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HEALTH EDUCATION FOR WOMEN AT RISK: HIV PREVENTION EDUCATION  
FOR INCARCERATED WOMEN

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**Abstract:** HIV-prevention education is an important topic for health care professionals and health occupations educators. This study used grounded research to examine the effects of an HIV peer education program on individuals, the organization, and the community. The findings revealed that the unanticipated consequences for all three stakeholders were far greater than the

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anticipated outcomes. The findings are **discussed** in terms of benefits participatory health education as compared to traditional health care education.

### Introduction

HIV-prevention education is an important topic for health care professionals and health occupations educators. Health care professionals have targeted specific HIV-prevention and treatment programs **to** many high-risk subgroups within the population, including drug users, teenagers, homosexuals, and heterosexuals. Often, peer education is an important strategy in such programs. In this article, we report a case study that extends previous work by examining the consequences of an HIV peer education program for the individuals, the organization, and the community. The peer education program targeted a largely ignored, high-risk subgroup, incarcerated women. Before reporting the case study, we examine HIV peer education literature.

### Peer Education: A **Strategy** for HIV Health Education

Peer education is a strategy for providing HIV **health** education that can (a) provide information about the HIV disease and (b) change beliefs and attitudes concerning high-risk behaviors. Peer-directed interventions have been used in a variety

of settings and appear to be effective for several reasons. First, peer educators often are seen as credible, especially if they are members of the population being targeted for the educational intervention. Second, peer educators are in a position to speak frankly and openly about sensitive issues that health professionals may know about theoretically but not experientially. Third, peer educators may be viewed as helpful for changing group norms and more available to the community than other health occupation specialists (Catania et al, 1991).

The efficacy of peer education is supported by research. Briefly we overview three examples. The first example is a study conducted by the Center for Population Options (CPO). The findings revealed that adolescents were more willing to listen to a discussion about living with the disease from an HIV-positive person who was their own age than a health educator or famous person (CPO, 1990). The second example is a study of a peer education intervention that targeted African-American youth and relied on pre-and post-intervention surveys to assess their knowledge and intentions to use barrier protection. The individuals who participated in this peer education program indicated increased knowledge about the disease and the desire to consistently use condoms (Lem, Sumaraga, & Packer, 1994). The third example occurred in a health care setting. The study relied on random assignment of subjects to a peer, professional, or control group and found that participants in the professionally-led and peer-led groups

gained **knowledge** that was superior to the control group, and they had more positive attitudes toward practicing protective behaviors (**Rickert, Jay & Gottlieb, 1991**). Also, participants in the peer-led group asked more questions of the peer educators, which could indicate the comfort level involved when learning **from people who are contemporaries**.

The three examples that we described focused on the benefits of HIV **peer-**based education to individuals. The measures of success included the amount of knowledge that individuals gained and individual intentions related to **future** actions. Because educational programs that impact individuals may be **insufficient** to prevent **HIV**, information is also needed on how HIV educational programs impact institutions and communities. To extend knowledge about HIV peer education, we asked the following research question, “What are the effects of an HIV peer education program on individuals, the organization, and the community?”

Understanding the interrelationships of program impacts on **all** three levels can provide a foundation for developing more complete theories of HIV peer education. Such understanding can also provide a basis for developing more effective **HIV** peer education programs.

## Methodology

To answer the research question, we used grounded research and explored one case in-depth. The case was the Incarcerated Peer Education Program that was implemented in the Tulsa, Adult Detention Center and the Eddie Warrior Correctional Facility.

The methodology for this case was grounded theory as described by Glaser and Strauss (1967). Grounded theory is appropriate for answering the research question because grounded theory researchers “are much concerned with discovering *process*. . . *the* reciprocal changes in patterns of **action/interaction** and in relationship with changes of conditions either internal or external to the process itself” (Strauss & Corbin, 1998a, p. 169). Grounded theories are conceptually dense, explicitly address multi-level phenomena, and embrace the fluidity of process and, therefore, are particularly relevant to real world application (Strauss & Corbin, 1998b). Grounded theory-building is also appropriate when facing an ambiguous situation that needs to be framed and for including the voices and perspectives of those who are studied.

