bookshelf.

References

Bennett, C.C., Anderson, L.S., Cooper, S., Hassol, L., Klein, D.D. & Rosenblum G. (1966). Community psychology; A report of the Boston conference on the education of psychologists for community mental health. Boston, MA; Boston University Press.

McMillan, D. W., & Chavis, D. M. (1986). Sense of community a definition and theory. Journal of Community Psychology, 14 (1) 6-23.

McMillan, D. W. (1996). Sense of Community. Journal of Community Psychology, 24 (4) 315-325.

Sarason, S.B. (1974). Psychological sense of community: Prospects for a community Psychology. San Francisco, CA: Jossey-Bass.

Practical Considerations for Sustainable Prevention Science and Service

Review of Jason L.A. & Glenwick, D.S. (Eds.). (2002). *Innovative strategies for promoting health and mental health across the life span*. New York, NY: Springer Publishing Company, Inc., by Kelly D. Richardson, Vanderbilt University, Nashville, TN

Although community psychology's roots in the area of prevention can be traced to its birth in the 1960's, the integration of prevention science and community psychology is relatively new. Community psychology has struggled to find its voice and place in the broader discipline of psychology. The traditional focus in psychology on clinical practice at the individual level of analysis and emphasis on positivist methods is often incongruent with the goals of community psychology. This volume illustrates that community psychology theories and practices can be useful for addressing prevention and health promotion from multiple perspectives of the individual, family, and community. Community psychology and similar disciplines are well positioned to tackle these problems because of their focus on the individual's relationship to his or her community, action and social change orientation, and willingness for interdisciplinary collaboration.

This volume is a follow-up to the 1993 edited text by Glenwick and Jason, *Promoting health and mental health in children, youth, and families*. Several chapters have been added to this volume on important issues salient to prevention and health promotion such as aging, chronic health problems, racism and sexism, delinquency, prevention training, and research dissemination. The editors state that the purpose of this new volume is to "summarize the latest findings in the field and to provide recommendations for the assessment and prevention of problems" (p. 13). The editors achieve this is by drawing from the various perspectives of multiple disciplines. Leading researchers in community psychology and related fields who are noted for their strong methodological and interventional approaches, were solicited to address well-researched topics that are delineated in the text in four sections and 15 chapters. The first section discusses *Prevention Science*, the second *Problems of Parenting and Youth*, third *Problems in Adulthood,* and fourth *Community and Societal Issues*. Focusing on substantive issues and social problems, the chapters offer both sound empirical and practical information. All chapters include a description of the problem, a

critical literature review, description of an applied intervention project, and a discussion of unresolved issues and future directions for research and practice. The literature reviews are thoughtful and comprehensive, offering readers multiple references in various disciplines for further reading. The case examples go beyond simply describing a program and discuss the process of designing and implementing the program, including challenges experienced. Values central to community psychology such as collaboration with community members in the development of interventions are not addressed in individual chapters but are incorporated into several chapters. This approach is a strength rather than a limitation as it points out that these core values should be woven throughout the work and not simply addressed as isolated concepts.

The authors speak to concepts such as social change, public policy implications, and collaboration with communities as important elements in prevention and health promotion. Authorities in prevention science consider these concepts essential elements to sustainable prevention and health promotion efforts. The prevention models described in this volume, based on public health frameworks, behavioral science, and community psychology principles, are being applied to some of the most difficult social problems community-based researchers and practitioners address. The scope of these problems further demonstrates the need to approach issues from a multi-dimensional perspective including psychological, social, political, economic, and environmental. As asserted by Jim Kelly in the forward, this work includes examples of how to implement prevention research, has implications for the future of community-based prevention, and illustrates the authors' emphasis on the "explicit value" of rigorous research methods based on efficacy and effectiveness research. The case studies clearly demonstrate the use of ecological and developmental paradigms, social competence, and empowerment. These themes tie the chapters together.

The strongest features of the volume are the emphasis on participation of community members in the research process, multi-level and multi-dimensional approaches to addressing social problems, contextual issues and how they impact communities, and the view that people are inextricably linked to their environment. The authors' skillful use of real-world case examples and the practical utility of their suggestions for next steps offers encouraging evidence that we are getting closer to the often stated goals of meaningfully integrating research, science, and practice. Paramount in this volume are the values of collaborating closely with communities, creating and supporting sustainable, cost-effective programs that lead to human development, emphasizing changes in the social and physical environments to support healthy lifestyle choices and promote social justice, utilizing empirically supported treatments, and investing in widespread dissemination of research.

The authors recognize the challenges of implementing prevention programs and strategies yet little emphasis is placed on practical issues such as funding limitations that has historically been a challenge in prevention. The authors stress the importance of quantitative research but not qualitative or mixed methods. Readers may find that the lack of emphasis on naturalistic inquiry appears to devalue these methodologies, which are often essential for telling the stories of communities, or pursuing questions that quantitative methods cannot adequately address. Although the case studies often employ some of these methodologies, support of these methods is not explicit. Finally, the chapter on teaching about prevention does not address ethics, cultural competence, and action research methods. These are all salient issues in teaching community-based prevention science.

This volume offers a foundation for those interested in prevention science, practice, and rigorous research. The book demonstrates how lessons learned from public health, social work, community development, and other fields have been integrated with the best practices psychology and largely community psychology has to offer. Additionally, the authors go on to challenge researchers and practitioners to ensure that interventions are evidence-based, collaborative, efficient, and effective. This multi-disciplinary, action-oriented approach that bridges science and service is truly what makes this compilation innovative.

The authors do not attempt to offer a cookbook panacea to social problems. This volume is intelligently written, interesting, and flows logically. A key feature that demonstrates its wide-ranging utility is that the chapters can be read alone for specific topical information without losing content. Potential audiences include researchers, scholars, students, practitioners, policy-makers, and lay people. Because of the inclusion of empirical and theoretical literature, intervention strategies, innovative practical approaches to preventing a range of problems, and future directions, this volume would be useful across a range of disciplines. The editors have succeeded in providing a compilation of thoughtful chapters that offer ideas for prevention approaches in various settings, potential challenges, and suggestions for how the field of community psychology may use its skills to fill the identified gaps in order to have the greatest impact on sustainable prevention science.

Student's Column

by Michèle Schlehofer-Sutton and Omar Guessous

Updates on the SCRA Biennial

Roundtables of Interest to Students at the SCRA Biennial

We are very excited about this year's SCRA biennial, which is being held from June 4th to 7th in Las Vegas, New Mexico. We would like to announce two roundtable sessions that are of particular interest to students. The first session, entitled ***The Student-to-Professional Transition: Positives, Challenges, and Tactics***, will be held on Wednesday June 4th at 3:45pm. To addresses the process of moving from being a graduate student to being a professional, a panel of presenters, all in the first 3 years of their career, will openly discuss their transitions, including both previous and on-going experiences. Secondly, a roundtable entitled ***Fostering Community in Graduate***

Programs will be held on Thursday, June 5th, at 3:45pm. This roundtable will focus on how we as students can work to increase a sense of community among students in our department and in the division. We encourage you to attend one or both of these roundtables.

Student Night Out at the SCRA Biennial

The SCRA Biennial gives students an opportunity to not only present their work, but also to meet other students in the field! We would like to organize a students' night out at this year's Biennial in New Mexico. However, we need some help from you!! What types of activities would you be interested in doing? Would you prefer an informal or a more formalized activity? Please send your suggestions to Omar at oguessous@attbi.com. And, please be sure to watch the SCRA student listserv for details on the specifics of this event!

Mentoring Lunch at the SCRA Biennial

As you may have heard through the SCRA student listserv, a mentoring initiative is being put together at the Biennial by Andrea Solarz and Gloria Levin in order to provide students the opportunity to join in more personalized and intimate conversations with various senior members of the field. Keep an eye out on your email inbox for more details.

Students of Color Interest Group

The students of color interest group was first established at the 1999 Biennial. Its creation came about in response to a seeming set of common experiences, needs, and challenges as they were expressed by students of color from various graduate programs.

A meeting of all interested students will be held at the Biennial, over lunch, on Friday June 6th at 12:30pm. The purpose of this meeting is to collectively assess and evaluate the group's mission, structure and short- & long- term objectives. This interest group's current mission statement reads as follows:

"To better understand and meet the needs of students of color; to develop a network among students of color; to address issues regarding research with communities of color, and to discuss the unique contributions that communities of color can offer to the field of community psychology and vice versa."

So mark your calendars, and contact Omar at oguessous@attbi.com and/or check your Biennial schedule for more detail.

Updates on the APA Convention

Student Activities at the 2003 APA Convention

This year's APA convention will take place in Toronto from August 7th to 10th, 2003. We are currently planning a student social hour at the convention, to be hosted in the division's suite. Please watch the division listservs for information on the exact day, time, and room location of this event. Additionally, the annual student poster-judging contest will again be taking place at this year's APA convention. If you are presenting a poster during the division's poster sessions, you are automatically entered into the contest. A panel of judges will rate the quality and clarity of student posters. The student who wins the contest will receive a certificate, and is formally recognized in the TCP.

A *Student Social Hour* is also in planning for SCRA students at APA. More details to follow.

Student Travel Awards to the 2003 APA Convention

We are happy to announce that we will be awarding travel awards worth $150.00 each to three students to off-set expenses related to attending this year's APA convention. Please see this issue of TCP for the application for the award. Alternatively, you can request an electronic copy of the application from Michèle by emailing her at Michele.Sutton@cgu.edu. Applications must be received by **6/01/03** to be considered for a travel award. To apply, please complete the application and submit it to Michèle at Michele.Sutton@cgu.edu (or via postal mail at: Dept of Psychology, Claremont Graduate University, 123 E Eighth St., Claremont, CA 91711).

Call for Papers- Summer Issue of The Community Student

Please consider writing a paper for *The Community Student*! *The Community Student* is published twice annually and features articles written by students about their experiences within community psychology. We encourage you to begin sending in articles for the Summer 2003 edition of *The Community Student*, with submissions due in by **July 31st, 2003**. We will accept articles anytime for publication in later editions. The Community Student is a great way to share your ideas with other students and all SCRA members. It's also a great way to add a publication to your curriculum vitae! Articles should be between two and four pages long, double-spaced, and can be submitted electronically to Michèle at Michele.Sutton@cgu.edu. Please contact Michèle for additional information.

Increased Student Editorial Involvement in AJCP

One of the topics brought up at the division's mid-winter meeting concerned ways to increase student involvement in the division's publication, the *American Journal of Community Psychology*. We are pleased to announce that the editor of the journal, Dr. William Davidson, was open to the idea of placing more students on the editorial board. As a result of communication over the listserv, we are happy to announce that thirteen students were recently added to the editorial board of AJCP! Congratulations to these students!

The Special Issues Graduate Student Research Grant

Just a reminder that it's not too late to apply for the Special Issues Graduate Student Research Grant! The grant is specifically devoted to supporting pre-dissertation or thesis research in under-funded areas of community psychology. This year's grant focuses on funding research in one of three areas: 1) research or activism in oppression; 2) community development and organization; or 3) public

Annual Convention of the
American Psychological Association
Toronto, Canada
August 7-10th, 2003

SCRA STUDENT TRAVEL AWARD APPLICATION

1. **Contact Information**

Name: _____

Affiliation: _____

Mailing Address: _____

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City *State* *Zip* *Country*

Daytime Phone: _____

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2. Are you a SCRA student member? ❑ Yes ❑ No

3. **Presentation Information**

Type of Presentation: ❑ Poster ❑ Symposium ❑ Roundtable ❑ Other_____

Title of Presentation: _____

Are you participating in more than one presentation? ❑ Yes ❑ No

If so, please list the name(s) of the first author(s):

_____

_____

_____

4. Please include a brief description (no more than 300 words) of how your proposal meets the criteria for this award (i.e., quality of the proposal, relevance of the proposal to community psychology interests, distance traveled, etc.).

5. Please attach your Curriculum Vitae and a copy of your acceptance letter(s).

If you have any questions, please contact Michèle Schlehofer-Sutton at Michele.Sutton@cgu.edu.

Send completed applications to: Michele.Sutton@cgu.edu.
Alternatively, you can submit your application via postal mail to:
Michèle Schlehofer-Sutton
Dept. of Psychology
Claremont Graduate University
123 E Eighth St.,
Claremont CA 91711
Applications must be received by **June 1, 2003**.
Decisions will be announced by July 18th

policy. Grantees are awarded $500.00 for one year. Applications for an award are due by **July 1st, 2003**. The RFA was previously printed in the Winter 03 issue of TCP. If you have any questions, or would like to request an electronic copy of the RFA, please contact Omar at oguessous@attbi.com.

Subscribe to the SCRA Student Listserv!

The SCRA student listserv is a forum to increase discussion and collaboration among students involved and interested in community psychology. It is a great place to get up-to-date information relevant to students, such as upcoming funding opportunities, job announcements, and opportunities to become involved in the division. To subscribe to the listserv, send the message SUBSCRIBE S-SCRA-L@lists.apa.org <first name> <last name> to: listserv@lists.apa.org. Messages can be posted to the listserv at: S-SCRA-L@lists.apa.org. If you have any questions or need help signing on to the listserv, please contact the listserv moderator, Omar, at oguessous@attbi.com.

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Dear Student Presenter,

The Society for Community Research and Action invites you to apply for a Student Travel Award to the Annual Convention of the American Psychological Association held August 7th to 10th. These awards are offered to assist students with their travel expenses. These awards are highly competitive, and the award committee will take into account both the quality of the work being presented, and the financial hardship posed by the cost of travel to the conference site, Toronto, Canada. International student presenters are especially encouraged to apply.

Applicants must be a student member of SCRA and must be presenting for the SCRA constituency on a topic clearly relevant to community psychology.

If you meet the criteria above, I strongly encourage you to apply. We would like to see as many SCRA students participating at the APA conference as possible and hope that these travel awards will aid in that effort.

Please e-mail your completed application by **June 1st** to:

Michèle Schlehofer-Sutton
Michele.Sutton@cgu.edu

Thank you and good luck,

Michèle Schlehofer-Sutton and Omar Guessous
SCRA Student Representatives

Special Feature

HIV/AIDS in Asia and among Asian Americans and Pacific Islanders, Edited by Frank Wong and Rich Jenkins

An Introduction

Frank Y. Wong, George Washington University

The HIV pandemic continues to rage and, entering its third decade, many predict that Asia and the Pacific will be the next major epicenter – creating human disasters that could be larger than those in sub-Sahara Africa. China alone is projected to have 10 million infected individuals by 2010, a mere 7 years from now. The special collection of articles in this issue of The Community Psychologist were chosen to (1) raise awareness of the crisis, (2) describe the epidemic affecting Asians and Pacific Islanders (including those living in the U.S), and (3) postulate strategies that may have the potential to slow or halt the spread of the virus.

The collection begins with an overview on HIV in Asia and the Pacific by Rich Jenkins. In addition to a historical review of the pandemic in Asia, Jenkins argues that any meaningful dialogue needs to address how the socio-cultural and political, as well as economic, contexts shape the epidemic – for example, the relative success of Thailand's 100% condom campaign represents an effort to bring together the public health sector, law enforcement, and the technically illegal sex work sector. Frank Wong and Royce Park extend this argument by providing an overview of HIV among Asian Americans and Pacific Islanders (AAPIs) in the U.S. – a population often being overlooked by many who engage in HIV research and treatment efforts, despite evidence of serious epidemics within this community (e.g., proportionately AAPIs have more AIDS cases among men who have sex with men than any other racial/ethnic group other than Whites). A majority of the AAPIs (over 60%) are foreign-born, a pattern that is also present in AAPI AIDS cases, thus HIV prevention needs to integrate migration-related issues (socio-cultural and economic) that may affect HIV transmission. The authors present a conceptual model with preliminary data, arguing that there is a window of opportunity to stem a potential explosion of HIV among AAPIs.

Together with Dominicus So, Wan Yan Hai (a Chinese HIV doctor and activist who recently made international headlines for exposing blood contamination in China) describes the growing epidemic in China as well as prevention efforts there. Using India as a case study, Gauri Bhattacharya describes how cultural guidelines shape and regulate sexuality and expressions of sex (including commercial sex, condom use, and sterilization) and how these relate to HIV prevention. Mark Barrett and colleagues present preliminary findings from a study of decision-making strategies used by Thai youth and female Thai sex workers in the context of HIV-related risks. Vince Crisostomo describes the slow progress and challenges, as well as the limited successes, in conducting HIV prevention in the Pacific region.

Tooru Nemoto and colleagues present preliminary findings of a study of HIV risk behavior among AAPI male-to-female (MTF) transgendered individuals (71% foreign-born) in San Francisco. The authors contend that this is both an at-risk group for acquiring HIV and a high-risk group for HIV transmission, and that socio-cultural and economic factors need to be an integral component of HIV prevention efforts in this community. Finally, Ezer Kang and Bruce Rapkin present qualitative data on adherence to antiretroviral medication among a sample of AAPI HIV-positive individuals (all foreign-born). These data persuasively argue for the importance of socio-cultural factors in HIV treatment and care among AAPIs.

Taken together, these papers help illustrate the diversity of the API community in the US and their societies in Asia and the Pacific. They also highlight the potential for explosive growth in the epidemics among AAPI, as well as the epidemic in Asia and the Pacific, and the political, socio-cultural, and economic issues that must be addressed to prevent these epidemics from growing further. As community psychologists, drawing on multi-disciplinary backgrounds, we can play a role in preventing HIV in these communities and addressing related issues such as discrimination, acculturation, and community development; these papers begin to outline the importance and potential impact of such efforts.

HIV in Asia: An Overview

Richard A. Jenkins, Divisions of HIV/AIDS Prevention, Centers for Disease Control & Prevention, Atlanta, GA

This paper will briefly review the scope and recent history of HIV in Asia, as well as describe evolving social and economic dynamics in the epidemic, and the interplay between culture, HIV, and social change. In places like Thailand, where the first large scale epidemic in Asia was noted, HIV has not only been affected by the culture, but also has been a factor in social change. In considering the other papers in this volume, it is important to realize that the factors that give rise to HIV epidemics are not static and that even successful efforts, like Thailand's, to bring the epidemic under control can have unintended consequences which can influence new sources of risk.

