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Common Threads: An Integrated HIV Prevention and Vocational Development Intervention for African American Women Living with HIV/AIDS

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ABSTRACT

Current policies and initiatives call for the integration of social determinants of health into HIV/AIDS prevention and care interventions. According to the World Health Organization's Commission on Social Determinants of Health, the lower a person's socioeconomic status, the worse the health outcomes. One way to alleviate poverty among African American women with HIV/AIDS is to help foster their vocational development and economic empowerment. The National HIV/AIDS Strategy Implementation Plan specifically directs federal agencies to find ways to integrate people living with HIV/AIDS into broader employment initiatives. The purpose of this manuscript is to examine medical, psychosocial, financial/legal and vocational social determinants of health through the lens of the Client-Focused Considering Work Model (Goldblum and Kohlenberg, 2005). The authors then apply this model to the development of a culturally sensitive, integrated HIV prevention and vocational development intervention: Common Threads.

Keywords: Social Determinants of Health, African American Women, HIV/AIDS, Vulnerabilities and Vocational Development

INTRODUCTION

There has been increasing recognition in recent years of the role social determinants of health play influencing HIV/AIDS health outcomes and the rate of new infections within the United States, and the need to actively address the interaction of a variety of structural and social context factors as part of our national response to the domestic HIV/AIDS epidemic. According to the World Health Organization's Commission on Social Determinants of Health, "all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the

worse the health” (p.1). Women of color, especially African American women, currently represent the majority among women living with HIV/AIDS (Centers for Disease Control and Prevention [CDC], 2012, 2013) and face numerous social and economic factors that both increase their vulnerability to HIV infection and decrease their access to care. These negative outcomes are largely due to the inequitable distribution of power, money and resources (Webel et al., 2013) and highlight the need for greater social and economic empowerment of these women.

The recent publication of a White Paper on the Social Determinants of Health by the Centers for Disease Control and Prevention’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (CDC, 2010) is one key indicator of the increased recognition of the impact of social and economic factors on HIV transmission and health in the United States. This report documents the disproportionate burden of HIV on African American women and highlights the need to complement individual level interventions with those that include a greater focus on “interpersonal, network, community and societal influences of disease transmission and health” (p.1). This report specifically recommends the development of comprehensive approaches that address “where we live, work, learn and play” (p. 1).

More recently, President Obama issued an Executive Order (July 15, 2013) in which he reaffirmed his administration’s commitment to responding to the domestic HIV epidemic and established an HIV Care Continuum Initiative to further support and promote the implementation of the National HIV/AIDS Strategy (NHAS). This executive order emphasizes the need for increased integration of HIV care and prevention efforts, including the development of innovative ways to sustain individuals in the continuum of care. Importantly, the NHAS Implementation Plan explicitly acknowledges the importance of addressing social determinants of health, including a directive for federal agencies to “consider ways to increase supports for employers to hire and maintain employment of people with HIV and how to integrate them in broader employment initiatives for people with disabilities” (p. 25). This inclusion of employment and vocational services in the NHAS acknowledges the critical role that both can play in addressing important determinants of health. According to the WHO Commission on Social Determinants of Health (2008), work can provide “financial security, social status, personal development, social relations, and self-esteem and protection from physical and psychosocial hazards” (p.72).

These recent public policy initiatives are supported by an emerging body of research that highlights the ways in which effective vocational services and stable employment can increase quality of life, reduce levels of depression, improve HIV self-management and reduce HIV-stigma and health risks associated with the transmission of HIV (Conyers, 2004, Hunter, 2009, Webel, 2013, Rueda et al., 2012; Rueda et al., 2011). However, employment conditions vary considerably and many of the factors that increase African American women’s vulnerability to HIV and limit access to care also impede their access to effective employment services and stable, healthy employment options. Unstable or marginal employment settings can lead to negative health outcomes and impede prevention outcomes, especially if these work settings interfere with engagement and retention in care, adherence to antiretroviral medications (Musheke, Bond & Merten, 2012, World Health Organization,[WHO], 2007, 2008), or increase social and economic vulnerability.

Based upon a review of the vocational rehabilitation research and their clinical experiences providing vocational counseling to people living with HIV/AIDS, Goldblum and

Kohlenberg (2005) developed a Client-Focused Considering Work Model that provides guidance on how to approach this relatively new area of service delivery in a way that recognizes the diversity within this population and advocates for an individualized approach. This model reviews four key domains of influence (medical, psychosocial, financial/legal and vocational) that reflect an intersection of varied social determinants of health that can impact employment outcomes. This model also describes four stages of change (contemplation, preparation, action, and resolution) that can reflect levels of engagement in the considering work process and help to identify ways of approaching and conceptualizing vocational interventions.

In light of the potential benefits of stable employment on improving health and quality of life of African American women with HIV/AIDS (and the risks associated with insecure employment), it is imperative to develop innovative vocational development interventions that address their unique social and cultural vulnerability to negative health outcomes and that enhance their social and economic empowerment. Common Threads is a peer-led HIV group intervention that addresses social determinants of health as an integrated health, vocational development and prevention intervention that leads to an increase in self-esteem, social engagement, and HIV self-management while at the same time reducing the silence and isolation associated with HIV/AIDS.

The purpose of this paper is to (a) review the vocational needs of African American women with HIV/AIDS (b) apply the Client-Focused Considering Work Model to examine the key medical, psychosocial, financial/legal and vocational factors impacting the considering work process of African American women and (c) discuss the development of an integrated HIV prevention and vocational development intervention: Common Threads.

