

Assessing the Feasibility and Acceptability of Implementing Evidence-Based HIV Prevention Interventions for Women Working in Industrial Estates in St. Kitts



With the support of



This report was made possible by support from the U.S. Agency for International Development (USAID) through Cooperative Agreement number: 538-A-00-07-00100-00.
The authors' views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

Table of Contents

	Page
Foreword	2
List of Acronyms	3
Acknowledgements	4
Executive Summary	5
Chapter 1. Saint Kitts and Nevis Country Profile	7
1.1 Overview of the HIV and AIDS epidemic	
1.2 Objectives of the study	
Chapter 2. Study Methods	9
2.1 Study design	
2.2 Sampling and selection of participants	
2.3 Data collection	
2.4 Data analysis	
2.5 Ethical approval	
Chapter 3. Study Findings	12
3.1 Characteristics of the women who work in the industrial estates	
3.2 Economic, social and cultural issues influencing women	
3.3 HIV risk, prevention and condom negotiation	
3.4 Self-esteem and lack of empowerment	
3.5 Issues of privacy and confidentiality	
3.6 Summary of intervention related issues affecting women	
3.7 Feasibility of different intervention approaches and components	
Chapter 4. Recommendations for Implementation of an Evidence-Based Intervention	24
References	29
Appendix I: Core Elements of Feasible Evidence-Based Prevention Interventions	31
Appendix II: Interview Guides	33
Appendix III: Intervention Feasibility Dissemination Workshop Summary	42



Foreword

It is with pleasure that we present this report, *Assessing the Feasibility and Acceptability of Implementing Evidence-Based HIV Prevention Interventions for Women Working in Industrial Estates in St. Kitts*. Undertaken by the International HIV/AIDS Alliance (IHAA)/Caribbean HIV & AIDS Alliance (CHAA) and the University of California, San Francisco (UCSF) with funding from the US Agency for International Development (USAID), the goal of this feasibility study was to gather strategic information to determine which evidence-based intervention (EBI) would be feasible and acceptable to implement for the women in this setting.

This ground breaking study is part of the Eastern Caribbean Community Action Project (EC-CAP). The aim of the project is to work with vulnerable communities to increase access to HIV and AIDS services in four islands in the Eastern Caribbean, St. Kitts and Nevis, St. Vincent and the Grenadines, Antigua and Barbuda, and Barbados. The research carried out under this project assists in building programmes which are relevant, culturally appropriate and effective within the EC-CAP countries, National AIDS Programmes and in civil society. The research will also inform behavioural change and counselling and testing projects or capture lessons learnt for application in future efforts.

CHAA is a regional Non Profit Organisation and recently became a linking organisation of IHAA. CHAA works specifically to mobilise vulnerable communities to carry out HIV prevention, AIDS care and education activities with three key populations: men who have sex with men (MSM), sex workers (SW) and people living with HIV (PLHIV) and AIDS (PLWA). The portfolio of the CHAA consists of five main elements, as follows: (1) Prevention; (2) Health services and empowering PLHIV; (3) Care and support of PLHIV; (4) Peer support; and (5) Acceleration of the private sector response to HIV and AIDS.

CHAA country offices were established in the four implementing countries in order to facilitate greater capacity to participate in national projects as well as engage with national AIDS programmes. In keeping with the philosophy that partnerships are a critical part of our strategic vision, this report was developed as a joint effort of a team of researchers from CHAA and the UCSF with the support of the Government of St. Kitts and Nevis. It represents a strategic and proactive approach to HIV programming and demonstrates a model of systematic programme oriented research by building on a situational assessment study conducted in 2007 in St. Kitts and Nevis. This study identified women working in the large industrial estates in St Kitts as one of the population segments most at risk for HIV.

As has been the case in other global settings, with adequate tailoring, evidence based interventions hold promise in the Eastern Caribbean. In this report, service providers and women in St. Kitts found elements of the Popular Opinion Leader and SISTA interventions to be feasible and acceptable. The potential for stemming the tide of new HIV infections among these at-risk women may be achieved by tailoring and implementing these proven effective interventions. This report provides recommendations towards this end.



List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral Therapy
B/BSS	Biological/Behavioural Surveillance Surveys
CAREC	Caribbean Epidemiology Centre
CDC	United States Centers for Disease Control and Prevention
CHAA	Caribbean HIV&AIDS Alliance
CSW	Commercial Sex Worker
DEBI	Diffusion of Evidence Based Interventions
EBI	Evidence Based Interventions
IHAA	International HIV/AIDS Alliance
IRB	Institutional Review Board
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
PHSC	Protection of Human Subjects Committee
POL	Popular Opinion Leaders
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UCSF	University of California, San Francisco
UNAIDS	The Joint United Nations Programme on HIV / AIDS
UNGASS	United Nations General Assembly Special Session on HIV / AIDS
USA	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Acknowledgements

The research team for this study consisted of Dr. Janet Myers, Principal Researcher; Andre Maiorana, Co-Investigator/Qualitative Analyst; Dr. Navindra Persaud, Evaluation Director; Rosemary Lall, Senior Research Officer and Nadine Kassie, Research Officer.

The Caribbean HIV&AIDS Alliance and the University of California at San Francisco would like to express our sincere gratitude to all those individuals and organisations who contributed to the successful planning and execution of this study. Special thanks to the staff of the Ministry of Health and the National AIDS Secretariat for their guidance during the process and for freely providing us with requested information.

We also acknowledge the invaluable contribution by staff of the Women's Affairs Division, especially Ms. Ingrid Gumbs and Ms. Celia Christopher, who scheduled all of the interviews and focus groups and assisted with the logistical arrangements during data collection. We would also like to thank Kevin Farara, Programme Officer, CHAA, St. Kitts and Nevis, for being a good host during the planning and executing of this project.

This study would not have been possible without the participation of the women working in the factories who provided extremely useful information, and openly discussed sensitive and personal issues. Finally, special thanks are extended to USAID for providing the funding to support this much needed assessment.

Executive Summary

The evidence based interventions recommended by the US Centers for Disease Control and Prevention were designed and developed within the framework of the United States. However, once tested and tailored to meet local needs, these interventions have considerable potential to positively impact the epidemic within vulnerable populations in different environments. As this project has shown, both the researcher and the community have critical contributions to make to the success of these interventions. Evidence based interventions have not been previously implemented in the Eastern Caribbean region. As such St. Kitts and Nevis can be considered ahead of the field in this area and poised to make a significant contribution to HIV prevention.

Background: A situational assessment conducted in 2007 in St. Kitts and Nevis (USAID/MEASURE/CHAA, 2007) regarding HIV prevention needs and vulnerable populations identified women who work in St. Kitts' large complex of industrial estates as one of the population segments most at risk for HIV. This report describes a follow-up study to identify feasible HIV prevention interventions for this at risk population.

The goal of this study, undertaken by the Caribbean HIV&AIDS Alliance (CHAA) in partnership with the University of California at San Francisco (UCSF), was to gather strategic information and assess the feasibility and acceptability of evidence-based HIV prevention interventions (EBI) for low income women working at the industrial estates in St. Kitts. Results from this study will guide the development of relevant evidence-based prevention interventions for these women, and help expand and better evaluate community and national HIV and AIDS programmes in the region.

Methods: This study used secondary data sources and qualitative methods, including individual interviews and focus groups, as well as observations to assess the feasibility and acceptability of evidence-based prevention interventions for women and the barriers and facilitators to implementing these interventions. One-on-one in-depth interviews and focus groups discussions were conducted with 42 key informants, including: staff members from government agencies and community-based organisations who worked with women and/or delivered HIV prevention; factory managers, and women working at the industrial estates.

Findings: Women working in the industrial estates are low income with limited formal education and skills. The women vary in ages from relatively young to middle aged. Most of the women are single mothers, the "breadwinners" in families that many participants described as comprised of children who may have different fathers.

Executive Summary

cont'd

The majority of the women are mostly concerned with their financial well-being and ability to provide for their children. As a result the women may engage in transactional sex in exchange for goods or money with either a steady or casual sexual partner. These partners may be serial and may be the father of one of their children. While women who work at the industrial estates have access to HIV information, they face issues which make it difficult to refuse sex or to negotiate safer sex and condom use. In the presence of low self-esteem and lack of empowerment, and because of poverty, economic need, and cultural norms that condone multiple and/or concurrent partnerships and transactional sex, the majority of the women have limited power to negotiate condom use with their male partners.

Recommendations: Future prevention interventions need to address empowerment, self-esteem, issues of citizenship and motherhood, and help the women realise their own strengths and self-worth. Findings suggest an intervention that focuses on community mobilisation and changing community norms as well as empowerment of women. The intervention may be based on two evidence-based prevention interventions recommended by the US Centers for Disease Control and Prevention (CDC).

The goals of our proposed intervention are:

- To empower women and increase their self-esteem;
- To affect community norms and break the cycle of women's dependence on men and the perceived power inequalities in relationships;
- To provide the skills to apply their knowledge and existing HIV information and negotiate safer sex and condom use;
- To help women make their own informed decisions regarding sex and when to have children.



Saint Kitts and Nevis Country Profile

Chapter 1.

