

Project AIM

An evidenced-based program to reduce
HIV sexual risk behavior among youth



Starter Kit

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Case Study Sites

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Community Advisory Board

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Section 1: Overview of *Project AIM*

What is *Project AIM*?

Project AIM is a group-level, youth development intervention designed to reduce HIV risk behaviors among youth ages 11 to 14. The intervention is based on Markus' Theory of Possible Selves, which states that a person's motivation is determined by a balance of positive and negative ways people see themselves in the future. Individuals who are able to imagine both possible positive and negative futures are more likely to work toward their life goals and achieve future success. Thus, *Project AIM* encourages youth to imagine a positive future and discuss how current risk behaviors can be a barrier to a successful adulthood.



Project AIM consists of twelve 50-minute sessions conducted by 2 facilitators to groups of 10 to 18 youth. *Project AIM* is implemented in small groups twice a week, over a six-week period. *Project AIM* is divided into four parts.

- | | |
|------------|--|
| Part One | Encourages youth to explore their personal interests, social surrounding, and what they want to become as an adult. Youth also identify people in their lives who may be barriers or supporters to their successful adulthood. Young adults from the community who are on their road to success are invited to speak with youth. |
| Part Two | Allows youth to envision themselves in a future career and connect current behavior with success as an adult through activities such as completing a career interest inventory, developing business cards and resumes, and participating in interviews. |
| Part Three | Engages youth in role-plays around communication and small group activities involving planning and decision-making. |
| Part Four | Provides the opportunity for youth to think about their future in terms of milestones to accomplish goals and overcome potential obstacles they may encounter in life. |

Goals of *Project AIM*

The goal of *Project AIM* is to reduce sexual risk behaviors among low-income youth 11 to 14 years old by providing them with the motivation to make safe choices and to address deeper barriers to sexual risk prevention (e.g., hopelessness, poverty, risk opportunities in low-income environments).

Theory Behind the Intervention: Theory of Possible Selves

The Theory of Possible Selves offers a new approach to HIV prevention by focusing on adolescents' desires and motivations for attaining adulthood goals. In brief, the theory asserts that behavior change is motivated by both what youth hope to become (positive possible future self) and what they wish to avoid becoming (negative possible future self). *Project AIM* promotes the capacity of at-risk young adolescents to persevere in their efforts to attain a positive future and to avoid risk behaviors that would endanger the success of a positive future adulthood.

The more clearly youth can envision and communicate the positive future selves (their hopes, goals, and dreams), the more attainable (or real) they seem and the more motivated youth become to achieve them. The more youth imagine a negative future, the more they may believe it will come true, and the more hopeless they feel. Being in jail, addicted to drugs, and homeless are some examples that youth may envision of a negative future. In communities of poverty, youth are often overwhelmed by images of the negative future possible selves based on what they see around them in their immediate environment.



It is important for youth to have a balance of images of both positive and negative potential futures. If youth envision only positive future selves, they may not accurately gauge their chances at success, or properly prepare themselves for obstacles, setbacks, or short-term disappointments. On the other hand, with only negative future selves in mind, there is no belief that a positive future is possible, no plans for the future, and no motivation to pursue long-term goals. It is a balance of both positive and negative future images that makes youth most likely to persevere in efforts towards achieving goals. Therefore, enhancing a young person's ability to envision a positive possible future self, while also envi-

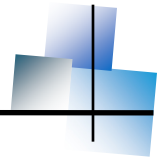
sioning a negative possible future self, motivates the young person to make healthier choices in the present.

How *Project AIM* Works

Project AIM is different from other HIV prevention programs. Historically, programs to prevent HIV risk behaviors in adolescents have taken one of two approaches: an abstinence-based approach or a comprehensive sex education approach. The goal of abstinence-based programs is to delay the initiation of sexual intercourse or to stop having intercourse for youth who have already begun. Activities in these programs address refusal skills and norms for waiting to engage in sex. The challenges to these programs are the lack of evidence that they are effective in getting youth to abstain. Comprehensive sex education approaches also try to encourage youth to abstain but also are based on the idea that while some youth may engage in sexual intercourse we can still reduce the harm by promoting the use of condoms or reducing the number of sex partners that an adolescent has. These programs are generally based on Social Behavioral Learning Theories and include activities such as condom use skills and condom negotiation.

Project AIM affects change in sexual behavior without focusing explicitly on sexual risk. *Project AIM* is based on a motivational theory that engages youth in activities that reduce their engagement in risky behaviors. It is designed to encourage young people to think about their desired future and how current risky behavior choices can adversely affect it.

Project AIM's efficacy to change youth's behaviors are due to the holistic approach of applying the theories of motivation towards helping youth with adult identity exploration, a task developmentally associated with adolescence. The overall objective of *Project AIM* is more than changing a specific sexual behavior, it's about offering alternative positive choices to defining themselves as successful adults and providing them with actual opportunities of achieving success within the program.

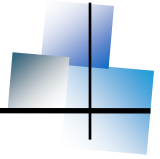


Youth Development

Youth development programs promote healthy adolescent development and resilience through positive activities that encourage appropriate, age-relevant skills and attributes. *Project AIM* is considered to be a youth development approach. The strategies and activities that are used in *Project AIM* protect them from engaging in risky behaviors and also foster important aspects of youth development such as:

Youth Development Constructs	Project AIM Strategies & Activities
Clear and positive identity	<i>Project AIM</i> enhances youth’s articulation of future self through interest inventories, business cards, and resumes. Youth conduct self-examination of their strengths, talents, interests, needed resources, and are encouraged to perceive themselves as one who is on the path to success.
Belief in the future	Based on the theory of possible selves, <i>Project AIM</i> activities require youth to see themselves in terms of succeeding in their future; and in terms of the future as holding opportunities that will enable them to succeed in life.
Self-determination	Youth are asked to consider how their behaviors might promote or impede the achievement of desired future self-identities. There are peer discussions about risky behaviors, creating choices in their futures, and making decisions about what they want in life.
Self-efficacy	Youth engage in role-playing different styles of communication (aggressive, passive, and assertive) to practice self-expression and resist peer pressure. Facilitators conduct individual interviews with youth to enhance youth communication skills and help them identify their strengths and resources to increase the likelihood of future success.
Pro-social norms	The use of small group and role models (guest speakers and facilitators) create and sustain group norms of delaying or abstaining from sexual activity and other behaviors that could disrupt achievement of their goals.

Youth Development Constructs	Project AIM Strategies & Activities
Behavioral and social competences	<i>Project AIM</i> promotes skills in positive self-presentation such as writing business cards, resumes, decision-making and planning skills, interview skills, relationship & self-expression skills. Youth identify role of family, peers, and others in supporting or negatively impacting their future success.
Positive emotions	<i>Project AIM</i> activities encourage a sense of hope for the future, pride in self-attributes, and creative self-expression.
Resiliency	<i>Project AIM</i> includes activities around withstanding peer pressure and communicating with peers, accessing resources, and connecting with positive adults in their lives.



Research Results

Project AIM has been tested in a randomized behavioral trial of 240 African American seventh graders using random assignment of health education classes to *Project AIM* or the standard curriculum for the health education class.¹ The research was conducted in a city adjacent to Birmingham, Alabama. The community had mostly low-income households and the school was on academic probation, meaning that the average standardized test scores for reading, language, and math were in the bottom 50% of the country.

Results showed that *Project AIM* was effective in reducing sexual intentions and increasing sexual abstinence. Surveys about sexual activity were conducted before the intervention and 12 weeks and one year after the intervention ended. Research findings showed significant increases in sexual abstinence, across all youth in *Project AIM* from the baseline to 12 weeks after the end of the intervention.

Youth in *Project AIM* showed sexual risk reduction compared with youth not in *Project AIM*. *Project AIM* effects on abstinence remained for male youth one year after they finished *Project AIM*. *Project AIM* youth improved in academic outcomes and decreased in school suspensions across their 8th grade year. School records at the end of the eighth grade school year showed that youth who were in *Project AIM* received significantly higher grades in social studies and science than did youth who did not receive *Project AIM*. Disciplinary suspensions across the 8th grade school year were significantly lower for those who participated in *Project AIM* than those who did not.

¹ Clark L.F., Miller SM, Nagy SS, et al, 2005, Adult identity mentoring: Reducing sexual risk for African-American seventh grade students. *Journal of Adolescent Health*, 37:pp 337.

Core Elements and Key Characteristics

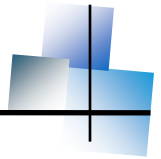
Core Elements

All packaged, CDC-Identified Effective Behavioral Interventions have what is referred to as core elements. Core elements are required elements that embody the theory and internal logic of the intervention and are thought to most likely produce the intervention's main effects. Core elements should be identified through research and program evaluation. Core elements essentially define an intervention and must be kept intact (i.e., with fidelity) when the intervention is being implemented or adapted, in order for it to produce program outcomes similar to those demonstrated in the original research.

There are three types of core elements: content, implementation, and pedagogical. Content core elements are the elements of what is being taught that are believed to be responsible for the behavior change. Implementation core elements relate to the logistics of the environment, while the pedagogical core elements refer to how the content is being delivered that reflects the theoretical framework of the intervention. *Project AIM* has the following 7 core elements:

Content Core Elements

1. Engage youth in thinking about a positive possible future self. Help youth:
 - **Look ahead** to the future as successful adults.
 - **Envision** a positive future self.
 - Engage in **goal setting** to achieve a positive future as an adult.
 - **Articulate** the specific details of a positive future self.
2. Engage youth in present actions to achieve future success. Help youth:
 - Develop skills to achieve effective **communication**.
 - **Identify** strengths and the resources needed for future success.
 - **Experience** success to reinforce youths' positive future self.
3. Encourage youth to **safeguard** the future through risk reduction. Help youth:
 - Develop strategies to safeguard the likelihood of a positive future self through risk reduction and a balance of their future possible positive and negative selves.