Vocational Needs of African American Women with HIV/AIDS

The idea of integrating vocational development interventions or employment services into the wide array of HIV/AIDS health and prevention services is fairly new. This is due in part because of the relatively recent development of effective antiretroviral therapy (ART) that fundamentally changed HIV/AIDS from a death sentence to a chronic illness. Prior to the development of ART medication protocols, the primary focus of HIV services was on health care crises and HIV prevention. The lack of widespread vocational services within the HIV/AIDS service system is also due to the restrictions prohibiting funding of vocational services within large federal HIV/AIDS initiatives, such as the Ryan White Care Act, and the overall tendency to isolate human service needs and services, rather than providing more comprehensive integrated services (Ciasullo & Escovitz, 2005). Furthermore, like many people with disabilities who receive social security benefits, many people with HIV/AIDS are afraid they may lose these benefits if they return to work, leading to greater financial vulnerability. According to Marini & Reid (2001) less than one-half of one percent of Social Security beneficiaries transition to employment each year. This is due, in part to the complexity of the work incentive policies, including the relatively high literacy rates needed to understand these incentives (Sykes, 2007) and cultural mistrust of the process (Alston, 2004). Consequently, women with HIV need increased access to benefits counselors who can help them assess this process and maximize their financial well-being (Conyers & Datti, 2009).

Research indicates that many African American women living with HIV/AIDS want or need to work yet face a range of barriers to employment (Conyers & Datti, 2008; Shamburger-Rousseau, 2013a; Webel, 2013). Due to the multiple barriers, and lack of expertise among AIDS service providers regarding the development and implementation of vocational rehabilitation

services, AIDS service professionals may prematurely dismiss opportunities to develop innovative programs to help these women engage in vocational development activities. However, with the current shift in public policy to further consider social determinants of health (such as poverty), there is emerging interest in developing vocational interventions and further examining the relationship among employment status, HIV health and successful prevention outcomes (Conyers & Boomer, in press, DOL, 2012).

In order to gain a better understanding of the vocational development needs of people with HIV and employment status as a social determinant of health, a sample of 2,506 volunteer respondents with HIV/AIDS were recruited to complete the National Working Positive Coalition Vocational Development and Employment Needs Survey (NWPC-VDENS, Conyers, 2008, DOL, 2011). The sample consisted of participants from diverse gender (65% male, 34% female and 1% transgender) racial (37% Black, 37% White, 18% Latino and 7% other) sexual orientation (48% Heterosexual, 44% gay and 8% bisexual) and educational (38% high school graduate or less, 38% some college, 2-year college or trade school and 25% 4-year college or graduate school) backgrounds. About a quarter of the sample reported never using email or the Internet and many reported a history of substance abuse (38%) incarceration (26%), and/or homelessness (43%). Fifty-three percent reported an income of \$15,000 or less per year. In terms of employment, 32% reported being employed and 68% were not working. Key findings from this study indicate that as a social determinant of health, employment is associated with improved health and reduced health risk behaviors for many. Additionally, despite advancements in medical treatments, people living with HIV/AIDS have a wide range of health outcomes, needs and co-existing illness and/or disability that impact their vocational development as well as their economic and social context in complex ways (DOL, 2011).

In follow-up studies specifically examining an African American female sub-group (n=313) from the NWPC-VDENS study, Shamburger-Rousseau, (2013a, 2013b) has examined a number of key factors that help to illustrate both the ways in which HIV/AIDS can impact vocational development and the relationship between employment and important health and health-risk outcomes. One key finding relates to the dramatic impact that an HIV/AIDS diagnosis had on loss of employment for many women. Although 41% of the African American female respondents reported being employed at the time they were diagnosed, only 26% were employed when the study data were collected (Shamburger-Rousseau, 2013a). Among these African American female respondents, 72% reported a diagnosis of HIV and 28% reported having AIDS at the time the survey was completed (Shamburger-Rousseau, 2013a). Fifteen percent reported unstable health during the past 12 months and seven percent expected their health to be unstable over the next five years (Shamburger-Rousseau, 2013b). Ninety percent of respondents reported additional health concerns beyond their HIV/AIDS diagnosis.

Shamburger-Rousseau (2013b) also examined personal health outcomes as well as public health outcomes associated with risk of HIV transmission. With respect to the employed African American female respondents (N=82), the majority reported positive personal and public health outcomes since beginning their current job. For example, 51% reported an increase in self-care after beginning their current job with 24% of participants reporting no changes. Similarly, 45% reported an increase in CD4 count while 28% reported no change. In addition, 28% of these respondents reported increased medication adherence while 51% reported no change. By comparison, respondents reported relatively low negative outcomes related to decrease in: medication adherence (7%), self-care (10%) and CD4 count (17% decrease), With respect to

health risk behaviors associated with HIV transmission, 26% of the employed African American female respondents reported that their use of alcohol decreased since their current job, while 55% reported no change. A similar trend is reported for decreased drug use (23%) with 57% reporting no change in drug use. Regarding unprotected sex and number of sex partners, 27% reported a decrease in unprotected sex, 51% reported no change and 28% of the respondents reported a decrease in number of sex partners, while 51% reported no change. Relatively few respondents reported increased health-risk behaviors including increases in alcohol use (1%), unprotected sex (2%), and number of sex partners (2%). No increase in drug use was reported (Shamburger-Rousseau, 2013b). Importantly, these trends noted for the African American female respondents are consistent with patterns of responses for the overall sample in the NWPC-VDEN study (Conyers, 2010). In light of the relationship between employment and improved HIV-related health outcomes and reduced health-risk behaviors associated with HIV transmission, having a conceptual framework to address these concerns is essential.