The **first** author for this article was the primary investigator for this study and took a participant-observer role. She implemented the peer education program while simultaneously working as a doctoral student. The second author was a university faculty

member in human resource development, and she had no affiliation with the prison. The authors worked together to explore the information. The interaction of the two authors and the on-going link between one author and the individuals, organization, and community facilitated obtaining multiple viewpoints. Obtaining multiple viewpoints is a strategy that Strauss and Corbin (1998b) recommended for controlling the intrusion of bias into the analysis while maintaining sensitivity to what is being said.

The iterative process that we used involved reviewing the literature; considering the individual, organization, and community framework; and contrasting these with the experiences and patterns that emerged from developing and implementing the program. During the analysis process, we followed Straus and Corbin's (1998a) advice to remain sensitive to the number and types of properties that might pertain to the phenomena that otherwise might not be noticed.

#### The Incarcerated Peer Education Program

We begin this section by describing the HIV peer education program and the impetus for the program, and the threat and costs of HIV to those in prison. We conclude by describing how the peer education program was implemented.

### The HIV Peer education Program

The case study focused on the Incarcerated Peer Education Program for women in the Tulsa, Adult Detention Center and the Eddie Warrior Correctional Facility. The Oklahoma State Department of Health, HIV/STD Service began the HIV peer education program in 1995. Support for this program included a \$4000 grant from the National AIDS Fund as well as support from the Tulsa Community AIDS Partnership. The objective of the Incarcerated Peer Education Program was to train incarcerated women as educators on the basic concepts of HIV prevention with the expectation that they then would provide educational outreach to fellow inmates. Specifically, the educational outreach was expected to focus on the steps that incarcerated women could take while incarcerated or upon release to prevent themselves from contracting HIV disease or transmitting it to their partners. Before describing the process of providing peer education, we first examine the impetus for the HIV education program.

### Threat and Costs of HIV in Prisons

The statistics on HIV disease in prisons highlight the health care need. Women in prison are among the highest risk group for HIV disease (El- Bassel et al, 1995). In fact, the Centers for Disease Control and Prevention (CDC) (1997) reported that individuals in prison are seven times more likely to be infected with HIV than individuals

living in the community. **The** percent of women entering jails and prisons with a history of **HIV** infection range from 0-25% (**Hammett**, Gross, & Epstein, 1994). Further, **HIV seroprevalence** in correctional facilities reflect the trend in the general population toward elevated rates of the disease in women. At the end of 1994, the **National** Institute of Justice reported that the number of female inmates incarcerated in state facilities who were infected with HIV totaled 1,953 and the number of female jail offenders who tested positive totaled 911 (United States Department of Justice, 1996).

Statistics also point to the rising tide of HIV disease for incarcerated women. For example, the National Institute of Justice reported the rate of HIV disease in incarcerated women increased by **88%** from 1991-1995 (United States Department of Justice, 1996). AIDS is now the third leading cause of death among women aged 25-44, according to the CDC (1997), and it is the leading cause of death among female inmates.

Individual women bear a high emotional cost because the disease both threatens and takes lives. Incarcerated women report many high-risk activities that lead to HIV infection, including injection drug use, sex work, and having engaged in unprotected sex (Stevens et al, 1995). Often the **activity** that led to incarceration also places women at high risk for contracting HIV. The pandemic of HIV is **analogous** to the pandemic of incarceration.

What causes women to engage in high-risk behaviors? Zierler and Krieger (1995) claimed that gender inequality, drug use, racism, and violence are social injustices that produce risk-taking behaviors in women. In addition, females who have survived sexual abuse are prone to **difficulty** in their relationships with men, are at higher risk for substance use, and suffer from depression (Finkelhor, 1986). Many **chemically** dependent women have reported histories of childhood and adult mental abuse, incest, and rape (Benward & Densen-Gerber, 1975; Schaefer & Evans, 1987; Walker et al., 1992; Wilsnack, 1984). These traumatic circumstances are likely to impact a woman's ability to negotiate protective measures, such as using condoms, sterile needles and syringes.