The components of the three content core elements form the word **LEGACIES**.



Implementation Core Elements

4. Use two skilled and trained facilitators whom youth find credible to deliver *Project AIM*.
5. Deliver multiple intervention sessions, with sufficient time between sessions for youth to process information they are learning, draw conclusions, and invest in their goals.

Pedagogical Core Elements

6. Have youth create a compilation of their work representing their positive future, possible future self, and the activities to achieving that possible future self.
7. Deliver activities in ways that support youth with enthusiastic positive feedback that focuses on their individual strengths.

Key Characteristics

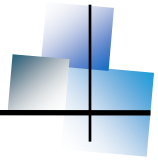
Key characteristics are important, but not essential, attributes of an intervention’s recommended activities and delivery methods. They may be modified to be culturally appropriate and fit the risk factors, behavioral determinants, and risk behaviors of the target population and the unique circumstances of the venue, agency, and other stakeholders. Modification of key characteristics should not compete with or contradict the core elements, theory, and internal logic of the intervention.⁷

Project AIM has the following key characteristics:

1. The optimal group size is between 10-18 youth. For a larger group size, it is recommended to have an assistant work with the facilitators to help with the out of session tasks.
2. It is recommended that facilitators are young adults from backgrounds similar to youth, preferably one male and one female, AND able to relate/interact positively with youth.
3. Session length is 50 minutes. However, sessions could be extended to accommodate for more in-depth discussions about key concepts and/or to facilitate supplemental activities that reinforce the core elements.
4. Guest speakers share their experiences with working towards a positive future and the challenges they may have encountered; these presentations can be in-person (preferable), video, or other format.
5. *Project AIM* uses the career software and the internet to match youth interests to career possibilities.



⁷ McKleroy, V., Galbraith, J., Cummings, B., Jones, P., Harshbarger, C., Collins, C., et al. (2006). Adapting evidence-based behavioral interventions for new settings and target populations. *AIDS Education and Prevention* 18 (Suppl. A): 59-73.



Understanding *Project AIM* Logic Model

The *Project AIM* logic model is the explanation of the relationships between the intervention, risk group, theory underlying the intervention, behavioral determinants, intervention activities, and the intended outcomes.

The purpose of a logic model is to teach the specific logic of change underlying *Project AIM*. It shows the main elements of *Project AIM* and how they work together to modify changes in behavior. For example, these logical relationships can aid understanding to select and adapt interventions.

Target population refers to the individuals for whom *Project AIM* was designed and tested. Characteristics of the target population may include (but not limited to) race/ethnicity, gender, and/or age.

Risk behaviors are behaviors that place the target population at increased risk for HIV and that *Project AIM* intends to modify.

Risk factors are descriptions of behaviors and contexts in which HIV is likely to be transmitted.

Behavioral determinants are the basic determinants or constructs of the behavioral change models or theories that the intervention directly focuses on in order to modify risk. These are mediators of behavioral change and should correspond to risk factors identified in the problem statement.

Intervention activities address the behavioral determinants. These are action-oriented, measurable activities of *Project AIM* which are most likely to have the desired effect on the outcomes or the behavioral determinants.

Outcomes are expected changes as a result of activities targeting behavioral determinants.

Project AIM Behavior Change Logic Model

Problem Statement

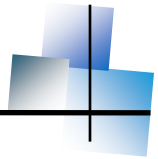
Project AIM is designed for at-risk African American, Hispanic/Latino, an other at-risk male and female youth, between the ages of 11 to 14. This target population is at risk for HIV due to early initiation of sexual behaviors, unprotected sex, and multiple sexual partners.

Major risk & contextual factors for HIV include: living in communities impacted by high prevalence of HIV, poverty, violence, high rates of school drop-outs, substance abuse, and racism; sense of hopelessness about the future; barriers to engaging in positive activities; and lack of vision to achieve a positive future.

Behavior Change Logic

Behavioral Determinants <i>Corresponds to risk or contextual factors</i>	Activities <i>To address behavioral determinants</i>	Outcomes	
		Immediate Outcomes	Intermediate Outcomes
<ul style="list-style-type: none"> Negative or non-existent view of positive possible future self Lack of a balance of positive and negative possible future selves Feeling of hopelessness for future Present versus future life orientation Lack of connections to positive adults & organizations Lack of self-efficacy to achieve future goals 	<ul style="list-style-type: none"> Utilize role models to reinforce positive view of self & allow youth to experience success Reinforce the balance of positive & negative future possible selves Create, envision & set goals of a positive possible future self Identify positive and negative influences in youth's life Identify strengths and resources to achieve future possible positive self Promote skills to achieve effective communication Strategize on safeguarding their positive future through risk reduction Use of small group activities to create & sustain low-risk group norms 	<ul style="list-style-type: none"> Increased motivation towards school achievement Increased motivation to achieve positive future self Increased ability to identify & cope with barriers Increased skills to enable reaching goals Increased self-esteem/self-efficacy achieving positive future Intentions to reduce sexual risk Increased abstinence or delay of initiation of sex 	<ul style="list-style-type: none"> Improved grades Belief in the positive future Further development of positive possible future self Engagement in coping and problem solving related in achieving future goals Engagement in safer sex activity Reduction in other risk behaviors (drug use, delinquency) Delay of initiation of sex or continued abstinence Decreased disciplinary problems





Modifications to *Project AIM*

Project AIM was field tested in two community-based settings, including a church setting, by non-research staff with African American and Latino youth. This intervention package is appropriate for implementation in community settings by agency staff with African American, Latino, and other at-risk youth. With minor adaptations, the intervention package also may be appropriate for youth of other races or ethnicities living in low-income neighborhoods. *Project AIM* has been field tested in low-income school districts across the United States.

During its preparation for use in the field, *Project AIM* was adjusted in the following ways to make implementation easier.

- The original version of *Project AIM* consisted of 10 sessions for delivery in school settings with African American youth between the ages of 11-14. *Project AIM* was expanded to 12 sessions for implementation in community-based organizations (CBOs) with African American and Latino youth. A session was created for the guest speakers, while 2 activities from the original version were re-organized to create another session. This modification was based on the feedback from facilitators from the pilot study who expressed the need for more time to allow for more time to engage youth in discussions and complete activities.
- During the pilot study, Latino youth also participated due to the geographical location of the CBOs and the demographic profile of their clients. In addition, African American and Latino youth face similar issues of living in impoverished areas. Therefore, the intervention was also broadened to Latino youth to meet the needs of the CBOs.
- Two supplemental sessions were created for CBOs who have the resources to plan a local field trip with their youth and conduct one of the *Project AIM* activities in a computer lab to access more information about their future careers and education. These sessions are optional and can be found at the end of the *Facilitator Handbook*.
- The Community Advisory Board that consulted with the *Project AIM* replication team strongly recommended assigning activities to youth at the end of most sessions. Thus, *To-Do Tasks* were added to each session to reinforce *Project AIM* core elements and enhance communication between youth and their parents or trusted adults in their lives.

Section II: Getting Started

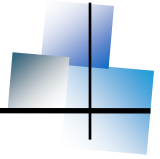
Overview

A key part of getting started is for an agency to put together an implementation plan. Before getting started, agencies must understand how, where, and for whom *Project AIM* will be implemented, and mobilize the support necessary for smooth implementation. Agency capacity issues and developing the budget are two central getting started activities. It is important to note that these activities do not happen strictly in the order that they appear in this manual; they may happen simultaneously. These activities appear in this order in the manual because they build on one another; capacity issues lead to the discussions around budget development.

This section provides all of the information and tools that are part of effective implementation plan, including:

- Agency capacity self-assessment
- Getting stakeholders buy-in
- Stakeholder's checklist
- Developing a budget
- Staffing requirements
- Suggested timeline





Agency Capacity Self Assessment

The following is a brief self-assessment tool intended to help agencies (e.g., CBOs) determine whether they possess the capacity, or can build the capacity, to adopt and implement the *Project AIM* intervention. Please review each item and then place a check mark (✓) in only one response option.

Capacities and Resources Needed for <i>Project AIM</i>	Yes, we have this capacity	We do not presently have this capacity, but can build the capacity	No, we do not have this capacity
One program manager (10-20% FTE) to supervise and coordinate implementation of <i>Project AIM</i> .			
Two staff persons (15-25% FTE) who are trained facilitators with appropriate characteristics and experience as outlined later in the manual.			
Agency commitment to and completion of 3-day training course for facilitators.			
Agency commitment and support (executive, managerial, staff) to implement and sustain <i>Project AIM</i> over time.			
Ability to recruit 10 to 18 African American, Latino, or other at-risk youth ages 11-14 to participate in 12 sessions of <i>Project AIM</i> .			
Capacity to collect, maintain, and use process and outcome monitoring data.			
Access to a private space to conduct 12 sessions of <i>Project AIM</i> with youth without distractions.			
Resources to provide low-cost incentives for youth participants (e.g., transportation vouchers, snack, stipends, local field trip)..			
Access to basic supplies such as newsprint, markers, and pens for use during the sessions.			



