

## **MCHB/ OWH April 23, 2008 Webcast**

### **Intersection of HIV/AIDS and Violence Among Women**

PETER VAN DYCK: Good afternoon, everybody. I'm Peter van Dyck, Associate Administrator of the Maternal and Child Health Bureau in the Department of Health and Human Services. It is great to be here today with a wonderful panel. Thank you for joining us for this webcast on the intersection of HIV/AIDS and violence among women. HRSA's Office of Women's Health in conjunction with HRSA Women's Health coordinating committee is pleased to partner with three HSS office on women's health grantees to discuss "Intersection of HIV/AIDS and Violence Among Women".

Women account for more than one quarter of the new HIV/AIDS cases today. In fact, in 2005, according to the CDC, HIV/AIDS surveillance report an estimated 37,000 plus diagnoses were made among female adults and adolescents in the United States. High risk heterosexual contact was the source of some 80% of these newly diagnosed infections. For a significant number of women, intimate partner violence dramatically increases their vulnerability to HIV infection. As such, violence against women continues to be a critical public health issue that plays a role in the HIV/AIDS epidemic. The Ryan white HIV modernization act of 2006 which authorizes care and treatment for low income, uninsured and underinsured men, women, children and youth with no other means to meet their medical care and support needs. We hope these presentations will provide an opportunity for you to learn more about the intersection of HIV/AIDS and violence and how we can all work together to help women practice safe and healthy behaviors that will prevent HIV transmission or get care if HIV positive.

Note that copies of the presentation for today's webcast are available online at [mchcom.com](http://mchcom.com) on the registration page. We'll provide the webcast for you again during the web address today. Now today we're really pleased to have speakers with us. They include Amelia Cobb, Laverne Morrow-Carter in Alexandria, Virginia and Dr. Laura Granato, licensed professional counselor and family therapist from Vienna, Virginia. Each of the speakers will say more about their affiliations and expertise during the presentations. Dr. Sabrina Matoff-Stepp, the staff director of the HRSA Office of Women's Health will also provide brief closing remarks. I want to thank you again today for joining us and hope you'll find this webcast helpful. There will be time at the end for you to ask questions, to email questions and for comments from the speakers. Now to get started, some helpful hints on participating in the webcast from Lieutenant Morrissa Rice from the HRSA Office of Women's Health.

MORRISA RICE: Thank you, on behalf of the committee I thank you for participating in this webcast. Now I would like to provide you with some helpful webcast hints. Slides will appear in the central window and should advance automatically. The slides changes are synchronized with the speaker's demonstrations. You may need to use the slide control at the top of the messaging window. Each speaker has been allotted 15 to 20 minutes for their presentation to allow for questions and answers at the end of the webcast. We encourage you to ask the speakers questions at any time during the presentation, simply type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you are participating from. The questions will be relayed onto the speakers periodically throughout this broadcast. If we don't have the opportunity to respond to your questions during the broadcast, we'll email you afterwards. Again, we encourage you to submit questions at any time during the

broadcast. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking on the loudspeaker icon. Those of you who select accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast the interface will close automatically and you will have the opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your response will help us plan for future broadcasts in this series and improve our technical support. Now we will hear from Amelia Cobb, our first presenter. Thank you.

AMELIA COBB: Thank you, Morrissa. Hello, everyone. I'm very excited about this webcast as I know the other speakers here are today. Today I'm going to speak with you briefly about the partnership to reduce intimate partner violence and HIV and give you a little background on our pilot project.

Next slide, please. So the partnership to reduce intimate partner violence and HIV was developed by The Wright Group, a Health and Human Services consulting group that focuses on developing solutions to amplify the impact of the organizations or agencies we work with, their practices with the communities they serve specifically. This project we began in 2006 was a pilot project funded by the Office of Women's Health, a small business contract for the prevention and intervention aids-related services for survivors of domestic violence initiative. Briefly before I go into exactly what the partnership is I want to highlight some of the definitions that we're using. Oftentimes domestic violence is used interchangeable with intimate partner violence. We're defining intimate partner violence as a pattern of assaultive and company derisive behavior including physical, sexual, psychological abuse that adults or adolescents use against their intimate partners. Intimate partner violence can be seen at all socio-economic levels, in all races and both

same sex as well as heterosexual relationships. What is the intersection between IPV and HIV? According to research. The presence of intimate partner violence among women at risk for HIV may be as high as 67%. The association between the risks are infection, may be explained in part by the fact that the abused woman faced difficulty in negotiating safe sex matters with her partner, increasing her risk significantly for infection.

Next slide, please. What is the partnership to reduce intimate partner violence and HIV? I'll go on later to talk about what we mean by the partnership but again as I said it began as a pilot project in 2006 as a growing national effort to partner with domestic violence agencies to provide educational training, support and promotion with domestic violence centers to reduce the risk and rate of women who are female survivors of domestic violence. We have been successful in continuing our project, the pilot project last year to get funded for a second year for 2007, 2008 and I'll discuss some of those activities right now going on later.

Next slide, please. So the partnership has a few focus areas. The first one is to train counselors and shelter workers on the intersection of IPV and HIV. To strengthen the messages and meet the woman more or less where they are at, or the agency. Secondly our goal is to increase access and awareness locally and regionally on testing. Utilization of state and regional HIV services, referrals and truth in partnerships. Specifically not just with the HIV community or with the women's health community but more importantly integrate all social services. And then lastly build HIV capacity and intimate partner violence agencies for institutional and systems change. That's a very key focus of our partnership is systems change. Our goal is to come into an organization that normally had no participation in HIV and build up their infrastructure in IPV and HIV prevention messages for the women in their counseling services and intake processes and develop

the organizational leadership of the staff with respect to HIV particularly the executive director, program managers, shelter staff and actually potentially secure an additional funding and grants to do a full-fledged focus program internally for HIV. Next slide, please. This past year, meaning 2007/2006 our pilot project had two main primary goals. The first one was to provide a three-day eight-hour training series for at least 20 IPV providers to increase their knowledge, understanding of the intersection between the two and their understanding of the risks that women who are survivors of domestic violence actually undergo each day. They are each day are when they are being sexually active with their husband or partner. Our goal at the time was to enroll 50% of agency shelter staff for the training series. We really pushed that because we need everyone to be on board and as we know, in a lot of non-profit organization or social services agencies there is high turnover so if we get 50% of the staff on board that creates the opportunity for trying to train the model if someone is to leave.