#### Implementing the Incarcerated Peer Education Program

The Incarcerated Peer Education Program enabled the women in the Tulsa, Adult Detention Center and Eddie Warrior Correctional Facility to design their own educational program. The program began in the Tulsa Adult Detention Center where twelve women were invited to attend a focus group. During this session the women stated that they would be interested in participating in a peer education program. The program was framed as a participatory effort between the **first** author and the peer educators. The women decided that they would design and develop an HIV prevention

manual that spoke to the issues of women who were incarcerated. Topics included in the manual were used to dialogue about HIV prevention and included substance abuse, co-dependence, domestic violence, the dysfunctional family, alcohol/drug use, and sexually transmitted diseases.

The program was designed to “fit” the context. For example, the structure of a prison seeks to protect visitors and educators from the violence that can occur in penal institutions. In this situation, correctional officers assured safety of state employees by establishing a cap on participants in each training session. To insure that women could speak freely about what was happening in their lives, guards, and jail employees agreed to not join program participants.

Today, the peer education program at the Tulsa Adult Detention Center is no longer operating—instead, the program has been moved to facilities where women are housed for longer terms. The peer education program is operating effectively within the Eddie Warrior prison. Peer educators are being trained, manuals are being distributed, and incarcerated women are receiving the health care information they need to control this aspect of their lives. In addition, the women peer educators have created a document entitled *AIDS is Not My Only Problem* that describes root causes of HIV disease and incarceration, such as substance abuse, incest, domestic violence, and

gender inequality. And they are constantly updating the course.

### Outcomes of the Incarcerated Peer Education Program

In this section we discuss the anticipated and unanticipated outcomes of the HIV peer education program for individuals, the organization, and the community. The following sections focus in turn on each stakeholder.

#### Individuals

The objective of the Incarcerated Peer Education Program was to train incarcerated women as educators on the basic concepts of HIV prevention with the expectation **that**, then, they would provide educational outreach to fellow inmates. This objective was met. During the **first** year of the program, nine hundred manuals were distributed to female prisoners. Incarcerated women distributed most of the manuals. They also began to offer peer education. The peer training sessions provided opportunities for dialogue, discussion, and reflection on personal choices. For example, one woman told of years of abuse inflicted by her father and then her husband. She claimed that her husband would leave for days and would return home in a drunken rage. He would then demand affection and if she requested condom use or refused his sexual advances he would savagely beat her. It was during her prison sentence and emotional

emancipation that the true danger of her past situation crystallized. She admitted that chronically low self-esteem stemming from her abusive childhood prevented her from leaving her husband and seeking an independent lifestyle. During the session, her peers reminded her that being safe from HIV means being involved in a relationship where trust builds on dialogue, mutual concern, and respect for one another. The woman also realized that her own choices affected her health care.

The peer educators reported that teachable moments occurred within small group dialogue sessions, in the showers, in *the cafeteria, and in the dark of night through* whispers and cries for information. Women who were infected began to learn about the medications needed to sustain life, and correction **officials learned** that medication given prophylactically prevented costly visits to the hospitals. Women were eager to come to the group that met weekly for three years. As soon as a woman was transferred to another penal facility, another **participant** filled the slot.

In summary, the HIV peer education program met the anticipated objectives related to individuals. It offered offenders the opportunity to focus on health care and to be part of a captive learning environment that encouraged acquiring new attitudes, knowledge, skills, and behaviors. Also, the program provided offenders with opportunities for reflection about past experiences and passages in their lives that may

have contributed to their risk of infection. Through the process of becoming HIV prevention educators, many women learned the lessons for themselves. Once trained, the peer educators instructed others.

An unanticipated outcome of this program was that some women's view of themselves as peer educators extended beyond the program. Through the program, peer educators gained voice, discovered that being heard was important to them, and took action to assure their continued voice. For example, some peer educators who were transferred or released began to express a desire to develop and implement peer education programs. This outcome affected the prison and the community, so we also discuss it in those sections.

