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P1 National Security Classified Information [(a)(1) of the PRA]
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b(1) National security classified information [(b)(1) of the FOIA]
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Conf - 9/98
see inside

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

September 17, 1998

File

Sandra Thurman
Director
White House Office of National
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736 Jackson Place, NW
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Dear Ms. Thurman:

The Division of Adolescent and School Health would like to express appreciation to you for your participation as a speaker at the 1998 National Leadership Conference to Strengthen HIV/AIDS Education and Coordinated School Health Programs in Atlanta, Georgia.

Enclosed please find a copy of the Final Participants Directory and handouts for plenary speakers, Ron Valdisseri and Thomas Coates.

As you reflect on the conference, you may have suggestions or ideas as to how next year's conference committee can improve the conference. If so, please call Judy Powers or send her your suggestions. She may be reached at (770) 488-3167 or fax (770) 488-3110. Our conference is important and we strive for continued improvement.

Again, thank you for your contribution to the conference. We look forward to a continued working relationship with you and your organization.

Sincerely yours,

Beth Patterson

Beth Patterson
Associate Director
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You were great!

National Leadership Conference to Strengthen HIV/AIDS Education and Coordinated School Health Programs

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Handouts from Ron Valdiserri's Plenary Session

Update on HIV/AIDS

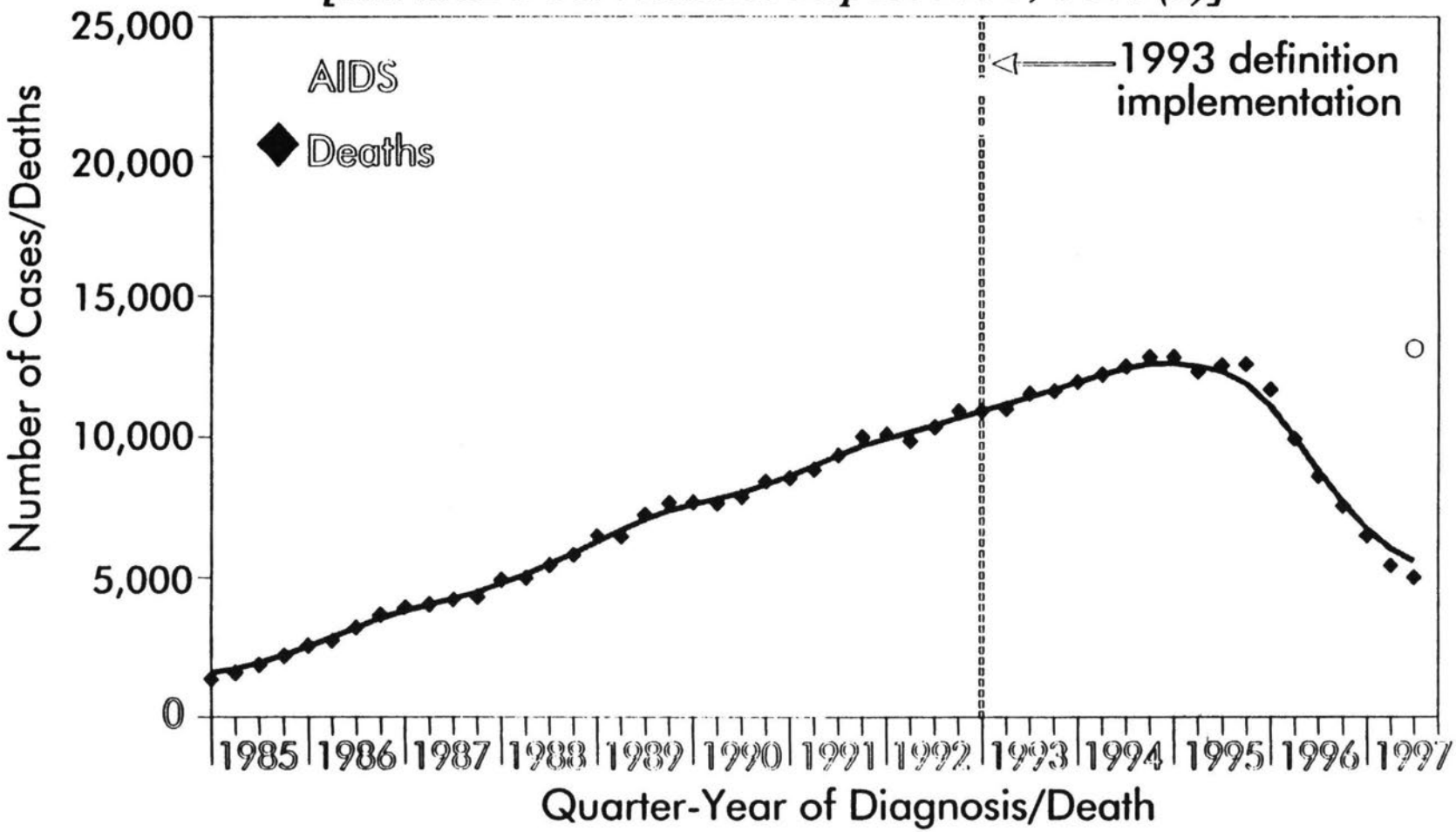
Ronald O. Valdiserri, M.D., M.P.H.

August 12, 1998

CDC

Estimated incidence of AIDS and deaths of persons with AIDS, adjusted for delays in reporting, by quarter-year of diagnosis/death, United States, January 1985 through June 1997

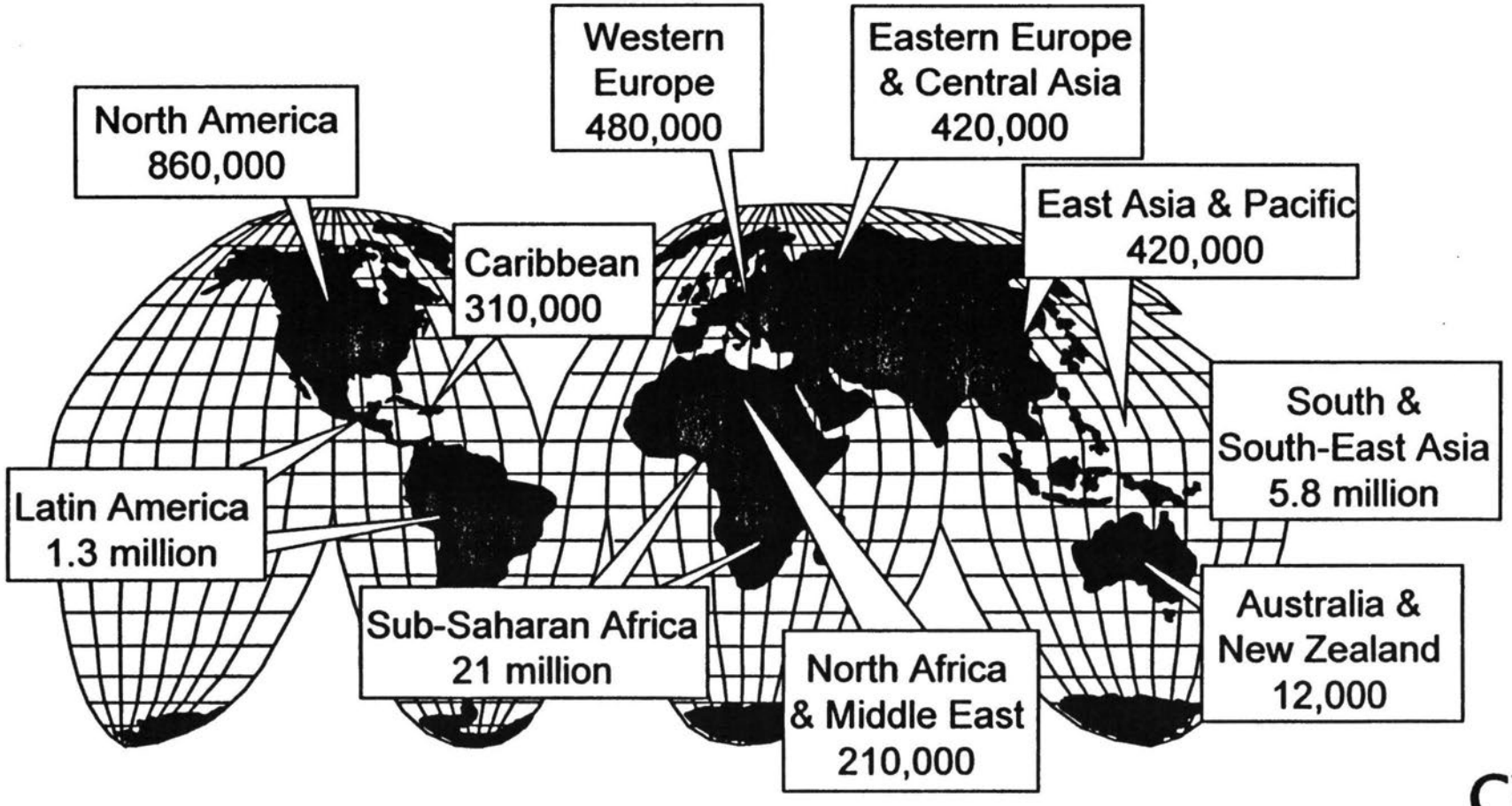
[HIV/AIDS Surveillance Report 1997; Vol 9(2)]



AIDS Cases and Deaths and Change from First Half of 1996 to First Half of 1997, by Gender and Race

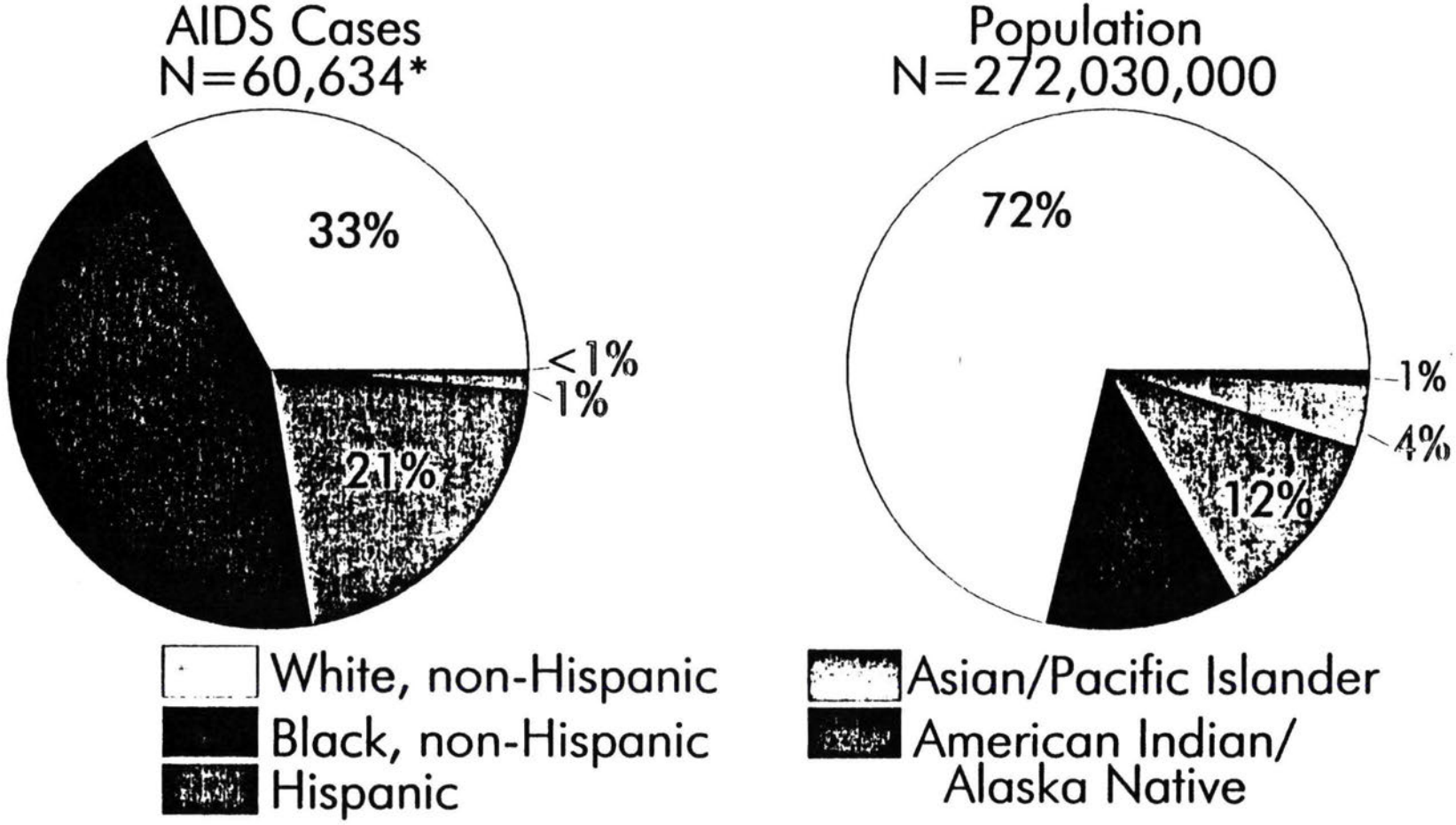
	AIDS Cases		Percent Decrease	AIDS Deaths		Percent Decrease
	Jan - Jun 1996	Jan - Jun 1997		Jan - Jun 1996	Jan - Jun 1997	
Total	33,243	28,370	15	21,281	11,479	45
Men	26,059	21,837	16	17,394	9,282	47
Women	7,184	6,533	9	3,887	2,467	37
White	11,963	8,999	25	8,501	3,920	54
African American	14,425	13,398	7	8,705	5,467	37
Hispanic	6,381	5,543	13	3,830	2,222	42

Adults and Children Living with HIV/AIDS
Total 30.6 Million
(UNAIDS, Global Report, 6/98)



CDC

AIDS Cases Reported in 1997 and Estimated 1997 Population by Race/Ethnicity, United States



*Includes 242 persons with unknown race/ethnicity

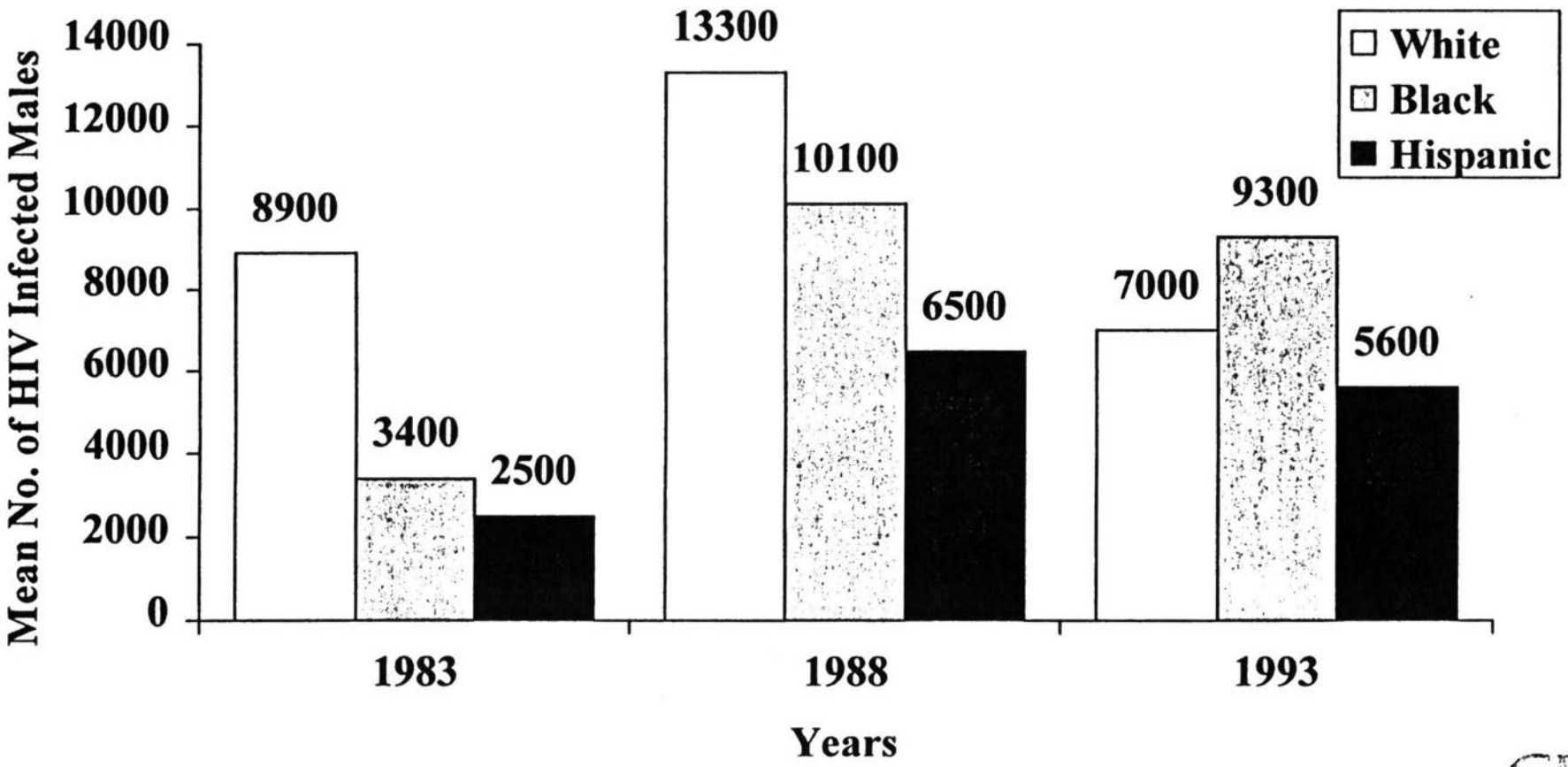
Comparison of Disease Status at Initial Diagnosis, by Selected Characteristics, from 25 HIV Reporting States, January 1994 - June 1997

(MMWR 1998; 47:309)

	HIV		AIDS	
	Number	Percent	Number	Percent
Men	37,996	72	16,866	83
Women	14,689	28	3,348	17
White	17,929	34	9,171	45
African American	30,229	57	9,127	45
Heterosexual	9,279	18	2,428	12
Age 13-24	7,200	14	653	3

Trends in HIV Prevalence in U.S. Males Aged 18-22 Years: Race/Ethnicity

(JAMA 1998; 279:1894-1899)