The second goal was to increase networking between intimate partner violence agencies and HIV agencies to encourage HIV testing, referral services for females who are survivors specifically in the area. Our project for 2006-2007 started in the district of Columbia and focused there as the pilot project. We have expanded to other areas which I'll go into later. Those areas are Atlanta, Georgia and Baltimore also Los Angeles currently. So as a way of that we established the D.C. partnership working group and I will talk about some of those outcomes further on in the slide.

Next slide. So what are the partnership components? First thing is, as I said before, a key component is organizational change. We make all of our partners undergo a needs assessment to see where are they in their HIV awareness practices from an organizational perspective. Secondly we develop a specific HIV IPV curriculum that is

focused on HIV prevention models and a curriculum but we interweave into that intimate partner violence throughout the entire workbook and curriculum that all of our participants go through. We conduct a pre-training assessment for the individuals who are participating. They have to undergo at least 24 hours minimum of training. This is what we did in the first again I'm speaking of the project our first pilot. There were three models to that. Focused -- the module I HIV/AIDS 101, confidentiality, II, intimate partner violence and relationship in women. III counseling skills for IPV and HIV risk reduction and a follow-up for evaluation pre-and post-test for modules I and II. Model III is case based and interactive. We would train two agencies together and they would learn from each other. Do different scenarios with each other and different cases with each other and beyond it being a good networking group, it also at the end the team kind of builds more or less good relationships that they fostered to actually discuss what some of their fears are. The group got so comfortable that some members would say I don't feel comfortable treating someone who might be HIV positive and we had a code that did not leave the room at the time just like the evaluations were not reported back to the agencies we're partnering with. Everyone who participated had a number so everything would be reported collectively as a group and not singled out to the individuals who knew which questions they had wrong or which questions they had right which made the participants very comfortable. We also did a three-month follow-up, an optional six-month follow-up. Six month follow-up was a little challenging. I'll go into those challenges later. When you talk about social service agencies you have a very high turnover and very limited staff.

Next slide, please. Going back to the working group, D.C. our working group was very successful. We had nine community based organizations in DC that were part of the HIV group. Two there from HIV organizations and everyone else was from an IPV group. Locally we developed recommendations that will be provided to the mayor during this

year's May national women's health week. We originally were going to disseminate the findings in October once we got refunded, however, based on the funding scheduled we thought it would be best to wait this year to do it since we could gather more information, talk to more people. So if anyone is interested in receiving that, please feel free to email me. You can get our contact information at the bottom of our slides on the first page of the our website but what we were able to do is come up with recommendations that we are sending to the mayor of the district of Columbia, the office on women's policies. Over 40 non-profit organizations servicing women in D.C. and the D.C. HIV prevention community planning group. For those of you watching this and keep up with HIV policy, over the past few years D.C. has had some challenging, for lack of a better phrase, very challenging areas in HIV locally, let alone regionally. So we felt like we would give the recommendations on what we thought we could either help them with or some areas they might want to consider that are specific to women. That is the key here. Every document we reviewed we found very little to know things specific to women. The project results from a nine-month intervention, the pilot project was 12 months. We worked with organizations for nine months. We were successful in training 31 IPV providers in HIV prevention. Four substantial abuse professionals, three outreach health educators and other professionals that classified themselves in this IPV category. The backgrounds of the participants were at least more than half were African-American, five were white or Caucasian, six were Hispanic and Latino. We tried to recruit as many Hispanic Latino people in the program. That population is growing across the country and also incorporated language translation materials for women who are survivors. That was very key since a lot of DV agencies have offsite locations where they either recruit, work with a case manager, work with a legal advocate. We found those to be very useful and George Washington University School of Public Health and health services was responsible for our evaluation.

Next slide, please. For module I there was a 20 item questionnaire. We found it increased knowledge almost five points. The three-month follow-up we saw that the knowledge did not retain exactly to the amount but we were pretty successful. It retained 4.5 from their original average of 13.5 points of getting their answers correct.

Next slide, please. For module II there is a 14-item pre-test and post-test that took place that we developed that were not found in the public domain that we developed from social advocates in domestic violence and research. Those focused on the knowledge of the actual intersection of intimate partner violence and HIV which a lot of agencies are very unaware of. We were able to increase those points almost two points and it did drop, though, in the third follow-up month. We attribute that to the turnover. We weren't able to get all 31 to come back and actually do the testing. Some of them answered questions, some of them didn't. We had them do it again anonymous. As we know the demands of an everyday non-profit organization they were just filling them out and we were grateful to even get a baseline.

Next slide, please. Our project achievement. Our goal to train 20 providers, we trained 31. We established HIV prevention testing referral recommendations and the intake process for all of our partners and how they intake women and map out the concept points of where they can introduce prevention messages. We establish the HIV confidentiality policy recommendations for their clients. Upon being a partner, I found that in our other consultants found at the time that agencies thought even the executive directors thought they had HIV confidentiality policies and they told me that. So we responded and said let's see them and we found that they came back and said oh, I'm embarrassed, we really don't. We have a duty to harm policy not a confidentiality policy. In shelters how does a

woman know who the survivors of domestic violence that she can talk about her risks, being tested. In her mind she believes she has to go somewhere else to ask for it. Some of our dissemination outcomes we provided information and testing referral information locally to over 700 women. 727 to be exact. Over 50% above our original objectives to actually provide the 250 women. We were able to provide it to 727 women. That's including one site that we had in Baltimore, which is the house of Ruth, we were able to work with them as well. So I encourage you, if you have additional questions, I want to know a little more information about who our partners are. You can go through our website, [reduce IPV and HIV.org](http://reduceIPVandHIV.org).

