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# SIECUS

## REPORT

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## CALL FOR SUBMISSIONS

The *SIECUS Report* welcomes articles, reviews, or critical analyses from interested individuals. Upcoming issues of the *SIECUS Report* will have the following themes:

- **Integrating Prevention Efforts: STDs, HIV, and Teen Pregnancy**
  *February/March 2003 issue*
  *Deadline for article submission:December 4,2002*
- **Young People Talk about Sexual Health, Education, and Rights**
  *April/May 2003 issue*
  *Deadline for article submission: January 2,2003*
- **The Debate about Sexual Addiction and Compulsion**
  *June/July 2003 issue*
  *Deadline for article submission: March 3, 2003*
- **Monitoring Sexuality Education in the United States/Tenth Anniversary**
  *August/September 2003 issue*
  *Deadline for article submission: May 1, 2003*

# AIDS SPREAD TO MILLIONS WORLDWIDE SIGNALS URGENT PREVENTION NEEDS

Mac Edwards

The *SIECUS Report* is usually filled with original articles on sexuality-related issues. But this one is different, and that's not a bad thing. This issue is heavy with data—from the recent International AIDS Conference in Barcelona as well as from individual AIDS service organizations.

Yet the data paint a picture as vivid as any commentary we have ever had. That picture is of a shift in HIV/AIDS to young people, women, and minorities such as African Americans, Latinos, Native Americans, and Asian Pacific Islanders.

It sends an urgent message: We must reevaluate prevention programs so that we can reach these people with the information they need.

UNICEF reported at the AIDS Conference that half of the young people in more than a dozen countries at particular risk of HIV have never heard of the virus. It also reported that a significant percentage of at-risk young people may still be unaware of how to protect themselves.

Sherri Watkins, a writer/editor at the National Minority AIDS Council in Washington, DC, calls for new education programs directed at minority communities, where the virus is striking disproportionately.

A lack of information, particularly when it relates to sexual behavior, can bring unintended and potentially dangerous results. This *SIECUS Report* is designed to help educators develop new, effective prevention curricula.

## EDUCATION

Dr. Peter Aggleton, director of the Thomas Coram Research Unit of the Institute of Education at the University of London, says the information young people receive about HIV/AIDS is often "too little, too late." He blames educators for focusing too much on who must be "taught," who must learn the "right attitudes," and who must become "skilled." Rarely, he says, is there concern about what people feel and what they do.

To help educators rethink their approaches to prevention education, we asked Dr. William Yarber of the University of Indiana to update the "Standards for STD/HIV Prevention Curricula in Secondary Schools" that he first developed for us a little over a decade ago.

## GOVERNMENT SUPPORT

Obviously, educators will need the help of the federal government to provide funds and support for their prevention efforts.

SIECUS Director of Public Policy William Smith writes in his policy update about the disturbing lack of action and funding on the part of the Bush Administration regarding HIV/AIDS prevention programs.

He says that at the heart of the problem is the Administration's focus on abstinence-only-until-marriage programs that prohibit educators from giving information to young people that they can use when they become sexually active—and at risk for HIV/AIDS.

Terje Anderson, executive director of the National Association of People with AIDS (NAPWA) in Washington, DC, writes that work on behalf of effective AIDS programs must increasingly be fought in the political arena. Yet, it is unclear if advocates are truly willing to take the risks.

"It may be safe to give advocacy speeches and blow whistles among like-minded people at an AIDS conference, but how many of us are willing to do the same when it could mean loss of government funding, loss of access to decision makers, unemployment, social isolation, personal experience of discrimination and stigma?" he asks.

We are including some proven strategies that policymakers may want to consider in developing new prevention programs.

First, "A 10-Step Strategy to Prevent HIV/AIDS Among Young People" is excerpted and adapted from guidelines developed by the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Health Organization.

Next, "Recommendations for Meeting the Global HIV Prevention Challenge" are strategies developed by the Global HIV Prevention Working Group.

I think they both provide clear, concise recommendations and ideas that are worth considering.

## RELATED INFORMATION

We felt it was important to include an updated and expanded version of our *Fact Sheet on Condoms* with this *SIECUS Report*. It contains important information related to HIV/AIDS prevention.

Altogether, I feel that this "HIV/AIDS Update" contains a great deal of important information that individuals can apply to the development of new programs and curricula. I hope that you will use it in your work.

# TRUE DISCOURSE KEY TO PREVENTION EFFORTS

Tamara Kreinin, M.H.S.A.

This summer, I traveled to Barcelona to attend the International AIDS Conference. It gave me an amazing opportunity to meet colleagues both old and new, to reflect on how far we have come since the pandemic began, to question why we have not made more progress worldwide, and to re-energize for the challenges that still lie ahead.

## ACTIVISTS' VOICES HEARD

Throughout the conference, I was struck by the presence of activists and the major role they played in raising awareness on some of the most controversial issues.

One of the most disruptive efforts was the heckling of U.S. Secretary of Health and Human Services Tommy Thompson. His speech was drowned out by protestors angry with the Bush Administration for inadequate funding and other decisions about HIV/AIDS.

I found myself torn by this turn of events. On the one hand,I felt that grassroots activism has always played a major role in securing the public and political support needed to advance prevention and treatment efforts.And the protesters in Barcelona definitely had some real concerns about the Administration's funding priorities when it comes to HIV/AIDS work, both domestically and abroad. It is the right, and some may even say the responsibility, of activists and advocates to make these concerns known.

At the same time, true discourse is only possible when all voices are heard. Although I might not personally have agreed with Thompson's remarks, I was anxious to hear what he had to say. His explanation of the Bush Administration's actions and future plans could have helped me better understand the issues which we will have to deal with in the coming years and better respond to these issues. We can't hold people accountable if we don't hear the message.

## RE-VISITING ACTIVISM

Upon returning from the conference, I had another opportunity to reflect on this event when I learned that the Department of Health and Human Services, at the behest of Members of Congress, was investigating the federal funding of more than a dozen AIDS organizations, many of which participated in the Barcelona demonstration against Thompson.

While accountability for use of federal funds is necessary, this investigation felt like retaliation and a threat against future activism.Again,true discourse is only possible when all voices are heard. It is disheartening to see the Administration attempting to block the voices of those who disagree.

## CHANGING FEARS

SIECUS has always said that fear is not a good motivator of individual behavior and that prevention curricula should never be based on fear. However, in the beginning of the pandemic, fear was a good motivator for action.

Early AIDS activists were members of those communities hardest hit, most notably the gay community, who watched too many friends and family members die. These activists were scared.As a result they were loud, they were bold,and to a large degree they were successful.

In today's political climate, with investigations and audits brought on by both outspoken activism and prevention efforts that "push the envelope," the fear is changed. Rather than fearing the devastating impact on a community if bold action is not taken,activists must now fear the devastating impact on funding if it is.

And now is not the time to be timid. Fueled by improvements in treatment that allow people with HIV to live longer and healthier lives, a generalized feeling that the crisis in the United States is over has apparently led to an increase in unsafe behavior.

We have learned a lot about prevention over the last two decades, and one of the most important lessons is that prevention efforts cannot remain static. What works for one group at one point in time may not work at a later date. To develop ever-changing messages, organizations dedicated to prevention must have sufficient funding and sufficient freedom to flex their creative muscles.

In fact,now more than ever we need prevention efforts that push the envelope. Activists and policymakers must work together to foster an environment in which organizations are not afraid to take bold action.

## COMPLA CENCY MISPLACED

I know that I do not have to tell *SIECUS Report* readers that the complacency that some feel about HIV/AIDS in the United States is misplaced and dangerous. Being among colleagues from all over the world helped me feel once again the sense of urgency with which we must fight this pandemic.

I hope that activists and elected officials will share this sense of urgency and not allow differences to prevent progress.

# HIV/AIDS PREVENTION AND SEXUALITY EDUCATION MUST CHANGE TO MEET THEIR PROMISE

**Peter Aggleton, M.Ed., Ph.D.**
Director, Thomas Coram Research Unit,
Institute of Education, University of London
London, England

All over the world, education is identified as having a critical role to play in teaching people about sex, sexuality, and the prevention of HIV/AIDS. Yet all too often, the radical potential of education to promote safer and more pleasurable kinds of sex and to effect change remains unfulfilled.

In study after study, for example, young people state that what education they have received about HIV/AIDS was "too little, too late," and substantial numbers of adults continue to have serious misconceptions about the epidemic.

These range from the view expressed in a recent Australian study of young heterosexual men that HIV/AIDS is a disease of "dirty women and gay men" to the continued belief among large numbers of adults in developing countries that condoms have holes through which HIV can pass. Clearly, in many ways, education is failing to live up to its potential—and we as educators must bear some of the responsibility for this.

I want to address some of the issues upon which education must focus if it is to fulfill its promise in HIV/AIDS prevention and care. There has never been a better moment for this. A new strategic framework for such education to which the United Nations Education, Scientific, and Cultural Organization (UNESCO) and all other cosponsors from the Joint United Nations Programme on HIV/AIDS (UNAIDS) have signed, is currently being finalized. This offers an excellent starting point for more explicit and coordinated efforts.[1]

## FOCUS OF EDUCA TION

It should go without saying that much HIV/AIDS education has focused heavily upon knowledge, attitudes, and behaviors. Both adults and young people have been taught the "facts" in the belief that they will then act on the basis of what they know.

Alternatively, they have been given the chance to reflect on existing attitudes they may hold or others around them may hold—attitudes toward sexual practices, for example.

Beyond this, there has been an emphasis on skills acquisition—so-called "life skills" related to decision making as well as skills of sexual "communication" and "negotiation."

But too often, the focus is on the isolated individual who must be "taught," who must learn the "right attitudes," and who must become "skilled." Rarely, if ever, has there been concern about the affective and emotional—what people feel about the issues as well as what they know and do.

All of us probably know that our judgement about sexual and drug-related matters can be swayed by circumstance. And if this is true for us, then it must be true for others.

But why is this true? At least part of the answer is found in the different *meanings* that operate within a given context. What sex or drug use signifies, for example, can influence whether or not someone engages in it. And meanings shift and change depending on circumstances.

Notions of *honor*, for example, are central to sexual self-understanding. For many young men and some young women, it is "honorable" to show that they are sexually experienced. For many young people involved in sex work in countries such as Thailand, it is "honorable" to send earned money to parents in the village. For many of us,it is "honorable" to remain faithful to our sexual partners. But these "honors" differ according to context and circumstance.

It is also important to recognize *irrationality* as a powerful force structuring sexual life. Rarely are the kinds of interaction that lead to sex best understood in terms of the negotiation and communication taught in "Just Say No" programs.

Rarely does one weigh all the pros and cons of having sex in the ways suggested by rational decision-making models of risk-related behavior and behavior change. While actions can be re-constructed in this way after the event, at the time they are more often than not responses to opportunity and chance.

The power of transgression—or the excitement that comes from doing something unusual or naughty, that is forbidden—is, I believe, also underestimated. True, there has been talk about such issues within the context of some gay men's apparent abandonment of condoms and the adoption of new and more complex forms of negotiated safety. But there has been relatively little attention given to transgression within heterosexual "safer sex" education or drug-use education.

Finally, there is the thorny issue of love, a concept conspicuous by its absence on the agendas of many conferences dealing with sexuality-related issues. While concepts of love vary considerably around the world, they are real enough for many people (at least some of the time).

As Francios Delor's recent work on sero-discordant couples in France shows, love legitimizes a range of sexual practices where the likelihood of HIV transmission is very

real—unsafe sex between long-established sero-discordant partners, for example, who believe that the passions of first encounters will last.[2]

We are left, therefore, with a series of important absences in the focus of much education relating to HIV/AIDS.

## RANGE OF MATTERS ADDRESSED

The absence of certain subjects in education is compounded by what might be called a series of approaches to such education that have solidified over the years. I will say something about five.

First, until recently, the majority of general population or school-based HIV/AIDS education initiatives have proceeded from the erroneous belief that *all of those whom educators are trying to reach are HIV negative*. This is dangerous not only because the majority of individuals simply do not know their sero status but also because, in an increasing number of circumstances (and most certainly within schools throughout Africa), a substantial proportion of both teachers and pupils may be (and may know themselves to be) HIV positive. The barriers between primary prevention and other forms of prevention are breaking down.

Second, and not unrelated to the above, is the erroneous belief that *people with HIV/AIDS are some kind of a problem and not part of the solution to the epidemic*. Frightening imagery of the physical effects of HIV/AIDS, together with warnings to young people to avoid those who might pose a "risk" do little to build the kinds of social solidarity central to an effective response. In contexts where relatively few people know their sero status, this assumption reinforces denial, making the educated "take sides" in a divisive and unnecessary battle against the epidemic.

