

YOUNG PEOPLE AND STDs/HIV/AIDS

PART II: PROGRAMS TO ADDRESS THE PROBLEM*

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Programs to prevent the transmission of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) among adolescents and young adults are relatively new. Given the high rates of STDs among this age-group, and the fact that young people represent more than half of all new HIV infections, there is increased urgency to identify and evaluate effective program models. Although some STDs are curable, others, including HIV, are not. For this reason, many emerging projects for young people emphasize education and prevention rather than treatment. Knowledge alone, however, will not accomplish prevention goals. Young people also need to be helped in developing positive attitudes about themselves, skills, and access to services, especially condoms.

What kinds of STD/HIV prevention programs have been implemented for young people? Have such programs had positive results?

Projects designed to prevent STDs and HIV among young people are usually based on education, communications, and counseling activities. They tend to be located in schools, health care facilities, residential treatment

centers, or, through outreach, in the kinds of locations in which young people like to congregate. Although only a limited number of such projects have so far been evaluated, some evidence of success can be observed:

- Schools are a key location for HIV prevention efforts because they provide a means of reaching large numbers of young people. Several US evaluations of high school prevention programs found modest gains in students' knowledge and risk-reduction behavior (including having fewer sexual partners and using condoms more often). At the same time, researchers concluded that considerably more than 5-15 hours of instruction is required for there to be a major impact.^{8,9,18}

Community-based projects are quite varied, reaching young people where they work and socialize.

- A Thai project for young female factory workers studied by the International Center for Research on Women, showed gains in both knowledge and enabling skills (such as taking responsibility for contraception). Young women who participated in peer-led sessions showed the most significant gains when compared to those in adult-led sessions or self-instructional formats.³

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- An evaluation in Nigeria and Ghana, which emphasized peer education activities in community settings, showed that the program had significantly positive effects on young people's knowledge and self-efficacy, and on the likelihood of their taking protective measures against STDs/HIV (abstinence, limiting the number of partners, and condom use).¹⁰

- A HIV/ acquired immunodeficiency syndrome (AIDS) peer education project in Jamaica held educational sessions in schools, community locations, and outdoor spaces ("on verandahs and under trees") in both rural and urban settings. Among the peer educators in the project, there were significant gains in knowledge, the dispelling of myths, knowing where to go for STD treatment, and the intention to delay sexual intercourse or to use condoms if sexually active.¹⁴

- A project carried out by CARE Kenya used a peer-to-peer education strategy. Young people who participated in the project demonstrated better knowledge, more positive attitudes, and indications of positive behavioral changes in terms of STD/HIV prevention (such as limiting the number of sexual partners) when compared to a control group.⁴

Reaching street children, runaways, and young sex workers is important because these target groups are at a disproportionately high risk of contracting STDs and HIV. Project examples of this type include:

- A model HIV prevention project for Brazilian children and adolescents living and/or working in the streets. The project placed special emphasis on communications that were culturally relevant and on interactive learning sessions. After preliminary evaluation of less than a year's activities, the project showed significant levels of repeat participation and gains in AIDS awareness and knowledge.^{12, 13}

- An HIV-prevention project in the United States was designed to stress skills training and behavioral self-management among runaway youth living in publicly-funded shelters. Evaluation showed increases in consistent condom use and reductions in patterns of high-risk sexual behavior (such as having many sexual partners or many sexual encounters) three and six months after the intervention. Gains were more significant among young people who attended the most sessions.¹⁶

Communications and social marketing programs are key interventions for youth because they reach and inform people who are especially tuned in to popular culture. Some programs of this type that have been assessed include:

- A project in Uganda uses multiple media formats that stress the message: "Safer Sex or AIDS: the Choice is in Your Hands." An evaluation of the campaign's first phase, conducted after about 18 months of activities, showed that significantly more Ugandan youth now know how to protect themselves from HIV infection.¹⁷