Next slide, please. I really kind of want the focus on the challenges and lessons learned here. Since this was a pilot project there has to my knowledge been yet a federal agency or outside agency to fund this type of initiative in detail to train domestic violence workers in HIV prevention. It has been done before. There is very little information about it in the domestic literature. There is more information from an international health perspective. The key thing that we're continuously finding, we have expanded our project to focus on Maryland and Atlanta and now expanding to L.A. as well is that IPV agencies don't think this is a public health issue because they're focused on domestic violence. That's a true, indeed, we have done surveys. In Georgia we called and followed up and did a mini three-question survey to many executive directors. 67 agencies. Oftentimes that's what we got. There is high turnover staff, as I said before, in CBOs. They don't have the capacity for that. Some agencies are run by two people. That's a lot of demand. The impact of local government in relationship to CBO participation. We have four people who are key people from an organization that participate in our working group but unfortunately they won't be able to be listed in our publication that is coming out in May because they receive funding from D.C. government and don't want the backlash of that. Not that they

would but that is an issue that we face when we're talking about policy here. So if we're talking about policy in the federal and local government funds you sometimes there is a concern as to the executive director or the manager to push back on that so we are finding that documentation of clients HIV testing and follow-up, that's a big challenge. We're working on that this year. In the pilot we were unable to do that because a lot of agencies didn't want the liability for it. We found ways where we're making it mandatory and incorporating how it will work and establishing the partnership early. And IPV partners do not want direct access to clients. They don't want us to have direct access to clients, which we understand that but it makes it hard to follow up in the counseling sessions that they are providing the messages and that information. So those are some of the key challenges that we have. From a systems change model it's very hard to change IPV and HIV and bring that together. Again, that has to be a leadership decision and everyone has to come on board with that. I just want to hone in one message when we're talking about women and HIV. We have to meet the client or the organizations where they are. I think that if there is one message from all of these projects I'm sure today that is something that I would like to just throw out there and start off with. That is very key because you won't get anything accomplished. You have to meet them where they are. And you have to take every -- we take every partner on a case by case basis. Every agency is different. Their intake process is different. Their shelter is different. Their policies are different. When you're talking about HIV and trying to incorporate change, that's very key. I want to just highlight where we are now.

Next slide. I believe you can continue to go onto the next slide because I believe I talked about some of these challenges before. I think you moved to the right slide, I think. Did she go to the right slide? You did, great, thank you. Very, very good. Our goals this year will stay the same with the exception we're adding a third and new goal to increase the

number of IPV survivors and HIV testing and try to track that. We're doing something a little different. We're having our eight-hour training series but we're breaking it up because DV agencies, you can't leave somewhere for a whole day. Hard to do that. We've broken it up in three different modules, full day, half day and workshops and we're having follow-ups every single month. So we've kind of changed what we're doing. Using the same curriculum we developed. We've incorporated and developed a new needs assessment that is developed from McKenzie, one of their capacity building needs assessment. We've taken that and created our own around the five phases of change. That's really been helpful. We're currently developing our Baltimore work partnership working group and our Atlanta partnership working groups and those meetings will start next month. But the key thing is testing. It's very challenging. I think the last thing is to reach women and other IPV agencies. We're in the process of developing an online training module for not only women who are in rural areas that we necessarily can't get to but women who particularly might have disabilities working with other women with disabilities. So that is kind of where we're moving. I wanted to focus on what we found last year in our pilot project. I don't want to highlight all the ideas from the slides because you guys have them, but right now we are in the second year and we hope to potentially get funding for a third year to retest as many women as we can. So that, I believe, I'll turn it over to Laverne Carter.

LAVERNE MORROW-CARTER: Yes, Ma'am.

>> Thank you.

LAVERNE MORROW-CARTER: Thank you very much. Good afternoon, everyone. It is such a pleasure to be here. I would like to thank the HRSA office on women's health for this invitation. I'm president and managing principal of research and evaluation solutions,

REESSI for short. We work with government and non-government agencies to reduce premature death, disability and lifelong poverty. Poverty is the key link in that for us. In communities of color. Our focus is primarily in communities of color. Our service areas include program planning, program evaluation, intervention research and building the capacity of communities and organizations to solve their own health problems. We find that when you work at a grassroots level, many community members, if you interface with them, they know the problems and they can give you the solutions. Our services are provided in four states. We're based in all Alexandria but provide services in other areas. I want the focus on the problem statement, the solution of the intervention that we're talking about, our 2007 outcomes and our 2008 focus. The program is entitled J.E.W.E.L.S. which stands for Junior Education on Womanhood, Excelling in Life, and Self-Esteem. It's a community-based intervention that focuses on the multiple threats that young girls face. Our program focuses on girls who are age 10 to 15. Let me move next to the problem statement.

Next slide. We looked at transdisciplinary literature from public health, psychology, juvenile justice. As a person who likes to look and compare things and go outside the dots I was struck when I did a matrix that looked at risk factors. That the risk factors for many of the things that we look at, HIV/AIDS, STDs, gang involvement, substance abuse, juvenile Dell inQuincy conversion. We see them overwhelmed by multiple social threats. What are these risk factors? I don't like to focus on risk factors because I think we need to begin to think about assets but it's important to look at what the risk factors are. They're classic. I've been in public health for 25 years and these are classic risk factors. Low socio-economic status. Emotional estrangement from parents. Associating with peers who engage in risk factors. And exposure -- these girls share with us they're exposed to violence everywhere. Family, school and community. A major risk factor and this is really

a passion for me when I look at self-esteem I get choked up. Girls who have no hope. Do not feel that the future belongs to them. And just basically low self-esteem, we see that and those are very powerful risk factors. Some other things that are dear to my heart when we look at youth and it troubles me and I'm appalled by it and I think we're missing it because we focus with HIV/AIDS on so many other populations, but black youth age 13 to 19 are 69% of the aids cases reported in 2005. And I go slow on those figures. 62% through 2002. There is a 7% increase so we're seeing it escalate. Remember, HIV/AIDS is an exponential disease. And the dormancy and how it rests, just think about where folks will be when they are in their 30s. 16% of all U.S. teens, that's what you want to look at. Black teens only make up 16% of the U.S. Population. Latinos about a year ago people were like well, you know, that's okay because their rates are averaging what they are in the U.S. Population. But we're seeing an escalation in that area. 22% of new aids cases. In suburban cook county, what we run into with our Latino parents, many of them, I don't like the term illegal. We've learned to say undocumented. I don't think we see the full scope of what is going on with the Latino population because there is so much that isn't even on the table. One of our communities, summit, Illinois, I get these calls at 10:00 at night from my Latino staff who say to me, we found, we have a Latino who has HIV/AIDS and we don't know what to do. The hospitals have turned them away because the parents are undocumented and they've been told to go back to Mexico. A colleague of mine was chief of HIV/AIDS for the State of Illinois. I called her at midnight. They don't know anything about this case in summit so that's an anecdotal story but very real in terms of what we see with Latino populations. Females now you move into another issue comprise the largest share of HIV/AIDS cases among teens than among the adult segments of the population. 39% among 13 to 19-year-olds look at that age, 13, which is why we dropped down 10 to 12. We were in the 9 to 12 but the 9-year-olds told us they weren't ready for what we were presenting so we're looking at what we're calling a