Third, AIDS education programs are among the relatively few educational programs to date where stigma, discrimination, and human rights are central to prevention work. It is a sad fact that it has taken nearly 20 years for the first World AIDS Campaign to focus on what arguably is the greatest social ill associated with the epidemic: namely, *the willingness of people to ostracize, vilify, and reject their brothers and sisters, sons and daughters, friends and lovers*. HIV/AIDS education needs to get real in addressing these elements of social abuse.

Fourth, until recently our understanding of gender has been relatively superficial in our educational work. True, it cannot be denied that women, and young women in particular, are systematically disadvantaged in the majority of the world's societies. And true, for many young women, education represents a route out of poverty and away from sexual health risk. Having said this, and as Dr. Geeta Rao Gupta of the International Center for Research on Women in Washington, DC, has pointed out in the last two international HIV/AIDS conferences,[3] we have failed to engage adequately with the manner in which *gender systems work to ensure that both women and men are rendered vulnerable to the epidemic*: men, through ideologies that encourage them to appear knowledgeable when they are not (for fear of threatening their manhood); women, through ideologies that encourage them to be "innocent" about sex when they need to know.

Fifth, there has been the belief that *the messages and approaches that worked early on in the AIDS epidemic will continue to do so*. Nothing could be further from the truth. It is now abundantly clear from research with some of the first groups known to be infected (gay men, sex workers, and injecting drugs users) that messages and approaches have to be changed over time. Not only are new generations of especially vulnerable people always in the making, but they enter into this world in circumstances very different from those that prevailed early in the epidemic, when any talk of effective treatment was nothing short of a fantasy.

## THE ISSUE OF PEDA GOGY

Too often, HIV/AIDS education has proceeded from what Professor Richard Parker of Columbia University and I have called a model of "liberal enlightenment."[4] Here, those who know best intervene to correct the "bad" thoughts and actions of others.

This "banking" theory of pedagogy, as the educator Paulo Freire once described it, sees the minds of those who are being educated as empty vessels waiting to be filled with the good ideas of intervention specialists and communications experts.[5]

A parallel set of assumptions leads us to understand sex as a behavior to be controlled, not a passion to be played with safely. Needless to say, people are rarely taken in by such formal pedagogic approaches. More often than not, they end up paying lip service. They may appear to listen carefully but change little behind the scenes.

More successful by far are efforts to unleash the power of critical and systematic thought based on people's own positions in life. Such approaches usually have their starting point in the everyday concerns of individuals, not in those of intervention experts and specialists.

It is this kind of pedagogy that has characterized, at various times and in disparate ways, the prevention work of programs and projects as diverse as the Sonagachi project working with female sex workers in India, TASO (The AIDS Service Organization) working with a wide range of individuals in Uganda, the Gay Men's Health Crisis (GMHC) in New York City, the various AIDS Councils in Australia, and Grupo Pela Vidda in Brazil.

In each case, the principal aim of the pedagogy was not to tell people what to do but to unleash the power of community to take charge and fight back. The importance of such approaches—which seek to consolidate and build *social capital*—is well documented, especially in contexts where "popular education" was used to help develop not only

understanding but also to combat the social inequality and exclusion that disempowers those most vulnerable to HIV.

## THE ISSUE OF CONTEXT

Perhaps the most important thing to take into account in planning future work relating to AIDS education is the notion of context. Far from being peripheral to the effectiveness of education, *context*—the "background noise"—is vitally important to understanding how people respond to learning opportunities.

Let me give you an example. It might matter enormously what we should do to promote safer sex in an educational setting if that sex is: (1) first sex or regular sex, (2) sex within an enduring marital relationship or sex on an occasional basis outside this relationship, (3) sex with love or sex in order to satisfy a momentary feeling of lust, (4) sex freely entered into by consenting adults or sex within the context of "ethnic cleansing," or (5) the sex that occurs between men in prisons or the sex that takes place in loving gay relationships.

Ultimately, there are no universal panaceas to discover in prevention science. The approaches we use must be *context specific*. Context matters when it comes to planning interventions and thinking about what education can achieve.

*Context* is important because of its intimate relationship with what we call *vulnerability*. Undertaking HIV/AIDS prevention requires focusing not only on individual risk-taking behavior but also on the environmental, political, and economic factors that influence susceptibility or vulnerability.

We need to take into account key sets of variables: factors linked to social networks and relationships, factors pertaining to the quality and coverage of services and programs, and broad-based societal factors.

## OTHER FACTORS

The programmatic factors that educators need to take into account are the cultural appropriateness of HIV/AIDS and sexuality education programs, the accessibility of services due to distance, the cost of programs and services, and the capacity of health systems to respond to a growing demand for care and support.

Societal factors influencing vulnerability include cultural norms,laws, social practices, and beliefs that act as barriers or facilitators to prevention messages and approaches. Such influences may lead to the inclusion, neglect, or exclusion of individuals.

Inequalities of age, gender, sexuality, poverty, and social exclusion are among the many factors enhancing vulnerability to HIV/AIDS. They do so in enormously complex ways. In the case of poverty, for example, violations of rights, physical abuse, sexual exploitation, and the withdrawal of entitlements can deepen the gap between those who benefit from economic growth and those who suffer its ill effects.[6]

Somewhat paradoxically, development policies and programs themselves may have inadvertently negative effects on the spread and impact of HIV/AIDS. They may, for example, increase disproportionately the economic gap between immediate beneficiaries and others. The very poor may become vulnerable to HIV/AIDS as a result of increased marginalization on economic grounds and the need for dependence on alternative means of livelihood (for example, sex work).

If the new and more realistic forms of learning are to be an important element of future HIV/AIDS education, they must take place alongside structural or environmental interventions to change the social context in which individuals and communities live.[7] These might logically seek to address the broader political, economic, and social forces that determine HIV/AIDS-related vulnerabilities and prevent people from acting on the basis of what they feel and what they know.

## CONCLUSION

Some 20 years into the global HIV/AIDS epidemic, the time is ripe to re-evaluate what counts as HIV/AIDS education. New and more realistic programs and interventions are needed if we are ever to meet the goals set out in the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS).[8]

Business as usual will not work. We need to radically renew and upgrade our efforts if the potential of education to change lives and to promote reductions in HIV/AIDS-related vulnerability and risk is to be fully realized.

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*(For more information, contact Professor Aggleton at Thomas Coram Research Unit, Institute of Education, University of London, 27-28 Woburn Square, London WC1H 0AA, United Kingdom. His e-mail address is P.Aggleton@ioe.ac.uk)*

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7. M. Sweat and J. Dennison, "Reducing HIV Incidence in Developing Countries with Structural and Environmental Interventions," AIDS, 1995, vol.9,supplement A,pp. S225-57.

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# A 10-STEP STRATEGY TO PREVENT HIV/AIDS AMONG YOUNG PEOPLE

This "10-Step Strategy" was released during the International AIDS Conference in Barcelona to help countries as well as communities develop their own HIV/AIDS program guidelines based on individual situations and needs.

**1. End the silence, stigma, and shame**

National and community leadership must break the silence, challenge the stigma, and eliminate the shame associated with HIV/AIDS. They must have the courage to talk openly and without judgment about adolescent sexuality, about violence against girls and women, and about drug use.

Policymakers must ensure that adolescents have the information, services, and support they need. Leaders must marshal the necessary financial resources for the fight against AIDS and develop strategies based on thorough analysis of the local situation.

In countries where strong political leadership has fostered openness about the issues and wide-ranging responses—such as Brazil, Senegal, Thailand, and Uganda—the tide is turning.

**2. Provide knowledge and information**

Young people cannot protect themselves if they do not know the facts about HIV/AIDS. Adolescents must learn the facts before they become sexually active, and the information must be regularly reinforced both in the classroom and beyond.

*Increasing knowledge through schools.* Good-quality education fosters analytical thinking and healthy habits. Better educated young people are more likely to acquire the knowledge, confidence, and social skills to protect themselves from HIV. Prevention education should be timely, age-appropriate, and relevant to the situations and culture of the young people and their families.

*Increasing knowledge through communities.* Parents as well as community and religious leaders need to recognize the importance of their own roles in providing life-saving information and skills.

For example, health workers in Masaka, Uganda, have taken on the role of traditional *sengas* (usually paternal aunts) who give guidance to adolescent girls. In rural Zambia, birth attendants and traditional chiefs travel in teams to deliver the facts about HIV and lift the taboo on providing sexuality education to young adolescents.

*Increasing knowledge through the media.* The media is a powerful weapon against HIV/AIDS. Good programming can counter popular misconceptions about adolescents, reveal the discrimination and abuse young people face, and highlight the contributions they make to their communities.

Different types of theater and entertainment have also been used to break the silence surrounding HIV/AIDS. In Brazil, for example, street theater is part of a program for young people that helps increase their condom use. In South Africa, the weekly television drama *Soul Buddyz* runs in tandem with a radio series.

**3. Provide life skills to put knowledge into practice**

Young people cannot change their behavior by knowledge alone. They need skills to put what they learn into practice.

Life skills—involving negotiation, conflict resolution, critical thinking, decision-making, and communication—are vital for young people. These skills will help them learn to relate to one another as equals, work in groups, build self-esteem, peacefully resolve disagreements, and resist both peer and adult pressure to take unnecessary risks. They can be taught in many creative and innovative ways, both in and out of school.

In Bangladesh, life skills training is linked to other training programs related to developing marketable skills and employment opportunities. Over 20,000 young women have received such training through the Bangladesh Centre of Mass Education and Science.

**4. Provide youth-friendly health services**

The services to help prevent HIV and other sexually transmitted diseases include access to condoms as well as access to voluntary HIV counseling and testing. For young women who are pregnant and HIV positive, the clinics can provide information and services to help them avoid transmitting HIV to their infants.

In Thailand, "health corners" for adolescents are part of many health clinics. Teams of nurses and social workers provide counseling on sexual health and arrange referrals for young people requiring medical care.

**5. Promote voluntary and confidential HIV counseling and testing**

Nine out of 10 people living with HIV/AIDS do not know they are infected. Yet studies show that young people have a strong interest in knowing their HIV status.

Voluntary and confidential HIV counseling and testing is an important tool for preventing HIV. This allows adolescents to evaluate their behavior and its consequences. For example, a negative test result offers a key opportunity for a counselor to reinforce the importance of safety and risk-reduction behaviors. Young people who test positive for HIV must receive referrals for medical care and must talk to individuals who can help them understand what their HIV-positive status means as well as the responsibilities they have to themselves and others.

Despite the importance of such counseling and testing, fewer than 50 percent of young people in many countries know where they can receive such help. For example, only 16 percent of girls 15 to 19 years of age in Cambodia know where to go for tests.

**6. Work with young people and promote participation**

Energetic, enthusiastic, and creative young people are a tremendous resource in all areas of HIV prevention and care. Their input is invaluable in developing program design and outreach, ensuring that prevention and care efforts are meaningful to their peers, and making certain that information is communicated through effective channels.

Involving young people in prevention efforts educates them about HIV and gives them a sense of responsibility and pride. With the right skills, young people are extremely effective messengers in reaching high-risk individuals and groups.

**7. Engage young people living with HIV/AIDS**

A major challenge in HIV prevention is to convince young people that HIV/AIDS can strike anyone. One of the most effective ways to accomplish this is to get young people living with HIV/AIDS to share their experiences.

Young people living with HIV/AIDS are in a strategic position to reinforce information about the need to adopt and maintain safe behaviors. They, more than anyone else, can convey the message that individuals must make every effort to ensure that no one contracts HIV from them.

They can also reduce the stigma associated with HIV by showing that the virus can infect anyone and can serve as effective role models for living productive lives.

**8. Create safe and supportive environments**

Providing young people with information and skills without ensuring that they feel safe and supported at home, at school, and in their community severely limits their ability to protect themselves from HIV.

Parents, schools, and social institutions need the knowledge and skills to create an environment in which young men and women are safe from harm, are cared for equally, and are treated with respect.

Schools and communities must condemn sexual violence, abuse, and exploitation. Governments must make sexual violence unacceptable by enacting and enforcing laws that protect young women and men from all forms of sexual violence, inside and outside of marriage, as well as imposing criminal penalties on their abusers. Media and education campaigns must encourage equality between men and women and denounce all forms of violence against women, children, and adolescents.

**9. Reach out to young people most at risk**

Those young people especially at high risk for contracting HIV—young men having sex with men, children living on the street, child soldiers, young refugees, children orphaned by AIDS, and others—are often on the periphery of society and face enormous difficulties obtaining help.