If all of your responses were in the columns *Yes, we have this capacity* and *We do not presently have this capacity, but can build the capacity*, your agency is likely ready for *Project AIM*.



If some or most of your responses were in the column *No, we do not have this capacity*, these are the areas of development where your agency will need to further explore and identify resources in order to successfully implement *Project AIM*. CBOs may consider forming partnerships with other agencies in the local community to build the capacity.

Getting Stakeholders Buy-In

Getting buy-in is crucial because it assures the support of agency administration and lets agency resources be used for intervention implementation. Getting buy-in is done best with an intervention champion. The champion is often the project manager or could be a facilitator or a team of people. Regardless of the number of champions, the main issue is convincing the agency that the implementing *Project AIM* would make the quality of its prevention services better and that the agency is able to implement *Project AIM*.

A champion is someone within the agency generally who is a mid-to-upper level administrator and who links the administration and staff. The champion must be good at answering questions and at helping make any changes in organizational structure. The champion can negotiate any necessary trade-offs or compromises. The champion becomes the intervention's spokesperson, anticipates the reservation of the staff, and answers questions about the intervention needs and resources. The champion must have excellent knowledge of the intervention including its costs, Core Elements, and Key Characteristics. The champion can use the marketing materials in the intervention package to gain supporters. Also, the champion can use the information presented in this manual and the rest of the package to answer any questions or concerns about *Project AIM*.

Your agency's intervention champion can use the following stakeholder's checklist to obtain support for implementing *Project AIM*. The stakeholders are those people on your Board of Directors/Executive Board, in your community, agency, your staff, or your funding source who have an interest in the successful implementation of an intervention.



Stakeholder's Checklist

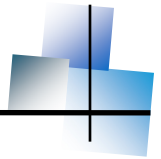
Step 1: Assess the community to determine whether they will support *Project AIM*.

Step 2: Identify your stakeholders.

- a. Your agency's Board of Director/Executive Board
- b. Staff members from your agency who will have a role in the operation of the intervention
 - (√) Administrators who will obtain support
 - (√) Supervisors who will monitor the intervention
 - (√) Staff who will implement the intervention including recruitment of youth and co-facilitating the sessions
- c. Local agencies from which to recruit participants
 - (√) After-school programs serving youth between the ages of 11 and 14.
 - (√) Local community centers
 - (√) Youth-serving agencies (i.e., Boys and Girls Club, YMCA, Big Brother/Big Sister)
 - (√) Middle schools
 - (√) Social service agencies
 - (√) Faith-based organizations
 - (√) Group homes for youth
 - (√) Department of Parks and Recreation
 - (√) Department of Probation
 - (√) Department of Children and Family Services (Child Protective Services)

Stakeholder's Checklist

- d. Local agencies from which to recruit facilitators
 - (√) Any youth-serving agency from above list
 - (√) Local colleges and universities seeking internship positions to work with youth
- e. Organizations which could provide assistance or other resources
 - (√) Local merchants for incentives and refreshments
 - (√) Agencies that can provide a venue for the intervention
 - (√) Agencies that can provide transportation
 - (√) Agencies that can help identify local guest speakers
 - (√) Agencies that can provide funding sources
 - (√) Advisory board to help modify the intervention to the youth
 - (√) Agencies, merchants, printers, publishers, broadcasters to help advertise the intervention
 - (√) Agencies that can provide facilitators
 - (√) Other collaborating agencies to provide information and services to youth for resources
- f. Other agencies with which to collaborate or partner
 - (√) Local school districts
 - (√) Local youth serving agencies
 - (√) City council
 - (√) Health departments
 - (√) After school programs
 - (√) Parent Teacher Association



Stakeholder's Checklist

Step 3: Determine needs from stakeholders based on Agency Capacity Checklist

Step 4: Getting stakeholders informed, supportive, and involved

a. Decide in advance what specific assistance is needed from each stakeholder. Possible assistance includes:

- (√) provide financial support
- (√) provide letters of support
- (√) refer youth to the intervention
- (√) be a resource to which you can refer youth
- (√) join your community advisory board
- (√) help tailor the intervention for your target population
- (√) provide a room in which the sessions can be held
- (√) provide or donate resources such as small incentives and refreshments
- (√) help with recruitment and outreach effort

b. Send letters to inform stakeholders about *Project AIM*, its importance, that your agency is/ will be making the intervention available, what specific role(s) you think that they might play in the success of the intervention, and offer an opportunity for them to learn more.

Stakeholder's Checklist

- d. Follow-up your letters with a phone call to assess their interest. If they are interested, schedule a time to meet (i.e., one-on-one, group meeting at your agency, presentation at their agency for their staff or association members).
- e. Gaining their support
 - (√) Describe several specific role(s) they could play (i.e., youth incentives, space to conduct *Project AIM*, recruit youth, guest speakers)
 - (√) Emphasize the benefits of their involvements to themselves, their agency, the community, and the youth. Answer their questions.
 - (√) Invite them to commit to supporting *Project AIM* by taking on one or more roles. Keep track of commitment.
- f. Getting them involved
 - (√) Soon after meeting with your stakeholders, send thank you letters that specify the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later.
 - (√) For persons who committed to a role that is important to pre-implementation, put them to work as soon as possible.
 - (√) For persons who committed to involvement later in the process, send them brief progress updates and a timeline on when their support/assistance will be needed.
 - (√) Hold regular meetings to acknowledge and value their support, update them on the intervention progress, and keep them engaged.



Project AIM Staffing Requirements

In order for *Project AIM* to run smoothly you will need a Project Manager and at least 2 trained co-facilitators.

Project Manager

This list of items below contains some of the Project Manager’s primary responsibilities. They are not necessarily the only tasks that the program manager will do in the course of the intervention.

PROJECT MANAGER DUTIES	
✦ Managing the budget	✦ Preparing the agency for the intervention
✦ Conducting quality assurance	✦ Deciding with which organizations to work
✦ Monitoring fidelity	✦ Hiring and managing the intervention team
✦ Recruiting and selecting the advisory board	✦ Setting up training and technical assistance
✦ Overseeing the advisory board	✦ Establishing and overseeing the evaluation plan
✦ Preparing the intervention materials	✦ Overseeing the intervention
✦ Working with other agencies	✦ Conducting debriefing sessions
✦ Recruiting participants	

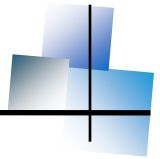
PROJECT MANAGER CHARACTERISTICS & SKILLS
✦ Ability to work collaboratively with staff, other leaders, members of a school or organization, and members of the broader community
✦ Previous experience with providing staff supervision
✦ Commitment to <i>Project AIM</i> and the belief in its effectiveness
✦ Skills in developing and managing the evaluation plan, recruitment/marketing plan, budget, and other administrative activities related to <i>Project AIM</i>

Facilitators

As mentioned before, *Project AIM* requires two facilitators. The list of items below contains some of the Facilitator’s primary responsibilities. They are not necessarily the only tasks that Facilitators will undertake in the course of the intervention. The characteristics and skills for *Project AIM* would also apply for any group facilitator.

FACILITATOR DUTIES	
✦ Attend the training course for <i>Project AIM</i>	✦ Order and organize intervention materials
✦ Conduct orientation meetings to parents and community about <i>Project AIM</i>	✦ Recruit participants
✦ Co-facilitate 12 sessions of <i>Project AIM</i> for each cycle	✦ Complete out of session tasks
✦ Debrief with supervisor and co-facilitator	✦ Collect and maintain process and outcome evaluation (if necessary)

FACILITATOR CHARACTERISTICS & SKILLS	
ATTRIBUTES	SKILLS
✦ Trustworthy	✦ Empathetic, supportive, & active listener
✦ Patience in working with youth	✦ Promote youth self-efficacy
✦ Dynamic and friendly	✦ Respect & value youth’s ideas, experiences, & opinions
✦ Commitment to <i>Project AIM</i> and the belief in its effectiveness, youth development, & empowerment.	✦ Flexibility to adjust to meet needs of the group
	✦ Communicate in a direct and non-judgmental manner



FACILITATOR CHARACTERISTICS & SKILLS CONTINUED

GROUP SKILLS/KNOWLEDGE

- ✦ Previous experience in facilitating youth groups
- ✦ Creates a safe, warm and welcoming environment that promotes youth participation in a group setting
- ✦ Ability to manage problems and issues with youth in a positive manner
- ✦ Ability to build rapport and establish appropriate boundaries with youth
- ✦ Willingness to learn from the group
- ✦ Comfort in addressing topics such as sexuality, sexual health, and substance use
- ✦ Culturally competent



adult



identity



mentoring

Where to Find Effective Facilitators and Project Managers

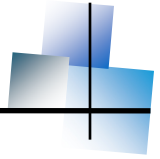
- ✦ Local colleges and universities seeking internship positions to work with youth
- ✦ After-school programs serving youth between the ages of 11 and 14
- ✦ Local community centers
- ✦ Youth-serving agencies (i.e., Boys and Girls Club, YMCA, Big Brother/Big Sister)
- ✦ Middle schools
- ✦ Social service agencies
- ✦ Faith-based organizations
- ✦ Group homes for youth
- ✦ Department of Parks and Recreation
- ✦ Department of Probation
- ✦ Department of Children and Family Services (Child Protective Services)

Development and Training of Facilitators

All facilitators should go through formal training for *Project AIM*. Formal training is designed to familiarize facilitators with the goals, purpose, and specific details of *Project AIM*. The *Project AIM* training will enhance specific knowledge and skills needed to deliver the program.

