WHAT WORKS

IN HIV PREVENTION

for youth

until it's over
AIDS ACTION

What Works in HIV Prevention for Youth is the third in a series of AIDS Action HIV prevention guides. Others in the series include what works guides for gay men, substance users, women of color, and incarcerated populations.

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AIDS Action is the national voice on AIDS. We are committed to advocating for people affected by HIV/AIDS "Until It's Over" — until no more people become infected with HIV, until people living with HIV have the care and support they need, and until a cure is found.

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chapter 1

INTRODUCTION and OVERVIEW

Above all, HIV prevention works: there is a wide range of proven strategies to reduce behaviors that increase the risk of transmitting or acquiring HIV.

— INSTITUTE OF MEDICINE, 2000

As each generation comes of age, there is a substantial increase in the rate of infection as individuals enter their late teens and early twenties, with infection rates peaking in the mid-to-late twenties. Sustained, targeted prevention for each group entering young adulthood is what will keep these waves from developing.

— CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), 1997

Despite remarkable advances in research and clinical practice, AIDS is not over. Without a stronger commitment to HIV prevention for youth, it never will be. Even the very best treatments fall far short of a cure, and a vaccine is nowhere in sight. Young people need the tools to protect themselves from HIV infection, and we know a lot about what works. Making proven interventions available to young people is the only way to stop the spread of AIDS with this generation.

Every year, public health officials announce that at least half of new HIV infections in the U.S. are in young people under the age of 25, a statistic so often repeated that it is losing its ability to shock and alarm. As the frontline in the war on AIDS, community-based organizations (CBOs) have a special responsibility to keep Americans from growing accustomed to over 20,000 young people becoming HIV infected each year. CBOs are well-positioned to protect young people from the devastation of AIDS and the consequences of decisions made too young.

What Works in HIV Prevention for Youth offers insights from prevention science and community-based programs about strategies and approaches that can help prevent new HIV infections among America's adolescents and young people. It is a collaborative effort of AIDS Action and AIDS Alliance for Children, Youth & Families. We hope that this guide will be useful to community-based organizations wishing to begin, improve, or expand HIV prevention services targeted toward youth.

> After nearly 20 years of the HIV/AIDS pandemic it can be said with confidence that:
> - Prevention works.
> - Prevention is cost effective.
> - HIV/AIDS prevention promotes better overall health.
>
> Presidential Advisory Council on HIV/AIDS (2000)

An Intractable Problem

Noting that at least one young American under age 20 was becoming infected with HIV every hour of every day, the Office of National AIDS Policy (ONAP) in 1996 called American youth a "generation at risk." Today, this characterization is as true as it was five years ago. Although protease inhibitors and other new treatments dramatically reduced the AIDS death rate for youth — a 35 percent decline among those 15 to 24 years of age, from 1996 to 1997 alone — there has been no decline in the number of new HIV infections among young people. AIDS remains a brutal disease and a significant threat to America's youth.

Any young person who engages in the normal experimentation and sexual curiosity that mark adolescence as a developmental period is at some risk for HIV infection, especially in geographic

regions with a high HIV prevalence. But, as it does with adults, AIDS most threatens youth who already face poverty, racism, homophobia, gender inequality and other power differentials in relationships, poor access to health care, and homelessness. These same young people may also be struggling with sexual identity, self-esteem, and discrimination or exploitation. Homeless and runaway street youth, juvenile offenders, and young people who exchange sex for drugs, money, or affection are especially at risk.

Solutions

While HIV/AIDS among youth is a problem that defies easy solutions, HIV prevention science does provide some answers. We know much about what works to prevent HIV infection in youth, including programs that are frank and targeted — employing both the languages and vocabularies of the young people and communities the programs are trying to reach, and offering risk- and harm-reduction strategies to youth who are doing things that put them at risk. Unfortunately, such programs are not available in most schools and communities (ONAP, 2000).

If preventing HIV infection among young people were simply a matter of applying research data, prevention programs across the country would feature "school-based HIV education for youth, condom availability, explicit public service messages targeted to people most at risk, and needle exchange and syringe purchase, as well as more traditional abstinence-based approaches" (FCAA, 1997, p.8). Clearly, there is an enormous gap between this ideal and what actually exists in local communities. In part, that's because HIV is contracted through sexual and drug-using behaviors that adults don't want to talk about with adolescents; they don't want to believe that teens even have sex or use drugs. In part, it reflects the triumph of politics over science. But it is never too late to do the right thing for America's youth.

Community-based organizations are uniquely able to fill the gap between what prevention science identifies as effective HIV prevention for youth and what is available locally. Indeed, a central tenet of the CDC's HIV prevention programs is that "those closest to the problem, equipped with needed information and tools, are best able to solve it" (CDC, 1998a, p.1). As families, schools, youth-serving organizations, and policy makers struggle to integrate their desire to protect adolescents from AIDS with their concerns for traditional values and community norms, CBOs are providing leadership locally. They are helping to develop a community consensus for HIV prevention and putting in place effective science-based HIV prevention interventions targeted for those most in need. This document seeks to support these efforts by offering those closest to the problem an update on what is working in HIV prevention for youth.

Overview of the Guide

Chapter Two, "Youth and HIV/AIDS Today," is a snapshot of the current epidemic among young people in the United States, including the disproportionate impact of HIV and AIDS on young men who have sex with men and young African American and Latina women. The behaviors and life circumstances that put certain groups of young people at very high risk for HIV infection are reviewed, and the need for voluntary HIV counseling and testing for youth is outlined.

Chapter Three, "What Prevention Science Research Says," summarizes findings from research on effective HIV prevention programs for youth, as well as on characteristics of effective prevention interventions across the board. The need for both individual-level and community-level interventions is stressed.

Chapter Four, "What's Working in Local Communities," provides examples of HIV prevention strategies and models that community-based organizations are putting into practice to help reduce new HIV infections among adolescents and young people. Programs from across the country using peer education and social marketing are profiled. A contact person is listed for readers who want more information about individual programs.

Chapter Five, "Summary and Resources," concludes the guide by inviting CBOs to accept the challenge of reducing the 20,000 new HIV infections each year among America's youth and advising careful adaptation of proven HIV prevention interventions to meet local needs and circumstances. It also refers CBOs who want to explore more fully the art and science of HIV prevention for youth to a variety of resources for more information, most of which is obtainable free of charge, either through the Web or through toll-free numbers.

"References" includes the references for the cites used throughout the document.

chapter 2

YOUTH and HIV/AIDS TODAY

Teenagers, especially young women and men in disadvantaged urban communities of color, are poised to become the tragic new face of AIDS in the United States.