These individuals need access to livelihoods, education, and services to help them to build their future. Interventions must take into account the range of constraints they face and help to establish an environment marked by respect, acceptance, and stability. This is key to helping them to integrate into society.

**10. Strengthen partnerships, monitor progress**

Protecting young people from HIV is too big a job for any one sector of society. To make a real and lasting difference, the commitment and resources of all sectors must be mobilized, coordinated, and channeled to families and communities. There must be a commitment to bring people together at every level—community, nation, region, world—to invest in young people.

The partners must include nongovernmental and civil society organizations, including faith-based groups and the private sector; governments; young people; academic and research institutions; private foundations; bilateral donor agencies; and the United Nations and other multilateral agencies.

Defeating HIV/AIDS will also require tracking change, both in the infection rates and in the knowledge, awareness, and behavior of young people. Collecting information on their knowledge and behavior will not only help to monitor progress but will also help to identify which programs are succeeding and why.

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*These strategies are excerpted and adapted from* Young People and HIV/AIDS: Opportunity in Crisis *developed by the United Nation's Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Health Organization (WHO).*

# DEMOGRAPHIC SHIFTS CHANGE NATIONAL FACE OF HIV/AIDS

**Sherri A. Watkins**
Writer/Editor
National Minority AIDS Council
Washington, DC

As the global HIV/AIDS pandemic enters its third decade, it is impacting people of color most dramatically. Despite the fact that the health of the U.S. population has improved significantly over the last 50 years, ethnic and racial minority groups still continue to lag behind the white population, experiencing substantial disparities in health outcomes.

Recently released figures from the U.S. Centers for Disease Control and Prevention (CDC) confirm that HIV/AIDS is continuing to strike disproportionately and devastatingly in the heart of minority communities. In fact, they are making up far greater percentages of new cases than their populations would otherwise suggest.[1]

While race and ethnicity themselves are not risk factors for HIV infection, they are associated with key factors in the United States that determine health status—factors such as poverty, access to quality health care, health care-seeking behaviors, illicit drug use, and high rates of sexually transmitted diseases (STDs).

## INCREASED HIV PREV ALENCE

Despite the advances in AIDS drug therapies that have led to dramatic drops in deaths since 1996, ethnic and racial minorities continue to lag behind Whites in those decreasing rates. Between 1996 and 1997, deaths due to AIDS dropped 45 percent overall. Comparatively, they dropped 54 percent for Whites, 44 percent for Latinos, and 38 percent for African Americans.[2]

Overall, however, the prevalence of people living with HIV infection continues to increase, the result of new cases being diagnosed coupled with improvements in treatment regimens that result in people living longer after diagnosis.

## WOMEN

Minority and young women face increasing risks for HIV and AIDS, with heterosexual contact now posing the greatest threat. Together, African American women and Latinas make up less than one-quarter of the U.S. female population. Yet the CDC reported that they represented fully 80 percent of AIDS cases reported in women in 2000 alone.[3]

Thirty-eight percent of women living with HIV were infected through heterosexual exposure, while transmission through injection drug use accounted for an additional 25 percent of cases. According to the *CDC Surveillance Report*: "In addition to the direct risks associated with drug injection (sharing needles)...a significant proportion of women infected heterosexually were infected through sex with an injection drug user."[4]

## AFRIC AN AMERICANS

As of December 2000, the CDC had received reports of 774,467 aggregate AIDS cases; of those, 292,522 affected African Americans. Representing only an estimated 12 percent of the total U.S. population, African Americans now make up a staggering 38 percent of all AIDS cases reported in this country. It is estimated that almost 129,000 African Americans were living with AIDS at the end of 1999, more than any other racial/ethnic group. African Americans have a rate of new infections more than two times the rate for Hispanics and eight times that of Whites.[5]

Among African American males, the CDC reports that "the leading exposure category for AIDS is men who have sex with men (38 percent of the cumulative cases and 31 percent of new AIDS cases reported in 1998)." In those AIDS cases where causal relationship could be established, another 35 percent was attributed to injection drug use and seven percent were attributed to heterosexual contact. Of the latter, 35 percent of those infections were due to sex with an injection drug-using female and 63 percent were attributable to sexual contact with an HIV-positive person whose status was either unknown or undisclosed.[6]

Of the cases of heterosexual transmission among African American women, 28 percent were related to having sex with an injection drug user; four percent were related to having sex with a bisexual man, and 35 percent did not report or identify the risk factor. The CDC has found that "historically, more than two-thirds of AIDS cases among women initially reported without identified risk were later reclassified as heterosexual transmission."[7]

STDs such as syphilis, gonorrhea, chlamydia, and herpes are fueling the sexual spread of HIV infection because those infected with any of these diseases are at increased risk of contracting HIV during sexual activity. By the late 1990s, African Americans accounted for over 80 percent of reported syphilis cases and nearly 80 percent of the cases of gonorrhea, rates that are, respectively, 44 and 32 times greater than rates for Whites.[8]

Further fueling expansion of the HIV/AIDS epidemic is

the intersection of substance abuse and HIV. Over one-quarter of new AIDS cases are due to injecting drug use. The CDC says that "studies of HIV prevalence among patients in drug treatment centers and STD clinics find the rates of HIV infection among African Americans to be significantly higher than those among Whites. Sharing needles and trading sex for drugs are two ways that substance abuse can…[put] sex partners and children of drug users at risk as well."[9]

A variety of factors contribute to the disparities in AIDS incidence and mortality experienced by African Americans. These include late identification of HIV infection, less access to experienced HIV/AIDS physicians, less access to HIV therapy that meets the U.S. Public Health Service guidelines, and lack of health insurance to cover HIV care and medications.[10]

Since the beginning of the epidemic, African Americans have accounted for over a third of U.S. AIDS deaths. The latest trends indicate that the AIDS mortality rate is still declining, though far more slowly than among Whites. African American deaths fell 17 percent in 1998, compared to 35 percent in the previous year. Among Whites, AIDS deaths fell by 22 percent and 51 percent, respectively, in the same years.[11]

Unfortunately, African Americans are under-represented in the HIV prevention community planning process. In a March 1998 report, the CDC indicated that African Americans represent 27 percent of the 1,064 members of community planning groups nationwide while accounting for 45 percent of the new AIDS cases reported in 1998.[12]

## LATINOS

Among minority groups, the Latino population ranks second among those most heavily impacted by HIV/AIDS. According to projections made by the Harvard School of Public Health, the number of new AIDS cases among Latinos will surpass that of Whites by 2005.[13] These trends portend disaster for the Latino population in the new millennium.

With a large and growing population, numbers indicate that Latinos represented 13 percent of the total U.S. population in 2000 (including residents of Puerto Rico) while accounting for 19 percent of the total number of new infections. The CDC reports that the rate of new of infections for Latinos in 2000 was more than three times the rate for Whites, but still just over one-third the rate for African Americans.[14]

Within the Latino community, men account for about four out of every five reported cases, with men who have sex with men (MSMs) leading the exposure category with approximately 40 percent of the new infections. Thirty-six percent are attributed to injection drug use, seven percent to sex with men who inject drugs, and five percent through heterosexual contact. Among Latinas, heterosexual transmission accounts for 40 percent of new cases while nearly half of all new infections were due to unidentified or unreported risk factors.[15]

At any given time, at least three-quarters of the one to four million migrant farm workers in the United States are Latino, and migrant and mobile populations are among the most medically underserved populations. Among those workers, HIV prevalence is estimated at between three and 13 percent.[16] According to the Health Resources and Services Administration (HRSA), mobility among migrant farm workers and the high percentage of multiple health problems they experience make the delivery of consistent medical care very difficult.[17]

Under-representation in the health professions also has serious impact on access to care for Latinos, particularly since they comprise such a high proportion of the country's uninsured population and Latino physicians are the ones most likely to provide care to the uninsured.[18]

Language challenges also contribute significantly to the barriers to prevention and care, given that 64 percent of Latino adults feel most comfortable speaking in Spanish and 68 percent of Latino AIDS cases are among foreign-born individuals whose first language is Spanish.[19]

## NATIVE AMERICANS

The Native American population—approximately one percent of the U.S. population—is disproportionately affected by many social and behavioral factors that contribute to disparities in health outcomes and increased vulnerability for HIV infection. The population is relatively young and has high rates of poverty, STDs, and drug and alcohol abuse.[20]

Moreover, the policy of forced relocation of Native Americans throughout the United States and attempts to relocate them to urban areas, coupled with the racism and discrimination they have encountered, have led to a legacy of high rates of poverty, unemployment, welfare dependency, obesity, diabetes, alcoholism, substance abuse, and family violence.[21]

The AIDS epidemic among Native Americans (American Indians and Alaskan Natives) continues to grow. As of December 1996, the CDC had reported a cumulative total of 475 cases of HIV infection and 1,569 cases of AIDS among Native Americans. By December 1998—a two-year period—the cumulative HIV infection cases increased by 33 percent to 632, and the AIDS cases increased by 24 percent to 1,940.[22]

Males make up 80 percent of the AIDS cases reported among Native Americans, with MSMs leading the exposure categories by accounting for nearly 60 percent of those infections. Injection drug use comes in first for women, now accounting for over half of the newly diagnosed cases. In overall mortality, by the late 1990s Native Americans had accounted for .25 percent of the cumulative U.S. AIDS deaths.[23]

It is probable that the number of HIV and AIDS cases is higher than what has been reported to the CDC due to

misclassification of the ethnicity of Native Americans by health care workers and officials as White, Latino, or Asian.

## ASIAN AND PACIFIC ISLANDERS

Strong deterrents contributing to the under-reporting of HIV/AIDS cases among APIs include the fact that many are non-citizens who fear that their residence in the United States may be placed in jeopardy if they test positive for HIV as well as the shame and loss of face that accompanies having contracted a socially stigmatized disease.[24]

Few states collect or report HIV/AIDS surveillance data by Asian and Pacific Islander (API) national origin/ethnicity, and several do not separately report any data on APIs. Instead, these states subsume any data on APIs in an "Other" category. In addition, anonymous HIV testing data is not included in the national surveillance reports on HIV cases. Yet APIs have high rates of utilization of anonymous HIV counseling and testing sites.

The cumulative number of AIDS cases reported among APIs through the late 1990s was approximately .8 percent of the total U.S. infections, with API males accounting for nearly 90 percent of the population's infections. MSMs experience the most severe impact of HIV and AIDS among this group, accounting for 56 percent of the reported AIDS cases among adult and adolescent males. Injection drug use accounted for five percent of the AIDS cases, while heterosexual contact accounted for less than 10 percent of infections. In at least one-third of the cases, a risk factor was not identified. Among females, half of HIV infections were due to heterosexual contact and nearly 20 percent to injection drug use, leaving large numbers of cases not attributed to an identified risk factor.[25]

## RECOMMEND ATIONS

Anecdotal information from many organizations providing prevention services in minority communities indicates that they are under-funded and may not receive sufficient resources to do the job.

There is an evident need for more education and prevention efforts across the board—efforts that must focus on high-risk behaviors, be sustained for MSMs, target women who expose themselves to unknown risks, enable female-controlled prevention methods, address the intersection of drug use and sexual contact, and culturally focus on specific populations.

These organizations that provide prevention services need to reach out not only to those infected and/or affected by HIV/AIDS in communities of color but also to those community institutions—such as religious groups—that might help them. Such institutions are uniquely positioned to bridge cultural barriers that often stand in the way.

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*With more than 3,000 AIDS service organizations nationwide amassed under its umbrella, the National Minority AIDS Council (NMAC) has made it a priority to develop local resources and build leadership to fight and win the battle against this disease in communities of color. For more information on NMAC and its work contact Sherri Watkins at 1931 13th Street, N.W., Washington, DC 20009. Phone: 202-48306622. Fax: 202/483-1135. E-mail: swatkins@nmac.org*

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# RECOMMENDATIONS FOR MEETING THE GLOBAL HIV PREVENTION CHALLENGE

The Global HIV Prevention Working Group* made these recommendations at the International AIDS Conference to scale up strategies to reach those in need and reverse the epidemic's projected course. They include:

**Substantially Increasing and Sustaining Prevention Funding**

- *Increase international resources.* Annual investment in HIV prevention in low- and middle-income countries should quadruple by 2004—from approximately $1.2 billion in 2002 to $4.8 billion in 2004.
- *Enable countries to prioritize resources for HIV/AIDS.* Every effort should be made to give countries the ability to prioritize resources for HIV/AIDS, especially resource-poor countries financially encumbered by debt.