The twin island Federation of Saint Kitts and Nevis is located in the Caribbean Sea with an estimated population, at the end of 2006, of approximately 49,000 inhabitants. The crude birth rate in St. Kitts & Nevis was 13.2 per 1,000 population and the annual population growth rate was 0.5 percent while the net migration rate was -3.51 migrants/ 1,000 population. The maternal mortality rate was 1.5 per 1,000 live births and the infant mortality rate was 11.0 per 1,000 live births while the crude death rate was 6.3 per 1,000 population (UNGASS Report, 2008). The majority of persons are of African origin, with a few of British, Portuguese, and Lebanese descent.

Industry accounted for 26% of the GDP in St. Kitts in 2001. The principal manufacturing plant and largest industrial employer was the St. Kitts Sugar Manufacturing Corporation, a government enterprise that ground and processed sugarcane for export until 2005 when it was closed after decades of losses. To fill the void that would have been created by the closure of the sugar factory, a process of diversification of the economy was embarked upon which saw the emergence of four main industrial estates. These estates house factories that manufacture and assemble a wide range of items including electronics and garments, most of which are exported.

1.1 Overview of the HIV and AIDS Epidemic

According to the UNGASS Report for 2007 that was submitted by the National Advisory Council on HIV and AIDS in St. Kitts and Nevis, the first case of HIV and AIDS in St. Kitts and Nevis was reported in 1984 and by the end of 2006 a cumulative total of 270 HIV/AIDS cases were reported to the Health Information Unit at the Ministry of Health. This gives a cumulative incidence rate of 551 per 100,000 population. The report also indicated that over the years there have been a wide variation in the number of cases reported annually and that the majority of persons who were diagnosed with HIV are within the 20 – 49 year old age group. The report further stated that whereas the average age at diagnosis of HIV-infection was 35.1 years, it was slightly higher in males than females (36.4 years vs. 33.6 years).

Seroprevalence data are only available from the ongoing programme for the prevention of mother-to-child transmission of HIV infection, and from a survey among prisoners conducted in 2004. According to the UNGASS report for 2007, of the 324 pregnant women who were seen in the public sector in St. Kitts during March 2005 to December 2006, and were tested for HIV-infection, two (0.62%) were found to be HIV positive. A 2004 survey among inmates of Her Majesty's Prison in St. Kitts and Nevis found an HIV seroprevalence of 2.4% among inmates of the prison [Boisson et al, 2005].

Study Methods

Chapter 2.

2.1 Study design

This study used secondary data sources and a combination of qualitative methods, including individual interviews and focus groups as well as observations to assess the feasibility and acceptability of evidence-based prevention interventions for women and the barriers and facilitators to implementing those interventions.

Secondary data related to HIV and women in St. Kitts, including the Situational Analysis conducted in 2007 described in section 1.1 above, was first reviewed. This was followed by informal discussions with staff from the HIV Secretariat at the Ministry of Health and the Gender Affairs Department. These informal discussions provided useful information that helped to refine the research questions, as well as guided the preliminary selection of three potential prevention interventions developed for women in the US, which were subsequently discussed with the participants in the feasibility study.

Data were then collected through qualitative semi-structured interviews and focus groups with key informants. Members of the study team also conducted observations in the factories in order to better understand the working conditions and facilities at the industrial estates.

2.2 Sampling and selection of participants

A total of 42 persons participated in the study. Purposive sampling was used to select a diversity of participants who could share different views, experiences and perceptions regarding HIV prevention needs of the women working at the estates. Participants included staff members from government agencies, medical providers, staff members of community based organisations who worked with women and/or delivered HIV prevention, factory managers and women working at the industrial estates. Participants were recruited with the support of staff from the Gender Affairs Unit. Table 1 below shows the characteristics of the 42 persons who participated in the study.

Table 1: Distribution of participants

Participants	Number of Participants
Individual interviews with HIV prevention and medical care service providers	5
Focus group with prevention staff from government and organisations	10
Individual interviews with women working at the factories	4
Focus groups (2) with women working at the factories	20
Interviews with managers at different industrial sites	3
Total Number of participants	42



2.3 Data collection

Data collection was conducted by staff members from CHAA and the UCSF between 28th September and the 3rd October, 2008. Each focus group lasted approximately 120 minutes and individual interviews lasted approximately 60 minutes. All participants provided verbal informed consent to participate. All interviews and focus groups were audiotaped. Women employed at the factories were reimbursed \$25 US dollars for their time and participation.

Data was collected using qualitative methods. Qualitative methods allow the perspectives and voices of the research participants to be heard since data collected are largely related to the way the interviewees perceive the world around them. Those perceptions are built on factors such as education, religion and family background.

Interviews and focus groups were conducted using the semi-structured interview guides shown in Appendix II. During the interview, participants were asked to describe the characteristics of the women who work at the industrial estates, their HIV risk, specific HIV prevention messages that may be necessary for these women and how feasible and acceptable different intervention approaches, such as individual or group level sessions, would be for these women. In addition, participating staff members from the health sector were shown the core elements of three evidence-based interventions recommended for women by the US Centers for Disease Control and Prevention (CDC) as part of the Diffusion of Effective Behavioural Interventions (DEBI) and asked to describe how each of them could be adapted and/or implemented in St. Kitts.

The DEBIs that were reviewed included Real AIDS Prevention Project, Popular Opinion Leader (Kelly et al, 1991) and SISTA (DiClemente and Wingood, 1995). A more detailed description of these and other evidence based interventions are available at <http://www.effectiveinterventions.org>. Observations to better understand working conditions, facilities and environment and to explore possibilities for intervention delivery were conducted during site visits to three of the factories within the industrial estates. The site visits were previously arranged and the observations were unobtrusive to the women working at the factories.

2.4 Data analysis

The process of data analysis was iterative. During the data collection period, members of the data collection team met at the end of each day to debrief, share, discuss, and compare findings, observations, and interpretations related to the data collected that day. Notes were taken during those staff discussions to identify and document themes arising from the data. The thematic classifications were based on a priori issues (such as those included in the interview guides) and issues arising during data collection. The research team subsequently spent approximately three weeks transcribing and summarising the interviews and focus groups. During this process the concepts and themes emerging from the data were captured and used to guide the preparation and structure of this report.

2.5 Ethical approval

The study procedures were reviewed and approved by the Committee for Human Research, University of California, San Francisco and the Chief Medical Officer in St. Kitts.



Study Findings

Chapter 3.

3.1 Characteristics of the women who work in the industrial estates

The women working in the industrial estates are low income, with limited skills and formal education. Most of the women are young; many of them are single mothers and the “breadwinners” in families. Some participants have described these families as comprising children who may have different fathers. Within St. Kitts and Nevis approximately 47% of households are headed by single women. This trend was reflected within the factories. The women and their children may live with the woman’s parents or mother who may themselves have been single mothers.

The women live throughout the island and use either public transport, in most cases a mini-bus, or get “car rides” every day to work. They work full-time from Monday to Friday from 8 am to 4 pm and occasionally overtime in one of the industrial estates in the outskirts of Basseterre, the capital town on St. Kitts. They receive minimum wage conducting light assembly, or “menial” jobs, as stated by a study participant, and perform sedentary tasks seated in rows in large rooms at these factories. The Factories produce goods as diverse as electronics components and transformers to moulded plastics, garments, and shoes.

Women in the factories appear to mix easily with each other. Also, the labour force is largely settled and permanent with relatively low turnover. The factories are also the main source of income for most of the women on the Estate. While the government offers some assistance to low income women, the industrial estates provide one of the few sources of regular income for women with limited skills and education in St. Kitts. In the case of at least one factory, the owners have invested in economic infrastructure and are financing the building of a new school for the children of the women who work at the factories. In addition, based on our data and the precedent of previous community and health related activities already implemented at the factories, owners and managers seem to be supportive and interested in the well-being and development of the women.

When they are not at work, the women are busy doing housework and attending to their children. On weekends women may socialise at the town square or recreational grounds. They may also go to the beach strip where everyone goes to party, drink, socialise, meet for dates, and even have sex late at night or in the early hours of the morning.



3.2 Economic, social and cultural issues influencing women in the industrial estates

Women's lives are driven by poverty and limited financial and economic resources. Considering their low incomes, the majority of the women are mostly concerned with meeting day to day expenses and being able to provide for their children. In addition, some study respondents referred to what they considered women's "misguided priorities." This included their desire for access to consumer-oriented commodities such as the newest and trendiest clothes, shoes, jewellery, mobile phones, and other items such as tickets to the annual music festival in St. Kitts. Their desire for these commodities is coupled with a need to give the impression that they are in good economic standing.

Women's lives also are influenced by social and cultural factors that condition the way they see themselves, their relationships with men and their ability to protect themselves from HIV. A number of studies in the Caribbean have shown that traditional gender roles in the Caribbean place men in the position of power and authority in the family. While participants acknowledged that those social and cultural patterns are rapidly changing, they referred to St. Kitts as still sharing in a patriarchal Caribbean culture where men have a domineering role and the women think the men are in control. There is a significant power differential where the men are "in control" as women are afraid that the men will go elsewhere if their needs are not met. "Whatever their gentleman says, that's it", was the statement used by a factory manager to illustrate that situation.

Research shows that cultural values about gender roles may influence the behaviour of men and women in sexual situations at a number of levels. According to Wasserheit (1991), gender roles may influence sexual behaviour at the relationship level by defining the general behaviour of men and women toward each other in relationships and by playing a role in how sexual behaviour is negotiated and ultimately enacted. Because traditional gender roles depict men as leaders and decision makers, they are more likely to maintain control over sexual encounters. Women who accept these roles may place themselves in risky sexual situations as they may leave important sexual decisions up to their partners.