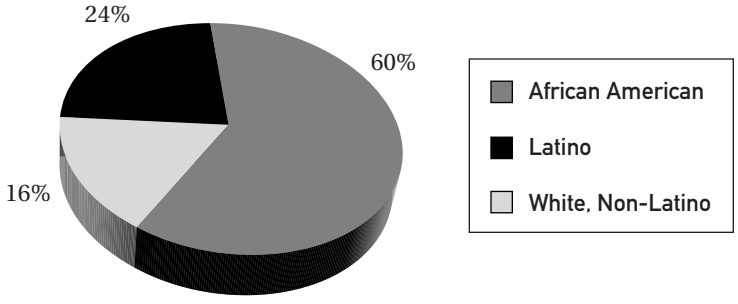
— THE KAISER FAMILY FOUNDATION, 1999

AIDS has already exacted a heavy toll on young Americans; over 126,000 of them have developed AIDS in their twenties (CDC, 2001). The typical delay between HIV infection and the onset of AIDS means that most of them were infected as teenagers. There continues to be 40,000 new HIV infections in the United States every year, and it has long been estimated that young people under age 25 account for at least 20,000 of these new infections, while youth between the ages of 13 and 20 make up half of that 20,000 (CDC, 2000c). But not all young people are equally at risk. This chapter profiles the epidemic among American youth, including the population groups most affected today and the behaviors that are putting young people at risk.

Unequal Jeopardy

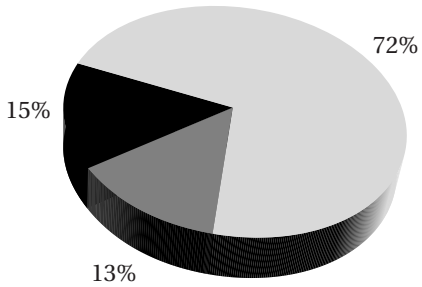
Young people whose life circumstances contribute to high-risk behavior have been especially hard hit by HIV and AIDS. Just two groups — young gay and bisexual men and young black and Latina women infected through heterosexual sex — are thought to account for at least 75 percent of HIV-infected youth. Also at high risk for infection are youth of color, those exploring same-sex relationships who do not identify as gay or bisexual, drug and alcohol users, young people who have been sexually abused or exploited, out-of-school youth, those who are homeless, migrant youth, juvenile offenders, and other young people living on the margins of society. There is considerable overlap among these groups of young people, confounding

Figure 1
New AIDS Cases Among Adolescents Reported in 1999, by Race/Ethnicity



[Total = 3,082]
Source: CDC (2000a)

Figure 2
U.S. Adolescent Population by Race/Ethnicity



[Total = 38,543,000]
Source: US Census Bureau (2000)

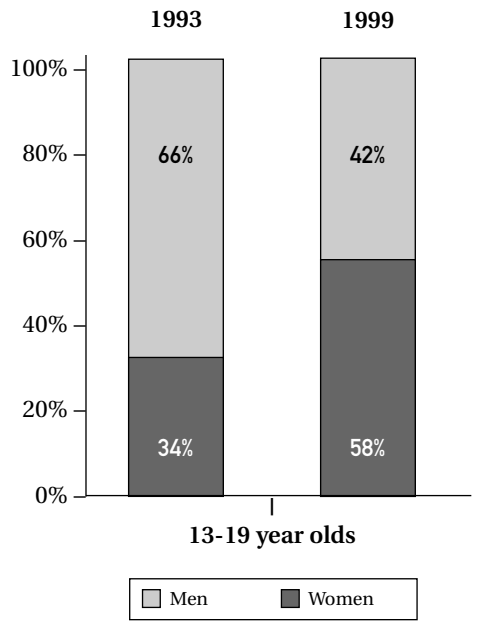
risk factors and making it difficult for many who do become infected to identify just how and when.

Among adolescents, race is even more a factor in the epidemic than it is among adults (Collins, 1997). African American and Latino youth — gay and straight, male and female — are affected by HIV and AIDS far out of proportion to their numbers in the population (see Figures 1 and 2). Although African Americans make up only 15 percent of U.S. teenagers, they account for 60 percent of new AIDS cases reported in 1999 in that age group (13-19 years), up from 57 percent reported in 1998 (CDC, 2000b; Kaiser Family Foundation (KFF), 2000). Latinos, who constitute 13 percent of the adolescent population, represent 24 percent of new AIDS cases among teens in 1999 (CDC, 2000b). Together, black and Latino youth represent 84 percent of newly reported cases of HIV infection (Schemo, 2000).

For most of the epidemic, males have greatly outnumbered females among people living with HIV and AIDS. In 1999, for the first time, more females than males were diagnosed with HIV among 13 to 19 year olds — over six out of every 10 new HIV infections reported in this age group (CDC, 2000b). In that same year, girls account for 58 percent of new AIDS cases reported among adolescents (KFF, 2000b).

Figure 3

Young Women (Ages 13-19) as a Proportion of AIDS Cases Among All Adolescents, 1993 and 1999



Source: CDC (1994, 2000) and the Kaiser Family Foundation (2001)

Young Gay and Bisexual Men

Half of young men ages 13 to 24 reported to be living with HIV through June 2000 were exposed to the virus through sex with other men, and half of AIDS cases reported in 1999 in that age group were also among men who have sex with men (CDC, 2000a, 2000c). As with all other ages and exposure categories, young African Americans and Latinos are overrepresented among men who become HIV infected through sex with men when compared to their numbers in the general population. In a recently released six-city CDC study, young urban gay and bisexual men had an alarming 12.3 percent rate of HIV infection, compared to a 7 percent overall rate in a similar study from 1994-1998 (Valleroy, et al., 2001). Most alarming, though, was the finding that 30 percent of young gay and bisexual black men, ages 23-29, are HIV infected.

Unsafe sex is clearly a problem among some groups of young gay and bisexual men. In the 1994-98 CDC study of 3,500 men ages 15 to 22 who have sex with men, 41 percent reported having engaged in unprotected anal sex, an extremely high-risk activity, in the previous six months. Bisexual men also are a bridge for HIV transmission to women. One in six of those young men had recently had sex with women, and nearly one-fourth had recently had unprotected sex with both men and women. Because sexual identity and sexual behavior do not always match, HIV prevention programs and strategies must be developed for young men who have sex with men but do not think of themselves as gay or bisexual. Such men are not likely to be reached by prevention messages aimed at men who identify as part of the gay community.

Young Women of Color

Young disadvantaged women, particularly African American women, are becoming HIV infected at higher rates — and at younger ages — than their male peers (CDC, 1998). This was demonstrated

conclusively through HIV test results from over 350,000 16 to 21 year olds entering the Job Corps, a federally funded training program for disadvantaged out-of-school youth. Among the young women, rates of HIV infection were seven times higher for African Americans than for their white counterparts. For the population as a whole, black and Hispanic adolescents and women ages 13 to 24 account for more than three-fourths of all AIDS cases reported among females in that age group (CDC, 2000b).

Homeless and Runaway Youth

Homeless and runaway youth also are among those at highest risk for HIV and AIDS. No one knows how many young people are living in these circumstances. Estimates vary widely, ranging from 730,000 to 1.3 million (ONAP, 2000). In order to survive on the streets, many of these young people exchange sex for money, food, or shelter; many also use injection and other drugs. The rate of HIV infection in homeless and runaway youth is also unknown, with one four-city study finding a median HIV infection rate of 2.3 percent among homeless youth, and some shelters reporting rates as high as 10 percent (ONAP, 2000).

Geography

One of the greatest risk factors for young people is where they live, because they tend to socialize, explore, and develop relationships close to home. A high HIV prevalence in a community greatly increases their risk of becoming HIV infected compared to youth living in communities where few people are infected. The highest rates of adolescent HIV infection are in the South and along the East Coast, as well as in Texas, California, and some Midwestern states. However, new HIV infections are appearing all over the country, and young people in rural and other low-prevalence areas who live in high-risk circumstances also need HIV prevention education and access to targeted HIV prevention interventions.