During training, facilitators will learn the content of the Facilitator's Handbook. Training will also emphasize the theory and core elements of *Project AIM*. During the training, participants will experience all the activities in *Project AIM*. The participants will also have a chance to facilitate some of the activities themselves. This hands-on approach is the first step in ensuring that facilitators are implementing *Project AIM* successfully.

After participants attend the formal *Project AIM* training, they will still need to practice the intervention activities before implementing with youth. A great way is to hold practice sessions. Participants for these sessions can be recruited from the staff or agency volunteers. But, if volunteers participate, it is important to make sure they understand their role and the goals of the practice sessions. One of the goals of the practice session is to give the facilitators an opportunity to spend time learning the intervention before implementing with youth. Before each session, the facilitators should decide who will lead each activity. These roles may be adjusted between practices.



The practice sessions will provide an opportunity to manage behavior and conflict. The practice sessions will increase facilitators' comfort-level with the intervention process and promote flexibility in adjusting the agenda to the needs of the participants. In addition, the practice session will help facilitators assess their facilitation skills. Project managers and staff members may want to observe the practice sessions and give facilitators feedback. The project manager may choose to use the *Project AIM* fidelity checklist found in the *Monitoring and Evaluation Guide* to evaluate the practice session.

Once implementation with youth begins, the project manager may want to have a plan in place to ensure quality of delivery. Quality assurance is discussed in detail in the maintenance section of this document.



Developing a Budget

This budget is an example of possible costs of implementing *Project AIM*. Depending on how often you implement or what your specific agency needs, these figures will vary from organization to organization. This is only a guide.

Agency Staff Requirements

An agency will need a part-time project manager (10%-20% FTE) to coordinate all activities of *Project AIM* from program planning, implementation, monitoring, to evaluation. In addition, two part-time staff persons (12.5% FTE each) are needed to recruit youth participants and to co-facilitate *Project AIM*. Facilitators will need time to attend and complete a 3-day training course, while the program manager has the option to attend the entire training course or the first day of training only. It is highly recommended for the program manager to attend the entire training course to gain a more in-depth understanding of *Project AIM* in order to support and supervise the facilitators. Estimated intervention delivery time of 5 hours per facilitator per week includes:

- 2 hours to deliver 2 sessions of *Project AIM* per week (6-week period)
- 1 hour to set-up before and clean-up after each session
- 1 hour to debrief with supervisor
- 1 hour to complete additional tasks between sessions



Equipment

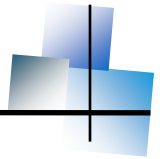
Facilitators will need access to a computer and a printer with the ability to access the internet and print materials from a CD disk or downloadable website.



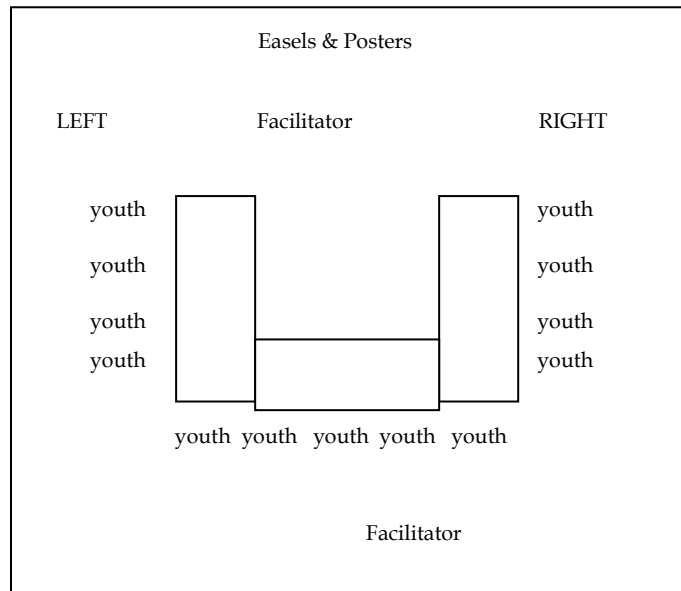
Location, Room Logistics and Time

Project AIM is designed to take place either in or near the community of the target population. Here are some suggestions for selecting a location and room logistics:

- Youth-friendly space
- Venues where youth currently congregate (e.g., recreation centers, after-school programs)
- Central location - along major transit routes so participants can easily get to the location
- Flexible seating and table arrangements:



- Room needs to be big enough to accommodate 2 facilitators and seat 10-18 youth comfortably that allows for group discussion as well as individual and group activities.
- The most ideal room set-up is as follows:



Several factors should be considered when choosing the days and times for your session(s). It is critical that the intervention is held twice a week with enough days in between sessions to allow enough time for (1) youth to process what they are learning and (2) facilitators to complete out of session tasks.

If you do a community assessment, you can ask about the appropriate times for holding session(s) that are most convenient and suitable to the youth. Otherwise, your staff may be aware of other factors that will affect the decision. The availability of the facilitators and the room also needs to be considered.

Intervention Materials

Materials needed to implement the intervention are in the *Project AIM* intervention package and on the *Project AIM* CD-ROM. These materials are:

- *Facilitator Handbook (Curriculum)*
- *Implementation Manual and Technical Assistance Guide*
- *Monitoring and Evaluation Guide*
- *Project AIM* Fact Sheet
- Posters
- Youth Workbook
- *Project AIM* Stationary
- *Self-Confidence* cards
- *Role-Play Scenario* cards
- *Communication Style* cards
- *Directory of Images*
- *Career Puzzle Pieces*
- *Positive and Negative* sheets

The materials listed below are AIM-related items not included in the *Project AIM* intervention package. These items reinforce the core elements and are integral parts of *Project AIM*. Implementing agencies need to purchase these items for each youth:

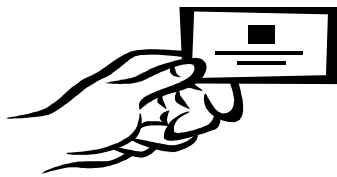
- Key Chains (Session 2)
- *Career Game Explorer* booklets and Web Tickets (Session 5): For more information on how to order the booklets and Web Tickets, go to <http://www.careergame.com>
- Portfolios (Session 12)





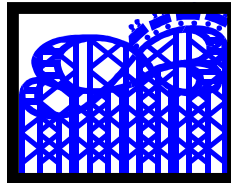
The following items are basic supplies that agencies will need to acquire before implementing *Project AIM*. These are also listed in the budget.

- Easels with Newsprint Pads
- Markers (non-permanent)
- Envelopes
- Pens
- Calculators for student use
- White/Colored Paper
- Certificate Paper
- Business Card Stock



Incentives

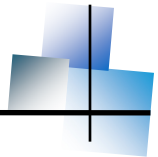
Incentives are used for multiple reasons: to keep youth engaged during sessions and to motivate youth to complete the to-do tasks between sessions. One suggestion is to distribute raffle tickets to youth who completed and shared their to-do tasks. At the end of *Project AIM*, youth received small prizes for their raffle tickets. Other suggestions for incentives include snacks, food coupons, discount store gift cards, movie rental cards, and a local field trip. Use creativity when identifying incentives for the youth. If your agency doesn't have money to buy incentives, it may be possible to ask for donations from the community and offer those donations as incentives.



Sample Cost Sheet

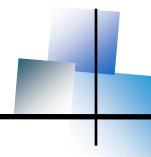
The following cost sheet provides an agency with a general cost analysis of expenditures associated with implementing *Project AIM*. This cost sheet makes the following assumptions (see page 28) and amount will vary depending on the agency's location, infrastructure capacity and access to resources:

CATEGORIES		
Staff ¹ (based on 1 year of implementation)	Salary	Total Cost
Project Manager (1 @ 10% FTE)	Annual salary x 10%	Total Cost (1)
Facilitator (2 @ 12.5% FTE each)	Annual salary x 12.5% x 2 staff	Total Cost (2)
Fringe Benefits (25%)		[(1)+(2)] x 25% =(3)
(A) Total (Staff)		(1)+(2)+(3)
Intervention Materials	Cost/Unit	Total Cost
**YOUTH MATERIALS		
Workbook (cost incurred by agency to print out 17 worksheets) <i>Copies (black and white or color)</i>	Insert cost per page x 17 worksheets x # of participants	Total Cost
Career Interest Inventory Booklet and Web Ticket	Insert cost per unit x # of participants	Total Cost
Portfolio	Insert cost per unit x # of participants	Total Cost
Card Stock (10 business cards per youth)	Insert cost x 10 cards x # of participants	Total Cost
Self-Confidence Card	Insert cost per unit x # of participants	Total Cost
<i>Project AIM Stationary (2 per youth) Copies (black and white or color)</i>	Insert cost per unit x 2 stationeries x # of participants	Total Cost
Key chain	Insert cost per unit x # of participants	Total Cost
Certificate Paper	Insert cost per unit x # of participants	Total Cost
(B) Total Cost of Intervention Materials		\$