**Building Capacity and Scaling Up Proven Prevention Strategies**

- *Increase local capacity*. Resources should be devoted to training local personnel and providing necessary technology so that affected countries can rapidly and sustainably scale up prevention programs.
- *Expand existing prevention strategies*. With additional resources and access to training and prevention tools, countries should rapidly bring to scale key prevention interventions that can work together to achieve maximum prevention impact.

**Encouraging Vocal Political Leadership**

- *Make HIV/AIDS a priority*. Political leaders should speak often and forcefully about the importance of HIV prevention, support policies that effectively fight AIDS and stigma, and make HIV/AIDS a permanent agenda item at important global and regional political gatherings.

**Using Prevention Resources More Strategically**

- *Improve tracking of HIV/AIDS*. Developing countries should receive training and financial and technical assistance to enhance their ability to track HIV/AIDS and plan prevention interventions accordingly.
- *Ensure strategic planning*. By 2003, every country should have a strategic HIV prevention plan.
- *Coordinate funds.* By 2003, all low-income countries should convene annual "donor roundtables," bringing together all key funders to measure available resources, identify resource gaps, and enhance program coordination.

**Expanding Access to Key Prevention Tools**

- *Ensure an adequate supply of prevention tools.* Donor nations should ensure an adequate global supply of high-quality HIV prevention tools (e.g., condoms and HIV test kits) for use in developing countries.
- *Increase access to treatment*. Access to HIV treatments, including anti-retrovirals, should be dramatically expanded—both to reduce HIV-related sickness and death and to buttress HIV prevention efforts by reducing stigma and encouraging knowledge of HIV status.

**Accelerating Research into New Prevention Technologies**

- *Increase funding*. Public sector funding for research and development should increase by $1 billion for HIV/AIDS vaccines and $1 billion for microbicides by 2007, and grow substantially for other new prevention technologies.
- *Coordinate efforts*. Industry, donors, multilateral agencies, and nongovernmental organizations should work together on an ongoing basis to identify obstacles to acceleration of HIV vaccine and microbicide research and development, and agree on approaches to overcoming such obstacles.
- *Ensure access*. Donor nations,developing countries, and multilateral agencies should immediately develop and implement strategies to ensure future access to HIV/AIDS vaccines and microbicides.

**Confronting Social Factors That Facilitate the Spread of HIV**

- *Fight stigma.* Countries should enact HIV-specific human rights protections, and people living with HIV/AIDS should be involved at every stage in the planning and implementation of HIV prevention programs.
- *Reduce poverty*. Accelerated efforts are needed to reduce the poverty that facilitates HIV transmission and worsens the social and economic impact of HIV infection.
- *Empower women*. Global efforts to empower women must be dramatically expanded.

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**The Global HIV Prevention Working Group was convened by the Bill and Melinda Gates Foundation and the Henry J. Kaiser Family Foundation to generate a greatly expanded commitment to preventing HIV transmission. For more information, go to www.gatesfoundation.org or www.kff.org*

# THE GLOBAL IMPACT OF HIV/AIDS ON YOUNG PEOPLE

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This article provides an overview of the impact of HIV/AIDS on young people around the world, generally defined as those between the ages of 10 and 24.It uses a variety of sources and studies. Readers are cautioned that global data sets and studies specific to young people are in short supply; therefore, country- or community-specific information is often used to illustrate key points.

Because of its focus on young people, this article does not discuss mother-to-child transmission (MTCT); however, MTCT remains a major route of transmission in some parts of the world and contributes to the number of young people living with HIV or at increased risk of infection.

## CURRENT IMPACT

HIV/AIDS prevalence among young people is already high in many hard-hit countries around the world, and young people continue to make up a significant proportion of new infections.

***Prevalence and incidence.*** There are an estimated 40 million people living with HIV/AIDS worldwide, more than a third of whom (38 percent) are under the age of 25.[1] They account for 33 percent of adults ages 15 to 49 estimated to be living with HIV/AIDS.

Of the five million people newly infected with HIV in 2001, almost six in 10 (58 percent) were under the age of 25.Those 15 to 24 years of age represented four in 10 of these new infections. Young people ages 15 to 24 account for half of all new infections among individuals 15 to 49. This amounts to almost 6,000 infections per day among 15- to 24-year-olds, or approximately one every 15 seconds. When infections among children under the age of 15 are factored in, an estimated 8,000 young people become infected with HIV every day worldwide.[2]

In regions where the epidemic is mostly related to heterosexual transmission, new HIV infections occur disproportionately among girls and young women. In regions where injection drug use and male-to-male sexual contact are primary modes of transmission, rates of new infections among young men exceed or are equal to those among young women.[3]

Overall, most people newly infected with HIV or already living with HIV/AIDS are in sub-Saharan Africa. Among young people, approximately three quarters (76 percent) of those already infected live in this region,[4] as do over 90 percent of the world's AIDS orphans (some 12.1 million children). Children orphaned by AIDS are more likely to become or remain impoverished and to become infected themselves.[5]

In sub-Saharan Africa, as many as 11 percent of young women and six percent of young men age 15 to 24 are estimated to already be living with HIV/AIDS. Within the region, Botswana and Lesotho have the highest proportions of infected youth. In Botswana, for example, up to 45 percent of young women and 19 percent of young men age 15 to 24 are estimated to be living with HIV.[6] In Lesotho, up to 51 percent of young women and 23 percent of young men are estimated to be living with HIV.[6]

Countries in other regions of the world also have high HIV/AIDS prevalence rates among youth. Approximately 15 percent of young people living with HIV/AIDS are in the East/South Asia and Pacific region of the world.[7] In Cambodia, as many as three percent of young women are estimated to be infected, as are one percent of young men. In Haiti, HIV prevalence is as high as seven percent for young women and five percent for young men.[8]

Even in developed countries that have had important successes in prevention and treatment leading to reductions in new infections, morbidity, and mortality, such as the United States, recent data indicate a rise in incidence among some young populations. Young people under the age of 25 continue to represent as many as half of new infections.[9]

***Nations with young populations hard hit.*** High rates of HIV infection among young people are, for the most part, occurring in countries with very young populations. Sub-Saharan Africa is one of the youngest regions of the world. Over half of its population is estimated to be under the age of 18 (with one in four people between the ages of 10 and 19).[10] In Zambia, Malawi, Kenya, and Mozambique, over half of the population is below the age of 18. In South Africa,more than 40 percent of the population is below the age of 18.

Hard-hit countries in other regions of the world also have young populations. Almost half of Haiti's population is below 18. By comparison, about a third of the world's population is below the age of 18, and slightly more than one quarter of the U.S. population is below 18.[11] The confluence of high HIV/AIDS prevalence and disproportionately young populations results in a concentration of infections among young people that has vast and long-term consequences for the course of the epidemic and for the future of many highly-affected countries.

The National Intelligence Council, part of the Central Intelligence Agency, has identified a number of countries with "youth bulges" (defined as those in which the ratio of 15- to 29-year-olds to 30- to 54-year-olds exceeds 1.27.)[12] Most of these are in sub-Saharan Africa and correspond to those countries with already-high prevalence of HIV among young people. Of the 25 sub-Saharan countries with youth bulges, over half have prevalence rates of HIV among young males and/or females higher than 10 percent.[13]

Analysis of data from the U.S. Census Bureau[14] indicate that the youth bulges will increase in many highly affected countries, including Botswana, Burundi, Lesotho, and Mozambique, due in part to the effects of the epidemic (as those in slightly older cohorts die prematurely).

## PROJECTED IMPACT

The HIV/AIDS epidemic is expected to have far-reaching demographic impacts on many nations, affecting the population structures of hard-hit countries.[15] Teens and young adults will be increasingly affected.

***Prevalence among young people.*** The U.S. Census Bureau estimates that HIV/AIDS prevalence rates among adults age 15 to 49 will continue to rise at least through 2010 in many hard-hit countries in Africa, Asia, and Latin America.[16]

The number of young people living with HIV/AIDS is also expected to grow over the next decade. Analysis of U.S. Census Bureau data indicates that if current trends persist, the global total of young people living with HIV/AIDS could rise from the current estimate of 12.4 million to 21.5 million in 2010, an increase of more than 70 percent.[17] This estimate is based on analysis of data from 49 highly affected countries in Africa, Asia, and Latin America, which represent approximately 75 percent (or 9.3 million) of the global estimate of young people currently living with HIV/AIDS.

***AIDS-related deaths.*** One of the most direct measures of the epidemic's impact is mortality. In countries where 15 percent or more of all adults are estimated to be infected with HIV—nine countries as of the end of 2001—it has been projected that at least one-third of boys now aged 15 will die of AIDS unless treatment improvements or a vaccine is introduced.[18] In Botswana, where prevalence is particularly high, a 15 year-old now has about an 80 percent chance of dying of AIDS.[19]

Deaths due to HIV/AIDS are premature deaths, and many who die from AIDS-related causes were infected as teens and young adults.[20] UNAIDS estimated that the survival time from HIV infection to death in sub-Saharan Africa is approximately eight to nine years.[21] As such, most of those who die from AIDS-related causes between the ages of 20 and 34 were infected an average of eight to nine years earlier, as teens or younger adults. U.S. Census Bureau data from 50 highly affected countries were analyzed to assess this impact.[22]

In these 50 countries, it is projected that, between 1990 and 2010, a total of 26.7 million people age 20 to 34 will have died from AIDS-related causes. The majority (59 percent) of these deaths will be among young women. In addition, most of these deaths will occur in the current decade (78 percent or 20.7 million between 2000 and 2010).

***Population growth rates.*** In addition to the direct measures of HIV/AIDS prevalence and HIV-related mortality, the epidemic will also have broader population affects. Growth rates for populations in many countries have already been reduced. The U.S. Census Bureau estimates that AIDS will result in negative population growth in several countries before the year 2010, including Botswana, Lesotho, Mozambique, South Africa, and Swaziland. Several other countries are estimated to experience flat growth rates by the year 2010, including Namibia and Zimbabwe. Population growth rates are also expected to be affected in Latin America, the Caribbean, and Asia.[23]

***Life expectancy.*** HIV/AIDS has also affected life expectancy, the average age to which a person born today can be expected to live. Due to HIV/AIDS, life expectancy in many hard-hit countries has already been reduced and could drop below age 30 in some countries by the year 2010, reversing steady gains over the last century.[24]

Life expectancy in Botswana, for example, is projected to decrease to 27 years by 2010, a net decrease of 47 years due to AIDS. In Zimbabwe, life expectancy is projected to be 35 years in 2010, a net decrease of 36 years.[25]

## ADOLESCENT VULNERABILITY

Several factors make youth particularly vulnerable to HIV infection, including their biological and emotional development and their financial dependence. In many parts of the world, young people have limited access to health care services and reliable information about sexual activity and its implications. They are often unlikely or unable to protect themselves appropriately as they demonstrate an inclination to sexual experimentation, often with multiple partners.[26]

These sexual behaviors, and sex in conjunction with drug and/or alcohol use, may increase the likelihood of becoming infected with HIV. In addition, young people's sense of invulnerability ("it can't happen to me"), combined with lack of experience, may leave them unaware of the

consequences of their actions and therefore less likely to take precautions against risk of infection.[27]

***Awareness and knowledge.*** Surveys indicate that although many young people across the world have now heard about the HIV/AIDS epidemic, awareness is not universal. UNICEF reports that in more than a dozen countries, over half of young people had never heard of AIDS.[28]

In addition, awareness does not necessarily translate into practical knowledge: a significant percentage of at-risk young people may still be unaware of how to protect themselves or harbor misconceptions about HIV transmission. Surveys in 17 countries found that one in two adolescents could not name a single method of protecting themselves from HIV infection (with girls knowing less than boys in all instances).[29] Researchers working in Mozambique found that 74 percent of young women and 62 percent of young men (age 15 to 19) were unaware of any way to protect themselves from HIV.[30] A recent survey of young South Africans found high levels of concern about HIV/AIDS, but many still did not know important facts about the disease or how to prevent or treat HIV infection.[31]

Awareness of HIV/AIDS among young people may also not translate into a perception of personal risk, even among those in countries with very high prevalence.[32] This may be in part due to a lack of visibility of HIV-positive youth, with most young people living with HIV not even knowing they are infected.[33]

Health experts note that the availability of appropriate youth-targeted information varies across regions and within nations and communities. Social, religious, and economic influences lead to widely-varying opinions on how and what to provide to young people concerning HIV prevention.[34] In some places, therefore, young people may be more vulnerable because they are less likely to know enough about HIV to protect themselves.[35]

Lack of information, particularly when it relates to sexual behavior, can bring unintended and potentially dangerous results. For example, some heterosexual youth, to avoid pregnancy and maintain virginity, may engage in alternatives to vaginal intercourse such as anal or oral sex, believing these practices are not "having sex" (and therefore carry no risk, even though anal sex is one of the most efficient ways to transmit HIV, and oral sex, though not as risky, is not entirely safe).[36]

***Other sexually transmitted diseases.*** Being infected with another sexually transmitted disease (STD) also increases the likelihood of both acquiring and transmitting HIV.[37] The prevalence of STDs other than HIV among youth is high.[38] A broad, cross-national survey of STD data among developed countries (North American, European, and Scandinavian countries plus Russia and Romania) found that syphilis, gonorrhea, and chlamydia disproportionately affect adolescents and young adults, with generally higher incidence among females than males.[39]

In the United States, it is estimated that two-thirds of the 12 million cases of STDs diagnosed annually are among people under the age of 25.[40] In England and Wales, cases of gonorrhea and syphilis—again documented disproportionately among young people—have hit their highest levels in more than a decade.[41]

Data from developing countries are more limited. The World Health Organization (WHO) reports that age-specific data from developing countries show peak incidence of STDs among those 15 to 29. Studies of gonorrhea in several African and Middle Eastern nations found the highest levels of infection among those in this same age group, with the highest among those aged 15 to 19.[42]

***Socioeconomic factors.*** Most young people at risk for HIV infection or already living with HIV/AIDS reside in the world's poorest regions. Their vulnerability to HIV operates within a broader context of poverty, which may include lack of access to education, economic opportunities, and health-related services.