Risk Behaviors

Membership in a particular population group does not confer automatic risk for HIV infection. Risk depends on behavior, and millions of American youth are engaging in sexual and drug-using behaviors that put them at risk for HIV. In fact, experimentation and risk-taking are considered fundamental to the period of adolescence, and as long as the epidemic exists each generation of American youth will need access to the information and skills necessary to make good decisions and to stay healthy.

More than in any other age group, HIV is spread sexually in young people (Collins, 1997). The good news is that there has been a drop in sexual risk behaviors and an increase in condom use among sexually experienced high school students (National Center for Health Statistics (NCHS), 2000). The bad news is that two-thirds of the 12 million Americans who have sexually transmitted diseases (STDs) are under age 25, and each year three million teenagers contract a STD (CDC, 1999) — indicators of continuing high-risk sexual behavior among young Americans. Despite significant drops in the prevalence of sexual intercourse among high school students in the past decade, by their senior year 65 percent of American students have had intercourse.

Although condom use reported at last intercourse by high school students went up from 46 percent to 58 percent between 1991 and 1997 (KFF, 2000b), too many sexually active youth are not using condoms. And, there are signs that young people at highest risk in particular are not consistently protecting themselves with condoms, such as the 46 percent of young urban men who have sex with men in one study who reported recent unprotected anal sex (Valleroy, et al., 2001). Among some groups of young women, not using a condom may be a statement about their feelings for their partners. In interviews with over 500 African American adolescent females, Crosby and his colleagues (2000) found that more than 75 percent had sex with a steady partner, while less than 10 percent had casual sex; not using a condom with a steady partner was seen as a sign of intimacy in the relationship and trust in their partner.

This is consistent with findings from several recent studies that many sexually active teens, despite knowing the facts about HIV and STDs, do not consider themselves at risk for infection. A recent Kaiser Family Foundation/MTV survey found

that 68 percent of sexually active 15 to 17 year olds do not think they personally are at risk (Kaiser, 2000b).

Drug and alcohol use among youth also contributes to sexual risk behaviors, putting many young people at risk for HIV infection by impairing their judgment. One in four sexually active high school students say they were under the influence of alcohol or drugs the last time they had sex. Substance abuse also is a direct risk for some young people through shared needles: one in 50 high school students say they have injected illegal drugs (CDC, 1997).

Clearly, American youth are at risk for HIV infection from the same behaviors that put adults at risk. Young people, however, may have less power and fewer skills when it comes to navigating through high-risk circumstances. Many studies have documented that youth whose first sexual intercourse occurred in their early teens report a very high incidence of involuntary or coerced sex, and in some groups of girls, early sex is relatively common. Almost one-third of babies born to 15-year-olds have fathers who are at least 21 (FCAA, 1997). Coercive early sex and early sex with partners several years older are both factors associated with high risk for HIV infection.

Counseling and Testing

Because most youth who are HIV infected don't know it, they are not receiving the care that can help prevent or delay HIV's early damage. Getting tested is a first step to getting the health care they need and learning how to protect themselves and their partners. Those who test negative can get counseling and support to help them stay that way.

Voluntary counseling and testing is an important component of youth HIV prevention, but adolescents and young people face significant barriers to getting tested. Many who are at risk have no health care provider they can turn to for advice and do not know how to arrange for an HIV test. A recent Kaiser Family Foundation national survey found that two-thirds of teens do not know for sure where to go to get tested, including a majority of those who are sexually active (KFF, 2000a). Some counseling and testing facilities are open primarily during school hours. Many sites are geared toward adults and are not youth-friendly in language, environment, or approach. In some states, parents will be notified of an adolescent's HIV-positive test result. In others, parental permission is a significant barrier for youth who are afraid to tell their parents why they need to be tested. Even when young people manage to overcome these barriers and get tested for HIV, many never return for their test results.

Community-based organizations can change this for the better. Where feasible, a CBO might choose to open a youth-friendly counseling and testing program. Those already operating testing programs can review them to see if they are, in fact, youth friendly and how they can be modified, if necessary, to better serve adolescents and young people. CBOs not in a position to offer such services directly can form strong links with youth-friendly testing sites and actively encourage young people in high-risk circumstances to get counseled and tested.

chapter 3

WHAT PREVENTION SCIENCE RESEARCH SAYS

Prevention science has identified programs that can reduce risk behavior.... Some of the proven programs were designed for small group or classroom use. With an emphasis on communication, negotiation, and refusal skills, they state clearly that abstinence is important, and also provide information about condoms and other contraceptives. Other effective programs offer individualized counseling to high-risk youth, or use outreach workers to deliver prevention messages. A final group of programs mentor young people in activities that make the future seem brighter and staying safe seem worthwhile.

— OFFICE OF NATIONAL AIDS POLICY, 2000

Prevention science combines behavioral and social science perspectives to evaluate the effectiveness of HIV prevention. Many questions are still unanswered — especially with respect to youth of color, both young men who have sex with men and young black and Latina women — but the evidence is clear and compelling: prevention works. A variety of HIV prevention interventions have been proven effective in reducing HIV risk behavior among youth (see Chapter Five references, *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* and *Replicating Effective Programs Plus*). No one intervention is best for all young people, and both individual-level and community-level interventions are necessary to defeat the epidemic in America's youth (Kelly, 2000).

This chapter offers an overview of what prevention science has to say about what works for preventing HIV infection in young people.

Characteristics of Effective Prevention

Although HIV prevention interventions must be targeted to the specific needs of individuals and communities, prevention science has discovered principles and characteristics of effective prevention generally. Coates and his colleagues (1996) identify nine such principles, which can be a useful guide for CBOs considering initiating HIV prevention programs as part of their constellation of services:

PRINCIPLES OF EFFECTIVE HIV PREVENTION

1. Sustained interventions are more likely to lead to sustained behavior change.
2. More intense interventions are more likely to result in greater risk reduction.
3. Accessibility to devices that are necessary for safer practices reduces risk of HIV infection.
4. Skill building and the modification of social norms appear to enhance behavior change.
5. Timing of interventions matters.
6. Individual-level interventions can change behavior, but are probably not equal to the task of risk reduction for populations with high prevalence of HIV infection.
7. HIV counseling and testing have a place in HIV risk reduction, but are not sufficient for HIV prevention.
8. Working at the level of community can sometimes lead to significant behavioral changes.
9. Media interventions can sometimes lead to significant general population behavior changes. (Coates et al., 1996, p.1146)

These principles are consistent with the findings of the CDC's HIV/AIDS Prevention Research Synthesis Project (1999) and the recent report to Congress from the Institute of Medicine (2000) on the state of HIV prevention in the United States.

Targeted Prevention

Prevention research and the experiences of CBOs both attest to the importance of targeted HIV prevention. Prevention can be targeted in a variety of ways to match multiple risk factors and circumstances. Interventions can be targeted by age, gender, sexual experience, ethnicity, behavioral risk, or neighborhood, among others. Many HIV prevention programs and interventions use a combination of factors in targeting their services.