CATEGORIES		
Basic Office Supplies	Cost/Unit	Total Cost
Easel with Newsprint Pad	Insert cost of Easel with Pad	Total Cost
Markers (non-permanent)	Insert cost of Markers	Total Cost
Letter (8 ½ x 11) sized envelopes	Insert cost of Envelopes	Total Cost
Pens for youth to use during each session	Cost of pens x # of youth	Total Cost
1 Calculators per groups of 4-6 youth	Insert cost of Calculators	Total Cost
	(C) Total	\$
Incentives (optional expense)	Cost/Unit	Total Cost
Snacks/ Refreshments	(Insert cost) per session x 12 sessions	(Insert cost) per session x 12 sessions
Gift Cards (as optional incentives)	(Insert cost) per youth	(Insert cost) x # of youth
Transportation Vouchers (as needed)	(Insert cost) per youth	(Insert cost) x # of youth
	(D) Total	\$
Travel	Cost/Unit	Total Cost
Miles to/from intervention location (if other than regular work place)	# miles X cents/mile	# miles X cents/mile
	(E) Total	
	Cost/Unit	Total Cost
SUB TOTAL (Staff)	Insert Sub Total Cost	(A)
SUB TOTAL (intervention materials)	Insert Sub Total Cost	(B)
SUB TOTAL (Basic Office Supplies)	Insert Sub Total Cost	(C)
SUB TOTAL (Incentives)	Insert Sub Total Cost	(D)
SUB TOTAL (Travel)	Insert Sub Total Cost	(E)
DIRECT COSTS GRAND TOTAL		SUM of (A) + (B) or (C) + (D) + (E)

- ¹ Staff salary is based on a 1-year implementation plan of *Project AIM*.
- One cycle consists of twelve sessions over a period of six weeks. Group size ranges from 10-18 youth. This annual budget is based on conducting between 6-8 cycles (or groups) across a 12-month period.
- The agency may have access to intervention participants through outreach within their agencies or the surrounding community.
- The agency has an appropriate facility to hold (12) 50-minute group sessions.
- The agency is located either in or in close proximity to the community where the intervention will be delivered.
- The facilitators have access to a computer and printer with Internet access to reproduce some intervention materials.
- Indirect costs should be formulated based on the agency's rate.

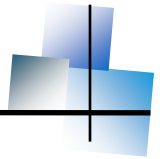


Suggested Timeline

A timeline covering all stages of *Project AIM* is a useful resource to aid with planning and implementation of *Project AIM*. A suggested timeline with specific tasks follows.

MONTH	ACTIVITIES	NOTES
1	Conduct <i>Agency Capacity Self-Assessment</i> to ensure agency has the capacity to implement <i>Project AIM</i> .	
1	Identify key stakeholders to obtain buy-in, support, and/or needed resources to implement <i>Project AIM</i> . Use the <i>Stakeholders Checklist</i> to assist with this process.	
2	Identify members of the Program Implementation team (Project Manager, Facilitators, support staff).	
2	Secure <i>Project AIM</i> intervention package, AIM-related items, incentives, and other basic supplies.	
3	Arrange training for facilitators and identify potential sites for training.	
3	Send facilitators to training.	
3	Develop an evaluation and quality assurance plan.	
3	Develop a marketing and recruitment plan. Create flyers, information sheets, and other marketing/recruitment tools.	

MONTH	ACTIVITIES	NOTES
4	Begin recruitment of youth. If necessary, conduct orientation meetings to parents and community to inform about <i>Project AIM</i> .	
4	Secure venue to conduct <i>Project AIM</i> sessions.	
4	Schedule <i>Project AIM</i> sessions.	
4	Arrange for transportation and snacks/food as needed.	
5	Begin facilitation coordination and practice. Set up regular meeting time with co-facilitators to review and prepare for each session.	
5	Organize intervention materials and other paperwork (such as client forms, staff forms, and evaluation forms).	
5	Enroll youth who will participate in Project AIM and obtain written permission from their parents or guardians.	
5	Provide youth and their parents/guardians information about the program location, dates and times.	



MONTH	ACTIVITIES	NOTES
6	Develop a crisis/referral system for youth who may need additional help.	
6	Conduct pre-implementation evaluation as needed.	
6-7	Implement 1 cycle of <i>Project AIM</i> .	
6-7	Co-facilitators schedule regular meetings with Project Manager during implementation of <i>Project AIM</i> to debrief about the sessions and troubleshoot any issues that may arise.	
6-7	Observe program activities and/or review facilitators' procedures to ensure quality and fidelity.	
8	Conduct post-implementation evaluation as needed.	
8-9	Review and analyze the evaluation data.	
10-11	Use the evaluation data to adjust your program as necessary.	
12	Provide progress reports to funders, agencies, and other key stakeholders.	

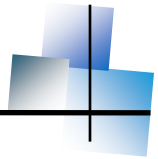
CDC Information Materials

Important Information for Users

This HIV/STD risk-reduction intervention is intended for use with persons who are at high risk for acquiring or transmitting HIV/STD and who are voluntarily participating in the intervention. The materials in this intervention package are not intended for general audiences.

The intervention package includes implementation manuals, training and technical assistance materials, and other items used in intervention delivery. Also included in the packages are (1) the Centers for Disease Control and Prevention (CDC) factsheet on male latex condoms, (2) the CDC Statement on Study Results of Product Containing Nonoxynol-9, (3) the Morbidity and Mortality Weekly Report (MMRW) article “Nonoxynol-9 Spermicide Contraception Use—United States, 1999,” (4) the ABCs of Smart Behavior, and (5) the CDC guideline on the content of the HIV educational materials prepared or purchased by CDC grantees (Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in CDC Assistance Programs).

Before conducting this intervention in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved, the intervention package materials are to be used by trained facilitators when implementing the intervention.



For more information:
CDC's National Prevention Information Network
(800) 458-5231 or www.cdcnpin.org

CDC National STD/HIV Hotline
(800) 227-8922 or (800) 342-2437
En Espanol (800) 344-7432
www.cdc.gov/std

Fact Sheet for Public Health Personnel:

Male Latex Condoms and Sexually Transmitted Diseases

In June 2000, the National Institutes of Health (NIH), in collaboration with the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the United States Agency for International Development (USAID), convened a workshop to evaluate the published evidence establishing the effectiveness of latex male condoms in preventing STDs, including HIV. A summary report from that workshop was completed in July 2001 (<http://www.niaid.nih.gov/dmid/stds/condomreport.pdf>). This fact sheet is based on the NIH workshop report and additional studies that were not reviewed in that report or were published subsequent to the workshop (see "[Condom Effectiveness](#)" for additional references). Most epidemiologic studies comparing rates of STD transmission between condom users and non-users focus on penile-vaginal intercourse.

Recommendations concerning the male latex condom and the prevention of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies of condom use and STD risk.

The surest way to avoid transmission of sexually transmitted diseases is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who has been tested and you know is uninfected.

For persons whose sexual behaviors place them at risk for STDs, correct and consistent use of the male latex condom can reduce the risk of STD transmission. However, no protective method is 100 percent effective, and condom use cannot guarantee absolute protection against any STD. Furthermore, condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV and other STDs. In order to achieve the protective effect of condoms, they must be used correctly and consistently. Incorrect use can lead to condom slippage or breakage, thus diminishing their protective effect. Inconsistent use, e.g., failure to use condoms with every act of

intercourse, can lead to STD transmission because transmission can occur with a single act of intercourse.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer.

Sexually Transmitted Diseases, Including HIV

Sexually transmitted diseases, including HIV

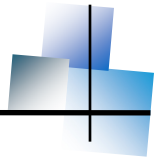
Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases (STDs), including discharge and genital ulcer diseases. While the effect of condoms in preventing human papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

There are two primary ways that STDs can be transmitted. Human immunodeficiency virus (HIV), as well as gonorrhea, chlamydia, and trichomoniasis – the discharge diseases – are transmitted when infected semen or vaginal fluids contact mucosal surfaces (e.g., the male urethra, the vagina or cervix). In contrast, genital ulcer diseases – genital herpes, syphilis, and chancroid – and human papillomavirus are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Condoms can be expected to provide different levels of protection for various sexually transmitted diseases, depending on differences in how the diseases are transmitted. Because condoms block the discharge of semen or protect the male urethra against exposure to vaginal secretions, a greater level of protection is provided for the discharge diseases. A lesser degree of protection is provided for the genital ulcer diseases or HPV because these infections may be transmitted by exposure to areas, e.g., infected skin or mucosal surfaces, that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing rates of STDs between condom users and nonusers in real-life settings. Developing such measures of condom effectiveness is challenging. Because these studies involve private behaviors that investigators cannot observe directly, it is difficult to determine



accurately whether an individual is a condom user or whether condoms are used consistently and correctly. Likewise, it can be difficult to determine the level of exposure to STDs among study participants. These problems are often compounded in studies that employ a “retrospective” design, e.g., studies that measure behaviors and risks in the past.

As a result, observed measures of condom effectiveness may be inaccurate. Most epidemiologic studies of STDs, other than HIV, are characterized by these methodological limitations, and thus, the results across them vary widely--ranging from demonstrating no protection to demonstrating substantial protection associated with condom use. This inconclusiveness of epidemiologic data about condom effectiveness indicates that more research is needed--not that latex condoms do not work. For HIV infection, unlike other STDs, a number of carefully conducted studies, employing more rigorous methods and measures, have demonstrated that consistent condom use is a highly effective means of preventing HIV transmission.

Another type of epidemiologic study involves examination of STD rates in populations rather than individuals. Such studies have demonstrated that when condom use increases within population groups, rates of STDs decline in these groups. Other studies have examined the relationship between condom use and the complications of sexually transmitted infections. For example, condom use has been associated with a decreased risk of cervical cancer – an HPV associated disease.