J.E.W.E.L.S. junior with 9-year-olds that will focus more on relationships which is what they told us they wanted. Moving on, one quarter of teens age 15 to 17, this is profound, have not had discussions with a parent, guardian or an adult about sex, birth control, condoms or STDs. I linger on this because it is profound when we look at where we will be ten years from now when our youth are young adults. Now to do some other links. We focus on gang activity. If suburban cook county we're finding that gang activity is moving from the City of Chicago to suburban areas where law enforcement agencies are underfunded and overwhelmed. Y'all can look at the slide. I want to share with you something that gang activity in most cases, if you don't know, is economics. The big industry historically has been drugs. But there is a new game in town particularly in Cook County. It is prostitution. So we're told by law enforcement officials that we interface with them that they're -- there are girls called could bes. And these are girls who are under age 9 who could be gang members. And then there are wannabes, girls who are 13 and older who have not been initiated into gang activities. Again I'm telling you all that my topic is multiple social threats. And I'm just hitting only the tip of the iceberg. Female gang members we're seeing an increase in juvenile delinquents. It's running away. We don't even want to talk about all the things that happen with girls when they run away from home and then second is prostitution.

Now, what is the J.E.W.E.L.S. solution? Our solution is not to focus on the risk factors, but to look at building what many scholars and advocates call developmental assets and protective factors. Our project was funded in 2007 much like what Amelia shared by the Office of Women's Health. I would like to plug them right now. One of the benefits of the Office of Women's Health is provision of seed money to go outside the nine dots and work on innovative projects such as what we're talking about today and they're very supportive in their efforts in working with contractors and grantees. The concept and the educational

components for the J.E.W.E.L.S. Project were developed by our staff at REESSI, it's grounded in theory, the information, motivation and behavior theory, the theory we use. We find that one theory is deficient so frequently and especially when you're dealing with communities of color you have to borrow pieces from different theories to get at the change, the knowledge gain that you want and then we were struck by a theory of personal integration theory by a group out of California and what I liked about that theory was the focus on social identity and the self-esteem link for young people. It employs a peer leader strategy. I can't tell you how critical that component is. Those girls are not trying to hear me because they think I'm grandma and they view me as an elder. They think I'm funny and they like to hang with me but they're going to listen to those girls who are 13 to 15. So even in our staffing, we have an intergenerational approach. I'm in my 50s, my project manager is 35, we have another person in their 20s and our peer leaders are 13 to 15 and we're grooming our peer leaders to be leaders. Each generation brings something different to the table. Those girls will come to me when I'm in town for one set of things but as they told me last week, the 30 something is my G, that's my girl. They would not say that's my G to me but they think I'm hip. So we use an intergenerational staffing approach. The sessions are delivered through games, group exercises, video, drama and music. A bit about music. What we've done this year that they love is we introduce every session with a music theme. I love music. We not only give them the music but we give them the lyrics so we've had two talks talking about Brenda's pregnant. We've had life talking about sex, the non-explicit version and we give them the lyrics and tonight they're doing my life 06 and it is important to look at 06 as opposed to when Mary Jane Blige did it in 2004. The girls share with me they love the opening with the music and then we do a video and the peer leaders do their things and we're doing pre-and post-tests. The knowledge level is increased. With the Office of Women's Health we can't get into any really heavy duty research. That's something we're doing in the sustainability

phase of our project. It is based in a safe community setting and we have to say that because of gang activity. In summit, Illinois, there is a conflict between the black gangs and the Latino gangs and we had sessions in the black side of town and the Latino girls were afraid to come. Now we do it at the library, a neutral space setting. Those things are important. The program covers four modules. Myself, I think everything begins with who are you. Understanding yourself, me and others. I've been reading literature about relationship education and that our children, many of these threats that they face come in the context of relationships. But I've been in HIV/AIDS education since the early 1980s when people were trying to discover what it was. I think it's ludicrous now for at this point to talk about don't have sex and don't use drugs and don't do this. But we give our children no understanding of what a healthy relationship is and how to be involved in a relationship. So me and others is all about relationships and they like those sessions. Then we get into the social threats. They don't even know what the social threats are because they're living it every day and they view it as this is my life, this is what I'm doing every day. What is so special? A footnote on me, I'm the oldest of nine children raised by a single mother who was an alcoholic. I didn't know I was poor until I took sociology 106 in undergrad school. It devastated me. They're talking about me, my family and that neighborhood. I had that experience 30 something years ago. A lot of the young ladies don't even know what we're talking about. We need to translate this and bring it down not only for the children but for their parents who are in their late 20s and 30s. It's a profound ministry at work. Our 2007 strategy to move on because I could spend a lot of time on this and I won't, monthly training, counseling. We have a relationship with the mental health facility and I have to say about mental health services, we've sought it out. The mental health services are overwhelmed. So I have a girl talking about depression and killing herself and the mental health facility is telling me she can't get in for four months. One of the things that has been in my mind is how do I get a licensed clinical social worker that

volunteers or is on my staff to do group counseling sessions with our girls on a monthly basis? I'm seeing major, major mental health issues not only in the girls but in their families. And we have the peer leaders were 13 to 15. Last year we did five, three-hour sessions.