The women's partners tend to be men belonging to the same socio-economic strata, who work on construction sites, perform odd jobs, or do not work. Many of them spend their time playing dominos in places such as the Ferry Terminal, and drinking alcohol. Some of the women's partners, as mentioned by our informants, may be imprisoned because of drug, gang, or other crime related activities. The women may initially be drawn to some of these men because they have extra money, but then the men may be convicted of a crime resulting in imprisonment. This leaves the women and their children with one income and possibly limited financial resources.

Study Findings

Cont'd

Chapter 3.

3.2 Economic, social and cultural issues influencing women

Cont'd

The women may provide the sole source of financial support for the children. Staff stated that it is common that the men are not involved in child-raising, and do not provide financial support for their children, particularly when they are no longer in a relationship with the women, or that their support is inconsistent or irregular and only provided for actual or urgent needs such as clothing or medical expenses. Because of lack of communication and clear and established financial arrangements, a staff member stated that the women maintain an *“almost adversarial relationship”* with their partners or ex-partners, where the women perceive sex as part of their cajoling role to extract money from the men. Staff stated that having to take men to court used to be considered a disgrace and that only recently have the women taken advantage of that option in order to secure financial support for their children.

A cultural norm in the Caribbean is that men should provide financially for their sexual partners and children. Where a stable relationship with a partner does not exist, women are likely to enter into multiple partnerships as a means to cover economic needs and provide additional support for children. They believe that ‘it is necessary to “have a man” who provides economic support’ (Bombereau and Allen, 2008). As a consequence, women and girls are particularly in danger of entering into sexual-economic exchanges from disadvantaged, stigmatised positions, and thus hold little real power with which to negotiate safe sex (Kempadoo and Taitt, 2006). This study found that to meet the needs of the family or for clothes, alcohol or “rides,” some of the women may engage in transactional sex, exchanging sex for goods or money with either a steady or casual sexual partner.

These partners may be serial, or multiple and concurrent, and may be the father of one of their children. One female member of the focus group illustrated this by stating, *“People change their boyfriends as they put on their underwear.”* Staff also stated that women may have two partners *“one for the money, one for the honey”*, in what she defined as fixed dynamic relationships. In that context, and in the absence of other financial resources (or their perception that they lack resources), sex, and even children, become a commodity for material gain. Women may become pregnant and have children as a way of *“keeping the man”* and getting money from a partner. Sometimes, this includes re-engaging with their ex-partners, *“the occasional visitor that comes with money and she agrees to have sex with”* in exchange for goods or the resources that will alleviate their financial strain and help support the family. By doing that, though, the women perpetuate a cycle of dependence on the men, and send out mixed messages, *“I am done with you but I am not done with you,”* while possibly putting themselves at risk for HIV and other STDs. Staff also mentioned that some women think the only way to make money is to have children from several men, who will provide financially: *“Some [women] think that the only way to make money is to have several children from several men even if they have to go to court to have them give some money each month that will help their income.”* Thus, sex becomes transactional and a commodity that the women use to try to ensure the men will contribute to their finances.

3.2 Economic, social and cultural issues influencing women cont'd

As part of the women's economic strategies, staff also described instances where the mother may benefit from a "sexual subsidy" and look the other way or tolerate the men her teenage daughter goes out with, as long as he provides for some of her or the family's needs. This can be understood in light of the established influence of money and other gifts on sexual activity among young women, particularly schoolgirls, and in the wider context of gender relationships in the Caribbean. The male is expected to provide financially and therefore there is nothing morally wrong with the female looking for the best financial option in choosing a partner (Stuart, 2000). Conversely, as the main caregivers of their families, some women are also concerned about their teenage children, more specifically daughters, who may be on the brink of becoming sexually active or are already engaging in sex.

We explored with the participants different issues that may affect women. Among these, we asked participants about alcohol use among women as well as situations of domestic violence. Participants reported that, overall, alcohol use among women is not high. The men are the big drinkers, having "Guinness for breakfast."

Domestic violence and abuse does occur but is very "hush, hush [not talked about]," and is kept under wraps. Women tolerate these instances because they are ashamed, do not want to report them to the police, and even justify them by saying that "if he didn't beat me he wouldn't love me, a man has his rights." Women may only report violence when they cannot take it anymore. A factory manager thought violence was not a big problem because "only" one woman had been killed by her husband. Another manager offered an example of one employee who had been abused by her boyfriend: A girl came to work one morning black and blue and when asked by the manager what is wrong she replied that her children were playing with stones and one of the stones hit her. Subsequent investigations revealed that it was her boyfriend who hit her.

Staff stated that violence can also contribute to HIV risk as "a woman in this situation cannot refuse sex or else she gets beaten." The cultural acceptance of gender based violence is noted to continue to exist in the Caribbean where society's understanding of the appropriate male and female behaviours and roles endorses the ideology of male domination (Bombereau and Allen, 2008). Future HIV prevention interventions need to consider and address the influence of these issues in women's lives. For the purposes of developing a prevention intervention, the industrial estates constitute an ideal place for implementing such interventions. They have a captive audience of women who are easily accessible, and who share the same socioeconomic background and HIV prevention needs.

3.3 HIV risk, prevention and condom negotiation

Participants reported that, in general, women already have information on HIV but lack the self-esteem and are not empowered in their relationships and communication with their male partners to practise safer sex and to negotiate condom use. However, women at the factories also explained that the messages are not specific enough to answer practical questions such as, “Do you get HIV immediately? Can you have it and not know? How do you know you have it? Can you have a negative test even if you have the virus? When are people contagious? How will people treat me once they know I’m positive? How do you encourage people to test? What next after I am diagnosed positive?”

The government and other organisations, including churches of some denominations, have implemented HIV information campaigns through the mass media or through specific events such as health fairs. In addition, health-related activities and workshops that included information on HIV also have been implemented on an ad hoc basis for the women at the industrial estates. Staff who participated in the implementation of the Income Generation Workshops and the Women’s Health Project at the factories stated that the women were very interested in these programmes and receptive to health-related information, including family planning, drugs, sex, and HIV; guidelines on food and diet, obesity, and diabetes; developing new skills; and exploring other economic alternatives, such as how to grow their own vegetables. The same staff reported that women also liked the attention they get through these classes and activities, which helps their self-esteem.

Women may not feel they are at risk for HIV because they think it cannot happen to them, they do not know anyone with HIV, they trust their partners, or may not consider themselves at risk for HIV even if they know or suspect their partners have sex outside their relationship. Staff illustrated this by referring to women’s responses during pre-HIV testing risk assessments, “Oh no, I only have one partner.” Does your partner have any other partners? “Oh, probably”. They don’t connect that it makes them at risk if they are having unprotected sex. A factory manager stated the following when referring to the women’s perceptions of risk, “...they think, ‘I have one life to live, life is short, I’m going to enjoy it.’ It is okay to talk about HIV, but most people don’t. It’s not visible: she doesn’t know anyone in her community who has it.”

Participants repeatedly referred to the high rates of pregnancies among the women as an indicator of unprotected sex. Women are at risk for HIV because of lack of condom use with one or multiple sex partners, who may in turn have other partners. Condom use seems to be heavily dependent upon the power dynamics with their male partners and the views of the partners regarding condom use. Even if they are aware and concerned about their HIV risk, participants stated that the women themselves, or their partners, do not want to use condoms because it does not feel the same and insisting on condom use is often equated with mistrust and the suspicion or implication that either partner is having sex with someone else. Women are not “courageous enough” to talk to the men. As stated by a factory manager, “Because of the balance of power, women do not feel that they have the ability to ask their men to use condoms”. In addition, the assumption that asking for condoms will negatively influence the receipt of goods or money in exchange for sex further diminishes the ability of the women to negotiate safer sex because, “*nails, hairstyles, cars, sweet words convince you to believe in the man or take risks.*”

The following two quotes describe the relationship between condom use and dependency on men for financial support, “*The women feel like the man is the one who gives them money, and so they can't ask to use condoms*” (Female Factory Manager II). “*Money issues and poverty can leave a woman dependent on the man, and then she feels as though she doesn't have a right to demand the use of a condom, she feels like she has to do what he says*” (Factory woman, Focus group).

One stakeholder commented that the power dynamics affect condom use in all socioeconomic groups in the region. While women may already have enough information and awareness on HIV, their lack of empowerment in their relationships and communication with their partners limits their ability to practise safer sex and to negotiate condom use.

3.4 Self-esteem and lack of empowerment

The need for the empowerment of the women and the development of their self-worth and self-esteem were clearly expressed by staff and managers, as well as, even if less directly, by the women themselves. Staff referred to the fact that growing up in the Caribbean, women have traditional roles and that their self-esteem and self-worth must be enhanced for them to realise they have power in relationships with men: “Even if married they do not have to be dependent on the man but can make their own money...so also if something happens to him they are not lost without any resources.” Women tend to do things that will please their partners but need to know that they can survive and stand on their own without the help of the man.

Study Findings

Cont'd

Chapter 3.

3.4 Self-esteem and lack of empowerment

cont'd

Staff also stated that the women need to learn how to value themselves and to develop better judgement at making better decisions regarding their life choices, controlling when to get pregnant and have children, understanding that having children can limit choices, developing skills on how to relate to men, and maintaining a relationship with their current partners and/or ex-partners, as well as having control over their sex lives. In terms of HIV risk, women need to be educated about how not to be fooled by the men who may try to convince them that they are safe and how much they love them.