The Asian & Pacific Islander Coalition on HIV/AIDS (APICHA) in New York City is one such program. This CBO seeks to meet the needs of New York's Asians and Pacific Islanders, richly diverse communities that vary greatly with respect to culture and ethnicity. Therefore, APICHA offers a broad range of HIV prevention programs to reach these communities, many of whose members do not use mainstream services because of language and cultural barriers. The Young People's Project's bilingual volunteers reach youth with HIV prevention interventions through school-based workshops and one-on-one street outreach at community centers, video arcades, pool halls, and other places where Asian young people gather.

Timing, Frequency, and Intensity

Early and often are good guideposts for HIV prevention interventions for youth. Early prevention education encourages young people to adopt healthy behaviors and to avoid beginning unhealthy ones. Prevention is most effective when it reaches adolescents before they initiate sexual and drug-using behaviors that put them at risk for HIV. In a study on the impact of mother-adolescent communication on HIV prevention among 372 sexually active teens, the CDC found that condom use increases only among teens whose mothers talk to them about condoms before they have intercourse for the first time (CDC, 1998c). These teens are three times more likely to use condoms than teens who either never discuss condoms with their mothers or who discuss them only after initiating sexual activity. Condom use at first intercourse dramatically predicts future use, with youth who use condoms at first intercourse 20 times more likely to use condoms subsequently.

Below a certain threshold of frequency, many youth HIV prevention interventions are not effective in changing risk behavior. The frequency differs with the intervention and the group targeted, but, in general, effective interventions for youth are sustained and intense. In a social marketing campaign aimed at getting prevention messages out to youth, more frequent exposure to the messages resulted in youth feeling more able to avoid sexual risk. Reporting on a scientific review of successful interventions, Collins (1997) called 10 to 14 sessions with homeless and runaway youth a "full dose," while 12 session interventions produced substantial change in risk behavior among gay men.

Information Combined with Skill Building

Behavioral prevention interventions attempt to prevent someone from acquiring or transmitting the virus by trying to change individual sexual and drug-using behavior. In the early days of the epidemic, most interventions were based on the assumption that knowing the facts about HIV transmission would prevent someone from becoming infected. Despite early successes, however, it soon became apparent that information is not enough; high rates of risky behavior continue in hundreds of thousands of individuals who know how HIV is transmitted. Dozens of prevention science studies have since demonstrated that behavioral interventions that combine information with skills building are more effective in producing sustained behavior change and risk reduction. For example, Lawrence and colleagues (1995) in study with 246 African American adolescents compared a cognitive-behavioral intervention with information only and found that one year after intervention almost three times as many abstinent teens had initiated intercourse in the information-only group than had in the skills training and information group.

Involving Families

Prevention science has demonstrated that involving parents is an effective strategy for preventing HIV infection in youth. Frank discussions about sex between parents and young people can lead youth to adopt healthy behavior, such as condom use. One survey of 522 African American adolescent girls found that those who regularly discussed sex with their parents were significantly less likely to engage in risky sexual behavior and much more likely to bring up STD and HIV prevention with their sexual partners when compared to girls whose parents did not talk with them about sex (Crosby, et al., 2000).

The AIDS and Adolescents Network of New York (AANNY) demonstrates how involving parents can help overcome community resistance to HIV prevention education in the schools. AANNY recruits and trains lesbian and gay youth, their parents, and lesbian and gay parents to serve as advocates and educators for school-based AIDS education. Since 1987, this diverse group of youth service providers, health care providers, teachers, activists, researchers, parents, and youth have been promoting HIV/AIDS education and prevention programs for young people, as well as advocating for public policies to end the epidemic among youth. AANNY offers a series of small interactive workshops facilitated by parents and youth who have experience in peer education and advocacy around HIV. Among the workshop content are: HIV/AIDS 101, adolescent development, sexual identity issues, attitudes about sexuality, communication, and living with HIV/AIDS in the family.

Sexuality Education and HIV Prevention Education

Both the Institute of Medicine and the President's Council on HIV/AIDS recently identified a key problem in preventing HIV among America's teenagers — the proliferation of abstinence-only sexuality education in our schools at the expense of comprehensive programs:

> ... the nation is spending approximately $440 million in federal and state funds over five years on abstinence only sex education — in the absence of any evidence that this approach is effective, much less cost-effective — solely because of social forces that prevent effective comprehensive sex education courses from being offered. (IOM, 2000, p.9)

> Unlike many other nations, the U.S. government has been unwilling to implement systematic, population-wide education that teaches children and adults about sexual and drug-related risks for transmitting HIV. This barrier to explicit sexual and drug-related conversations with young people has had enormous consequences.... Fears that explicit sexual information would increase sexual initiation among U.S. youth have not been supported by studies that have evaluated such claims. Yet too many policy makers continue to push to censor the prevention that youth receive by mandating and funding "abstinence only" approaches. (PACHA, 2000, p.20)

One of the most persistent challenges to HIV prevention for youth is the widely held belief that early sexuality and HIV prevention education lead to promiscuity, a myth that underpins the abstinence-only movement. In fact, the opposite is true. Several studies reviewing the scientific literature found that teens who receive HIV education are less likely to engage in sexual intercourse; those who do have sex less often and use contraceptives more when they have intercourse (IOM, 2000; Kirby, 1995). In contrast, no scientific evidence supports the effectiveness of abstinence-only programs.

Although most young people know the facts about HIV transmission (KFF, 2000b), they still want and need to know more, including how to protect themselves. Unfortunately, in schools all across the country, they are being taught less now than they were a dozen years ago. Abstinence-only programs are proliferating: in 1999, 23 percent of public school sexuality teachers reported teaching abstinence as the only way to prevent STDs, including HIV, compared with 2 percent in 1988 (Alan Guttmacher Institute, 2000).

HOW CBOS CAN HELP SCHOOL HIV PREVENTION PROGRAMS

- Send speakers on HIV prevention to classes or special events. (Many schools have found that people who are HIV positive can make effective educators for adolescents.)
- Assist in training teachers, school staff, or peer educators about HIV.
- Out-station HIV counselors or peer educators at school clinics or in the health resource room.
- Accept referrals for counseling, case management, and support groups for students, family members, or school staff.

Source: N. Freudenberg & A. Radosh. *Protecting youth, preventing AIDS*, 1998.

Because policies on sexuality education and condom availability are to a large extent determined locally, community-based organizations are much better positioned than national ones to advocate for comprehensive sexuality and HIV prevention education in their local schools. Where such advocacy is not successful, CBOs can help to fill the gap by offering these kinds of programs for youth.

Even when schools do provide comprehensive programs, many youth at highest risk are out of school entirely, while others do not attend regularly. These young people will not be reached by school-based programs, and they are significantly more likely than in-school youth to be sexually active, to have had four or more sex partners, and to have used alcohol and other drugs (Harper & DeCarlo, 1999) — all behaviors that put them at very high risk for HIV infection. Prevention programs for these young people are needed in venues accessible to them, and CBOs can play an important part in meeting this need.

Peer Education

Peer education is a highly effective prevention strategy with youth. In fact, it is more than just a strategy; it is also an "approach, a communication channel, a methodology, [and] a philosophy" (UNAIDS, 1999, p.2). Peer education uses young people as credible prevention messengers to effect change among other young people. It has been successful both at the individual level, in changing attitudes and skills, and also at the societal level in influencing group norms. Peer education is consistent with several behavior change theories, among them social learning theory, the theory of reasoned action, the diffusion of innovation theory, and the theory of participatory education.