The Scope and Recent History of the HIV Epidemic in Asia

The HIV epidemic in Asia and the Pacific ranks second only to the epidemic in Africa, in size. The most recent UNAIDS data (UNAIDS, 2002) estimate that there are 7.2 million people living with HIV/AIDS in Asia (out of 42 million, worldwide) and that this number represents a 10% increase from 2001. Across the region, the prevalence of HIV is less than 1%, however, there are tremendous variations from country to country and some "low prevalence" countries like China and India have large, localized epidemics.

The HIV epidemic in Asia has many common threads, but there are also important local differences. The first cases of HIV were seen in the mid-1980s and by 1990 virtually every country in the region had reported some cases. Thailand experienced the first large epidemic in the region, with prevalences of 15-20% among young men in some northern provinces by the early 1990s (Mason, et al., 1995). This epidemic was largely driven by transmission of HIV between female sex workers (FSW) and their clients, with subsequent transmission to wives and girlfriends. Prevalence declined sharply during the mid-1990s with implementation of the 100% condom campaign, which included sanctions for sex establishments that did not promote condom use and a major nationwide educational campaign (Rojanapithayakorn & Hanenberg, 1996). Less progress has been apparent in Thailand's smaller epidemic among injection drug users (IDU), which is based largely in Bangkok, where HIV prevalence among in-treatment IDU has hovered in a range of 40 to 50% over the past decade (AIDS Division, Department of Disease Prevention, Royal Thai Ministry of Public Health, 2002).

More recently, sharp increases in HIV prevalence have been seen in Vietnam, Cambodia, and Burma, as well as parts of China, and India. Vietnam's epidemic was first apparent among IDUs, particularly in Ho Chi Minh City and along drug trafficking routes near the Chinese border. More recently, cases have been seen among FSW, particularly in areas near the Cambodian border, where many of these women have returned from working in Phnom Penh and other Cambodian cities (Hien, et al., 1999). FSW and their clients seem to be the major affected groups in Cambodia, although there are encouraging early signs from Cambodia's effort to implement a version of the 100% condom campaign (UNAIDS, 2002), which had been so successful in Thailand. Cambodia's efforts are remarkable because its public health infrastructure has very limited supplies of trained personnel, medicines, or other materiel. The highest prevalence in the region is believed to be in Burma, where estimates range as high as 400,000 cases (UNAIDS, 2002). It is difficult to get data from Burma (also known as Myanmar), although available information do suggest that infection is prevalent among IDU and FSW, particularly in urban areas.

The largest numbers of people living with HIV/AIDS in Asia are in China and India, which have tremendous variation in their epidemics across their large landmasses. Both countries have experienced explosive increases in cases in the past half-decade. For most of the 1990s, the Chinese epidemic was largely centered on Yunnan, a southwestern province that borders Laos and Burma and is near the Golden Triangle opium-growing region. In addition to the province's significant problem with opiate injection drug use (IDU), many women from Yunnan have migrated to and from Thailand where they were engaged in sex work (Mahatdhanobol, 1998). Economic growth in China has coincided with increased IDU in many areas of the country and establishments with FSW have become common in provincial capitals. In addition, commercial blood donation programs in several provinces have been linked to HIV infection because of their use of pooled blood and re-used equipment. As a result, epidemics are appearing in many areas of the country that had seen few or no cases until recently. It is estimated that about 1 million people are living with HIV/AIDS in China and that the number could multiply without rapid intervention (UNAIDS, 2002). The government has recently taken more aggressive action and is working to better manage the blood supply and to foster development of prevention activities in areas

that have only recently begun to see HIV cases. The Indian epidemic is focused in urban areas, particularly in the northern part of the country and the majority of reported cases involve FSW and their clients, with perinatal transmission and IDU as other major concerns (UNAIDS, 2002).

Populations At-Risk in Asia

HIV transmission in Asia has generally been through heterosexual sex. FSW and their clients have been the populations at highest risk in most countries. However, secondary transmission from men who visit sex workers to their wives and girlfriends has been increasing in some areas. Injection drug use has played varying roles within the region. Significant IDU epidemics have been noted in Vietnam, Thailand, Burma, China, and most recently Indonesia, where injection drug use has shown rapid increases in urban areas (UNAIDS, 2002). Most Asian countries have emphasized interdiction and other punitive measures to stem drug use, although efforts to promote harm reduction have begun to develop grassroots support. Although some of the first HIV cases seen in Asia were among men who have sex with men (MSM), very little is known about the prevalence of HIV among MSM in Asia. Homosexuality is heavily stigmatized throughout Asia and openly gay communities are only beginning to emerge in a few places (e.g., Bangkok, Hong Kong). Efforts to study HIV epidemiology among MSM have occurred only in Thailand and Vietnam, although work is being undertaken in other countries (China and Cambodia). During the early 1990s, it appeared that MSM were at lower or comparable risk for HIV than the rest of the Thai male population, however, more recent research suggests that there may be higher prevalence among MSM in Thailand (Beyrer, et al., 1995).

While there are important differences in risk patterns by country and even within countries, there are factors such as migration and drug trafficking which carry the epidemic across national borders. For example, Vietnam's highest non-urban HIV prevalences are in provinces that are on trafficking routes for drugs to and from China and provinces that serve as the origin (and eventual place of return) for women who work as FSW in Cambodia (Hien, et al., 1999). Similar patterns exist in China's Yunnan province which is located on routes used for trafficking drugs and FSW (Mahatdhanobol, 1998). Fishermen, who often visit ports in a variety of countries are another mobile population that also appears to be at high risk (Entz, et al., 2001).

Economic Development and HIV in Asia

Economic development appears to be a double-edged sword for HIV in Asia. Emerging industrial economies like Thailand's are able to provide prevention for mother-to-child transmission (Amornwichet, et al., 2002) and medical care for at least some HIV-seropositive citizens (UNAIDS, 2002). On the other hand, development often paces the growth of the epidemic. China is seeing the growth of injection drug use and sex work in its prosperous urban areas. Migration to cities for a better economic life often is associated with HIV risk, as in the cases of FSW. In some places, the lack of development seems to act as a protective factor. In Thailand, the poorest region of the country has consistently recorded the lowest prevalence of HIV. However, the second poorest region, the upper North, has been affected the most by the epidemic (AIDS Division, Department of Disease Prevention, Royal Thai Ministry of Public Health, 2002).

Asian HIV Epidemics: Dynamics and Change

The Asian epidemics, like those elsewhere, have been dynamic. Most countries have begun with denial and with fear-oriented interventions that often directed attention at outside influences or marginalized risk groups (Beyrer, 1998). The most successful interventions such as the 100% condom campaign have surmounted many of these early obstacles, although the campaign content has been viewed as perpetuating risk group stereotypes (Lyttleton, 2000).

The epidemiology of the epidemic also has been dynamic and has shown considerable interplay with intervention. For example, in Thailand, reduction of HIV transmission among FSW and their clients and a successful program to reduce perinatal transmission (Amornwichet, et al., 2002) have meant that other populations, particularly IDU, make up increasing proportions of new cases (Beyrer, 1998; Rojanapithayakorn & Hanenberg, 1996). On the other hand, data are beginning to suggest that the 100% condom campaign needs reinvigoration and that more attention is also needed to begin condom use in non-commercial relationships (Jenkins, et al., 2002). One consequence of HIV and intervention in Thailand appears to be a sharp decline in sex work patronage and a decline in many segments of the sex trade (Hanenberg & Rojananapithayakorn, 1998). At the same time, changing sex roles have made premarital sex more acceptable for ordinary Thai women and the need to focus on risk within casual or serial committed relationships has emerged (Allen, et al., 2003).

The Interplay between Culture, HIV, and Social Change

The dynamic character of the Thai epidemic, which has had more time to evolve than epidemics in other Asia countries, illustrates the interplay of culture, risk, policy, and intervention. Along these lines, it shows how the epidemic may be diminished in some populations, but not others, and can even return to populations where past intervention has been successful. It also illustrates how the epidemic itself may change behavior and set the stage for more insidious spread of HIV, which may be more difficult to address than when the epidemic is concentrated in well-defined populations and settings like FSW in brothels. The needs for intervention in Asia, as elsewhere, are multifaceted and require attention to culture, policy and the potentials for social and behavioral change. Much of the intervention in Asia has built on past public health efforts in the region, particularly family planning and maternal-child health, although some grassroots NGO activity has focused specifically on HIV particularly in Thailand and India. The epidemic's concentration in relatively marginalized populations has made it necessary to address social issues that formerly tended to be hidden from view, such as men having sex with other men, alternatives to punitive measures for drug use, and the social and legal statuses of FSW. Yet, at the same time, HIV epidemics have opened up discussion of sexuality in many countries where public discussions of sex have been viewed as improper and have

begun to draw attention to the limitations of existing approaches to stem drug use. The future of HIV prevention in the region will require continued attention to the multi-faceted nature of the epidemic and its varied consequences.

References

AIDS Division, Department of Disease Prevention, Royal Thai Ministry of Public Health (2002). HIV/AIDS situation in Thailand. Bangkok: Author.

Allen, D.R., Carey, J.W., Jenkins, R.A., Manopaiboon, C., Uthaivoravit, W., Kilmarx, P.H., & van Griensven, F. (2003, forthcoming) Sexual Health Risks Among Young Thai Women: Implications for HIV/STD Prevention and Contraception. AIDS & Behavior.

Amornwichet, P., Terraratkul, A., Simonds, R.J., Naiwatanakul, T., Chantharojwong, N., Culnane, M., Tappero, J.W., Kanshana, S. (2002). Preventing mother-to-child HIV transmission: The first year of Thailand's national program. JAMA 2002; 288:245-248.

Beyrer, C. (1998). War in the blood. London & New York: Zed Books.

Beyrer, C., Eiumtrakul, S., Celentano, D.D., Nelson, K.E., Ruckhaopunt, S., & Khamboonruang, C. (1995). Same sex behavior, sexually transmitted diseases, and HIV risk among young northern Thai men. AIDS, 9, 171-176.

Entz, A., Prachuabmoh, V., van Griensven, F., & Soskolne, V. (2001). STD history, self treatment, and healthcare behaviours among fishermen in the Gulf of Thailand and the Andaman Sea. Sexually Transmitted Infections. 77, 436-440.

Hanenberg, R, & Rojananapithayakorn, W. (1998). Changes in prostitution and the AIDS epidemic in Thailand. AIDS Care, 10, 69-79.

Hien, N.T., Long, H.T., Chi, P.K., van Ameijden, E.J.C., Deville, W., & Wolffers, I. (1999). HIV Monitoring in Vietnam: System, Methodology, and Results of Sentinel Surveillance. Journal of Acquired Immune Deficiency Syndrome, 21, 338-346.

Jenkins, R.A., Manopaiboon, C., Samuel, A.P., Jeeyapunt, S., Carey, J.W., Kilmarx, P.H., Utaivoravit, W., & van Griensven (2002). Determinants of condom use and intentions to use condoms among northern Thai youth. AIDS Education & Prevention, 14, 228-245.

Lyttleton, (2000). Endangered relations: Negotiating sex and AIDS in Thailand. New York: Harwood.

Mahatdhanobol, V. (1998). Chinese women in the Thai sex trade. Bangkok:Chinese Studies Center, Asian Research Center for Migration, Institute of Asian Studies, Chulalongkorn University.

Mason, C.J., Markowitz, L.E., Kitsiripornchai, S., Jugsudee, A., Sirisopana, N., Torugsa, K., Carr, J.K., Michael, R.A., Nitayaphan, S., & McNeil, J.G. (1995). Declining prevalence of HIV-1 infection in young Thai men. AIDS, 9, 1061-1065.

Rojanapithayakorn, W., & Hanenberg, R. (1996). The 100% condom program in Thailand. AIDS, 10, 1-7.

UNAIDS (2002). AIDS epidemic update, 2002. Geneva: Author. http://www.unaids.org/worldaidsday/2002/press/Epiupdate.html

HIV/AIDS among Asian Americans and Pacific Islanders in the US:

A Small Problem or Harbinger of Greater Problems to Come?

Frank Y. Wong and Royce J. Park, George Washington University

This paper will provide an overview of Asian Americans and Pacific Islanders (AAPIs) in the U.S., and describe scope of AIDS/HIV in the AAPI communities. Outward differences between the HIV epidemic among AAPIs in the U.S. and the epidemics in their home countries in Asia and the Pacific will be briefly examined, and accompanied by a conceptual model for understanding HIV/AIDS among AAPIs in the U.S. Finally, preliminary findings from an ongoing study are presented, arguing that a window of opportunity is still available to prevent a potential escalation of HIV/AIDS in the AAPI communities in the U.S.

Who, What, and Where are the AAPIs

The term "AAPIs," used by the US government for gathering public health statistics, subsumes more than 40 culturally distinct groups with more than 100 languages and dialects. For example, these groups differ in their migration histories (e.g., Chinese and Japanese migrations began in the 1800s, a significant numbers of Southeast Asians such Cambodians and Vietnamese migrated after 1975) and their religious beliefs (e.g., most Filipinos are Catholic, most Indonesians are Muslim, different branches of Buddhism and Hinduism are present in other countries), among other factors. Meanwhile, most US government sources do not disaggregate AAPI ethnic data by specific ethnicity or country of origin. Although there are similarities among some AAPI groups, the diversity of the AAPI communities makes simple categorization problematic. Therefore, the term "AAPI" is used here to categorize this diversity here, with recognition of its limitations. In addition, it is acknowledged that several of the Pacific Island jurisdictions are transitioning from United States trust territories into independent, sovereign nations under the Compact of Free Association and do not characterize themselves as "Americans."

AAPIs are proportionately one of the fastest growing racial/ethnic minorities in the United States (from 1.5% or 3.5 million people in 1980 to 3.9% or 10.9 million people in 2000). It is estimated that of the 10.9 million AAPIs, 6.7 million (61.4%) are foreign-born and 7 million (63.7%) ages 5 and above speak an AAPI language at home (U.S. Census Bureau, 2001). Six (6) AAPI ethnic groups have populations of over 1 million: Chinese (2,734,841), Filipino (2,364,815), Asian Indian (1,899,599), Korean (1,228,427), Vietnamese (1,223,427), and Japanese (1,148,932). The largest concentration of AAPIs is in the West (~ 50%), followed by the Northeast (~ 20%), South (~18%), and Midwest (~12%). Some cities, such as San Francisco, have more than one-third of their residents claiming an AAPI heritage.

AIDS/HIV among AAPIs

Official AIDS statistics indicate that AAPIs make up less than 1% of the total AIDS cases in the U.S. (Centers for Disease Control and Prevention or CDC, 2002), however, the figure may not tell the full picture of HIV/AIDS issues faced by this under-studied and under-served population. Since the first documentation of AIDS cases among AAPIs by CDC in 1987, the literature reveals the following findings:

- Among cumulative AAPI AIDS cases proportionately more are men who have sex with men (MSM) (72%) than all other racial/ethnic groups except Whites (74%) (CDC, 2002);
- Among cumulative AAPI AIDS cases proportionately more women have been infected by a bisexual partner or a partner who uses drugs than in any other racial/ethnic groups (CDC, 2002);
- The majority of the cumulative AIDS cases of AAPIs are foreign-born (CDC, 2002)
- Compared to other racial/ethnic groups, AAPIs are more likely to be identified at an advanced stage of AIDS disease (Eckhodt & Chin, 1997) and have opportunistic infections upon diagnosis (Eckhodt, Chin, Harris, & Kim, 1997);
- AAPIs, compared with Whites, are more likely to cite "illness" as the major reason for seeking HIV testing (Wong, Campsmith, Nakamura, Crepaz, & Begley, 2003);
- Compared to other racial/ethnic MSM, young AAPI MSM had one of the highest rates of never having been tested for the virus (18%) and for unknown HIV status (18%) (Wolfe, 1999); and
- AAPI MSM are equally likely to engage in high-risk behaviors and practices as other non-AAPI MSM despite high prevalence of knowledge of HIV (Choi, Han, Hudes, & Kegeles, 2002; Chng & Geliga-Vargas, 2000).

Why Does There Seem to be a Discrepancy in HIV Etiology Between AAPIs and Asia?

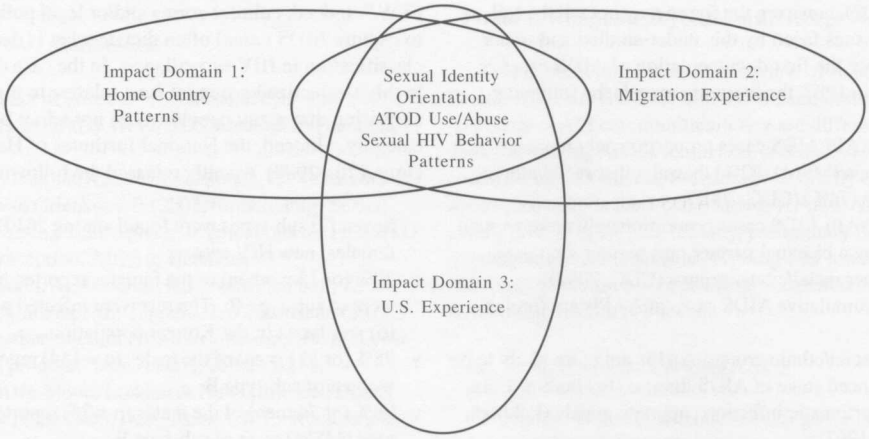
Although the HIV epidemic in Asia and the Pacific is second to Africa in size (see Jenkins, 2003), a recent report, The Second Wave of the HIV/AIDS Pandemic: China, India, Russia, Ethiopia, Nigeria – A Conference Report of the CSIS Task Force on HIV/AIDS (Cooke, 2002) by the Center for Strategic and International Studies ominously predicts that countries such as China and India will soon have bigger human disasters in their hands than even Africa. China, alone, is projected to have as many as 10 million people living with HIV/AIDS by 2010, a mere seven years from now. Jenkins (2003) indicated that majority of the HIV infection in Asia and the Pacific is attributed to commercial sex (usually involved female sex workers [FSW] and their clients), thus, assumed to be heterosexually transmitted), followed by injection drug use. Acknowledging the lack of a uniform global (or perfect) surveillance system, and given a majority of the AAPIs in the U.S. are foreign-born and still have ties with their home country and a majority of the AAPI AIDS cases are foreign-born MSM, one may want to know why there is just a discrepancy on the manifestation of HIV, i.e., Why do MSM predominate among AAPIs in the U.S., whereas infections in their home countries is predominately attributed to heterosexual transmission? Jenkins (2003) has argued that " … The needs for intervention for Asia, as elsewhere, are multifaceted and require attention to culture, policy, … The epidemic's concentration in relatively marginalized populations has made it necessary to address social issues that formerly tended to be hidden from view, such as men having sex with other men, alternatives to punitive measures for drug use, and the social and legal statuses of FSW." Indeed, cultural norms and/or legal policy (e.g., what and how to capture AIDS cases) often dictate what is deemed appropriate for classification in HIV surveillance. In the case of Asia, MSM is a highly stigmatized group (at least relative to the U.S.), and it is not surprising that many people would not admit belonging to this category. Indeed, the National Institutes of Health in South Korea (June 17th, 2002) recently released the following statistics:

- Seven (7) sub-types were found among 261 (230 males and 31 females) new HIV cases;
- 50% (or 15 women) of the females reported being infected by men were of sub-type B. The rest were infected with one or more of six (6) sub-types in the Korean population.
- 98% (or 151 men) of the males (n = 154) reported being infected by women of sub-type B
- 98% (or 74 men) of the males (n = 76) reported being infected by men (MSM) were of sub-type B.