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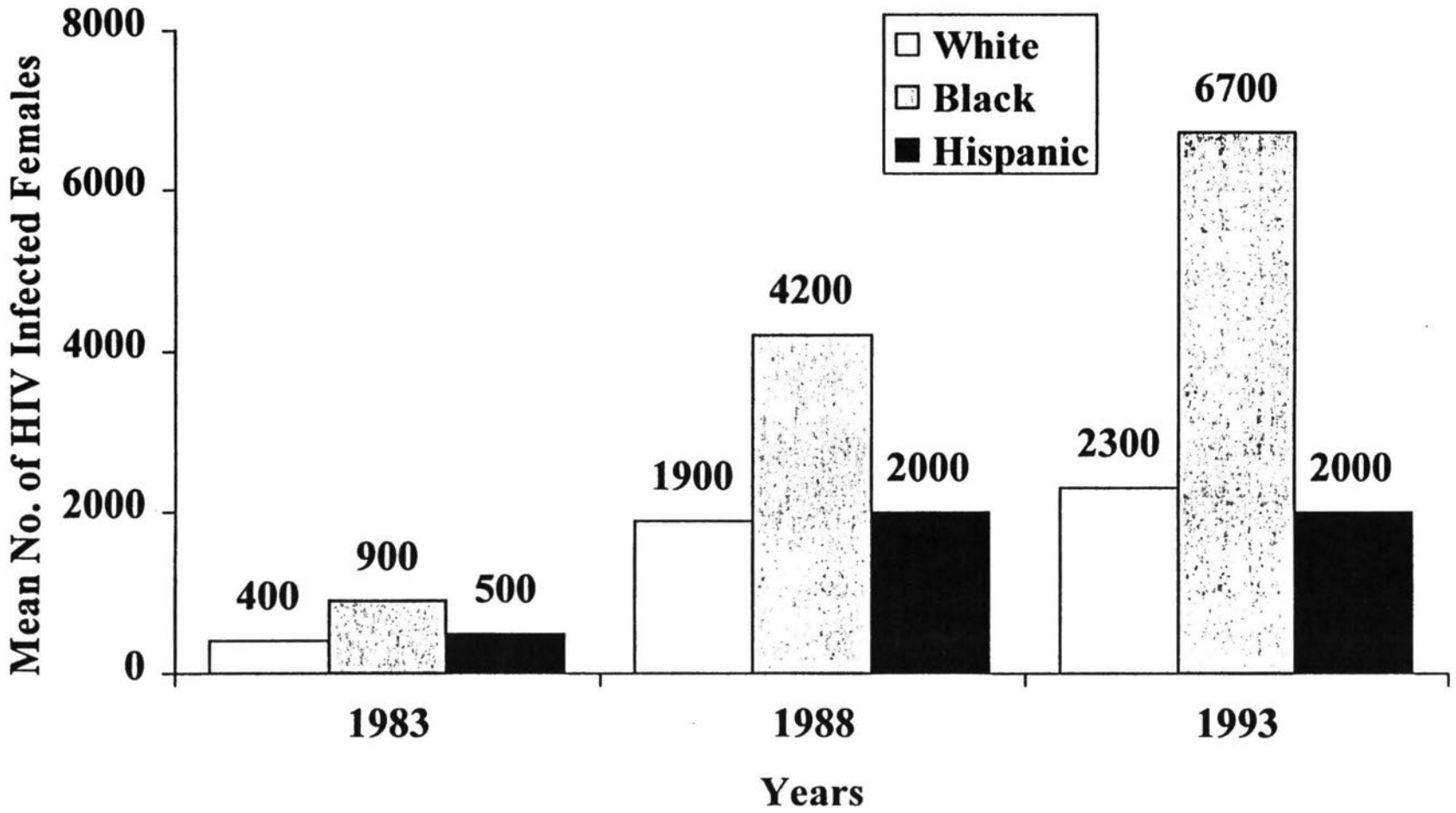
Trends in HIV Prevalence in U.S. Females Aged 18-22 Years: Race/Ethnicity

(JAMA 1998; 279:1894-1899)



Trends in HIV Prevalence in U.S. Males Aged 18-22 Years: Transmission

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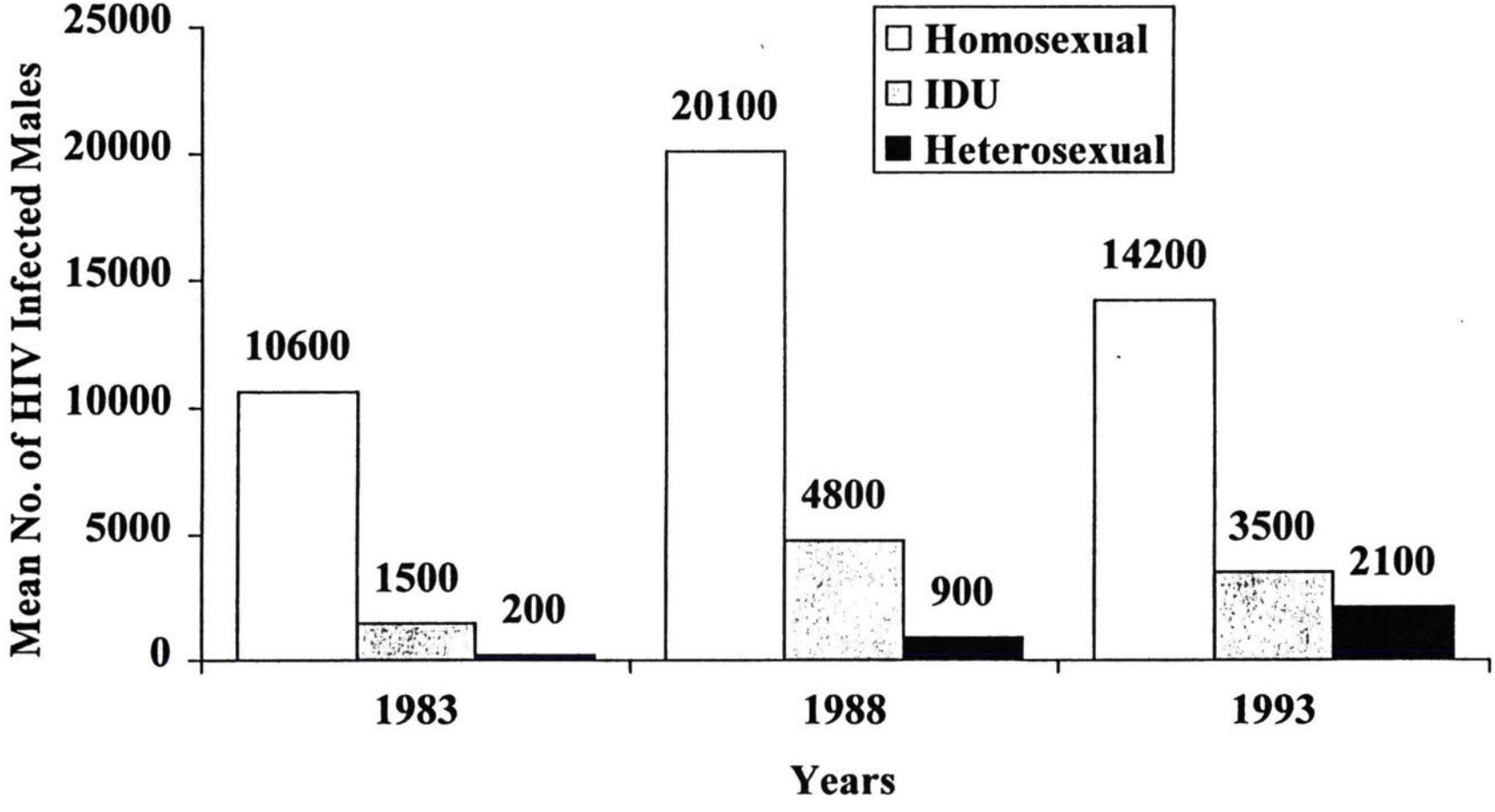

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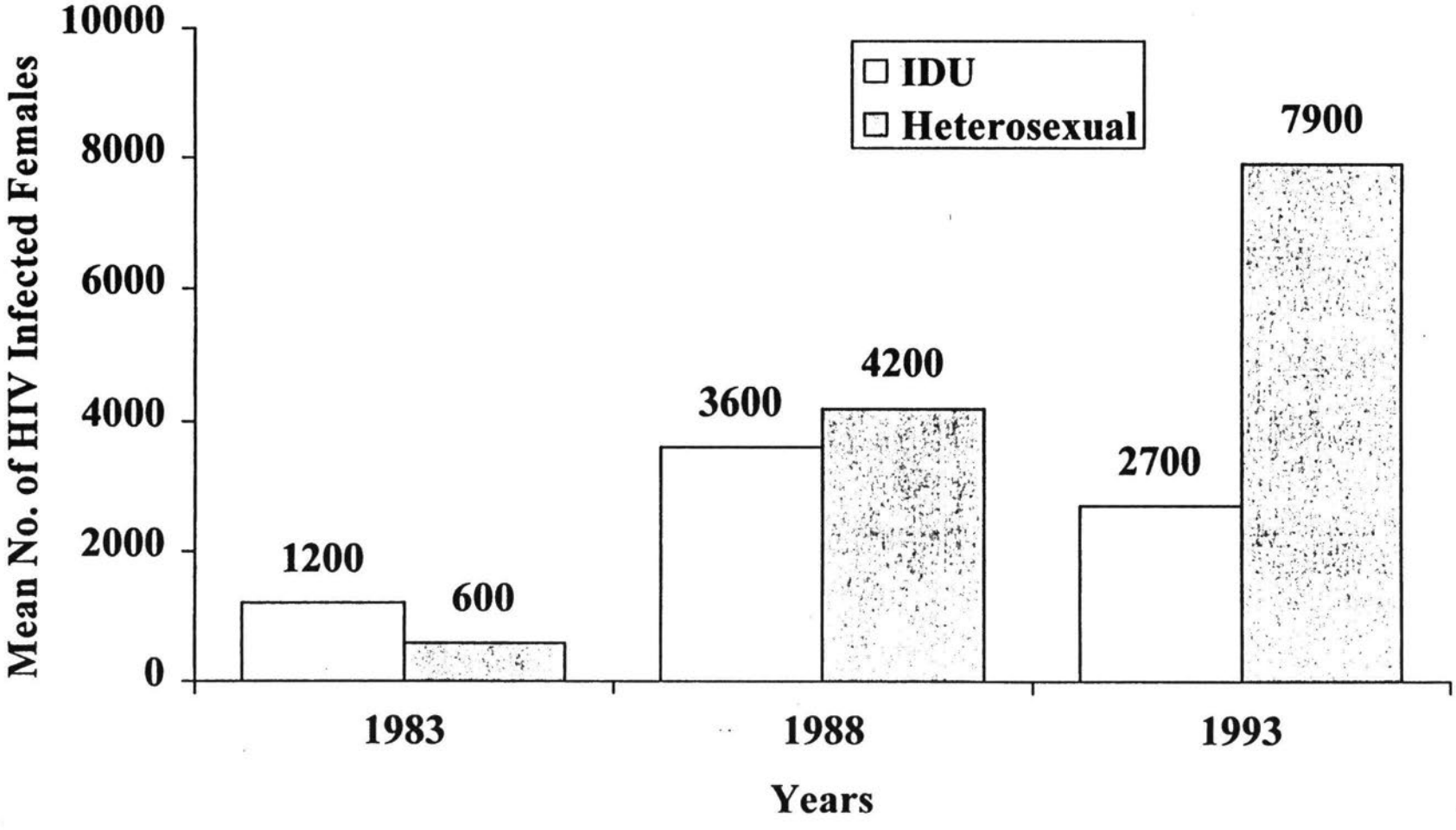
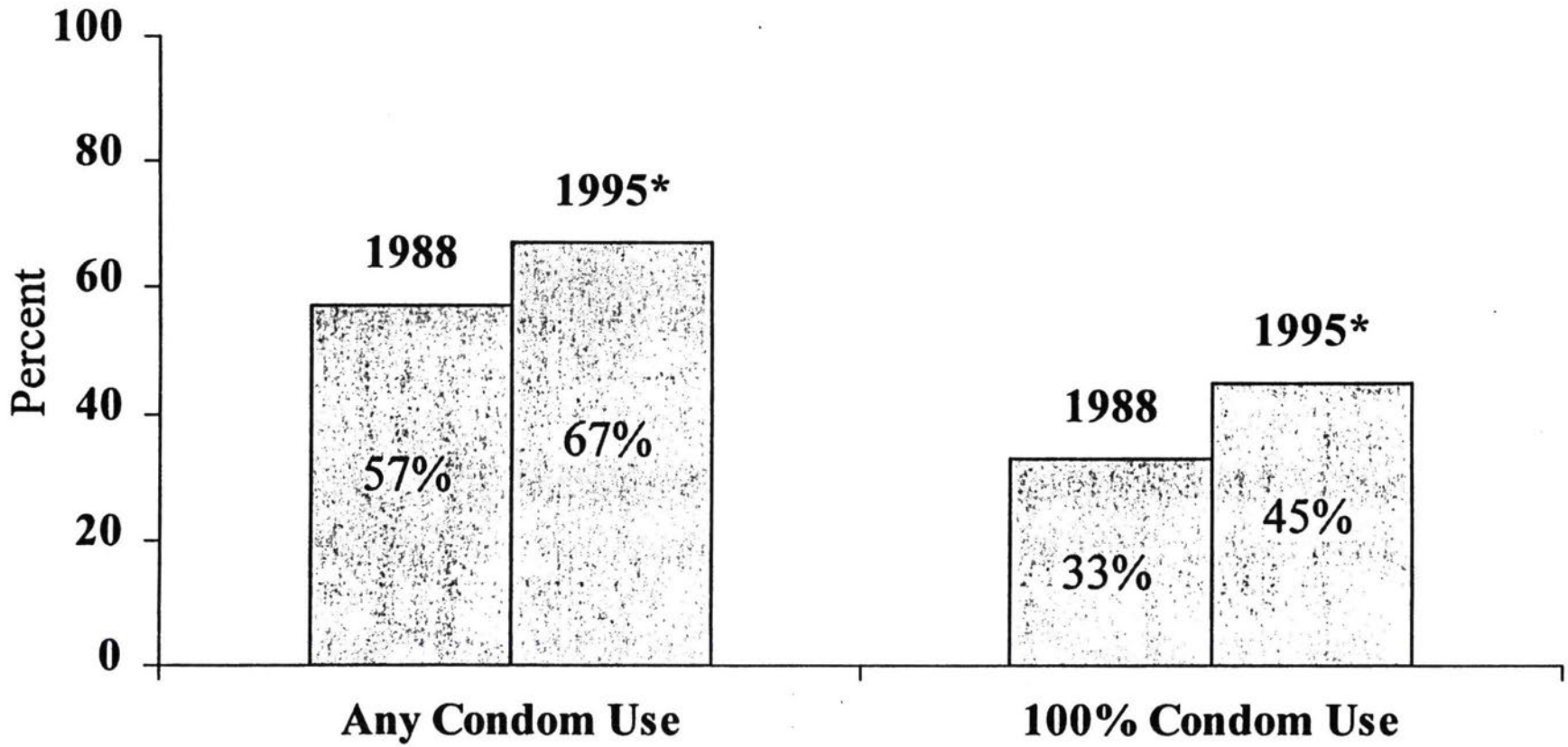


National Survey of Adolescent Males, 15-19 years, 1988 *vs* 1995

(Am J Public Health 1998; 88:956-959)



* p < .01

Younger Age and HIV Risk in Gay/Bisexual Men in the U.S.

(Mansergh et al., XII World AIDS Conference)

- Cohort of 1629 HIV negative gay & bisexual men (Chicago, Denver, San Francisco)
- Baseline and every 6 months x 2 years
- Inverse relationship between age and:

  HIV seroconversion; unprotected receptive anal and unprotected insertive anal intercourse
- Strong associations with perceived peer norms and using bars to meet/socialize with gay men

CDC

National Survey of Adolescent Males, 15-19 years, 1988 *vs* 1995

(Am J Public Health 1998; 88:956-959)

"Despite these improvements, more than a quarter (27%) of teenaged males were still having unprotected sex in 1995. While only 23% of White teenaged males had unprotected sex during the last year, the rates were much higher among Black (39%) and Hispanic (37%) males."