Social Marketing

Community-level interventions have demonstrated considerable efficacy in preventing HIV infections. The social marketing of condoms in developing countries is one often-cited example of a remarkably effective community-level intervention (IOM, 2000). Social marketing uses advertising expertise — media campaigns and other marketing strategies — to reach large numbers of people and influence their attitudes and behavior, motivating them to healthy behavior change. Because advertising is so effective in helping to define youth culture, social marketing for HIV prevention has great potential for use with young people. Evaluations of social marketing stress that the messages must be delivered through diverse channels, be sustained over time, and respond to changes in the market (Collins, 1997).

SOCIETAL-LEVEL HIV PREVENTION

Societal HIV prevention interventions try to change social and environmental factors that contribute to individuals' HIV risk. AIDS Action (1997) articulated three kinds of interventions that Thomas Coates identified at this level:

- Community Interventions — Community interventions seek to change social norms to discourage risk-taking behavior and promote the social acceptability of risk avoidance. Community interventions reach people within the context of their social lives and the things they care about and like to do.

- Policy/Legal — Policy/legal interventions change law or policy to reduce HIV infection, such as overturning restrictions on needle exchange or instituting public health monitoring in bathhouses.

- Superstructural — Superstructural interventions address long-term societal issues that contribute to HIV infection, such as sexism, racism, homophobia, and violence against women.

The CDC studied the effectiveness of social marketing approaches with adolescents in a five-city project called the Prevention Marketing Initiative (PMI). Volunteer coalitions that included youth as members planned and launched youth-oriented media campaigns that reached thousands of young people with HIV prevention messages. In one city, in 15 zipcodes with high STD rates, 60 percent of 15 to 18 year olds reported hearing of PMI, and the campaign was associated with significant increases in condom use (Kennedy & Mizuno, 1999).

One effective social marketing approach uses members of high-risk populations who are popular with other members to advocate behavior change at the community level. This "opinion leader" model, developed by Kelly and his colleagues at the Center for AIDS Intervention Research (CAIR), recruits popular people within a community and trains them to deliver and model prevention messages to their peers. This approach has been used successfully with gay men in bars, with inner-city women in housing developments, and with young people, among others.

PREVENTION STRATEGIES & APPROACHES THAT ARE WORKING FOR YOUNG PEOPLE

- age-appropriate and developmentally appropriate interventions
- early sexuality education
- peer education
- school-based peer-led programs
- small group counseling
- intensive, repeated education
- skill building to build self-esteem
- skill building for negotiating safer sex
- skill building for proper use of condoms
- social marketing and community-level approaches that change peer norms

Sources: Office of National AIDS Policy; CAPS, University of California, San Francisco; Funders Concerned About AIDS

chapter 4

WHAT IS WORKING IN LOCAL COMMUNITIES

We are here to promote self-worth for the girls, especially self-esteem to empower them to make good and healthy decisions for the future.

— KELEIGH MATTHEWS, METRO TEENAIDS, WASHINGTON, D.C., 2000

We believe that empowering gay youth and building a strong gay community are as important to HIV prevention as teaching them how to use condoms.

— GAY CITY, SEATTLE, WASHINGTON, 2001

Communities affected by AIDS also have great strengths. One of the most important strengths is the presence of ordinary people who are willing to help in the fight against AIDS.... Interventions developed and carried out not just by professionals but in concert with community members themselves have great potential because they are owned by community members and draw upon their power through the strengths of its people.

— JEFF KELLY, 2000

Community-based organizations, often in partnership with researchers, grantmakers, and government, are developing innovative HIV prevention programs for youth. This chapter describes several CBO programs and one state health department initiative that translate findings from prevention science into behavioral and community-level interventions for adolescents and young people. Each of the programs highlighted features peer education or social marketing — two approaches that have been shown to be especially effective with young people — or combines both strategies.

Program Highlights

AIDS Alliance and AIDS Action spoke with youth-serving and HIV prevention organizations across the country to identify programs that are using peer education and social marketing to reach young people with HIV prevention messages. The examples that follow reflect the rich diversity of such programs in terms of geography, populations of young people served, and sponsoring organization. Three of the five programs profiled are in community-based organizations dedicated to HIV prevention, two are parts of organizations with much larger missions, and one is sponsored by a state health department.

QUEERCORE
PEER EDUCATION AND SOCIAL MARKETING

Queercore, a program for men under 30, is part of Gay City, a community-based HIV prevention organization in Seattle, Washington, where 75 percent of new infections in the county each year remain among men who have sex with men. Gay City's mission is to promote gay and bisexual men's health and prevent HIV transmission by "building community, fostering communication, and nurturing self esteem."

Gay City's holistic approach to HIV prevention addresses the causes of unsafe behavior, blending

grassroots organization, culturally relevant marketing, and empowerment theories to nurture a culture in which gay and bisexual men see their lives as worth living. Gay City creates a variety of innovative ways to do this, including gay summer camp and community forums that attract large, diverse audiences, one fourth of whom are men under age 25. Gay City's HIV prevention programs are constructed from several science-based theories of mass behavior change, including empowerment education (Freire), social marketing (Kotier and Roberto), and diffusion of education (Kelly).

Queercore's goal is to empower young gay and bisexual men to take control of their own lives, health, and future. Rather than offering "HIV 101," Queercore wants to connect young men with others in the community, creating a friendly space to meet new people and make new friends and providing alternatives to the "mainstream gay scene" in Seattle. Retreats, film nights, forums, "Coffee Talks" and other informal discussion nights, and even camp — which Queercore describes as "a weekend of fun, creativity, and bonding in the bush" — all provide social alternatives to bars.

Other Queercore activities have included "The Dish," a talk show held at the Broadway Performance Hall at Seattle Central Community College, which used true stories and invited comments and questions from the audience to raise issues of concern to young gay and bisexual men, such as fetishes of older men and meeting guys in chatrooms. A "Queer and Loathing" forum addressed reasons why many young men who know the facts are still having unsafe sex that puts them at risk for HIV and STDs.

Queercore also performs theater pieces at local theaters, including "Fruit Cocktale," a full-length piece in 1999 dealing with interracial dating. The success of "Fruit Cocktale" stimulated interest in the arts among Queercore participants, which resulted in the creation of "Spout," a website area that Queercore describes as a "space for gay and bi guys in Seattle under 30 to express themselves through the written and visual arts."

All of Queercore's materials and programs use the vocabulary and communication styles of the young men they want to reach, the kind of frank, targeted approach that characterizes effective HIV prevention. One Queercore outreach flyer to young men reads:

> Today, one young Seattle queer will get infected with HIV. Will it be you? Will you pass it on? Do you even care? Queercore is young fags, queers, bi-guys and gay boys taking action to make this STOP! AIDS is not inevitable. We can change our behavior. We can change our community.

Evaluation. Gay City evaluates its events and activities in a variety of ways. Survey data from post-event questionnaires indicate that 70 to 80 percent of participants feel more pride in and connection to the gay community, while 70 to 90 percent report an increased commitment to protecting their health. A random follow-up telephone survey found that in the two weeks following an event, participants, on average, discuss the information presented with eight other people. Annually, that means that in addition to the 2,400 people reached directly by Gay City events, an additional 19,000 are indirectly reached.