The imbalance between the numbers of women infected with sub-type B and the number of men with sub-type B who claim heterosexual transmission raises a number of provocative issues. For example, some of this imbalance may result from sex with female sex workers (who probably see many partners), sex with other men or injection drug use. MSM behavior and drug use are heavily stigmatized and may not be disclosed. Going to sex workers is not uncommon but still carries stigma for married men. The presence of non sub-type B among men only, suggests that they may have been infected outside their home countries in places like China, India, Thailand, or Vietnam where other sub-types predominate and where Korean often visit for work, which serve as a reminder that migration is a concern for HIV prevention in Asia as well as among AAPIs in the U.S

Similarly, investigation of HIV targeting AAPIs in the U.S. needs to take a contextual and dynamic approach. Chng, Wong, Edberg, Park, and Lai (in press) propose a tripartite model (see Figure 1) for studying HIV-related issues among AAPIs in the U.S. It is most useful to understand HIV-related issues among AAPIs as outputs of a process that encompasses one or more generations and moves through three domains. In basic terms, the process begins with the home country and its cultural norms, practices and understandings related to health and disease (Impact Domain I). These norms are then affected by the nature of the migration/immigration experience, which among AAPIs (e.g., Cambodian, Vietnamese) often have included severe trauma and the endurance of prolonged hardship (Cambodian, Vietnamese refugee experiences) (Impact Domain II). Third, the norms, practices, and understandings that were socialized in the home country are affected by situations faced by AAPIs as they adapted to a new life in the U.S. (Impact Domain III). An important subset of the third domain is the generational factor – Impact Domains I and II may be less salient for those who were either very young at the time of immigration or those are born in the U.S. For these latter individuals, we can postulate that the set of salient

Figure 1: Impact Domains



impact domains will be significantly different, though this varies by the degree to which a particular immigrant community remains insulated (e.g., through language, social networks, cultural practices, workplace, economic arrangements) vis-à-vis the surrounding community and the larger influences of "mainstream" US cultural practices and norms.

Some Preliminary Findings from an Ongoing Study

Wong, Edberg, Park, and Corey (2003) provide data that help illustrate the interactions among factors like travel and intersections between home country and US culture that can influence HIV risks. Their multi-year project is examining HIV-related risks among three groups of Southeast Asian (Cambodian, Laotians, and Vietnamese) immigrants and refugees living in the Washington, DC metropolitan area (N = 111; 57% female and 43% male). Their preliminary focus group findings indicate that the most common impact domain across all groups is travel back and forth to the home country. Traveling home to visit family members is relatively common, especially around New Years celebrations and other events. In addition, younger and middle-aged men often travel home, to places like Phnom Penh, Vientiane, or Hanoi to look for a "traditional" spouse, a girlfriend, or just to have fun. Hence, they may be fulfilling an expectation of finding a spouse who is from their ethnic group and reflective of home country values or they may discretely seek a partner outside of marriage, a practice that is tolerated in these cultures as long as it is not visible to the outside so as to shame the family. The dollar's economic power and the relative poverty of these three countries, make it particularly easy for men to find sex for money or relationships that are influenced by money. Spousal or girlfriend relationship may be facilitated by money and, in addition, sex work may involve recurrent partnership or partnerships that extend across a visit of several days or weeks. It is generally acknowledged in focus groups that the sex trade is growing, particularly in Cambodia and Vietnam, and money can influence some sex workers to forgo condoms. Moreover, focus group participants said that treatment for sexually transmitted diseases (STDs) and/or HIV are not widely available or costly, so that many sex workers simply "live with" their conditions. Travelers are thus at significant risk for HIV infection, and if not aware, may serve as a bridge for HIV transmission in the U.S. once they return. The cultural norms of the home countries generally make condom use insulting and unattractive for wives, but acceptable with commercial partners. Hence, some of the home country risks can be addressed in a culturally acceptable framework, although the desire to have a relationship not deemed "commercial" may lesson this.

A majority of the focus group participants had little knowledge of MSM activities. They appeared to be relatively unaware of the fairly organized Asian gay/bisexual and/or MSM community in the Washington DC metropolitan area. Thus, these individuals were not able to discuss HIV/AIDS-related risks in same-sex sexual behaviors (e.g., unprotected anal sex). The few who indicated that they knew someone who is gay did not appear to be comfortable in discussing same-sex issues in front of other focus group participants. In brief, level of acculturation (both to the mainstream American culture as well as the gay culture) might play a role in people's awareness and/or willingness to discuss same-sex sexual issues. In other words, those few individuals who knew someone who is gay may operate under the often-heard saying, "Don't Ask, Don't Tell, Don't Know" (a double or closet life), in the Asian community about same-sex sexual issues.

In addition, there were very few terms mentioned in focus groups related to MSM activities. Among the three communities, HIV/AIDS-related risk practices are discussed using culturally-specific terminologies, though it is important to note that there is often no indigenous term (or no well-known term) for some culturally proscribed risk practices – a kind of "linguistic denial," as it were. Among Vietnamese, MSM is called "pê dê," though in Lao and Khmer the expressions used are more descriptive in nature.

behaviors difficult to address suggest the possibility of rapid growth in the AAPI epidemics in the future. Given the small number of current AIDS cases among AAPIs there is still a brief window of opportunity to halt the epidemic.

References

Centers for Disease Control and Prevention. (2002). HIV/AIDS surveillance report. Atlanta, GA: Author.

Choi, K-H., Han, C-S., Hudes, E. S., Kegeles, S. (2002). Unprotected sex and associated risk factors among young Asian and Pacific Islander men who have sex with men. AIDS Education and Prevention, 14, 472-481.

Chng, C. L., & Geliga-Vargas, J. (2000). Ethnic identity, gay identity, sexual sensation seeking and HIV risk taking among multiethnic men who have sex with men. AIDS Education and Prevention, 12, 326-329.

Chng, C. L., Wong, F. Y., Edberg, M. C., Park, R. J., & Lai, D. S. (in press). A conceptual model for understanding sexual health among Asian American/Pacific Islander (AAPI) men who have sex with men in the United States. AIDS Education and Prevention.

Cooke, J. G. (Ed.). (2002). The second wave of the HIV/AIDS pandemic: China, India, Russia, Ethiopia, Nigeria – A conference report of the CSIS Task Force on HIV/AIDS. Washington, DC:: Center for Strategic and International Studies.

Eckhodt, H., & Chin, J. (1997). Pneumocystis carinii pneumonia in Asians and Pacific Islanders. Clinical Infectious Diseases, 24, 1265-1267.

Eckhodt, H. Chin, J., Harris, C., & Kim, D. (1997). Opportunistic infections in the United States: Focusing health care and needs for people with AIDS. Poster presented at the 12th World AIDS Conference, Geneva, Switzerland.

Jenkins, R. A. (2003). HIV in Asia: An overview. The Community Psychologist.

South Korean National Institute of Health. (October 17th, 2002).

U.S. Census Bureau. (2001). 2000 Census. Washington, DC: Author.

Wolfe, D. (1999). Sexual health survey: Sexual health and practices of gay, bisexual and homosexuality active men in New York City. New York City: Gay Men Health Crisis.

Wong, F. Y., Campsmith, M. L., Nakamura, G. V., Crepaz, N. & Begley, E. (2003). Reasons for testing and care utilization among a group of HIV-positive Asian Americans and Pacific Islanders in the United States: Findings from a supplemental HIV/AIDS surveillance project. Paper to be presented at the National HIV Prevention Summit, Atlanta, GA, August.

Wong, F. Y., Edberg, M. C., Park, R. J., & Corey, K. (2003). Preliminary qualitative results from an ongoing study of HIV/AIDS in three Southeast Asian immigrant and refugee communities. Manuscript under editorial review.

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Private Websites and AIDS in China

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The emerging AIDS epidemic in China

Projections and estimates from various sources suggest HIV/AIDS is becoming a major public health problem in China. Official data, released by the Minister of Health of the People's Republic of China (PRC) on December 26, 2002, indicated that the toll of HIV infection had just reached 1 million cases, partially because of the widespread blood contamination in some 23 provinces where people in villages sold their own blood for money. Government projections for the future of HIV in China have varied widely, with estimates ranging from 2.2 to 12 million cases by 2010. UNAID's Theme Group on HIV/AIDS in China (2002) has projected that the number of HIV infections may reach 10 million by 2010. U.S. intelligence sources (National Intelligence Council, Center Intelligence Agency, 2002) estimate an even higher number of cases (10-15 million) by the same year. Despite these projections, the official Chinese government continues to suggest heterosexual transmission as the major mode of HIV infection and to downplay the impact of male homosexual transmission (Wong & Park, 2003). Same-sex behaviors remained a highly-stigmatized and tabooed topic in China, even after the Chinese Psychiatric Association had removed homosexuality from its diagnostic categories in 2001.

In response to the emerging AIDS epidemic and societal taboo of homosexuality in China, the "Tongzhi movement" (gay movement) began in the mid 1990s when many Chinese had just ventured into the Internet for information and news. Realizing the Internet's potential power for networking millions of otherwise unreachable mainland Chinese, many non-governmental, grassroots organizations targeting men who have sex with men (MSM) started establishing their own websites as a community service and social forum for MSM. The first wave of HIV-positive MSM and other private individuals also started using their websites for distributing information about AIDS education and MSM issues. Since 1999, Aiqing Baipishu Zhonghua Tongzhi Wang (www.gaychinese.net), for instance, provided the MSM community with a comprehensive magazine-like website consisting of news, sexual health, gay-affirmative information, literature, counseling, legal knowledge, and a chatroom. Many other similar organization and private websites continue to support the "Tongzhi Movement". Beijing Aizhixing Institute of Health Education (formerly Aizhi Action Project established in 1994), based in Beijing China, runs a website at www.aizhi.org to provide the Chinese MSM community with sex education, MSM newsletter, AIDS news, legal assistance, and public policy commentaries. These websites are organized in ways similar to the U.S. counterparts. However, these websites are unique

because they are presented in the Chinese language and target mostly MSM in mainland China. This current study attempted to investigate the potential impact and issues of developing private websites as a way to control HIV infection among MSM in China.

Methods

Our current data are derived from a survey conducted from August to October, 2001. The Beijing Aizhixing Institute of Health Education (www.aizhi.org) and Aiqing Baipishu Zhonghua Tongzhi Wang (www.gaychinese.net) conducted the survey to assess the development of Chinese gay and lesbian websites and their use for AIDS education in China.

Participants were website owners who have been running private websites for the purposes of community building and HIV prevention. Their web sites are not sponsored by the government, but owned, developed, and maintained by these private individuals. These owners were chosen if their website was identified as gay/lesbian-owned, gay-friendly, or targeting only gays and/or lesbians in China. Most of the web sites were owned and run by mainland Chinese in China.

The survey was posted on Aiqing Baipishu Zhonghua Tongzhi Wang (www.gaychinese.net). Key informants in the local gay and lesbian community identified these gay-identified websites and encouraged the website owners to participate in the study posted at www.gaychinese.net. The initial participants also referred other website owners to the research website. All of their answers were kept confidential.

The survey included twenty-two (22) questions that asked about the purpose of each website, site management and usage issues, health- and AIDS-related messages, sources and categories of web content, site development, and cost-benefit issues, as well as owners' AIDS concerns and health education, and training needs for website owners. The entire survey took 5-10 minutes to complete and participants were not compensated for their participation. A total of 66 surveys were completed.

Results

Purpose, nature, and content. The majority of the website owners reported that the purpose of establishing their websites was to allow users to make friends and establish emotional connections with each other. Education, health, or news purposes are rare. Eighty-three percent (83%) of the site owners identified their sites as targeting gay men, 6% percent targeted lesbians, while 8% targeted both gay men and lesbians. As reported by the website owners, the emphases of their content included: literary writing (72%), news (64%), health (64%), socialization (51%), entertainment (47%), and art (28%). Pornography (4%), politics (2%), economics (2%), scientific research (4%), and education (9%) were considered as rare.

Site development, server, cost/benefit, and usage. All of the websites were established between 1998 and 2001, with an average history of 13 to 15 months in operation at the time of the study. Seventy-three percent (73%) of the sites used freely available server space; 20% were on rented independent servers; and 7% were on shared servers. Ninety-six percent of the servers were in mainland China. The annual maintenance cost is approximately US$600. The cost was paid for by site owners (81%), friends (9%), private foundations (2%), e-commerce (2%), or other sources (3%). Site owners spent 2 hours per day, on average, for the editorial tasks of their sites. About half (47%) of the owners were operating the sites at a financial loss, while 35% made a profit. The average daily number of hits by visitors is 1070. Across all of the participating sites, this would translate into nearly 26 million hits per year.

Health messages. The majority (91%) of the site owners included some health messages on their sites: HIV/AIDS (33%), physical health maintenance (17%) mental health (13%), lifestyle (13%), and health news (13%). The most important values of the gay community, as rated by site owners were: tolerance (23%), unity (20%), health (13%), trust (10%), happiness (7%), stability of sexual relationship (7%), and being out (7%).

Editorial issues. Two thirds (67%) of the site owners used their personal interests to select writings to be posted on their site; only 2% used surfers' needs as the primary basis for site content, while 32% used both. Their main sources of health messages were the mass media (58%), gay and lesbian organizations (32%), and expert sites (27%). Site owners prioritized the importance of the different aspects of health information as follows: basic knowledge (44%), news (35%), public interest items (26%), and health policies (17%).

AIDS and health concerns. While 86% of the site owners are concerned about AIDS, an alarming 14% were not. About three quarters (77%) of the site owners know of a friend who is living with AIDS. Seventy-two percent (72%) of the site owners defined personal health as psychosomatic health.

Training and development issues. The majority (86%) of the site owners believed that the editors of the Chinese gay websites should receive gay and lesbian health education, and 83% believed that the editors should meet to discuss gay and lesbian health education issues. Sixty one percent (61%) said they would send a representative to participate in this kind of health education training activity. They indicated that the following areas would be important in the training sessions for websites: website collaborations (58%), mental health (56%), basic AIDS knowledge (55%), safer sex behavior (52%), sharing of website experiences (50%), technology transfer (44%), and information about sexually transmitted diseases (44%).

The main hurdles web owners face are: lack of time (48%), server instability (44%), lack of personnel (42%), inadequate technology (33%), inadequate financial resource (32%), lack of legislative protection (30%), inadequate server space (23%), personal security (21%), antagonistic hosting companies (17%), and internet hackers (12%). While more than one third of the site owners (37%) had found no solution to their problems, others tried solving problems on their own (22%), using a private server/hosting company (11%), seeking others' help (11%), fund-raising (7%), strengthening site management (7%), and changing their domain name (4%). Close to two thirds (63%) of the site owners were optimistic about their web site while 6% were not.

Discussion & Recommendations

Conclusion. The potential for using private websites for HIV education and prevention in China is great but not yet fully realized. Our findings indicate that most owners of gay-identified websites in China were aware of and concerned about HIV infection in China, and had included HIV education in their websites' missions. However, such potential has not been fully realized for several reasons. Much of the HIV related web content comes from the news media and may not be authoritative in its content. The website owners also cited strict legal regulation, lack of funding, technology, and limited time as hindrances for posting more careful and accurate HIV related information on their websites. In order to provide better HIV prevention services for MSM in China, the website owners hoped to receive more education about HIV/AIDS and gay/lesbian health issues, as well as more education about technical website issues.

Methodological problems. First, participants were not randomly selected, suggesting a possible self-selection bias. Because we used website owners' word of mouth to recruit other website owners, we were more likely to have participants who are in that unofficial "network" of website owners. Thus, our findings are more likely to reflect the views of the more established web site owners and less likely to reflect those of owners of newer, less established websites. In addition, the site owners who responded to our survey appeared not to be completely underground, and thus might have self-censored both their responses to us and their posting on their sites. They tend to target the more affluent educated segment of the Chinese MSM population which also affects their opinions. Owners of websites that appeal to other audiences in China (e.g., English-speaking segment of the population and non-Chinese residents and business travelers) or have content different from what was reported here (e.g., sites that are primarily pornographic) may not have been captured by the snowball sampling and may have different opinions on various survey items. It is worth noting that mainland Chinese MSM probably also make extensive use of websites that originate in Western countries such as the U.S., and that originate in other Chinese-speaking countries. We did not attempt to look at the impact of sites established and hosted outside China in nearby Taiwan, Singapore, and Hong Kong, or those intended for populations other than mainland Chinese. The potential of such development should not be underestimated.

Non-disclosure and non-gay-identification among MSM. Due to the scope of this study, most of the website owners targeted gay men who were likely to have self-identified or disclosed to others as gay. Compared to gay-identified MSM, non gay-identified MSM in China may be as likely to engage in unprotected anal intercourse with male partners, but more likely to be unaware of their HIV infection and have female sex partner(s) as well. Data on other non-disclosing MSM of color in the U.S. indicate these trends (Center for Disease Control and Prevention, 2003). Thus, future studies in China should conduct research on sites heavily used by MSM who have not yet acknowledged or identified themselves as gay or bisexual.