Formal educational systems can contribute directly and indirectly to the impact of HIV on young people. Teachers and schools can improve awareness of risk and teach strategies for protection through good-quality sexual health education programs, which help delay initiation of sexual behavior and protect sexually active youth from HIV, STDs, and pregnancy.[43]

However, educational systems in many countries, already struggling before the spread of AIDS, have been significantly affected by the epidemic. About one million African children and young people are estimated to have lost their teachers to AIDS in 2001.[44] Prior gains in school enrollment, resulting from increased investments by many developing countries, have been adversely affected as teachers succumb to AIDS or leave to seek health care.[45] Students who are infected may be stigmatized and/or pressured to leave.[46] Students orphaned by AIDS are often unable to pay educational fees and, if forced to leave school, face increased risk of poverty and HIV infection.[47] Girls may be particularly affected by this phenomenon because they are often the first to be taken from school when sick parents need help or their families need income.[48]

Lack of economic opportunity is also an important contributor to HIV-related vulnerability. This is particularly true of girls and young women, who have less access to and control over income, property, land, and credit.[49] Though the extent of gender disparities in economic opportunity vary from country to country, they are ubiquitous.[50]

Without options, young women may exchange sex for money, shelter, or safety—often under threat of violence.[51] Studies of unmarried adolescents in several sub-Saharan countries have found that 13 to 38 percent of girls have received or been given money or gifts in exchange for sex.[52]

Alternatively, because they have nowhere else to go, they may be forced to remain in relationships with partners who are violent or are believed or known to be infected with HIV.[53] Young women often lack the power to insist on the use of condoms.[54]

Lack of economic opportunity is not just a problem for women. Gay and bisexual (and sometimes heterosexual) boys and young men in many countries trade sex for money, drugs, or shelter with wealthier men—both for survival and to enhance income.[55]

## HEALTH CARE ACCESS

Systemic disparities in access to health care for young people can heighten vulnerability to HIV. Many of the countries hardest hit by HIV/AIDS lack sufficient infrastructure and resources to deliver needed HIV-related services, including prevention and treatment services,HIV counseling and testing, and mental health care.[56] In addition, there are some persistent barriers to these health services for youth in developing and developed nations alike—lack of privacy and confidentiality, staff insensitivity to young people's special needs and perspectives, lack of affordable services, and lack of services geared toward adolescents ("teen friendly").[57] Health care access may worsen as the burden of caring for so many millions of people suffering from AIDS-related illnesses takes an increasing toll on health infrastructures.[58]

Stigma may also play a role in young people's willingness to seek services.[59] Young women and girls, for example, may avoid health care services, including HIV testing and treatment for STDs, because of fear of stigmatization or even of violence—particularly if it becomes known that they're sexually active (before or outside of marriage) or infected with HIV.[60]

## THE MOST VULNERABLE

Certain subpopulations of youth have been identified as bearing a disproportionate share of HIV's proliferation and/or are at increasing risk: young women and girls, young men who have sex with men, injecting drug users, sex workers, and children who have been orphaned by AIDS.[61]

***Young women and girls.*** Women comprise an increasing proportion of adults living with HIV/AIDS, rising from 41 percent in 1997 to 50 percent in 2001.[62] In sub-Saharan Africa, women represent more than half of all people living with HIV/AIDS.[63]

Prevalence of HIV is typically higher among young women in sub-Saharan Africa,[64] who represent the majority of young people living with HIV/AIDS in that region and in Asia.[65] Among women, peak HIV prevalence is around age 25, while in men it occurs 10 to 15 years later and generally at lower levels.[66] Infections among South African girls, for example, peak at age 15 to 19; among boys they peak at age 20 to 24.[67]

In some of the most affected countries,the rates of new HIV infections among girls are as much as five to six times higher than those among boys.[68] In Botswana, for example, up to 45 percent of women age 15 to 24 are estimated to be HIV positive, about twice the proportion of HIV-positive men in the same age group.[69]

Although it is most pronounced there, this trend is not unique to the developing world. In the United States, women now represent 30 percent of new HIV infections and an increasing proportion of new AIDS cases as well (rising from seven percent in 1985 to 25 percent in 2001).[70]

Biologically, the risk of becoming infected with HIV during unprotected vaginal intercourse is greater for women than men.[71] The immaturity of young women's reproductive organs makes them even more vulnerable than mature women to HIV infection by providing enhanced opportunity for exposure and infection.[72]

Cultural and economic factors also contribute to increased vulnerability of young women and girls. For example, lack of economic autonomy may induce young women to partner with older men for protection and support.[73] Growing evidence suggests that sexual relationships between older men and younger women are responsible for much of the gender disparity between young women's and men's infection rates and for the increasing numbers of infections among younger girls.[74]

Young women who have sex with older partners are at greater risk for infection because these older partners are more likely to be infected than age-equivalent partners would be.[75] In some countries, younger and younger girls are put at risk because some men are seeking partners who are not infected, fueled in part by an expectation that younger girls are less likely to be infected or by a misguided belief that having intercourse with a virgin will cure or prevent AIDS.[76]

Condoms,though effective in reducing the risk of HIV transmission, require that the male partner agree to their use. Insisting that a partner (or husband) wear a condom might be interpreted as a challenge to long-accepted rules, and could raise questions about loyalty, fidelity, and trust.[77]

As mentioned previously, sexual violence and coercion put women at risk of infection and may keep those already HIV-positive from seeking available care. UNAIDS reports that some new cases of HIV infection among women are caused by gender-based violence in their homes, schools, work places, and social spheres.[78] In South Africa, for example, a woman who made her HIV infection public was stoned to death by neighbors who felt she had brought shame upon their community.[79]

***Young gay and bisexual men.*** Because of the efficiency

of anal intercourse as a mode of transmitting HIV, men who have unprotected sex with men are at a relatively high risk for HIV. Worldwide, approximately five to 10 percent of all HIV infections are due to sexual transmission between men.[80] UNAIDS estimates that male-to-male sexual transmission is a predominant risk factor for HIV in several countries, including the United States, Brazil, Costa Rica, and Mexico, and may be playing an increasing role in Eastern Europe.[81] The U.S. Centers for Disease Control and Prevention (CDC) estimates that half of new AIDS cases reported in the United States in 2000 among males age 13 to 24 were among men who have sex with men (MSMs).[82]

Stigma, social exclusion, and lack of information can result in increased risk-taking among MSMs.[83] These factors make it difficult to obtain accurate data on the extent of MSM behaviors and related risks.[84] Many societies outlaw homosexual behavior or in some way officially condemn or ignore its existence. In Vietnam, for example, AIDS cases among MSMs are simply not reported.[85]

Many young MSMs may also be sexually involved with women, acting as "viral bridges" by introducing HIV into the larger population. A UNAIDS survey in Cambodia found that 40 percent of self-identifying MSMs also reported having sex with women in the month before being surveyed.[86] Research in Budapest found that the percentage of men who identified themselves as gay or bisexual but who had sex with a female at least once was high (77 percent), with 26 percent reporting sex with a female within the last year.[87] This same group reported a low rate of condom use for vaginal intercourse (23 percent).[88] Similar rates of bisexual behavior were found in Russian[89] and Brazilian[90] studies.

Despite encouraging reductions in unsafe sex practices in the early 1990s, risky behaviors and HIV infection rates among young MSMs may be on the rise again in the developed world. A recent survey of 23- to 29-year-old MSMs in six U.S. cities found high HIV prevalence rates among Whites (seven percent), Hispanics (14 percent), and particularly Blacks (32 percent).[91] An earlier sample of younger MSMs (15 to 22) in seven U.S. cities found a seven percent overall HIV prevalence rate, with higher rates among Black (14 percent) and Hispanic (seven percent) youth than among Whites (three percent).[92] Public health experts have expressed concern that recently-noted outbreaks of STDs among MSMs may signal a resurgence of risk-taking among older MSMs and a lack of awareness or concern among younger MSMs.[93]

***Young injection drug users.*** Intravenous injection is the quickest and most efficient route of HIV transmission because infected blood is delivered directly into a user's blood stream. Approximately 10 percent of HIV infections globally are due to injection drug use.[94] Eastern Europe and Central Asia are experiencing a rapid spread of HIV due largely to high numbers of youth injecting drugs.[95]

In the Russian Federation, where HIV is predominantly transmitted through injection drug use, HIV is concentrated largely among 18 to 30 year-olds; the average HIV-infected drug user is 24. A 1999 survey of 15 to 16 year-olds in Moscow found that six percent admitted to having used heroin at least once in their lives; also in 1999, 40 percent of clients of a St. Petersburg drug treatment program were young people, up from 13 percent two years earlier.[96]

In Central Asia, 70 percent of injection drug users are under age 25.[97] Canada, China, Latvia, Malaysia, Moldova, Russia, Ukraine, and Vietnam reported that more than half of all new HIV infections in 1998 to 1999 occurred among injection drug users, an increasing percentage of whom are young people.[98]

***Children and youth orphaned by AIDS.*** Children orphaned by AIDS present a significant challenge. Since the epidemic began, an estimated 13.2 million children—most of whom live in the developing world—have lost their mothers or both parents to AIDS.[99]

Prior to the onset of the AIDS epidemic, approximately two percent of children in developing countries were orphans. By 1999 in some African countries the rate was more than 10 percent. In 2000, one child every 14 seconds became an orphan because of AIDS.[100] This impact is expected to worsen. The United States Agency for International Development (USAID) has estimated that as many as 44 million children will be orphaned by AIDS by 2010.[101]

The impact of HIV/AIDS on children begins well before the death of their parents. Children living in households headed by HIV-positive parents face increased risk of hunger, malnutrition, material deprivation, reduced access to school and health care, and increased emotional distress.[102]

After parents die, in much of the world the burden for caring for orphans falls on families and communities—and particularly on young women. However, these care networks are being overwhelmed by the magnitude of the needs put upon them, leaving many children vulnerable to malnutrition, exploitation, and abandonment.[103] UNAIDS reports that orphans living with extended families or in foster care are more prone to discrimination, including limited access to health, education, and social services.[104] As alternatives, some children maintain their own households or assume other adult burdens; others take to the streets.[105] Without support systems and resources, they are at substantially increased risk of malnutrition, abuse, illness, and HIV infection.[106]

Communities and societies are impacted as well. The U.S. National Intelligence Council notes that the large number of children orphaned by AIDS, located largely in countries that are already disproportionately young, will strain family systems and contribute to crime and political instability.[107]

***Sexually exploited children.*** The sexual exploitation of children also contributes to increased incidence of HIV

transmission. Prostitution, trafficking, child pornography, and forced marriages all heighten risk of HIV infection for children and communities within which such practices occur.[108]

Approximately one million children enter the world's sex trade every year,[109] placing them at greater risk for HIV infection.[110] Rates of HIV infection among young sex workers can be high. For example, studies have found HIV prevalence of 17 percent among sex workers in urban Nepal, 72 percent for sex workers under 18 in Mumbai, India, and 30 percent for sex workers age 13 to 19 in Cambodia.[111] Younger sex workers may be particularly vulnerable because of their inexperience in negotiating condom use and, as previously mentioned, because their clients may assume that sex with a child or virgin decreases their risk of infection or may even have preventive or curative powers against HIV.[112]

Sexual exploitation of children is exacerbated by the large number of children orphaned by AIDS. These children, parentless and in poverty, increase the pool of those young people vulnerable to exploitation or, in some cases, dependent upon trading sex for survival.[113]

Trafficking in children may also serve to increase the spread of HIV. Reports of children trafficked across continents and oceans to meet "demand" suggest the consistency with which the practice occurs and the potential it brings of increasing the spread of HIV. In one case, over 1,000 children were sent from China,Laos,Malaysia,Thailand,and Vietnam to Atlanta,GA,to work as prostitutes.[114]

## HIV/AIDS PREVENTION

Several recent prevention reviews demonstrate effectiveness in reducing risky behaviors and HIV transmission.[115] Few large-scale prevention efforts, however, have been geared toward youth, and youth may need different prevention strategies than older adults.Where they do exist, such efforts have been shown to lead to increased knowledge about HIV/AIDS, delays in sexual activity, and increased condom use among those having sex for the first time. Prevention efforts have also led to reductions in HIV transmission among some populations.[116]

The impact of the epidemic on young people is expected to grow, particularly in hard-hit countries that already have very young populations.Therefore, the level of available resources and how those resources are used will continue to challenge global and national leaders.[117]

Projections of demographic shifting over the next decade and beyond show that—absent significantly enhanced prevention and treatment efforts, and perhaps the introduction of new technologies including microbicides and vaccines—the combination of young populations and the spread of HIV will result in the continued growth of the HIV/AIDS pandemic.