CDC

Community-Level HIV Prevention Intervention

(Kelly, et al. Lancet 1997; 350:1500-05)

- Randomized trial: 4 U.S. intervention cities (n=265) and 4 control cities (n=173)
- Written materials in gay bars *vs.* trained opinion leaders
- Target: non-monogamous men frequenting gay bars
- Intervention cities: 30%↓ unprotected AI
  50%↑ condom use
- Control cities: no behavior changes after 12 mos. F/U

Effective HIV Prevention for Young Gay Men

(J. de Wit et al., 2nd Intl. HIV Prevention Symposium, Geneva 1998)

- 282 young gay men ($\bar{x}$ = 25 years) randomly assigned to: Information; Motivation; Behavioral Skills, or Control
- Information and condom motivation interventions were most effective for men who were already sexually experienced in anal intercourse
- Skills training interventions were more successful among sexually inexperienced young gay men
- Interventions should be tailored to level of sexual experience

CDC
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Safer Sex Interventions for African American Adolescents

(Jemmott et al., JAMA 1998; 279:1529-1536)

Intervention →	3 mos.		6 mos.		12 mos.	
	consistent condom use in past 3 mos.	sexual intercourse past 3 mos.	consistent condom use in past 3 mos.	sexual intercourse past 3 mos.	consistent condom use in past 3 mos.	sexual intercourse past 3 mos.
Abstinence	38%	12%	44%	17%	41%	20%
Safer Sex	66%	17%	50%	15%	62%	16%
Control	36%	21%	37%	23%	51%	23%

Secondary Prevention With HIV Positive Youth

(Rotheram-Borus & Miller AIDS CARE 1998; 10:17-34)

Formative Findings:

- HIV positive youth peer leaders require ongoing training & support
- Youths may not understand or adhere to medical regimens
- Substance abusing youth often present to health providers when "crashing" -- opportunity to intervene

Principles for Preventing the Spread of HIV in Youth

(Wren, et. al., J Adol Health 1997; 21:309-317)

Quantitative & Qualitative Review of 11 Projects

- Small group discussions
- Involvement of peer educators
- Recognition of adults' roles (e.g. parents,teachers)
- Use of structured settings to gain access (e.g. schools, clubs)

Characteristics Of Outcome Evaluation (*n*=110) Of Sexual Health Interventions For Young People

(AIDS 1998; 12:S191-S196)

Country	***n***	**%**
North America	92	84
Europe	15	13
Developing countries	2	2
Other	1	1
Total	110	100
Intervention setting*		
Educational institution	77	70
Healthcare unit	15	14
Community/home	14	13
Outreach	6	5
Other/unclear	8	7

* Total does not equal 110 or 100% due to overlap

Characteristics Of Outcome Evaluation (*n*=110) Of Sexual Health Interventions For Young People

(AIDS 1998; 12:S191-S196)

(continued)

Type of intervention*	***n***	**%**
Information only	72	66
Skills only	10	9
Information and skills	27	25
Advice/counseling	16	15
Other	2	2

* Total does not equal 110 or 100% due to overlap

Characteristics of Successful HIV Prevention Efforts for Young People

(Peersman & Levy, AIDS 1998; 12:S191-S196)

- Personalize information
- Active learning models (not didactic)
- Strengthen group norms around unprotected sex
- Base interventions on assessments of young people (values/beliefs/needs)
- Integrate pregnancy and STD
- Provide access to social/medical services

CDC

School Based HIV/AIDS Education

(SIECUS Review 1995; J Sch Health 1995; 65:302)

- 39 states require school-based HIV prevention
- 25 states mandate abstinence instruction
- 37% of programs have any direct instruction regarding condom efficacy/use
- 81% of programs with condom availability require parental consent
- Variability of instruction is great

CDC

Condom Availability in Schools and Sexual Behavior

(Guttmacher et al. AJPH 1997; 87:1427-1433)

Cross sectional survey in 1994 of students grades 9-12

- NYC: 7119 students; 12 randomly selected schools; condoms available in schools
- Chicago: 5738 students; 10 matched schools; condoms not available in schools

NYC and Chicago students no sig. diff. in terms of: % sexually active; frequency of sexual activity; type of sexual activity

NYC students had higher rates of condom use at last intercourse ($p < .01$)

CDC

Impact of a High School Condom Availability Program

(Schuster et al. Fam Plng Perspt 1998; 30:67-72)

- Baseline (1992) *vs* Follow-up (12 mos. post-implementation) cross sectional survey grades 9-12 in Los Angeles county
- Baseline n=1945; Follow-up n=1112
- No significant change in sexual activity
- Significant increase in consistent male condom use from 37% to 50%

"Improved prevention of STDs should be an essential component of a national strategy for preventing sexually transmitted HIV infection."

The Hidden Epidemic: Confronting STDs
Institute of Medicine, 1996

CDC

STD Prevention: Challenges

- 12 million Americans with STDs annually; 25% in teens
- 87% of cases of 10 most commonly reported diseases in U.S., 1995
- STDs concentrated among adolescents, marginalized minority populations; across South; in rural areas of South
- U.S. STD rates up to 50-100 times rates in other industrialized countries
- $10 billion spent annually on non-HIV STDs & sequelae

CDC

Genital Chlamydia Infections without Symptoms

	Mean	Range
Men	52%	14-90%
Women	75%	70-80%

Principles of Effective and Sustainable Interventions

- Base on sound scientific principles
- Adapt to changing circumstances
- See recipients as change agents -- not as targets
- Deliver at multiple levels

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Principles of Effective and Sustainable Interventions

- Consider context of behavior/practice/attitudes
- Require partnerships
- Support with technical assistance and evaluation
- Provide "combination therapies"

CDC

"No, no, we are not satisfied, and
we will not be satisfied until
justice rolls down like waters and
righteousness like a mighty stream"

Dr. Martin Luther King
1963

Handouts from Thomas Coates' Plenary Session

Reducing HIV Transmission

What Works?
What's Needed?

Thomas J. Coates PhD.
Center for AIDS Prevention Studies
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Preventing HIV Transmission

Motivating Risk Reduction

Establishing Social Conditions for Risk Reduction

UCSF AIDS Research Institute/ CAPS

Targets for Prevention

- **Abstinence (from drugs or sex)**
- **Reducing number of partners (sexual or needle sharing)**
- **Protective barriers (male or female condoms)**
- **Microbicides/virucides**
- **Treatment**

Prevention Strategies That Work

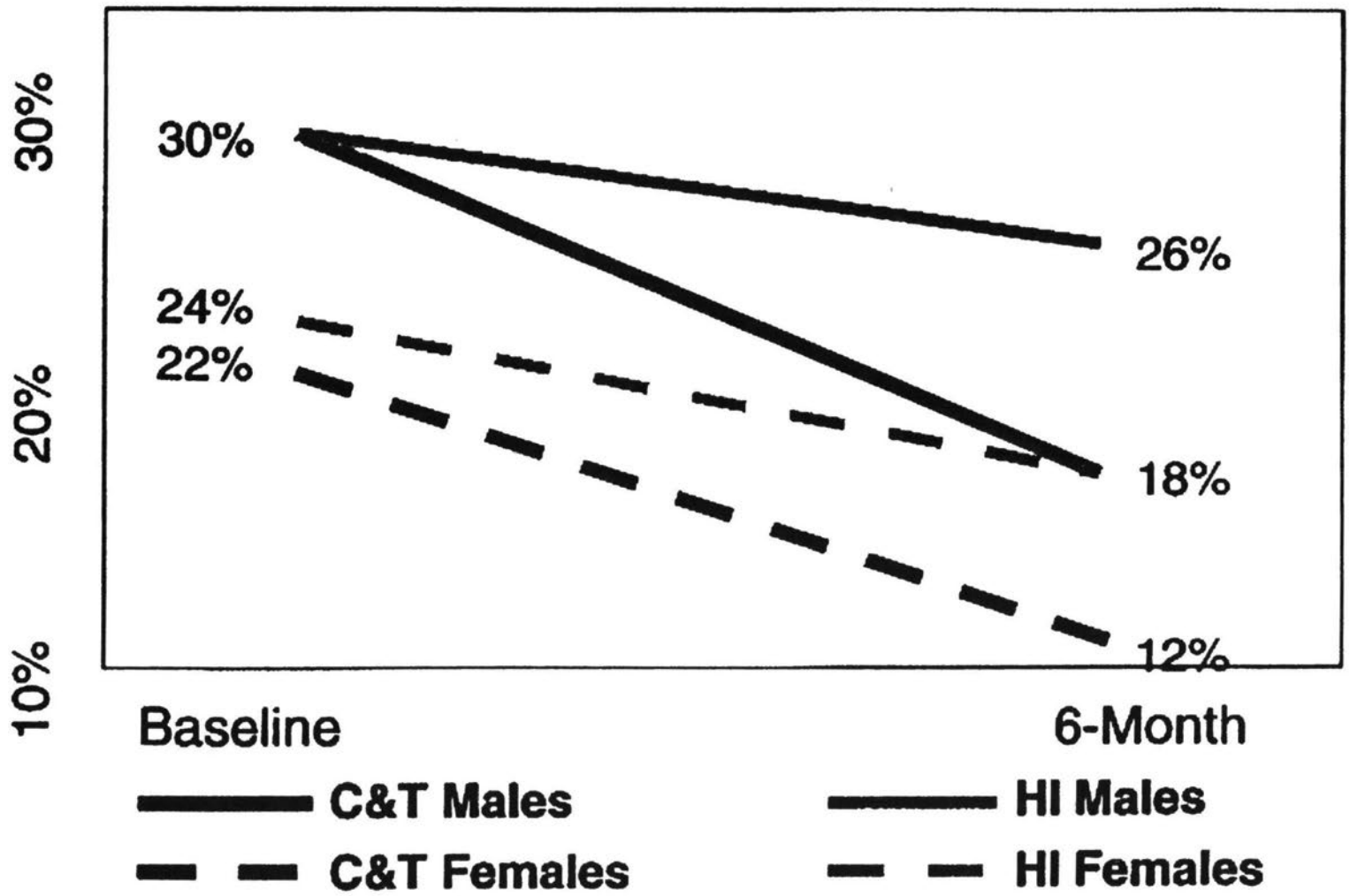
1. Access To:

- Needles (Needle Exchange Studies; Connecticut Evaluation)
- Condoms (Guttmacher et al)
- Female Condoms
- Testing (e.g., for blood supply)
- Treatment (for STDs, for Drug Use, for HIV)

Prevention Strategies That Work

1. Access To:
2. Counseling and Educational Strategies
   - Counseling and Testing (CT Efficacy Trial)
   - One-to-One Counseling (Project Respect)
   - Small Group Counseling (NIMH Multisite Trial)
   - Couples Counseling and Testing (Allen; CT Efficacy Trial)

Participants Who Enrolled Individually.
Percent Reporting Unprotected Intercourse
With Any Non-Primary Partner During the Previous 2 Months.



UCSF AIDS Research Institute/ CAPS

When partners were referred for testing

- **4.1% seroconversions before**
- **1.8% among women whose partners were tested**
- **3.4% among women whose partners were not tested**

Serodiscordant Married Couples Undergoing Couples Counseling and Testing Reduce Risk Behavior with Each Other but Not with Extra-Marital Partners

	Sex with Spouse		Unprotected Intercourse with Spouse	
	Baseline	Six months	Baseline	Six Months
+F+	100%	52%	75%	38%
+F-	100%	55%	100%	45%
-F+	84%	71%	79%	50%
-F-	97%	79%	93%	70%

UCSF AIDS Research Institute/ CAPS

Urban Men's Health Study

- **Cross-sectional household survey**
- **SF, LA, NYC, Chicago**
- **Survey 'ghetto" and "non-ghetto" areas**

Condom Use: Primary Partner

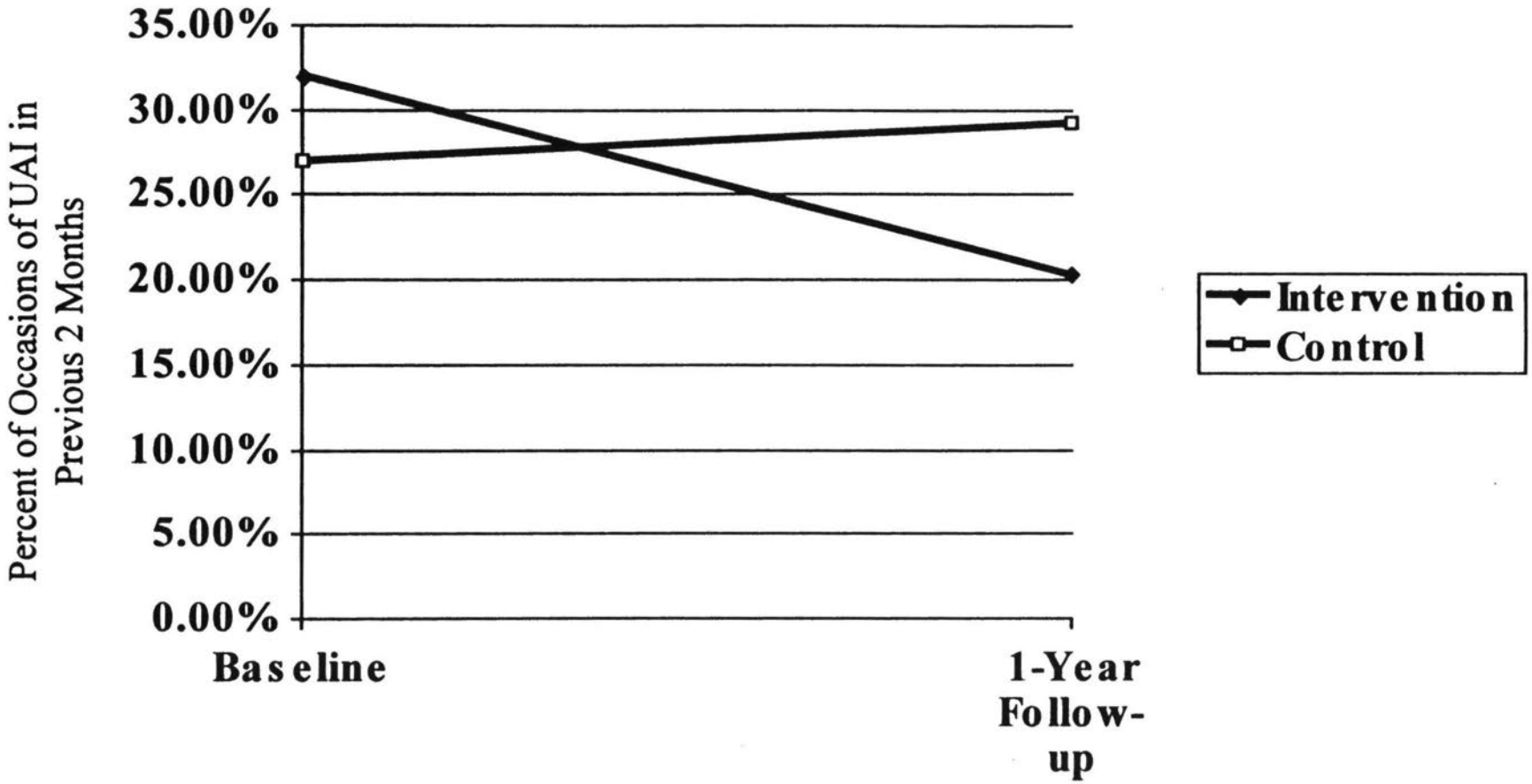
HIV + / Both	21%
HIV - / Both	41%
Discordant	67%
Never Tested	25%

39% had primary partners

Prevention Strategies That Work

1. Access To:
2. Counseling and Educational Strategies
3. Institution-Based Strategies
   - Schools
   - Prisons
   - Bars

Change in Population Risk Behavior from Baseline to 1-year Follow-up



Kelly et. al 1997

School Based Programs Face Daunting Challenges

- Many factors encourage unsafe sex

  -- hormones
  -- emotional and physical needs
  -- risk taking
  -- ambivalence about pregnancy
  -- peer pressure
  -- sex as portrayed in the media

- Short educational programs cannot impact all of these forces alone

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Abstinence Only Programs?

- Abstinence until marriage
- Little discussion of contraception or
- Contraceptive failure to provide complete protection against pregnancy and STDs

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Five Published Studies

None found a consistent and significant impact in ...

- delaying the onset of intercourse
- one study found that they did not delay onset of intercourse

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Sex and HIV Education Programs

- Discuss both condoms and other methods of contraception
- To protect against STDs and pregnancy
- Wide range of programs

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Sex and HIV Education Programs

- Strongly support the conclusion that sexuality and HIV education do not increase sexual intercourse by

  ⇨ hastening the onset of intercourse
  ⇨ increasing the frequency of intercourse
  ⇨ increasing the number of sexual partners

- Based on 16 well controlled studies

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Sex and HIV Education Programs

- Some of these programs increased condom use or contraception use

- "Be A Responsible Teen" (St. Lawrence et al)

  delayed onset of intercourse, reduced frequency of intercourse, reduced number of partners, and increased use of condoms

- "Be Proud, Be Responsible" (Jemmott, Jemmott)

  reduced number of sexual partners, frequency of sex, and frequency of sex without condoms

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Sex and HIV Education Programs

- "Focus on Kids" (Stanton et al)
  increased condom use

- "Get Real About AIDS" (Main et al)
  reduced number of sexual partners increased condom use

- "Reducing the Risk" (Kirby et al)
  delayed onset of intercourse

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Sex and HIV Education Programs

- "Safer choices" (Coyle et al)
  increased condom use

- "Young African-American Women" (DiClemente et al)
  increased condom use

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Characteristics of Effective Programs

1. Focused clearly on one reducing one or more behaviors that lead to HIV/STD or pregnancy

   --narrow range of behaviors
   --did not address other issues such as gender roles, dating or parenthood
   --clear message: directed toward convincing students about goal

2. Appropriate to age, sexual experience, and culture

   --younger youth: focus on delaying intercourse
   --high school students: avoid unprotected intercourse
   --college students: avoid high risk situations, use condoms
   --from Kirby

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Characteristics of Effective Programs

3. Based on theoretical approaches demonstrated effective in influencing other health risk behaviors

   --social cognitive theory
   --social inoculation theory
   --social influence theory
   --theory of reasoned action

   --go beyond cognitive and focus on social influences, changing individual values, changing group norms, and building assertiveness skills

4. Lasted a sufficient length of time

   --10 or more hours
   --or fewer hours, but small group settings
   --from Kirby

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Characteristics of Effective Programs

5. Employed a variety of teaching methods to involve the participants and personalize the information

   --active learning methods
   --experiential classroom and homework activities
   --small groups, games, simulations
   --brainstorming, role-playing
   --written rehearsal
   --verbal feedback,coaching
   --field trips to locate condoms in drug stores
   --visiting family clinics
   --interviewing parents
   --peer educators, videos

6. Basic accurate information about the risks of intercourse without condoms and methods of avoiding it

   --just the basic facts

--from Kirby

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Characteristics of Effective Programs

7. Included activities to address social pressures on sexual behaviors

    --situations leading to sex
    --lines used to get others to have sex
    --social barriers to using condoms
    --how to overcome those barriers

8. Provided modeling and practice of communication, negotiation, and refusal skills

9. Selected teachers or peers who believed in the program they were implementing and provided adequate training for them

--from Kirby

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Prevention Strategies That Work

1. Access To:
2. Counseling and Educational Strategies
3. Institution-Based Strategies
4. Media-Based Strategies
   - Condom Social Marketing

Prevention Strategies That Work

1. Access To:
2. Counseling and Educational Strategies
3. Institution-Based Strategies
4. Media-Based Strategies
5. Community-Level Strategies
   - Young Gay Men