The following includes specific information for HIV, discharge diseases, genital ulcer diseases and human papillomavirus, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV / AIDS

HIV, the virus that causes AIDS

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS.

AIDS is, by far, the most deadly sexually transmitted disease, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual transmission of HIV is both comprehensive and conclusive. In fact, the ability of latex condoms to prevent transmission of HIV has been scientifically established in “real-life” studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as semen and vaginal fluids, blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate conclusively that the consistent use of latex condoms provides a high degree of protection.

Discharge Diseases, Including Gonorrhea, Chlamydia, and Trichomoniasis

Discharge diseases, other than HIV

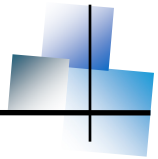
Latex condoms, when used consistently and correctly, can reduce the risk of transmission of gonorrhea, chlamydia, and trichomoniasis.

Gonorrhea, chlamydia, and trichomoniasis are termed discharge diseases because they are sexually transmitted by genital secretions, such as semen or vaginal fluids. HIV is also transmitted by genital secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against discharge diseases such as gonorrhea, chlamydia, and trichomoniasis, by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of chlamydia, gonorrhea and trichomoniasis. However, some other epidemiologic studies show little or no protection against these infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the discharge diseases. More research is needed to assess the degree of protection latex condoms provide for discharge diseases, other than HIV.



Genital Ulcer Diseases and Human Papillomavirus

Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male or female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Correct and consistent use of latex condoms can reduce the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. While the effect of condoms in preventing human papillomavirus infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through “skin-to-skin” contact from sores/ulcers or infected skin that looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/fluids. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are, or are not, covered (protected by the condom).

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of syphilis and genital herpes. However, some other epidemiologic studies show little or no protection. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the genital ulcer diseases. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers in settings where chancroid is a leading cause of genital ulcers. More research is needed to assess the degree of protection latex condoms provide for the genital ulcer diseases.

While some epidemiologic studies have demonstrated lower rates of HPV infection among condom users, most have not. It is particularly difficult to study the relationship between condom use and HPV infection because HPV infection is often intermittently detectable and because it is difficult to assess the frequency of either existing or new

■

infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against HPV infection.

A number of studies, however, do show an association between condom use and a reduced risk of HPV-associated diseases, including genital warts, cervical dysplasia and cervical cancer. The reason for lower rates of cervical cancer among condom users observed in some studies is unknown. HPV infection is believed to be required, but not by itself sufficient, for cervical cancer to occur. Co-infections with other STDs may be a factor in increasing the likelihood that HPV infection will lead to cervical cancer. More research is needed to assess the degree of protection latex condoms provide for both HPV infection and HPV-associated disease, such as cervical cancer.

Department of Health and Human Services

For additional information on condom effectiveness, contact
CDC's National Prevention Information Network
(800) 458-5231 or www.cdcnpin.org

**MMWR**

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Notice to Readers: CDC Statement on Study Results of Product Containing Nonoxynol-9

During the XIII International AIDS Conference held in Durban, South Africa, July 9--14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (1). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, <http://www.cdc.gov/hiv>; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

1. van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9--14, 2000, Durban, South Africa.

* Use of trade names and commercial sources is for identification only and does not constitute endorsement by CDC or the U.S. Department of Health and Human Services.

Reported by: *The Alan Guttmacher Institute, New York, New York. Office of Population Affairs, U.S. Dept of Health and Human Services, Bethesda, Maryland. A Duerr, MD, C Beck-Sague, MD, Div Reproductive Health, National Center Chronic Disease and Public Health Promotion; Div of HIV and AIDS Prevention, National Center HIV/AIDS, STDs, and TB Prevention; B Carlton-Tohill, EIS Officer, CDC.*

Editorial Note:

The findings in this report indicate that in 1999, before the release of recent publications on N-9 and HIV/STDs (4,6,7), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9--lubricated; this is consistent with trends in condom purchases among the general public (8). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV infection and other STDs (7). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continue to be distributed provided the condoms have not passed their expiration date. The amount of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the studies in Africa and the use of N-9--lubricated condoms is preferable to using no condom at all. In the future, purchase of condoms lubricated with N-9 is not recommended because of their increased cost, shorter shelf life, association with urinary tract infections in young women, and lack of apparent benefit compared with other lubricated condoms (7).

Spermicidal gel is used in conjunction with diaphragms (1); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year (1).

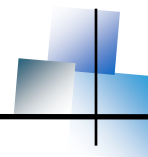
The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of 49% of all pregnancies were unintended (9). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (1). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (2,7). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

References

1. Trussell J. Contraceptive efficacy. In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology: 17th Revised Edition*. New York, New York: Ardent Media, 1998.
2. Roddy R, Zekeng L, Ryan K, Tamoufe U, Weir S, Wong E. A controlled trial of nonoxynol-9-film to reduce male-to-female transmission of sexually transmitted diseases. *N Engl J Med* 1998;339:504--10.
3. Kreiss J, Ngugi E, Holmes K, et al. Efficacy of nonoxynol-9 contraceptive sponge use in preventing



- heterosexual acquisition of HIV in Nairobi prostitutes. JAMA 1992;268:477--82.
4. Van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9--14, 2000, Durban, South Africa.
 5. Louw WC, Austin H, Alexander WJ, Stagno S, Cheeks J. A clinical trial of nonoxynol-9 for preventing gonococcal and chlamydial infections. J Infect Dis 1988;158:513--23.
 6. Roddy RE, Zekeng L, Ryan KA, Tamoufe U, Tweedy KG. Effect of nonoxynol-9 gel on urogenital gonorrhea and chlamydial infection, a randomized control trial. JAMA 2002;287:1117--22.
 7. [CDC. Sexually transmitted diseases treatment guidelines 2002. MMWR 2002;51\(RR-6\).](#)
 8. Moran JS, Janes HR, Peterman TA, Stone KM. Increase in condom sales following AIDS education and publicity, United States. Am J Public Health 1990;80:607--8.
 9. Henshaw SK. Unintended pregnancy in the United States. Fam Plann Perspect 1998;30:24--9,46.

Table 1

TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contraception, by Title X Family Planning Region — United States, 1999

Region*	No. of women served	Male condoms		N-9 products†	
		No.	(%)	No.	(%)
I	179,705	27,726	(15)	1,251	(1)
II	404,325	73,069	(18)	21,515	(5)
III	487,502	73,088	(15)	4,807	(1)
IV	1,011,126	93,011	(9)	29,630	(3)
V	522,312	61,756	(12)	2,489	(1)
VI	478,533	40,520	(8)	11,212	(2)
VII	238,971	15,949	(7)	1,386	(1)
VIII	133,735	15,131	(11)	4,885	(4)
IX	672,362	109,678	(17)	14,547	(2)
X	186,469	17,320	(9)	1,275	(2)
Total	4,315,040	527,248	(12)	92,997	(2)

* Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, Virgin Islands; Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee; Region V=Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin; Region VI=Arkansas, Louisiana, New Mexico, Oklahoma, Texas; Region VII=Iowa, Kansas, Missouri, Nebraska; Region VIII=Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming; Region IX=Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, Palau; Region X=Alaska, Idaho, Oregon, Washington.

† Primary method of contraception reported by these women was one of the following: spermicidal foam, cream, jelly (with and without diaphragm), film, or suppositories.

Table 2

TABLE 2. Number of nonoxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/territories, 1999

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods				
		Condoms with N-9	Condoms without N-9	Gel	Vaginal			Foam
					Film	Insert	Jelly	
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841	2,400
New York†	283,200	1,936,084	NA	0	73,788	NA	3,112	23,830
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200	9,900
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760	25,920
Tennessee	111,223	2,865,160§	717,088	0	94,500	12,528	756	2,758
Michigan	166,893	631,000	254,000	0	0	NA	1,000	1,200
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200	0
Oregon	57,099	151,900	276,000	345	25,764	2,074	272	3,007

* Not available.

† 41 of 61 grantees responded.

§ Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.



The ABCs of Smart Behavior

To avoid or reduce the risk for HIV

A stands for abstinence.

B stands for being faithful to a single sexual partner.

C stands for using condoms consistently and correctly.



CONTENT OF AIDS-RELATED WRITTEN MATERIALS,
PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY



INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR
DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS

Interim Revisions June 1992

1. Basic Principles

Controlling the spread of HIV infection and AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can fully protect themselves from acquiring the virus. These methods include abstinence from the illegal use of IV drugs and from sexual intercourse except in a mutually monogamous relationship with an uninfected partner. For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages can be controversial. These principles are intended to provide guidance for the development and use of educational materials, and to require the establishment of Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

- a. Written materials (e.g., pamphlets, brochures, fliers), audio visual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.
2. Written materials, audiovisual materials, and pictorials should be reviewed by Program Review Panels consistent with the provisions of Section 2500 (b), (c), and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c), and (d), as follows:

"SEC. 2500. USE OF FUNDS.

(b) CONTENTS OF PROGRAMS. - All programs of education and information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such activities.

(c) LIMITATION. - None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or encourage, directly, homo sexual or heterosexual sexual activity or intravenous substance abuse.

(d) CONSTRUCTION. - Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to, or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene."

c. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

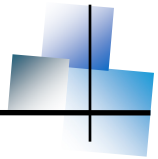
d. Messages provided to young people in schools and in other settings should be guided by the principles contained in "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (MMWR 1988; 37 [suppl. no. S-2]).