#### The Organization: The Prison System

The intended outcomes of the program did not specify outcomes for the prison. In this case, the prison system had paid the high financial cost of HIV disease. Prisons are required legally to provide individuals who have been incarcerated with medical treatment. In 1976, the U.S. Supreme Court ruled that "deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain proscribed by the Eighth Amendment of the Constitution (National Commission on AIDS, 1991 )." Legally, prison officials must provide health care for prisoners who are

HIV infected. So, it was not surprising that 59% of the representatives from 80 state and city/county adult penal systems who participated in a 1994 National Institute of Justice study responded to a specific question that they would like to receive public health education assistance with their HIV program for inmates (United States Department of Justice, 1994). Potentially, HIV education could financially benefit a prison system. Educating prisoners to prevent the spread of HIV and other opportunistic infections such as Tuberculosis caused by damaged immunity is less expensive than providing inmates with medical treatment for these diseases. While this benefit was suggested for inclusion in this study, the long-term cost benefit analysis of prevention education as opposed to treatment and care is not available at this time and was beyond the scope of this study.

One unanticipated outcome of the program was increased funding to the prison system for purchasing books, films and other educational material. The prison's officials found that they could access funding to furnish classrooms with the equipment for sustaining a learning environment.

A second unanticipated outcome was extension and expansion of the program. In 1997 the Eddie Warrior Correctional Center in Taft, Oklahoma, at the request of inmates, agreed to continue the HIV Peer Education Program. The Tulsa Community AIDS Partnership granted an additional \$4,000 to fund Tulsa Community College

tuition. Many offenders were anxious to earn one college credit for becoming a peer educator. Oklahoma State Health Department employees worked with prison personnel to gather high school transcripts and process the paper work at Tulsa Community College. Thirty women participated in the curricula design and **successfully** completed the program. For many, this was their first successful experience in college.

A third unanticipated outcome of the program involved the interaction of the women with the prison officials. Some women in prisons are uninformed and have low self-esteem and power. Through the peer education **program**, women gained self-esteem and the power of knowledge. The women who had been educated about what they needed to be healthy began to request, and at times demand, that the prison officials meet these needs. This is a different paradigm from the traditional view of powerless and uninformed prisoners and required the prison officials to adapt their behavior and thinking. The ensuing dialogue, in turn, caused prison **officials** to learn more about HIV health education and to reconsider their values. It also caused the women to dialogue with the prison officials and reconsider their perspectives in light of financial and other resource limitations.

### The Communities

The intended outcomes of the program for communities was unspecified.

However, communities bear both high financial and emotional cost from HIV disease. Offenders who leave the penal system or move to another penal system, uneducated, undiagnosed, and untreated, run the risk of infecting another community. As the disease continues, women may enter the hospital for acute attacks and illnesses, such as cervical cancer, that incur astronomic treatment costs. The emotional costs of the disease within the community may be even higher.

In this case, the unanticipated outcomes of the peer education program spread to *the* community. In some cases, the community was a town or city. In some cases, the community was a prison. Through the peer education program, some women had found **their** voices — and they began using these within their communities. For **example**, as some peer educators recentered their town or city communities, they began contacting community-based organizations and offering their services as prevention educators. Many of these women had compelling stories to share. Their experiences with incarceration and living with HIV disease offered other women unique insight about the consequences of unsafe behaviors. In addition, community- based organizations now had available the documentary developed by the peer educators.

Some women, who had been sentenced and transferred to long-term State Department of Correction Institutions, wrote state **health** employees to request copies of

the manual and help in starting a similar program. The need for education and prevention materials in state facilities became even more apparent. Many women were infected and knew little about the disease. Medication was not always available. **Berkman** (1995) recently described prison public health and claimed that the rehabilitation model, which paid lip service to the social, educational, and medical needs of the inmate, has practically disappeared from **penological** and public discourse. The women's requests for information and medical treatment highlighted this discrepancy and in some cases led to intense dialogue between the women and prison officials.

Another unanticipated outcome of this program for the community was the creation and use of a documentary entitled, *AIDS is Not My Only Problem*. Over one hundred copies have been distributed to community-based organizations, health departments, correctional facilities, and universities. Alcohol and drug treatment facilities, juvenile detention centers, health departments, and penal institutions in a number of states are currently using the film during group education sessions to encourage dialogue about the barriers to prevention that can ultimately lead to HIV diseases and safer behaviors. Universities are using the documentary as an example of a preventative health education program that resulted from a cooperative project among the private sector, the community, public health, and department of corrections.