Prevention interventions directed at youth will therefore be critical to altering the future course of the pandemic.[118] In fact, where national prevention efforts have been most successful—in Uganda and Thailand—young people are often the first to respond to prevention interventions and to show positive results.[119] In Uganda, for example, HIV prevalence declined significantly among pregnant women, with the greatest decline among those in the youngest age group (15 to 19 years old). In Thailand, HIV prevalence rates declined among young military recruits (a proxy of national success for Thailand's HIV prevention campaign).

A new analysis of the potential impact of different prevention interventions, including increased condom use and a reduction in the number of sexual partners, among young people 15 to 19 years old in South Africa projects significant reductions in HIV incidence and prevalence over time.[120] In addition, projection models demonstrate that even modest changes in behavior—such as increased condom use and STD treatment—can significantly reduce HIV/AIDS prevalence.[121]

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# AIDS CONFERENCE REGISTRANTS MUST TURN KNOWLEDGE AND COMMITMENT INTO ACTION

**Terje Anderson**
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I stand before you as a person living with HIV, as a former injection drug user, as a former sex worker, and as a gay man. I also stand before you fully aware that I am alive today largely because I had the good fortune to have been born a white man in North America.

While I share much with my infected comrades—my fellow HIV-positive friends around the world—I do not, and neither can this International AIDS Conference, pretend to speak for those who cannot be here. There are millions of people who will never be able to join us, yet whose lives depend on the success of our discussions being turned into reality.

While sessions throughout this Conference highlighted that disparity, it is vital that we remember that those voices have largely been unheard here, that those of us with travel budgets, with education, with access, have presumed to speak for them. We must find a way in future Conferences to bring those voices into more meaningful presence.

## URGENCY , FRUSTRATION

A clear consensus has developed at this Conference across all disciplines and backgrounds, from all parts of the world—that is, a sense of urgency for effective action and a clear frustration between knowledge of what is possible and the reality of what is happening now.

We consistently saw that,in order to successfully pursue policy aims, advocacy must be multi-pronged and flexible, that a variety of approaches are essential for success.

This was illustrated, for example, in a series of discussions on approaches to overcoming drug prices. Negotiated price reductions, company donations, patent law, international trade agreements, and generic production were all explored and viewed as relevant in different situations.

We saw that, around the world,advocates are successfully using law and establishing a legal framework to respond effectively to HIV/AIDS. Perhaps nowhere was this more visible than in the widely discussed recent South African court decision on drug access. Yet, it also became clear that bad laws can be a barrier to effective HIV policies, including the detrimental effect on prevention efforts presented by punitive laws.

## PEOPLE AND MONEY

Much of this Conference focused on the important question of mobilizing sufficient resources for mounting an effective response, and we learned much about which countries were shouldering their fair share of the burden and which, including my own,still are not doing enough.

Yet many questions remain unanswered—about the degree of investment and the complex question of cost-benefit analysis—questions that will need to be answered if we are to be successful in marshalling needed resources.

We heard repeatedly that the debate over "prevention versus care" is over—yet we all know, and heard continually in various sessions about resource allocation decisions, that that debate is in many ways just beginning in terms of implementation in the real world.

We repeatedly said at this conference that the key issue is one of scaling up, and I certainly share in that consensus. Yet this ignores the reality that,in all parts of the developing and developed world, we are still trying to learn the best ways to deliver care and prevention services.

And without question, we found in the Conference sessions and speeches a stronger awareness than ever before that marginalization and stigma continue to shape and define this epidemic. Yet for all the increased discussion of issues such as the human right to travel freely, it is unclear that any of us will have the means to change the most egregious policies that we protest.

## POLITIC AL AREN A

Finally, this Conference clearly showed that, more than ever before, this fight is being fought, and must be fought, on a political plane. That this fight requires engaged political leadership and that it is our responsibility to engage that leadership when it does not appear to pay attention the way it must.

Yet it remains unclear if scientists, doctors, PLWHAs (People Living with HIV/AIDS), NGOs (nongovernmental organizations), service providers, and other relevant players are truly willing to take the risks associated with entering the political arena.

It may be safe to give advocacy speeches and blow

whistles among like-minded people at an AIDS conference, but how many of us are willing to do the same when it could mean loss of government funding, loss of access to decision makers, unemployment, social isolation, personal experience of discrimination,and stigma?

What we do while here in the safe "bubble" of an International AIDS Conference may bear little resemblance to what happens when we leave. Will we have the courage and perseverance to really "turn knowledge and commitment into action" or will it become business as usual for another two years? Can those whose voices are not here really count on us to make good on our promises, or will millions die because of our inability to take action?

## CONCLUSION

I want to end by recalling a quotation that Helen Gayle, who works for the Bill and Melinda Gates Foundation, used in one of her plenary presentations at this Conference: "Justice will come when those who are not injured are as indignant as those who are." We must leave this Conference more indignant, angrier, more impatient, and more ready to act than when we arrived. Only if we do that can the Conference meet the test to turn knowledge and commitment into action.

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*Terje Anderson was the chief reporter for the advocacy and policy track at the International AIDS Conference in Barcelona this summer. He provided SIECUS with this synopsis of the report he delivered to Conference registrants at the close of the meeting.* ***–Editor***

# HEALTH CONNECTIONS: AIDS EDUCATION LESSONS TO SUPPLEMENT LITERATURE-BASED INSTRUCTION

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As all of us know, adolescents are at high risk for sexually transmitted infections (STIs), including HIV, because of their sexual behaviors. Education is one strategy for helping them reduce such risks.

So I was excited when I heard that health, English, and language arts teachers had collaborated to write lesson plans that integrate mandated HIV/AIDS education with the core literature used in California schools. I was truly amazed when I actually saw the resource binder, developed for the California Department of Education, which contains all 20 lesson plan booklets. Called *Health Connections: AIDS Education Lessons*, the resources focus on critical thinking about the health choices of ethnically diverse literary characters. Teachers can quickly integrate the resources into any classroom.

The lessons teach AIDS-prevention skills such as problem solving, decision making, conflict resolution, dealing with peer pressure, and assertive communication. For example, the suggested lesson plan for high school students reading *Brave New World* helps them understand the connection between high-risk behaviors and their consequences by allowing teens to create a game called "Life or Consequences." Students research and debate many of the important issues raised in *Brave New World* and also look at the effects the media has on their decisions by creating ironic advertisements.

Sixth-grade students reading *Bridge to Terabithia* examine passages from the story that show Jess' lack of self-esteem and discuss the characteristics of people who have low self-esteem and those who have high self-esteem. Students re-write passages to give Jess high self-esteem, and discuss how self-esteem and peer pressure are related to each other. Eighth graders reading *Dance Hall of the Dead* analyze the relevance of the setting to the mood, tone, and meaning of the text while also learning to recognize and understand how communicable diseases are transmitted.

Students will find these lessons engaging as they reach beyond the plot and to reflect on risky behaviors, apply decision-making skills, practice assertive refusal communication, and recognize the need to show compassion for those infected with HIV. At the same time, the students will learn how STIs are transmitted, how STIs magnify the risk of HIV infection, and how some infections can be passed on through direct skin-to-skin, lesion-to-skin, or lesion-to-mucous membrane contact, with no blood, semen, or vaginal secretions involved.

Each lesson plan provides strong teacher support including lesson and literature summaries, sample parent letters, and teacher alerts with concrete suggestions on how to manage a classroom while teaching with clearly stated objectives.

Resources include information on using role play, promoting assertive refusal skills, and handling difficult personal questions. There also are connections to *Health Challenge and English/Language Arts Standards*, a summary of California state laws that govern what public schools are required to teach students; a lesson overview; a teacher-friendly Ready/Set/Go format; blackline masters of student handouts; and additional resources.

*Health Connections: AIDS Education Lessons* is a cutting-edge resource in AIDS education. I believe that even those teachers who question whether they want to teach such a controversial subject will find that these resources will make their classes on HIV/AIDS crucial and rewarding.

These are some of the literature selections *in Health Connections: AIDS Education Lessons*:

- *Izzy, Willy-Nilly*
- *Bridge to Terabithia*
- *The Canterbury Tales*
- *The House on Mango Street*
- *To Kill a Mockingbird*
- *The Lottery*
- *Of Mice and Men*
- *The Outsiders*
- *Brave New World*
- *Diary of Anne Frank*
- *If Beale Street Could Talk*
- *Lord of the Flies*
- *Love Medicine*
- *Summer of My German Soldier*

*Available for $39.95, plus shipping and handling, from: Healthy Kids Resource Center, 313 West Winton Avenue, Hayward, CA 94544-1198. Phone: 510/670-4581.*

# STANDARDS FOR STD/HIV PREVENTION CURRICULA IN SECONDARY SCHOOLS

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This is a checklist of 63 standards that school officials and educators can use to evaluate their existing STD/HIV prevention education programs or to develop new curricula and materials.

These standards include topics,messages, and learning approaches.They emphasize health-enhancing behaviors as opposed to biomedical information.They also reflect a teaching approach that is based on the common characteristics of sexual risk-prevention programs that have proven effective over the years.

These standards reflect current information about the epidemic and disease as well as the philosophies, goals, and methodologies of current school-based STD/HIV prevention education programs.They are based on an analysis of professional literature as well as interviews with health scientists and STD/HIV prevention educators.

The standards were originally published in the August/September 1989 *SIECUS Report,* at the close of first decade of the HIV/AIDS pandemic.This is the first update.

