

Gender affirmation

An empowerment approach to addressing transgender health disparities



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HIV-related disparities among transgender ('trans') women

- » 34 times higher odds of infection than general population in U.S. ¹
- » Highest percentage of newly identified HIV cases ²
- » Almost 3x higher community viral load than non-trans adults in San Francisco ³
- » African-American transgender women are disproportionately affected ^{4,5}

HIV treatment-related disparities

- » Trans women living with HIV are less likely to take antiretroviral therapy (ART) ⁶

- » Those who do initiate ART:
 - have lower rates of medication adherence
 - report lower self-efficacy for integrating ART into daily routines
 - report fewer positive interactions with health care providers than non-trans adults ⁷

Trans women and pre-exposure prophylaxis (PrEP)

- » Low levels of awareness, even in areas with stronger medical and social supports ⁹
- » No trans-specific guidance for implementation
- » Low levels of enrollment and retention in demonstration projects ¹⁰
- » Rarely included in observational studies, rarely disaggregated ^{11,12}
- » Of the existing clinical trials, iPrEx is the only one with confirmed enrollment of trans women ¹³

Trans women in iPrEx

- » Of the 2499 participants:
 - 29 (1%) identified as women
 - 296 (12%) identified as “trans”
 - 14 (1%) reported use of feminizing hormones
 - 339 (14%) reported one or more of these characteristics.
- » Among trans women:
 - 11 HIV infections in the active arm
 - 10 in the placebo arm
 - Hazard ratio of 1.1 (95% CI: 0.5 to 2.7)
- » **Zero effectiveness on an intention to treat basis**
- » Those on hormones were less likely to have protective PrEP drug levels than those not on hormones ¹⁴





**Transgender women
have highest rates
of HIV of any group**

These rates are
included in rates of
**HIV among
MSM**

Impact on Services:
Prevention and treatment
programs are based on
MSM-specific data

**Trans invisibility
perpetuates health
disparities**

Impact on Research:
We know LESS than we think
we do about what works for
trans women

\$\$\$ is allocated
to research and
services for MSM
based on these rates





Trans-specific barriers and facilitators to HIV treatment engagement, PrEP uptake, and medication adherence

| Barriers | Facilitators |
|---|--|
| Avoidance of healthcare due to stigma and past negative experiences | Access to gender affirming, trans-informed health care |
| Prioritization of transition-related healthcare (e.g. hormones, surgery) | Integration of hormone therapy and HIV treatment or PrEP provision |
| Concerns about adverse interactions between antiretrovirals (HIV tx or PrEP) and hormone therapy ⁸ | Education about ART and PrEP from trusted sources, such as trans peers ¹⁴ |



Importance of/ Need for gender affirmation

Desire for transition-
related procedures

Desire to be affirmed
as female

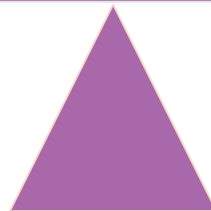
Desire to “pass” or
“live stealth”

Satisfaction with/ Access to gender affirmation

Gender affirming
health care

Affirming
relationships: Family,
peers, and/or lovers
and sex partners

Ability to “pass”



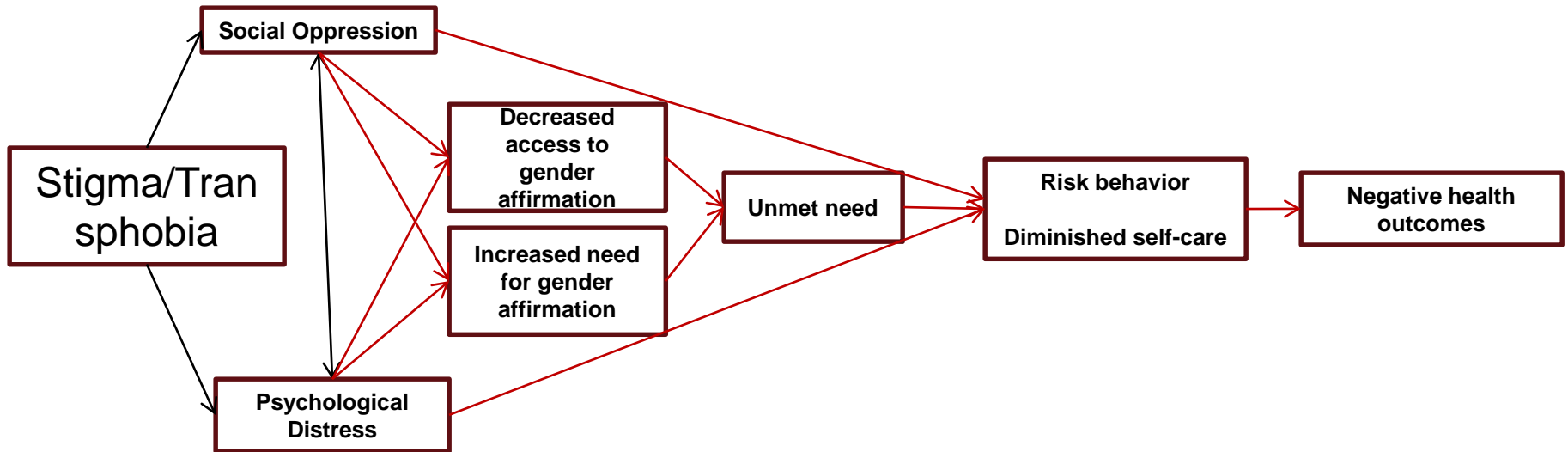


ACCESS to gender affirmation

NEED
for gender affirmation

| | LOW | HIGH |
|------|---------------------|--------------------|
| LOW | Lower risk | LOWEST risk |
| HIGH | HIGHEST risk | Lower risk |

Model of Gender Affirmation



Objectification Theory

(Fredrickson and Roberts 1997;
Moradi and Huang 2008)

Identity Threat Model of Stigma

(Major and O'Brien 2005)

Oppression and Sex in High Risk Contexts

(Diaz et al. 2001, 2004)

Gender affirmation, depression and ART adherence (n=861)

| | Depression | | | |
|---|------------|---------|---------|--------|
| | OR | 95% LCL | 95% UCL | p |
| Importance/need for gender affirmation | 1.142 | 1.015 | 1.286 | 0.0279 |
| Satisfaction/access to gender affirmation | 0.717 | 0.62 | 0.829 | <.0001 |
| Body satisfaction | 0.668 | 0.575 | 0.775 | <.0001 |

| | Adherence to ART | | | |
|------------|------------------|---------|---------|--------|
| | OR | 95% LCL | 95% UCL | p |
| Depression | 0.609 | 0.379 | 0.977 | 0.0398 |

Gender affirmation, retention in care and viral suppression (n=861)