## Discussion

What theoretical framework can contribute to our understanding of the program's success? We turned to the work of Paulo Freire (1970) on participatory education. He noted that traditional education approaches assume that the learners are like empty bank accounts into which the facilitator makes deposits. A well-known symbol for this approach is the teacher at the front of the classroom. The teacher is the source of knowledge and through lecture imparts the knowledge to students. Students learn what the teacher instructs.

An alternate approach is participatory education, which assumes that people gain control over their lives through dialogue and critical thinking. This leads to identifying and analyzing the social and historical roots of problems, envisioning alternatives, and bringing about social change (Wallerstein, 1992; Wallerstein, Bernstein, 1988). In **dialogical** communication, the teacher does not have all the answers. Instead, creative power is enhanced as the facilitator listens to the participants as they become "beings for themselves" (Freire, 1970, p.65). Using peer educators also facilitates designing educational programs that will be heard by the target audience. Wingood and DiClemente (1997) assert that when designing HIV prevention messages they must be

tailored to the cultural, contextual, gender related, and cultural characteristics of the population.

In this case, the peer educators became the co-teachers and experts, and they shared responsibility for the program. Once women were incarcerated, they reported having the time to think about the damage and painful experiences that had occurred outside prison walls. Peer education opened the door for dialogue between women who had shared life experiences and who had traditionally not had a voice in their own sexual health. Using this pedagogical method offered an **opportunity** for oppressed women to form meaningful relationships and to develop support systems for healthy life activities while in prison and upon release. Offenders often have mistrust of people working within the prison system and are often reticent to disclose high-risk behaviors such as prostitution **and** injection drug use for fear of reprisal from prison **guards** and administrators. Receiving information from peers offered an ethic of care, notions of responsibility, and the belief that one can make a difference in another's life even while incarcerated.

### Conclusions

Given its serious consequences for individuals and communities, HIV prevention education is an important topic for health care professionals and health

occupations educators. In this paper, we describe the anticipated and unanticipated outcomes of an HIV peer education program for individuals, the organization, and the community. We discuss the outcomes in terms of the high costs of not educating incarcerated women about HIV.

Costs accrue to individuals, the prison system, and communities. HIV prevention education can target the root causes of the disease, which include the lack of knowledge, **poverty**, gender inequality and drug use. An effective method of prevention which women can control combined with the understanding of women's **social** status **illuminates** the psychosocial risks for women (**Amaro**, 1995). The Incarcerated Peer Education Program provided a strategy for enacting such illumination for one population, women in prison. This study has implications for future research. This study revealed that the unanticipated outcomes of the peer education program were far greater than the anticipated outcomes. Future studies should examine whether peer education programs that are directed to other health education topics produce similar outcomes. Additional study is also warranted on specific unanticipated outcomes for HIV peer education. For example, the long-term costs and benefits for prisons or communities of HIV prevention education as opposed to treatment and care should be explored.

A limitation of this study, as for any grounded theory study, is the potential bias of the researchers. Future studies could address this limitation by examining the outcomes of peer education programs from different perspectives. For examples, peer educators could be asked to diary their own experiences. Such research could provide additional insight about the unique perspectives of peer educators over time.

This study also has implications for future practice. Moving beyond the traditional approach to education and trying a new approach takes resources. Based on the success in **this** case, the participatory approach warrants consideration for use in future HIV education. The challenge of using participatory education is that it requires new behaviors for health occupation educators, prison officials, and incarcerated women. With this approach leadership comes through participation and facilitation rather than mandate or lecture. By working together, health occupations educators, prison officials, and incarcerated women **can** develop and implement proactive health education that reduces the burden of this costly disease.

Occupational health educators work on issues that have both immediacy and high costs for individuals and society. HIV education is one such issue. By taking a leadership role and using new approaches such as participatory education, occupational health educators may be **able** to lower the risks and *costs* for everyone.

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