We did newsletters, next slide. Our performance measures included the number of participants. Our goal was 80. We ended up with 101 participants who came. It was active. We did do an analysis of the pre-and post test and had significant knowledge gain of .001 which is very significant. Participants reports on satisfaction were very high. That's critical. Young people will tell you if they like it or if they don't like it. I did get a question last week about why they have to do so many tests. Why so much paperwork and I kind of translated and explained that we have a war going on and everything is competitive and money is short and people want to see what works. And they got it. The 10 to 12-year-olds got it and understood it. Some of our other accomplishments for those people in the Chicago area, we've created a suburban cook county Youth Opportunities Network called YONET. We've collaborated on the submission of four programs, really, we want to test J.E.W.E.L.S. and take it to the other level and do a randomized trial to see if J.E.W.E.L.S. really works. We've submitted four abstracts for presentations. Our peer leaders presented at the U.S. conference on aids in palm springs and they were a hit. Had overflow session with people going into the hallways. Kind of moderated. It was nice and we had three abstracts that were accepted and one was a scientific abstract. Our 2008 strategy built on our lessons learned, we have -- we've wanted 46 participants in two towns. The two towns for those people in Cook County are Maywood, Illinois and summit, Illinois. We could probably end up doing a whole lot more towns if we had money so we're looking at through our non-profit part at soliciting and getting other monies. I think J.E.W.E.L.S. is at a point now where we can focus on ages 10 to 15. Again, the

peer leader piece is very important and it's a major leadership development component. A peer leaders go through intensive training. We had two retreats with the peer leaders and their moms that was very powerful. And we learned a lot and the peer leaders go through a once a month leadership session in addition to facilitating the 15-week enhanced primary prevention intervention. Again, the content is presented through popular music, videos. We have monthly events just to share with you one example, a couple of months ago we had a monthly event called mother's wisdom. It was a talk show format where the peer leaders interviewed three generations of mothers about what was it like when you were a teenager and I understand, I got all kinds of feedback from that. 80 participants in that session. The mothers were very honest. It was a nice intergenerational bridge building and it was a powerful session that we had. We did something else innovative about two weeks ago we introduced them to community, to teach them that you live in a community, you need to give to a community and that was an interesting session. I want to talk about -- and I did bring a handout. It is not on the slides. Last week I was fortunate enough to be in Chicago and observe the session on violence, street life violence. That session went over by 45 minutes because the girls had so many stories to tell once they understood what violence was and what we do in our sessions is we give them definitions and what I said to the staff, they said we need to dumb it down for them and my response was no, we need to bring them up. So what we do in our curriculum and in our handouts is we always have a handout that gives them definitions and that's one of the most popular things that they like because they try out new words and you hear them throwing around and the definitions of violence cause tremendous discussion and it was phenomenal to sit and listen to them go over the definitions and have really mature conversations around these definitions and I was there when we talked about violence is verbal, physical and mental. It includes the use of physical force, speaking hurtful words, they -- they just thought it was physical. They didn't see all of the other things as part of violence. That

was a very powerful session. If we can, I think we can, upload this curriculum so that people can see what we covered in that session and so far this -- that's like session 10 and while they like all the sessions, they said this was the most popular session and they had a lot of stories about family violence, personal violence and bullying. That was a big thing for them. Challenges. I want to give you four challenges we've had. Parents, parents, parents, and number four, mental health issues of girls and families. But parents. That's the one I wake up at 4:00 a.m. in the morning because the parents are the kids. I remember 30 years ago folks were saying oh, you know, what are we going to do when these children that have issues start having children? Well, Ladies and Gentlemen, for those of us on the front line doing it, we're living with that right now. We're here, we're in it. And it hit me one day two weeks ago like an epiphany, this is it. We're living this. What are we going to do? We have to deal with the whole person and to those people who are policymakers and funders and project officers, I think we have to look more at funding things that are more holistic. When the people we serve present to us, they don't present with just HIV or just violence. They present with everything. Then when you get the mothers involved and the mother's boyfriend and the grandmother and the aunt, I mean, it is a holistic thing. I think the challenge as we move forward is how do we deal more holistically. This is how we're approaching it, with the family, the extended families, the girls and the people you're working with, and it's a magnificent work. It is just where I want to be at this time in my career.

>> Thank you very much. And now we'll be moving on to Dr. Granato. Thank you.

LAURA GRANATO: Well, I'm excited to be here today, too and this presentation that we're going to give kind of piggybacks on Amelia and Laverne were saying. Today we'll talk

about a program. It is funded through the Office of Women's Health and in our second year. A pilot program last year was very successful. We did make some changes.

>> If you wouldn't mind speaking up a little bit for us. Thank you.

LAURA GRANATO: Go on to the next slide. Today we're just going to give you an overview of our program, the prevention and risk factors for the girls. The program is targeted for girls that are gang involved. When you talk about gang involved they're in a gang or have an immediate family member or close friend that's gang involved. These programs are in the community. We don't specifically ask those questions but we're targeting them. It's gender specific and it does focus on factors as -- [inaudible] The healthy girls program, move on to the next slide, somehow I don't have that one. Okay. The Granato Group, a little bit about our organization that provides health and education programs and consulting services and professional counseling. We have licensed professional counselors, family therapists, social workers. Our staff is ideally situated to address the emotional issues.

Next slide. Our program is nine months long. It is a -- down there you'll see the program components. We have weekly skills groups that service the girls with. We've had a weekly counseling group. Individual counseling that's available to the girls. We also have multi-family groups where we invite the families to participate so the girls are learning the skills and the families and the parents are learning the skills as well. There is mentoring, academic tutoring and also a community service project that the girls do. The goal of the program are to meet the gap in services to reach the -- [inaudible] by providing a community program that is gender specific, empowering and appealing to adolescent girls. That's the key is to get the girls in. The program is appealing. You'll see that. Some of

the incentives we offer, we speak their language. There is -- as Laverne had said with the music, you have to get into the culture and make it something they want to participate in.

Another goal is to reduce the spread of HIV/AIDS and high risk behaviors by providing intervention services for at-risk girls in a non-restricted community program that they consider safe. They can get support. It's a -- based program. The emphasis on building the girls' strengths and empowering them to make good choices and take control of their own lives to really delve deep into the girls and find their individual strengths and use those to better survive what is going on in their world. The program started at alternative house. It was a community center and we did the program last year. We did have some gang issues as was brought up earlier. That was specific to one gang and then another gang showed up and the police were involved. This year we're running the program at schools and other community centers.