The women's lack of empowerment translates into not being able to have safer sex and negotiate condom use with their partners. A staff summarised these points when she stated that, "Women can control their sexual life but they need to be encouraged to be strong and negotiate condom use, and how women can support each other." A manager added that women do not have negotiating power in a relationship and are afraid the men will go "elsewhere" if they do not do what the man wants. She concluded that there is a scarcity of men and that the women do not want to lose their partners. Staff stated that the women already work hard and know how to cope with adversity but need to be able to recognise and appreciate their own strengths. They also mentioned that similarly to how the women are able to assert themselves with the managers regarding work conditions, they need to be able to learn how to utilise and translate those skills to communicate with their partners.

Considering that communication with their partners is an issue, nursing staff referred to the role plays and exercises used as part of community health programmes to help women find their own answers to different issues they face in their relationships. A practical example provided by the same staff was how they advised the women to bring their partners grocery shopping. The men would then have a better idea of how much things cost instead of complaining every time the woman asked him for money, while also improving communication and helping to avoid quarrelling between the partners. The quote below, from one of the women who work at the factories illustrates the difficulties she has communicating with her boyfriend of 20 years.

"It is very difficult to express myself with him. Most of the time I know what I want to say in my head but trying to get it out I might say it in an aggressive way and he might get offended and it might just cause a confusion, so sometimes I just stay mute....I don't believe it is me. I believe it is him. His attitude towards me may just cause me to just say nothing at all".

Referring more specifically to sexual issues and condom use, another woman stated that men do not listen if women want to use condoms. The men instead "they love to say they'll pull out." A third woman, while aware of the health risks, referred to economic need as her justification to have transactional sex.

Study Findings

Cont'd

Chapter 3.

3.4 Self-esteem and lack of empowerment

cont'd

"I don't really think that we can protect ourselves. It might sound funny but to women, it's so much circumstances that we as ladies face that we don't have the time to think about how to protect ourselves from AIDS...you have bills, you have kids, men not supporting their kids, and you have to think about the kid first. But at the same time, it's my health, but then the children them have to eat, so you do it".

A staff member stated that, *"First thing is empowering them on the negotiation skills since their self-esteem is very low and no matter what you do, you can talk until you are blue in the face, but unless they are empowered they are not going to change."* Another staff member stated that integrating empowerment-related content and activities to a prevention intervention would open the doors for the women to deal with other contextual and structural issues beyond HIV and safer sex, while strengthening the women socially and psychologically and contributing to changing community norms. Furthermore, this would help women not to perpetuate the cycle and think that, *"Since my mother had 6 children and she didn't have a husband that is good for me"* and instead teach the daughters they are raising not to become pregnant as a teenager. A woman summarised the above when she stated, *"We need to get a little more strength, we need a little bit more power to say, 'this is me, and they are going to do it [get an HIV test, in this context] if they need to be with me."*

Due to the issues mentioned above, the consensus among the study participants was that HIV interventions for women should also include men since based on the culture in St. Kitts, the male dictates whether or not a condom is used in a sexual encounter. While, in general, heterosexual men have not been targeted for HIV prevention, participants agreed their engagement would be crucial since "just empowering the ladies alone is not enough" and the men also need to assume responsibility for their actions and behaviour. Some staff shared that in their experience some men do not even know how to use a condom. Other staff considered that men could be reached out to for HIV prevention activities at construction sites, bars, and barber shops. Yet another staff illustrated how men could be engaged in different activities by providing the example of a family day where, by the end of the community event, the men were playing with the children, and in some cases learning how to hold a baby for the first time, instead of being in a group by themselves.



Study Findings

Cont'd

Chapter 3.

3.5 Issues of privacy and confidentiality

There is a widespread belief in St. Kitts that people have little ability to “keep secrets.” Because of this, addressing issues of privacy and confidentiality will be crucial for the development and implementation of a prevention intervention. Participants referred to distrust of the health care system and a perceived lack of confidentiality among health care workers who may reveal patients’ information, including results of an HIV test and their HIV status. Furthermore, in a small country, where everyone knows each other and “each other’s business,” the women fear that information can be easily leaked and are afraid of discussing personal issues within the community. The staff we interviewed had conflicting opinions regarding this issue. Some staff stated that the women’s concerns were justified while others stated that the perceived lack of confidentiality is just a myth and that health care workers follow strict procedures to protect the confidentiality and privacy of patients. Regardless, it will be critical to protect the confidentiality of intervention participants.

The women stated that they do not talk much among themselves about what they do in different situations and added that they would not go to their co-workers for advice because “you can’t trust nobody with your problems.” They do not talk to each other about personal business because of fear the information will get out. A woman said that women would not trust peers to keep their personal information confidential. However, the women stated that they would trust and talk to a foreigner, someone who does not know them, or does not live in St. Kitts. One staff member elaborated on this issue and further explained that people are afraid of their medical or personal information being disclosed and that is why the women trusted the foreign medical students who did not have access to their charts. She added, however, that while the women may talk to a foreigner, they may also think that that person does not understand them or cannot identify with them.



3.6 Summary of intervention related issues affecting women

Table 2:

Findings on potential barriers and facilitators to condom use among factory women in St. Kitts.

Factors	Facilitators	Barriers
Those related to self	<ul style="list-style-type: none"> * Knowledge and awareness about HIV * Awareness of efficacy of condom as a protective method 	<ul style="list-style-type: none"> * Poverty and perception they need to depend financially on men * lack of self-esteem and empowerment among women * Perception that the man is in control * Not seeing the need to use condoms * Lack of skills to negotiate condom use with partners
Those related to partner	<ul style="list-style-type: none"> * Recognition of the need to assert themselves * Increased tendency to assert themselves as demonstrated by their willingness to take the fathers' of their children to court for maintenance 	<ul style="list-style-type: none"> * Men do not like condoms * High rate of partner change * Lack of communication with partners
Cultural factors/ community norms	<ul style="list-style-type: none"> * Acceptance of women's right to work * Concern for future of teenage children 	<ul style="list-style-type: none"> * Men are in control and women see themselves as being able to please men * Acceptance of male domination * Acceptance of "macho" culture among men * Social norms condoning early sexual debut and pregnancy among single women
Health systems	<ul style="list-style-type: none"> * Access to free general and reproductive health care 	<ul style="list-style-type: none"> * Perceived lack of confidentiality among health care providers and community members

3.7 Feasibility of different intervention approaches/components

In addition to collecting in depth information about aspects of women's lives that would influence receipt and success of an HIV prevention intervention, we asked participants specifically about the feasibility of three evidence-based interventions. We presented staff with the core elements of the evidence-based interventions for them to comment which one would be feasible to implement (see Appendix I). In response to those questions, participants expressed a wide variety of ideas regarding what may work. Although most participants gave responses reflecting what they were used to - didactic, lecture-type education sessions – once we explained each of the core elements of the interventions, they were able to talk easily about each intervention, reflecting on the feasibility and acceptability of each.

Staff and managers very clearly expressed the view that considering the gender imbalance in St. Kitts, an intervention would need to include a component that addresses empowerment in order to be successful. The women themselves expressed the same sentiment, although often less directly, when referring to their low self-esteem and difficulties communicating with men, but trusting a couple of close female friends, with whom they already talk about domestic issues. Strategies for interventions mentioned included role plays and drama, as well as songs and stories or scenarios that the women themselves write to present different scenarios or situations. The messages part of the intervention would need to include gender identity, self-esteem issues, citizenship and motherhood.

Women and staff members felt that other women – peers – could be trained to share in discussions that would include an empowerment component, and be trained to talk to their co-workers, friends, and other women in the community either in a group or through one-on-one conversations as appropriate. Considering the privacy and confidentiality concerns discussed above, establishing trust and very clear confidentiality and privacy rules within the group of peers will be essential. In the case of the peers trained to deliver prevention interventions, they would not necessarily need to have access to any kind of confidential information, but could be instead the providers of information, prevention messages, support, and referrals. Staff considered that, "If you can get one or two who they can trust, it could work absolutely beautifully." Taking measures so that the intervention is not directly publicised, for instance on TV, was also recommended by staff to establish and maintain the trust of the peer women facilitating the intervention.

3.7 Feasibility of different intervention approaches/components cont'd

Staff stated that women would participate in group activities because there is “safety in numbers” and that including role plays and exercises would increase their self-confidence and help women to actively participate. The women also stated they would participate in a group since it may be easier to learn, express themselves, or share things in a group situation. Some deterrents to participation included fear of judgement or criticism by other women as well as reluctance to share sensitive information in a group. The women stated a preference for sharing sensitive information with a trusted colleague or friend. Staff suggested that group meetings should include enough time afterwards for the women to ask or approach the facilitators’ one-on-one if they wanted to address issues they did not want to discuss in front of a group.

There is a precedent of community and health related activities being implemented at the industrial estates with management support, such as “Income Generation Workshops” and “Women’s Health Project”. Women were interested and motivated to participate in those activities. Participants indicated that the training/meetings could be implemented during worktime, considering that the factories have previously sponsored other health-related activities.

The company is very open-minded. They are willing to collaborate with an NGO to implement a programme for these workers. They are even willing to use company time... (Factory Manager) .

Implementing the intervention trainings/meetings outside the factories would be more difficult and less feasible to assemble the women during weekends, as well as more costly to reimburse the women for their transportation costs.



Recommendations for Implementation of an Evidence-Based Intervention

Chapter 4.