Community response, public policy, and law. Given the recent as well as projected future growth in the HIV epidemic in China, the need for health and HIV education information is urgent and clearly indicated by our findings. Although few sites were set up to provide health education, an overwhelming proportion include health messages, suggesting the potential value of these private websites for HIV prevention efforts. The majority of their posting is based on website owners' personal interests, and it is alarming that a substantial minority of website owners are not concerned about AIDS. The unplanned and unchecked nature of current HIV and health information on some of these websites may pose the problem of spreading inaccurate HIV information and unintentionally fostering risky sexual practices. Nevertheless, overly restrictive law may result in no HIV information at all at the grassroots level. The current public policy and law in China may make some of these websites inoperable because many sites are generally not registered or approved by appropriate government agencies, as required by the applicable legal codes such as the Measures for Managing Internet Content Provision (PRC State Council, 2000) and the Measures for Managing Internet Medical and Health Content and Services Provision (PRC Ministry of Health, 2001).

Future of private websites. Current AIDS research and HIV prevention in China is in its infancy. The scope of this study reflects that status. We were able to conduct the first research on informal, online, non-governmental AIDS education efforts in a country probably with millions of high risk MSM. It is a ground-breaking achievement that potentially opens the possibility of collaboration among website owners on health and HIV education for a country with an increasing threat of an HIV pandemic within a decade. With close to 26 million hits by visitors per year on the sites in this study alone, private websites certainly have great potential to impact the spread of HIV prevention messages to high risk, often closeted MSM in China. In the short run, community intervention can be done using these site owners as the Chinese MSM community leaders or popular opinion leaders. HIV intervention efforts can be made to create a website with comprehensive HIV information in Chinese and to train the Chinese website owners to routinely search that site and use the information to post on their own, or provide links to that site. Moreover, website evaluation research in the future is likely to contribute more to prevention efforts if evaluations use methods in addition to site owners' self-report. In addition, future research in the long run may also tap into the use of the internet for Chinese MSM to connect for sex outside cyberspace. Community psychologists have great potential to come together to fight AIDS in the cyberspace communities, in China and beyond.

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References

Center for Disease Control and Prevention (2003, February 7). HIV/STD risks in young men who have sex with men who do not disclosure their sexual orientation – Six U.S. cities, 1994-2000. Morbidity and Mortality Weekly Report, 52(05), 81-85. Retrieved February 19, 2003 from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5205a2.htm

National Intelligence Council, Center Intelligence Agency, (2002,

September). The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China. Retrieved September 2002 from http://www.cia.gov/nic/pubs/other_products/ICA%20HIV-AIDS%20unclassified%20092302POSTGERBER.htm

PRC Ministry of Health. (2001, January 8). Measures for Managing Internet Medical and Health Content and Services Provision. Beijing, China.

PRC State Council. (2000, September 25). Measures for Managing Internet Content Provision. Beijing, China.

UN Theme Group on HIV/AIDS in China (2002, June). HIV/AIDS: China's titanic peril. 2001 Update of the AIDS Situation and Needs Assessment Report. Retrieved June 2002 from www.unaids.org/whatsnew/newadds/AIDSchina2001update.pdf

Wong, F.Y, & Park, R.J. (2003). HIV/AIDS among Asian Americans and Pacific Islanders in the U.S.: A small problem or harbinger to come? The Community Psychologist.

Cultural Guidelines, Cognitive Scripts, and Sexual Meanings: Promoting HIV Infection Prevention in India

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Research on HIV and AIDS has emphasized the urgent need to understand the psychosocial aspects of HIV transmission to develop HIV infection prevention programs. In this approach, sexual behavior is viewed not as isolated individual acts, but as sexual experiences influenced and shaped by the social and cultural construction of sexual norms and expectations (Parker, Barbosa, & Aggleton, 2000). This perspective focuses on the contexts and meanings of the sexual behavior to the participants rather than seeing sexual behavior exclusively as a quantifiable independent variable leading to HIV infection. Understanding of how an individual internalizes the cultural scripts and constructs his or her sense of self and social role is essential for initiating changes in sexual attitudes, perceptions, and behavior (Diaz, 2000). Such information can be helpful in identifying factors that may contribute to not practicing safe-sex among at-risk populations. Linking data on HIV incidence and prevalence with social and cultural contexts is urgently needed to reduce HIV infection and advance health promotion activities. This article examines the logic and rationale of not using condoms among heterosexual married couples in India.

Epidemiological data show that 84% of AIDS cases in India are attributed to heterosexual HIV transmission, and that one in every four cases of HIV infection is among women (National AIDS Control Organization, NACO, 2001). Many married couples in India are at risk for HIV because social norms permit husbands to have pre-marital and extramarital partners which may be unknown to their wives, whereas these sexual outlets are not considered acceptable for Indian women. Heterosexual married women who report monogamous sexual relationships with their husbands are increasingly becoming a high-risk group for HIV. The Government of India AIDS Control Program emphasizes the consistent use of condoms as one strategy for reducing the risk of HIV transmission at the population level (NACO, 2001). The use of condoms among married couples in India is extremely low, although some increase in their use has occurred in the past few decades. Condom use was reported by 1% of the total reproductive population in India in 1970-71 and it increased to 3% in 1994-95 (Gopalan & Shiva, 2000). Another consideration is that the vast majority of Indian women (97% in 1992-93) did not use any contraceptive before the birth of their first child (International Institute of Population Studies, IIPS, 1995). In addition, permanent sterilization is a common mode of contraception for women in India and the median age for sterilization is 27 years and has been dropping (Gopalan & Shiva, 2000). Consequently, the use of condoms as contraceptives may not appear relevant for many married couples in India.

No comprehensive study of heterosexual married couples in India has explored how sociocultural issues influence individuals' beliefs about societal norms and expectancies of sexual behavior. Relatedly, research has not systematically examined the reasons why unprotected sex may become meaningful to individuals in that cultural context. This article aims to partially fill that knowledge gap and examines the underlying sexual behavior-related beliefs that may be barriers to condom use in this population, and may help to inform the development of culturally appropriate methods for increasing condom use in India.

To understand the beliefs associated with not using (or using) condoms, first, this article describes how normative beliefs of sexual behavior may influence condom use among heterosexual married couples in India. Second, it discusses the culturally shaped beliefs about condom use as a contraceptive and why not using condoms becomes meaningful in the context of marriage. Third, this article presents how perceptions of HIV risk in India are culturally constructed and, in particular, linked to commercial sex work (CSW)

and why married women may believe they are not at risk of HIV and find no reason for their husbands to use condoms. Health indicator data from World Health Organization Reports on HIV/AIDS (WHO), United Nations Reports on AIDS (UNAIDS), World Bank Reports on HIV and AIDS, and Government of India Reports on HIV and AIDS (NACO) and published ethnographic, historical, and sociological studies, as well as findings from major international and regional conferences are reviewed in this article.

Normative Beliefs of Sexual Behavior

The patriarchal family structure in Indian society has two unique characteristics: patrilineal descent, meaning that family name, succession, and inheritance pass from father to son; and patri-virilocal residence, meaning that after marriage, a woman lives with her husband in his father's house (Mukhopadhyay, Nandi, Nundy, & Sivaramayya, 2000; Nag, 1996). This family structure shapes the expected sexual behaviors of men and women in India, and the use of condoms may conflict with the prescribed sexual roles of married couples. First, although societal norms do not encourage sexual activity outside marriage, men's engagement in pre- and extramarital sex is tolerated for the sake of gaining "experience" in being sexual decision makers and for fulfilling a perceived need for men to have regular outlets for their sexual needs (Mane, Rao Gupta, and Weiss, 1994; Mukhopadhyay et al, 2000). A traditional norm of virginity for unmarried girls is highly desired to maintain their "purity" and so that they will remain highly desired candidates for motherhood. Thus, having multiple sex partners is socially accepted, normative behavior for men in India, but sexual experience for unmarried women is not. Second, marriage is the institution that gives women permission to initiate sexual relationships with their partners and to gain societal identity as members of their husbands' families. If women enter marriage with knowledge of HIV transmission and safer-sex practices, they may be suspected of having engaged in premarital sex. Third, women experience family pressure to procreate after they marry and, especially, to bear sons, since sons are deemed necessary to continue the family lineage. Because the family structure allows only sons to inherit property, married women often find it economically difficult to leave their husbands even in cases of domestic violence (Agnes, 1998).

Use of Condoms as Contraceptives

Because condoms are identified with birth control, married heterosexual couples may be disinclined to use them for HIV prevention. Women feel societal pressure to prove their fertility after marriage and may find no reason to delay child birth and use condoms as contraceptives. As mentioned earlier, the majority of women (97%) did not use any contraceptive before their first child was born (IIPS, 1995). In addition, Indian women are expected to have at least two sons who survive to adulthood. This expectation influences them to undergo repeated pregnancies in the hope of bearing sons. In a country where 30% of all child mortality occurs under age 5, the fear of losing a child may influence fertility-related behaviors that effect family size, birth spacing, and the use of condoms as a contraceptive (Gopalan & Shiva, 2000). The consequence of these conditions and typical norms for women's role in the family is that women are not inclined to encourage condom use, because it would interfere with their efforts to establish their position in the family. Such beliefs make it difficult to promote condom use for the prevention of HIV infection.

Sterilization rules out the use of condoms as contraceptives.Sterilization is a far more widely used and preferred method of contraception among women in India than in other countries, which further contributes to the low level of condom use in married couples. In addition, sterilization has become increasingly popular for contraception by women in recent decades . The ratio of males to females who resort to sterilization underwent a dramatic reversal—from 2:1 in 1970-71 to 1:31 in 1994-95. During that period, the use of sterilization, relative to other methods, sharply increased from 8% to 30.2% of all methods used (Gopalan & Shiva, 2000). The median age of sterilization for women is 27 years and has been dropping. Since more than 75% of the total fertility in urban and rural areas occurs between ages 20 and 30, women undergo sterilization during their peak reproductive years (Gopalan & Shiva, 2000; Pachauri, 1999). Unless the use of condoms is associated with something more than contraception, couples in which either the husband or wife has been sterilized may not be motivated to consider using condoms to prevent HIV infection.

Condom Use Is Linked with Commercial Sex Work (CSW)

In India, condom use is synonymous with sex work, wherein there is typically no expectation of future emotional involvement between client and the commercial sex worker. In this situation, condoms are perceived as devices to prevent conception with female CSWs and also to prevent sexually transmitted diseases (STDs) (Nag, 1996). However, because condoms are associated with CSWs, married women may think that using condoms with their husbands is incompatible with the female virtue of a "good" family woman. It is also possible that if a woman suggests or insists that her husband use condoms, he may believe that she suspects him of having an STD or being HIV positive. At the same time, he may accuse her of having extramarital sex and, thus, defying the institution of marriage (as it is understood in the Indian context). It is worth noting that similar dynamics are present in other Asian societies (e.g., Thailand; Knodel & Pramualratana, 1996).

Discussion

This article illustrates how some sociocultural beliefs may explain married couples' nonuse of condoms, particularly with respect to short- and long-term expectations of marital roles for women. Because wives may not know about their husband's outside or premarital partners including CSW, they may be exposed to HIV without knowing it. The risk of HIV transmission increases exponentially if one partner is exposed to repeated and frequent unprotected sexual acts with an HIV-infected individual over a longer duration.

While the limited space of this article does not allow for a description of the multi-pronged strategies the Indian government must pursue to promote condom use to reduce HIV infection prevention among married couples, two approaches are suggested in this context. First, there is a need to demystify and dissociate the use of condoms from contraception and "illicit" sex with CSWs. Instead, the use of condoms to protect the family may be an acceptable alternative in India. Inherent in this approach is the need to

reemphasize the role of both husband and wife as partners in family well-being. Second, there is a need to implement an outreach strategy to educate and motivate both men and women to understand their risk and vulnerability to HIV are intimately connected to this partnership without blaming husbands as agents of HIV infection because of their greater sexual freedom. To develop such strategies necessitates understanding, recognizing, and responding to the differential normative beliefs of men and women, meanings of sexual behavior, and benefits and constraints of individual partners based on the sociocultural contexts of India. Changing normative beliefs is a long-term strategy that requires the transformation of gender roles and more gender-equitable relationships that both partners find meaningfully convincing and beneficial as a unit.

Conclusions

It is a public health imperative that married women recognize that the use of condoms will reduce HIV infection. But achieving this aim will depend on the ways that married partners, individually and as a couple, can confront the dilemmas between the cultural scripts of family obligation and scientific rationality. When the right thing to do is overshadowed by sociocultural scripts, as illustrated in this article, the right way may be to understand the logic behind one's nonuse of condoms. To show the couple the availability of alternative pathways requires convincing both partners of the feasibility and benefits of following that other path. No one claims that this task will be easy for policy makers and program developers, but "it is the right thing to do."

References

Agnes, F. (1998). Violence against women: Review of recent enactments. In S. Mukhopadhyay (Ed.). In the name of justice. New Delhi, Manohar Publishers.

Diaz, R. (2000) Cultural regulation, self-regulation, and sexuality: A psycho-cultural model of HIV risk in Latino gay men. In R. Parker, R. M. Barbosa and P. Aggleton, P. (eds.) Framing the sexual subject: The politics of gender, sexuality, and power. Berkeley, CA: University of California Press, 191-215.

Gopalan, S and Shiva, M. (Eds.) (2000) National Profile on women, health and development: Country profile—India. New Delhi: Voluntary Health Association of India and World Health Organization.

International Institute of Population Studies. (1995). National Family Health Survey MCH and Family Planning, India 1992-1993. Bombay: Author.

Knodel, J., & Pramualratana, A. (1996). Prospects for increased condom use within marriage in Thailand. International Family Planning Perspectives, 22, 97-102.

Mane, P., Rao Gupta, G., & Weiss, E. (1994). Effective communication between partners: AIDS and risk reduction for women. AIDS (8), S325-S331.

Nag, M. (1996) Sexual behavior and AIDS in India. (New Delhi, India: Vikas Publishing House).

National AIDS Control Organization. (2001) Combating HIV/AIDS in India, 1999-2000. New Delhi: Ministry of Health and Family Welfare, Government of India.

Pachauri, S. (1999) Implementing reproductive health agenda in India: The beginning. New York: Population Council.

Parker, R., Barbosa, R. M., and Aggleton, P. (Eds.). (2000) Framing the sexual subject: The politics of gender, sexuality, and power. Berkeley: University of California Press.

Strategies for Protection from HIV infection Among Youth and Female Sex Workers in Thailand.

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Thailand was one of the first Asian countries to have experienced an HIV/AIDS epidemic, which began in the early 1980's. HIV was first seen among men having sex with men, and several years later large numbers of cases were identified among intravenous drug users (IDU) and female sex workers. It has been estimated that one million Thais were infected with HIV by the year 2000 (The World Bank, Thailand Office, 2000), with most HIV infections attributed to heterosexual sex. The epidemic among FSWs and their patrons appeared to be the major source of this infection, with subsequent transmission to wives and girlfriends. Given this background, a major component of the Thai government's efforts to prevent the further spread of HIV infection was the policy of 100% condom use at brothels which was implemented through a program of education, free condom distribution, and sanctions against sex establishments, which was very effective in slowing down the epidemic in this sector (Rojananapithayakorn & Hannenberg 1996) bringing down the prevalence of new cases overall (Mason, et al., 1995). Educational efforts also identified FSW as a significant risk group, and subsequent research has suggested that many Thais have focused more on avoiding sex with FSW and other identified risk groups than on risks in their own behavior (Lyttleton, 2000). Perhaps related to this, is the decline in sex worker patronage that began in the early 1990s. Previously, sex worker patronage had been very common particularly among unmarried men. Instead, it appears that the decline in sex worker patronage has paralleled a trend toward young men having sex with their girlfriends, instead. Social norms had previously proscribed premarital sex for young women, although these norms had begun to change in a more permissive direction even prior to the HIV epidemic.

Condom use with girlfriends or casual partners generally has been far less frequent than with sex workers in Thailand and there has been relatively less attention to the risk that may occur when partner change takes place frequently with these non-commercial partners. There are signs that they may be living under "illusions of safety" (Thompson, Kent, Thomas & Vrungos, 1999) by adopting strategies that provide a sense that they are effectively dealing with the risk of contracting a sexually transmitted disease without barrier protection. These conditions suggest that a new epidemic could develop among non-commercial heterosexual partnerships without greater attention

to personal risks. Another problem is that there are indications that condom use with commercial partners may be declining (e.g., Jenkins, 2002). Therefore, more attention needs to be given to what is taking place in the commercial sex sector, including the FSW perspective.

HIV risk and decision-making

There has been little research to investigate decision-making processes and strategies used for protection with respect to HIV infection among Thai youth, although a small literature existed for FSW prior to the 100% condom campaign. Therefore, we decided to 1) examine how Thai youth think, feel, and behave in sexual encounters with respect to HIV infection, 2) ask about situation and social factors that may influence their behaviour , and 3) identify the behavioral strategies they use to protect themselves from possible HIV infection. Given the exploratory nature of the work, a qualitative research approach was used. Data were collected from sexually active young adult males and females and a sample of young FSW. This paper will give an overview of some of the main findings; we intend to publish more detailed accounts of the findings of each study in the future.

Method

Young Adult Sample.

The sexually active, unmarried male (n = 20) and female (n = 20) young adults (age 18 to 25 years) were undergraduates at a polytechnic college in Bangkok. Interviews were conducted by a male psychology graduate student, who had been trained to do qualitative interviewing. Interviews lasted for approximately 20 to 30 minutes and respondents were offered a small incentive (a pair of movie tickets) for their time and participation in the study. All participants completed informed consent agreements before the interviews took place.

Female Sex Worker Sample.

The FSW sample consisted of 20 young women (age 18 to 39 years), between the ages of 18 and 30, working in Chiang Mai, Thailand. Of the 20 FSW, 15 were recruited from a public sexually transmitted disease (STD) clinic and 5 from street locations where sex was solicited. The interviewers were two male staff of the Department of Psychiatric Nursing at Chiang Mai University and had previous experience interviewing FSWs. Participants were offered an incentive of 500 baht (about $12, and the going rate for "short time" services) to participate in the study and provided informed consent.

For the young adults and the FSW, Thai-language semi-structured interview schedules were used and covered a list of topics related to HIV risk behavior and protective strategies. The questions included items about sexual behaviour with regular, casual and commercial partners in a variety of situations and items from an "illusory strategies" questionnaire derived from Thompson et al. (1999).