The Client – Focused Considering Work Model

The Client-Focused Considering Work Model provides a framework to help conceptualize four key social context factors that influence the employment decision-making process for people living with HIV/AIDS. Given the need for vocational services among African American women, it can be helpful to review these factors (medical, psychosocial, financial/legal and vocational) within the unique social and cultural context of these women. A brief overview of these factors and how they may impact the considering work process for African American women living with HIV/AIDS is provided below.

Medical Domains of Influence

Medical outcomes for African American women living with HIV/AIDS are quite dire. The mortality rate of African American women living with HIV/AIDS is over 20 times higher than non-Hispanic White women (CDC, 2008). Recent clinical trials have identified key factors that help explain these statistics such as lack of early intervention, low participation rate in HIV care, lower response rates to treatment, and high prevalence of co-occurring disorders (Currier et al., 2010; Shamburger-Rousseau, 2013a; Smith, 2010). According to the World Health Organization Commission on Social Determinants of Health (2008), much of the inequitable burden of illness that leads to this type of alarming premature loss of life results from the social and economic context in which people work, live and develop, which must be addressed to alleviate this problem.

Effective medication adherence has a strong association with positive employment outcomes for people with disabilities, including those living with HIV/AIDS (Haslam, Atkinson, Brown, & Haslam, 2005; Simoni, Frick, & Huang, 2006). Disabling side effects of medications and/or difficulty adapting to complicated medication protocols can limit the ability to work (Haslam, Atkinson, Brown, & Haslam, 2005; Kohlenberg & Watts, 2003). Establishing and maintaining adherence to antiretroviral medications has important personal and public health implications. Effective adherence (95% or greater) can lead to establishing an undetectable viral load, which in turn can lead to increased survivability and a reduction in the risk of HIV transmission by 96% (The White House, Executive Order, 2013). Understanding how to monitor and interpret one's lab results is a critical aspect to the medical management of HIV/AIDS, especially as one makes a transition into or out of employment.

Although drug use has shifted from being the primary cause of HIV transmission for African American women over the last twenty years, and is now the second leading cause of

HIV transmission in the African American community (Laurencin et al., 2008; Shamburger-Rousseau, 2013a), the impact of substance abuse on vocational development and ability to maintain employment remains a significant challenge. Substance abuse is associated with unstable employment as well as individuals being more likely to engage in unprotected sex, sharing needles, and other health-risk behaviors. Medical adherence is also affected when individuals are under the influence of drugs or alcohol. Research indicates that employment can play a critical role in the recovery process and can help to maintain sobriety (Laurencin et al., 2008; Sacks, 2004). As such, effective employment interventions may also help to reduce the spread of HIV/AIDS indirectly by reducing excessive use of alcohol and other drugs and therefore reducing overall risk while improving individual health outcomes.

In determining the medical feasibility of working, biological markers of immune system function, physical capacity, and work environment must be assessed (Goldblum & Kohlenberg, 2005). Research indicates that among a sample of otherwise healthy women in Sweden and Finland, loss of employment was associated with a negative impact on their immune system (Roos, Burstrom, Saastamoinen & Lahelma, 2005). This decline was reversed, however, when the women re-entered the workforce. These findings suggest that more research is needed to evaluate the impact of employment transitions on health outcomes for women, including consideration of the psychosocial aspects of different work environments.

Psychosocial Domains of Influence

Sorensen et al. (2003) defined social context as patterns that reflect larger societal and systematic forces, which affect individuals' daily realities. Employment opportunities and health status have a significant impact on daily life. "Psychosocial" vulnerabilities that affect vocational development and HIV self-management include poverty, access to health care, homelessness, multiple life roles (mother, wife, employee), and pervasive societal oppressions (sexism, racism, classism; Bozzette et al., 1998; Hackl et al., 1997; Hodder et al., 2010; Hunter, 2009; Mernstein et al., 2009; Schuster et al; Webel & Higgins, 2012).

Among the more than 1.1 million people living with HIV/AIDS in the United States, 280,000 (24%) are women (CDC, 2012). Prevalence rates among women are not random as HIV trends reflect a pattern of targeted demographic groups marked by poverty rates, geographic location, race/ethnicity and transmission mode (Hodder et al., 2010). Although African American women only comprise 12% of the female population, they represent the largest group (57%) of all newly identified HIV women in the United States (CDC, 2011; Kaiser Family Foundation [KFF], 2011). Heterosexual African American women represent the fourth largest subgroup of all who are newly diagnosed with HIV (CDC, 2011).