**FIGURE 1**
**MAJOR HIERARCHICAL COMPONENTS OF SCHOOL STD/HIV PREVENTION EDUCATION CURRICULA FOR TEEN AGERS**

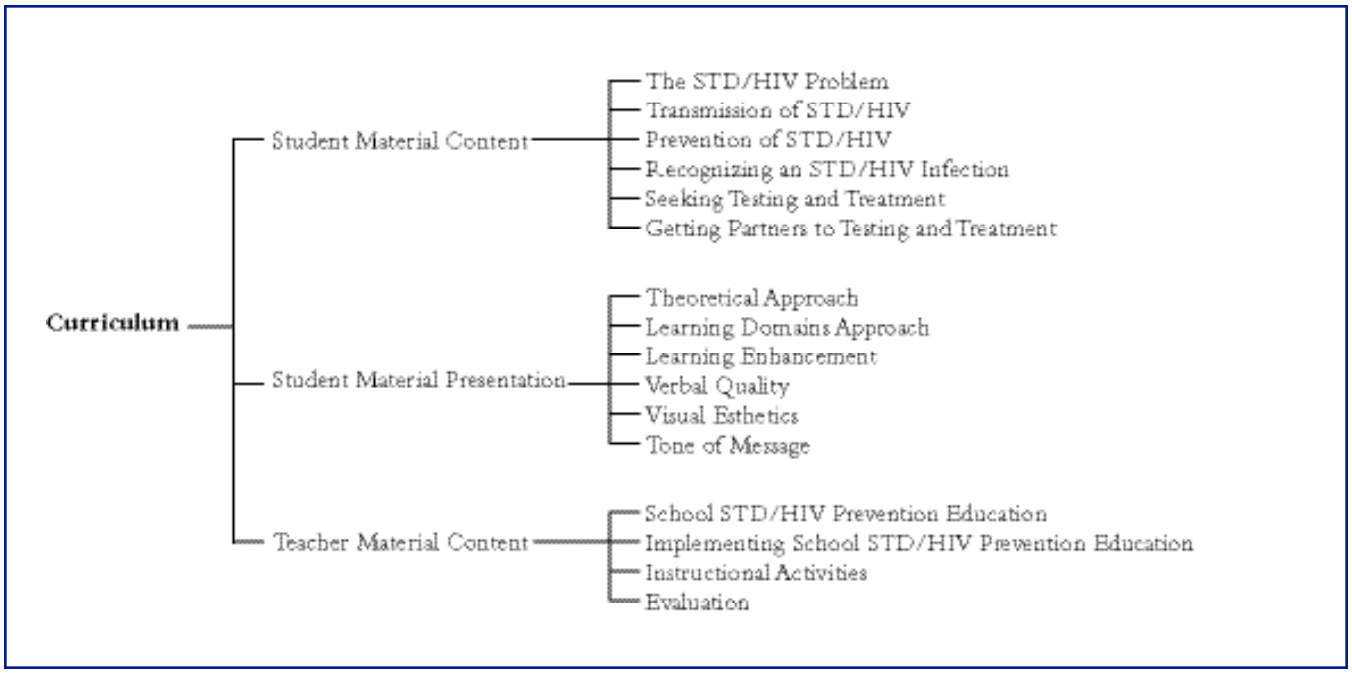
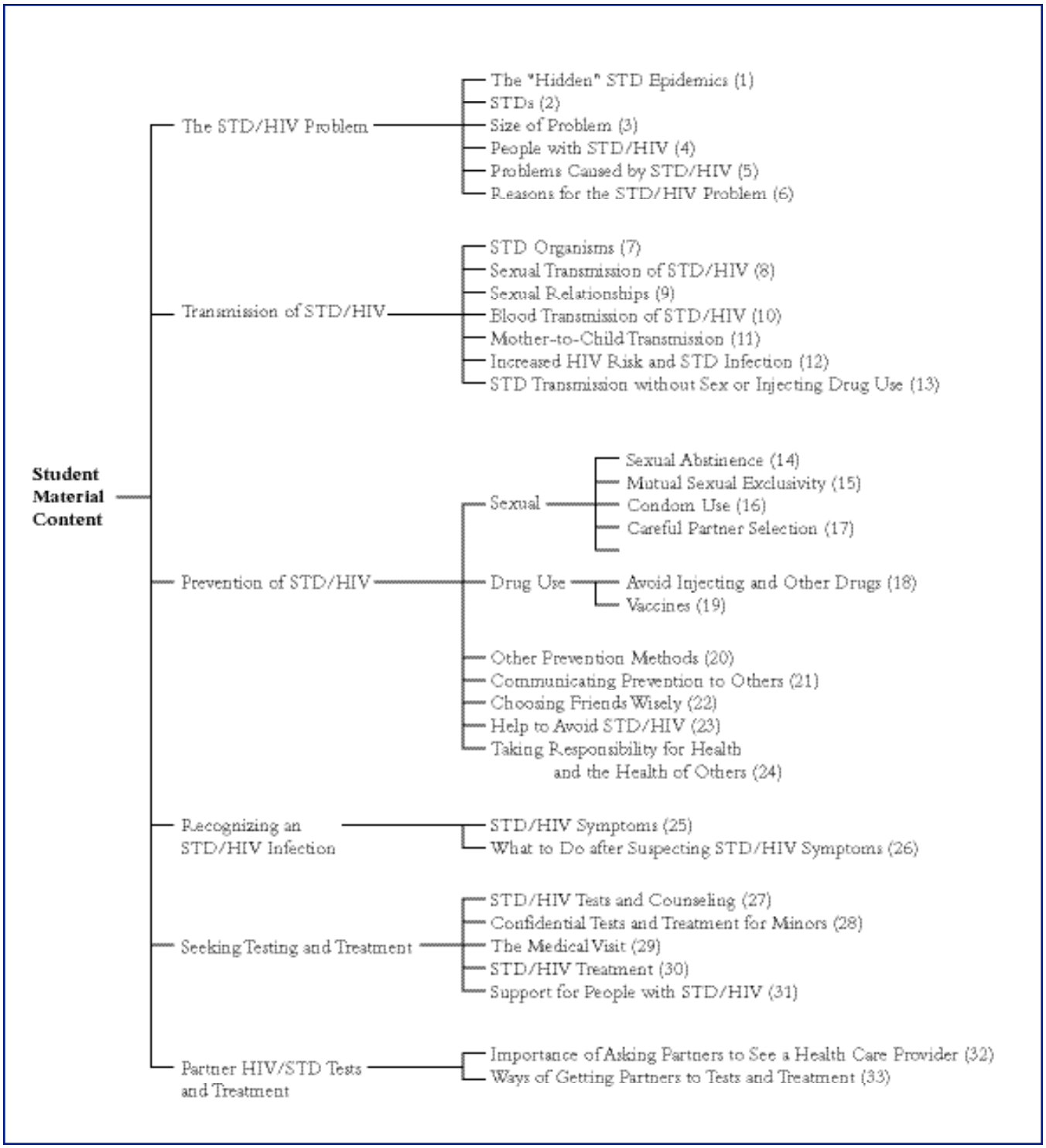
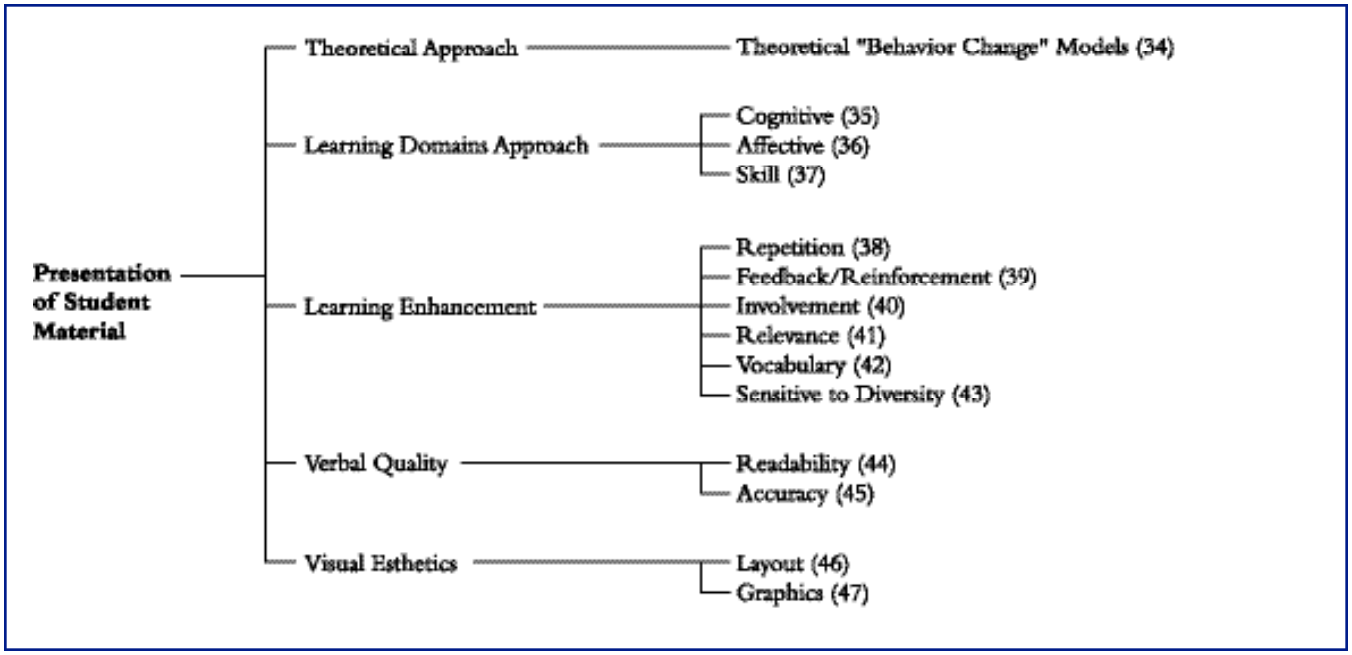


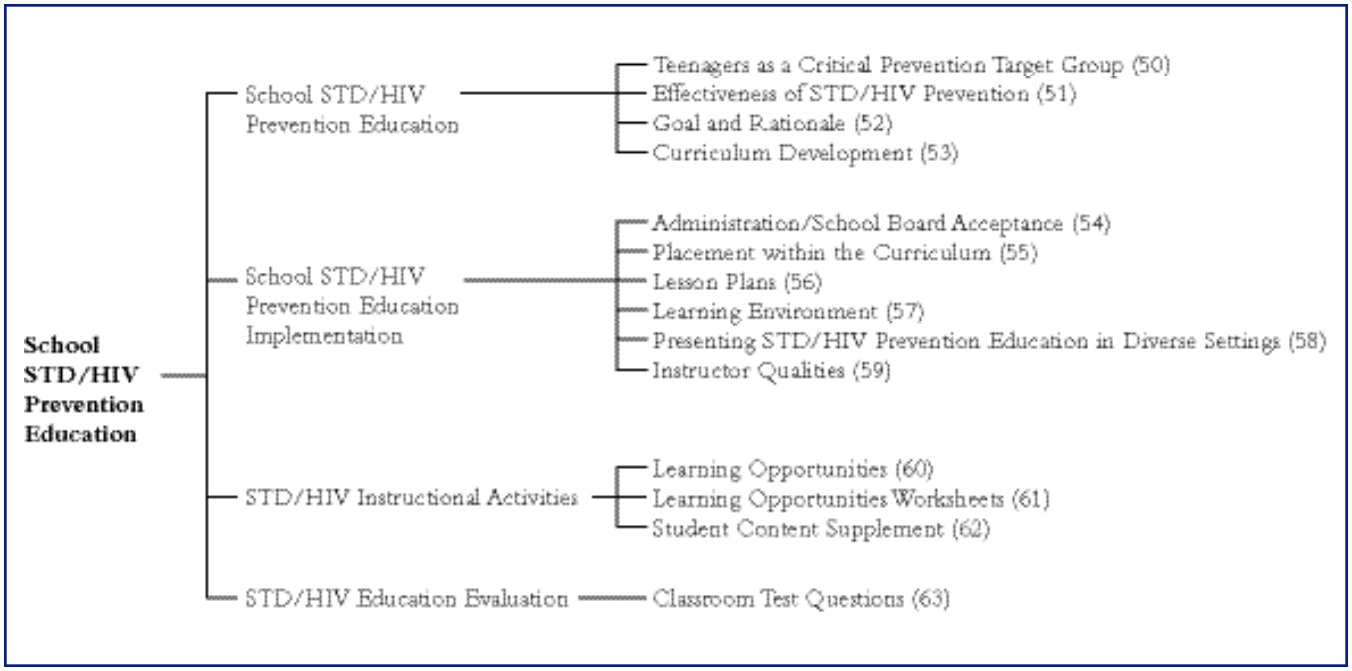
**FIGURE 2**
**SPECIFIC HIERARCHICAL COMPONENTS OF THE STUDENT MATERIAL CONTENT**



## FIGURE 3
## SPECIFIC HIERARCHICAL COMPONENTS OF THE STUDENT MATERIAL PRESENTA TION




## FIGURE 4
## BACKGR OUND FOR TEACHERS



## CHECKLIST TO EV ALU ATE CURRICULA

This checklist to evaluate curricula includes 63 specific criteria/performance standards.It presents essential topics and components to include in the curriculum (regular typeface) as well as health-enhancing behaviors that curricula should promote and encourage (italic typeface).