Results

Young Adult Sample

Many of the young adults reported numerous sexual relationships during their lifetime; 45% of males reported encounters with FSW, while none of the females reported such encounters. Regular steady partners were reported by 90% of males and 100% of females while 80% of males and 25% of females reported having had one or more casual partners. Only 3 out of the 20 males (15%) and 5 out of the 20 females (25%) reported "consistent" condom use with the regular partner. In contrast, majorities of males and females reported consistent condom use condoms with casual partners, although this was not always true with all casual partners.

Generally, both male and female respondents understood basic concepts of HIV transmission and they used condoms in at least some of what they considered to be risky sexual encounters (i.e., casual or commercial sex partners). Both males and females relied on a number of signs or indicators of whether a prospective regular partner might be safe (e.g. appearance, health, trust, social status and education). For females these also included the length of time they had known the partner, having checkups before having sexual intercourse, and informal assessments of personality and behaviour.

The three primary themes related to recent unprotected sex among males were: use of alcohol, trust/love of partner, and difficulty in controlling sexual urges. Among females unprotected sex was related to trust of a regular partner (60%), and difficulty in controlling sexual urges while engaging in sexual activities (15%). It was not clear if these urges referred to the female, her partner, or both. There was a greater tendency for females to report being pressured by male partners to not use condoms, than for males to be pressured by their female partners. Common social norms in Thailand inhibit the assertiveness by women in areas related to negotiating sex.

The male and female students reviewed a list of possible HIV prevention strategies (Thompson et al., 1999), and provided their most common endorsements. The primary strategy was "avoiding risky groups," (85% of all students) in which both males (80%) and females (90%) felt they could tell by certain signs whether or not one a prospective partner may be HIV infected (i.e., prostitutes, one night stand, drug addicts, persons with unhealthy appearance). The next most frequently endorsed strategy was having sex only in the context of a "loving relationship" (77.5% overall; 70% of males, 85% of females). Consistent condom use, one of the only really effective methods for protection, was endorsed by 72.5% of the sample, but more highly endorsed by males (85%) as compared to females (60%). However, this may have been due to the frequent use of condoms reported by males during encounters with FSWs. Other common strategies (reported by 50% or more of the total sample) included: getting to know the partner before sex, withdrawal before ejaculation, showering or douching, and luck.

Chiang Mai FSWs

The FSWs reported almost always using condoms, during both vaginal and oral sex while working, because they were very concerned about HIV infection. Like the college students, they also appeared to have an adequate understanding of basic HIV transmission. They trusted condoms as an effective strategy to protect them from infection. On the other hand, nearly all of the

FSWs indicated that they did not use condoms when they had sex with their regular, steady partners (i.e., boyfriends or husbands). The reasons given were that they "loved them" and "trusted in them." Even so, many FSW felt that it was probably unsafe to have unprotected sex with their regular partners, however, their husbands or other regular partners expected trust from them, and they feared that suggestions to use condoms would jeopardize their relationship and possibly lead to punishment. They described condoms as "tools of the trade", associated with commercial sex. Therefore, asking steady partners to use a condom might be construed as meaning the partner is "dirty", risky, untrustworthy, unfaithful, etc. Yet many felt that their steady partners probably were promiscuous and did not engage in safe sex with their other partners.

In addition to the risk of unprotected sex with regular, non-commercial partners there were a number of outwardly illusory strategies that were reported, including the inspection of partners to detect signs or characteristics of safe partners (healthy appearance, politeness, social class and education) and presence of HIV (smell, sores on skin). There also was a reliance on the risky groups strategy (i.e., drug addicts or strangers are riskier). In addition, cleaning the body after having unprotected sex (to kill the virus) was a common strategy.

Conclusions

This pilot study yielded a number of themes that require further research and also suggest areas for intervention. The main finding of interest is the vulnerability to HIV infection due to lack of barrier protection during sexual intercourse with "regular" partners for both FSW and the male and female students. Although participants were generally aware of issues regarding risk of HIV infection in commercial and even casual sex situations, few of them were aware of the need to protect themselves with regular partners. Becoming intimate, knowing a partner, and trusting and loving that partner seemed to be sufficient justification for non-use of condoms. In some situations this may be illusory where they are with one partner at any one time (serial monogamy) but are not cognizant of that person's history (or their own) Interestingly, the same person might be considered risky if engaging in a one-night-stand during one encounter, and yet be considered safe if engaging in sex with someone who s/he knows well and with whom s/he has formed a relationship. Even so, encountering the same person in a casual context would not necessarily lead to using protection.

The FSW and the students demonstrated accurate basic knowledge about HIV infection and the effectiveness of condoms in preventing infection, although they also endorsed many illusory strategies. The usual reasons given for not using protection were trust and love of the regular partner. In the case of females (students and FSW), "trust" sometimes seemed to be conflated with a sense of powerlessness in negotiating condom use with their regular male partners. Interestingly, very similar patterns were present with FSW with respect to their regular partners. While FSW were more cognizant of possible risks from their regular partners, the need to appear trusting still appeared very important. Some of the strategies mentioned were: avoiding risky groups, cleansing the body, judging risks based on healthy appearance or smell, social status and other personal attributes, the withdrawal method and even luck.

The findings here suggest that HIV prevention education needs to move away from the stigmatizing and potentially misleading emphasis on "risk groups" and address situations which can place ordinary young people at risk, while addressing illusory sources of control. The presence of sexual activity outside of primary relationships (both by FSWs and their partners, as well as among the general young adult male and female population) also suggest the need to develop prevention approaches to promote negotiation of safer sex without jeopardizing the bond of trust within the couple. There have been efforts to promote this in Western behavioral research and examples include "negotiated safety," (Crawford, Rodden, Kippax & Van de Ven, 2001) and cognitive restructuring regarding the benefits and costs of both using and not using condoms with regular partners (Parsons, Halkitis, Bimbi & Borkowski, 2000). Negotiated safety involves having couples test together, and if HIV-negative, maintain unprotected sex only within their relationship, while using condoms with any outside partners. This may be difficult to adapt to Thailand unless norms change to foster more open discussion of sexuality by women. In addition, the association of condoms with commercial sex may make it difficult to implement this with casual, non-commercial partnerships. Cognitive restructuring interventions focus less on the relationship than on more realistic appraisal of unprotected sex and may be more easily adapted to Thai society, particularly given the importance of concepts like mindfulness and karma (e.g., recognizing that consequences may ultimately come from behaviors harmful to others) derived from Buddhism. Difficulties in the cultural adaptation of existing interventions from Western research suggest the need to investigate principles of effective intervention which can address illusory measures and promote realistic self-assessment and management of sexual risk in a Thai cultural context.

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References

Crawford, J.M., Rodden, P, Kippax, S & Van de Ven, P. (2001). Negotiated safety and other agreements between men in relationships: Risk practices redefined. International Journal of STD and AIDS, 12,164-170.

Jenkins, R.A., Manopaiboon, C., Samuel, A.P., Jeeyapant, S., Carey, J.W., Kilmarx, P.H., et. al. (2002). Condom use among vocational school students in Chiang Rai, Thailand. AIDS Education and Prevention, 14, 228-245.

Lyttleton, (2000). Endangered relations: Negotiating sex and AIDS in Thailand. New York: Harwood.

Mason, C..J., Markowitz, L.E., Kitsiripornchai, S., Jugsudee, A.,

Sirisopana, N., Torugsa, K., Carr, J.K., Michael, R.A., Nitayaphan, S., & McNeil, J.G. (1995). Declining prevalence of HIV-1 infection in young Thai men. AIDS, 9, 1061-1065.

Parsons, J.T, Halkitis, P.N, Bimbi,D & Borkowski, T. (2000). Perceptions of the benefits and costs associated with condom use and unprotected sex among late adolescent college students. Journal of Adolescence, 23 (4), 377-391.

Rojanapithayakorn, W., & Hanenberg, R. (1996). The 100% condom program in Thailand. AIDS, 10, 1-7.

Thompson, S. C., Kent, D. R., Thomas, C., & Vrungos, S. (1999). Real and illusory control over exposure to HIV in college students and gay men. Journal of Applied Social Psychology, 29, 1128-1150.

The World Bank, Thailand Office (2000). Social Monitor Thailand. Bangkok: The World Bank.

HIV/AIDS in the U.S. Affiliated Pacific Island Jurisdictions

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This paper will provide a brief overview of HIV/AIDS in the U.S. affiliated Pacific Island Jurisdictions (PIJs) which are comprised of three U.S. territories (American Samoa, the Commonwealth of the Northern Mariana Islands [CNMI] and Guam) and three U.S. freely associated states (the Federated States of Micronesia [FSM], the Republic of the Marshall Islands (RMI), and the Republic of Palau). Contemporary histories of the Pacific Island Jurisdictions are complex, with legacies of colonization by Spain, Germany, Japan, as well as the U.S. The current U.S. involvement in the region is equally complicated; issues of self determination, land rights, federal dependency, U.S. military presence, nuclear weapons testing and related consequences, immigration policies, and labor conditions continue to dominate this relationship.

The year 2001 saw these island states and territories presented with their first indigenous HIV/AIDS cases, however the low numbers of HIV reported cases very likely underestimate HIV cases in these jurisdictions and the burden of care that HIV services pose on the jurisdictions. There still exists a denial in these jurisdictions that HIV/AIDS is in the community and a denial of the possibility that one is at risk (Pacific Islander Jurisdiction AIDS Action Group, 2003). People may test HIV positive off island but later return home in the late stages of disease. This is especially true for Pacific Islanders, where the cultural and linguistic, as well as familial ties, bring many People Living With HIV/AIDS (PLWHA) home when they become sick and require care (Pacific AIDS Education & Training Report 2000). The main barriers for PLWHAs in the Pacific Island Jurisdictions are the lack of a continuum of HIV care services in each jurisdiction and the lack of coordinated care services in the region. PLWHA may not be accessing services because, in most jurisdictions, there are no services to access. The lack of coordinated HIV care services throughout the region has repeatedly been reported as a barrier to care throughout the region. In the sections that follow I will present information that includes an overview of HIV, HIV Prevention and Care Services and finally some successful recommendations and strategies developed and implemented by service providers from all six PIJs with assistance from the Pacific Island Jurisdictions AIDS Action Group (PIJAAG). The information is drawn from a needs assessment conducted by the University of Hawaii affiliated Pacific AIDS Education & Training Center (PAETC), a Capacity Building proposal submitted to the Health Resources & Services Administration (HRSA), and notes and minutes from the face to face meetings of the Pacific Island Jurisdictions AIDS Action Group (PIJAAG).

HIV/AIDS

Though there are only a few reported cases of HIV/AIDS, the projections of HIV in the region are high in relation to population size. For example, in American Samoa, six PLWHA, not tested in the islands, came to American Samoa with end-stage AIDS (Pacific AIDS Education and Training Center Report, 2000). However, these were not reported as AIDS cases in American Samoa and the island has "zero" "official" AIDS cases in 2000. Unfortunately, the year 2001 saw all of the Pacific Island Jurisdictions presented with their first indigenous HIV infections. Small numbers of HIV/AIDS cases in island locations that lack the infrastructure to provide the proper care and support can quickly drain the available resources because of the complex medical and psychosocial needs of many PLWHA .

HIV/AIDS cases in these Pacific Island jurisdictions are primarily in Pacific Islander and Asian populations. AIDS case data from 1999 in Guam indicated that 72% of the cases were Pacific Islander or Asian; this population also accounted for 60% of HIV cases that year. In 2000, Guam's seven new cases included five Chamorro/Guamanian and two FSM citizens. CNMI's cumulative HIVAIDS cases through 2000 indicated that 95% of PLWHA were Pacific Islanders or Asians. Previously, HIV has not been a high priority for local health care providers because there were so few cases and because the medical systems were already overloaded by other, more common diseases such as diabetes, hypertension, coronary heart disease, and TB. HIV projections may be a more accurate way to describe the potential burden of care each jurisdiction will face.

The subpopulations at highest risk for HIV/AIDS varies by jurisdiction. In Guam, for example, Men having Sex with Men (MSM) continue to be the group at highest risk for HIV/AIDS, comprising 70% of HIV cases and 63% of AIDS cases in 1999. Injecting drug users and heterosexual men, and heterosexual women each accounted for 10% of new HIV cases (Guam Title II application). Historically, MSM have been the highest risk group in CNMI, however, the epidemiology has been changing to include women, teenagers, and newborn babies. Cumulatively, heterosexual men comprise 29% and heterosexual women comprise 29% of the HIV cases in CNMI (CNMI Title II application). Most of FSM's HIV/AIDS cases are among the male population (FSM Title II application).

HIV/AIDS SERVICES IN THE PIJs

A detailed investigation is needed to understand the full scope of the situation in the region. While all jurisdictions are providing HIV prevention interventions to their local populations, there is much variation in the implementation of those interventions. For example, FSM is providing HIV antibody testing (on the island of Chuuk), but doesn't have the current capacity to provide pre- and post- test counseling, a critical component of all HIV prevention strategies.

Also, testing in FSM is not available in every state and is inaccessible to many people because of the time, cost, and logistics of inter-island travel. Testing itself has been an issue, as lab specimens need to be sent off island to Hawai'i or Australia for actual laboratory testing; FSM and Palau have experienced problems with the only air carrier for the region, because it refuses to transport "infectious agents", even if the specimens are properly packaged. Even when successfully sent, the time necessary for test results to be returned can be lengthy; for example, in American Samoa, there are only two flights a week (Mondays and Fridays) and it may be 4-6 weeks before results are provided. In at least one instance, results took 2 months (PIJAAG April 2001 meeting). Currently, only Guam and FSM (Chuuk) have on-island lab facilities to conduct ELISA tests (the test used for initial screening of HIV). However, all Western Blot confirmatory tests must be sent to Hawai'i or Australia. Safe blood supply is also an issue for some of the jurisdictions, e.g., FSM and American Samoa currently do not screen donated blood (PAETC 2000 Report and PIJAAG February 2001 meeting), due to the lack of equipment and trained staff.

HIV care services fare much worse, with only Guam currently offering HIV-specific primary care services to PLWHA. Only Guam is able to provide CD4 counts and viral load testing which are the main tools for disease monitoring and only Guam has funds for drug therapies. However, Guam is limited in its resources and cannot offer early intervention or case management services. With this gap, Guam is NOT able to provide client-centered services to link individuals with primary health care, psycho-social and other services in a timely manner; provide on-going assessment of the client's needs, or develop a service plan. Guam's health department does work closely with the only AIDS service organization in the region, Coral Life Foundation, to provide some limited HIV care services (through foundation money) and HIV prevention, but the resources are minimal.

CNMI has some of the infrastructure to provide primary health services to PLWHA, though not specifically HIV primary care. There are some coordination plans with other federal services as well as linkages with prevention and substance use programs. Recently, the HIV/STD Program has been given a government building that in the future will be a center for PLWHA support activities.

The Republic of Palau is in the early stages of development, with no specific HIV care services currently in place. With 2 new cases in 2000 and 2001, Palau is facing a difficult situation because of the lack of HIV care service infrastructure. Medication has been provided for prevention of prenatal transmission for an HIV positive pregnant woman; however, the treatment was initiated without baseline CD4 counts and viral load testing, which are currently unavailable in Palau. Blood specimens, as previously mentioned, are not accepted by the only airline carrier in the region and medication for this woman had to be borrowed from another jurisdiction. Provision for future treatment of PLWHA in Palau is still not clear (Palau Title II application). American Samoa, RMI and FSM currently do not have HIV care services but are in the process of developing them. Both RMI and FSM do not have funds for medication (and are ineligible for Medicaid programs). Currently in FSM, the only treatments available to PLWHA are antibiotics and intravenous fluids (PIJAAG April meeting, FSM Title II application).

FUNDING FOR HIV PREVENTION AND CARE SERVICES

In 2001, all jurisdictions began receiving HRSA Title II Funds at the baseline amount ($50,000) for HIV care services, these monies are specifically designated to serve PLWHAs and are based on a formula. Additionally, Guam receives some AIDS Drug Assistance Program (ADAP) funds. Each jurisdiction also receives Center for Disease Control (CDC) funds for HIV prevention activities; 5 of the 6 also receive Division of Adolescent School Health (DASH) funds from CDC. DASH funds the Youth Risk Behavior Survey which measures priority health-risk behaviors among youth, including HIV/STDs.

Coral Life Foundation, a community based organization in Hagatna, Guam and the only community-based organization (CBO) funded to do HIV/AIDS work in the PIJs, has received funding from the Guam Department of Public Health, CDC, and private foundations like the Gill Foundation and Mac Cosmetics. Unfortunately, after a number of setbacks, CLF has had to limit operations in recent months.

Each jurisdiction will continue to develop its HIV care services through their newly awarded Title II funds. However, as newly funded jurisdictions, they will need on-going assistance to ensure each jurisdiction is able to provide a continuum of HIV care services appropriate to their area. At their base funding of $50,000 per year, this is hardly enough to support a continuum of HIV care services.

RECOMMENDATIONS

The Guam Conference Report from the University of Hawai'i from its January 2001 conference for health care professionals in the Pacific Island region, identified five areas of need for the management of HIV in the jurisdictions:

1. Communication among the jurisdictions needs to be improved, including the sharing of information about migrating PLWHA throughout the region. The group suggested a tracking mechanism, but realized the complexity of coordination and protection of client confidentiality. Communication between the regions also would help peer-to-peer support.
2. Communication and support within each jurisdiction is needed to coordinate HIV care services.
3. The jurisdictions need to have access to information from outside the region.
4. Training for health care providers and the community-at-large on the continuum of HIV related issues and community mobilization strategies are needed.
5. Funding for programs, training, and medications is needed (University of Hawai'i Guam Conference Report).

The findings from this report are similar to those from an assessment by the San Francisco-based Asian Pacific Islander American Health Forum who proposed a project in June 2001 to the Health Resources & Services Administration (HRSA). This project would provide a unique regional approach that can more effectively and efficiently address the lack of HIV care services in the jurisdictions. The project done in collaboration with the Pacific Island Jurisdictions AIDS Action Group (PIJAAG) proposes to build the HIV care service delivery capacity of the region through overall regional activities coordination, regional capacity-building assistance, as well as one-on-one capacity-building with each of the jurisdictions. The project will 1) increase coordination and collaboration between the jurisdictions, 2) develop and support HIV training and technical

assistance in the region, and 3) work with each jurisdiction to develop capacity for baseline standard of HIV care services. Objectives include yearly training to increase capacity to serve HIV clients, standardized policies and procedures for the region to ensure client confidentiality and rights, enhancement of each jurisdiction's internal infrastructure to provide services, and the development of a shared medical records system between the jurisdictions. Sharing resources in the region will be critical in ensuring all PLWHA will have access to HIV primary care services, early intervention, and case management. This proposal, ambitious as it is, was submitted to HRSA in June 2001 and while it made an acceptable grade as of February 2003, has yet to be funded.