3.7 Feasibility of different intervention approaches/components cont'd

The following recommendations reflect the findings of this study and include the type of evidence-based interventions to develop, as well as a list of issues to consider for effective adaptation and implementation of those interventions. Our findings indicate that while women who work at the industrial estates have access to HIV information, they face issues which make it difficult to negotiate safer sex and condom use. In the presence of low self-esteem and lack of empowerment, and because of poverty, economic need, and cultural norms that condone multiple and/or concurrent partnerships and transactional sex, the majority of the women have limited power to negotiate condom use with their male partners.

Based on these findings, we propose an intervention that combines a focus on community mobilisation and shifting community norms, as well as the empowerment of women. Two evidence-based prevention interventions recommended by the Centers for Disease Control and Prevention (CDC), as part of the Diffusion of Effective Behavioural Interventions (DEBIs), emerged as likely candidates for implementation in St. Kitts. Those two interventions are the Popular Opinion Leader (Kelly et al, 1991) and SISTA (DiClemente and Wingood, 1995).

When combined, elements of the interventions will:

- Empower women and increase their self-esteem;
- Affect community norms and break the cycle of women depending on men or feeling they are unable to assert themselves in relationships;
- Provide the skills to apply their knowledge and existing HIV information and negotiate safer sex and condom use, and;
- Enable women to make their own decisions regarding sex and when they are ready to have children.

4.1 RECOMMENDATION: Use the Popular Opinion Leader (POL) model integrating a strong empowerment component to train women working in the industrial estates as POLs.

The POL model focuses on mobilising and training community popular opinion leaders to promote change in sexual risk behaviour and norms throughout a community. POL is designed to identify, enlist and train opinion leaders to encourage safer sex norms and behaviours within their social networks of peers, friends and acquaintances through risk reduction conversations. Based on diffusion of innovation theory, POL attempts to diffuse the innovation of sexual risk reduction through communication by well-respected, popular opinion leaders using specific pathways (verbally), in a purposeful manner, to members of their social group. POL's core elements are described in Appendix I.

Recommendations for Implementation of an Evidence-Based Intervention

cont'd

Chapter 4.

The POL model was found to be effective when targeted to gay and bisexual men in the US (Kelly et al., 1997; Kelly et al., 1991; Kelly et al., 1992) and with women living in US public housing projects (Sikkema et al., 2005). POL has been adapted in international settings; however, to ensure the success of the intervention, significant attention to adaptation has been critical. In Peru, where an NIMH-funded trial was recently completed, adaptations considered differences in: culture (gender, power and the local definition and identification of “popular, well-trusted and respected leaders”); at-risk target populations; socioeconomic status; access to HIV and STI information and services and communication styles (Rosasco et al).

Examples from settings where the intervention has not been adapted successfully highlight the tension between fidelity to the core elements of the intervention and fit to the local culture and population receiving the intervention (Castro, Barrera, & Martinez, 2004). While there are no absolute rules regarding adaptation, Backer’s (2001) approach for navigating intervention fidelity and adaptation emphasises a careful and thorough understanding of the new target population; feasibility of implementation of the intervention’s core elements; appropriate human and financial resources; documentation of adaptation efforts; community involvement and ongoing evaluation of adaptation efforts.

The potential reach of the POL model as a community-level intervention is large. Community-level interventions, in contrast with individual interventions, focus on affecting the entire community in order to promote change in norms and sexual risk. In this case it would involve training the women who work at the factories in St. Kitts as POLs, but since the women live all over the island their role would be as agents of change diffusing prevention messages and changing community norms not only among their co-workers but also among other women throughout the island.

4.2 RECOMMENDATION for integrating the empowerment component from SISTA into the POL model

SISTA is a peer-led group-level intervention developed to provide African American women who have sex with men with coping and skills training around sexual risk reduction behaviours and decision-making, ethnic and gender pride, and a sense of empowerment to actively protect themselves from HIV infection. Based on the Theory of Gender and Power, SISTA can address the issues of disempowerment among women in St. Kitts. The empowerment component of this intervention would fit very well with the POL model and help fulfill the needs of the women as expressed by the participants in our study.

Recommendations for Implementation of an Evidence-Based Intervention

cont'd

Chapter 4.

4.3 RECOMMENDATIONS for adapting the content of POL and SISTA

The content and prevention messages of these two interventions originally developed in the United States will need to be tailored and culturally adapted for women in St. Kitts. Adaptation, tailoring and development of the intervention and related prevention messages should be done in collaboration with local cultural experts. Different stakeholders, such as the International Nursing School, Gender Affairs Department, and the AIDS Secretariat need to be kept informed of the process of developing the intervention and are potential partners in its development and implementation.

Women and public health officials alike recommended using strategies such as drama, visuals, stories from women's lives, role plays and working with local folk music groups to perform songs with an empowering message written by POLs.

Intervention messages and other intervention components, such as condom negotiation and skills, should be developed in the context of difficulties women face in negotiating condom use with men (power dynamics related to economic issues between men and women, men refusing to use condoms and domestic violence).

The content of the intervention will need to include confidentiality and privacy issues. POLs must be adequately trained in confidentiality and privacy issues since respondents indicated that there is a general lack of confidence in the ability of co-workers to maintain confidentiality.

There are co-workers at the factories that the women look up to and already trust. Staff also emphasised the importance of POLs establishing trust and credibility, for example by not lying about their behaviours, and ensuring that conversations they have with other women who are their peers remain confidential. POLs would be selected through a nomination form, stating in advance that confidentiality will be in place and that the POLs "Will not carry stories from here to there." Because of concerns regarding confidentiality, it may take time for women working in the factories to come to trust the POLs. Considering that women are used to interventions that aim to increase knowledge, but not necessarily change norms, they will have to have time to learn to trust each other, to support each other and to experience the individual and community-level empowerment that are at the core of the proposed interventions. In addition to changing norms around HIV prevention, these interventions have the potential to change community norms regarding trust and support, which participants indicated women needed.

4.4 RECOMMENDATIONS for implementation of the intervention

Based on previous studies, the following implementation guidelines should be considered when implementing the intervention:

Recommendations for Implementation of an Evidence-Based Intervention

cont'd

Chapter 4.

1. The target for the intervention should be 15% of women who work at the factories would be POLs. For instance if there are 700 women in the factories a total of 75 women will need to be trained over time as POLs.
2. The duration of the intervention should be at least one year.
3. Convene trainings once per week for four or five consecutive weeks in different waves until the required number of women are trained as POLs.
4. Convene follow up reunions with POLs every two months, for a year.
5. POL trainings and reunions should be held during work hours because women come to work from all over the island and need to return home to pick up children, do housework, etc. Factory managers have been supportive of providing work release for community and health-related activities already conducted at the factories. The specifics of providing work release time for women to participate in the intervention will need to be worked out with the factory owners/managers regarding how much time, how often, and available space at the factories once the intervention has been designed. If trainings and reunions were done outside office hours, transportation to and from home (encompassing the entire island) would need to be provided for women to attend.
6. Use incentives such as food plus a raffle at the end of the trainings for a professional development activity such as a course or training programme.
7. Prior to implementation, the intervention procedures, content and messages should be pilot tested with a group of women. The results of this pilot test will be used to refine the intervention based on the input of the participating women.
8. An intervention manual will be developed to document the intervention design and its contents and facilitate future replication.

4.5 RECOMMENDATIONS for process evaluation and outcome monitoring

Process evaluation data will be collected to assess the processes of implementation and the feasibility and acceptability of the different intervention components. The process evaluation will take place periodically during the intervention and include a combination of quantitative, qualitative and observational methods to capture the perceptions of staff and women participating in the intervention.

Recommendations for Implementation of an Evidence-Based Intervention

Chapter 4.

cont'd

Outcome monitoring data will be collected to assess the reach of the intervention and the extent and content of the conversations POLs maintain with peers and other women. Outcome monitoring will take place periodically during the intervention and include a combination of quantitative and qualitative measures such as short surveys and interviews with POLs and women in the community.

4.6 RECOMMENDATIONS for staffing

It will be important that adequate human resources are allocated to allow for appropriate intervention development, implementation and support and sustainability.

Appropriate staff time will need to be dedicated for the development of the intervention design, content, procedures, pilot test, intervention manual and process evaluation measures.

A minimum of two intervention facilitators will be needed to implement the intervention. Staff activities will include identification and recruitment of POLs, facilitation of POL training and periodic follow up reunions and support of POLs throughout the one year of the intervention, logistics, and process evaluation.

The intervention facilitators will need to be Caribbean women, preferably from St. Kitts, trained on how to implement POL and SISTA.

Other service providers in the country could be important collaborators, if trained alongside CHAA staff, they could help to ensure sustainability of the intervention after the grant period is over.

4.7 RECOMMENDATION for additional intervention components to be added over time

The intervention should include linkages and referrals to other services available for women in St. Kitts, such as HIV testing, counselling, family planning, domestic violence, and micro-financing. It may also be possible to integrate VCT services into the intervention.

It is highly desirable that the intervention team considers integrating or developing a separate intervention for men. The consensus among our informants was that any intervention with women will need to include men as they are the ones putting women at risk and not much prevention work has been done with heterosexual men.