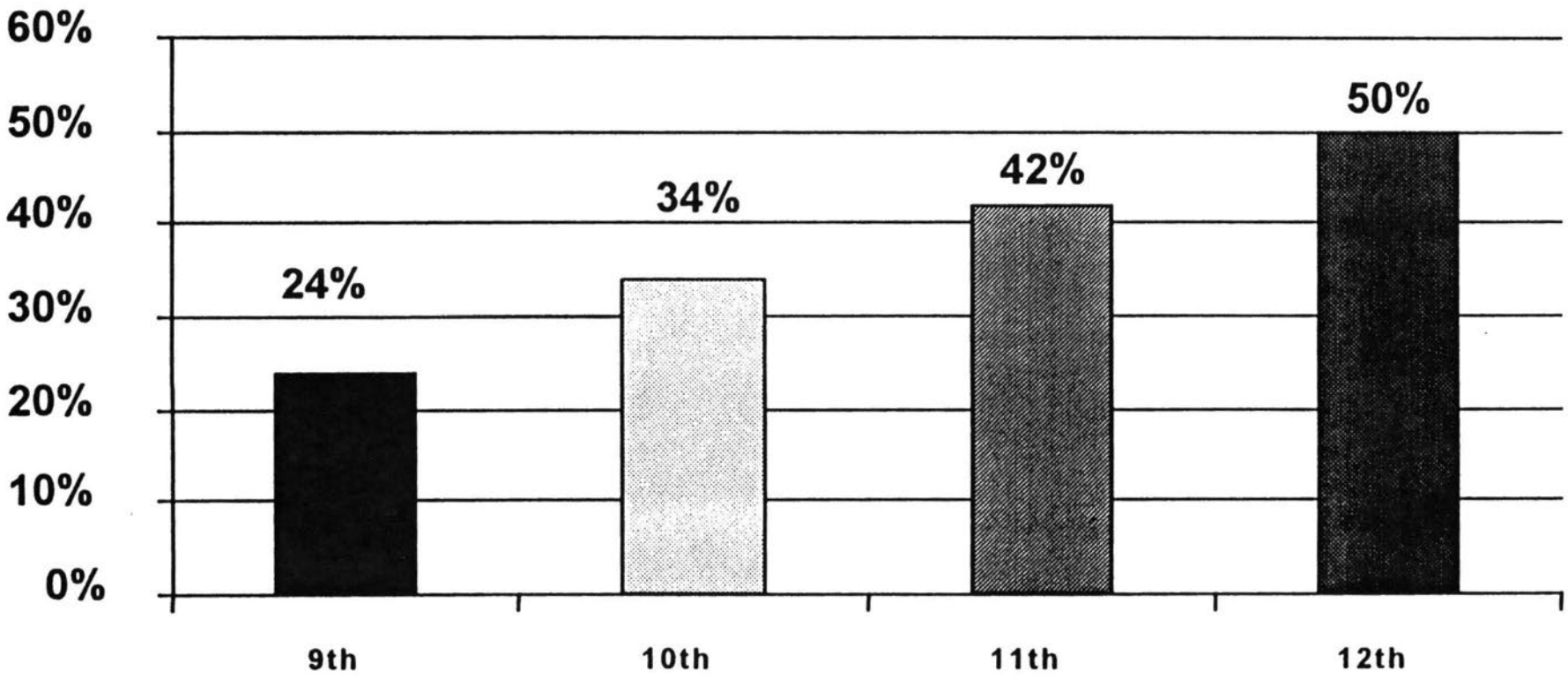
Prevention Strategies That Work

1. Access To:
2. Counseling and Educational Strategies
3. Institution-Based Strategies
4. Media-Based Strategies
5. Community-Level Strategies
6. Medical Strategies
   - Treatment of Sexually Transmitted Infections
   - Drug Treatment
   - Antiretroviral Therapy to Reduce Vertical Transmission (?)
   - Antiretroviral Therapy to Reduce Sexual Transmission

1995 Youth Risk Behavior Surveillance System

- **CDC**
- **Representative sample of 10,904 high school students**
- **Grades 9-12**

Percentage of High School students who were Currently Sexually Active* by Grade



* Sexual intercourse during the 3 months preceding the survey.

1995 National Youth Risk Behavior Survey

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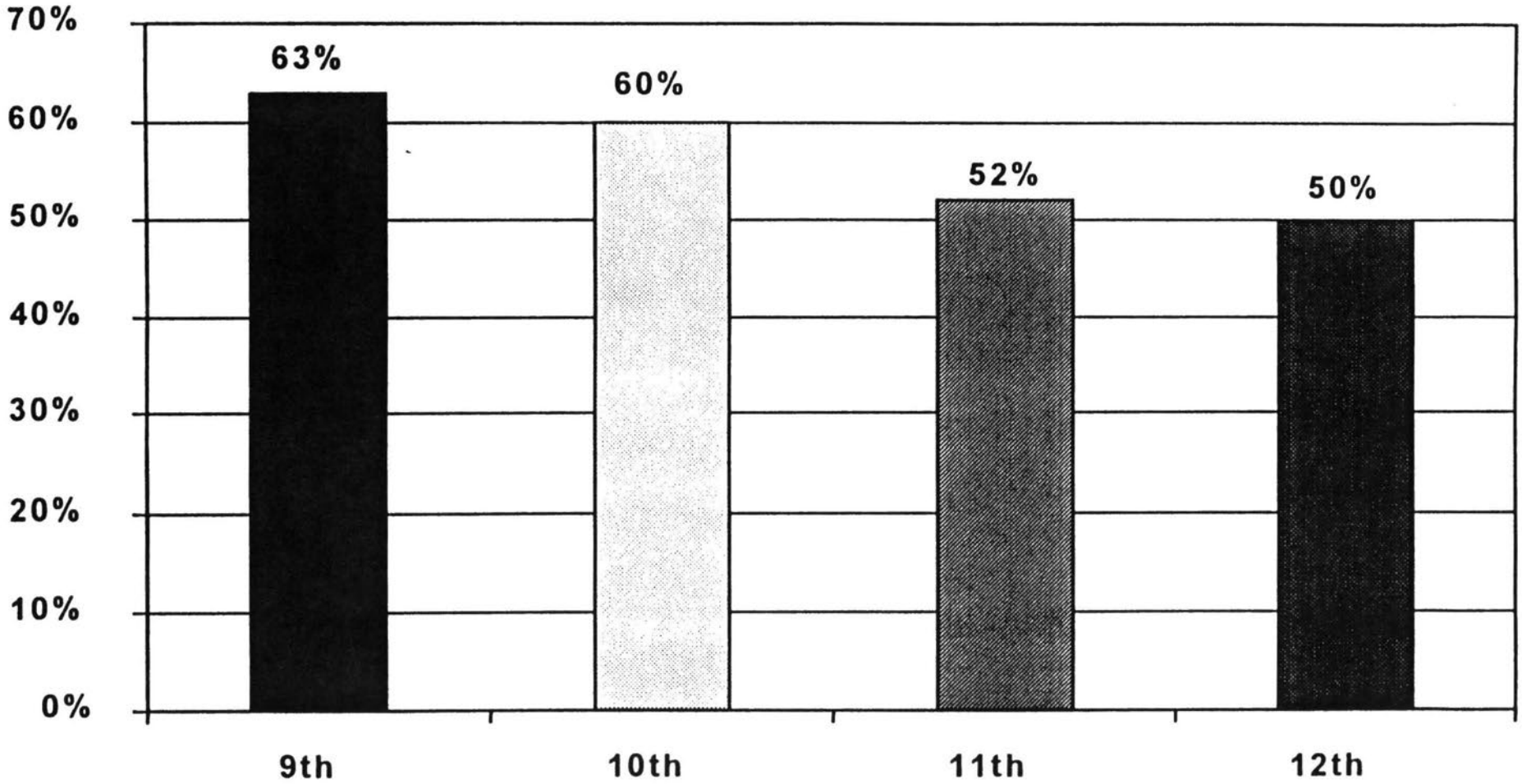
Percentage Of High School Students Who Used A Condom During Last Sexual Intercourse, * by Grade



* Among currently sexually active students.

1995 National Youth Risk Behavior Survey

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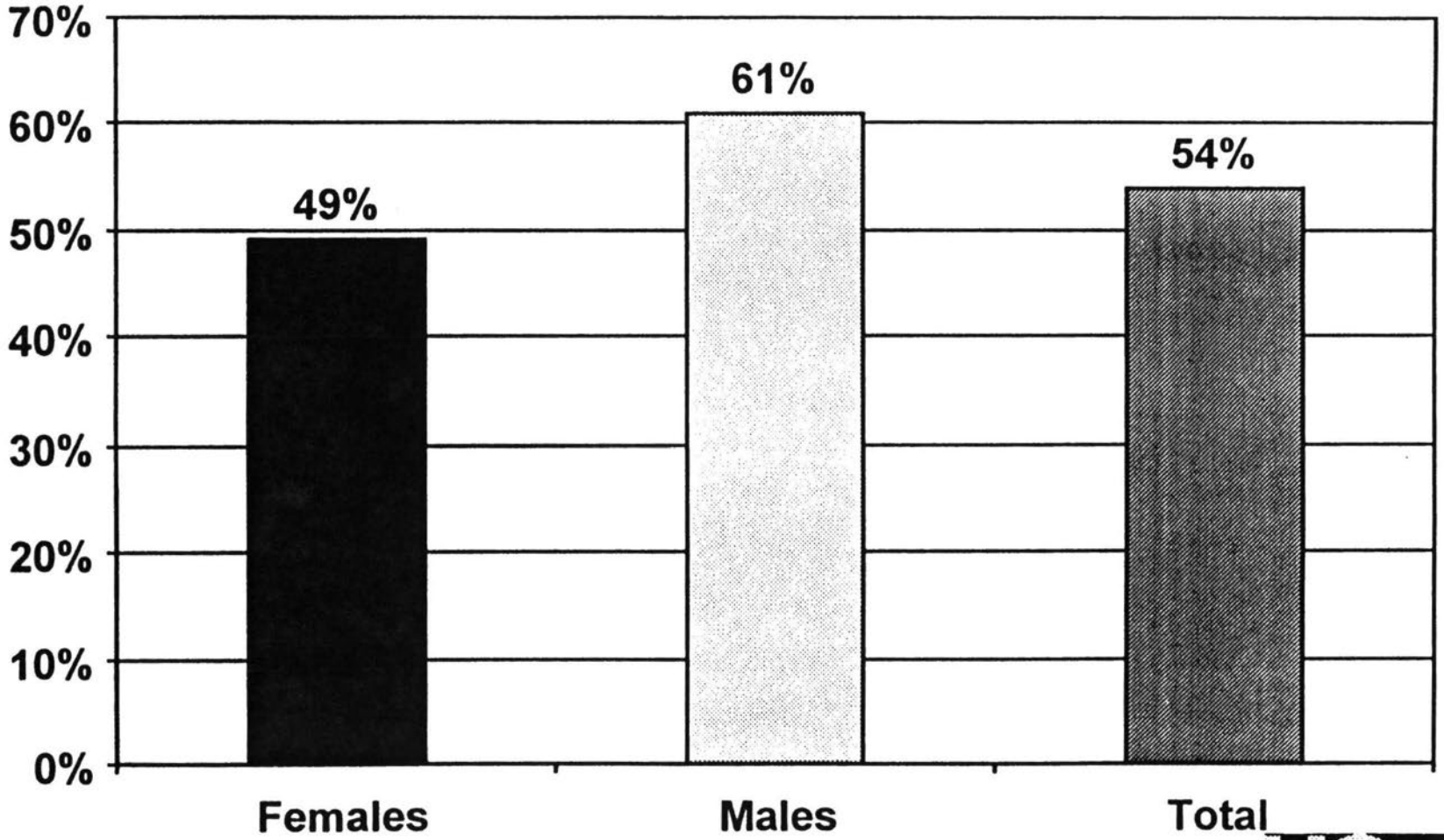
Percentage of High School Students who used a Condom During Last Sexual Intercourse, * by Sex



* Among currently sexually active students.

1995 National Youth Risk Behavior Survey

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REMEMBER

-- *ADOLESCENTS ARE SEXUAL*

-- *PATHOGENS ARE PERVASIVE*

-- *UNWANTED PREGNANCY OCCURS ALL TOO OFTEN*

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Essential Components of a Comprehensive STD/HIV Prevention Program

1. Participatory community planning

2. Surveillance to know where the problems are

3. STD counseling, testing, treatment, referral, and partner services

4. Individual level health education, risk reduction, and skills building

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Essential Components of a Comprehensive STD/HIV Prevention Program

5. Community level interventions to change norms, attitudes, and practices through social marketing, community outreach, and mobilization

6. Public information programs to dispel myths and transmit facts

7. STD prevention and treatment capacity building

9. Evaluation and research

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1995 National Survey of Family Growth

- 10,847 Women
- 15-44 years old

1995 National Survey of Family Growth

- **Proportion reporting sexual intercourse ever, decreased in the 1990's**
- **Marked increase in condom use (first intercourse and current)**
  - **3.6 million in 1982**
  - **5.1 million in 1988**
  - **7.9 million in 1995**

1995 National Survey of Family Growth

- 8% report 1st intercourse is involuntary
- 20% report forced intercourse
- 10% of birth unwanted (12% in 1984-88)

1995 National Survey of Family Growth

Condom use at first intercourse

- All women 29%
- year: 1990-1995 - 54%

  1985-1989 - 36%

  1980-1984 - 25%

1995 National Survey of Family Growth

Condom use at first intercourse

- all women 54%
- Hispanic 38%
- White 60%
- Black 50%

Challenges for the Future

1. Maintenance Over the Long Haul

Challenges for the Future

1. Maintenance Over the Long Haul
2. Targeting Unreached Populations

Challenges for the Future

1. Maintenance Over the Long Haul
2. Targeting Unreached Populations
3. HIV Prevention in the Era of Combination Therapy and Hope for Vaccines

Challenges for the Future

1. Maintenance Over the Long Haul
2. Targeting Unreached Populations
3. HIV Prevention in the Era of Combination Therapy and Hope for Vaccines
4. Young People, Especially Young Women

Challenges for the Future

1. Maintenance Over the Long Haul
2. Targeting Unreached Populations
3. HIV Prevention in the Era of Combination Therapy and Hope for Vaccines
4. Young People, Especially Young Women
5. Women in Stable Relationships

Challenges for the Future

6. Alcohol and HIV Transmission

Alcohol and Drug Use at Last Sexual Intercourse

- 24.8% of currently sexually active students reported that they used alcohol or drugs at last sexual intercourse.

- Male students (32.8%) were significantly more likely than female students (16.8%) to report that they used alcohol or drugs at last sexual intercourse.

Challenges for the Future

6. Alcohol and HIV Transmission

7. Sexually Transmitted Clinic Attendees

Challenges for the Future

6. Alcohol and HIV Transmission

7. Sexually Transmitted Clinic Attendees

8. Advocacy to Change Public Policy

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001. statement	re: HIV Prevention [Personally Identifiable Information] [partial] (1 page)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19425

FOLDER TITLE:
Conferences - 9/1998

2018-0764-F
jm2692

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P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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HIV Prevention:
A 10-Point Program to Protect the Next Generation

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Acknowledgments

Preparation of this manuscript was supported in part by NIMH Grant No. MH42459 (Center for AIDS Prevention Studies), by a grant from the Henry J. Kaiser Jr. Family Foundation entitled "HIV Prevention: Looking Back, Looking Ahead," and by a grant from SmithKline Beecham Pharmaceuticals.

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That HIV is spreading rapidly throughout the world can be attributed to two problems: strategies proven to be effective have not been implemented because of political opposition, and the resources dedicated to prevention efforts have been inadequate to address the problem sufficiently. Everyone is waiting for the "magic bullet"-the vaccine. An effective vaccine will save many lives. But the entire developed world spends only $600m annually on HIV in the entire developing world. That is as much as we spend in the US alone. Increasing the budget to $2.5b (1% of the US defense budget) would save innumerable lives. HIV prevention science is at a highly advanced stage. We now need to use it.

The Epidemic of HIV In The US Is Unnecessary

The Centers for Disease Control and Prevention (CDC) estimate that 40,000 new HIV infections occur annually in the U.S. (Holmberg, 1996). Most of these infections are avoidable because evaluations from several developed and developing countries have demonstrated unequivocally that epidemics of HIV can be avoided and also can be turned around once they appear to be out of control. The US has lacked the political will to implement strategies known to be effective in managing the epidemic (see Coates , Aggleton, Gutzwiller, et al, 1996). Australia and New Zealand contained the spread of HIV through quick implementation of sound prevention practices. Australia reported 5833 cases of AIDS (72% or 4196 deceased) to the end of March, 1995 (National Centre, 1995). The number of new HIV infections among men who have sex with men decreased from a peak of 2,284 in 1987 to 772 in 1994 and New Zealand reported 511 cases of AIDS to the end of September, 1995 with sharply declining rates since 1992 (Sharples, Dickson, Paul & Skegg, 1996). About 80% of new infections and cases in both countries have occurred through homosexual contact. Neither Australia nor New Zealand experienced an HIV epidemic among injection drug users (IDUs). The strategies for accomplishing this were not complicated, but relied on close and continuing collaboration between affected communities and public health officials, treatment for drug and alcohol abuse

on demand, and pragmatic harm reduction strategies to insure that HIV would spread as little as possible.

HIV Prevention Among All At-Risk Populations Requires Multiple Levels of Intervention

HIV transmission is caused, as with most heath problems, by processes at the individual and societal levels. We conceptualize HIV prevention of six levels of influence (Tables 1 and 2) and present examples of effective strategies at every level.

Insert Tables 1 and 2 about here

The **Individual Level** helps individuals to change by providing knowledge, or altering beliefs, attitudes, perceived norms, motivations, skills, or biological states related to high risk activities. Interventions at the individual level attempt to change intra-psychic factors such as knowledge, skills, and motivations to use both. Interventions at the individual level also assist individuals in reducing use of drugs related to high risk activities. Examples abound of individual and small-group strategies aimed at modifying individual level variables to modify sexual and injection behaviors to reduce HIV transmission (Kelly et al, 1992; Rotheram-Borus et al, 1991; Jemmott, Jemmott, & Fong, 1992; DiClemente & Wingood, 1995). These studies have demonstrated the impact of such interventions on self-reported behavior, but evaluations demonstrating reductions in incident infections are few and far between.

Project Respect (see Kamb et al, 1996) is a multi-center randomized controlled trial evaluating HIV prevention counseling in increasing condom use and reducing STD (including HIV) incidence conducted at 5 STD clinics. HIV-negative heterosexual participants were randomly assigned to 1 of 3 face-to-face interventions: HIV education (2 sessions with brief HIV/STD prevention messages; HIV Prevention Counseling (2 sessions aimed at increasing risk perception using specific, achievable steps toward behavior change; and Enhanced Counseling (4 sessions based on theoretical constructs of behavior change also using small steps). A total of

5872 patients were enrolled; 3340 men and 2532 women. Follow-up was 70% at 3 and 6 months and 65% at 9 and 12 months. Through the 6-month follow-up, participants in both counseling arms had a reduced risk of a new STD (enhanced counseling vs. control, RR=0.80, p=.003; HIV prevention counseling vs. control, RR=0.84, p=0.02). The two counseling conditions did not differ from each other. Reported condom use increased in all intervention arms although the enhanced counseling has the highest condom use at each follow-up.