PIJAAG, through its successful advocacy efforts, has seen CDC increase prevention funding to the PIJs by $600,000 and create HIV prevention planning guidance that is sensitive to the resources and current infrastructure of each PIJ. PIJAAG also will convene their first regional HIV/AIDS conference on Palau in Spring, 2003. Advocacy with HRSA also has shown some success. Guam's HRSA-funded Title III Planning Grant for PLWHAs to Access Primary Care resulted in the creation of the Guam System of Care Services (SOCS) For People Living With HIV/AIDS (PLWHAS). SOCS recently held a conference in February 2003 which resulted in a Mission Statement and 13 PLWHAS stepping forward to advocate and raise awareness of their needs.

INCLOSING

Often neglected, the PIJs welcome these successes in building capacity and infrastructure as well as improvements to funding, while at the same time embracing the challenges that HIV has brought to their island communities. The collaborative efforts of their service providers (done in conjunction with PIJAAG, nationally funded capacity builders like APIAHF and Federal supporters sensitive to their needs) is just beginning. The impact that HIV will have in the PIJs remains to be seen.

HIV Risk Behaviors among Asian and Pacific Islander Male-to-Female Transgenders

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Over the past two decades of the HIV/AIDS epidemic in the United States, little attention has been paid to Asian and Pacific Islander (API) populations, particularly to male-to-female (MTF) transgenders. Recent studies revealed that MTF transgenders are at high risk for HIV infection and transmission (Clements-Nolle, Marx, Guzman, & Katz, 2001; Nemoto, Operario, Oggins, Keatley, & Soma, 2003). HIV/AIDS prevention and care for MTF transgenders must be addressed in social and cultural contexts which include issues of human rights, discrimination, prejudice, social stigma, violence against transgenders, and access to health care and other services specific to transgenders (c.f., Lombardi, 2001). Transgender is a new word for many API cultures, which have used their own terms to describe biologically born men who live as women (e.g., Mahu in Hawaii and Hijra in India) and the definitions and roles of these MTF persons vary depending on their culture and society.

A large number of API gay and bisexual men reside in San Francisco where over a third of the general population are APIs. Consequently, a high number of AIDS cases has been reported among APIs (809 cases and 13% of the U.S. API total; San Francisco Department of Public Health [SFDPH], 2001). The rate of increase in API AIDS cases from 1992 to 2002 in the City was 113% among APIs, following Native Americans (162%) and African Americans (122%) (SFDPH, 2002). API AIDS cases may be under-reported because many API immigrants living with HIV do not use mainstream health services in the U.S. (Gock & Ja, 1995), and instead seek support and medical care in their home countries.

HIV seroprevalence and seroincidence rates among API MTF transgenders parallel the rapid increase of API AIDS cases in San Francisco. Recent studies reported high HIV seroprevalence rates among MTF transgenders in the City: 13% among APIs, 47% African American, 23% Latina, and 17% Caucasian (Clements-Nolle et al., 2001). Another study reported similar HIV rates: 13% among APIs, 43% African American, and 24% Latina (Nemoto et al., 2003). Although the seroprevalence rates among API MTF transgenders were lower than other racial groups, API MTF transgenders reported engaging in high-risk behaviors, including multiple sex partners, unprotected anal sex, sex work, and injection drug use (Clements-Nolle et al., 2001; Nemoto et al., 2003).

Multiple factors contribute to HIV infection risks among MTF transgenders. Sex work is one of the main risk factors unique to MTF transgender and they are more likely to engage in commercial sex for money or drugs than heterosexual females and homosexual/bisexual males (Nemoto, Luke, Mamo, Ching, & Patria, 1999) because of economic necessity for survival, gender discrimination in the regular job market (Elifson et al., 1993; Clements-Nolle, Wilkinson, Kitano, & Marx, 1999), and financing for gender confirmation surgery and other medical treatment (Bockting, 1998). It is also common for customers to offer more money to transgender sex workers for not using a condom (Asian AIDS Project, 1995; Boles & Elifson, 1994; Gattari, Spizzichino, Valenzi, & Zaccarelli, 1992).

Use of alcohol and illicit drugs further elevates the risk for HIV infection and transmission. Over one-third of 392 MTF transgenders in one study had a history of injection drug use (IDU), and of these IDUs, nearly half reported recent use of someone else's syringes (Clements-Nolle et al., 2001). Nemoto, Luke et al. (1999) found that nearly one third of the MTF transgender participants used drugs by injection, and that MTF transgenders had more steady sex partners who had injected drugs than did heterosexual females and homosexual/bisexual males. Transgender commercial sex workers tended to use methamphetamine and crack in order to work longer hours or to relieve the stress from sex work (Asian AIDS Project, 1995).

Cultural barriers to heath care and social services further elevate vulnerability for HIV infection among API MTF transgenders. Service providers often lack transgender and cultural sensitivity as well as communication skills in Asian languages. API transgenders tend to distrust Western establishments and systems, particularly undocumented immigrants who avoid contact with public services

due to fear of deportation (Nemoto, Luke et al., 1999). Furthermore, cultural ideas among APIs, such as fatalistic ideas (e.g., karma and reincarnation), can further delay seeking access to health care systems (Chavez, Hubbell, Mishra, & Valdez, 1997; Mayo, Ureda, & Parker, 2001).

This study aimed to describe HIV related risk behaviors among API MTF transgenders, particularly focusing on their methamphetamine use and sex work. The study results will be utilized to plan future HIV prevention intervention programs, targeting this high risk but historically neglected population.

METHODS

Procedures

API MTF transgenders (18 years or older) (N=75) were recruited at community venues (e.g., bars and clubs) in San Francisco and through referrals from study participants and transgender staff at a local API AIDS service organizations between October 1998 and March 1999. The refusal rate was about 20%. Informed consent was verbally obtained from the participants using a study information sheet. A total of 40 individual interviews were conducted by either a trained Vietnamese female interviewer or an Asian male project director using a structured survey questionnaire that included Likert-scales and anchored questions. The other 35 participants choose to self-administer and completed the questionnaire privately. There were no significant demographic differences between participants who were interviewed and those who self-administered the questionnaire. Participants took about one hour to complete the interview or self-administer the questionnaire. Questionnaires were printed only in English. We expected the majority of the MTF transgender sample to be Filipina, who typically are fluent in English. Each participant was provided with cash reimbursement and a resource guide to local community-based organizations that offer culturally and transgender sensitive HIV prevention programs for API transgenders.

Participants

The average age was 32 years (20% in 21-25 years; 52% in 26-35 years; 28% in 36-55 years). About half of the participants (49%) were Filipina (11% Laotian; 8% Vietnamese; 7% Hawaiian; 4% Thai; 8 % Other; 13% Multiple ethnicity). The majority of participants (71%) was born outside of the U.S. and had lived in the U.S. more than 10 years (83%). More than half of the participants (56%) had completed college or had some college education including trade or technical school. Fifty-five percent of the participants reported commercial sex work as their main source of income in the past six months. During the past six months, 45% earned income less than $1,000 a month (25% earned between $1,000 to $3,999; 27% earned $4,000 or more a month).

Measures

The structured survey questionnaire consisted of questions about demographic background, drug use, hormone use, sexual behaviors with private partners and commercial sex customers, and general health status, modified from our previous study (Nemoto, Luke et al., 1999).

RESULTS

Sexual Behaviors in Sex Work

The majority of the participants (84%) reported a history of exchanging sex for money, and 22% reported a history of exchanging sex for drugs. Eighty-three percent of the participants reported having exchanged sex for money during the past six months (on average, working 6.3 hours per day and 4.2 days per week). The median for working as a sex worker was 4.5 years (47% in 0 to 3 years, 24% in 4 to 9 years, and 30% 10 years and over). The HIV infection rate was 6.1% among the participants who had been tested and reported the most recent results (n = 66). Five reported being never tested for HIV and four skipped the question. Most API MTF transgenders who had exchanged sex for money in the past six months reported having oral sex (95%) and anal sex (76%) with their customers. Four out of five (80%) post-operative transgenders reported having vaginal sex with customers. As would be expected, full-time sex workers (whose primary income came from sex work) reported more customers than casual sex workers ($p<.01$), and full-time sex workers were more likely to engage in anal sex with customers than casual sex workers ($p<.01$) during the past six months (see Table). The average number of customers in the past six months was 40 (Range = 0 - 600 customers); however, nearly 30% of the participants reported having more than 91 customers (17% None; 30% 1-30; 20% 31-60, 5% 61-90 customers). High rates of unprotected sex (not always using a condom) with customers in the past six months were reported for oral sex (34%) and anal sex (25%). Furthermore, foreign-born participants had significantly more customers in the past six months than U.S.- born, $c\,2 = (3, N = 60) = 9.56$, $p<.05$.

Sexual Behaviors with Private Partners

Study participants reported having had multiple private sex partners who did not pay for sex and with whom the participants were in a relationship. Participants reported a number of private partners in the past year (8% None; 50% 1-5; 15% 6-15; 27% 16 or more partners). About half of the participants (44%) reported inconsistent condom use with private partners in the past six months. The participants who had both private partners and customers in the past six months reported more frequent condom use for oral sex with customers ($M=4.5$) than with private partners ($M= 3.7$), $t\,(35) = 3.0$, $p<.01$ (Scale: 1=Never to 5=Always). There was no significant difference in the frequency of condom use for anal sex between types of sex partners. Nearly one-quarter (24%) did not know their private partner's HIV status. The reasons included never asking (39%), not wanting to know (23%), and partner refusing to answer (15%).

Substance Use

Substance use was common among the study participants; 32% had used marijuana, 45% used alcohol, 17% smoked "shabu" (methamphetamine), and 13% injected amphetamine in the past six months. A significantly higher proportion of sex workers had used marijuana in the past six months compared to casual sex workers (see Table). One quarter of the participants (n= 19) reported having injected drugs in their lifetime. Almost half (45%) of the injection drug users (IDUs) had shared needles, and 56% of these IDUs had shared

with sex partners. A significantly larger proportion of the current methamphetamine users had ever injected drugs ($p<.01$) and used marijuana in the past 6 months ($p<.01$) compared with non-current methamphetamine users (see Table 1). During the past six months, there were no significant differences between current and non-current methamphetamine users in engagement in oral or anal sex with private partners, and in oral sex with customers. Also, there was no significant difference between these two groups in the number of customers in the past 6 months. However, current methamphetamine users were more likely than non-users to have engaged in anal sex with customers during the past six months. A higher proportion of the participants born in the U.S. (48%) had injected drugs compared with the immigrant participants (17%), $c\ 2\ (1, N = 75) = 7.66, p<.01$.

Sex Under the Influence of Alcohol or Drugs

Sex with customers under the influence of alcohol or drugs was very common among the participants. In the past six months, 68% and 78% had used alcohol and drugs with customers before having sex, respectively. These participants had used amphetamines (89%), marijuana (59%), cocaine (39%), ecstasy (39%), crack (22%), hallucinogens (11%), and heroin (6%) with customers. The participants (28%) had also injected drugs with customers, and 40% of those who injected drugs with customers had shared needles with customers. Among the participants who had private partners in the past 6 months, 15% and 17% had sex with them under the influence of alcohol and drugs, respectively. Current methamphetamine users ($M = 2.7$: Scale: 1= never to 5=always) had more often engaged in sex under the influence of drugs with private partners than non-current methamphetamine users ($M = 1.03$), $t\ (44) = 6.46, p<.01$. Similarly, sex workers ($M = 1.8$) had more often engaged in sex with private partners under the influence of drugs than casual sex workers ($M = 1.1$), $t\ (42) = 2.43, p<.05$.

DISCUSSION

Although the self-reported HIV infection rate (6.1 %) among the study participants was lower than those in other studies among API MTF transgenders [13% in Clement-Nolle et al. (2001); 13% in Nemoto et al., (2003)], the study revealed that API MTF transgenders had frequently engaged in substance abuse, unprotected sex with customers and private partners, and sex under the influence of drugs and alcohol. These risk behaviors were found more often among full-time sex workers than casual sex workers and among current methamphetamine users than non-methamphetamine users.

Many MTF transgenders engage in sex work because of the sparse job opportunities and discrimination against transgenders in the job market (Clement-Nolle et al., 1999; Elifson et al., 1993), lower socioeconomic status (Nemoto, Luke et al., 1999), drug dependence, psychological corroboration of female gender (Nemoto et al., 2003; Clements-Nolle et al., 1999), and earning extra income for gender confirmation surgery (Bockting, 1998), or a combination of these factors. MTF transgenders in this study reported having a large number of customers and using alcohol and drugs with customers. One quarter of the participants had used condoms inconsistently with customers for anal sex during the past six months. Because the majority of the study participants were pre-operative transgenders, they engaged mainly in oral and anal sex with customers, not vaginal sex. The study revealed that full-time sex workers and methamphetamine users were more likely to engage in anal sex with customers than casual sex workers and non-methamphetamine users. It is apparent that the combination of sex work and drug use, particularly methamphetamine use, elevates their vulnerability to HIV/STD infection and increases the possibility of transferring these diseases to a large number of customers.

Participants' sexual behaviors with private partners also increased risk for contracting and transmitting HIV/STDs. The findings further confirm the previous studies (Nemoto et al., 2003; Clements-Nolle et al., 1999). Participants had multiple private partners in the past year (e.g., 30% had more than 16 private partners). One quarter of the participants did not know their private partners' HIV status, and more than half had never asked or did not want to know about their partners' HIV status. In many Asian countries, open dialogue about sexual behavior is considered taboo, especially when it is initiated by females, and acknowledging personal risk for HIV/AIDS leads to loss of face for the individual (Ja & Aoki, 1993). These cultural norms may strongly influence API MTF transgenders' motivation to ask about a partner's HIV status and negotiate condom use. Prevention intervention programs must target high-risk groups such as methamphetamine addicted MTF transgender sex workers who have a large number of both private and commercial sex partners. They should be provided with services to enhance communication and negotiation skills for practicing safe sex at their work and private environments as well as with referrals to drug treatment programs.

Study participants reported using marijuana, alcohol, and methamphetamine (13% injected methamphetamine) more often than other drugs. Methamphetamine users in the study were mostly Filipino (82% who smoked "shabu"; 67% who injected methamphetamine in the past six months). Our previous studies indicated that compared to Chinese and Vietnamese, Filipinos used methamphetamine more frequently (Nemoto, Aoki et al., 1999), and Filipino methamphetamine users had used the drug before or during sex and used condoms infrequently (Nemoto, Operario, & Soma, 2002). Therefore, future HIV prevention programs may need to target Filipina MTF transgenders who inhale and/or inject methamphetamine. Study participants had more often engaged in sex under the influence of drugs (mostly methamphetamine) or alcohol with customers than with private partners. MTF transgender sex workers use methamphetamine to cope with job and financial stress (Asian AIDS Project, 1995). Our study findings strongly suggest providing outreach and substance abuse treatment services to this population.

Nearly half of this sample was Filipino. Within APIs, patterns of drug use and HIV risk behaviors differ among ethnic groups in the population (Nemoto et al., 1996; Nemoto, Aoki et al., 1999). Also, participants were recruited in San Francisco where attitudes toward gender and ethnic diversity are relatively liberal and a number of MTF transgender specific HIV/AIDS prevention programs are available. Therefore, caution should be paid in generalizing the study's findings.

Table 1. Sexual and Drug Use Behaviors by Sex Workers and Casual Sex Workers, and Current and Non-Current Methamphetamine Users

	Full-time Sex Workers (n = 40)	Casual Sex Workers (n = 33)	χ2
Sexual Behaviors (past 6 months)	% (n)	% (n)	
Private partners			
Oral sex	(n = 17)	(n = 26)	
YES	82 (14)	89 (23)	.32
Anal sex	(n = 17)	(n = 26)	
YES	82 (14)	54 (14)	3.68
Customers			
No. of customers	(n = 38)	(n = 21)	13.85**
0	5 (2)	33 (7)	
1 - 19	11 (4)	29 (6)	
20 - 89	45 (17)	19 (4)	
90 and over	40 (15)	19 (4)	
Oral sex	(n = 39)	(n = 25)	
YES	97 (38)	92 (23)	1.01
Anal sex (n = 37)	(n = 25)		
YES	92 (34)	56 (14)	10.99**
Drug Use Behaviors			
Ever injected drug: YES 30 (12)	21 (7)	.73	
Marijuana use (past 6 months): YES45 (18)	18 (6)	5.89*	

	Current Methamphetamine Users (n = 19)	Non-Current Methamphetamine Users (n = 56)	χ2
Sexual Behaviors (past 6 months)	% (n)	% (n)	
Private Partners			
Oral sex	(n = 10)	(n = 35)	
YES	80 (8)	89 (31)	.50
Anal sex	(n = 10)	(n = 35)	
YES	90 (9)	57 (20)	3.67
Customers			
Oral sex	(n = 18)	(n = 47)	
YES	94 (17)	96 (45)	.05
Anal sex	(n = 17)	(n = 46)	
YES	94 (16)	70 (32)	4.13*
Drug Use Behaviors			
Ever injected drug: YES 58 (11) 14 (8)	14.26**		
Marijuana use (past 6 months): YES	58 (11)	23 (13)	7.84**

Note: *p < 0.05, **p ≤ .01

Recommendations

Future research and HIV prevention strategies should take into consideration the broader social and cultural contexts among API MTF transgenders, particularly targeting Filipina methamphetamine users. Culturally competent HIV prevention programs are necessary for API MTF transgenders to practice safe sex with customers as well as private partners and to avoid the sexual encounters or situations under the influence of alcohol or drugs. Issues, such as cultural norms and HIV risk behaviors, coping strategies for stress, immigrants' legal status, and job opportunities other than sex work, need to be addressed in HIV and substance abuse prevention programs for API MTF transgenders in the U.S. It is necessary to provide transgender sensitivity training to social and health service providers, as well as to increase their cultural competency toward API populations. Findings form this study warrant greater efforts to increase access to drug treatment programs, condom use negotiation skills, and culturally competent and transgender specific services for this historically neglected group.