2. Program Review Panel

- a. Each recipient will be required to establish or identify a Program Review Panel to review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group

session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization (s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or another CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:

- (1) Understand how HIV is and is not transmitted; and
 - (2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.
2. The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or procedure of the recipient organization or local governmental jurisdiction.
 3. Applicants for CDC assistance will be required to include in their applications the following:
 - (1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review panel, except as provided in subsection (d) below. In addition:
 - (a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either through representation on the panels or as consultants to the panels.
 - (b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a State or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.
 - (c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.
 - (d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.
 - (2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:
 - (a) Concurrence with this guidance and assurance that its provisions will be observed;
 - (b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.
 4. CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multi state), or statewide in scope, or that plan to distribute materials as described above to other organizations on a national, regional, or statewide basis, must establish a single Program Review Panel to fulfill this requirement. Such national/regional/State panels must include as a member an employee of a State or local health department, or an appropriate designated representative of such department, consistent with the provisions of Section 2.c.(1). Materials reviewed by such a single (national, regional, or state) Program Review Panel do not need to be reviewed locally unless such review is deemed appropriate by the local organization planning to use or distribute the materials. Such national/regional/State organization must adopt a national/regional/statewide standard when applying Basic Principles 1.a. and 1.b.



5. When a cooperative agreement/grant is awarded, the recipient will:
 - (1) Convene the Program Review Panel and present for its assessment copies of written materials, pictorials, and audiovisuals proposed to be used;
 - (2) Provide for assessment by the Program Review Panel text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals which are under development;
 - (3) Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the Program Review Panel specifying the vote for approval or disapproval for each proposed item submitted to the panel; and
 - (4) Provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

HIV/AIDS among Youth



1-800-CDC-INFO (232-4636)
In English, en Español
24 Hours/Day
cdcinfo@cdc.gov
<http://www.cdc.gov/hiv>

June 2006

Young people in the United States are at persistent risk for HIV infection. This risk is especially notable for youth of minority races and ethnicities. Continual HIV prevention outreach and education efforts, including programs on abstinence and on delaying the initiation of sex, are required as new generations replace the generations that benefited from earlier prevention strategies. Unless otherwise noted, this fact sheet defines youth, or young people, as persons who are 13–24 years of age.

STATISTICS

HIV/AIDS in 2004

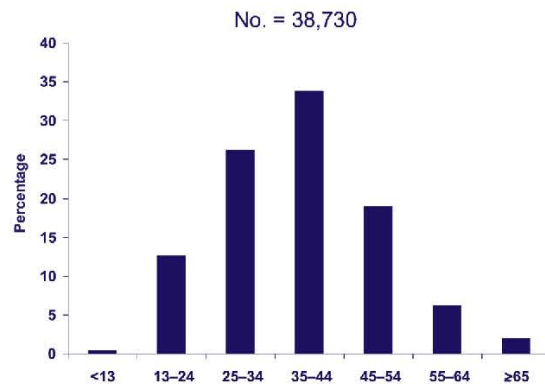
The following are based on data from the 35 areas with long-term, confidential name-based HIV reporting.*

- An estimated 4,883 young people received a diagnosis of HIV infection or AIDS, representing about 13% of the persons given a diagnosis during that year [1].
- HIV infection progressed to AIDS more slowly among young people than among all persons with a diagnosis of HIV infection. The following are the proportions of persons in whom HIV infection did not progress to AIDS within 12 months after diagnosis of HIV infection:
 - 81% of persons aged 15–24
 - 70% of persons aged 13–14
 - 61% of all persons
- African Americans were disproportionately affected by HIV infection, accounting for 55% of

all HIV infections reported among persons aged 13–24 [2].

- Young men who have sex with men (MSM), especially those of minority races or ethnicities, were at high risk for HIV infection. In the 7 cities that participated in CDC's Young Men's Survey during 1994–1998, 14% of African American MSM and 7% of Hispanic MSM aged 15–22 were infected with HIV [3].
- During 2001–2004, in the 33 states with long-term, confidential name-based HIV reporting, 62% of the 17,824 persons 13–24 years of age given a diagnoses of HIV/AIDS were males, and 38% were females.

Age of persons with HIV infection or AIDS diagnosed during 2004

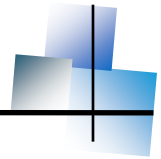


Note. Based on data from 35 areas with long-term, confidential name-based HIV reporting.

AIDS in 2004

- An estimated 2,174 young people received a diagnosis of AIDS (5.1% of the estimated total

*See box on page 5 for a list of the 35 areas.



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of 42,514 AIDS diagnoses), and 232 young people with AIDS died [1].

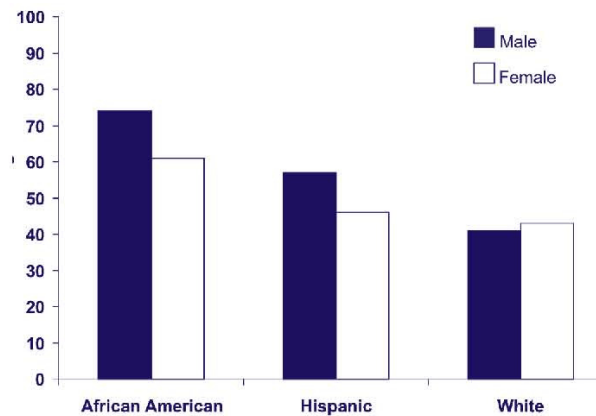
- An estimated 7,761 young people were living with AIDS, a 42% increase since 2000, when 5,457 young people were living with AIDS [1].
- Young people for whom AIDS was diagnosed during 1996–2004 lived longer than persons with AIDS in any other age group except those younger than 13 years. Nine years after receiving a diagnosis of AIDS, 76% of those aged 13–24 were alive, compared with
 - 81% of those younger than age 13
 - 74% of those aged 25–34
 - 70% of those aged 35–44
 - 63% of those aged 45–54
 - 53% of those aged 55 and older [1].
- Since the beginning of the epidemic, an estimated 40,059 young people in the United States had received a diagnosis of AIDS, and an estimated 10,129 young people with AIDS had died. They accounted for about 4% of the estimated total of 944,306 AIDS diagnoses and 2% of the 529,113 deaths of people with AIDS [1].

RISK FACTORS AND BARRIERS TO PREVENTION

Sexual Risk Factors

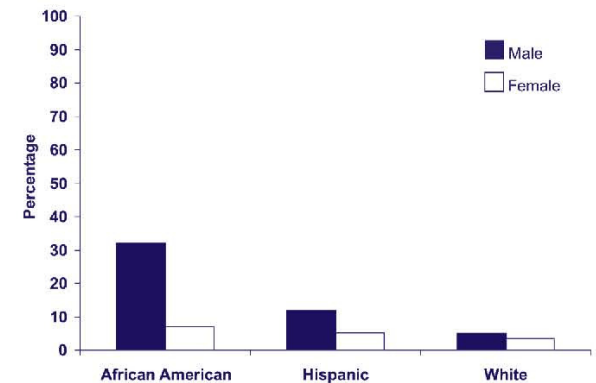
Early age at sexual initiation. According to CDC’s Youth Risk Behavioral Survey (YRBS), many young people begin having sexual intercourse at early ages: 47% of high school students have had sexual intercourse, and 7.4% of them reported first sexual intercourse before age 13 [4]. HIV/AIDS education needs to take place at correspondingly young ages, before young people engage in sexual behaviors that put them at risk for HIV infection.

High school students reporting ever having had sexual intercourse, 2003



Source. CDC’s Youth Risk Behavioral Survey, 2003. (See reference 4.)

High school students reporting sexual intercourse for the first time before age 13, 2003



Source. CDC’s Youth Risk Behavioral Survey, 2003. (See reference 4.)

Heterosexual transmission. Young women, especially those of minority races or ethnicities, are increasingly at risk for HIV infection through heterosexual contact. According to data from a CDC study of HIV prevalence among disadvantaged youth during the early to mid-1990s, the rate of HIV prevalence among young women aged 16–21 was 50% higher than the rate among young men in that age group [5]. African American women in this study were 7 times



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as likely as white women and 8 times as likely as Hispanic women to be HIV-positive. Young women are at risk for sexually transmitted HIV for several reasons, including biologic vulnerability, lack of recognition of their partners' risk factors, inequality in relationships, and having sex with older men who are more likely to be infected with HIV.

MSM. Young MSM are at high risk for HIV infection, but their risk factors and the prevention barriers they face differ from those of persons who become infected through heterosexual contact. According to a CDC study of 5,589 MSM, 55% of young men (aged 15–22) did not let other people know they were sexually attracted to men [6]. MSM who do not disclose their sexual orientation are less likely to seek HIV testing, so if they become infected, they are less likely to know it. Further, because MSM who do not disclose their sexual orientation are likely to have 1 or more female sex partners, MSM who become infected may transmit the virus to women as well as to men. In a small study of African American MSM college students and nonstudents in North Carolina, the participants had sexual risk factors for HIV infection, and 20% had a female sex partner during the preceding 12 months [7].

Sexually transmitted diseases (STDs). The presence of an STD greatly increases a person's likelihood of acquiring or transmitting HIV [8]. Some of the highest STD rates in the country are those among young people, especially young people of minority races and ethnicities [9].

Substance Use

Young people in the United States use alcohol, tobacco, and other drugs at high rates [10]. Both casual and chronic substance users are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol [11]. Runaways and other homeless young people are at high risk for HIV infection if they are exchanging sex for drugs or money.