Something to be careful of. The program was originally for our girls between the ages of 14 and 17 but when we were running it last year we realized that going into the community and marketing the program there was a need for it at a younger age level. We adjusted it and we have two curriculums now. One for the younger children and one for the older. Now it is from 9 to 17-year-olds. Most of our participants are Latinos who are bilingual. That's the information up there specific to Fairfax County if any of you are interested as far as where we're running the program. When we look at this population, again, they have a history of trauma, abuse, physical, emotional, sexual. A lot of them are -- [inaudible] Why did we choose to do an after school program? Crime by juveniles peak in the afternoon and then in the hours between 3:00 to 7:00 p.m. They're together and they have time to get into trouble after school. So let's see, after school programs have been found to be effective in working with the community. That's why we chose to do that. And the

research saying that these are -- there are a lack of funding for after school programs. We want to -- still having problems? Okay. That we want to use this as an opportunity to create another after school program that would have an impact in the community. We have three cohorts that we run of ten students each. They're small groups specifically because coming from the mental health field we want to make sure we get the group process going. We want the really get that group process so the kids are sharing, they're impacting each other. They have that peer support and after the program is done they still have their support network that has been created. We can remove ourselves and there is sustainability in the community. It's really important to make sure it's a safe place for the girls to meet. Last year the girls decorated the room that they met in. They came and cleaned it up. They painted, they did decorations, they kind of took ownership and made it their own and created a safe environment for them. One thing that we do is try to make it rewarding and fun and make sure that when we get the girls there on that first session that they see the benefit of being there. Right away we have to make sure we touch them and have the impact on them so they come back. So with that our facilitators understand the needs of economically disadvantaged students and they have the ability to motivate, empathize with them and being non-judgmental. You never know what is going to be brought up every day. Laverne mentioned some things. These kids need a safe place to go. So it's interactive. We have exercises, music, videos, they do role plays, have group discussion. We have a format that we follow but we also have flexibility because you never know what is going to come up in a session. It's really hard to be able to not be flexible when you're encouraging the girls to bring up their issues that they're facing on a weekly basis. So even though there is a set curriculum, there is some flexibility within that. The group format gives them the opportunity to learn new skills, to practice the dynamics that go on in the community within the group. As many of you know, when you have a mental health or counseling group going on, this is a safe place for them to

practice those skills and take them home and use them with their families, in their schools and communities. So we're on to incentives. We have refreshments for the girls. Initially they said they wanted the toys, I remember going to the Doritos and Fritos, and then they wanted fruit and wanted to be healthy. We saw an immediate change in them. For the maximum attendance we do offer incentives. They're geared towards things the girls will want to have. They'll get manicures, gift certificates for clothing, to download videos, bookstore gift certificates and then what happens is each session that they attend they earn points and the points will give them different gifts and different incentives and so then they can earn up to an iPod. So every couple weeks they're getting these points and the incentives and it keeps them coming when they feel like not showing up. The other incentive is the group process because now you have your peers saying why didn't you show up? Why didn't you come? If somebody is missing when there is a counseling group going on it's noticed. Some of the other tools that we use are listed here. We use the children's depression inventory, the Macy. This helps us then in addition to the groups we have individual counselors that are available 24-7 that can provide them with individual counseling support. We also have network of people in the community that we can refer families to if they need to but we can also provide that on-site. For the skills group we use what is called DBT. Dialectical behavior therapy that focuses on creating a vision and creating this life for yourself that you can be happy with and focusing on the strengths that you bring. So here there is just a brief overview of some of the components of being mindful, focusing on the mind and directing the attention to how you feel. A lot of these teens aren't familiar with how they feel, they just know anger. That's what they've been taught and the only feeling that's okay. Some of them really need to get in touch with some of the hurt, some of the frustration, some of the sadness. Emotional regulation is reducing the emotional intensity. Once they come in touch with some of these feelings, how do you put them in control? Distress tolerance when they're under a lot of stress.

How can they reduce impulsivity. Think about things and spend time before you take action.

Interpersonal effectiveness. How they relate to each other. Becoming aware of how they relate to family members and other people. We call it walking the middle path. Helping the teenagers to manage some of the family problems that they face. There is a little information up here on dialectical behavior therapy and some research found about its impact and why we chose it because it has been very effective in working with adults and creating lasting behavior change so we started using it with the teens. One important assumption that I want to point out with this DBT is that it focuses on -- the next slide, the last bullet. We are doing the best we can even though we need to learn ways to work better. So that brings to the children the adolescents, the assumption that they're okay. There is nothing wrong with them but this is to help them function better.

Next slide. The piece that is called the health and wellness component to it so in addition to the counseling and the DBT skills group they are getting health and wellness component. There is education on drugs, alcohol, HIV/AIDS, STDs, unsafe sexual behaviors, dating violence, you know, we touch upon all these topics and what happens, too, is this compliments some of the DBT because it gives them to okay the talk about some of the things that are going on. A girl can bring up, you know, last week I was raped by eight boys, they looked me in a room and this is what happened. They can say that as we're talking about dating violence. So it goes hand in hand to kind of compliment each other and create that safe environment for the girls. Again we mentioned the counseling. You know, on different levels. They have individual counseling, the group counseling and the family multi-family group and we have people available 24 hours a day, seven days a week to support the girls. Something interesting is we were anticipating that more of the

girls would take advantage of the individual counseling. They take advantage of it but they prefer the group counseling. They get really involved in with the group process and only when it's an absolute necessity will they go to the individual and then they'll bring it -- the individual counselor is encouraging them to bring it back to the group to get the support they need there. Again the multi-family group, the mentoring. They have the opportunity to participate in mentoring. We have community volunteers that help us with that and they're paired up with a mentor. We'll spend time with them. There is also a community service project. I had mentioned briefly before the girls get together and decide as a group what they want to do. I think Eileen is going to talk a little bit about that with you. Some of the things they've chosen to do and that supports the group process of getting the girls together and they take it out into the community.

Next slide. We have academic tutoring that's available to the girls that need it. We encourage them to take use of it and some of them have. A lot of them want to plan to go to college and they're kind of overwhelmed with how do I do it and make it happen? One of the incentives we do offer as part of the program that I did not mention this, is a scholarship. We awarded a scholarship to a girl last year. It was a graduation ceremony that we had. We formally presented it to her. The good news was we were able to get a local news station to come in and broadcast our graduation so not only did our program know about it and -- but then the community was able to know hey, we're a group doing this and look at what happened. Following graduation we had a lot of girls that requested to be participants this year. So they wanted to still be involved. They didn't want to say goodbye. Especially the scholarship winner said I want to help the girls coming through next year if the program runs again. That was important. Next we'll talk about some of the research and some of the findings and I'll turn it over to Eileen to take care of that.