One of the significant psychosocial vulnerabilities that many African American women face is the pervasive lack of awareness about the rates of HIV among women and the level of risk associated with heterosexual contact (Hodder et al., 2010). HIV/AIDS is often thought of as a gay man's disease as many are aware of the higher prevalence rates among men who have sex with men. Like women from other racial/ethnic backgrounds, however, the vast majority of African American women with a new HIV diagnosis are likely to be exposed through heterosexual contact (84%; CDC, 2013) with only 16% being exposed through injection drug use (CDC, 2013). This statistic is alarming and highlights the need for a more comprehensive approach to AIDS education and prevention that addresses economic vulnerability as one of the many structural factors that make African American women more vulnerable to HIV/AIDS. Research indicates that among other factors, financial dependence on male partners (Doherty,

Schoenbach & Admiora, 2009) and social and economic gender inequalities limit some women's capacity to negotiate safer sex practices, including condom use (El-Bassel, Caldeira, Ruglass, et al., 2009; Wingood & DiClemente, 1998). The cultural silence regarding the impact of HIV on women makes it more difficult to secure needed resources to provide gender specific vocational, health and prevention services. Because of this silence and pervasive gender inequalities, efforts to advocate for additional resources for women often go unheard (30for30 Campaign, March, 2012).

Power imbalance among men and women is another crucial issue in HIV care and access to vocational rehabilitation services and training (Shamburger-Rousseau, 2013a). From a cultural perspective, African American women who maintain an African worldview usually prioritize family needs over their own health care, leaving limited opportunities for vocational development and economic advancement (Akbar, 1985, Shamburger-Rousseau, 2013a). While helping African American women living with HIV/AIDS increase their self-efficacy, self-reliance, and economic independence, it is also important to provide resources for them to help balance care for self and others, such as affordable childcare and flexible work schedules (Shamburger-Rousseau, 2013a).

Financial/Legal Domains of Influence

Women of color are one of the most economically disadvantaged groups in the United States. Once diagnosed with HIV or AIDS, African American women face even greater challenges to economic advancement and often the vocational and economic needs of these women are neglected, exacerbating their ongoing risk for negative health outcomes and higher mortality rates. African American women who completed the NWPC-VDENS (Shamburger-Rousseau, 2013b) reported multiple financial/legal barriers to employment including a history of homelessness (52%) and incarceration (31%). Additionally, almost half of the NWPC-VDENS African American female respondents (48%) reported an income of less than \$15,000 per year (Shamburger-Rousseau, 2013a). These multiple factors often intersect, creating a strong need for employment for economic survival while also substantially increasing barriers to employment and vocational development.

Unemployed African American women who responded to the NWPC-VDENS ($N=229$) reported that the need for increased income (86%) and gaining access to employment benefits such as health and/or life insurance (76%) were key motivators to consider employment (Shamburger-Rousseau, 2013a). However, despite this motivation, about 16% to 37% of the sample reported a range of financial and legal barriers to considering work, including the potential loss of housing and income benefits, discrimination, losing health insurance, health deteriorating and others finding out their HIV status (Shamburger-Rousseau, 2013b).

In light of the role that poverty places in increasing one's exposure to HIV and limiting access to care, professionals who work with women with HIV/AIDS need to understand the factors that can interfere with their vocational development and advancement as well as the resources and effective models for addressing these barriers. In the considering work process, financial and legal issues play an important role (Mwachofi, 2009). According to Goldblum and Kohlenberg (2005), the financial/legal influences on considering work include eligibility for health insurance and housing subsidies, government and/or private disability income, and understanding legal definitions of disabilities and one's rights under the Americans with Disabilities Act (ADA).

The Americans with Disabilities Act Amendments Act (2008), mandates that employers make reasonable accommodations for people who have disabilities. However, to be covered by the ADA, one must know their disability status and be willing to disclose. Due to HIV-related stigma, fear of discrimination, employer alienation, breaches of confidentiality, fear of losing jobs, and lack of knowledge about the ADA and strategies for requesting accommodations, many individuals living with HIV/AIDS may choose not to disclose their disability status (Simoni et al., 2000; Peterson, 2010).

In addition to contending with illegal discrimination based upon health and/or disability status, many African American women also have to deal with discrimination based upon race and gender (Shorter-Gooden, 2004; Clark et al., 1999). Fesko (2001) also reinforced that the risk of illegal workplace discrimination is especially salient for racial and ethnic minorities living with HIV/AIDS including gender/sexual minorities. Thus, African American women living with HIV/AIDS may encounter multiple forms of discrimination at work, and these experiences may result in lower work performance and self-efficacy. Hackett and Byars (1996) stated that African American women who have been exposed to discrimination against other African American women may be concerned about facing similar employment barriers.

Socioeconomic and racial disparities in the U.S. cause difficulties in access to high-quality health care for African American women (Aral, Adimora & Fenton, 2008). Unemployment and the associated lack of employer-based health insurance are major reasons that individuals have not had access to health care (Sherbourne, Dwight-Johnson & Klap, 2001). The lack of access to health care and advanced treatment options have contributed to poor health outcomes, which often then result in an additional barrier to employment.

Conyers & Datti (2009) examined the unmet vocational rehabilitation (VR) needs among women with HIV, and reported that very few women living with HIV were aware of key legal rights and protections. This is also consistent with findings from later studies (Conyers, 2010; Shamburger-Rousseau, 2013a). This lack of knowledge is often attributed to the complexity of regulations associated with maintaining access to health insurance and public benefits when transitioning to work (Sherbourne, Dwight-Johnson, & Klap, 2001; Hunn & Heath, 2011). One of the greatest disincentives to considering employment is the fear of losing public income benefits and/or health insurance (Conyers & Datti, 2009).