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METRO TEENAIDS PEER EDUCATION

Metro TeenAIDS is a community-based organization in Washington, D.C., dedicated to preventing HIV infection among youth and improving the quality of life for those already infected. Through a variety of HIV prevention programs, Metro TeenAIDS seeks to empower youth, improve their self-esteem, and make it less likely that they will engage in risky behavior. Believing that youth learn from youth, Metro TeenAIDS relies on peer education as a mainstay of its HIV prevention interventions.

Sisters for Life, targeted to girls between the ages of nine and 14, is a mentoring program serving three

public housing communities in Alexandria, Virginia. The program builds the life skills of African American girls, supporting their efforts to develop into healthy, responsible adults who avoid HIV infection, substance abuse, STDs, and other negative consequences. Based on the black sorority model and the seven Kwanza principles, Sisters for Life teaches girls that they have the power to make healthy decisions. It promotes academic accomplishments, as well as self-worth and self-esteem. Girls are offered guidance through homework and tutoring workshops, lectures by peers and elders in the community, and retreats and other small group interactive activities.

Sisters for Life addresses risks surrounding HIV/AIDS indirectly, concentrating on supporting the girls as maturing youth and addressing high-risk behaviors in the larger context of the girls' lives. Each year, girls who complete the Sisters for Life program take part in a ceremony based on African rites of passage that welcomes graduates into the realm of sisterhood.

Project Lifeguard is Metro TeenAIDS's peer-led support program for youth at high risk in the Metro Washington, D.C. area, with three local drop-in centers — The STOP in Virginia, Freestyle in D.C., and The HOUSE in Maryland, each tailored to the needs of neighborhood youth. Lifeguard conducts case finding and outreach to troubled adolescents, provides prevention case management, organizes recreational activities, and offers both peer-support groups, such as Sister to Sister and Protecting Our Brothas and Sistahs, and professional-led groups, such as Alcoholics and Narcotics Anonymous and teen mother groups.

The centers, open during weekday after-school hours, combine HIV prevention information with general health education, skills building, and empowerment tools. They share a goal of making it possible for youth to express themselves while having fun and to learn to make informed, healthy decisions. Center activities may include small group sessions, community empowerment projects, art and other creative endeavor workshops, field trips, sports, discussions with guest speakers, and psychoeducational skills empowerment. The STOP, for example, offers a job preparation course focused on producing a resume and developing interview skills.

Evaluation. Metro TeenAIDS uses an external evaluator to measure the outcomes of its prevention programs. Evaluation data document that Metro TeenAIDS reaches 35,000 youth annually with community/street outreach, peer education, and both individual and group interventions. Sixty percent of these young people are male; 40 percent are female. Seventy-six percent are African American, 7 percent are white, 12 percent are Latino, and 5 percent describe themselves as "other." Almost two-thirds are 16-18 years old; 21 percent are 13-18, 9 percent are 19-21, and 5 percent are 22-24. Metro TeenAIDS' risk assessment survey shows that 90 percent of the 35,000 youth served each year have at least one risk factor.

On site group-level interventions are evaluated using the Knowledge, Attitude and Behavior (KAB) Survey, which is administered on a client's first day and at three-month intervals. After one year, youth demonstrate an 85 percent increase in knowledge about HIV prevention, a 50 percent change in attitude, and a 25 percent change in risky behavior. Off-site group-level interventions are evaluated with a pre- and post-test survey. After a six-session series, participants demonstrate an 80 percent increase from pre- to post-test.

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MIDWEST AIDS PREVENTION PROJECT
PEER EDUCATION AND SOCIAL MARKETING

The Midwest AIDS Prevention Project (MAPP) in Ferndale, Michigan, is one of Michigan's oldest and largest community-based organizations dedicated to preventing HIV infection. Its HIV prevention programs — developed in conjunction with the Michigan Department of Community Health —

include a variety of interventions targeted toward youth. MAPP targets students in middle school through high school, as well as students in alternative education centers and out-of-school youth. MAPP reaches gay and lesbian youth, minority youth, incarcerated youth, runaways, sexually abused youth, and other young people in high-risk situations, as well as the general student population.

MAPP works with school and community organizations to develop and implement its peer education programs, first selecting teen educators and then training these young people to provide HIV prevention information to their peers. MAPP also counsels teachers and school counselors. MAPP advises other CBOs to get youth invested in HIV prevention programs by encouraging them to have as much input into program design and implementation as possible.

MAPP employs a variety of behavior-based workshops, outreach projects, theater programs, and educational programs to reach young people. Alaye — Yoruba for "Fit to Be King" — is a MAPP program targeted toward African American youth from 13 to 24 years of age. Alaye emphasizes self-esteem, self-reliance, communication skills, and relationships to help young men make safe and healthy decisions and lead healthy lives. The program is presented over three sessions at local Detroit youth service agencies. MAPP's theater program, "The Many Faces of AIDS," is a 90-minute eight-vignette play shown to students and teachers in school auditoriums, using live theater to help both teens and their teachers understand AIDS. Among the topics covered in the vignettes are: myths and mysteries, Joe Condom, still a virgin, getting tested, AIDS wears many faces, double trouble, what men will say to get what they want, and the news that no parent wants to hear. A discussion period led by a MAPP AIDS education specialist follows the play.

Through its Teen Leadership Corps (TLC), MAPP trains popular teens to serve as endorsers of HIV risk reduction to their friends. TLC translates CAIR's prevention science research on opinion leaders into a program designed to change social norms among teenagers. Teens identified as popular and influential within their social network are chosen to participate in TLC. They learn basic information about HIV and other STDs, substance abuse, ways to assess risk, practical strategies for changing risky behavior, and ways to communicate with peers. The most important prevention messages that TLC opinion leaders deliver to their peers are that unprotected intercourse is not what teens do today, and that there are many ways to safely express sexuality.

Teen ADAPT is MAPP's youth version of its Alcohol and Other Drug Abuse Prevention Training (ADAPT) program. ADAPT was developed to increase the gay, lesbian, bisexual, and transgender population's awareness of the link between drug abuse and increased risk for HIV and other negative outcomes, as well as to increase their ability to get substance abuse services that are sensitive to their needs as a community. Teen ADAPT combines social marketing and peer education approaches to reach this population of teenagers, including opinion leader trainings and a media campaign. An easy-to-use Teen ADAPT field guide offers teen peer educators ideas for starting conversations, signs of substance abuse, barriers to safer behaviors for teens, and other resources. The media campaign, "Out. Proud. Sober." uses posters, postcards, and print advertising to advise youth to "Rebel against the people who want you to stay in the closet, and rebel against those who are trying to talk you into experimenting with alcohol or drugs."

Evaluation. Since it was founded in 1988, MAPP has distributed over a million AIDS education materials and condoms to more than 300,000 people. Until recently, MAPP's evaluation focused on counting services and other documentation measures, as well as on post-event satisfaction measures, which show a high level of satisfaction with services. Recognizing the need for pre- and post-event evaluation, MAPP is now working with the Michigan Department of Community Health to develop these outcome measures.