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REFERENCES

Asian AIDS Project (1995). Needs assessment among API transgenders. San Francisco: Author.

Boles, J., & Elifson, K. W. (1994). The social organization of transvestite prostitution and AIDS. Social Science and Medicine, 39, 85-93.

Bockting, W. O., Robinson, B. E., & Rosser, B. R. S. (1998). Transgender HIV prevention: A qualitative needs assessment. AIDS Care, 10, 505-526.

Chavez, L. R. Hubbell, F. A., Mishra, S. I., & Valdez, R. B. (1997). The influence of fatalism on self-reported use of Papanicolaou smears. American Journal of Preventive Medicine, 13 (6), 418-424.

Clements-Nolle, K., Wilkinson, W., Kitano, K., & Marx, R. (1999). HIV prevention and health services needs of the transgender community in San Francisco. The International Journal of Transgenderism, 3(1&2).

Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. American Journal of Public Health, 91(6), 915-921.

Elifson, K. W., Boles, J., Posey, E., Sweat, M., Darrow, W., & Elsea, W. (1993). Male transvestite prostitutes and HIV risk. American Journal of Public Health, 83(2), 260-262.

Gattari, P., Spizzichino, L., Valenzi, C., & Zaccarelli, M. (1992). Behavioral patterns and HIV infection among drug using transvestites

practicing prostitution in Rome. AIDS Care, 4, 83-87.
Gock, T. S., & Ja, D. Y. (1995). Providing substance abuse treatment to Asian Pacific clients. In O. Amulerli-Marshall (Ed.), Substance abuse treatment in the era of AIDS: Vol 2. (pp. 223-249). Rockville, MD: Center for Substance Abuse Treatment.
Ja, D. Y., & Aoki, B. (1993). Substance abuse treatment: Cultural barriers in the Asian-American community. Journal of Psychoactive Drugs, 25, 61-71
Lombardi, E. (2001). Enhancing transgender health care. American Journal of Public Health, 91(6), 869-872.
Mayo, R. M., Ureda, J. R., & Parker, V. G. (2001). Importance of fatalism in understanding mammography screening in rural elderly women. Journal of Women Aging, 13 (1), 57-72.
Nemoto, T., Aoki, B., Huang, K., Nguyen, H., Aquino, J., Wong, W., & Muriera, A. (1996). Drug use and HIV risk behaviors among Asians. Paper presented at the 8th National AIDS Update Conference in SF.
Nemoto, T., Aoki, B, Huang, K., Morris, A., Nguyen, H., & Wong, W. (1999). Drug use behaviors among Asian drug users in San Francisco. Addictive Behaviors, 24(6), 823-838.
Nemoto, T., Luke, D., Mamo, L., Ching, A., & Patria, J. (1999). HIV risk behaviors among male-to-female transgenders in comparison with homosexual or bisexual females. AIDS Care, 11, 297-312.
Nemoto, T., Operario, D., Oggins, J., Keatley, J., & Soma, T. (2003). Ethnic differences in health status and HIV risk behaviors among male-to-female transgenders. Unpublished manuscript, University of California at San Francisco.
Nemoto, T., Operario, D., & Soma, T. (2002). Risk behaviors of Filipino methamphetamine users in San Francisco: Implications for prevention and treatment of drug use and HIV. Public Health Reports, 117, 15-29.
San Francisco Department of Public Health. (2000). HIV/AIDS Epidemiology Annual Report. Available at: www.dph.sf.ca.us
San Francisco Department of Public Health. (2001). HIV/AIDS Epidemiology Annual Report. Available at: www.dph.sf.ca.us
San Francisco Department of Public Health. (2002). Quarterly AIDS Surveillance Report. Available at: www.dph.sf.ca.us/PHP/AIDSSurvUnit.htm

Adherence to Antiretroviral Medication Among Undocumented Asians Living with HIV Disease in New York City

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As a result of continued improvements in HIV therapeutic regimens, longer survival and improved quality of life are within reach for persons living with HIV/AIDS, however, adherence to highly active antiretroviral treatment (HAART) and consistent utilization of primary care services are critical to achieving these benefits (Paterson et al., 2000). Even brief episodes of missed HIV medication doses can permanently undermine treatment, leading to reduced efficacy of and increased resistance to medications. Numerous studies to date have found that adherence to antiretroviral therapy improves virologic outcome (Cunningham et al., 1998) and health-related quality of life (Andersen et al., 2000; Cunningham et al., 1995) However, not all persons living with HIV/AIDS are able to take advantage of these medical treatment improvements due to arduous regimens that can interfere with everyday life style (Gifford, et al., 2000) and competing subsistence needs such as housing, transportation, and financial constraints (Cunningham et al., 1999). Asian and Pacific Islanders (API) and other ethnic minorities are particularly at risk for poor access and nonadherence to HIV treatment (Andersen, et al., 2000). The goal of the current qualitative study was to understand factors that affect adherence to antiretroviral therapy among HIV-seropositive API undocumented noncitizens (UNWHAs) living in New York City who either entered the US illegally or entered the country legally but violated their immigration status (Loue, 1992).

Method

Participants and Procedures

We conducted individual 2- to 3-hour semi-structured interviews with a convenience sample of 37 HIV-seropositive APIs referred by community-based organizations, and hospitals, along with acquaintances of persons who had already completed the interview. Findings from this study were based on interviews with a subset of 16 UNWHAs. Written informed consent was obtained prior to each interview, and the interviewer also explained the purpose of audio-taping the interview as well as the option of discontinuing the recording upon the participant's discretion. All participants were reimbursed for their involvement in the study. Interviews were conducted at community-based organizations, the principal researcher's office, or the participant's place of residence. Interviews were conducted in English, Cantonese, Mandarin, Korean, Bengali, or Hindi. Each interview was transcribed and translated into English, if necessary.

Sixteen (n = 16) HIV-seropositive Asian UNWHAs, (mean age = 38 years old, SD = 7.9) who have lived in the US for a mean of 7 yrs (SD = 4, Range = 2 - 15 yrs), were interviewed. UNWHAs were Chinese (63%), Japanese (13%), Indian (6%), Bengali (6%), Burmese (6%), and Mixed (6%). The mean years of education completed was 10 yrs (SD = 6.4). Nineteen percent (n = 3) of UNWHAs self-identified as homosexual and 81% self-identified (n = 13) as heterosexual. Thirty-eight percent (n = 6) were single, 56% were married (n = 9), and 6% (n = 1) were divorced or widowed.

Measures

Interview domains were identified through a review of the literature and focus groups with API UNWHAs. Open ended questions pertinent to HIV treatment adherence included: (1) are you currently taking HIV medications? If so, what has been your general experience? and (2) has the development of new medical treatments for HIV changed your outlook on life? If so, how?

Data Analysis

Qualitative thematic analysis was used to systematically identify and make sense of patterns that emerged from the interviews (Boyatzis, 1988). The specific steps of analysis were: (1) sampling by immigration status (documented vs. undocumented); (2) reducing narratives by creating an outline or synopsis of each interview; and (3) identifying themes within samples by comparing all the summaries from each sub-sample.

Principles that have been used in feminist participatory research and qualitative thematic analysis informed our approach to data analysis (Abrums, 2000). A feminist participatory research approach underscores the importance of recognizing the power differential between the researcher and participants, and how it influences the analysis and interpretation of data (Thompson, 1991). We established an advisory committee of 14 community leaders to review the content, presentation, and implications of findings. We also endeavored to anticipate use of the data such as ways that it could be used to support anti-immigrant policies.

Results

Medication Side Effects and Stigma

The UNWHAs in our sample were not fully adherent with their medication regimen and attributed this to concerns about visible side effects (e.g., skin blemishes or significant weight loss) and the ensuing risk of being identified as HIV-positive. UNWHAs regarded any overt sign of illness, regardless of etiology, as an invitation to public scrutiny and possible treatment with contempt and ostracism. These fears are evident in a 45-year old Chinese man's description of the lumps on his skin.

"The thing that I'm afraid of is the side effects of the medication on my skin. I'm afraid of letting people see this. It's not that people would be like this, but I'm just afraid that my body would suddenly be changed, but that can't be helped because of the side effects of the medication. I'm not that afraid of death, but you're afraid of the lumps on your skin. When people see this they would be resentful, so I hide at home and avoid seeing anyone."

UNWHAs also were concerned that disruptions in daily living caused by medication regimens would raise public suspicion about one's HIV status. These regimens can require complex and multiple daily dosages (e.g., 10-20 pills daily), varied food and drink schedules (e.g., meals before or after medication), and refrigeration or other special needs to store medication. UNWHAs who are employed in settings such as restaurants face many challenges with these regimens because their work shifts may not permit discrete and timely taking of medication. Therefore, the importance of taking medication has to be weighed against the necessity of securing and maintaining employment. Employment may mean more than just sustenance, and wages may be used to meet financial obligations abroad and/or repaying exorbitant debts to "snakeheads" – the smugglers who arrange for their transport to the US. They cautiously averted situations that raised suspicions about their illness among employers and co-workers. A 27-yo Chinese man from Fujian recounted repeatedly changing jobs in fear that taking his medications at work would lead others to suspect his HIV-status.

"At first, when I was working some people saw that [medicine], and asked why did you take so many medicine and they get scared. At that time I was working only 3 days. I just left. Taking medicine is supposed to be a secret. If you working in your home, no problem, you can do whatever you want. But you are working in a restaurant, sometimes when you take medicine you must hide in bathroom so people won't see it."

Treatment Without a Cure

Many UNWHAs regard taking medicine for an incurable disease as futile and appeared largely unaffected by recent public perceptions of HIV/AIDS as a largely chronic and manageable illness with early treatment. Maintaining a complicated antiretroviral regimen to prolong life seemed pointless for many UNWHAs who hoped to secure a future for their families in the US – a hope now thwarted by their illness. A frustrated 28-yo Chinese man from Fujian, explained his experience of taking medicine with "no goal" in sight.

"I am so tired looking at these medicines, but I need to take them for long period of time. Its OK if I have a goal, but there is no goal in taking all the medicine. For example, if I take it for a year then I'll be cured. If I don't take the medicine, I will live for 5 more years, let it be that way, right? Then I live my 5 years without a care, right?"

UNWHAs' frustration and discouragement mounted as the promise of a cure appeared increasingly remote. Many UNWHAs endured their difficult regimen in hopes of living long enough for researchers to discover an HIV vaccine. They grounded their optimism on the prospects of being cured rather than on managing their HIV illness. Some initiated their antiretroviral treatment with hopes that strict adherence to their treatment regimen will cure their illness, as explained by a 27-yo Chinese man from Fujian who has been on treatment for 2 years.

"I have been taking the medicine for so long why couldn't it be cured? I know it's not easy to be cured but I've taken the medicine for 1 or 2 years already."

Medication: Reminder That Illness is a Reality

UNWHAs in this study developed a strong emotional aversion to HIV treatment because of how it has dramatically disrupted their lives. Each administration of medication reminds them of how their lives are regulated by their illness and treatment. Their desire to resume a "normal life" at the cost of compromising their health and mortality outweighed the importance of adhering to antiretroviral medications. A 54-year old Chinese man expressed his desire to resume a "normal life," albeit one that will likely be shortened should he decide to terminate treatment.

"Without this medication, maybe I'll just live 5 years. I don't want to take this medication. I just want to live like a normal person, even if it's only for 5 years. I really want to live the normal life as I had before. I go to work everyday, and go home, stuff like that. Every time I see the medicine, it reminds me of my disease, I'm tired of it."

A 37-yo Burmese man described the task of following his antiretroviral regimen as a "full-time job," which changed the meaning of everyday tasks. Preparing and eating a meal, for example, was no longer a means to nourish his body, but also a requirement for taking certain medications. Unfortunately, this routine proved to be tiring and the alternative of giving up the medication was not an option.

"I need to take so many kinds of meds. Before when I take my meds I need to prepare my food, then take the meds. Then I need to talk to myself not to throw up. And after that even if you don't throw up and feel bad, and dizzy, and stomach feeling uncomfortable, you want to lay down for awhile. Then you need to think about preparing your lunch even if you don't feel good. Then with lunch you need to take another medication right? Even though you don't want to eat, you force yourself, you must eat something. I put those meds on the table and then look at my food and I don't want to eat and I don't want to take the meds. I want to take a rest for awhile. I must do this everyday, you know, I'm fed up. Oh yes, but not taking the medication is impossible, so I don't think that much. Afraid that this body will break down. Sometimes I wish that if I could order, I want to get like 2, 3 more body parts to share my meds my troubles (laughs)."

Facilitators of Adherence

Eighty-one percent of UNWHAs in the study were enrolled in the AIDS Drug Assistance Program (ADAP), a New York State program under the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, which provides HIV-related prescription drugs to the uninsured and underinsured. Without financial limits on their access to medication, UNWHAs felt more inclined to follow their treatment regimen as explained by a 46-year old Chinese man.

"I think American government and doctors try to cure my disease without charging me any money, why don't I take the medication? Surely I will take. If they charge, I have no money, it might be a different story."

In addition to helping them enroll into ADAP, bi-lingual caseworkers from Pan-Asian AIDS organizations assist UNWHAs overcome language limitations as well as their unfamiliarity with dosing instructions and prescription refill procedures. The 46-year Chinese man introduced above describes the value of such assistance:

"Without [A&PI AIDS organization], I will [up is this in the response, or is it a typo?] give up medical care. If nobody interprets for me, how can I get medication? It's hard to find someone. Everyone works in America. When I have prescription, when I need to refill the prescription, she [caseworker] helps me get the medicine."

The availability of ADAP and social service support creates situations where medication regimens are followed out of obligation to their medical providers and caseworkers. Many feel torn between the challenges of treatment adherence and the responsibility of not squandering resources that are unavailable in their country of origin. The words of a 28-year old Chinese man from Fujian aptly described this situation:

"I really don't want to go but I think I am indebted to them so I must return, so I have to take the medicine. Every time I see the medicine I feel tired, feel dizzy. But no choice, I have to take them."

Discussion

Recent medical advances in HIV/AIDS treatment have substantially improved the life expectancy and quality of life for persons living with HIV/AIDS. However, the complex regimens associated with HAART protocols and competing immigration-related stressors make medication adherence a challenge particularly for undocumented APIs living with HIV/AIDS. This study highlights several challenges and facilitators to antiretroviral medication adherence among this vulnerable group.

First, improving adherence requires addressing illness stigma. Non-adherence serves a protective function for UNWHAs who fear public recognition of their HIV status and possible rejection if they take their medication in public or display obvious side effects. Although numerous studies have emphasized the undermining effects of illness stigma on HIV treatment and prevention particularly within communities of color, (Sankar et al., 2002; Valdiserri, 2002) few have focused on developing interventions to address this stigma.

Second, medication adherence decisions are largely informed by UNWHA's immigration-based experiences. Factors such as language barriers, the bureaucratic complexity of health and social services, illegal immigration status, precarious job circumstances, and the need to provide financial support to family in countries of origin need to be considered in developing adherence strategies for API UNWHAs. Knowledge- and efficacy-based interventions that emphasize the importance of patient understanding of medication and problem solving skills to eliminate adherence barriers are inadequate in contextualizing HIV treatment into the common experiences of Asian UNWHAs.

Third, state administered AIDS drug assistance programs coupled with bi-lingual case management and supportive services can facilitate adherence to HIV treatment among UNWHAs. The AIDS advocacy community must continue to ensure that program restrictions such as enrollment caps, and clinical eligibility criteria (e.g., specific CD4 or viral load ranges) do not affect ADAP's capacity to serve low-income, uninsured people of color.

In conclusion, the devastating impact of untreated HIV disease and the tremendous benefits that have been gained as a result of the new antiretroviral treatments necessitate a better understanding of the factors mediating adherence for specific vulnerable and understudied populations, such as Asian UNWHAs. Only with this information will we be able to develop and evaluate culturally sensitive and effective intervention models that will extend the utility of recent medical advances to APIs and, hopefully, other rapidly growing immigrant groups in the U.S.

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References

Abrums, M. (2000). "Jesus will fix it after awhile": meanings and health. Social Science and Medicine. 50, 89-105.

Andersen, R., Bozzette, S., Shapiro, M., St Clair, P., Morton, S., Crystal, S., Goldman, D., Wenger, N., Gifford, A., Leibowitz, A., Asch, S., Berry, S., Nakazono, T., Heslin, K., & Cunningham, W. (2000). Access of vulnerable groups to antiretroviral therapy among persons in care for HIV disease in the United States. HCSUS Consortium. HIV Cost and Services Utilization Study. Health Services Research, 35, 389-416.

Boyatzis, R.E. (1988). Transforming qualitative information. Thousand Oaks, CA: Sage.

Cunningham, W.E., Hays, R.D., Williams, K.W., Beck, K.C., Dixon. W.J., & Shapiro, M.F. (1995). Access to medical care and health-related quality of life for low- income persons with symptomatic human immunodeficiency virus. Medical Care, 33, 739-754.

Cunningham, W.E., Hays, R.D., Ettl, M.K., Dixon, W.J., Liu, R.C., Beck, C.K., & Shapiro, M.F. (1998). The prospective effect of access to medical care on health-related quality-of-life outcomes in patients with symptomatic HIV disease. Medical Care, 36, 295-306.

Cunningham, W.E., Andersen, R.M., Katz, M.H., Stein, M.D., Turner, B.J., Crystal, S., Zierler, S., Kuromiya, K., Morton, S.C., St Clair, P., Bozzette, S.A., & Shapiro, M.F. (1999) The impact of competing subsistence needs and barriers on access to medical care for persons with human immunodeficiency virus receiving care in the United States. Medical Care, 37,1270-1281.

Gifford, A.L., Bormann, J.E., Shively, M.J., Wright, B.C., Richman, D.D., & Bozzette, S.A. (2000). Predictors of self-reported adherence and plasma HIV concentrations in patients on multidrug antiretroviral regimens. Journal of Acquired Immune Deficiency Syndromes, 23, 386-395.

Loue, S. (1992). Access to health care and the undocumented alien. Journal of Legal Medicine.13, 271-332.