Despite these financial and legal barriers, with careful guidance and coordinated services many African American women living with HIV/AIDS may be able to find or maintain employment that will improve their economic status and overall well-being. This often requires consultation with disability benefits counselors (with expertise in evaluating the impact of work on any combination of state and federal income benefits) and experts who know how to assist individuals with a criminal record (who may be able to help expunge records or prepare for difficult interview questions). However, without this support, marginal or unhealthy work settings can pose a threat to an individual's health and increase negative public health outcomes.

Vocational Domains of Influence

The vocational domain of considering work includes exploring factors such as one's work history, vocational and academic skills, vocational identity and interests, as well as need for vocational services (Goldblum & Kohlenberg, 2005). Common vocational concerns for people living with HIV/AIDS include gaps in employment history, lack of job skills, and a need for job accommodations (Brooks et al., 2004; Martin et al., 2006). Work environment is another important factor that would need to be taken into consideration. Dyck (2000) indicated that the

work environment, job task modifications and a supportive work atmosphere enhance the experiences of women with disabilities at work (Dyck, 2000).

When the unemployed participants in the NWPC-VDENS study were asked if they were able to work, 43% of men and 38% of women indicated “yes”, 25% of men and 34% of women indicated “no” and 32% of men and 28% of women indicated “uncertain” (Conyers, 2010). Additionally, 34% percent of respondents indicated that they needed job skills and only about one quarter of respondents agreed that their service providers were knowledgeable about employment (Conyers, 2010).

These findings highlight that a large proportion of the sample are not currently working despite reporting an ability to work, which suggests some form of vocational intervention would be helpful to address the factors that are preventing these individuals from being employed. Additionally, about a third of the sample reported uncertainty regarding their ability to work. This suggests that vocational services may be helpful to allow these individuals to evaluate the benefits and risks of employment to be able to make an informed decision. The discrepancy in responses between male and female respondents, suggests that women may face more employment challenges than men and there may be a number of barriers leading to lack of employment other than one’s level of interest in being employed.

According to Social Cognitive Career Theory (SCCT; Lent, Brown, & Hackett, 1994), self-efficacy is a set of self-beliefs regarding one’s ability to perform a specific task. Within this vocational domain, self-efficacy regarding ability to become employed would influence the extent to which one would consider employment (Bandura, 1986). Self-efficacy also predicts career choice and performance. Lent and Brown (2006) stated that gender and race influence career and academic self-efficacy, which are learned from past experiences and societal values. Ethnic minority women learn from their experiences that their efforts, and those of their peers, are often not equally rewarded in society. Consequently, these negative experiences may contribute to lower employment outcome expectations. An important element of vocational rehabilitation services for African American women with HIV/AIDS is to help to increase their self-efficacy, especially in the face of some of the aforementioned health, financial and legal barriers to employment. Many women with HIV/AIDS may need vocational rehabilitation services to help address these barriers.

Unfortunately, research investigating the use of state vocational rehabilitation services by ethnic minorities reveals patterns of inequitable treatment in all major aspects of the rehabilitation process (Rehabilitation Act of 1973, as amended in 1992, p. 26). For example, the acceptance rates for African Americans were significantly lower than Whites and African Americans were less likely to attain successful employment outcomes (LeBlanc & Smart, 2007; Leung, Flowers, Talley, & Sanderson, 2007; Rosenthal, Ferrin, Wilson, & Frain, 2005; Wilson, Harley, McCormick, Jolivette, & Jackson, 2001). Although significant efforts continue to be made to reduce the disparities in vocational rehabilitation service utilization, additional efforts will be needed to help support effective engagement and use of these services for African American women living with HIV/AIDS.

Phases of Considering Work

A unique component of the Client-Focused Considering Work Model is that it not only identifies four key domains of influence, but also incorporates Stages of Change Theory (Prochaska, Norcross & DiClemente, 1994) to delineate four phases of considering work: (a) contemplation, (b) preparation, (c) action, and (d) resolution. Goldblum and Kohlenberg (2005)

point out that the process of considering work is a non-linear, dynamic process that typically starts with a perceived pressure for employment-related change. This change may result from a range of circumstances including: improved health, financial need (being denied benefits, having benefits cut, not being able to subsist on current level of benefits), loss of a partner (e.g., break-up, divorce, death, incarceration) and/or children transitioning to adulthood. The Client-Focused Considering Work Model provides a framework for understanding employment decision making processes by which pioneering HIV prevention and vocational rehabilitation programs can be established to target the specific needs of African American women living with HIV/AIDS.

Common Threads: Moving From Contemplation to Resolution

When considering gender responsive vocational interventions for African American women living with HIV/AIDS, it is important to tailor the intervention to the appropriate phase of considering work and to address the medical, psychosocial, financial/legal and vocational factors that can impede social and economic empowerment. Common Threads is a three-stage, peer-led HIV training that addresses social determinants of health as an integrated health, vocational development and prevention intervention that leads to an increase in self-esteem, sociability and HIV self-management while at the same time reducing the silence and isolation often associated with HIV/AIDS. Each phase of the Client-Focused Considering Work Model involves a careful evaluation of the benefits and risks of making a change for a person living with HIV/AIDS. As access to educational, vocational and medical resources is disproportionately impacted by race and ethnicity, tailoring interventions to the specific social and cultural context of African American women is critical (Hunter, 2009, Musheke, Bond, & Merten, 2012; 30for30 Campaign, March, 2012). This section will describe the development of the Common Threads intervention and how this program addresses the different phases of considering work and the four domains (medical, psychosocial, financial/legal & vocational) influencing health and employment outcomes for African American women with HIV/AIDS.