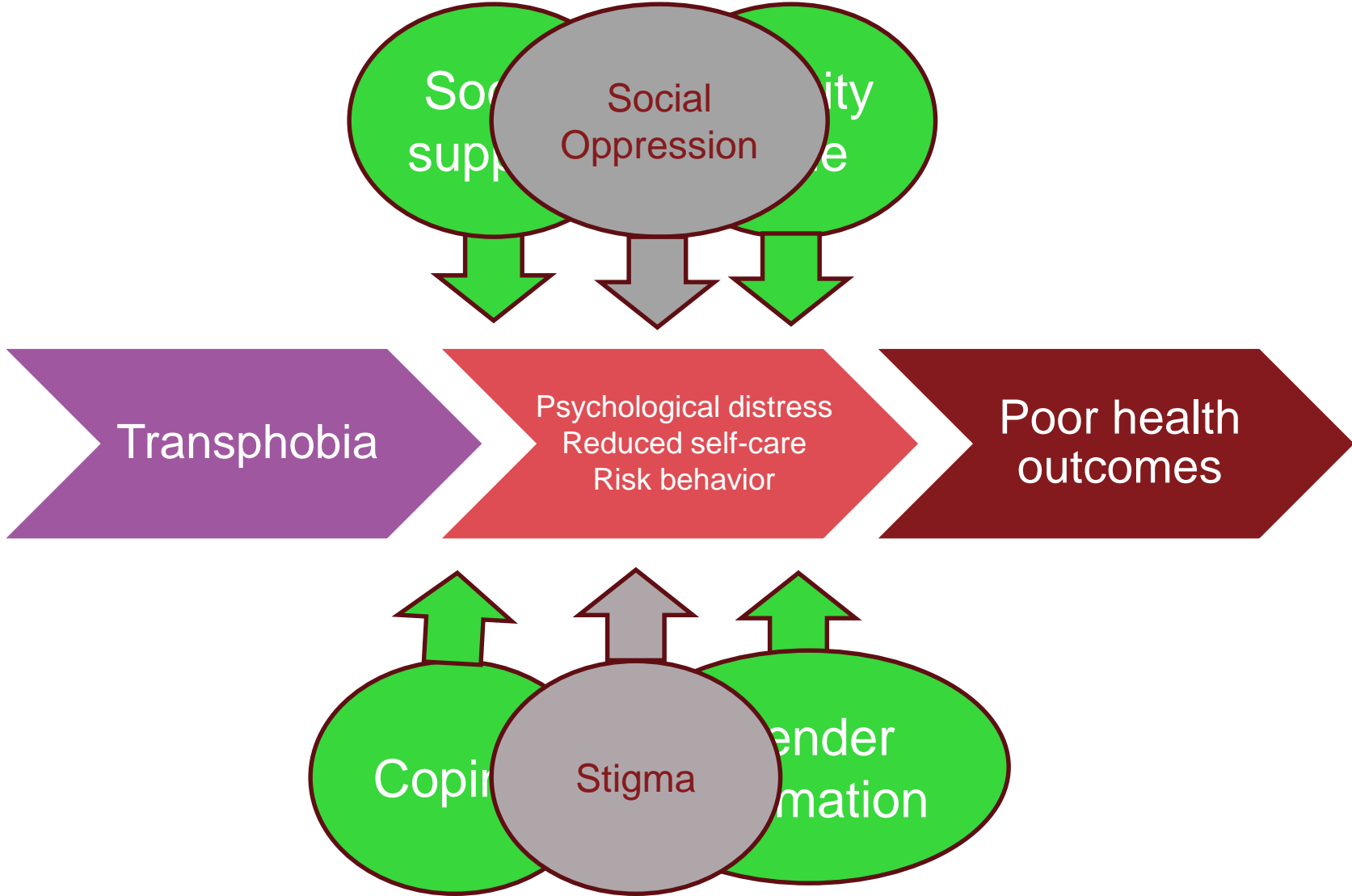
| | Retention in care | | | |
|---|-------------------|---------|---------|--------|
| | OR | 95% LCL | 95% UCL | p |
| Satisfaction/access to gender affirmation | 1.262 | 1.073 | 1.484 | 0.005 |
| Body satisfaction | 1.336 | 1.129 | 1.581 | 0.0008 |

| | Viral suppression | | | |
|---|-------------------|---------|---------|--------|
| | OR | 95% LCL | 95% UCL | p |
| Importance/need for gender affirmation | 1.144 | 1.012 | 1.293 | 0.0318 |
| Satisfaction/access to gender affirmation | 1.161 | 1.012 | 1.333 | 0.0335 |

Effects of Gender Affirmation



Resilience / Protective Factors





| Session | Topic |
|---------|----------------------------|
| 1 | Gender Pride |
| 2 | Looking Good, Feeling Good |
| 3 | Let's Talk About Sex |
| 4 | Taking Back the Power |
| 5 | Surviving and Thriving |