An intervention study conducted recently among commercial sex workers in India demonstrates both the potential and the limits of individual-level interventions. Bhave et al (1995) developed an innovative intervention to reduce new infections among commercials sex workers in the red light areas of Bombay (Bhave et al, 1995). The brothels contain 100-150 women, and the women are virtually captive once they are sold into prostitution. Their access to medical care is limited. Two relatively comparable houses were chosen in which to conduct an evaluation of the intervention using a quasi-experimental design. The quasi-experimental design was chosen in this case because an design using randomization of individuals would have been subject to contamination across treatment conditions. The intervention consisted of a six-month program using educational videos, small group discussions, and pictorial educational methods to address theoretically based variables, found through focus groups and baseline interviews, to be related to high risk-behavior. Three hundred thirty-four commercial sex workers received the experimental intervention and 207 commercial sex workers received the control intervention. The one-year seroconversion rates in the intervention vs. the control group (all $p<.01$) were 6% vs. 15% for HIV, 8% vs. 21% for syphilis, and 4% vs. 11% for hepatitis B surface antigen (all *ps*<.01). Certainly, the seroconversion rates in the intervention group were dramatically below that of the control group, but no one could be satisfied as long as 6% of any group was still seroconverting to HIV.

The **Dyadic/Familial Level** refers to interpersonal processes occurring between two individuals likely to have sexual intercourse or to share injection equipment. This level also refers to familial interactions likely to affect the course of HIV transmission. An example would

be parent/child communication about sexuality. Interventions at this level attempt to influence the couple or the family.

The need for interventions focused on couples comes from a variety of findings. Catania et al (1992, 1995), in the National AIDS Behavioral Surveys, found that women were more likely than men to have risky sexual partners, especially if the women were from their own income strata. Women, relative to men, were more likely to be in risky partnerships (i.e., where the partner injected drugs or had other male or female sex partners) where condoms were not being used. A total of 64% of the women with a risky partner were in cities where the prevalence of HIV is high. Women in these relationships may feel powerless to influence the risk behavior of their partners or to insist on protective actions that would prevent HIV transmission. A community-level intervention focused on young gay men (see Kegeles et al, 1996) was successful in reducing the proportion of men who engaged in unprotected anal intercourse with casual partners, but not in the percent of men reporting unprotected anal intercourse with boyfriends. Clearly, it is essential to focus on risk reduction in intimate relationships, and dyadic approaches may be essential for this process.

We are aware of few attempts to intervene at the dyadic level. One study carried out in Rwanda among a cohort of child-bearing women showed that while the prevalence of HIV infection was 32%, it was 25% among the majority of women who reported only one lifetime partner. Women exposed to HIV counseling and testing showed increases in reported condom use (Allen et al, 1992). Only 7% of the women had used condoms before the study and after one year of follow-up, 16% of HIV- and 35% of HIV+ women reported using condoms. Among a subsample of women whose partners volunteered to be tested, condom use rates were even higher (23% and 55% among HIV- and HIV+ women respectively). HIV seroconversion rates decreased to 1.8 per 100/py of observation in HIV- women whose partners were tested, but remained at 3.4 per 100/py among women whose partners were not tested. In another analysis of this study, marked increases in reported condom use were noted among discordant couples (57% of discordant couples were using condoms at the 1-year follow-up. Intensive and repeated

counseling also led to large increases in reported condom use (from less than 5% ever use to 71% regular use) and abstinence (from 0 to 28%) among couples found to be discordant in a research project in Zaire. We recently confirmed these findings in a multicenter randomized controlled study in three developing countries (Kenya, Tanzania, and Trinidad),

Interventions at the **Institutional/Community Level** attempt to modify social norms, influence social networks, resources and opportunities, and barriers to preventive practices in the community. Examples of change strategies include peer outreach, diffusion of innovation, community mobilization, mass media, condom marketing, and syringe exchange. Outreach and community mobilization strategies have been used effectively to reduce HIV risk among gay and bisexual men. Kelly et al (1992) demonstrated the impact of social influence intervention in small communities in the US. Population-wide surveys were conducted of all men patronizing gay clubs in each city to establish risk behavior base rates. After a small cadre of popular "trendsetters" were identified, they received training in approaches for peer education and then contracted to communicate risk reduction recommendations and endorsements to friends. Surveys were repeated at regular intervals in all cities, with the same intervention introduced in all cities in a lagged fashion. The interventions consistently produced systematic reductions in the population's high risk behavior (unprotected anal intercourse of 15% to 29% from baseline levels), with the same pattern of effects sequentially replicated in all three cities.

Kegeles et al (1996) developed and implemented a community-level HIV prevention program in mid-sized communities. The peer-led program had three components: outreach, small groups, and a publicity campaign. Independent from the prevention program, a cohort of young gay men was surveyed in this and in a similar comparison community pre- and post-intervention. Following the intervention, the proportion of men engaging in any unprotected anal intercourse decreased from 41% to 30%, from 20% to 11% with non-primary partners, and from 59% to 45% with boyfriends. No significant changes occurred in the comparison community over the same period. These data demonstrate the efficacy of a community-based prevention approach which is embedded into social activities and community life.

Interventions at the **Policy/Legal Level** attempt to influence laws and policies. Examples from other fields of disease prevention have documented the potency of changes at this level. Taxing cigarettes to reduce consumption, outlawing smoking in workplaces, requiring helments for motorcycle riders, fluoridating water to reduce cavities, and increasing penalties for driving while under the influence of alcohol have all had documentable and important impacts on risk behaviors and disease prevention.

Examples of changes at this level include widespread advertisement of condoms, laws allowing syringe and needle acquisitions, laws regulating commercial sex work, laws and policies regarding HIV testing and counseling, and laws outlawing discrimination on the basis of HIV disease. Change strategies include positive policies regarding condom advertisements, over the counter sales of syringes, and medical care for persons with HIV. Evaluations of syringe exchanges in the US and abroad provide an example of an environmental strategy dependent upon structural level changes. Syringe exchange is a strategy to increase access to sterile needles and syringes and thereby reduce the need for individuals to re-use or share contaminated needles and syringes (Lurie et al, 1993). Unfortunately, syringe exchanges in the US have run afoul of political issues, thier implementation has not been endorsed by the Federal government and has often been blocked in the courts. The cost in lives lost is enormous (Lurie & Drucker, 1997). This is in stark contrast to the governments of Europe and Australia where harm reduction approaches were embraced with predictable beneficial effects.

Connecticut recently changed its laws regarding syringe sales and possession, with dramatic effect (Groseclose et al, 1995; Valleroy et al, 1995). In July 1992, pharmacists were permitted to sell and individuals were permitted to possess up to 10 syringes without medical prescriptions. Groseclose et al (1995) conducted two serial-cross sectional surveys with IDUs recruited in drug-treatment centers, correctional facilities, and health department settings before and after the enactment of these laws. Among IDUs who reported ever sharing a syringe, syringe-sharing decreased after the new laws (52% before vs 31% after; $p=0.02$). Fewer IDUs reported purchasing syringes on the street after the new laws (74% before vs 28% after; $p<.0001$)

and more IDUs reported purchasing syringes from a pharmacy after the new laws (19% before vs 78% after; $p<.0001$). Needlestick injury rates after the new laws among Hartford police officers were lower after the new laws (6 per 1007 drug-related arrests before vs 2 per 1032 arrests afterwards).

Diaz et al (in press) analyzed data from an interview survey of 11, 757 patients 18 years of age or older with HIV or AIDS between June 1990 and August 1995 in 12 state or city health departments in the US (Arizona, Delaware, New Mexico, South Carolina, Los Angeles, Washington State, Atlanta, Connecticut, Denver, Detroit, Florida, and Jersey City). A total of 1525 persons had ever shared syringes and reported injecting in the past 5 years and 784 (51%) had injected in the year before the interview and of these 389 (49%) had shared during that year. The only statistically significant time trend was that the proportion of IDUs who shared decreased from 71% in 1992 to 15% in 1995. This trend appeared to be related to the 1992 changes in Connecticut laws which allowed purchase and possession of syringes without a prescription.

Interventions at the **Superstructural Level** attempt to identify and change deep and pervasive attitudes and structures in society which facilitate HIV transmission. Examples include sex phobia, homophobia, racism, acceptance of social and economic inequality, and sexism (see Lurie, Hintzen & Lowe, 1995; O'Reilly & Piot, 1996). Change strategies at the superstructural level include social movements, changes in constitutions governing countries (the fact that the Constitution of South Africa outlaws discrimination based on sexual orientation is important), legislative changes, and revolutions. Such changes take a long time and their modification is not easy; nonetheless, consideration of possibilities should be undertaken in a comprehensive HIV prevention strategy. Clearly, HIV prevention for women will require considerable effort at this level to insure better educational and occupational opportunities for women and to insure legal protections and power in society.[1]

[1]An example identified recently is a manual detailing the rights of women under Islam entitled "Claiming Our Rights: A Manual for Women's Human Rights Education in Muslim Societies." The manual contains instructions for conducting grass roots discussions and interpretations of the Koran, along with texts of major international agreements on human rights, particularly women's rights, which many Muslim nations

Scientific Breakthroughs in Pathogensis and Drug Discovery Require that HIV Prevention Be Reconceptualized

HIV prevention can also be accomplished through **Medical and Technological Interventions (see Tables 1, 2, and 3).** New technological and medical advances provide both hope and challenges.

Treatment of HIV Disease. It has been observed recently that triple combination therapy for HIV (with nucleoside analogs and protease inhibitors) can reduce circulating HIV in the blood to non-detectable levels (Carpenter, Fischl, Hammer et al, 1996). These findings offer great hope to HIV-infected individuals; both quantity and quality of life should be increased as a result (Feinberg, 1996). How this will affect HIV prevention is unknown. Certainly, people with HIV infection will be living longer; programs will need to be created to attend to their special needs to maintain low risk behaviors over a long period of time. It is also possible that effective treatment of HIV might reduce the potential for transmission through sharing of injecting equipment or through sexual intercourse.

Counseling and Testing. Counseling and testing has been an important mainstay of HIV prevention and is essential for getting infected individuals into care (Coates et al, 1990; Higgins et al, 1991). An important means to reduce HIV transmission in this country has been through routine HIV testing of blood donations; only 12 to 14 infectious donations are available annually of a total of 12 million donations (ref--NEJM). Advances in treatment for HIV as well as advances in testing technology (rapid tests, more accurate tests, home testing, tests of circulating virus before formation of antibodies), true home testing (Merson, Feldman, Bayer & Stryker, 1997) requires advancing the science of testing as well as practices and policies surrounding it. While there has been much discussion of the potential psychological consequences of HIV, most studies document the fact that most individuals cope with the results and do not experience long-term psychological consequences (Phillips & Coates, 1995). The social consequences, however,

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have signed. The objective is to stimulate a women's movement and gradual cultural change. *NY Times*, December 29, 1996, page 5.

can be devastating and merit more discussion and strategies to protect HIV infected individuals, especially women, against abuse and other negative effects (Van der Stratten et al, 1996).

Sexually Transmitted Diseases. STDs have long been implicated as a co-factor for HIV transmission (Adler, 1996). Such diseases are a major public health problem in most developing countries, and are endemic in certain parts of the US. In fact, the US has the highest rates of STDs of any developed country (Eng & Butler, 1996). A recent randomized clinical trial demonstrated the efficacy of aggressive syndromic treatment of STDs in reducing HIV transmission by 40% in rural Tanzania (Grosskurth, Mosha, Todd et al, 1995). Strategies are needed both for primary prevention of STDs (such as Project Respect, see Kamb et al, 1996) and for early diagnosis and treatment of STDs in order to reduce HIV transmission.

Vertical Transmission. Over 1.5 million children worldwide have been infected with HIV through maternal-child transmission. ACTG076 demonstrated that treatment with zidovudine before, during, and after delivery (to mother and infant) reduced vertical transmission by over 60% (Connor, Sperlling, Gelber et al, 1994). Following the release of these results, the CDC in collaboration with the National Institute of Health (NIH) and HRSA drafted guidelines to promote routine and universal HIV counseling and voluntary testing for all pregnant women and AZT therapy for HIV-infected pregnant women and their babies. These efforts have dramatically reduced AIDS cases in children. The incidence of perinatally acquired AIDS peaked in 1992; cases began to decline in 1993 and dropped dramatically in 1994 (by 8% from 1993) and 1995 (by 17% from 1995). Thus the number of perinatally acquired AIDS peaked at 905 during 1992 and was 663 in 1995 (CDC, 1996b). Studies are now underway to determine if triple combination therapy reduces chances of infection even further, and if other regimens that are simpler to administer and perhaps carry less danger to the fetus might be just as effective. Other strategies for reducing maternal-child transmission can involve effective family planning and contraceptive counseling for HIV-infected mothers (Allen, Serufilira, Gruber et al, 1993; King, Estey, Allen et al, 1995), reduction of unprotected intercourse (presumably from an HIV-infected partner) before, during, and after pregnancy (Bulterys, Chao, Dushimimana et al, 1993;

Matheson, Thomas, Abrams et al, 1996) and Cesarean delivery (Kuhn, Bobat, Coutsoudis et al, 1996).

Vaccines. The NIH has declared development of an effective vaccine against HIV-1 to be one of its highest priorities (Cohen, 1996); certainly control of infectious disease epidemics usually do not occur until an inexpensive, effective, and easily administered vaccine is available. HIV offers special challenges, not the least of which is its ability to mutate rapidly leading to high genetic diversity (Hu, Dondero, Rayfield et al, 1996). The scientific challenges in vaccine development are considerable but the social and behavioral challenges may be more so. It is unlikely that vaccines will be able to eradicate HIV in high prevalence areas unless they are combined with considerable risk behavior reduction (Blower & McLean, 1994). If risk behavior increases as a result of a vaccination campaign, then vaccination could have a perverse outcome by increasing the severity of the epidemic.

HIV Prevention Among Women Needs To Become the Highest Priority

Women are especially vulnerable to HIV and neglected at the same time. AIDS incidence among women has increased steadily since 1983; women now account for 19% of AIDS cases (CDC, 1996b). While women do not comprise a majority of AIDS cases in the US, they do in developing countries (Cohen & Trussell, 1996). All of the previous 9 points of this paper must be applied to HIV prevention among women (see also Ehrhardt, Exner & Seal, 1995):

- Women need interventions that are targeted to their special needs and that take into account their multiple roles;
- Interventions at all levels need to be developed including those at the individual level (to increase knowledge, skills, and motivations), at the dyadic level (to provide strategies for developing safety within relationships), the community level, the policy/legal level (to develop laws and legal systems which protect the rights of women and which also increase women's equality in society), and the superstructural level (to overcome economic and social barriers to women's rights);

- Medical and technological strategies need to assist women in treating their own HIV disease (apart from the need to prevent vertical transmission), to provide women-controlled HIV prevention technologies, to insure diagnosis and treatment of STDs, and to assist women in making decisions about counseling and testing, family planning, and treatment for HIV;
- Strategies for reaching young women are essential, as the age of infection among women tends to be lower than the average of infection among men (Cohen & Trussell, 1996);
- Reform of drug policy, especially as it relates to access to treatment and harm minimization, are essential as the vast majority of heterosexual transmission in the US occurs from IDUs to their sexual partners;
- Strategies targeted at communities of color in the US and developing countries are essential, as this is where the majority of new HIV infections among women are occurring;
- Social movements to increase educational and occupational equality and opportunities and to reduce legal discrimination and provide equal protection for women.

Progress Requires Emphasizing Only Important Research

HIV may continue to spread but not because of lack of know-how. Prevention science and practice have yielded strategies which can, if applied, decrease new HIV infections (see Coates et al, 1996b; Stryker et al, 1995). The challenges of HIV prevention have been enormous. HIV prevention research began in an extremely unfriendly era. Social and behavioral science research were deemed of little value and received few resources in the 1980's. Sexual behavior research had all but been stopped; remember that early estimates of the potential for the spread of HIV had to rely on Kinsey's statistics from the 1940's and 1950's. Drug abuse research was dominated by treatment and interdiction; harm reduction approaches took a long time to gain credence and to receive funding support. HIV prevention research has provided proven strategies for reducing high risk behaviors and HIV transmission.

Major advances have been made in the first 16 years of the HIV epidemic in identifying pathogenic mechanisms, in diagnosing and treating opportunistic infections, in developing therapies that have expand the quantity and increased the quality of life of infected individuals, and in developing effective prevention strategies. While some, especially in the popular media, have heralded the recent advances as the end of the epidemic, others have acknowledged that the advances are important and useful but perhaps only signal "...the end of the beginning of the epidemic." Current scientific progress only points the way to the possible; the remaining tasks are numerous and daunting.

TABLE 1

Levels of Causation and Change
Determinants of HIV Transmission

Level	Definition	Examples
Individual	how environment is experienced and acted upon by individuals; individual biological states	knowledge, risk perception self-efficacy, levels of intoxication, biological determinants of sexual behavior etc.
Dyadic/Familial	how couples interact and negotiate sexual and needle sharing behavior; how families communicate regarding sexual behavior	implicit and explicit "rules" governing power and sexual relations
Institutional/Community	social norms, resources, and opportunities, disease prevalence	access to condoms, needles, health care behavior and norms of peers
Policy/Legal	laws and policies	paraphernalia laws, discriminatory practices, inheritance laws, laws and policies regarding confidentiality
Superstructural	social and economic structures; widely held and pervasive societal customs and attitudes	social and economic restraints on women
Medical /Technological	medical treatment	drug, STD, mental illness, antenatal, and HIV treatment; and testing of blood donations; virucides and spermicides

Adapted from Sweat and Dennison, 1995.

TABLE 2

Levels of Causation and Change
Change Mechanisms with Intervention Examples

Level	Change Mechanism	Examples
Individual	educational, motivational appeals, skills-building, counseling	individual or small group strategies; drug and alcohol treatment
Dyadic/Familial	skills-building, couples counseling w or w/o testing	couples counseling and testing, family skills training
Institutional/Community	community organization and mobilization, condom marketing and distribution, syringe distribution, access to care	peer outreach, community mobilization, condom marketing and distribution, syringe exchange, drug and alcohol treatment on demand
Policy/Legal	legislation and policy reform	legislating syringe exchange and anti-discrimination, anonymous testing, movements and laws
Supertructural	social movements, revolution	anti-poverty programs, anti-discrimination programs, education opportunity programs
Medical/Technological	treatment can reduce or the likelihood of engaging in high risk behavior	drug treatment, STD treatment, antenatal care, virucides and microbicides

Adapted from Sweat and Dennison, 1995.