Common Threads is designed to move participants from contemplation to resolution. This movement is supported by the three stages of the Common Threads intervention. Stage I of Common Threads develops and enhances the capacity of participants to share their stories with family members, partners, friends, and community about specific life history and experiences stemming from select social determinants of health (e.g., poverty, sexism), which may have increased their susceptibility to HIV and/or negatively affected their health outcomes, retention in care and quality of self-care. Stage II prepares participants for The Microenterprise Circle (aka The ME Circle). The ME Circle is an economic intervention designed with the purpose of reducing the impact of poverty by increasing the financial independence and self-sufficiency of women living with HIV (Johnson, 2013). Stage III supports participant engagement in organized community and conference events incorporating space for vendors and exhibitors. Such events create opportunities for Common Threads ME Circle graduates, women living with HIV, along with affected family members, to sell their products in a marketplace environment.

Peer education is another key component in Common Threads. Peer education creates changes by modifying norms and facilitating collective action at a group or societal level (Crimson, 2012). The Common Threads training team consists of four female trainers, two of whom are peers living with HIV, one is a group facilitator, and the other is a licensed clinician (Johnson, 2008). Each trainer role models all techniques, including demonstration of storytelling skills as well as provides a safe environment within which participants can assess their own understanding of these experiences. Providing a safe, supportive, small group environment

encourages discussion, contributing to the conceptual understanding of the value of sharing individual life experiences with others and contemplation of making different choices going forth (Johnson, 2012). As African American women who have all achieved some level of acceptance of their own personal journey with HIV and are engaged in their own vocational development and social and economic empowerment, the peer-facilitators communicate the importance of self-care and establishing positive expectations for vocational development and employment success. Emphasis is placed on the need to balance self-care with care for others and reinforcing the benefits of economic independence and seeking social support to establish and pursue individual goals.

Most of the content in the Common Threads program focuses on facilitating participants ready to move from the contemplation phase to the preparation phase. Illustrations of HIV vulnerabilities at different levels (individual, family, and community) help women identify social context vulnerabilities similar to those reviewed within the Considering Work Model. The power of storytelling and the positive impact of peer leaders allow women to consider the meaning of disclosure. Exploring personal and family strength may encourage women to embrace their vulnerabilities and become ready to move to the action phase.

Given the individualized nature of the considering work process, however, not every participant is required nor expected to complete all stages of the Common Threads intervention. Due to individual life circumstances, some women may determine that they are not ready to move from contemplation to preparation or preparation to action and resolve not to move forward, leading to the resolution phase of the model after completing Stage One or Stage Two of Common Threads. Common Threads trainers strive to maintain contact with these women in case they decide to reconsider work options at a future time.

Exploration and Storytelling: Contemplation

Stage I of Common Threads, although not explicitly designed as an employment intervention, addresses critical pre-vocational and vocational development needs of its participants. It does this by promoting and supporting an exploration of (a), medical, psychosocial, financial/legal and vocational vulnerabilities and strengths as well as positive and negative responses used to cope with vulnerabilities and (b), options for disclosing life experiences, including HIV-positive status. The purpose of this initial training is to assist African American women living with HIV to understand: a) the commonality of life experiences; b) the interconnectedness of these life experiences, c) and how these experiences may or may not increase vulnerability to HIV infection, other related sexually transmitted infections (STIs), including Hepatitis C, and/or lead to poorer health outcomes for African American women living with HIV/AIDS (Johnson, 2008). Participant eligibility includes: a) having an HIV-positive diagnosis, b) a willingness to disclose HIV status, c) being linked to an AIDS service organization or community-based organization (ASO/CBO), and d) a willingness to explore and/or access post-training psychosocial support (Johnson, 2013). Additionally, participants are expected to make an ongoing commitment to the training (Johnson, 2008).

Given its emphasis on exploration and reflection, this stage of the Common Threads program is consistent with the contemplation phase of the Client-Focused Considering Work Model (Goldblum & Kohlenberg, 2005). During the contemplation phase women consider the possibility making changes, but have not yet made a decision. Within this phase the key question to address is: "Is any change feasible?" The uncertainty associated with potential changes may increase anxiety and confusion (Prochaska, Norcross & DiClemente, 1994). Generally, women

in this phase are willing to consider employment as an option, but may be hesitant to make a decision. This decision involves a thorough evaluation of the benefits and risks associated with each of the medical, psychosocial, financial/legal and vocational domains of influence.

In module one of the Common Threads training, trainers introduce the content and purpose of the training. Participants are encouraged to explore their own life experiences by engaging in a series of exercises, including creating a personal journal. Introduction of the concept of HIV vulnerability allows women to consider their medical, psychosocial, financial/legal, and vocational experiences along a timeline continuum, i.e. childhood, adolescence, young adulthood, and adulthood. Since Common Threads is based on the Learning Theory of Transformational Learning (TL; Merriam & Caffarella, 1999), which illustrates how adults interpret their life experiences and how they find meaning out of their experiences. In Stage I of Common Threads the psychosocial domain of the Client-Focused Considering Work Model has particular relevance. The impacts of gender roles, family history, education, past traumatic experiences, poverty, stigma, and HIV diagnosis are explored within a supportive environment and among peers. This exploration typically awakens and motivates many of the participants to seek connection with each other and/or to reconnect with loved ones and start to pursue their individual goals. Transitions to enter or return to the workforce may be one of many changes contemplated.