Funded by NIH/NIMH R34MH102109, K08MH085566, CHRP Community Collaborative Award



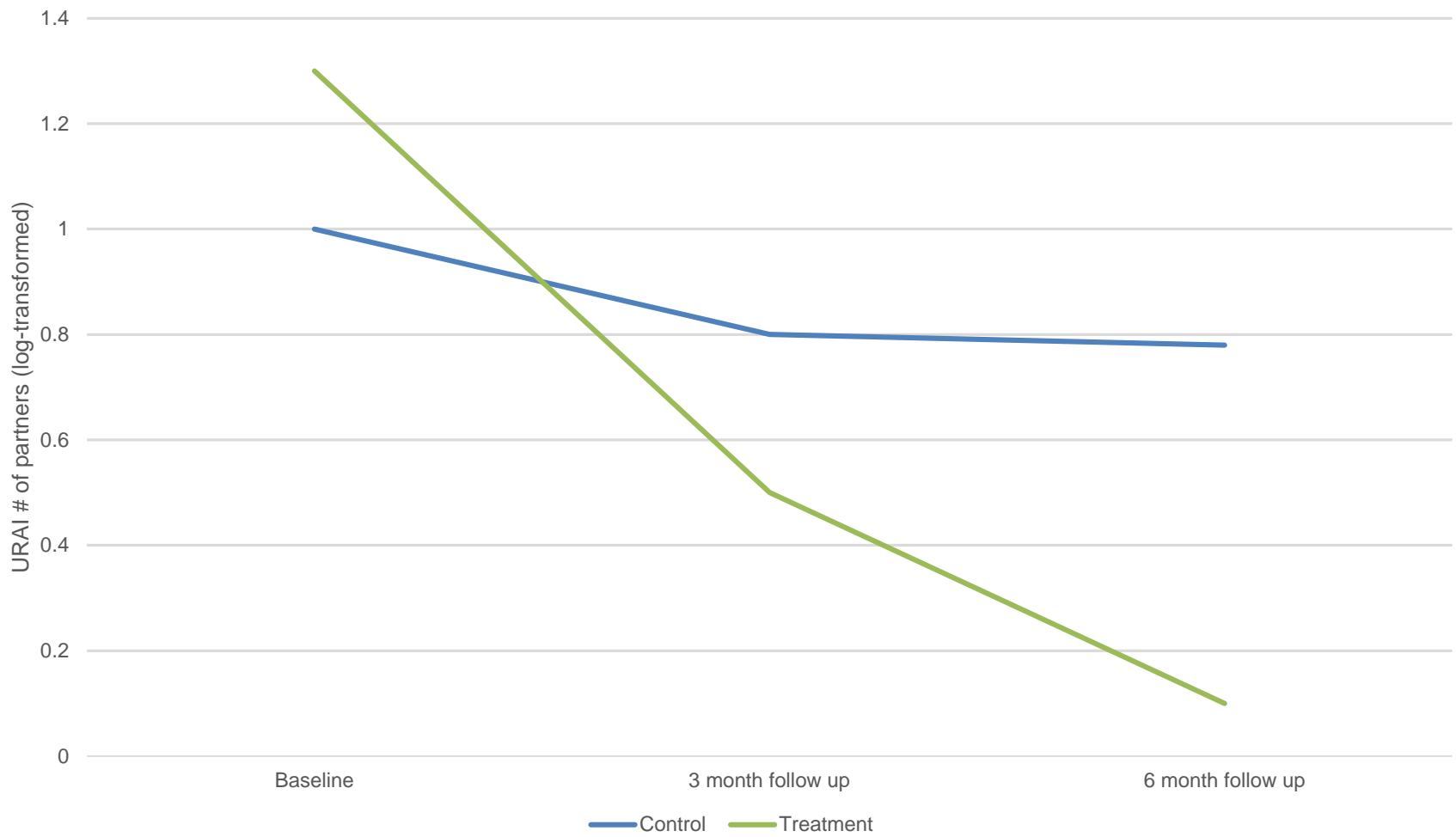


Gender affirmation - operationalized

| Session | Topic | Sample Objectives |
|---------|----------------------------|--|
| 1 | Gender Pride | <ul style="list-style-type: none">• Explore and discuss trans identities and historical figures• Explore values, decision, and relational contexts unique to trans women's lives |
| 2 | Looking Good, Feeling Good | <ul style="list-style-type: none">• Discuss gender affirmation and how it affects self-image, self-care and power to negotiate safer behaviors• Discuss transition-related health care• Explore connections between self-care and feeling good |
| 3 | Let's Talk about Sex | <ul style="list-style-type: none">• Provide accurate information on HIV/STIs• Discuss protection strategies of oneself and one's partners |
| 4 | Taking Back the Power | <ul style="list-style-type: none">• Explore the impact of transphobia on one's sense of personal power• Discuss assertiveness skills, basic self-defense information |



Pilot RCT (n=89)





Intervention to optimize engagement in HIV care and medication adherence among HIV+ transgender women



6 sessions with peer educator, 1 group workshop

Multi-site RCT: UCSF and Friends Research Institute (LA)

Funded by NIH/NIMH R01MH106373 (PI: Sevelius), California HIV/AIDS Research Program IDEA award, UCSF Academic Senate Individual Investigator Grant 555242-34935, CAPS Innovative Award



TRIUMPH



Trans Research Informed communities United in Mobilization
for the Prevention of HIV

- » First PrEP demonstration project initiative to focus on trans communities
- » Funded by California HIV/AIDS Research Program (CHRP) (PI: Sevelius)
- » Model of Gender Affirmation as conceptual framework, utilizes community mobilization strategies
- » Clinical sites:
 - La Clinica de la Raza, Oakland
 - Gender Health Center, Sacramento



The Power of Being Seen



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Context Matters: Addressing The Social Environment to Improve 90-90-90 in sub-Saharan Africa

Sheri A Lippman
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SBSRN, San Francisco 2017

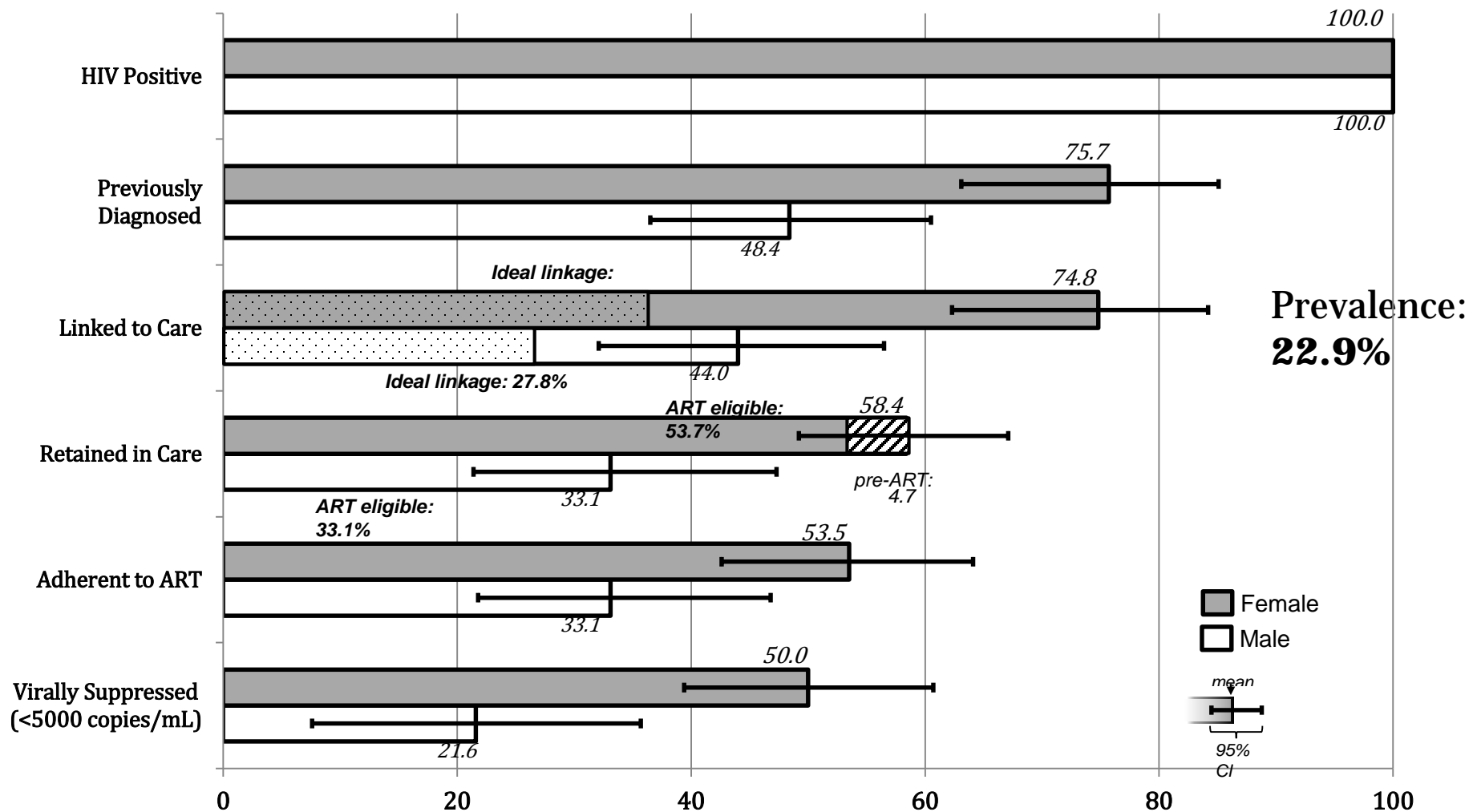


Social Epidemiology

Focuses on the social determinants of health and the ways in which our social context, including political, cultural, and economic circumstances, impact our health and shape our health behaviors.