EILEEN: Thanks, Laura. As we mentioned, Laura said we purposely chose an after school program. One of the things in looking at the research and the link between dropout and delinquent prevention. Crime happens in the after school hours and the failure in school is the start of serious offending and we wanted to focus on linking those things together and developing our program. As with boys, females often have a poor history of academic performance. They both have been violent behavior and delinquents have been associated with poor academic achievement. It was important to look at those factors in designing the program. Slide 24, please.

The next slide. There we go. Here is some of the criteria we've listed for what is an at-risk youth. Some has already been shared with you, the common criteria, academic failure, a drug or alcohol problem, is pregnant or already a parent, has come in contact with the juvenile justice system. A year behind grade level. Limited English proficiency. Could already be a gang member, is absent from school or dropped out.

Next slide. Some of the risk factors in girls. Some there is a lot of overlap, poverty, poor academic performance. Teen pregnancy, substance abuse, those types of things. The next couple of slides deal with the special issues of girls in our program and looking at some of the gender bias in society. A lot of the female behavior is internalized, not slashing tires as this example says, it's like slashing a wrist or hurting themselves. It often hasn't come to the radar screen as quickly as the issues with boys. But I think we do think that's starting to change and there is a lot of research about girls and why they might reach out to a gang and stuff like that. And as Laverne had said, a lot of girls are interested in the gang for a feeling of safety and a sense of belonging but actually what it does is put them at increased risk for violence, teen pregnancy, victimization, suicide even. It's really counter what they're looking for, the experience. We're going to jump in

the interest of time to slide 40 if we can. Some of the protective factors. You're seeing some statistics that you have in your packets on gang activity and youth gang statistics that I won't go into.

Slide 40. Okay, yeah, sorry. Keep going. Some of these are the same factors that Laverne had also mentioned but protective factors like gender identification, interpersonal relationships, self-esteem, individualism. Future orientation, physical development. Family, school and community support. These have all been shown in research to be important to girls. In designing the program we looked at all these factors and how could we incorporate this into the program that we were offering these girls? And once we get there each of these factors are described in more detail in the Power Point presentation you have available. There we go. It should be the next one, there we go. Those are just the factors that I have read off and then the subsequent slides discuss these in more detail, each of the gender identification you see here, interpersonal relationships, self-esteem and stuff. I'm going to skip to slide 50, if you can skip up ten and the heading is evaluation. So I can discuss some of the results of the evaluation from our pilot program. As Laura said, we had the pilot program last year and received subsequent funding to run the program this year. We conduct a written evaluation following each activity. It is a short six-question survey. Did they learn the activities for that day? Did they feel the goal was achieved? What did they like the best about the session? What did they like least? Did they feel they had learned something they could use in the session? We do pre-and post-test with the girls so we can assess the learning. What did they learn? In our findings from the pilot program is that were very positive that 100% of the girls felt they had learned how to care for their body and mind better and new skills for thinking and acting. 91% learned how to prevent HIV and aids as well as 100% of the girls reported

they would use what they learned in their daily lives and it was very important for us and them and that their relationships improved as a result of the program.

Next slide. Some of the lessons that we learned from the pilot program, assign responsibility within the group. The girls took ownership if they were involved in it. It wasn't coming and listening to something else. It was the group process. They felt involved with it. Extending the program for the entire school year. When we first did the pilot program we had a six-month program and felt we needed to run it the entire school year especially for the girls who needed tutoring and mentoring. Follow-up with no shows, not only is the group process the members of the group hold each other accountability but important for the facilitator to call and say we missed you, is anything wrong? We hope you'll be there next week just to let them know that somebody did care whether they showed up or not. Using the same counselor for group and individual sessions, if possible. Most people are using the groups for counseling as opposed to the individual sessions but what we're finding is that often after the group the girls want to stay behind and they have a question for the facilitator. We're doing a lot more of that on the spot coaching, so to speak and dealing with individual issues that maybe they weren't ready to bring up in front of the group yet. Rather than come back for an individual counseling they're wanting to talk to somebody right after the group. Using established mentoring organizations. It's a lesson we learned. During the pilot program we recruited, trained and monitored community mentors and found with the time involved it's a lot easier to use an existing mentoring organization. If you wanted to do with mentors. We have instead opted to use group graduates or peer mentors. Some of the graduates are interested in maintaining the connection. Also high school honor students interested in giving back and serving as mentors for the group so we're doing that as opposed to assigning each person individually. Then incorporating cultural and educational trips. This is important to show

girls that there is a world outside their neighborhood. Earlier this month we took girls in the 13 to 17-year-old group to a local university where they were able to meet with staff and students from the campus. We were very fortunate where the director of Latino affairs came out and spoke with the girls, gave them her business card, talked about her personal struggles in attending college. She was the first person in her family to attend college and gave them her card, said, you know, just focus on getting here. My office will help you pay for it. So it was very uplifting. On the way home the girls were like -- very excited, couldn't wait to go to college. It was just showing them there is a possibility and as Laura said the scholarship is available and then to hear it from somebody at the university setting that said just focus on getting here. We'll help you pay for it when you get here was very empowering for the girls. Then we also have another field trip today where the 9 to 12-year-old girls are going to meet with the older girls. The 13 to 17-year-old and they're putting on a skit on how to deal with peer pressure as well as answering questions such as what is high school like and helping them make the transition. The younger girls are going to be taking pictures of all the positive messages that they hear and reporting back to their communities so very much -- all of them, the girls have a very active say in what the educational trips are and wanting to do them. As the community service projects, we had one earlier this month where they had an open house day at the an en Dale high school. The group named themselves girls on a mission. They had developed and done T-shirts and all wearing their T-shirts and they introduced themselves as healthy girls with a mission program. Helping them sees themselves as part of a larger community has also been very important. We'll answer questions at the end and we have contact information if there is anything that you would like to follow up with us on. Thank you.