Table 3

Technologies and Treatment Can Reduce HIV Transmission

1. **Routine HIV testing of the blood supply**
2. **More accessible HIV counseling and testing**
3. **Treatment of HIV using Triple Combination Therapy (?)**
4. **Treatment of sexually transmitted diseases**
5. **Antiviral treatment pre- and post-partum to reduce vertical transmission**
6. **Treatment of Drug and Alcohol Abuse**
7. **Treatment of Mental Illness**

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Behavioral and Social Approaches to Prevent STDs in Adolescents

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STDs, including HIV, are preventable diseases. We know how these diseases are transmitted. Such knowledge is a critical component in our defense against these diseases, but as we all sadly know, such knowledge is not sufficient protection and does not equal prevention for individuals or for populations. Many personal, social, and health problems in the world would be averted if individuals and societies were able to translate knowledge into action.

STDs are simultaneously diseases and phenomena. When viewed as diseases, it is not hard to wonder why knowledge and personal responsibility are not sufficient to prevent their spread. After all, people will want to avoid harm to themselves and will certainly want to avoid hurting others. When viewed as phenomena, STDs point to many things that are wrong with the societies in which they occur. They point to our failure to prepare young people either to delay sexual intercourse or to use condoms, and our reluctance to admit to and accept sexual diversity, to identify people with STDs and treat them, to manage complex health and social problems responsibly, to deal with difficult issues such as gender and racial inequality, and to care about improving the conditions of poor people and the poor countries of the world.

This perspective recognizes that STDs are caused, as are most heath problems, by processes not only at the individual but also at societal levels. Sweat and Dennison (1995) identified four levels of causation and we have added a fifth. This expanded model conceptualizes personal and social processes influencing behavior and offers a starting point for considering strategies at various levels for reducing transmission of STDs, including HIV infection. Each level refers to specific determinants of risky behavior, as well as to a variety of strategies for changing high-risk behavior.

The five levels of causation and change are: (1) The Individual; (2) Dyadic/Familial; (3) Environmental; (4) Legal/Policy; and (5) Superstructural. Table 1 presents hypothesized mechanisms of action, while Table 2 presents potential change strategies.

We address each of these levels in turn, discuss psychological and social processes at each level, and provide examples of interventions appropriate to that level.

Tables 1 and 2 go about here

INDIVIDUALS

The Individual Level works on the individual by interventions that provide knowledge, or attempt to alter beliefs, attitudes, perceived norms, motivation, skills, or biological states related to high-risk activities thereby altering intrapsychic factors. Interventions at the individual level also attempt to assist individuals in reducing high-risk activities. Examples abound of individual and small-group strategies aimed at modifying individual level variables to modify high-risk sexual and injection behaviors to reduce HIV transmission.

An intervention study conducted recently among commercial sex workers in India demonstrates both the potential and the limits of individual level interventions. Strictly speaking, this study did not focus on adolescents, but it demonstrates that interventions at the individual level are necessary but probably not sufficient to provide protection to significant portions of the population.

HIV is spreading rapidly in India, with high rates of infection among female commercial sex workers. Bhave et al., (1995) developed an innovative intervention to reduce new infections among commercial sex workers in the red light areas of Bombay. Prostitution in India is illegal. The brothels contain 100-150 women, and the women are virtually captive once they are sold into prostitution. Their access to medical care is limited. Two relatively comparable houses were chosen in which to conduct an evaluation of the intervention using a quasi-experimental design. The quasi-experimental design was chosen in this case because a design using randomization of individuals would have been subject to contamination across treatment conditions. The intervention consisted of a six-month program using educational videos, small group discussions, and pictorial educational methods to address theoretically important or relevant variables, found through focus groups and baseline interviews, to be related to high-risk behavior. Three hundred thirty-four commercial sex workers received the experimental intervention and 207 commercial sex workers received the control intervention. The results were remarkable: The one-year seroconversion rates in the intervention versus the control group were 6% versus 15% for HIV, 8% versus 21% for syphilis, and 4% versus 11% for hepatitis B surface antigen (all $p<.01$).

Certainly, the seroconversion rates in the intervention group were dramatically below that of the control group, but no one can be satisfied as long as 6% of any group was still seroconverting.

Interventions at the dyadic/familial level attempt to modify pressure and support for condom use with the couple and family. Interventions at this level also refer to the family unit and the ways in which the family unit can facilitate health enhancing behaviors.

We are aware of few studies (none among adolescents although the need is obvious) conducted with couples as the unit of intervention and analysis. The need is obvious both from studies in the US and abroad. Even though adolescent romantic/intimate relationships are often of short duration, it is well established that risk increases as the relationship persists. Data from the National AIDS Behavioral Surveys show that a minority of individuals who report sex with multiple partners in the previous year use condoms with primary partners 50% or more of the time. The rates are only slightly higher for condom use with secondary partners. Couples counseling, perhaps combined with counseling and testing, is one viable approach to a dyadic level intervention. One study carried out in Rwanda among a cohort of child-bearing women showed that while the prevalence of HIV infection was 32%, it was 25% among the majority of women who reported only one lifetime partner. Women exposed to HIV counseling and testing showed increases in reported condom use (Allen et al., 1992). Only 7% of the women had used condoms before the study and after one year of follow-up, 16% of HIV- and 35% of HIV+ women reported using condoms. Among a subsample of women whose partners volunteered to be tested, condom use rates were even higher (23% and 55% among HIV- and HIV+ women, respectively). HIV seroconversion rates decreased to 1.8 per 100/py of observation in HIV- women whose partners were tested, but not in the women whose partners were not tested. In another analysis of this study, marked increases in reported condom use were noted among discordant couples (57% of discordant couples were using condoms at the 1-year follow-up). Intensive and repeated counseling also led to large increases in reported condom use (from less than 5% ever use to 71% regular use) and abstinence (from 0 to 28%) among couples found to be discordant in a research project in Zaire. Based on these promising findings, AIDSCAP/Family Health International and the UNAIDS program, in collaboration with the Center for AIDS Prevention Studies at UCSF are currently conducting a randomized clinical trial in four countries (Tanzania, Kenya,

Trinidad, Indonesia) to determine the impact of counseling and testing on both couples and individuals (see De Zoysa et al., 1995).

Interventions at the Environmental Level attempt to modify social norms, resources, opportunities, and barriers to preventive practices in the community. Examples of change strategies include peer education outreach activities, community define, mass media, condom marketing, syringe exchange, and drug, STD, and HIV treatment. Condom social marketing involves strategies for improving the distribution of condoms, the accessibility of condoms (through competitive pricing and alternative outlets), and for increasing the desirability of condoms through aggressive social marketing. Condom social marketing has been an essential component of HIV preventive interventions for developing countries, and their success highlights one situation in which controlled trials are not necessary to demonstrate efficacy.

Interventions at the Legal and Policy levels aim to discourage or encourage (with penalty or benefit provided by laws, regulations and incentives) risk behaviors or preventive activities. Examples from other fields of disease prevention have documented the potency of changes at this level. Taxing cigarettes to reduce consumption, outlawing smoking in workplaces, requiring head protection for motorcycle riders, fluoridating water to reduce cavities, reduction of insurance premiums for non-smokers, and increasing penalties for driving while under the influence of alcohol have all had documentable and important impact on risk behaviors and disease prevention.

Examples of legal/policy level changes include widespread advertisement of condoms (including venues likely to reach adolescents), laws regarding providing HIV education in schools, practice of prevention in adolescent medicine, or school clinics, etc.

Finally, interventions at the Superstrucural Level attempt to identify and change socioeconomic and cultural systems and structures which facilitate STD/HIV transmission. Examples include sex phobia, homophobia, racism, acceptance of social and economic inequality, and sexism. Change strategies at the superstructural level include social movements, changes in constitutions of governments (e.g., the Constitution of South Africa outlaws discrimination based on sexual orientation, legislative changes, and revolutions. Such changes take a long time and their modification is not easy; nonetheless, consideration of possibilities should be undertaken in a comprehensive HIV prevention strategy.

Programs Aimed at the Level of the Individual

School-Based Programs *[Insert Kirby Modifications Here]*

Sex, STD and HIV education programs have been implemented in a variety of settings. The most common setting for programs for school-aged youth is, of course, schools. After all, an estimated 98% of young people between the ages of 5 and 17 are enrolled in schools (Office of National AIDS Policy, 1996), and schools are designed to provide information to young people.

Table 3 goes about here

Table 3 provides general conclusions from this body of work. Before examining the impact of these programs, two considerations should be recognized. First, these programs face a daunting challenge. A large number of forces encourage youth to engage in sexual activity, including sex without use of male condoms, e.g., changing hormones, emotional and physical needs and desires, desires to be adult and to take risks, ambivalence about becoming pregnant or having a child, peer pressures, and the omnipresent inaccurate portrayal of sex in the media. Thus, it may not be reasonable to expect that relatively short educational programs can overcome all these other factors and have a very dramatic impact upon sexual risk-taking behavior.

Second, it should be remembered that most kinds of educational instruction are evaluated by assessing the impact of instruction upon knowledge, not upon behavior outside of school. For example, history or civics classes are not evaluated by measuring their impact upon voting, breaking fewer laws or becoming better citizens more generally. In contrast, when researchers evaluate the impact of sex or HIV instruction upon sexual or contraceptive behavior, they use change of sexual or contraceptive behavior as the outcome measures, not information about same. Nevertheless, because of the need to identify programs that reduce sexual risk-taking behavior, these criteria are standard outcomes in research studies and in this review.

There are close to 50 published studies which have used experimental or quasi-experimental designs to examine the behavioral impact of curriculum-based school and community education programs designed specifically to reduce sexual risk-taking behavior among young adults. For statistical reasons, it was difficult, if not impossible, for most of these studies to measure the impact of programs upon actual HIV rates or other STD rates. However, it was possible to measure the impact upon behaviors which are logically related to HIV and STD rates: age of initiation of intercourse, frequency of sexual activity, number of sexual partners, and condom use.

Abstinence-Only Programs. Abstinence-only programs focus upon the importance of abstinence from sexual intercourse, typically abstinence until marriage. Either these programs do not discuss contraception or they briefly discuss contraceptive failure to provide complete protection against pregnancy and STDs. Typically, these programs are implemented in middle school or the first years of high school. Despite these common qualities, abstinence-only programs are quite heterogeneous, varying in terms of their values (postponing sex versus abstinence until marriage), their length (five sessions versus two years), and the number and type of components (instruction versus other kinds of youth activities).

Five published studies have measured the impact of abstinence programs upon the initiation of sex (Christopher and Roosa, 1990; Jorgensen, Potts and Camp, 1993; Kirby et al., 1995; Roosa and Christopher, 1990; St. Pierre et al., 1995). None found both a consistent and significant impact upon delaying the onset of intercourse, and at least one study provided strong evidence that the program did not delay the onset of intercourse. This last study evaluated a program entitled "Postponing Sexual Involvement", a five-session curriculum which was implemented among thousands of middle school youth in California (Kirby et al., 1995). Despite a rigorous evaluation design and large sample sizes, that study found that the curriculum did not affect the initiation of intercourse, the frequency of sex, the number of sexual partners, use of condoms or use of other forms of contraception. Similarly, the other five studies also failed to find a significant impact upon behavior. However, all of them had important methodological limitations that could have obscured program impact.

Thus, given the heterogeneity of abstinence-only programs and the limitations of existing studies, it is not currently known whether abstinence-only programs delay the onset of intercourse.

Sex and HIV Education Programs. These programs differ from the abstinence programs in that they discuss both condoms and other methods of contraception as methods of providing protection against STDs or pregnancy. This group includes a wide variety of programs, ranging from sex or AIDS education programs taught on high school or university campuses to programs taught in homeless shelters and detention centers. They reflect the considerable creativity and differing perspectives of these agencies.

The studies of these programs strongly support the conclusion that sexuality and HIV education curricula do not increase sexual intercourse, either by hastening the onset of intercourse, increasing the frequency of intercourse, or increasing the number of sexual partners. Of the 16 evaluations of middle school, high school, or community sexuality or HIV education programs that measured the impact of the programs upon the initiation of intercourse, none found that their respective programs significantly hastened the onset of intercourse (Eisen, Zellman & McAlister, 1990; Ekstrand et al., 1996; Howard and McCabe, 1990; Jemmott, Jemmott & Fong, 1992; Kipke, Boyer and Hein, 1993; Kirby, 1984; Kirby et al., 1991; Kirby et al., 1997; Levy et al., 1995; Main et

al., 1994; Nicholson & Postrado, 1991; St. Lawrence et al., 1995; Thomas et al., 1992; Walter & Vaughn, 1993; Warren and King, 1994). Similarly, none of the 11 studies which examined the impact of programs upon the frequency of intercourse found a significant increase (Howard & McCabe, 1990; Jemmott, Jemmott & Fong, 1992; Kirby, 1985; Kirby et al., 1991; Kirby et al., 1997; Levy et al., 1995; Main et al., 1994; Moberg and Piper, 1990; Smith, 1994; St. Lawrence et al., 1995; Walker & Vilella-Velez, 1992), and none of the seven studies that examined impact upon number of sexual partners found a significant increase (Jemmott, Jemmott & Fong, 1992; Kipke, Boyer & Hein, 1993; Kirby et al., 1997; Levy et al., 1995; Main et al., 1994; St. Lawrence et al., 1995; Walter & Vaughn, 1993). Thus, these data clearly demonstrate that sex and HIV education programs do not significantly increase sexual activity as some people have feared. Furthermore, studies indicate that some, but not all, sex or HIV/AIDS education programs reduced sexual risk-taking behavior, either by delaying the onset of intercourse, reducing the frequency of intercourse, or reducing the number of sexual partners.

These studies suggest that some, but not all, of the programs increased condom use or contraceptive use more generally. Four of the eight studies that examined program impact upon condom use found that the programs did increase some measure of condom use (Jemmott, Jemmott, & Fong, 1992; Kipke, Boyer & Hein, 1993; Kirby et al., 1997; Levy et al., 1995; Main et al., 1994; St. Lawrence et al., 1995; Walter & Vaughn, 1993; Warren and King, 1994). Similarly, four of the ten studies that examined program impact upon the use of contraception more generally found significant positive results (Eisen, Zellman & McAlister, 1990; Howard & McCabe, 1990; Kirby, 1984; Kirby et al., 1991; Kirby et al., 1997; Nicholson & Postrado, 1991; Schinke et al., 1981; Smith, 1994; Thomas et al., 1992; Walker and Vilella-Velez, 1992). In combination, these results are quite positive, indicating that some sex and HIV education programs can significantly increase condom or contraceptive use, while other programs do not.

There are at least seven sex or HIV education programs which have particularly strong evidence indicating positive change in behavior. They include "Be a Responsible Teen" which delayed the onset of intercourse, reduced the frequency of intercourse and the number of sexual partners, and increased use of condoms (St. Lawrence et al., 1995); "Be Proud, Be Responsible" which reduced the number of sexual partners, the frequency of sex and the frequency of sex without condoms (Jemmott, Jemmott, Fong, 1992); "Focus on Kids" which increased condom use (Stanton et al., 1996); "Get Real about AIDS" which reduced the number of sexual partners and increased condom use (Main et al., 1994); "Reducing the Risk" which delayed the onset of intercourse (Kirby et al., 1991); and "Safer Choices" which increased condom use and decreased the frequency of unprotected sex school wide (Coyle et al, 1997). In addition to these five curricula for teenagers, evaluations of two college HIV prevention programs have provided credible evidence that they reduced unprotected sex by increasing condom use (Basen-Engquist, 1994; Fisher et al., 1996), and an evaluation of a community program for young African-American women provided evidence that it increased condom use (DiClemente & Wingood, 1995). The common characteristics of these programs are discussed further below.

School Condom-Availability Programs

Given the threat of AIDS, as well as the threat of other STDs and pregnancy, more than 400 schools in the United States have begun making condoms available through school

counselors, nurses, teachers, vending machines, or baskets (Kirby and Brown, 1996). The number of condoms obtained by students from schools varies greatly from program to program; in some schools students obtain very few condoms from the school, while in other schools, they obtain large numbers (Kirby & Brown, 1996). In general, students in smaller alternative schools obtain many more condoms per student than students in larger schools or students in mainstream schools. In addition, when schools make condoms available in baskets (a barrier free method), students obtain many more condoms than when they must obtain condoms from school personnel. Finally, if schools have health centers, students obtain many more condoms than when schools do not have these centers.

Thus far, three studies have presented results on the effects upon behavior of school condom availability. The first study evaluated the effects of making condoms available through vending machines in five Seattle schools without school-based clinics and through vending machines and baskets in five additional Seattle schools with pre-existing school-based clinics. Survey data were collected from school-wide samples of students both before condoms were made available and again two years later and after condoms were made available. In neither group of schools did either sexual activity or use of condoms during last intercourse increase (Kirby et al., 1997). Notably, these schools had a strong educational intervention, but because it existed prior to the baseline data collection, the effect of the educational component was not measured.

The second study evaluated the New York HIV prevention program. The school district implemented a comprehensive AIDS prevention program in the city high schools. It included additional instruction about AIDS, school-wide activities, and condom availability. Analyses comparing students in New York schools with a matched sample from Chicago schools revealed that students in the New York schools were not more likely to have initiated intercourse, but were more likely to have used a condom the last time they had sex. These results were encouraging, but it is not known whether the difference between the two groups of students was due to the HIV education program, to condom availability specifically, or to other differences between the students or their communities (Guttmacher et al., 1997).

A third study measured the impact of making condoms available in baskets in nine Philadelphia schools (Furstenberg et al., 1997). Students in those schools could receive reproductive health information, condoms and general health referrals. Both before and after the centers were opened, youths were randomly selected for personal interviews from census tracts surrounding these nine schools and other comparison schools. Results revealed that in the schools with centers, changes over time in four measures of sexual behavior or condom use were not significantly different from the changes over time in the schools without centers. However, the authors noted that there were non-significant differences in the trends over time in the desired directions (i.e., students in schools with centers reduced their sexual activity and increased their condom use more than students in schools without centers). Relatively small samples may have limited the ability to detect programmatically meaningful results.

School-Based Health Centers

School-based health centers are clinics located on schools and offer services to students in their respective schools. All of these clinics provide basic primary health care services; some of them dispense contraceptives. When school-based clinics are

well staffed and well run and dispense condoms and other contraceptives, they have many of the characteristics of ideal reproductive health programs. School-based clinics do provide condoms or other forms of contraception to substantial percentages of sexually experienced youth. For example, in a study of four clinics that provided prescriptions or actually dispensed contraceptives, the proportion of sexually experienced females who obtained contraceptives through the clinic varied from 23% to 40% (Kirby, Waszak & Ziegler, 1991).