- **Identify / define social-environmental influences**
- **Investigate pathways of effect**
- **Devise ways to address social-environment**

Care Cascade RSA - Data from 2014



Addressing 90-90-90 through a social epi frame

90-90-90- woes

- People aren't testing
- People not engaging in care / treatment
- Disparities in testing, treatment, viral suppression

Social epidemiology

- Identify / define social-environmental influences
- Investigate pathways of effect
- Devise ways to address social-environment

Targets for change

Create an enabling environment for people to engage in care. Address

- Stigma
 - Gender norms
- Shore-up community resources
- Shared Concerns/ Cohesion / Collective Efficacy to encourage HIV testing & tx in the community



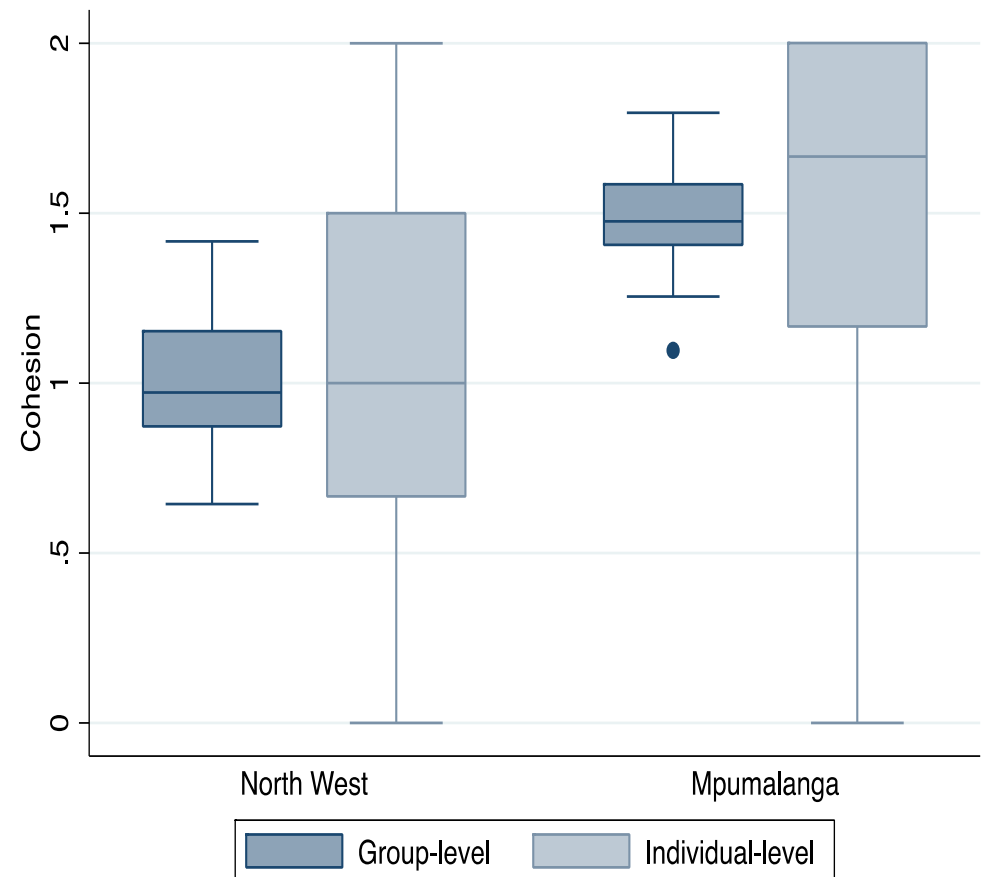
Collective Efficacy; Social Cohesion; Social Capital

- To tackle social problems, communities need some level of working trust and mutual expectation to intervene for shared interests.
- Social cohesion – shared values & identity; stick-togetherness; ties to group/place; feeds social cooperation
- Pathways of influence:
 - Impacts health behaviors through diffusion and reinforcement of healthy normative behaviors – diffusion is facilitated in more ‘cohesive’ communities
 - Cohesive communities can provide an environment that enables and encourages people to enact healthy behaviors – both for themselves and for their peers/neighbors

Social cohesion - 2 communities RSA

| Cohesion Scale – shared trust and solidarity | NW (N=43 clusters) | MP (N=27 clusters) |
|--|--------------------|--------------------|
| Items | % agree | % agree |
| People in this community are willing to help their neighbors | 47% | 68% |
| This is a close knit community | 38% | 73.4% |
| People in this community can be trusted | 24.2% | 63.7% |

Grp Cohesion: 1.00 ± 0.18 ; 1.49 ± 0.15 ($p < .01$)



Example: behaviors - two contexts

Data from population-based surveys 18-49

| Behaviors | North West (N=43 clusters; 1044 pts) N (Col. %) | Mpumalanga (N=27 clusters; 2057 pts) N (Col. %) | Chi square test p-value |
|--|--|--|----------------------------|
| Heavy drinking | | | |
| Men (N=401, 1004) | 179 (44.6) | 232 (23.1) | p<0.01 |
| Women (N=643, 1053) | 95 (14.8) | 22 (2.1) | p<0.01 |
| HIV testing in past year (among those not previously diagnosed) | | | |
| Men (N=372, 767) | 158 (42.5) | 554 (72.2) | p<0.01 |
| Women (N=555, 978) | 344 (62.0) | 819 (83.7) | p<0.01 |

Group cohesion and behaviors

| | Men POR (95% CI) | Women POR (95% CI) |
|--|----------------------------|------------------------------|
| Heavy drinking | | |
| Between-group effects | N=1335 | N=1695 |
| Study: Mpumalanga relative to North West | 0.15 (0.05, 0.43)* | 0.06 (0.03, 0.15)* |
| Cohesion in North West | 2.07 (0.83, 5.14) | 1.31 (0.78, 2.20) |
| Cohesion in Mpumalanga | 0.40 (0.25, 0.65) | 0.32 (0.07, 1.49) |
| HIV testing past 12 months | | |
| Between-group effects | N=1079 | N=1532 |
| Study: Mpumalanga relative to North West | 2.44 (1.14, 5.25) | 5.81 (3.35, 10.05)* |
| Cohesion in North West | 1.46 (0.65, 3.30) | 0.62 (0.42, 0.90) |
| Cohesion in Mpumalanga | 1.59 (1.10, 2.30) | 1.86 (1.01, 3.40) |

POR = Prevalence Odds Ratio * Denotes significant interaction term

Implications - context and risk

- Health benefits when group cohesion is high.
- No health benefits where group cohesion is low.
- A minimum threshold or level of group cohesion required to yield positive health effects?
- Some basic level of cohesion (and likely other community contextual elements) may need to be present before benefits can be realized.



SO: Can social cohesion be ‘built’?

One Man Can - Community Mobilization Program 2012-2014

Sonke Gender Justice's "One Man Can"

- Engaging men to question traditional norms of manhood & masculinity.
- Consider intersection of gender norms and HIV risk
- Personal action & encourage collective building of gender equity & HIV prevention

Cluster-randomized trial
Intervention conducted in 11 villages with 11 control villages
– within Agincourt HDSS .