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HUCKLEBERRY YOUTH PROGRAMS PEER EDUCATION

Huckleberry Youth Programs is a community-based organization serving homeless, runaway, and at-risk youth in San Francisco and Marin County. It began 30 years ago with the establishment of Huckleberry House in Haight Ashbury. Since that time, 24-hour services and emergency shelter have been available there for young people in trouble. Over the years other services these young people need grew up around Huckleberry House, including crisis and after care counseling for families of youth seeking services from Huckleberry. In 1992, the Cole Street Youth Clinic was established as a collaborative effort of Huckleberry, the San Francisco Department of Public Health, and the University of San Francisco's Department of Adolescent Medicine. The Clinic, which employs a team of peer educators, has become a national model of adolescent health services, addressing the primary health care needs of adolescents at risk, as well as their psychosocial needs.

With funding from the CDC, Huckleberry Youth Programs was one of the first community-based organizations in the U.S. to develop an adolescent peer counseling HIV prevention program. Huckleberry recruited youth from their target population and trained them to provide HIV prevention information and materials through street outreach and through presentations in the schools and the community. These peer educators were recognized by the National AIDS Commission.

Huckleberry Youth Programs is committed to decreasing high-risk behavior among youth and empowering them to make healthy choices in their lives. Huckleberry does this by creating safe and friendly places for youth, increasing their knowledge of health issues and awareness of HIV/AIDS, providing care, serving as a resource as needed, creating opportunities for youth to work towards self sufficiency, and educating peers. Huckleberry serves primarily multi-ethnic inner-city adolescents in San Francisco, including both in-school and out-of-school youth. The majority are at high risk for homelessness, substance abuse, and STD's — including HIV infection.

Huckleberry's HIV prevention peer education initiatives began in 1988 and have been adapted and revised over the years. Huckleberry works with the Violence is Preventable (VIP) Girls Collaborative and the Highway 101 Program, which serves youth living in shelters. Among Huckleberry's current peer education interventions are group sessions that run from one to six sessions in length, covering HIV/AIDS risk prevention, negotiating safer sex, and setting limits and boundaries. At the Huckleberry Teen Health Program at Montecito Plaza in San Rafael, these peer-led workshops are provided in middle and high schools, through street outreach, and in community sites such as Planned Parenthood. Creating access to reproductive health care for at-risk youth through linkages to community-based clinics is an essential component of the Montecito Plaza peer education programs.

Evaluation. In 2000, the Huckleberry Youth HIV/AIDS Prevention Program at Cole Street Clinic reached 287 youth through individualized peer education encounters, 304 youth through multi-session groups, and 591 youth through outreach efforts. The Huckleberry Teen Health Program at Montecito Plaza reaches over 2,000 youth each year. Benefits to the youth and community include increased awareness of HIV/AIDS and prevention methods and, for the youth, the opportunity to learn and talk in a comfortable, supportive setting. Huckleberry does not yet have outcome measures for long-term behavior change, but the California Wellness Foundation recently invested $400,000 in an independent evaluation of Huckleberry Youth Programs at Cole Street Clinic to provide behavioral outcome measures and to determine their potential as a national model.

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BASE — BE ACTIVE IN SELF-EDUCATION PEER EDUCATION

Be Active in Self-Education (BASE) is a peer HIV prevention education program that focuses on student empowerment, helping high school students teach each other about HIV prevention in youth-friendly, effective, and replicable ways. BASE began in 1991 in the New York City Public Schools; by 2000, 9,000 students in New York City had designed HIV/AIDS peer education projects and presented them to over 500,000 students. The program has been replicated in seven other cities: Atlanta, Kansas City, Los Angeles, Minneapolis, San Jose, Salt Lake City, and Albuquerque.

The BASE Program is founded on four principles:

- An assumption that young people are inherently smart and creative. Given the proper resources and thoughtful supervision, young people will come up with effective solutions to the challenges they face.

- Anyone who has lived through adolescence knows that young people have a tremendous influence on each other, lending strength to the peer education principle for this group.

- Merely providing information about HIV/AIDS is not sufficient to inspire behavioral change among adolescents. Young people must be involved in the learning process.

- HIV/AIDS education must be repeated over a sizable stretch of time. One-shot information sessions are not effective.

BASE works by helping high school students foster positive peer pressure that promotes healthy decision making and discourages HIV risk behaviors. BASE operates as a grantmaking program, with a student-designed and led process for soliciting and funding proposals from other students for innovative prevention projects. The projects address adolescent health issues, primarily HIV prevention, sexuality, peer pressure, STDs, and drug and alcohol abuse prevention. A student advisory committee writes and issues requests for proposals, coordinates a bidders conference with high schools and community agencies to help students write up their project ideas, and — working with foundation representatives and AIDS service providers from the community — decides which projects will be funded, with a funding level of up to $1,000 per project. The committee also reviews past projects and evaluates their effectiveness.

Successful student projects have included talk-show format videos, interactive theater presentations, support groups, posters and murals, T-shirts, buttons, comic books, health fairs, conferences, mobile van displays, school assemblies with guest speakers, awards and scholarships, and community service projects. In Kansas City, a BASE project raised awareness among their peers about the consequences of unprotected sex by organizing a student HIV testing campaign with the Kansas City Free Health Clinic. In the previous year, only 169 teens were tested at the clinic all year; the BASE campaign resulted in 112 students being tested in two months. Nine high schools in the Kansas City area now participate in BASE.

Some projects take on a life of their own, as did a BASE project at Monroe High School in the Bronx where a student-run AIDS awareness conference became an annual event. The Teen-to-Teen HIV/AIDS Peer Education Conference is so popular that it is now open to all public high school students in New York City. In at least one school, the BASE team grew beyond a focus on HIV prevention alone. At the LAB school, BASE now encompasses three additional causes: Free Tibet, Stopping Sweatshops, and Stop the Hate. Folding HIV prevention education into other causes popular with and important to youth can reduce the stigma often associated with HIV prevention messages and help ensure its acceptability to young people.

With as little as $7,500, a community-based organization can start a small peer grants program along the lines of the BASE Program. CBOs also can partner with their local public school system to help them develop a BASE program, providing community expertise for evaluating student HIV prevention proposals.

Evaluation. An independent external evaluation of the BASE Grants Program demonstrated the following key findings:

- Grantees increased their knowledge of HIV/AIDS and became much more aware of their personal risk for HIV infection.

- Grantees experienced an array of transformations, from gaining confidence and self-esteem to breaking the barriers that prevented them from becoming close to the people in their lives living with HIV/AIDS.

- Project grantees gained life skills, such as group dynamics, negotiation, and time management, that will assist them with their personal and professional goals.

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES SOCIAL MARKETING

The California Department of Health Services, Office of AIDS partners with local community-based organizations to develop and support a variety of HIV prevention programs targeted to youth, including diverse cultural experiences aimed at delivering community-level HIV prevention messages through social marketing.

The Lowrider Campaign. The Lowrider Campaign, launched in April 2000, targets at-risk Latino youth with the prevention messages "Respect Yourself, Protect Yourself" and "Tu Vida Cuenta, Usa Condones," in both English and Spanish. Those messages were incorporated into the Aztec-themed original artwork on a fully restored and customized 1953 Chevy Belair that serves as an attention-grabbing "moving billboard" traveling throughout the state to lowrider car shows and Latino cultural events. Local CBOs were invited to collaborate with the campaign by providing outreach and educational services at each event. A Modesta Lowrider group donated the use of the car and oversaw restoration.