To assist with sharing and disclosure, Common Threads incorporates the cultural tradition of storytelling as a main method in the intervention. As one of the most ancient African traditions, storytelling is a way of passing on beliefs, cultural practices and traditions, maintaining social order and codes of behavior (Johnson, 2009). Participants gain experience with storytelling demonstrations, interactive discussions, and journaling in the training (Johnson, 2009). Creative storytelling tools such as a developing a participant's family tree, personal timeline, and HIV diagnosis experience are introduced to help women explore their vulnerabilities and share their experiences. During the course of the training, women have opportunities to practice presenting their stories and gain feedback from each other. Through the formal exercises and informal social connection, Common Threads participants experience a reduction of the isolation often reported related to living with HIV/AIDS. The opportunity to be able to share information among peers, and better understand the common factors that influenced their vulnerability for HIV, helps to reduce the stigma associated with the common tendency to focus on individual behavior, guilt and self-blame. Within this setting, women gain opportunities for vicarious learning and to share self-care strategies for maintaining adherence to the medications and managing side effects.

In the last two modules of Stage I of the Common Threads training, participants are provided a chance to practice their storytelling skills and conduct presentations. As the training provides integrative, culturally sensitive support and pre-vocational skill building, participants may develop confidence and self-efficacy in sharing their stories and pursuing their career goals. Graduates from Common Threads are encouraged to deliver one presentation in their local communities within three months and to participate in an HIV prevention activity, such as an HIV testing event, within six months. Community engagement as peer educators breaks down isolation and stigma, develops vocational skills, and can provide opportunities for flexible employment that are personally meaningful and valuable.

As the vocational development needs of Common Threads participants shift from contemplation to preparation and action, additional Common Threads programming targets

further support of the economic empowerment of participants through each phase of the considering work process. As noted earlier, work may not be a viable option for some participants and a decision to make no change or not to continue in Stages II and III of the Common Threads intervention is not considered a failure. It may be a successful outcome of support for making a well-informed decision.

The Microenterprise Circle: Preparing for Action

The second Stage of the Common Threads intervention is its microenterprise initiative, The Microenterprise Circle (or The ME Circle). Graduates of Stage I of Common Threads are invited to come back for The Microenterprise Circle (The ME Circle) training, which builds off of and reinforces the foundation provided in Stage I to further explore the social context vulnerabilities of African American women and to further empower them through additional vocational development and flexible employment opportunities. Within the Client-Focused Considering Work Model, preparation is a phase during which a woman is intending to take action, but has not yet developed a plan (Goldblum & Kohlenberg, 2005). During the preparation phase, the key question is: "What change is best?" Within this phase, individuals explore and set goals and develop plans for meeting those goals. The decision-making process is still occurring in this phase; the pros and cons of potential changes still need to be evaluated (Goldblum & Kohlenberg, 2005). Tasks in this phase could be identifying sources of training, participating in workshops or seeking career counseling.

The ME Circle is a microenterprise intervention that assists women living with HIV/AIDS to combat poverty. This one-day training consists of four modules: 1) introducing the ME Circle, 2) preparing the economic collective, 3) jewelry-making, and 4) supporting the economic collective. Local crafters and artists are invited to teach women to make jewelry, pillows, and other crafts. These women then form economic collectives or ME Circles. The ME Circle provides skill-building training for the women participating to increasingly support themselves and develop opportunities to be seen in their communities showing their work. Working collectively strengthens interconnectedness among women participating, developing their support network and access to experience-based information about managing HIV and utilizing community resources – sharing of knowledge from greater community involvement. Vocational experts join this component of the training to provide training on common barriers to employment, and resources and strategies to address these barriers. Through participation in these activities, participants have the opportunity to evaluate vocational skills, potential barriers to employment, and other strengths to support their ability to make well-informed decisions about change within a safe environment. Engaging in discussions relating to the development of the Microenterprise Circle with peers provides concrete pre-vocational experiences such as developing a plan, exploring common interests, assessing stamina and the possible need for workplace accommodations (Lindstrom & Benz, 2002).

While engaging in these activities, participants may consider and discuss broader issues related to HIV self-management as they consider or prepare to integrate the Microenterprise Circle into their lives. This could include discussion of any needed changes in their routine or medication management to see if any changes may facilitate their ability to move forward in the considering work process. With peer and mentor support, there is a wealth of indigenous knowledge and experience to draw from to inform decision-making and help participants to anticipate and adjust to any needed changes. The vocational experts can also encourage clients to identify external factors which could support their decisions and plans, including social support

(family, mentors, and peer support), development opportunities (education), financial/legal supports (consultation with a benefits specialist, learning about their rights under the ADA and FMLA), vocational supports and resources (funding and training from the vocational rehabilitation and workforce development systems, and other public resources; Noonan, Gallor & Hensler-McGinnis, 2004) Developing an action plan and removing barriers are important in this phase.

For women living with HIV/AIDS, being able to commit to change not only reflects a willingness to take action but also increased self-efficacy. The commitment to this level of change often requires a shift in a woman's view of the medical reality of disability and its overall impact on their lifespan and functional capacity. As such, an important aspect of Stage II of the Common Threads intervention, The Microenterprise Circle, may also entail an exploration of fundamental beliefs about health and, depending upon the stability of health over time, a need to learn how to cope with medical uncertainties.