(R01MH087118, Pettifor;
R21MH090887, Lippman)



Gender and HIV Risk

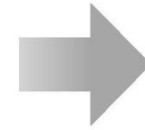
Lack of community dialogue gender equity and HIV prevention

Gender norms that discourage healthy behaviors (e.g. HIV testing, condom use)

Structural factors, such as unemployment, which contribute to stress, violence and alcohol use: promoting sexual risk and IPV



Components of Community Mobilization



**Shared concern
(Gender Norms/HIV)**

Community consciousness

**Workshops
(gender, HIV,
violence, alcohol)**

Leadership



**Establish community
action teams**



**Organizations/
networks**

**Community theater,
outreach, discussions**

**Collective
activities**

**Engage community
leadership**



**Social
cohesion**



Reduction in HIV Risk

Men engaged in HIV testing and care

Reduction in negative gender norms (GEMS) that promote HIV risk and IPV

Decrease in reported IPV

Decrease in unprotected sex acts

Decrease in reported concurrency

Increase in measures of community mobilization

HIV understood as community issue: community benefit to prevention

OMC intervention activities aimed at increasing social cohesion

| ACTIVITIES | Social cohesion |
|---|---|
| Establishing Community Action Teams (cadres of volunteers) | Create neighborhood volunteer structure – diffuse shared values/goals |
| Small group workshops | Foster a discussion group – shared goals, trust - Continued with future chat lists / contacts |
| Mini (2-3 hour) workshops | As above |
| Engaging CBOs/churches | Extend network messages for shared goals |
| Community Murals | Messaging towards common goals |
| Soccer tournaments | Activities with team – foster group |
| Community events/ forums/ feedback | Create larger dialogue in the community around shared goals |
| Photovoice workshops | Create common visual thread – building on shared experience |

Did we increase social cohesion?

Not at the community level (increased more in intervention villages – but not significantly so).

BUT - Cohesion scores were highly associated with increased exposure to OMC (intervention) activities

| | Control communities | | Intervention communities | | |
|------------------------|---------------------|----------------|--------------------------|----------------|--------------------------------------|
| Social Cohesion | baseline | endline | baseline | endline | Mean difference p-value [§] |
| Mean (sd) | -0.02 (0.20) | 0.11 (0.17) | -0.16 (0.21) | 0.04 (0.28) | 0.38 |

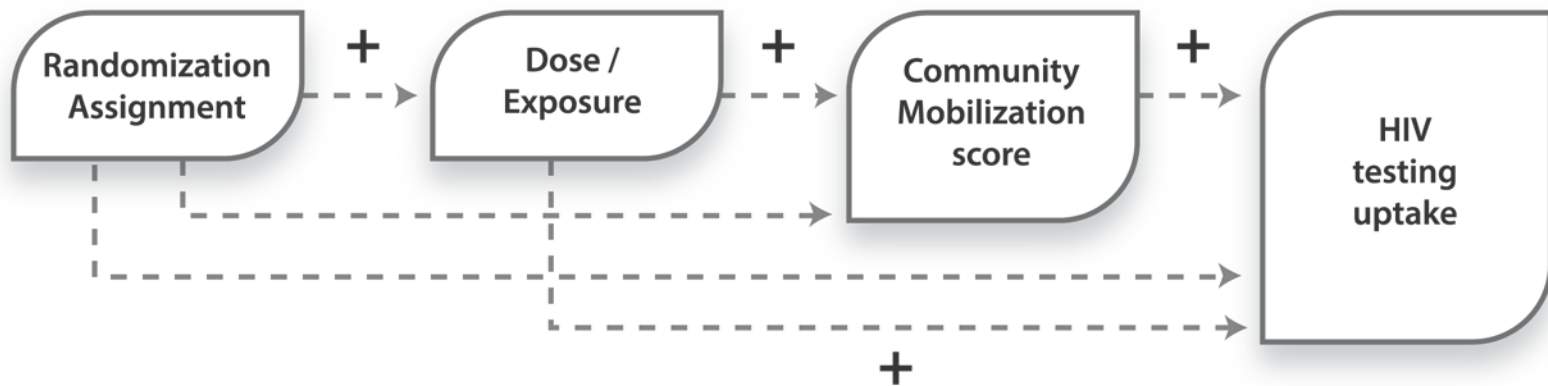
All survey data is weighted to account for sampling probabilities;

[§] t-test examining difference in means over time (n=22 villages).

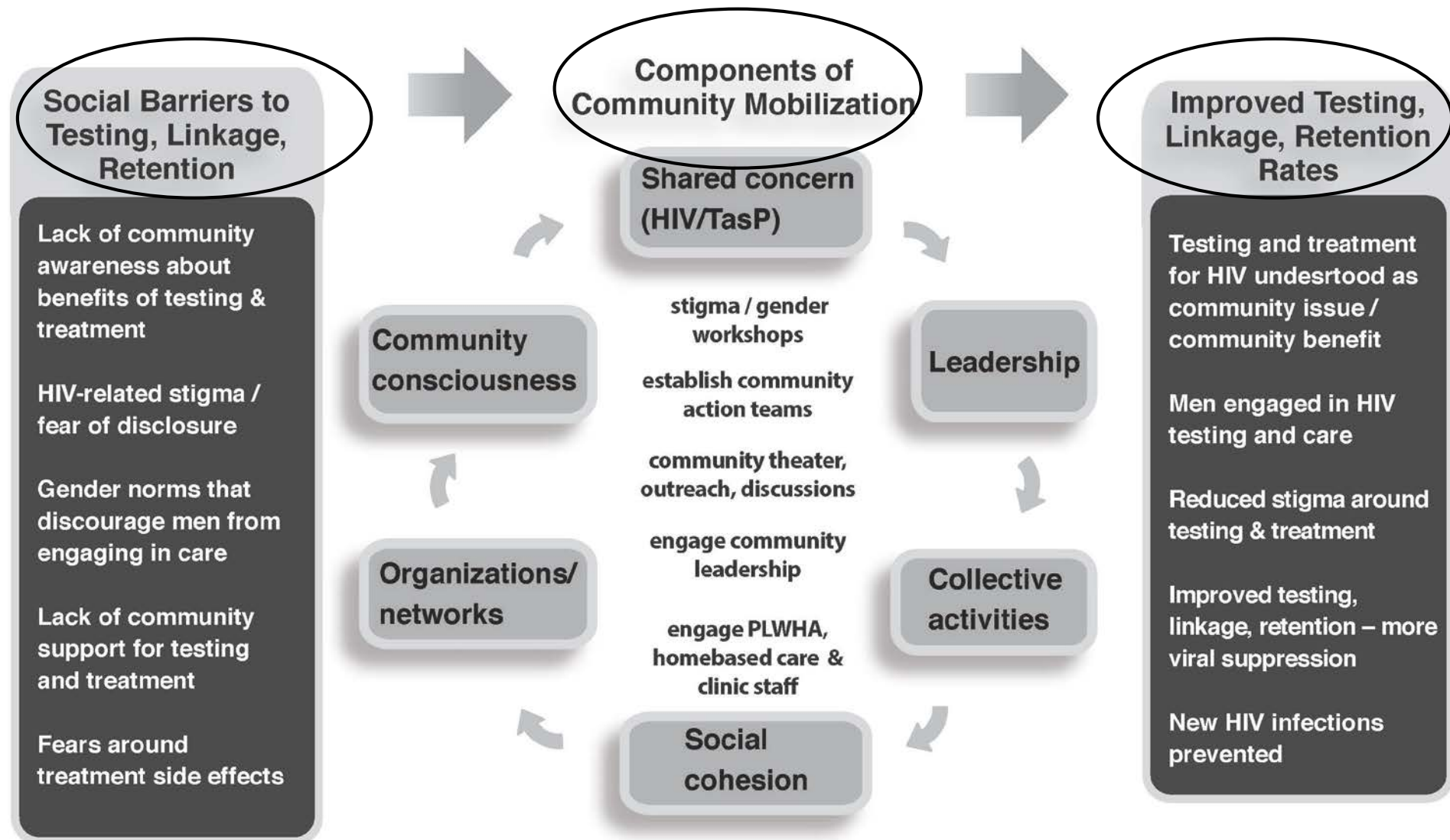
Did we increase HIV testing?