- A Zaire mass media project used television, radio spots, and songs specially created to address AIDS issues. It also used radio and TV soap operas and printed materials (notebooks and calendars) to reach young people. Impact evaluation conducted six months after the first phase of the project showed increased awareness of the issues surrounding AIDS, increased sexual abstinence and mutual fidelity, and increased condom use.⁵

- The Ghanaian Ministry of Health conducted a multimedia campaign to increase AIDS awareness and promote AIDS prevention among its population aged 15-30. The campaign involved television and radio advertisements, community meetings, the dissemination of promotional materials (such as posters and comic

books), and outreach to schools. A follow-up survey conducted 10 months after a baseline survey showed increased AIDS awareness, improved knowledge of HIV prevention strategies, a decrease in the number of sexual partners, and increased condom use among a range of sub-groups.¹¹

What are the lessons learned?

- Providing a range of prevention options gives different groups of youth a choice and gives "gatekeepers" (adult decision-makers) the opportunity to remain neutral or to support activities selectively. For example, in Haiti, an AIDS Control and Prevention (AIDSCAP) study showed that the AIDS prevention project's "Fleet of Hope" messages (abstinence, fidelity and monogamy, and condoms) offer a range of acceptable options for diverse community needs and interests.²
- Adult support can make a difference in levels of youth participation. As a result of efforts made to gain community support in an area of Kenya in which adults usually limit the involvement of girls in public events, large numbers of girls participated in an AIDS prevention project.⁴
- A US study to evaluate school-based reproductive health education programs found that those that successfully reduced unprotected intercourse (either by delaying the onset of intercourse, increasing the use of condoms, or reducing the number of sexual partners) shared several common elements: the use of social learning theory for program development; a narrow focus on reducing sexual risk-taking behaviors; the use of learning methods that actively involve young people; activities that address social and/or media influences and pressures to have sex; focus on clear values against unprotected sex; and the modeling and practice of communication or negotiation skills.⁹
- Including STD/HIV prevention and related activities in existing family planning services is a logical and practical type of service expansion to serve clients who would otherwise be missed. However, such service additions must be accompanied by clear protocols, appropriate training, and sufficient and suitable clinic space for providers and clients, as demonstrated in a South African health facility.¹
- Young people frequently prefer their peers as a source of information about reproductive health. A survey found that 99% of youthful respondents agreed that talking with peer educators was a good way to learn about HIV/AIDS, and that 81% identified peer educators as a preferred source of information.⁷ Young female factory workers, out-of-school Kenyan youth, and young people in a Ghana YWCA project all indicated a preference for peer educators.^{3,4,15}
- Although there is often high peer turnover in reproductive health and HIV peer-education projects, the strong positive impact of the work on the peer educators themselves may justify their use. An AIDSCAP study showed that 95% of peer educators had made changes in their own life and behavior, 31% were practicing safer sex and/or were using condoms, and 20% had reduced their number of sexual partners.⁷
- Skills-based training is recommended for peers working in AIDS prevention programs. Relevant skills deal with such areas as risk assessment, negotiation, safe sexual practices, violence and abuse, and encouraging the use of health services.⁶ In turn, these are important skills for the young target audience to learn. An experimental project studied by the University of Zimbabwe found that a skill-based participatory

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activity was more effective than an information-based intervention in changing AIDS-related attitudes and practices (increased knowledge about condoms and their correct use, increased self-efficacy, fewer sexual partners, and fewer coital acts without a condom).¹⁹

- The control of STDs, which facilitate HIV transmission, can reduce the incidence of HIV. A health intervention in rural Tanzania established an STD referral clinic, trained and supervised the new center's staff, supplied drugs on a regular basis, and offered health education. Evaluation showed a 40% reduction in HIV incidence over the two years of the study. The largest proportionate reductions occurred among women aged 15-24 and men aged 25-34.¹³

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] The *In Focus* series summarizes for professionals working in developing countries some of the program experience and limited research available on young adult reproductive health concerns. This issue was prepared by Judith Senderowitz and was reviewed by the FOCUS Editorial Board, some outside experts and the staff of the FOCUS program.