Paterson, D.L., Swindells, S., Mohr, J., Brester, M., Vergis, E.N., Squier, C., Wagener, M.M., & Singh, N. (2000). Adherence to protease inhibitor therapy and outcomes in patients with HIV infection. Annals of Internal Medicine, 133, 21-30.

Sankar, A., Luborsky, M., Schuman, P., & Roberts, G. (2002). Adherence discourse among African-American women taking HAART. AIDS Care. 14, 203-218.

Thompson. J.L. (1991). Exploring gender and culture with Khmer refugee women: Reflections on participatory feminist research. Advances in Nursing Sciences. 13, 30-48.

Valdiserri, R.O. (2002). HIV/AIDS stigma: an impediment to public health. American Journal of Public Health, 92, 341-342.

General Announcements

Mark Your Calendars: September 5-7,

Southeastern Eco Conference

Hosted by the Georgia State University Community Psychology Department, the conference will be held at Lake Logan in Ashville, NC.

For more information, please email us at GSU_Eco2003@yahoo.com

Exemplars of Community Psychology:

A 2-DVD set of interviews with 17 "founders" of our field

SCRA's Executive Committee is pleased to announce the first "screening" of this project that Jim Kelly has been working diligently on over the past 7 years. Persons attending the Biennial Conference in New Mexico will be able to view the DVDs and purchase them ($50 per set). The DVDs will also be used in a Biennial roundtable on "lineages" Saturday morning (hosted by Paul Toro, Murray Levine, and others) and perhaps other Biennial sessions.

The 2-DVD set includes three and a half hours of material. Those interviewed include: Jack Glidewell, George Fairweather, Emory Cowen, George Albee, Marie Jahoda, Steve Goldston, Bob Newbrough, Seymour Sarason, Murray Levine, Will Edgerton, Rudy Moos, Jim Kelly, Don Klein, Stan Schneider, Ira Iscoe, a "feminist panel," and others. Come to the Biennial with your checkbook (or credit card) handy and buy your very own "piece of history." All proceeds from the sale of the DVDs will go to SCRA.

111th Annual Convention of the American Psychological Association
August 7–10, 2003
Toronto, Canada

Preliminary Program Schedule
Division 27 - Society for Community Research and Action: Division of Community Psychology

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Thursday, August 7, 2003

8:00 a.m. - 8:50 a.m.
Cultural Competence II: Creating Social Change Through Research and Action (Discussion)
Lorna London, Ph.D., Irene Kim, Ph.D., Shirley Cornette, M.A., Amy Lam, M.A., Victoria Ngo, M.A., Winnie Mak, Ph.D., Sylvia Xiaohua Chen
Metro Toronto Convention Centre, Meeting Room 704

9:00 a.m.- 9:50 a.m.
Supporting a Rural Community Health Partnership From an Academic Setting (Symposium)
Peter Keller, Ph.D., J. Dennis Murray, Ph.D., Francis Craig, Ph.D., Nancy Cooledge, Ph.D.
Crowne Plaza Toronto Centrre Hotel, Niagara Room

10:00 a.m.- 10:50 a.m.
Community Response to Crisis Preparedness and Interven tion (Discussion)
Robert Delprino, Ph.D., Nanci Monaco, Ph.D., Bonita Frazer, M.S., C.T.S., Michael Weiner, M.S., M.B.A.
Crowne Plaza Toronto Centrre Hotel, Niagara Room

11:00 a.m.- 11:50 a.m.
Innovative Public Health Approaches to Child Psychology (Symposium)
Clifford Hatt, Ed.D., James Paulson, Ph.D., Gretchen LeFever, Ph.D., Korrie Allen, M.S.
Metro Toronto Convention Centre, Meeting Room 202A

4:00 p.m.- 4:50 p.m.
Self-Help Groups: What We Know, What We Need to Know (Symposium)
Paul Toro, Ph.D., Keith Humphreys, Ph.D., Greg Meissen, Ph.D., Francine Lavoie, Ph.D.
Metro Toronto Convention Centre, Meeting Room 202A

Friday, August 8, 2003

9:00 a.m.- 9:50 a.m.
Maternal Mental Health, Her Parenting and Outcomes for Her Children (Symposium)
Daphna Oyserman, Ph.D., Sang Kahng, Ph.D., Carol Mowbray, Ph.D., Laura Kohn, Ph.D.
Metro Toronto Convention Centre, Meeting Room 201C

2:00 p.m.- 3:50 p.m.
Better Beginnings, Better Futures: A Community-Based Prevention Project (Symposium)
Geoffrey Nelson, Ph.D., Kelly Petrunka, M.S., Ray DevPeters, Ph.D.
Metro Toronto Convention Centre, Meeting Room 205D

4:00 p.m.- 4:50 p.m.
Prevention and Community Change in the Context of Diversity (Poster Session)
Metro Toronto Convention Centre, Exhibit Hall

Community Development: Promotion Positive Behavior in Youth Sports
Jeanmarie Keim, Ph.D., L.C.S.W., Darcy Tessman, M.A.

Consumer Input on Developing Syring Exchange Programs in New Jersey
Ann Dey, Ph.D.

"Testifying" as an Urban Intervention Strategy
Theresa Miller, M.Ed.

Effects of Altering Memories on the Stigmatizing Attitudes of Children
Jennifer Hossli, B.S., Denis Nissim-Sabat, Ph.D.

Rehabilitation and Resource Acquisition: A Community-Based Model
Renee Taylor, Ph.D., Leonard Jason, Ph.D.

Adolescent Responses to Economic Strain: Prospective Associations with Psychological Adjustment
Lauren Berger, B.A., Martha Wadsworth, Ph.D.

Sustainability of School-Based Preventive, Social-Emotional Programs: A Model Site Study
Maurice Elias, Ph.D., Patricia Kamarinos, Psy.D.

Daring to DREAM: An Evaluation of a Local Mentoring Program
Katherine Meyer, B.A., Heather Bouchey, Ph.D.

Triumph Over Tragedy: A Model for Comprehensive Community Mental Health Responses to Disaster, Trauma, and Terrorism
Garret Evans, Psy.D., Brenda Wiens, Ph.D., Heidi Liss, Ph.D., Samuel Sears, Ph.D.

Intimate Violence on Campus: Victims' Perspectives on Their Community's Response
Mary Wandrei, Ph.D., Angelique West, M.S.

Development, Validation, and Application of the Commu nity Vigilance Interview
Marina Kahana, M.A., Elaine Vaughan, Ph.D.

Voices of Ethnic Minority Community College Students with Learning Disabilities
Katherine McDonald, B.S., Christopher Keys, Ph.D.

Enchancing Community Well-Being: Hope in Adults Seeking Private Assistance
Jennifer Teramoto Pedrotti, M.S., Lisa Edwards, M.S., Diane McDermott, Ph.D.

Enhancing Community Action: A Service-Learning Program Evaluation
Elizabeth Warter, M.A., Rosemarie Downey, B.A.

Relationships Between Children and Their Elder Parents' Assisted-Living Communities
Catherine Stein, Ph.D., Marcia Hunt, M.A., Lissa Mann, B.A.

Friday, August 8, 2003 *(Continued)*

Prevention and Community Change in the Context of Diversity
(Poster Session)

Cultural Constraints on Psychological Sense of Commu nity in Multicultural Contexts
Toshiaki Sasao, Ph.D., Mitsuru Ikeda, B.A., Azusa Koyama, B.A.

Methological Issues in Evaluating Community Interven tions
Maretha Visser, Ph.D.

Appalachian's Individualistic-Sub-Collectivistic Cultures and Subjective Well-Being
David Kimweli, Ph.D.

Parent and Adolescent Responses to Economic and Life Stress
Tali Raviv, B.A., Martha Wadsworth, Ph.D.

Well-Being, Life Satisfaction and Their Relationship to the Greek Culture
Merope Versi, Ph.D.

Medicaid Managed Care Coordination with Abused and Neglected Children
Karen Goodyear, Ph.D., Rodney Goodyear, Ph.D.

Depressive Symptoms and Health Care Utilization in Older Adults
Rebecca Crabb, B.S., John Hunsley, Ph.D.

The Experience of Discretionary Time in Urban African American Youth
Karen Kolmodin, M.S., Dina Tell, B.S., Nora Brodson, B.A., Pete Bruss, B.S., Sam Fazio, M.A., Elizabeth Franks, M.A., Melissa Jensen, B.A., Marysse Richards, Ph.D.

Evaluation of an Advocacy and Learning Intervention for Hmong Refugees
Jessica Goodkind, Ph.D.

The Role of Primary Prevention in Immigrant Children's Development
Adrine McKenzie, M.A.

Transmission of Economic Risk and Resource Characteris tics
Nathaniel Israel, M.A., Paul Toro Ph.D.

An Innovative Approach to Working with Community Elders at Risk for Abuse
Martha Corvea, Ph.D., Mark Rubert, Ph.D.

Stress, Frequent Internet Users, Healthy Lifestyle, and Optimism - Or Not!
Deepan Chatterjee, B.S., Dominicus So, Ph.D.

A Psychosocial Assessment of the Needs of an Innercity Neighborhood: Are Local Resources Sufficient at Address ing Needs?
Robin Kelley, Ph.D., Kellina Craig, Ph.D.

Three Schools, Three Contexts: Adaptation of a Preventa tive Intervention
Michelle Bloodworth, M.A., Shira Lee Katz, B.A., Jennifer Watling, B.A.

Immigrant Adolescents as Culture Brokers: Families from the Soviet Union
Curtis Jones, M.A., Dina Birman, Ph.D., Edison Trickett, Ph.D.

Civic Engagement of South Koreans in the 1980s and 1990s
Gregory Kim, Ph.D.

Perceived Discrimination and Acculturative Stress on New Immigrant Mental Health
Winnie Mak, Ph.D., Carrie Kwan, B.S.

Acculturation and Risky Behaviors in Immigrant Russian Girls
Ida Jeltova, Ph.D., Marian Fish, Ph.D.

Public Attitudes About "Madness" in Jamaica
Dahra Jackson, M.A., Laurie Heatherington, Ph.D.

Loneliness of the Homeless
Ami Rokach, Ph.D., Tricia Orzeck, B.S.

Friday, August 8, 2003 *(Continued)*

Prevention and Community Change in the Context of Diversity (Poster Session)

INNOVATIONS: Improving Mental Health Disparities Through Academic-Community Partnerships
Monica Mitchell, Ph.D., Lori Crosby, Psy.D., Lisa Mills, Ph.D., Kathleen Burklow, Ph.D., Lori Stark, Ph.D.

Predicting Women's Community Resource Utilization in Violent Relationships
Tami Sullivan, Ph.D., Suzanne Swan, Ph.D.

From Welfare to Work: Maintaining Long-Term Self-Sufficiency
Haleh Homayounjam, Psy.D., Lisa Mirabelli, Psy.D., Carla Elia, Ph.D., Lori Breeden, M.A., Ann Gerber, L.C.S.W.

A Model of Cultural Negotiation for Chinese Newcomers in Toronto
Izumi Sakamoto, Ph.D., Yanqui Zhou, M.A.

Saturday, August 9, 2003

9:00 a.m.- 10:50 a.m.
The Impact of Participatory Youth Program on Youth and Communities (Symposium)
Lois Holzman, Ph.D., Barbara Silverman, M.S.W., Diann Eley, Ph.D., Gloria Strickland, M.A., Kim Sabo, Ph.D., Edmund Gordon, Ph.D.
Metro Toronto Convention Centre, Meeting Room 201C

3:00 p.m.- 3:50 p.m.
The Current Status of Research on Religiosity, Spirituality, and Community Well-Being (Symposium)
Paul Toro, Ph.D., Kenneth Maton, Ph.D., Jacqueline Mattis, Ph.D.
Crowne Plaza Toronto Centrre Hotel, Caledon Room

4:00 p.m.- 4:50 p.m.
Presidential Address
Melvin N. Wilson, PhD, University of Virginia, Charlottesville, VA
Fairmont Royal York Hotel, Tudor Room 8

5:00 p.m.- 5:50 p.m.
Business Meeting, Fairmont Royal York Hotel, Tudor Room 8

6:00 p.m.- 6:50 p.m.
Social Hour, Fairmont Royal York Hotel, Tudor Room 7

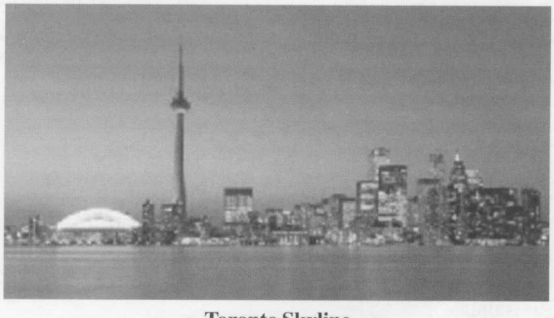
Sunday, August 10, 2003

9:00 a.m.- 10:50 a.m.
Is Community Psychology Relevant to Public Mental Health? (Symposium)
Michael Blank, Ph.D., Raymond Lorion, Ph.D., David Hargrove, Ph.D., Judy Primavera, Ph.D., Melvin Wilson, Ph.D., Jacob Tebes, Ph.D.
Metro Toronto Convention Centre, Meeting Room 802B

11:00 a.m.- 11:50 a.m.
Prevention and Wellness Promotion Programs for Children, Youth, and Families (Symposium)
David Glenwick, Ph.D., John Lutzker, Ph.D., Carol Metzler, Ph.D., Jennifer Treating, Ph.D., Leonard Jason, Ph.D.
Metro Toronto Convention Centre, Meeting Room 802B

12:00 p.m.- 12:50 p.m.
Developing Collaborative Relationships Between Universi ties and Middle Schools (Symposium)
Jean Rhodes, Ph.D., Paul Camic, Ph.D., Lynda Cafasso, Ph.D.
Metro Toronto Convention Centre, Meeting Room 704

1:00 p.m.- 2:50 p.m.
Community-Based Action Research: Jazzing it Up (Sympo sium)
Mary Brydon-Miller, Ph.D., Patricia Maguire, Ed.D., James Kelly, Ph.D.
Metro Toronto Convention Centre, Meeting Room 715A



Toronto Skyline

An Invitation To Membership

Society for Community Research & Action

The Division of Community Psychology (27) of the American Psychological Association

The Society for Community Research and Action (SCRA), Division 27 of the American Psychological Association, is an international organization devoted to advancing theory, research, and social action. Its members are committed to promoting health and empowerment and to preventing problems in communities, groups, and individuals. Four broad principles guide SCRA:

1. Community research and action requires explicit attention to and respect for diversity among peoples and settings.
2. Human competencies and problems are best understood by viewing people within their social, cultural, economic, geographic, and historical contexts.
3. Community research and action is an active collaboration among researchers, practitioners, and community members that uses multiple methodologies.
4. Change strategies are needed at multiple levels in order to foster settings that promote competence and well-being.

The SCRA serves many different disciplines that focus on community research and action. Our members have found that, regardless of the professional work they do, the knowledge and professional relationships they gain in SCRA are invaluable and invigorating. Membership provides new ideas and strategies for research and action that benefit people and improve institutions and communities.

Who Should Join

- Applied & Action Researchers
- Social and Community Activists
- Program Developers and Evaluators
- Psychologists
- Public Health Professionals
- Public Policy Makers
- Consultants

SCRA Goals

- To promote the use of social and behavioral science to enhance the well-being of people and their communities and to prevent harmful outcomes;
- To promote theory development and research that increase our understanding of human behavior in context;
- To encourage the exchange of knowledge and skills in community research and action among those in academic and applied settings;
- To engage in action, research, and practice committed to liberating oppressed peoples and respecting all cultures.
- To promote the development of careers in community research and action in both academic and applied settings.

Interests of SCRA Members Include

Empowerment & Community Development
Training & Competency Building
Prevention & Health Promotion
Self-Help & Mutual Support
Consultation & Evaluation
Community Mental Health
Culture, Race, & Gender
Human Diversity
Social Policy

SCRA Membership Benefits & Opportunities

- A subscription to the *American Journal of Community Psychology* (a $105 value);
- A subscription to *The Community Psychologist*, our outstanding newsletter;
- 25% Discount on books from Kluwer Academic/Plenum Publishers;
- Special subscription rates for the Journal of Educational and Psychological Consultation;
- Involvement in formal and informal meetings at regional and national conferences;
- Participation in Interest Groups, Task Forces, and Committees;
- The SCRA listserv for more active and continuous interaction about resources and issues in community research and action; and
- Numerous activities to support members in their work, including student mentoring initiatives and advice for new authors writing on race or culture.

The Society for Community Research and Action

Membership Application

Please provide the following information about yourself:

Name: _____

Title/Institution: _____

Mailing Address: _____

_____

_____

Day phone: (____) _____ - _____

Evening phone: (____) _____ - _____

Fax: (____) _____ - _____

E-mail: _____

May we include your name in the SCRA membership Directory?

❒ Yes ❒ No

Are you a member of APA?

❒ No ❒ Yes (APA Membership # _____)

If yes, please indicate your membership status:

❒ Fellow ❒ Associate ❒ Member ❒ Student Affiliate

Please indicate any interest groups (IG) or committees you would like to join:

❒ Aging
❒ Children & Youth
❒ Committee on Women
❒ Community Action IG
❒ Community Health IG
❒ Cultural & Racial Affairs Committee
❒ Disabilities IG
❒ International Community Psychology Committee
❒ Lesbian, Gay, Bisexual, & Transgender Concerns IG
❒ Prevention and Promotion IG
❒ Rural IG
❒ School Intervention IG
❒ Self-Help/Mutual Support IG
❒ Social Policy Committee
❒ Stress & Coping IG
❒ Students of Color IG
❒ Undergraduate Awareness

The following two questions are optional:

What is your gender? ❒ Female ❒ Male

Your race/ethnicity? _____

Membership dues (check one):

❒ SCRA Member ($45) ❒ Student Member ($20)
❒ International Member ($35)

❒ Payment is enclosed (please make checks payable to SCRA)

❒ Charge to credit card: ❒ Visa ❒ MasterCard

Account No.: | | | | | | | | | | | | | | | | |

Expiration Date: _____/ _____

Authorized Signature: _____

Signature of applicant: _____

Date: _____

Please mail this form with a check for your membership dues to:

SCRA, 1800 Canyon Park Circle, Building 4, Suite 403, Edmond, OK 73013