Structural equation model to assess pathways from intervention to HIV testing uptake.

Found CM intervention increased HIV testing through direct exposure (not indirect/diffusion)



Conceptual Framework - CM for TasP



Concluding thoughts

- **Social environment / social resources impact health**
- **Changing social context should have impacts far beyond one health outcome in a community – can impact a host of health outcomes – room for synergy**
- **But we're still figuring out:**
 - **How to optimize programming**
 - **What other ingredients go into the mix**
 - **How long we need to make change (personal change to diffusion?)**
 - **Who to target with activities / involve**
 - **Reminder that we've come a long way!**



Acknowledgements: collaborators

All over:

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 - **R21MH090887 (Lippman)**
- **Community Mobilization for TasP (2015-2018)**
 - **R01MH103198 (Lippman/Pettifor)**

Using Behavioral Economics to Improve HIV-related Behaviors



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Why Behavioral Economics?



- **Traditional policies often assume a “rational actor”:**
 - People do what is best for them
 - If they show unhealthy behaviors information is missing or prices are wrong
- **Limited policy options:**
 - Information provision
 - ‘Paying’ people to be healthy

WELL
A Simple Flashcard Test to
Detect Concussions



WELL
My Patient Doesn't 'Do'
Vaccines



WELL
Vegetarian Diet May Cut
Colon Cancer Risk



John D. Arras, Medical
Care Philosopher, Is Dead
at 69

Liberian Leader Concedes Errors in
Response to Ebola

Ebola Outbreak
Summer, U.N.

HEALTH

Study That Paid Patients to Take H.I.V. Drugs Fails

By DONALD G. McNEIL Jr. FEB. 24, 2015



- BE goes beyond this model, recognizes
 - *our cognitive limitations (how we process statistics, for example)*
 - *our struggle with self-control*

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 - *our struggle with self-*



economics

- **Behavioral economics** suggests that if we know a person's decision environment we can infer their behavior and influence it by:
 - Altering the decision environment
 - Designing incentives using decision-making errors ("biases") as entry points for interventions and policy

What does BE tell us about HIV as a decision-making environment?

People tend to make good decisions if:

- The decision is simple
- Action and outcome clearly linked
- Good feedback
- Example: headache/aspirin

What does BE tell us about chronic health decisions?

People tend to make good decisions if:

- The decision is simple
- Action and outcome clearly linked
- Good feedback
- Example: headache/aspirin

Most chronic health behaviors (incl. HIV prevention and ART adherence):

- Long-term behavior change needed
- Costs now, benefits far in the future
- Low salience health threat
- Infrequent feedback

HIV Prevention Through the Lens of Behavioral Economics

To the Editors:

A number of biomedical tools to prevent transmission of HIV are currently available including male and female condoms, pre-exposure prophylaxis (PrEP), microbicides, treatment as prevention (after the encouraging results

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which individuals are likely to make systematic decision-making errors or “biases” that in turn provide entry points for interventions. BE has shed new light on a range of health behaviors,⁵ but to date, few published studies exist for HIV-related behaviors, and most involve conditional cash transfers (payments in exchange for a certain behavior). These transfers are to a significant extent inspired by traditional (neoclassical) economics and have been described elsewhere.⁶ This letter instead discusses 3 BE biases that likely contribute to suboptimal prevention behaviors and suggests potential interventions to address them.

A key BE bias is *salience*, that is, the tendency for people to act on information that first comes to mind rather than making use of all available

www.jaids.com | e61

- **Salience**
- **Present bias**
- **Affect**

1. BE 'light': supporting other interventions:

- Increasing the effectiveness of information provision & messaging
- Improving recruitment
- Increasing retention

2. True BE-based interventions:

- Incentive provision
- Nudging
- Changing default options
- Etc.

Empirical evidence on the prevalence of BE biases and their impact on ART adherence



Rewarding Adherence Program (RAP) Kampala, Uganda

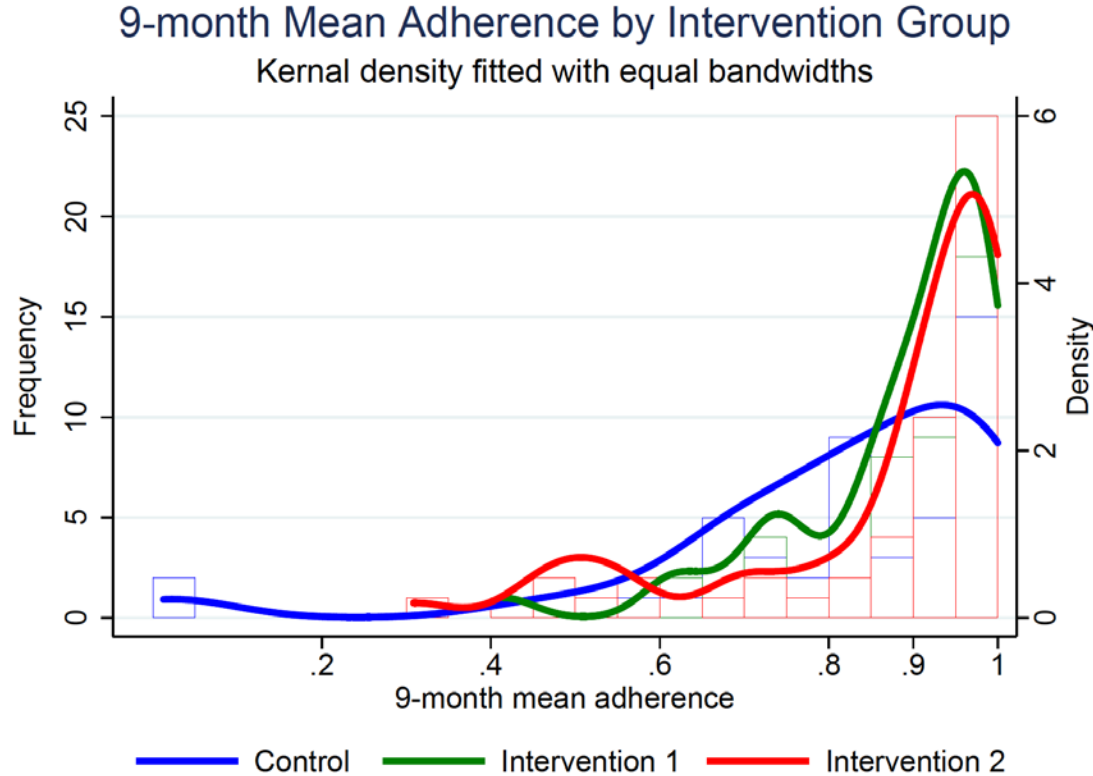




Prize value: \$2 USD per person/year



Small, non-monetary incentives successfully improve ART adherence



Linnemayr S, Stecher C, Mukasa B. "Lottery incentives to improve adherence to antiretroviral (ARV) drugs: evidence from the first nine months of a small randomized controlled trial in Uganda". *AIDS* 2017, 31(5):719-726.

SITA Study - Peer competition as non-monetary incentive:

- Weekly message, sent to 170 adolescents receiving HIV care in Uganda
- If successful, scalable and almost zero running costs

“Congratulations, you took 70% of your meds this week. Your friends took 85%...”