Rap It Up. "Rap It Up" Safer Sex Rap Writing Contest and Radio Promotion is a summertime promotion targeting sexually active adolescents and young adults ages 15 to 25 in the San Francisco and Los Angeles urban markets. Rap It Up is designed to raise awareness and acceptance of condom use through a safer sex rap writing contest. Prizes in 2000 ranged from a studio recording opportunity valued at $5,000 to cash prizes of up to $1,000. The promotion capitalized on the credibility of popular disc jockeys as prevention messengers. The deejays invited radio listeners to enter the contest by submitting a one-minute rap on safer sex. Listeners also were encouraged to call the California AIDS Hotline for more information about safer sex and HIV testing and counseling. The promotion included radio spots that played for four to eight weeks, live remotes, appearances at summer concerts and festivals, website hyperlinks, studio interviews, public service announcements, and promotional merchandise.

Evaluation. One way to evaluate social marketing campaigns is in terms of the number of messages that reach the target audience. In 2000, the Lowrider events reached tens of thousands Latino youth at over 12 venues. For every dollar in on-radio air time purchased for the Rap It Up campaign, the Office of AIDS received over six dollars in value, and the promotion delivered over 18 million gross impressions, effectively reaching large numbers of African American and Latino youth in high-risk circumstances.

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chapter 5

SUMMARY and RESOURCES

We do not yet have a cure or a vaccine to prevent HIV and AIDS. AIDS is still winning the war, but we do have an arsenal of weapons at our command. We have the resources and the know-how. Now we must have the will, the energy, and the passion to continue the fight. Community-based organizations on the front lines can make all the difference between a resigned acceptance of 20,000 new infections each year among American youth and an ardent recommitment to HIV prevention.

Key to making a difference for youth at the local level is the adoption or careful adaptation of successful HIV prevention interventions, paired with ongoing evaluation of their effectiveness in reducing risky behavior or increasing safer behavior. This concluding chapter refers CBOs to readily available resources that can help them achieve this goal.

Adapting Prevention Programs

Adapting proven HIV prevention interventions to meet local needs and client circumstances is a cost-effective and often-successful strategy for CBOs. Before a CBO chooses to adapt, it is critically important to understand the characteristics of the original intervention and its audience, and how they are similar to or different from the CBO's intended use. The Center for AIDS Prevention Studies illustrates this crucial aspect of adapting programs:

> One successful prevention program for gay men in small cities recruited popular opinion leaders from bars, and trained them to deliver and model prevention messages to their peers. This program was then adapted to address minority women in inner city housing developments. However, the program didn't work there. The reason? Women didn't know their neighbors, and because of high crime rates in the housing developments, were reluctant to open their doors to someone they didn't know. This program was then reworked, starting by helping women in the housing developments establish a sense of community through potluck dinners and music festivals. As a result, not only did the women increase condom use and communication, but the community began to tackle other issues besides HIV such as drugs and violence in the housing development. (DeCarlo & Kelly, 1996, p.3)

Failing to account for such differences can torpedo an intervention that might otherwise be successful. Recognizing them and making adjustments allows CBOs to tailor interventions to local needs and populations while retaining the core of what makes an intervention work.

Resources

CBOs interested in beginning or expanding their HIV prevention services for youth can choose from a wide range of easily obtainable resources, the majority of them free of charge. The CDC is a rich source of information, a great deal of it available on the Web. Many prevention science centers, such as the Center for AIDS Prevention Studies at the University of California San Francisco also have useful websites. CBOs, too, are increasingly making available information about their prevention programs through their own websites or through collaborative efforts. Finally, a number of local and national organizations offer CBOs direct technical assistance.

Centers for Disease Control and Prevention

The CDC is responsible for administering federal HIV prevention programs and is an excellent resource for a wide range of information from epi-

demiological data to fact sheets and updates to consensus documents on HIV prevention. Almost all of this information is available for downloading from the Web. The CDC's home page is www.cdc.gov.

Look for *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* at www.cdc.gov/hiv/pubs/HIVcompendium.pdf. The CDC developed the compendium to respond to requests from CBOs and others for science-based interventions that work. It is a collection of summaries of rigorously studied behavioral and social interventions that are state-of-the-science, have no negative findings, and have demonstrated evidence of effectiveness in reducing sex- and drug-related risk behaviors or improving health outcomes, with a statistically significant difference between the intervention and control groups. The summaries include content, method, intervention goal, setting, population, findings, and a contact person. Nine interventions included in the *Compendium* target youth.

Interventions included in the document were identified by CDC's HIV/AIDS Prevention Research Synthesis Project, an ongoing database of studies. For more information on the *Compendium*, contact Linda Kay at the CDC, 1600 Clifton Road, Mailstop E-37, Atlanta, GA 30333, (404) 639-1900.

Look also for *Replicating Effective Programs Plus* at www.cdc.gov/hiv/ projects/rep/default.htm. Like the *Compendium*, the REP+ site offers descriptions of science-based programs with demonstrated effectiveness in reducing risky behaviors or encouraging safer ones. The CDC has translated program information into everyday language and packaged it to be user-friendly. REP interventions are available for a variety of populations; information is provided on the research behind the interventions and on how to get program materials.

Center for AIDS Prevention Studies (CAPS)

CAPS is a program of the AIDS Research Institute at the University of California San Francisco. CAPS conducts theory-based HIV prevention research and focuses heavily on disseminating research results in a variety of user-friendly formats. For this reason, CAPS is an excellent resource for CBOs. CAPS' website, HIV InSite (www.hivinsite.ucsf.edu), offers a comprehensive array of prevention tools, fact sheets, monographs, reports, articles from the media, and links, including links to download documents from other sources. A stated goal of the site's prevention section is to help service providers build strong programs based on prevention science.

A CAPS publication of special interest to CBOs wanting to know more about targeting HIV prevention for youth is *Dangerous Inhibitions: How America is Letting AIDS Become an Epidemic of the Young*. The sections on "Understanding Risk" and "Rethinking the Message" offer a succinct analysis of why prevention paradigms for youth need changing and why some research methods are missing the mark.

CBOs can contact CAPS at: AIDS Research Institute, University of California San Francisco, 74 New Montgomery, Suite 600, San Francisco, CA 94105, (415) 597-9100.

The Kaiser Family Foundation

The Henry J. Kaiser Family Foundation is an independent philanthropy dedicated to health care issues. The foundation runs its own research and communications programs, often partnering with universities, policy think tanks, and other organizations. The Kaiser Family Foundation is a leading source for policy and program information related to HIV/AIDS, and disseminates the "Daily HIV/AIDS Report." Most foundation products are available free from the publications request line (1-800-656-4533) or through download from www.kff.org. The website includes a section devoted to HIV/AIDS prevention, including links to facts sheets, briefs, and reports.

Of special interest to CBOs concerned about youth-friendly HIV testing services is *Hearing Their Voices: A Qualitative Research Study on HIV Testing and Higher-Risk Teens*, a report on research conducted for the Kaiser Family Foundation about the attitudes and concerns of at-risk youth toward HIV testing. The report, which is based on a series of in-depth interviews and focus groups with 73 high-risk teenagers in Miami, Houston, New York City, and Newark, examines the complex issues surrounding adolescents' views of and experiences with HIV testing, including why they do or do not get tested.

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