References

- Backer TE (2001). Finding the Balance: Program Fidelity and Adaptation in Substance Abuse Prevention: A State-of-the-Art Review. Rockville, MD: Center for Substance Abuse Prevention.
- Boisson E, Gatwood J, Williams-Roberts H, Trotman C. (2005). HIV seroprevalence among male in-mates in Her Majesty's Prison, St. Kitts and Nevis. *West Indian Medical J.* 54 (suppl. 2): 67
- Bombereau G, Allen C (2008). Social and Cultural factors Driving the HIV Epidemic in the Caribbean: A Literature Review. Trinidad & Tobago, Caribbean Health Research Council.
- Castro FG, Barrera M Jr, Martinez CR Jr (2004). The cultural adaptation of prevention interventions: resolving tensions between fidelity and fit. *Prevention Science*; 5(1): 41-45.
- Committee on the Elimination of Discrimination against Women, Twenty-seventh session, United Nations, (<http://daccessdds.un.org/doc/UNDOC/GEN/N02/423/21/PDF/N0242321.pdf?OpenElement>. Accessed 21/5/2009).
- Diffusion of Effective Behavioral Interventions (DEBI) - available at <http://www.effectiveinterventions.org>
- DiClemente RJ, Wingood GM (1995). A randomized controlled trial of an HIV sexual risk reduction intervention for young African-American women. *Journal of the American Medical Association*; 274 (16): 1271-6
- Kelly JA, St Lawrence JS, Diaz Y E, Stevenson LY, Hauth AC, Brasfield TL, et al. (1991). HIV risk behavior reduction following intervention with key opinion leaders of population: an experimental analysis. *American Journal of Public Health*, 81(2): 168-171.
- Kelly JA, St Lawrence JS, Stevenson LY, Hauth AC, Kalichman SC, Diaz YE, et al. (1992). Community AIDS/HIV risk reduction: the effects of endorsements by popular people in three cities. *American Journal of Public Health*, 82(11): 1483-1489.
- Kelly JA, Murphy DA, Sikkema KJ, McAuliffe TL, Roffman RA, Solomon LJ, et al. (1997). Randomised, controlled, community-level HIV-prevention intervention for sexual-risk behaviour among homosexual men in US cities. *Community HIV Prevention Research Collaborative. Lancet*, 350(9090): 1500-1505.

References

cont'd

Sikkema KJ, Anderson ES, Kelly JA, Winett RA, Gore-Felton C, Roffman RA, et al. (2005). Outcomes of a randomized, controlled community-level HIV prevention intervention for adolescents in low-income housing developments. *Aids*, 19(14): 1509-1516.

Stuart S (2000) "The Reproductive Health Challenge: Women and AIDS in the Caribbean." In *The Caribbean AIDS Epidemic*. Eds. Glenford House and Alan Copley. University of the West Indies Press.

USAID and Measure Evaluation (2007). *An HIV and AIDS Situational Assessment: Barriers to Access to Services for Vulnerable Populations in St. Kitts and Nevis*.

Wasserheit J, Aral S, Holmes K, Hitchcock P (Eds). (1991). *Research Issues in Human Behaviour and Sexually Transmitted Diseases in the AIDS Era*. Washington DC: American Society for Microbiology.

(<https://www.cia.gov/library/publications/the-world-factbook/geos/sc.html>; <http://www.nationsencyclopedia.com/Americas/St-Kitts-and-Nevis-INDUSTRY.html>).

(Committee on the Elimination of Discrimination against Women, Twenty-seventh session, United Nations, <http://daccessdds.un.org/doc/UNDOC/GEN/N02/4323/21/PDF/N0242321.pdf?OpenElement>. Accessed 21/5/2009).



Core Elements of Evidence-Based Prevention Interventions

Popular Opinion Leader (POL):

POL is a community-mobilisation programme designed to identify, enlist and train opinion leaders to encourage safer sex norms and behaviours within their social networks of friends and acquaintances through risk reduction conversations.

Core Elements of POL

1. POL is directed to an identifiable target population in well-defined community venues where the population's size can be estimated.
2. Those persons who are most popular, well liked, and trusted by others in the population segment can be identified.
3. Over the life of the programme, 15% of the target population size found in the intervention venues are trained as POLs.
4. The programme teaches POLs skills for initiating risk reduction messages to friends and acquaintances in everyday conversations.
5. Four or five weekly group training sessions use instruction, facilitation modelling, and extensive role exercises to teach POLs skills and gain confidence in delivering effective HIV prevention messages to others.
6. POLs set goals to engage in risk reduction conversations with friends and acquaintances in the target population.
7. POLs conversations are reviewed, discussed, and reinforced at subsequent reunion and problem-solving training sessions taking place periodically during the life of the intervention.
8. Logos, symbols or other devices are used as "conversation starters" between POLs and others.

SISTA: Sisters informing Sisters on Topics about Aids

SISTA is a group level, gender and culturally relevant intervention, designed to increase condom use among heterosexually active women. Five peer-led sessions are conducted that focus on ethnic and gender pride, HIV knowledge, coping and skills training around sexual risk reduction behaviours and decision-making.

Core Elements of Evidence-Based Prevention Interventions

cont'd

Core Elements of SISTA

1. Convene small-group sessions to model skills development, role-play women's skills acquisition, and address the challenges and joys of being an African American woman
2. Use skilled African American female facilitators to implement SISTA group sessions
3. Use cultural and gender appropriate materials to acknowledge pride, enhance self-worth in being an African American woman (e.g. use of poetry by African American women)
4. Teach women to communicate both verbally and nonverbally to show that she cares for her partner and needs to protect herself (i.e. negotiation skills, assertive communication skills)
5. Instruct women on how to effectively and consistently use condoms (i.e. condom use skills)
6. Discuss cultural and gender-related barriers and facilitators to using condoms (e.g., provide information on African American women's risk of HIV infection)
7. Emphasise the importance of the partner's involvement in safer sex (i.e. enhance partner norms supportive of condom use)



Interview Guides

Interview and Focus Group Guide for Organisations and Government Staff

APPENDIX II

We are here to talk about HIV prevention for women and what else you think could be done to prevent women from being infected with HIV.

(Only for focus group) But first I'd like to go around the room and ask each of you to introduce yourselves and tell us what kind of HIV-related work you do and where you work.

Now I would like to ask you what makes St. Kitts special or unique compared to other Eastern Caribbean islands?

- Now I would like to ask how do you see HIV affecting women in St. Kitts?
- What puts women at risk for HIV?
- What segments of women are at risk?
- What places or venues that women frequent can be conducive to risky sexual behaviours?
- What expectations do women have of the men they are in a relationship/have sex with?
- How long do these relationships typically last?
- Who primarily makes decisions in these relationships?
- What do men expect of the women?
- How do women protect themselves from being infected with HIV?
- What else do you think can be done to prevent women from being infected with HIV?
- What would help for women to be able to prevent HIV?

Explore:
Having their partners use condoms
Using female condoms themselves

Interview Guides

Interview and Focus Group Guide for Organisations and Government Staff

APPENDIX II

cont'd

What works against women being able to protect themselves?

Probe:

- Economic circumstances
- Difficulties negotiating condom use
- Alcohol/Drugs
- Domestic violence
- Self-Esteem issues

Current Programmes/Knowledge

What HIV prevention programmes have been done here?

What did those programmes consist of?

Any specific programmes for women?

What do you think those programmes have achieved?

Future Programmes

- What else do you think can be done to prevent women from being infected with HIV?
- Who do you think women would feel comfortable or trust talking about HIV with?
Probe: Doctors
Nurses
Social workers/counsellors
Other women like them (peers)
Other women in the community they trust (eg. Hairdressers)
- What do you think would attract women to talk about prevention? What activities could be done for that?
- What would motivate them to participate in those activities?
- Would those be conversations one-on-one?
- Would women go to workshops to talk about HIV prevention?
- What if we organised a social activity, such as getting together to eat or to talk about some other topics and we included something about HIV prevention as part of those social gatherings?
- Who do you think would be interested in going to those?

Interview Guides

Interview and Focus Group Guide for Organisations and Government Staff

APPENDIX II

cont'd

Future Programmes

cont'd

- And if we had several of those gatherings, would women come back?
Probe: for reasons why women would come back/or not come back
- What would make women openly participate and talk about themselves?
- And could we invite all women to those get togethers or are there women that do not mix with each other?
Probe: Economic strata
Sexual risk
Other
- Based on the issues we talked about earlier and the reasons you mentioned why women cannot protect themselves, what specific messages about HIV prevention do you think women need?
- Where do you think those social activities/get togethers could take place so women would go?
Probe: Someone's house
A rented space
A community centre
- Based on other activities in women's lives, when should those get togethers take place so women feel they can go?
- And again, based on other activities in women's lives, how often would they be able/willing to attend these activities?
- What recommendations would you make to anyone developing HIV prevention strategies here?

Description of the Core Elements of Prevention Interventions

Before we end we wanted to get your input on a couple of prevention interventions that were developed in the US to see whether you think it would be feasible to adapt those for women in the Caribbean.

Participants will be shown the core elements of the two evidence-based interventions below and asked to describe how each of them could be adapted for the Caribbean.

Interview Guides

Interview and Focus Group Guide for Organisations and Government Staff

APPENDIX II

cont'd

Popular Opinion Leaders

A community-level intervention using opinion leaders to promote safer sex, sexual norms and behaviours through risk-reduction conversations within their social networks.

References: Kelly JA, St. Lawrence, JS, Diaz YE, Stevenson LY, Et al. (1991). HIV Risk Behaviour Reduction Following Intervention with Key Opinion Leaders of Population: An Experimental Analysis, *American Journal of Public Health*, 81 (2), 168 – 171.