>> We'll back out so you can see everyone here. We have one question here and it says I may have missed this in your talk. This is directed to the J.E.W.E.L.S. Program. Do you know if any of the girls in the J.E.W.E.L.S. Program have a history of sexual assault and rape and childhood trauma or incest problems. It can cause many young teens to join gangs, become truant and getting involved in risky behaviors because of a lack of love for themselves and guilt. She wants to thank you with all you're doing. It sounds like great work and totally agrees with the communities of color leadership.

>> Wow, oh, you know, it's a confidentiality piece but I did do a focus group a couple of weeks ago with our peer leaders and we are going to be analyzing that data, which is qualitative. The parents did approve and we did tape it and yes, there was discussion of those types of things. There was also discussions, huge discussion about substance abuse, parents, major drug addicts and two of our girls -- two have mothers in prison. That was very painful.

>> Also we're just requesting if anyone out there has any questions, feel free to provide them. That's the only question we have thus far. Are there any questions from anyone in the room?

>> I can make a comment.

>> Okay, thank you.

>> While we're waiting for more questions. One of the field trips that we did last year, too, was to a jail in Baltimore, a detention center. It was a women's jail, not a detention center and the woman who helped us arranged it she thought it would be good that we take the

girls up there. That was very eye opening for them to go and see what would happen and hear from the women who were in the jail directly from them what would happen if they didn't make some serious changes in their lives. So it was a difficult trip to arrange, it really was, but it was worth it. The girls really enjoyed it and I think they got a lot of benefit out of it.

>> Thank you. Thank you. Are there any other questions from the webcast, here in the room? Any other comments? Okay, at this time I'll turn it over to Dr. Sabrina -- the current director of the office for women's health for closing remarks.

SABRINA MATOFF-STEPP: I just want to take a minute and thank all of our wonderful speakers. I know they took time out of their busy days to come and talk with us here and I know these topics some of our audience members might want to think about and if you do come up with a question after the webcast and you're thinking oh, I lost my opportunity, I'm sure we can probably twist their arms and they might be able to answer your question afterwards and they've also provided contact information. So I wanted to thank them again. I want to thank Morrissa who has put in a lot of time to put it together. These webcasts take coordination and time and behind the scenes you probably have perhaps been accessing and communicating with our partner at the University of Illinois at Chicago. We have a distance learning contract with them to make this all happen behind the scenes. This is the amazing web technology that makes us able to do these kinds of things and reach out and get this information to more people than if we had to bring everybody together in a large meeting room. So really want to thank those, our partners at the University of Illinois at Chicago. I think like all of you this topic is a very important topic to HRSA and particularly also to the HRSA Office of Women's Health. We do a lot thanks to my passion around this topic, around focusing on women and HIV and AIDS and

sure we know some of the take home messages. It doesn't hurt to reiterate them again. Today more than a quarter of the cases of HIV/AIDS in this country in the U.S. are among women and we're not up there quite yet with the prevalence among men but we're getting there closer and closer and in the larger international community some of the statistics know we're already there. Women continue to be at risk because the culture, social, educational and economic inequalities. I think we've heard from all of our speakers directly or maybe indirectly that one of the areas that really contributes quite a bit to why women are at such greater risk is because of the issue around inequality and empowerment. If we can change some of those issues and increase education and social opportunities we end up affecting other areas and other health issues such as HIV/AIDS. I think we've also heard today focusing on strength-based models instead of some of the weaknesses is a new and growing way to reach women. Particularly around topics where they're facing some inequality issues. I would really encourage us all to continue to think about strength-based models. Areas where we build upon rather than focus on weaknesses. Once again I think that looking at this intersection. We've heard all of our speakers talk today about the disparate types of issues, HIV/AIDS and violence and how important it is to look at the intersection and address it from a leadership perspective, an innovation prospective, through collaboration and get people talking around the table it will only help us all reduce the number of cases. So again I think our challenge here is to prevent violence, to prevent HIV/AIDS transmission but we have to begin to really think about and continue to think about this and doing this at the same time. It's no longer we can deal with one issue and then get to the other issue. We really have to be focusing on these at the same time and that time really is -- we've heard all our speakers and Laverne said it eloquently the time is now. We can't wait another five to ten years. The time is now to focus on these issues at the same time. There is a lot of resources that our speakers have provided, there is a lot of resources that the federal government provides as well.

We can certainly provide those and some follow-up communications to all of the participants and many of you know them through the Office of Women's Health downtown as well as the national women's health information center but again, I think there are many free resources that you can access and again our speakers have provided, I think, their contacts as well as their websites and I would encourage you to take advantage of these pieces of information and to network among each other to find ways, again, to reach out and to deal with these issues. I know we've gotten a number of questions. How do you get these wonderful slides? They are posted on the webpage that you've registered on. MCHCOM.com So [www.mchcom.com](http://www.mchcom.com) You have two coms in there. It's a little weird, [mchcom.com](http://mchcom.com). There is a link, click on it, download them, you get them all. Reference them. They're great reference materials. The other point I'll make is this webcast that you've been watching in live time will be archived. It will be posted by our colleagues at the University of Illinois at Chicago in a couple of days. If you want to refer back to the live presentations, use it as a teaching tool, show your students, show your workgroup, show your colleagues. It will be available to you. So we like to continue to spread the knowledge and the education and we usually do keep them up fairly -- I don't know, for a long time. They will be available for you in a couple of days and we'll let you know when those are up. I think Morrissa says there is one more question. We want to remind you about the evaluation you should be seeing on your screen. Please take that evaluation, if you could, just a couple questions to answer on how we can better improve or continue these webcasts on different topics, we'd really appreciate it. Morrissa, another question.

>> This is the last and final question. This is for the J.E.W.E.L.S. Program again. Is the J.E.W.E.L.S. Curriculum available to purchase or review free of charge for other non-profits?

>> Yes. It's a 15-session curriculum and if the person emails me, we will -- we can provide it. We have both the curriculum guide and the Power Point slides.

>> Would you be so kind to give them your email address?

>> It's at the end of the slide, LM Carter @ REESSI.com.

>> On behalf of the HRSA and women's health committee we thank you for participating in this webcast and look forward to future webcasts that we'll have available. Thank you and have a good day.