- Behavioral economics is different from traditional economics in that it explicitly recognizes we all make mistakes
- These mistakes (“biases”) are predictable once we know the decision environment
- For chronic health behaviors, key challenges are
 - Need for daily action with delayed benefits → present bias
 - Slipping of health problem from mental priority list → low salience
- These same biases are entry points for interventions
 - Salience: mobile technologies / reminders?
 - Present bias: incentives?

- SBSRN for invitation
- NIH for funding most of the research this presentation is based on
- Study participants and Staff at Mildmay, IDI, and TASO clinics and Bienestar Human Services where the research was implemented

Thank you!

slinnema@rand.org

Appendix: Insights from BE for design of incentives

| | Traditional Economics | Behavioral Economics |
|--------------------------|---|--|
| Dealing with preferences | Overrides preferences | Supports individual's preferences Nudges towards those of the rational, 'cool' self 'Angel' (Dec 31) vs. Devil (Jan 1) |
| Type of incentive |  | Money (Can backfire!) In-kind Chance to be kind (self-identity) Social prestige ("Employee of the month") ... |
| Allocation mechanism | Fixed (Quid pro quo) | Contingent Unconditional Fixed Variable (Lotteries, raffles, ...) |
| Delivery | Does not matter | As a loss avoided (loss aversion) As a separate payment (saliency) |

Linnemayr S, Rice T. "Insights from Behavioral Economics to Design More Effective Incentives for Improving Chronic Health Behaviors, with an Application to Adherence to Antiretrovirals". *JAIDS* 2016, 72(2): 50-2

Examining social networks in context:

THE IMPORTANCE OF CHOSEN FAMILIES AND KINSHIP
IN HIV PREVENTION AND CARE WITH SEXUAL AND
ETHNIC MINORITY (SEM) YOUTH

Emily A. Arnold, Ph.D., Center for AIDS Prevention Studies, University of California San Francisco

What does ethnography contribute to research on HIV prevention and care?

Ethnographers can learn not just what people tell us they do, but what they actually do.

Ethnographic fieldwork has documented the salience of chosen family systems for sexual, gender and ethnic minority communities for decades, where 'kin' both provide and receive various social resources, including those related to HIV.

Kin can be constructed from a variety of social relationships

- Extended Kin (Stack, 1974): Friends become kin to overcome poverty
- Chosen Kin (Weston, 1991; Hawkeswood, 1996): Gay and Lesbian individuals become kin
- House Ball Communities (Arnold and Bailey, 2009): SEM youth create forms of kinship (houses) that compete in balls



Kin can be conceptualized as social networks and analyzed

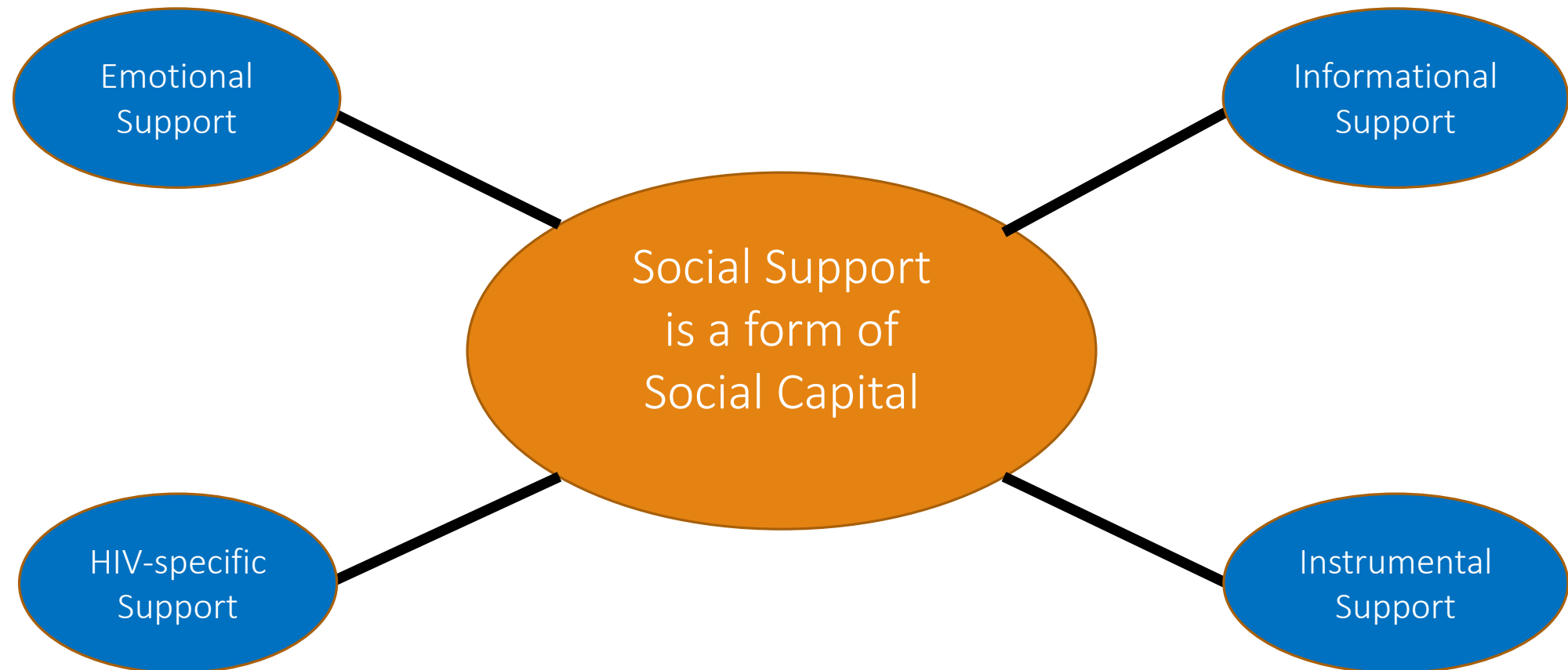
Individual connections govern:

- Flows of Information
- Access to Material Resources
- Social norms
- Health behaviors
- Disease Transmission

(Lin, 2001, Valente, 2010, Christakis and Fowler, 2011)



Social support flows through kin networks and impacts HIV-related health behavior



Houses and Gay Families are Kin for SEM youth





Chosen Kin Networks and HIV

- Social support and social norms around risk, testing, care, and treatment circulate within the houses and gay family networks of SEM youth
- Social Support is gendered, with “mothers” and “fathers” often acting as sources of different forms of support
- Support is reciprocal, especially among “siblings”
- Community events, such as prevention balls, convene family networks and reinforce norms around HIV prevention, testing and care

Kevin Blahnik and Mario B. Present

THE PRIDE MINI BALL



Women
Body
Runway
Butch
Streetwear
Realness
Face
BQID
Runway
Realness
Face
FQ
Face
Realness
Runway
Body Models v.
Luscious

Saturday, September 3, 2011
10pm - 2am
1738 Telegraph Blvd.,
Oakland
CA 94612
\$15 at the Door
Questions Call
Kevin Blahnik
5104354516

BQ
Sex Siren
Realness Pretty v. Thug
v. Schoolboy v.
Executive
RWT Part 1 and Part 2
Jeans and a T-shirt No Hats
Vogue Fem Soft'n'Cunt v.
Dramatics
BQ European Runway Tall v.
Small v. Big
All American Runway
Minigrand OTA Performance
Thunderdome \$10 pot
"Two Men Enter, One Man
Leaves"
Grand Prize OTA Runway
Winners Of The Runway
Categories Must Battle For The
Cash
All Categories are bring in Black
and White