Kelly J (2004). "Popular Opinion Leaders and HIV Peer Education: Resolving Discrepant Findings, and Implications for the Implementation of Effective Community Pro-grammes." *AIDS Care* 16(2): 139-150.

Core Elements of POL (Popular Opinion Leaders)

1. POL is directed to an identifiable target population in well-defined community venues where the population's size can be estimated.
2. Ethnographic techniques are systematically used to identify segments of the target population and to identify those persons who are most popular, well-liked, and trusted by others in each population segment.
3. Over the life of the programme, 15% of the target population size found in the intervention venues are trained as POLs.
4. The programme teaches POLs skills for initiating risk reduction messages to friends and acquaintances in everyday conversations.
5. The training programme teaches POLs characteristics of effective behaviour change communication messages targeting risk related attitudes, norms, intentions, and self-efficacy. In conversations, POLs personally endorse the benefits of safer behaviour and recommend practical steps needed to implement change.
6. Groups of POLs meet together weekly in sessions that use instruction, facilitation modelling, and extensive role exercises to help POLs refine their skills and gain confidence in delivering effective HIV prevention messages to others. Groups are small enough to provide extensive practice opportunities for all POLs to shape their communication skills and create comfort in delivering conversational messages.
7. POLs set goals to engage in risk reduction conversations with friends and acquaintances in the target population between weekly sessions.
8. POLs conversations are reviewed, discussed, and reinforced at subsequent training sessions.

Interview Guides

Interview and Focus Group Guide for Organisations and Government Staff

APPENDIX II

cont'd

9. Logos, symbols, or other devices are used as “conversation starters” between POLs and others

SISTA: Sisters Informing Sisters on Topics about AIDS

This group-level, gender and culturally relevant intervention, is designed to increase condom use with sexually-active African American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviours and decision-making. The intervention is based on Social Learning theory as well as the theory of Gender and Power.

Reference: DiClemente RJ, Wingood GM, (1995). A randomised controlled trial of an HIV sexual risk reduction intervention for young African-American women. *Journal of the American Medical Association*, 274 (16): 1271-6.

Core Elements of SISTA

1. Convene small-group sessions to discuss the session objectives, model skills development, role-play women’s skills acquisition, and address the challenges and joys of being an African American woman
2. Use skilled African American female facilitators to implement SISTA group sessions
3. Use cultural and gender appropriate materials to acknowledge pride, enhance self-worth in being an African American woman (e.g. use of poetry by African American women)
4. Teach women to communicate both verbally and nonverbally to show that she cares for her partner and needs to protect herself (e.g. negotiation skills, assertive communication skills)
5. Instruct women on how to effectively and consistently use condoms (e.g. condom use skills)
6. Discuss cultural and gender-related barriers and facilitators to using condoms (e.g. provide information on African American women’s risk of HIV infection)
7. Emphasise the importance of partner’s involvement in safer sex (e.g. enhance partner norms supportive of condom use)

Those are all the questions I have for you. Is there anything else you would like to add that we have not talked about?

Thank participants for their time and participation

Interview Guides

Interview and Focus Group Guide for Women

APPENDIX II

Thank you for taking the time to meet with us today. We are here to talk about HIV prevention for women and what you think could be done here to prevent women from being infected with HIV. This interview/group discussion will take approximately an hour/2 hours.

I have a series of questions for you related to relationships, sexual behaviours, and HIV as they affect women. The interview/group is anonymous in the sense that you do not have to give us your name in any way. I may take some notes as we talk, and we will tape-record the interview/group discussion so it can be typed up for the study investigators to read. Only members of the research team are allowed to listen to the recordings or read the transcript. We are also asking everyone in this group not to talk outside the group about what was said here or who said what. Does everyone agree to that?

There are no “right” or “wrong” answers to the questions; people differ in their experiences and opinions about things and we want to learn more about you, and your experiences and opinions. Some of the questions we have may be a little more personal, but everything you tell us will be kept completely confidential. If a question or topic comes up that makes you uncomfortable, just let me know and we will simply move to the next question.

Do you have any questions for me?
Let's begin!
I will turn on the tape recorder now.

(Only for focus group) But first I'd like to go around the room and ask each of you to tell us what your favourite thing is to do during your free time.

Interview Guides

Interview and Focus Group Guide for Women

APPENDIX II

cont'd

HIV Prevention

Now I'd like you to think back to the last time when you and a (woman) friend, relative or neighbour, or among a group of women, talked about a topic that was important to you. What did you talk about?

(Write list of topics on the board. Tell participants that you will go back to some of those topics on the board).

And where were you when you talked about those topics?

What other places can you think of where women go to talk to friends or socialise?

Now I'd like to switch topics and talk about HIV. How do you think HIV has affected women here?

If you can think of women that you know, either a friend, a relative, or a neighbour, what do you think makes her at risk of getting infected with HIV?

How do women protect themselves from being infected with HIV?

What works against women being able to protect themselves?

Probe:

- Economic circumstances
- Difficulties negotiating condom use
- Alcohol/Drugs
- Domestic violence

What would help for women to be able to prevent HIV?

Explore: Not having sex

- Having their partners use condoms
- Using female condoms themselves.

Current Programmes / Knowledge

Have you heard about any prevention programmes for HIV and AIDS here?

What did these programmes consist of?

Have you participated in any of those programmes?

What did you learn from those programmes?

What do you think that programmes have achieved on the island?

Interview Guides

Interview and Focus Group Guide for Women

APPENDIX II

cont'd

Future Programmes

And now, we have one more section to cover and then we are finished. As we said at the beginning we are interested in finding out what other prevention programmes are needed for women.

What else do you think can be done to prevent women from being infected with HIV?

Currently, if you have questions about your health and prevention of HIV in particular, where can you get information or have your questions answered?

I'd like you to think for a minute about women that you talk to, whether just to chat, gossip, or talk about things that are important to you. We don't need their names but who do you talk to?

Probe: friends, relatives, neighbours, professionals

Who do you think women would feel comfortable or trust talking about HIV with?

Probe: Doctors

Nurses

Social workers/counsellors

Other women like them (peers)

Co-workers

Hairdressers

Thinking of your women friends or relatives or neighbours what do you think would attract women to talk about prevention? What activities could be done for that?

Would those be conversations one-on-one?

Would they go to workshops to talk about HIV prevention?

What would motivate you to participate in those activities?

What if we organised a social activity, such as getting together to eat or to talk about some of the topics that you mentioned before (point out to topics on board) and we included something about HIV prevention as part of those social gatherings?

Who do you think would be interested in going to those?

And if we had several of those get togethers, would women come back?

Probe: for reasons why women would come back/or not come back

Interview Guides

Interview and Focus Group Guide for Women

APPENDIX II

cont'd

And could we invite all women to those get togethers or are there women that do not mix with each other?

What specific messages about HIV prevention do you think women need so they can protect themselves?

Where do you think those social activities/get togethers could take place so women would go?

Probe: Someone's house
A rented space
A community centre

Based on other activities in women's lives, when should those get togethers take place so women feel they can go?

And again, based on other activities in women's lives, how often would they be able/willing to attend these activities?

What recommendations would you make to anyone developing HIV prevention strategies here?

Those are all the questions I have for you. Is there anything else you would like to add that we have not talked about?

Thank participants for their time and participation.



9 June, 2009
Frigate Bay Resort, Conference Facility

INTERVENTION FEASIBILITY DISSEMINATION WORKSHOP

APPENDIX III

Background:

After completion of the report, it was disseminated through a workshop to stakeholders working in social services and HIV prevention in St. Kitts/Nevis. The purpose of the workshop was to disseminate the report findings to stakeholders and seek feedback on the recommendations set out in the report. The workshop was well attended and a lively discussion resulted in the following points, which should be used in combination with this report to guide intervention development.

Comments/ Questions:

- The International University of Nursing (IUN) located in St. Kitts has been conducting a project with women at the factories for two years. Sessions occur every month at approximately 13 factories. The project addresses issues such as obesity and hypertension. However, HIV and AIDS is not a topic covered. They see this intervention as an opportunity for collaboration between the IUN and CHAA. They would like to support the project and a recommendation was made to train and utilise the nursing students to assist.
- The empowerment component is core to the intervention being a success and should not be underestimated. There is a concern that low self-esteem and disempowerment issues are entrenched in women from a very early age and that it may not be possible to reverse it at the stage of the factory women.
- While the information provided about the factory women is not new, it was very useful to have it researched and documented using a structured scientific approach as opposed to having anecdotal information. It is also practical that the intervention is targeting a finite group of persons.
- There are patriarchal and societal norms that contribute to the way women perceive themselves and the way they behave. Women in St Kitts condition their daughters to defer to men. Women have grown to accept that a 'buss head' is a norm. So they themselves are enablers of the patriarchal society. It is something that is systemic and will take a lot of work with the women to try to change these norms. The intervention will have to target women who are strong individuals and who can point other women to seek help. The entry point for POLs should be at the secondary school level and be built into the life-skills curriculum.
- Self-esteem seemed to be a major issue for the stakeholders and how it will be incorporated into the intervention. The following were comments made regarding self-esteem.