Lack of Awareness

Research has shown that a large proportion of young people are not concerned about becoming infected with HIV [12]. Adolescents need accurate, age-appropriate information about HIV infection and AIDS, including how to talk with their parents or other trusted adults about HIV and AIDS, how to reduce or eliminate risk factors, how to talk with a potential partner about risk factors, where to get tested for HIV, how to use a condom correctly. Information should also include the concept that abstinence is the only 100% effective way to avoid infection.

Poverty and Out-of-School Youth

Nearly 1 in 4 African Americans and 1 in 5 Hispanics live in poverty [13]. The socioeconomic problems associated with poverty, including lack of access to high-quality health care, can directly or indirectly increase the risk for HIV infection [14]. Young people who have dropped out of school are more likely to become sexually active at younger ages and to fail to use contraception [15].

The Coming of Age of HIV-Positive Children

Many young people who contracted HIV through perinatal transmission are facing decisions about becoming sexually active. They will require ongoing counseling and prevention education to ensure that they do not transmit HIV.

PREVENTION

In the United States, the annual number of new HIV infections has declined from a peak of more than 150,000 in the mid-1980s and has stabilized since the late 1990s at approximately 40,000. Populations of minority races or ethnicities are disproportionately affected by the HIV epidemic. To reduce further the incidence of HIV, CDC announced a new initiative, Advancing HIV Prevention (http://www.cdc.gov/hiv/topics/prev_prog/AHP), in 2003. This initiative comprises

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4 strategies: making HIV testing a routine part of medical care, implementing new models for diagnosing HIV infections outside medical settings, preventing new infections by working with HIV-infected persons and their partners, and further decreasing perinatal HIV transmission.

Through the Minority AIDS Initiative (<http://www.cdc.gov/programs/hiv08.htm>), CDC explores ways to reduce health disparities in communities made up of persons of minority races or ethnicities who are at high risk for HIV. These funds are used to address the high-priority HIV prevention needs in such communities.

CDC provides 9 awards to community-based organizations (CBOs) that focus primarily on youth and provides indirect funding through state, territorial, and local health departments to organizations serving youth. Of these 9 awards, 5 are focused on African Americans, 3 on Hispanics, 1 on Asians and Pacific Islanders, and 1 on whites. The following are some CDC-tested prevention programs that state and local health departments and CBOs can provide for youth.

- Teens Linked to Care is focused on young people aged 13–29 who are living with HIV.
- Street Smart is an HIV/AIDS and STD prevention program for runaway and homeless youth.
- PROMISE (Peers Reaching Out and Modeling Intervention Strategies for HIV/AIDS Risk Reduction in their Community) is a community-level HIV prevention intervention that relies on role-model stories and peers from the community.
- Adult Identity Mentoring project, which encourages students to articulate personal goals and then teaches them the skills required to achieve those goals, can be effective in helping at-risk youth delay the initiation of sex [16].

CDC research has shown that early, clear parent-child communication regarding values and expectations about sex is an important step in

helping adolescents delay sexual initiation and make responsible decisions about sexual behaviors later in life. Parents are in a unique position to engage their children in conversations about HIV, STD, and teen pregnancy prevention because the conversations can be ongoing and timely [17].

Schools also can be important partners for reaching youth before high-risk behaviors are established, as evidenced by the YRBS finding that 88% of high school students in the United States reported having been taught about AIDS or HIV infection in school.

Overall, a multifaceted approach to HIV/AIDS prevention, which includes individual, peer, familial, school, church, and community programs, is necessary to reduce the incidence of HIV/AIDS in young people. For Guidelines for Effective School Health Education to Prevent the Spread of AIDS, visit <http://www.cdc.gov/HealthyYouth/sexualbehaviors/guidelines/guidelines.htm>.

REFERENCES

1. CDC *HIV/AIDS Surveillance Report, 2004*. Vol. 16. Atlanta: US Department of Health and Human Services, CDC; 2005:1–46. Available at <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2004report>. Accessed May 30, 2006.
2. CDC. *HIV Prevention in the Third Decade*. Atlanta: US Department of Health and Human Services, CDC; 2005. Available at <http://www.cdc.gov/hiv/resources/reports/hiv3rddecade/index.htm>. Accessed May 15, 2006.
3. CDC. HIV incidence among young men who have sex with men—seven US cities, 1994–2000. *MMWR* 2001;50:440–444.
4. CDC. Youth Risk Behavior Surveillance—United States, 2003. *MMWR* 2004;53(SS-2):1–29.
5. Valleroy LA, MacKellar DA, Karon JM, Janssen RS, Hayman DR. HIV infection in disadvantaged out-of-school youth: prevalence for U.S. Job Corps entrants, 1990 through 1996. *Journal of Acquired Immune Deficiency Syndromes* 1998;19:67–73.
6. CDC. HIV/STD risks in young men who have sex with men who do not disclose their sexual orientation—six US cities, 1994–2000. *MMWR* 2003;52:81–85.

HIV/AIDS AMONG YOUTH

7. CDC. HIV transmission among black college student and non-student men who have sex with men—North Carolina, 2003. *MMWR* 2004;53:731–734.
8. Fleming DT, Wasserheit JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections* 1999;75:3–17.
9. CDC. *Sexually Transmitted Disease Surveillance, 2004*. Atlanta: US Department of Health and Human Services, CDC; 2005. Available at <http://www.cdc.gov/std/stats/adol.htm>. Accessed May 16, 2006.
10. Substance Abuse and Mental Health Services Administration. 2004 National Survey on Drug Use & Health. Available at <http://oas.samhsa.gov/nhsda.htm>. Accessed May 16, 2006.
11. Leigh BC, Stall R. Substance use and risky sexual behavior for exposure to HIV: issues in methodology, interpretation, and prevention. *American Psychologist* 1993;48:1035–1045.
12. The Kaiser Family Foundation. National Survey of Teens on HIV/AIDS, 2000. Available at <http://www.kff.org/youthhivstds/3092-index.cfm>. Accessed May 15, 2006.
13. US Census Bureau. Poverty: 1999. Census 2000 Brief. May 2003. Available at <http://www.census.gov/prod/2003pubs/c2kbr-19.pdf>. Accessed May 15, 2006.
14. Diaz T, Chu SY, Buehler JW, et al. Socioeconomic differences among people with AIDS: results from a multistate surveillance project. *American Journal of Preventive Medicine* 1994;10:217–222.
15. Office of the Surgeon General. The Surgeon General's call to action to promote sexual health and responsible sexual behavior, July 9, 2001. Available at <http://www.surgeongeneral.gov/library/sexualhealth/call.htm>. Accessed May 16, 2006.
16. Clark LF, Miller KS, Nagy SS, et al. Adult identity mentoring: reducing sexual risk for African-American seventh grade students. *Journal of Adolescent Health* 2005;37:337.e1–337.e10.
17. Dittus P, Miller KS, Kotchick BA, Forehand R. Why Parents Matter!: the conceptual basis for a community-based HIV prevention program for the parents of African American youth. *Journal of Child and Family Studies* 2004;13(1):5–20.

Understanding HIV and AIDS Data

AIDS surveillance: Through a uniform system, CDC receives reports of AIDS cases from all US states and territories. Since the beginning of the epidemic, these data have been used to monitor trends because they are representative of all areas. The data are statistically adjusted for reporting delays and for the redistribution of cases initially reported without risk factors. As treatment has become more available, trends in new AIDS diagnoses no longer accurately represent trends in new HIV infections; these data now represent persons who are tested late in the course of HIV infection, who have limited access to care, or in whom treatment has failed.

HIV surveillance: Monitoring trends in the HIV epidemic today requires collecting information on HIV cases that have not progressed to AIDS. Areas with confidential name-based HIV infection reporting requirements use the same uniform system for data collection on HIV cases as for AIDS cases. A total of 35 areas—the US Virgin Islands, Guam, and 33 states (Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming)—have collected these data for at least 5 years, providing sufficient data to monitor HIV trends and to estimate risk behaviors for HIV infection. Recently, 9 additional areas have begun confidential name-based HIV surveillance, and data from these areas will be included in coming years.

HIV/AIDS: This term includes persons with a diagnosis of HIV infection (not AIDS), a diagnosis of HIV infection and a later diagnosis of AIDS, or concurrent diagnoses of HIV infection and AIDS.

For more information . . .

CDC HIV/AIDS

<http://www.cdc.gov/hiv>
 CDC HIV/AIDS resources

CDC-INFO

1-800-232-4636
 Information about personal risk and where to get an HIV test

CDC National HIV Testing Resources

<http://www.hivtest.org>
 Location of HIV testing sites

CDC National Prevention Information Network (NPIN)

1-800-458-5231
<http://www.cdcpin.org>
 CDC resources, technical assistance, and publications

AIDSinfo

1-800-448-0440
<http://www.aidsinfo.nih.gov>
 Resources on HIV/AIDS treatment and clinical trials

Project AIM



Project AIM is a group-level, youth development intervention designed to reduce HIV risk behaviors by providing youth motivation to make safe choices and to address deeper barriers to sexual risk prevention. Youth are motivated to achieve a positive future and avoid a negative future.

Project AIM helps and encourages youth:

- To understand the concept of legacy through the use of role models
- See a picture of themselves in the future as successful adults
- Set goals to achieve their desired future selves
- Identify strengths and resources needed for future success
- Build effective communication skills
- Protect their future through reducing risk behaviors today

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