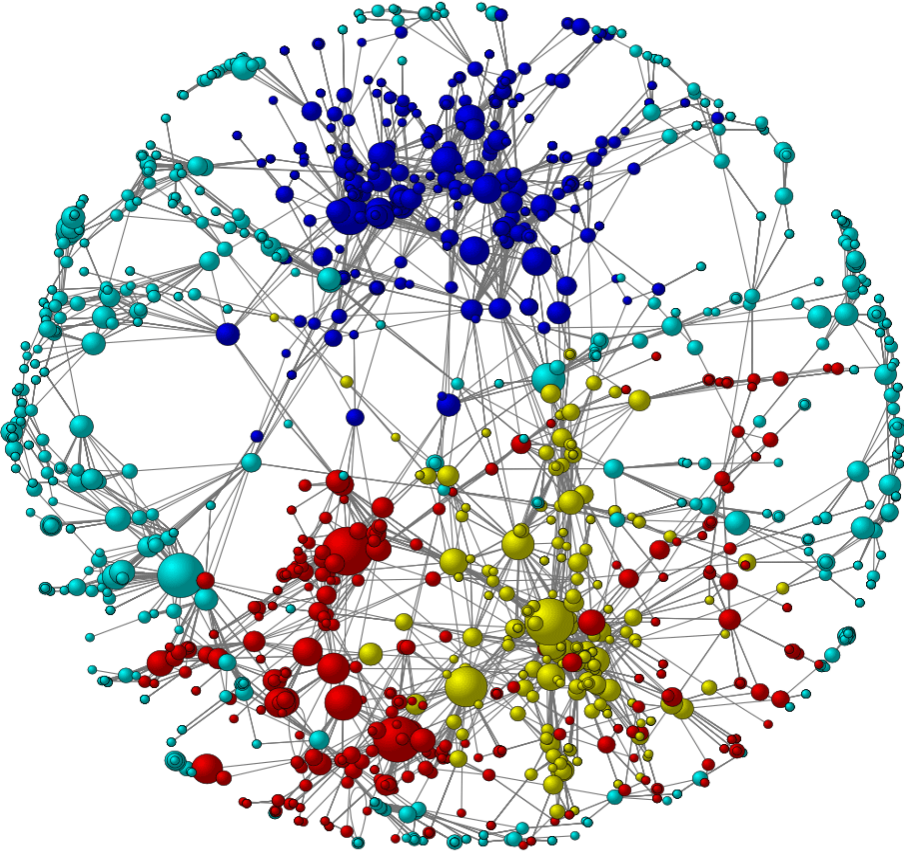
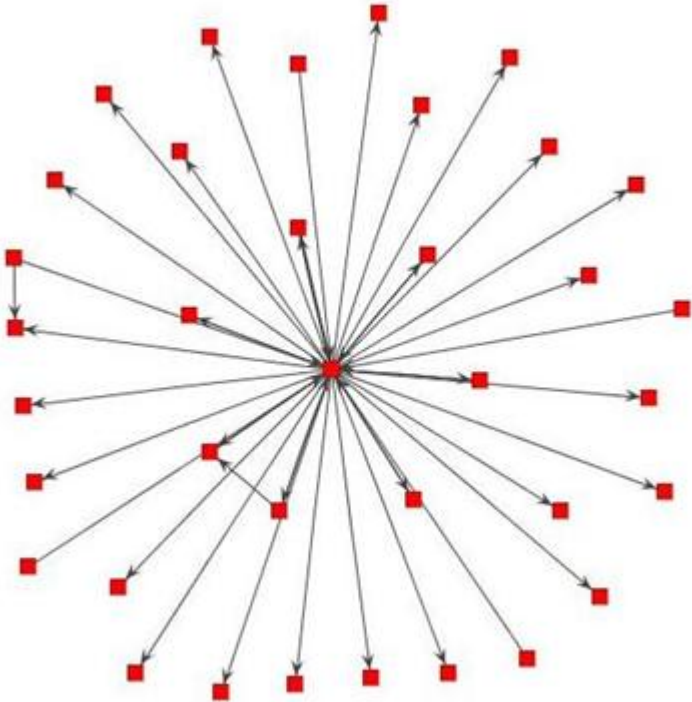
Chosen kin provide essential forms of support

I think there is definitely a lot of things that are necessary to my well-being that happen in the house... We definitely encourage each other...I've actually had these conversations with people, like, 'Let's go get tested. Let's go tomorrow. It doesn't take long at all.' (House of Revlon member)

[My gay father] always instilled morals and values and good advice in me as if he was really my father....When we do talk or text it's always encouraging things like, 'What's going on? Are you working? If you're not working are you looking? Do you need help with your resume?' And when I told him I was applying for school he was like, 'Do you have any fees that you need to be covered?' (Gay Family member)



What structural characteristics and types of support are associated with better HIV-related health outcomes for SEM youth?



We examined...

- Size
- Density (who knows who in the network)
- Homophily (how alike or different our participants were from the people in their networks)
- Provision of specific types of social support (instrumental, informational, emotional and HIV-specific)



HIV-specific Support and Homophily Matter

Participants with a higher percentage of alters who were supportive of HIV testing were more likely to have tested in the past 6 months ($p=.02$) and less likely to have had UAI in past 3 months ($p=.003$).

HIV testing in past 6 months was associated with social support for condom use, instrumental social support, and age.

UAI in the past 3 months was associated with homophily (based on sexual identity) in the network, social support for condom use, and HIV status.

(Arnold, Sterrett-Hong, Jonas, Pollack, 2016)

How do we use these findings to develop and refine intervention approaches?

We Are Family: Using kinship networks to reach the 90-90-90 for SEM youth

| Network Structure | Cognitive Social Capital | Intervention Activities and Delivery |
|-------------------|--|--|
| Density | Informational support HIV-Specific support Instrumental support Social Norms | <p><u>Identify houses and gay families to work with, especially ‘parents’ who provide HIV-specific support</u></p> <p>HIV-specific support should promote testing, linkage to care, engagement in care and treatment adherence</p> <p>Address HIV-related stigma and rehearse challenging norms that promote HIV-related stigma</p> |
| Homophily | Emotional support Instrumental support Informational support HIV-Specific support Social Norms | <p>Mimic house meetings or gay family gatherings, capitalizing on homophily within the networks</p> <p><u>Acknowledge SGEM diversity, and develop trans-specific content and resources</u></p> <p><u>Ensure that visuals affiliated with the project are representative of participants, encourage youth to provide content for online narratives</u></p> |
| Size | Instrumental Support Informational Support HIV-Specific Support Social Norms | <p>Convene Community-Level events (balls) to increase network size, shift norms, and underscore strength of family ties</p> <p><u>Mhealth and online approaches can be used to increase network size, provide informational support, and promote healthy social norms across the networks</u></p> <p>Local HIV-specific resources can be reviewed by members of the community, a form of HIV-specific support</p> |



Social Norms



Informational
Support



Social Norms



WF WE ARE FAMILY

REAL STORIES FROM THE COMMUNITY

KNOWLEDGE UP
GET THE FACTS

It is best to wait as long as possible before you start taking HIV medications.

YES **NO**

68% Think that today's HIV medications affect how you look. [The facts >](#)

Thank you

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