INTERVENTION FEASIBILITY DISSEMINATION WORKSHOP

- Self-esteem is a major issue and it is intertwined with poverty. There are limited options for women in St Kitts. As a woman, you can either become a beauty queen, an athlete or a mother. Women need more options and they need to be able to negotiate in the sexual arena.
- Low self-esteem is also linked to lack of education. There are many parents that lack self-esteem and they pass this on to their children. Work needs to be done with these parents.
- Staff of existing teenage mothers programmes that address issues such as self-esteem have found that changes are difficult for the young women that participate in these programmes since they continue to be exposed to the same environment at home.
- There is a teenage mothers support group that addresses empowerment of women. It is done at the community level. The women at the factories are from different communities but when you focus on one community there is effective change.
- There is a concern re:the sustainability of the intervention. What is the period of training? Is there any psychosocial support to be included for POLs?

Evaluation is important. There is a difficulty in envisioning the success of the intervention. What will CHAA be measuring? How will you measure self-esteem? How do you measure the impact of POLs?

- The media should not be involved. Society benefits if women are empowered, however because of the sensitivity of gender issues, empowerment needs to be addressed as part of the realisation of gender equality and not be publicised.

Recommendations:

- The process should be a collaborative effort. Factory managers have complained that too many groups are trying to address the same issues and having too many programmes takes time away from the employees' work. It would be more practical to have these groups work together in delivering programmes to reduce the time spent by the women away from work.
- Factory managers need to be involved in the process. They have been an invaluable source of information. They have identified some of the key issues affecting women in the factories, e.g. pregnancies, and were able to direct Gender Affairs in implementing programmes.

INTERVENTION FEASIBILITY DISSEMINATION WORKSHOP

APPENDIX III

cont'd

- There is a recommendation in the report to integrate men into the intervention. This is not needed for the intervention to be successful and should be left out. However, a mother and daughter approach can be considered. CHAA might want to explore the option of targeting the women first but extending the intervention to incorporate daughters of the women at the factories.
- It must be ensured that persons are getting the correct 'dose' of the intervention if you want to influence behaviour change. There is also a concern that not all the women at the factory will be reached.
- Human resources facilitators can be sourced from the Social, Gender and Health Ministries. Also recommended that retired health workers be considered as an option.
- The community nurses have already established links with the factories via the Gender and Health Ministries. CHAA may consider using these links so that the intervention does not come as another request to factory owners.

Duration:

- Increase the intervention period from 12 to 18 months. 12 months is too short a period for the intervention to work effectively.
- The following are suggested frequencies for conducting the "reunion" sessions:
 - Every 6 to 8 weeks
 - Every 2 months
 - Every 3 months

Selection of POLs:

- The level of knowledge of HIV and AIDS is high among the women but behaviour change is slow. Informal leaders at the factories can be used as POLs. They should be targeted with behaviour change interventions and then held up as examples to other women in the factories. There are a few informal leaders who are very vocal and can influence the women at the factories.
- Need to ensure that there is sufficient time to empower the POLs. A lot of work has to be done with the POLs before they start advocating. Behaviour change has to start with the POLs, so even though they may be popular they may not necessarily be positive influences. Therefore they need to be fully trained and bought into the intervention before they can become leaders themselves.

INTERVENTION FEASIBILITY DISSEMINATION WORKSHOP

APPENDIX III

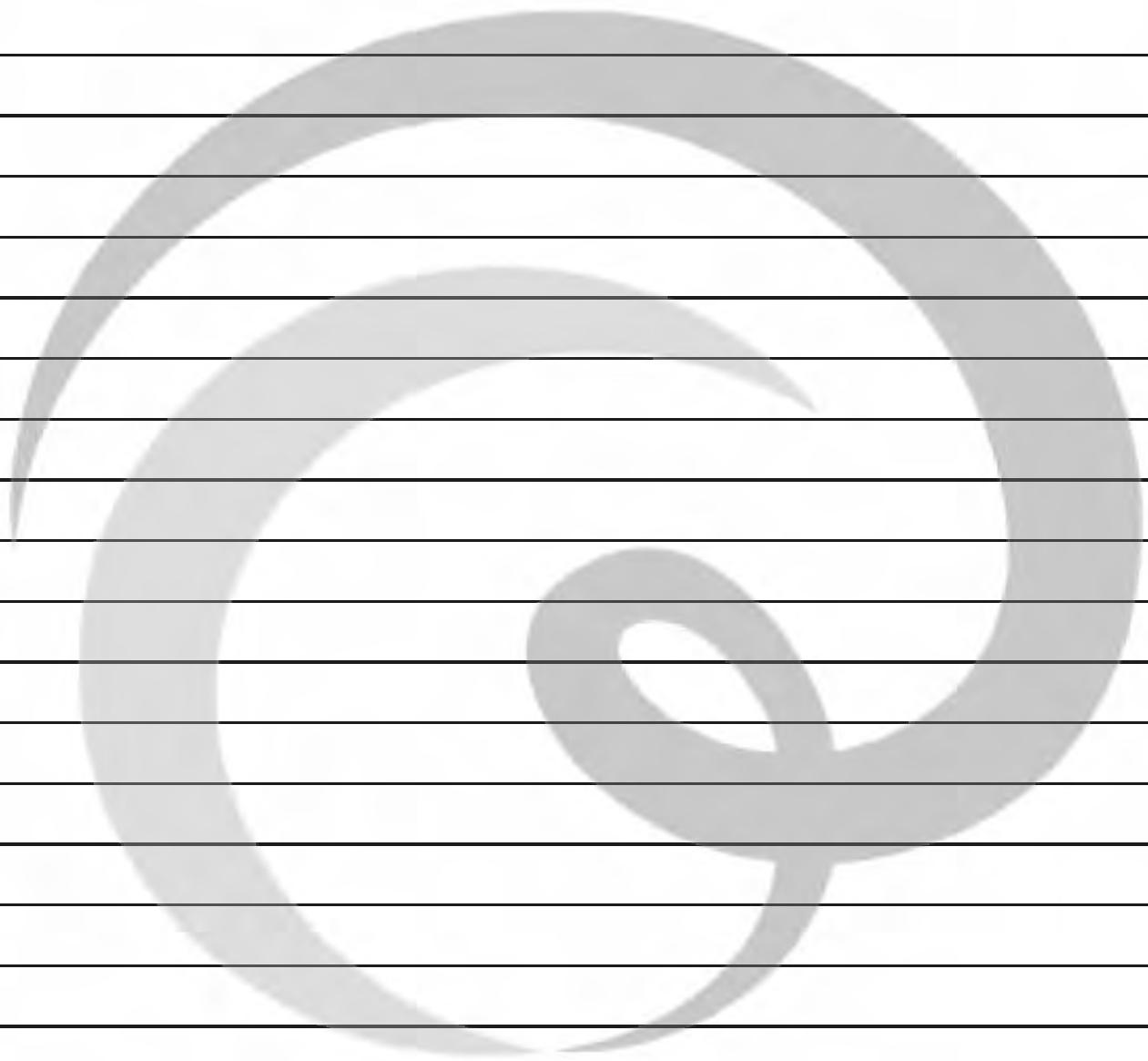
cont'd

- The intervention model does not incorporate paying a stipend to the POLs. There was disagreement on this issue as some participants felt that persons will not want to be POLs if they are not compensated while others felt that providing a stipend would contribute to the 'what's in it for me' pattern.
- Factory owners could help identify potential POLs.
- The factory women should nominate persons to be POLs through a voting process.
- There are already HIV Point Persons at the factories who can be potential POLs.
- Having factory owners appoint or select POLs may not be ideal. Managers may limit POLs to persons who are felt to be leaders in the workplace but not necessarily amongst peers.
- Peers should select POLs but instead of using a voting process, adopt a low-key approach and have workers identify persons without voting.
- POLs need to be trained in confidentiality issues. It is important for the women to be able to trust the POLs. According to one stakeholder, "The dilemma we face is how to maintain privacy and confidentiality in a nosey society, skilled at storytelling."
- It is important that there is a support system in place for POLs. Perhaps incorporating a social worker into the model to provide psychosocial support to POLs.
- The project needs to make provision for the initiatives of POLs. Their ideas and initiatives should be fostered.

Considerations by CHAA/UCSF:

- Mother/daughter approach could be incorporated in the 'reunion' session.
- There will be reunions and 'in-between' sessions for POLs to interact with intervention staff. However, a system can be developed for psychosocial support where there will be linkages to other services.
- To ensure effective 'dosage' of the intervention, the women can invite friends and integrate other women into the reunions.
- Triangulation process to be used in the selection of POLs.

NOTES



CHAA COUNTRY OFFICES

Antigua and Barbuda

Newgate Street
St Johns
Antigua
Tel (268) 562 7327 / 8

Barbados

Beaumont House
Hastings, Christ Church
Barbados
Tel (246) 228 4306

Jamaica

(Temporary Office)
522 Lantana Close
Kingston 6
Jamaica
Tel (876) 946 8630

St. Kitts and Nevis

10 Rose Lane
Greenlands
St. Kitts
Tel (869) 466 3909 / Fax 466 9923

St. Vincent and the Grenadines

P.O. Box 2995
Kingstown
St. Vincent and the Grenadines
Tel (784) 451 2044 / 2046



CHAA'S VISION

A region where people do not experience
discrimination or die of AIDS

CHAA'S MISSION

To facilitate effective and collective
community action to reduce the impact of
HIV and AIDS across the Caribbean.

CONTACT INFORMATION

Caribbean HIV&AIDS Alliance
Head Office
8 Gallus Street, Woodbrook
Port of Spain
Trinidad and Tobago

Phone: (868) 623 9714
Fax: (868) 627 3832
Email: info@alliancecarib.org.tt
Website:
www.caribbeanhivaidsalliance.org