The Marketplace: Action

Graduates from the Common Threads training/ME Circle are encouraged to maintain ongoing networking with each other, as well as with local community groups, and other small businesses located in their area. Stage III of Common Threads is an organized event called Made It Ourselves, which provides an opportunity for the ME Circle graduates, other women living with HIV/AIDS and their families, and crafters to participate in an organized market place to sell their products. The Marketplace, reflecting the action phase of the Client-Focused Considering Work Model, involves implementing the most critical changes and commitment (Goldblum & Kohlenberg, 2005). As one moves into the action phase of the Client-Focused Considering Work Model, the main question to address is: "How can I achieve my stated goals?" Refinement of goals and implementation of plans will be the main tasks in this phase. The Marketplace event requires that participants have used their skills to make the crafts that they intend to sell, made the appropriate transportation arrangements to arrive at the event, and have already developed the pricing and inventory of the items to be sold. This event provides opportunities to generate income while seeking to reduce societal HIV/AIDS stigma, as an opportunity for women living with HIV/AIDS to be visible in their communities, and reduce the silence that exists regarding the HIV/AIDS epidemic among African American women. Within this positive public context, the Common Thread graduates also counter common societal stereotypes by demonstrating that one need not be ashamed of being HIV-positive and that it is possible to thrive within a supportive social community of peers.

Given the degree of anxiety that can be generated in this process, as well as the normality of changing circumstances and information, it is critical that individuals have the flexibility to reconsider their goals. Allowing for reconsideration of their plans can help participants to be more open to thinking about changes associated with moving forward in the considering work process without fearing that they will be stuck in an unpleasant circumstance (Goldblum & Kohlenberg, 2005). Interventions that may be helpful in Stage III may include vocational skill training, symptom management training (Lofgren, 2006), work environment modifications, and other employment related activities (e.g. job search and interview skill building). Women and their peers can work on these tasks together to improve their self-efficacy and ability to achieve vocational goals (Lam et al., 2010). By working through their plans together, participants can deepen their connection and relationships and benefit from mutual support throughout this process. At times it may be disappointing when peers do not follow through on tasks or are not

ready to make the same level of commitment as others. However, being aware of the over all process outlined in the Client-Focused Considering Work Model provides a framework for women to engage in this exploration together with the shared premise of respecting individual decisions and having a structure and mechanism to explore these decisions together.

Common Threads Outcomes: Resolution

In addition to providing the opportunity for African American women with HIV/AIDS to progress through the phases of considering work and developing Microenterprise Circles, the expected outcomes of Common Threads also include: a) decreased HIV-related stigma, b) increased HIV testing and linkage to health care via health prevention messages delivered in the form of storytelling, and c) improved health and social outcomes (Johnson, 2012). Resolution is the final phase of the Client-Focused Considering Work Model where the main question to assess is: "Has the initial pressure to change been resolved?" It is during the resolution phase that participants may solidify their commitment to the Microenterprise Circle and planning for ongoing Marketplace events, or decide upon an alternative approach, including not to work at all. Resolution can be achieved by adapting to new work activities, or finding another way to meet personal needs through alternative approaches. Women may still face challenges and barriers seeking speaking engagements or developing and selling their wares (Julius, Wolfson & Yalon-Chamovitz, 2003). As they are sharing their stories and/or pursuing career goals, they will need to reassess their plans and modify strategies for their best interests.

Program evaluation of Common Threads demonstrates impressive outcomes. Madondo and Johnson (2012) conducted a mixed method program evaluation with 31 participants (excluding trainers) who were all African American women living with HIV/AIDS. Prior to the training, 66.7 % of the participants had not disclosed their HIV status via print media and 77.8 % had not disclosed via television. After the training, 95% of the participants answered that they were more willing to disclose their HIV status and share their life experiences to family members, friends and community members (Madondo & Johnson, 2012). Additionally, outcomes of the Microenterprise Circle included skills development, increase in sociability and a decrease in financial insecurity (Kelly, Williams & Johnson, 2012). Other outcomes of the Common Threads program are: engagement of often isolated women living with HIV/AIDS in an active process of self-reflection and sharing with peers, increasing participants' knowledge about HIV/AIDS and techniques for sharing their individual stories, and high satisfaction scores from program participants. Participants were able to return to their communities with enhanced skills and readiness to break the silence and stigma surrounding HIV/AIDS and a number of participants were also able to continue expanding their skills and developing a micro-enterprising consortium for selling their crafts in an open marketplace. In light of the strong conceptual foundation and positive initial program evaluation outcomes, more research is needed to replicate and assess the impact of this intervention to reduce economic and health disparities of African American women with HIV/AIDS.

CONCLUSION

Current policies and initiatives call for further integration of social determinants of health into HIV/AIDS prevention and care interventions. Poverty is a driving force fueling the transmission of HIV, especially among African American women with limited resources and who face multiple medical, psychosocial, financial/legal and vocational vulnerabilities that limit their access to HIV care and the opportunity to pursue personal and financial empowerment. The

Client-Focused Considering Work Model provides a strong conceptual framework to highlight the development of Common Threads, an innovative integrated vocational development and HIV prevention intervention. Program evaluation of Common Threads demonstrates many positive outcomes, suggesting that it could play a critical role in reducing HIV/AIDS stigma among African American women while fostering their vocational, social and economic empowerment. Further research is recommended to further explore the dynamics of considering work among African American women with HIV/AIDS as well as better understanding the role of vocational development interventions on HIV health and prevention outcomes.

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