Six studies have examined the impact of these health centers (Edwards, et al., 1980; Kirby, Waszak and Ziegler, 1991; Kirby et al., 1993; Kisker, Brown and Hill, 1994; Newcomer and Duggan, 1996; Zabin et al., 1988). Four of these studies examined programs in three or more schools. The outcomes they measured and their quasi-experimental designs varied considerably. In general, the quasi-experimental designs were not strong. Consequently, inferences should be drawn cautiously from these studies. In addition, these studies measured population effects. That is, they measured the effects upon the entire school population and not just upon those students who actually used the clinics for family planning services.

Although the results of different studies did vary, in general, the weight of the evidence from these studies indicates that providing condoms and other forms of contraception through school-based clinics did not significantly hasten the onset of intercourse, increase the frequency of intercourse, increase use of condoms, increase use of other forms of contraception, or decrease pregnancy rates or birth rates. Instead, there was a large substitution effect. That is, students who obtained condoms or other forms of contraception from the clinics would have obtained them elsewhere had the clinics not provided contraception.

In sum, these data on school-based clinics, in combination with the data on school-condom availability programs, suggest that simply reducing barriers to condoms by making them available in more convenient locations, or making them free of charge, does not significantly increase their use.

Interventions for Adolescents in High-Risk Settings

A substantial proportion of adolescents engage in STD/HIV-associated risk behaviors and initiate sexual activity at earlier developmental periods (Aral & Holmes, 1990). Adolescents, however, are not a homogeneous population. Of particular concern are adolescents seeking health care at adolescent-designated clinics, other clinical treatment settings (obstetrics clinic, STD clinic, family health center, drug treatment clinics) or other youth-serving agencies (e.g., runaway and homeless shelters and youth detention facilities). These youth often have a markedly higher prevalence of sexual and drug-related risk behaviors and are, therefore, at greater risk of STD/HIV infection.

Clinical settings and youth-serving agencies represent opportunity sites for accessing high-risk youth and implementing behavior change interventions as one component of a multicomponent STD/HIV strategy (Darrow & Siegel, 1990). In particular, clinical interactions provide an opportunity to assess the adolescents' sexual and drug risk behaviors, evaluate their physical and psychological maturation and implement developmentally-appropriate STD/HIV intervention programs designed to promote the adoption and maintenance of preventive practices (DiClemente & Brown, 1994). There are, however, surprisingly few STD/HIV prevention interventions evaluated in clinical environments.

An overarching assessment of clinic-based STD/HIV prevention interventions may be misleading. Reviewing the literature has identified a clear delineation separating programs that are more efficacious from those that are less efficacious based on the design characteristics of these programs (D'Angelo & DiClemente, 1996; Wingood & DiClemente, 1996; Choi & Coates, 1994; Kalichman, Carey & Johnson, 1996; Fisher & Fisher, 1992; Stanton et al., 1996). Specifically, non-theoretic interventions are less likely to demonstrate programmatic efficacy and, of those non-theoretic programs that report efficacy, they are more likely to have observed smaller programmatic effects, relative to interventions that are derived from and based on well-developed psychosocial theories of behavior and behavior change.

Differentiating Non-theoretic from Theory-based Interventions. Non-theory-based behavior change interventions are characterized by brief, usually single-session treatments, commonly administered by clinic staff. These interventions focus, to a large extent, on communicating STD/HIV preventive knowledge about risk and protective behaviors using didactic strategies such as individual counseling or video presentations. In general, non-theoretic interventions are designed and implemented

into the clinical environment. Therefore, non-theoretic interventions mirror, more closely, standard clinical practice and conform to the time constraints inherent in clinical settings.

Theory-based interventions, on the other hand, usually use multi-component approaches for modifying risk behaviors. These interventions, in general, are often group-based and focus not only on didactic or counseling intervention strategies, but on other interactive learning techniques that emphasize social competency and technical competency skills training, focus on modifying perceived peer normative beliefs, enhancing individuals self-efficacy to perform newly learned behaviors and creating a social environment supportive and reinforcing new behavior patterns. To accomplish this broader range of activities, these interventions are often administered by trained health educators and usually require multiple intervention exposures.

Non-theoretic interventions: An illustrative study. An example of a non-theoretic clinical intervention is that conducted by Mansfield and her colleagues (1993). This study evaluated the effects of physician's assessment of adolescent's risk behaviors and counseling about HIV risks and prevention in an inner-city hospital-based adolescent clinic. Ninety adolescents (mean age 17.6 years) seeking care were randomly assigned to one of two groups: a standard care group in which physicians interviewed adolescents about high-risk behaviors related to HIV disease and a counseling group in which physicians provided discussion of HIV risks and prevention. At follow-up approximately two months after baseline assessments and randomization, 32% and 18%, respectively, of the standard care and counseling group reported less sexual activity. Consistent use of condoms also significantly increased among adolescents in both groups; standard care. Use of condoms at last intercourse increased in the counseling group from 37% to 42% ($p=.03$). Overall, while STD/HIV-

preventive behavioral changes were reported for both treatment conditions, there was no clear advantage for the counseling condition relative to standard care condition.

Social Cognitive Theory: the predominant theoretic model underlying skills-based clinical STD/HIV intervention programs. Social Cognitive Theory (SCT) has been widely used to guide the development and implementation of clinic-based STD/HIV behavior change interventions as well as a host of interventions targeting other risk populations and intervention venues (Bandura, 1994). Social Cognitive Theory is a social psychological theory that examines social, environmental and behavioral influences on an individual's behavior. Social Cognitive Theory emphasizes observation, modeling, behavioral rehearsal, outcome expectancies, self-efficacy beliefs and social reinforcement as critical constructs associated with the adoption of preventive behaviors. While Social Cognitive Theory is a complex theory with many constructs, STD/HIV prevention interventions generally target four interactive determinants of behavior: (1) knowledge (provision of accurate information to enhance awareness and knowledge of risks associated with specific risk-producing and risk-reduction practices); (2) skills (development of social and technical competency skills and behavioral self-management techniques); (3) self efficacy (enhanced sense of self-efficacy, that is, the confidence to utilize newly learned risk-reduction skills in risky situations) and, (4) support (creating social supports and reinforcements to facilitate the adoption and maintenance of STD/HIV-preventive behaviors). Thus, Social Cognitive Theory integrates information, attitudinal change to enhance motivation, development and reinforcement of risk-reduction behavioral skills and self-efficacy as necessary components for achieving successful adoption of preventive practices.

Theory-based STD/HIV prevention programs: An illustrative study. Theory-based STD/HIV prevention interventions, in general, are more effective at promoting the

adoption and maintenance of risk-reduction practices; particularly condom use during sexual intercourse. One exemplary theory-based intervention focused on reducing sexual risk behaviors among single, pregnant young women (Hobfoll et al., 1994). Women ranged in age from 16-29 years, with a mean age of 21, the majority of whom were either African-American or Caucasian, recruited from inner-city obstetrics clinics. Women were randomly assigned to one of three intervention conditions: (1) a four-session risk-reduction condition (n=68) based on Social Cognitive Theory and the Theory of Conservation of Resources; (2) a health promotion condition (n=77); and (3) a control condition (n=61). Women randomized to the four-session intervention received education, assertiveness skills, negotiation skills, planning skills and relapse prevention skills. Peer leaders used role play exercises to enhance participant's proficiency to utilize these newly learned skills, create positive expectations of success, develop problem-solving strategies and enhance their sense of vulnerability to infection. Results indicate that women in the theory-based skills training condition, compared to those in the control condition, over a six-month follow-up period, had significantly higher scores for safer sex knowledge ($P<.05$), engaged in more discussions with sex partners about HIV ($P<.05$), were more likely to purchase condoms ($P<.05$) and, most important, increased spermicide and condom use ($P<.05$).

STD/HIV prevention for adolescents accessing youth-serving agencies. Another opportunity site for implementing STD/HIV prevention interventions that access high-risk and hard-to-reach adolescents is at youth-serving agencies such as homeless shelters and juvenile detention facilities. Adolescents entering these sites usually have a higher prevalence of STD/HIV-associated sexual and drug-related risk behaviors and higher rates of STDs and HIV infection relative to other adolescent subgroups. While these sites clearly represent logical prevention venues, there are few studies evaluating behavior change interventions in these settings, even fewer than in clinical settings.

An exemplary STD/HIV prevention intervention was conducted by Rotheram-Borus and her associates with high-risk runaway and homeless adolescents (1991; 1994). Over a two-year period (from 1988 to 1990), consecutive recruitment of adolescents at two residential shelters in New York City (one designated the nonintervention site and the other the intervention site) resulted in 79 and 188 runaways available for enrollment in the program at the intervention and nonintervention sites, respectively. After attrition, the final sample was comprised of 78 adolescents in the intervention condition and 67 adolescents in the nonintervention condition.

Runaways participating in the risk-reduction program were exposed to a multiple session intervention administered by skilled trainers. The program addressed the following: general knowledge about HIV/AIDS, coping skills, access to health care and other resources, and individual barriers to use of male condoms and other safer sex practices. General HIV knowledge was addressed by having adolescents participate in video and art workshops and view commercial AIDS/HIV commercial videos. Coping skills training addressed runaways' (unrealistic) expectations regarding emotional and behavioral responses in high-risk situations. Additional medical and mental health care and other resources were made available to address specific individual health concerns. Individual barriers to adopting and maintaining safer sex practices were reviewed in private counseling sessions. Participants in the nonintervention condition were exposed to individual counseling from staff; but this counseling did not specifically address HIV prevention. Condoms were available and staff members discussed condom use, on an unsystematic basis.

Runaways in the risk-reduction program demonstrated a significant and dramatic increase in consistent condom use and less frequently reported engaging in a high-risk

pattern of HIV-associated behaviors over six months. A high-risk pattern of sexual behavior was defined as consistent condom use occurring in fewer than 50% of sexual encounters, 10 or more sexual encounters, and/or three or more sexual partners. A greater proportion of adolescents (22%) in the control group reported this high-risk pattern of sexual behavior compared to those adolescents (9%) who received between 10 and 14 intervention sessions and those (0%) who received 15 or more intervention sessions. Reports of consistent condom use increased from about 32% of runaways at initiation of the project to 62% six months after receiving more than 15 intervention sessions. A two-year follow-up of the same sample continued to show significant reductions in risk acts among those who received the intervention.

STD/HIV prevention for incarcerated adolescents. Only one study has evaluated an intensive STD/HIV prevention program for incarcerated male adolescent drug users (Magura, Kang and Shapiro, 1994). In this study, adolescents 16-19 years of age, received either a group-oriented HIV prevention program based on Problem-Solving Therapy or served as wait-list controls because they were discharged or transferred before they could be offered the intervention. The intervention was administered by a male counselor in a small group format consisting of twice-weekly, one-hour sessions focusing on health education issues relevant to male adolescent drug users, with emphasis on HIV.

Behavioral outcomes were assessed at five-month follow-up after release from the detention facility through personal interviews. Statistical analyses, adjusting for baseline scores, showed that adolescents participating in the prevention intervention, compared to the wait-list control group, were significantly more likely to increase their use of condoms during vaginal and anal intercourse (P=.02 and P=.04; respectively),

to demonstrate increased positive attitudes towards acceptability of condom use (P=.05) and decrease high-risk sexual partnerships (P=.06).

State of the science for reducing STD/HIV behaviors among high-risk adolescents. The findings corroborate existing research which indicates that, in general, behavioral interventions that are theory-driven, emphasize motivational factors, provide skills training and attempt to modify peer norms are more effective at promoting the adoption of STD/HIV-preventive behaviors than those which do not incorporate these characteristics (Kalichman, Carey & Johnson, 1996; Kelly & Murphy, 1992; Fisher & Fisher, 1992; Coates, 1990; Choi & Coates, 1994; Wingood & DiClemente; D'Angelo & DiClemente, 1996). The findings from both, prevention intervention studies implemented in clinical settings and from studies implemented in youth-serving agency settings, are promising. Overall, the findings suggest that behavior change, even for high-risk/hard-to-access adolescents, is attainable. Significant reductions in adolescents' risk behaviors over a brief period, usually a six-months, and less often, over an extended follow-up period have been observed. Thus, while much more remains to be learned, these findings are encouraging and suggest key intervention constructs which may enhance the efficacy of the next generation of prevention interventions.

Characteristics of Effective Programs

Effective programs share nine characteristics, which may be linked to their success, while the ineffective programs may lack one or more of these characteristics.

1. *Effective programs focused clearly on reducing one or more sexual behaviors that lead to HIV/STD infection or unintended pregnancy.* There

are two aspects to this characteristic. First, these programs focused narrowly upon a small number of specific behavioral goals, such as delaying the initiation of intercourse or using condoms; relatively little time was spent addressing other sexuality issues, such as gender roles, dating, and parenthood. Second, these programs gave a clear message by continually reinforcing a clear stance on these behaviors. They did not simply lay out the pros and cons of different sexual choices and implicitly let the students decide which was right for them; rather most knowledge, most activities, most values and most skills were directed toward convincing the students that either avoiding sex or using condoms was the right choice.

2. *The behavioral goals, teaching methods, and materials were appropriate to the age, sexual experience, and culture of the students.* For example, programs for younger youth, few of whom had engaged in intercourse, focused upon delaying the onset of intercourse. Programs designed for high school students, some of whom had engaged in intercourse, emphasized that students should avoid unprotected intercourse, either by not having sex or by using male condoms or spermicides if they did have sex. And programs for college students or for higher-risk youth, many of whom were already sexually active, emphasized the importance of using male condoms and avoiding high-risk situations. Some of the curricula, e.g., *Be a Responsible Teen, Be Proud, Be Responsible,* and the program by DiClemente and Wingood were designed for African-Americans and emphasized statistics, values, and approaches that were tailored to them.

3. *Effective programs were based upon theoretical approaches that have been demonstrated to be effective in influencing other health-risk behaviors*, e.g., social cognitive theory (Bandura, 1986), social influence theory (McGuire, 1972), social inoculation theory (Homans, 1965), cognitive behavioral theory (Bandura, 1986; Schinke, 1981a), and the theory of reasoned action (Fishbein & Ajzen, 1975). These theories address many of the individual sexual antecedents of sexual risk-taking behavior that have been identified. These programs strive to go beyond the cognitive level; they focus on recognizing social influences, changing individual values, changing group norms, and building assertiveness skills.

4. *Effective programs lasted a sufficient length of time to adequately complete the activities described below.* Shorter programs appeared to have less effect, while longer programs provided the opportunity to complete more activities and were more effective. Effective programs tended to fall into two categories, those that lasted 10 or more hours, and those that lasted a smaller number of hours, but that implemented the curriculum in small group settings with a leader for each group. This may have enabled them to involve the participants more completely, to tailor the material to each group, and to cover more material and more concerns more quickly in each group.

5. *Effective programs employed a variety of teaching methods designed to involve the participants and have them personalize the information.* Instructors reached participants through active learning methods of instruction, not through didactic instruction. Participants were involved in

numerous experiential classroom and homework activities: small group discussions, games or simulations, brainstorming, role-playing, written rehearsal, verbal feedback and coaching, locating condoms and spermicides in local drugstores, visiting or telephoning family planning clinics, and interviewing parents. In addition to these experiential activities, a few effective curricula used peer educators or videos with characters (either real or acted) who resembled the students and with whom the students could identify. All of these activities helped the participants personalize the information.

6. *Effective programs provided basic, accurate information about the risks of intercourse without condoms and methods of avoiding it.* Although increasing knowledge was not the primary goal of these programs, effective programs provided basic information that students needed to assess risks and sex without condoms. Typically, this information was not unnecessarily detailed or comprehensive. For example, the curricula did not provide detailed information about all methods of contraception or different types of STD. Instead, they emphasized the basic facts needed to make behaviorally relevant decisions.

7. *Effective programs included activities that address social pressures on sexual behaviors.* This took several forms. For example, several curricula discussed situations that might lead to sex. Most of the curricula discussed "lines" that are typically used to get someone to have sex, and some discussed social barriers to using condoms (e.g., embarrassment about buying condoms) and how to overcome those barriers.

8. *Effective programs provided modeling and practice of communication, negotiation, and refusal skills.* Typically, the programs provided information about the skills, modeled effective use of the skills, and then provided some type of skill rehearsal and practice (e.g., verbal role-playing or written practice). There were, however, significant variations in the quality of and amount of time devoted to skill practice.

9. *Effective programs selected teachers or peers who believed in the program they were implementing and then provided training for those individuals.* The training ranged from approximately six hours to three days. In general, the training was designed to give teachers and peers information on the programs as well as practice using the teaching strategies included in the curricula (e.g., conducting role plays, leading group discussions, etc.).

Interventions Aimed At Couples and Families

We are aware of no studies focused on adolescent couples, even though such interventions might be important because of the tendency of adolescents to engage in serial monogamy and to discard use of condoms with increased length of relationships. With regard to families, in the United States, many parents believe, and society more generally believes, that parents should be the primary sex educators of their children (Gordon & Dickman, 1977; Koblinsky & Atkinson, 1982). Even adolescents have expressed the desire for their parents to be their primary educators (Davis & Harris, 1986; Fisher, 1986; Gordon, 1983). The perceived benefits of greater parent-child communication about sex are many. For example, adults (and some professionals in

the field) believe that greater parent-child communication will increase adolescent knowledge about sexuality, cause parents to be more open with their own children, and increase their children's understanding and acceptance of their parents' attitudes and values about sexuality, and that all of these developments, in turn, will delay the adolescent's onset of sexual intercourse and increase their contraceptive use thereafter.

Although there have been improvements in recent years in the United States, parents and their children often feel discomfort discussing sexual topics with each other, and consequently, parents and their children have remarkably few conversations about different sexual topics (Finkel & Finkel, 1975; Fox, 1979; Rothenberg, 1980). In comparison with mothers, fathers are especially unlikely to communicate with their adolescent children about sex (Jaccard & Dittus, 1993; Noller & Callan, 1990; Nolin & Peterson, 1992; Miller et al., 1995, Russo, 1991; Weis et al., 1974). To alleviate this problem of too little parent/child communication, many short educational programs have been designed to increase parent/child communication about sexual topics. These include programs for parents only, programs for parents and their children together, homework assignments in classroom sex education classes requiring communication with parents, and video programs with written materials to be completed in the home. With remarkable consistency, studies of these programs indicate that in the short term, these programs do increase parent/child communication about sex and comfort with that communication (Carton & Carton, 1971; Goodman & Goodman, 1976; Hambrick, 1985; Kirby, 1984). One program attempted to reach parents in their homes through video materials and increased knowledge and family problem-solving skills (Winett et al., 1992). However, the positive effects of all of these programs dissipated with time, typically within six months.

While parent-child communication is important, it may not in and of itself lead to adolescents' use of contraceptives or other protection during intercourse. Most studies have found no relationship between parent/child communication and either initiation of sexual intercourse or use of contraception (Casper, 1990; Fisher, 1993; Furstenberg et al., 1984; Kasnter, 1984; Newcomer & Udry, 1985), a few have found that greater parent/child communication was associated with earlier onset of intercourse (Galvotti & Lovick, 1989; Miller et al., 1987) and a few studies have found that greater parent/child communication was associated with either later onset of intercourse (Leland & Barth, 1993; Furstenberg, 1976) or greater use of contraception (Casper, 1990). At best there are complex relationships indicating that greater parent/child communication has a positive effect upon sexual or contraceptive behavior among only certain groups of parents and children. For example, if the mother does the communicating, if the mother holds conservative beliefs regarding teens having sex, if the adolescent is female, and if the communication takes place early enough, then greater parent-child communication may lead to a delay in intercourse (Jaccard, Dittus & Gordon, 1996). This suggests that what matters is not only that communication takes place, but also what kinds of communications take place.

Only two studies have examined the actual effects of these programs upon adolescent sexual behavior. The first of these was implemented by Girls Incorporated (formerly Girls Clubs) and included five two-hour sessions for mothers and their daughters (Nicholson & Postrado, 1991). Although the program group was much less likely to initiate intercourse, the result was not quite statistically significant. The second program included a well-designed video and written materials to be viewed at home (Miller et al., 1993). It also increased parent/child communication, but failed to delay the onset of intercourse, in part, because very few youth in the control group initiated sex in the very

conservative community where the study took place. Clearly, this is an area in need of extensive research and something that should be supported in future work.

Interventions Aimed At the Community

All of the interventions discussed so far in this chapter are designed to reach individuals in certain locations. In a real sense, the people targeted are "captured" audiences. The next sections deal with interventions designed to reach people not included in such settings or large population groups. Table 4 provides general conclusions from this body of work.

Table 4 goes about here

Outreach Projects

Outreach projects are designed to reach those who are not in settings (i.e., schools) where they can be reached easily or those who will not come in to participate in specialized risk reduction interventions, or whose behavioral patterns put them at higher than average risk of exposure to HIV infection. Examples include youth who are runaways, gays and lesbians, incarcerated, or homeless. Outreach projects use several approaches to reach these groups -- small group education/training to train staff or opinion leaders, peer networking, and small media (posters, pamphlets, key chains, tee shirts, etc.). A very successful approach is for specially trained staff or "opinion leaders" to canvas communities to find high-risk youth and then provide them with information and relevant materials (e.g., condoms).

One such approach has been developed by Dr. Jeffrey Kelly and colleagues at the Medical College of Wisconsin (Kelly, St. Lawrence, Diaz, et al., 1991; Kelly, St. Lawrence, Stevenson et al., 1992). The approach involves selection of popular opinion leaders from the relevant target group, who are then specially trained in approaches for peer education, and who then go out and "spread the word" among their peer group. In four 90-minute sessions, the opinion leaders are trained: (1) to correct others' misperceptions concerning AIDS risk, (2) to recommend to peers the strategies needed to implement risk reduction (e.g., keeping condoms nearby if sexually active, avoiding sex when intoxicated, negotiating safety commitment in advance with a potential sexual partner, and assertively refusing unsafe sex coercions), and (3) to personally endorse benefits, importance, and social acceptability of making precautionary behavioral changes. (Kelly et al., 1992, p1484). Each opinion leader is then contracted to have a certain number of conversations with peers. A special logo (traffic light) that appears on a small button worn by the opinion leaders, as well as on posters in strategic locations, aids in stimulating conversations. Thus, the approach incorporates the strategic use of "small media" or "environmental media"(Blair, 1995; Freeborn & Polen, 1995).

Mass Media

The mass media (radio, television, mass mailings, newspapers and magazines) have the potential to reach the whole population or large targeted subpopulations (e.g., gay men, adolescents). Thus, they are an ideal channel for reaching people to: (1) promote or provide information, to increase awareness, improve knowledge, change beliefs and attitudes, and (2) promote and demonstrate desired behaviors, or promote materials (e.g., condoms) that increase the likelihood of the desired behaviors. Much is known about how to use mass media to effectively alter health related knowledge, attitudes, norms and behaviors of whole populations (Backer, Rogers & Sopory, 1992;

Flay, 1987a; Flay & Burton, 1990; McGuire, 1984). First, as with any educational program, the message must be tailored for the target audience, be easily understood by them, and be acceptable to them. This requires extensive focus group research and process evaluation (Flay, 1987b; Worden et al., 1988). Second, the message must reach the target audience. This means using appropriate channels at appropriate times. For example, selected radio stations reach more adolescents than most television (with the possible exception of MTV). However, purchased times during popular television shows can reach adolescents (e.g., Worden et al., 1988). Third, campaigns must motivate interpersonal discussion among the target audience. This is similar to having opinion leaders engage in discussion with peers in the community outreach programs discussed earlier. Such discussion serves an important norm-setting function without which attitudinal or behavioral changes are less likely, and any changes brought about by media messages will not last. Fourth, simultaneous structural or other changes in the social environment are usually necessary for behavior change to occur and be maintained. Such changes may take the form of enhanced availability of condoms, or increased mention of safe sex in news, entertainment and other media outlets.

A few targeted campaigns regarding adolescent STDs or AIDS have been evaluated. Kirby, Harvey, Claussenius & Novar (1989) evaluated a direct mailing campaign. In a strong experimental design, they found improved knowledge, no change in attitudes, and 7% of the intervention group (9% of those who read the pamphlet) ordered condoms (compared to 1% in the control group). A multi-media campaign in Scotland (Hastings, Eadie & Scott, 1990) resulted in improved perceptions about AIDS. Inconsistencies between different phases of the campaign led to some confusion. A campaign by the Dutch Foundation for STDs in the Netherlands (de Vroome, Sandfort,

de Vries, et al., 1991) improved knowledge/beliefs, increased intentions to use condoms, and increased condom use in the 6 months before the posttest survey.

Successful multi-year mass media campaigns have been reported from Switzerland (DuboisArber, Lehmann, Hausser, et al., 1988) and Thailand (Hanenberg, Rojanapithayakorn, Kunasol & Sokal, 1994). The better designed and more comprehensive the campaign, the better the results. The Thailand case also provides an example where simultaneous structural changes included sanctions against commercial sex establishments where condoms were not used consistently.

Interventions Aimed At Multiple Levels

Social Marketing

The most comprehensive campaigns involve the systematic application of all of the above steps in the use of multiple channels, combined with community outreach and the use of small media -- called social marketing (Lefebvre & Flora, 1988). The Academy for Educational Development's AIDSCOM project, and Population Services International's Project ACTION are each good examples of social marketing campaigns that have been developed and implemented in multiple countries, including Mexico (Ramah & Cassidy, 1992), Zaire (Convisser, 1991) and the USA (Blair, 1995). In each case, both safer sex and condoms were promoted. Project ACTION, for example, includes an intensive community mobilization campaign, a motivational media campaign, a condom vending operation, peer skills building workshops, and outcome evaluation. These projects have reported positive outcomes. For example, the project in Oregon reported improved attitudes toward condom use to reduce STDs, and teen comfort with condoms; increased perception of peer support for using condoms, especially with new/casual partners; improved self-efficacy regarding obtaining and

using condoms; reduced adolescent sexuality (or delayed initiation), and increased condom use with new/casual partners (but not necessarily with main/steady partners). The project in Zaire reported improved knowledge about transmission and prevention methods, increased abstinence and mutual fidelity, and increased use of condoms.

Community Organizing

Young Gay Men. Researchers at the Center for AIDS Prevention Studies at UCSF (Kegeles, Hays & Coates, 1996) enhanced the approach, developed originally by Kegeles et al., (1992), by having opinion leaders run the project, by having the initial group of opinion leaders recruit other opinion leaders, and so on, thus setting up a self-perpetuating process for changing community norms. They also used an enhanced publicity campaign, using small media (as discussed above) to "spread awareness of the program and establish its legitimacy, invite young men to become involved, and provide a continual reminder of the norm for safer sex. (Kegeles et al., 1996, p 1131)." In addition, they hosted a wide variety of social events at a project facility to attract younger gay men. The approach has successfully increased condom use and decreased the proportion of men with more than one partner among gay men in several cities. The approach effectively influences community-level change through a process of informal communication and modeling by peers with interpersonal networks.

The median age of men in the Kegeles study was about 23, compared to about 30 in the Kelly et al., studies. Given the success of the Kegeles study, and the demonstrated effectiveness of peer leaders in school-based studies of smoking and drug abuse prevention, the approach is likely to also work with adolescents (Tobler,1986; Rickert, Jay & Gottlieb, 1991). To date, one study tested a program of a similar nature for Latino adolescents. Researchers at the new England Research Institutes in

Massachusetts (Sellers, McGraw and McKinley, 1994; McGraw, Smith, Crawford, Costa & McKinley, under review) used specially trained opinion leaders to conduct workshops in schools, community organizations and centers promoting the use of condoms; group discussion in the homes of youth; presentations at large community events; and door-to-door and street corner canvassing (including distribution of a kit that provided condoms and pamphlets on how to use them). Condoms were freely available at the project office and at all intervention activities. The use of condoms was also promoted through radio and television public service announcements, posters in local businesses and public transit facilities, and a quarterly newsletter. Like the earlier studies with young adults, this program increased the likelihood of condom use; it also lowered the rate of HIV risk. Importantly, it did not increase levels of sexual activity; indeed, it delayed the initiation of first sexual activity and the likelihood of multiple partners by girls. A similar project targeting young females in Texas (Santelli et al., 1995) with street outreach and small media materials, reported increased social norms in favor of HIV-prevention behaviors and increased condom use.

What's Next?

This chapter focuses more on HIV than other STDs. This reflects the fact that there are far more studies of HIV prevention programs than of STD education programs. The differences between HIV and the other STDs are important. Most STDs are curable if diagnosed in time and their transmission can be effectively reduced when STDs are treated promptly. Thus, any discussion of STD prevention must include a discussion of effective STD treatment for adolescents. This was not within the purview of this chapter, but barriers to and motivators for treatment of STDs, and increasingly HIV, should be a cornerstone of prevention.

The developmental perspective needs to be taken into account more completely when considering the development of HIV prevention programs. Obviously, there are tremendous differences between people aged 20 and people aged 13. The latter are just beginning their sexual careers; their self-identities are being created; they biologically have less ability to think abstractly and to think as clearly about the future; their sexual activity is sporadic; often they have not accepted the fact that they are sexual; typically they are not in a position, either financially or emotionally, to take care of an unintended child. Discussion of effective programs must take into account these developmental differences and provide evaluations of developmentally appropriate interventions.

Third, we have focused our discussion on HIV and STD's and have not included discussions of pregnancy prevention. A clear challenge for the future must involve strategies for motivating multi-method protections so that adolescents can be protected from STD's, HIV, and unwanted pregnancy.

To produce more definitive conclusions about the efficacy of behavioral interventions that prevent STDs, the research community needs to:

> Improve the quality and rigor of research by using experimental designs with random assignment (when appropriate to the research question), obtaining large sample sizes, tracking youth for at least a year and preferably longer, measuring actual sexual and condom behavior, conducting proper statistical analyses, and reporting results regardless of whether they are positive or negative. Whenever possible, these evaluations should be completed by independent parties.

Identify programs with positive behavioral results and re-evaluate them in different communities and with different program and research teams.

Design and evaluate programs for gay youth. Throughout the United States, there are very few high school programs for male youth who engage in sex with other males, and the behavioral impact of the few existing programs has never been carefully evaluated. Given that such youth are at particularly high-risk of contracting STDs and HIV infection, the dearth of such programs and the absence of any studies is appalling and should be remedied.

Conduct research to improve our understanding of how to replicate *with fidelity* those programs which are found to be effective in two or more studies.

Conduct research on outreach approaches to adolescents.

Use scientific strategies to evaluate the applicability of social marketing strategies for changing sexual behaviors of adolescents.

The Future: Multi-Level Interventions?

Adolescents are sexual, pathogens are pervasive, and unwanted pregnancy occurs all too frequently among adolescents. This review had demonstrated the advances that have been made in attempting to enhance the sexual safety of adolescents. Simultaneously, it shows all too clearly the difficulties in bringing about lasting changes in a way that has public health impact.

Having an impact on the sexual health of adolescents requires a carefully articulated long lasting strategy that uses combinations of well validated techniques, each employed for what it can accomplish best. Interventions that combine strategies aimed at individuals, with programs at schools, and with programs in the community and with the media may be needed to achieve public health impact. Clearly, individual level interventions with adolescents with difficult lives can be effective in reducing sexual risk. Classroom-based programs may be effective in imparting information and favorable attitudes and, under certain circumstances and with the right program, in improving behavioral outcomes. Community and marketing strategies can also have an impact.

However, none of these, in and of themselves, will have the level or extent of impact desirable and necessary for the effect that must be achieved. Needed are programs which combine the best features of the various levels of intervention in a cohesive and mutually reinforcing way and research which can demonstrate the impact of such articulated programs in reducing STDs and pregnancy among adolescents.
Public health leaders have advocated community organizing as an approach to HIV prevention (Bailey, 1991; Valdiserri, Aultman & Curran,1995). CDC has funded programs ($190 million in 1994) to develop and implement innovative strategies by city/state public health agencies, community-based organizations, and STD/AIDS service organizations. Essential components of a comprehensive STD/HIV prevention program include: (1) participatory community planning; (2) epidemiological and behavioral surveillance and research; (3) STD counseling, testing, treatment, referral, and partner notification; (4) individual-level health education, risk-reduction and maintenance interventions; (5) group-level health education, risk-reduction and maintenance interventions; (6) community level interventions seeking to change attitudes, norms, and practices, through health communications, social marketing, and

community mobilization; (7) public information programs for the general public to dispel transmission myths, support volunteerism, and reduce HIV discrimination; (8) STD prevention capacity building activities such as governmental and nongovernmental public health infrastructure development, quality assurance systems, and technical assistance delivery/capability; and (9) evaluation and research activities to conduct formative, process, and outcome evaluations and to assess cost-effectiveness and cost-benefit. (Vladiserri et al., p. 97, Table 3). This comprehensive approach has not yet been fully applied to adolescent STD prevention (or even HIV prevention) in any city or state; however, full implementation, especially including approaches of proven effectiveness in components 4-7, should prove very effective.

We have highlighted in this review what is known about effective HIV prevention programs and have attempted to provide a balanced view of their efficacy. Not discussed, but deserving equal attention, are the barriers to implementation of effective programs and attitudes in society which make it difficult to implement programs that would protect adolescents against STDs and HIV. Further analysis and study of strategies for modifying policy and legal barriers, as well as pervasive attitudes in society which inhibit useful discussion of sexual issues should be a top priority for future research.

TABLE 1

Levels of Causation and Change
Determinants of STD Transmission

Level	Definition	E
Individual	how environment is experienced and acted upon by individuals; individual biological states	Knowledge, risk efficacy, levels o biological determ behavior, etc.
Dyadic/Familial	how couples interact and negotiate sexual behavior; how families communicate about sexual issues	implicit and exp power and sexu
Environmental	social norms, resources, and opportunities, disease prevalence	assess to condo care behavior a
Legal/Policy	laws and policies	discriminatory p policies regardin regarding acces planning care fo
Super structural	macrosocial and political arrangements	poverty, ra

Adapted from Sweat and Dennison, AIDS, 1995.

TABLE 2

Levels of Causation and Change
Change Mechanisms with Intervention Examples

Level	Change Mechanism	E
Individual	educational, motivational appeals, skills-building, counseling	drug and alcoho
Dyadic/Familial	skills-building within couples or families	couples or famil testing
Environmental	Community organization and mobilization	peer outreach, c mobilization, co distribution, drug on demand
Legal/Policy	legislation and policy reform	anonymous test and family plani adolescents
Super structural	social movements, sound economic policies	movements and programs, anti-d programs, educ programs

Adapted from Sweat and Dennison, AIDS, 1995.

Table 3

Conclusions about Abstinence, Sex Education and HIV Education Programs and School Condom Availability Programs

Thus far, no abstinence-only education program has been found to delay the onset of intercourse, but very few such programs have been well evaluated, and thus there is little evidence to determine whether or not abstinence programs can delay intercourse.

Sexuality and HIV education programs that include discussion of condoms and contraception do not increase sexual intercourse, either by hastening the onset of intercourse, increasing the frequency of intercourse, or increasing the number of sexual partners.

Some programs have not measurably reduced unprotected sexual intercourse, either by delaying the onset of intercourse, reducing the frequency of intercourse, or increasing use of condoms.

Several studies with credible evidence found positive effects upon delay in the initiation of intercourse, frequency of intercourse, number of sexual partners, or use of condoms. However, few studies measured and found significant long-term effects.

These educational programs are not a complete solution to reducing unprotected sexual intercourse: Some program participants continued to engage in unprotected intercourse; rarely were long-term effects demonstrated; and never were positive changes in pregnancy rates demonstrated.

Nevertheless, some of these programs did have modest behavioral effect, and they can be an effective component in larger, more comprehensive HIV prevention initiatives.

In general, given the relatively wide availability of condoms in most communities, providing condoms in schools does not appear to markedly increase their use.

Table 4

What is known about outreach, media, and community organization approaches?

Outreach projects that utilize properly trained opinion leaders are very effective with adult gay men, and probably also with adolescents.

Mass media on its own is most effective for raising awareness and improving knowledge.

Sustained attitude changes require interpersonal interaction and acceptance by the community.

Behavioral change requires that desired behaviors be modeled, social norms be changed and shown to be acceptable.

Behavioral change is enhanced by supportive structural changes that increase the ease of access to critical materials (like condoms) or impose sanctions against those not complying.

Designing effective media programs requires careful development, piloting and formative research.

Combining mass media with community outreach and the use of environmental media increases the likelihood of success, and seems to enhance the level of effectiveness.

The social marking approach combines the above two recommendations -- and social marketing campaigns seem to have the most consistent success rates.

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