### STUDENT CONTENT

**The STD/HIV Problem**

1. The "Hidden"STD Epidemics

____STDs are the most commonly reported infectious diseases in the United States

____STDs are hidden for many reasons

____There are negative outcomes as a result of the hidden nature of STDs

____The STD/HIV risk for sexually active teenagers is underestimated

____The STD prevalence among teenagers is underestimated

____Sexually transmitted infections (STIs) is a new term used to describe STDs

2. STDs

____Over 25 STDs, including HIV/AIDS, currently exist

____Certain STDs have a particular impact on teenagers

____Teenagers have a greater chance of contracting STDs, other than HIV

____Teenagers are concerned about STDs and HIV

3. Size of Problem

____The prevalence of STDs

____The estimated number of new STD/HIV cases annually

____The number of people in the United States infected with STD/HIV

____The increase or decrease of STD prevalence

____The status of HIV/AIDS in the United States and around the world

4. People with STD/HIV

____Behavior, not sexual orientation, is a risk factor for STDs

____Infections occur in all communities and population groups

____Teens and young adults account for two-thirds of STD cases

____Teenagers and young adults are at great risk for specific reasons

____STDs have a greater impact on heterosexual men and women,as well as men who have sex with men,than on women who have sex with women

____Individuals in underserved communities and communities of color are disproportionately affected by STD/HIV

5. Problems Caused by STD/HIV

____Untreated and incurable STDs have health consequences

____Health damage is more serious for women and infants

____STD/HIV impact lives and relationships, finances, research and health care priorities, and prevention efforts

6. Reasons for the STD/HIV Problem

____Risky behaviors

____STDs are often incurable and difficult to treat

____Emotional factors, such as guilt and shame, prevent people from getting treatment

____Social and economic barriers prevent people from getting treatment

____Public silence

____Inadequate education,health care, and support

**STD/HIV Transmission**

7. STD Organisms

____STD/HIV are usually found in body fluids

____An individual can have more than one STD infection at a time

8. Sexual Transmission of STD/HIV

____STDs are most often transmitted through sexual intercourse

____STD/HIV are contracted during contact with an infected person

____Sex is defined in a variety of ways

____STD/HIV are more easily transmitted from men to women than from women to men

____Vaginal intercourse involves risk

____Anal intercourse involves risk

____Oral sex involves risk

9. Sexual Relationships

____People with one partner can be at risk

____People who do not know if their partner is sexually exclusive are at increased risk

____People who have multiple partners are at increased risk

____People with certain types of partners are at increased risk

____Teenagers with much older partners are at increased risk

____People who have an early sexual initiation are at increased risk

10. Blood Transmission of STD/HIV

____Blood-to-blood transmission is the second-most common way STD/HIV are contracted

____People who share injection drug needles and equipment are at increased risk

____Health care workers handling HIV-infected blood are at increased risk

____People who have their bodies tattooed and pierced are at increased risk

11. Mother-to-Child Transmission

____STD/HIV are sometimes passed from mother to child

____The child of a pregnant HIV-infected mother is at increased risk

____A child who is breast fed by an HIV-infected mother is at increased risk

____Medical treatment is available to reduce such a child's risk for contracting HIV

12. Increased HIV Risk with STD Infection

____People with an STD are at increased risk of contracting HIV

____People with HIV and an STD are at increased risk of transmitting HIV

13. STD Transmission without Sex or Injecting Drug Use

____ STD/HIV are not transmitted in certain ways

____HIV-infected individuals should not donate blood, bone marrow, organs, semen,or tissues.

____STD/HIV are not transmitted through casual, non-sexual contact

____Family members caring for a person with HIV/AIDS are not at risk

____Unreasonable fear exists about STD/HIV tranmission

**STD/HIV Pr evention**

14. Sexual Abstinence

____Definitions of sexual abstinence

____Normalcy of sexual abstinence

____Benefits of sexual abstinence

____Risks of early sexual involvement

____Naturalness of sexual feelings

____Religious and societal support for sexual abstinence

____Factors to consider prior to sexual intercourse

____The value of delaying sexual intercourse

____There are intimate behaviors other than vaginal intercourse, anal intercourse, or oral sex

____*People desiring to abstain from sexual contact are encouraged to adhere to their decision*

____*People are encouraged to support peers who choose to abstain from sexual contact*

____*People are encouraged to consider all factors when deciding to have sexual contact with someone*

15. Mutual Sexual Exclusivity

____Definitions of mutual sexual exclusivity

____Benefits of mutual sexual exclusivity

____Risks involved in having multiple partners

____Exclusive relationships other than marriage do exist

____A partner who is not sexually exclusive or uses injection drugs puts the other partner at risk

____*People are encouraged to avoid multiple sex partners*

____*People are encouraged to delay sexual contact until they are able to form a long-term, mutually exclusive relationship*

____*People who are sexually involved and want to remain so are encouraged to establish and/or maintain a mutually exclusive relationship*

____*People are encouraged not to have sexual contact with partners who do not agree to remain sexually exclusive*

16. Condom Use

____When an individual should use a condom

____Types of condoms people should use

____How to use a condom

____Effectiveness of condoms in preventing the spread of STDs

____Condoms are FDA approved

____How to discuss condom use with a partner

____How and where to acquire condoms

____The dangers of nonoxynol-9

____Research is needed on the female condom for STD/HIV prevention

____*People are encouraged to use latex or polyurethane condoms consistently and correctly*

____*People are encouraged not to use nonoxynol-9 with condoms*

____*When couples cannot use a male condom, they should consider using a female condom*

17. Careful Partner Selection

____Value exists in the careful selection of a partner

____Value exists in knowing if a partner is at risk for STD/HIV

____A partner's STD/HIV status is not certain as a result of appearance, familiarity, or reputation

____Certain people are at increased risk for STD/HIV

____Some STD/HIV-infected people are dishonest about their infection status and sexual history

____*People are encouraged to carefully select partners and to avoid sexual contact with people who might be at high risk for STD/HIV*

____*People are encouraged to seek STD/HIV testing of their partners and themselves*

____*People are encouraged to look for STD/HIV symptoms on their partners as one, but not a completely accurate, way of judging possible infection*

____*People are encouraged to get contact information from partners they do not know well*

18. Avoid Injecting and Other Drugs

____Injection drug use involves risk for STD/HIV

____Mixing alcohol, drugs, and sex involves risk for STD/HIV

____"Date-rape"drugs involve risk for STD/HIV

____*People are encouraged to identify and resist the pressure to use drugs*

____*People are encouraged not to use injection drugs*

____*People using injection drugs should not share needles, syringes, and other equipment*

____*People addicted to drugs are encouraged to seek professional help*

19. Vaccines

____Hepatitis B is the only STD with a vaccine

____Efforts are underway to create an HIV vaccine

20. Other Prevention Methods

____Alternatives to intercourse, such as masturbation and massage, significantly minimize the chance of contracting STD/HIV

____Laws require the disclosure of STD/HIV infection to sex and injection drug partners

____Laws require the screening of donated blood,semen, tissues,and organs

____Donation of a person's own blood for his/her own surgery will prevent the risk of contracting an STD or HIV

____*People infected with STD/HIV are encouraged to avoid exposing others*

____*People are encouraged to limit partner affection to such activities as hugging, massaging, and/or masturbating until criteria are met for more intimate sexual behavior*

____*People are encouraged not to allow blood,semen,or vaginal fluids to touch their genitals, mouth,or anus*

____*People are encouraged not to engage in open-mouth kissing of an HIV-infected person*

____*People who are infected with STD/HIV are encouraged not to use injection drugs and not to share injection equipment*

____*People at high risk for HIV are encouraged not to donate blood, bone marrow, organs, semen,and tissues*

____*Pregnant women are encouraged to get tested for HIV*

____*HIV-infected women are encouraged to seek medical care before and during pregnancy;they should not breast feed*

____*Women thinking about becoming pregnant should know if their partner has an STD or HIV*

____*Women planning to become pregnant should avoid sexual contact with anyone who has practiced risky sexual behavior or used injection drugs*

____*Pregnant women are encouraged to insist that male partners use a condom if they have practiced high-risk behavior or have an uncertain STD/HIV-infection status*

____*People seeking body tattoos and piercing are encouraged to ask the parlor staff people about their license and if they follow regulations, such as sterilizing their equipment*

____*People who bleed during sports are encouraged to stop participating until the wound stops bleeding and until it is properly cleaned and securely bandaged*

21. Communicating Prevention to Others

____There is a need for and a value to communication

____There is a need to communicate values

____There is a need to be certain of beliefs and values

____People should suggest ways to improve communication about sexuality-related issues

____People should avoid negative peer pressure

____People should suggest ways for others to resist negative peer pressure

____*People are encouraged to clarify their values and stand by the health-enhancing ones*

____*People are encouraged to learn how to resist negative peer pressure*

____*People are encouraged to avoid and/or leave situations involving negative peer pressure*

____*People are encouraged to rehearse good communication skills*

____*People are encouraged to talk about STD/HIV prevention with possible partners*

____*People are encouraged to seek the sexual and injecting drug history as well as the STD/HIV infection testing and status of a possible partner*

____*People are encouraged to be honest with possible sex and drug injecting partners about their past sexual behavior, injecting drug use, and STD/HIV testing and status*

____*People are encouraged not to have sex with a person who will not talk about STD/HIV prevention*

____*People are encouraged to talk with their parents or other adults about good communication skills relating to HIV/AIDS prevention*

22. Choosing Friends Wisely

____Influence of peer norms and friends is important

____Friends who support preventive and risk-reduction behaviors are important

____*People are encouraged to choose friends who are supportive of avoiding STD/HIV risk behavior*

23. Help to Avoid STD/HIV

____Value exists in the encouragement and support of others

____People need to know who might help them avoid STD/HIV

____*Teens are encouraged to talk with their parents or other supportive adults about sexuality, growing up, and STD/HIV prevention*

24. Taking Responsibility for Health and the Health of Others

____There is a value in individual efforts to control STD/HIV

____People should serve as responsible role models

____People should serve as accurate information sources

____People should support STD/HIV control efforts

____People should support friends with STD/HIV

____People should keep informed about STD/HIV

____*People are encouraged, in taking responsibility for their own health, to avoid STD/HIV, pay close attention to their own bodies, seek medical care if STD/HIV are suspected, avoid spreading STD/HIV if they are infected, and get partners to treatment*

____*People are encouraged to practice STD/HIV prevention to be a healthy role model as well as for personal safety*

____*People are encouraged to create an HIV/AIDS resource center in their school or town*

____*People are encouraged to continue being friends with those having STD/HIV*

____People are encouraged to organize fund-raising drives or to contact a local STD/AIDS agency to see what they can do

____*People are encouraged to serve as STD/HIV volunteers*

____*People are encouraged to stay alert to proposed legislation related to STD/HIV and to voice opinions to officials and legislators*

____*People are encouraged to keep up-to-date about STD/HIV*

____*People are encouraged to inform their friends that they know the latest STD/HIV facts and are willing to share them*

____*People are encouraged to correct fallacies when talking with others*

**Recognizing STD/HIV Infections**

25. STD/HIV Symptoms

____Value exists in seeing a health care provider promptly if a person suspects having STD/HIV

____STD/HIV symptoms are often similar to other infections

____STDs frequently have no early symptoms

____People should know the symptoms of STD/HIV

____People can have an STD or HIV without symptoms

____People can transmit STD/HIV when they have no symptoms

____Males have STD symptoms earlier than females even though they have fewer

____*People should become aware of their bodies*

____*People are encouraged to become alert to the symptoms of STD/HIV, especially those people having sex with more than one partner, those who share injection drug needles and equipment,and those having sex with partners at risk for STD/HIV*

26. What to Do After Suspecting STD/HIV Symptoms

____Value exists in deciding to stop having sexual contact

____Value exists in prompt medical treatment

____Value exists in getting a partner to treatment

____*People are encouraged, after suspecting STD/HIV symptoms, to stop having sexual contact, to stop using and sharing injection drugs and their equipment, to go to a doctor or clinic promptly, and to get a partner to treatment*

____*People who have no symptoms of an STD but still suspect an infection are encouraged to see a health care provider*

**Seeking STD/HIV Tests and Treatment**

27. STD/HIV Tests and Counseling

____Who should receive tests

____Benefits and limitations of tests

____How an STD/HIV is detected

____There is an HIV "home test kit"

____There are confidential and anonymous tests

____Local resources for tests and counseling

____National hotlines and Internet resources

____How a person can remember sources of help

____What people can do when they have no money for tests

____*People who have practiced high-risk behaviors are encouraged to seek counseling/tests*

____*People who have multiple partners are encouraged to check regularly for STD/HIV*

____*People are encouraged not to try to diagnose their own STD/HIV status*

____*People are encouraged not to donate blood to determine their HIV infection status*

____*People are encouraged to call their local health department to find STD/HIV medical care in their community*

____*People are encouraged to seek STD/HIV health care even if they have no or little money*

____*People are encouraged not to take frequent HIV tests in place of prevention and risk-reduction methods*

28. Confidential Tests and Treatment for Minors

____ For young people facing health issues, value exists in talking to parents and guardians

____Some teens experience difficulty talking to their parents about having STD/HIV

____There are laws that permit minors to get STD/HIV treatment without parental consent

____*Teenagers are encouraged to talk with their parents or guardians about having STD/HIV*

____*If teenagers cannot talk to their parents about having STD/HIV, they are encouraged to see a health care provider*

29. The Medical Visit

____People should receive counseling about tests

____Different types of treatment exist

____Hotline information is available on HIV/AIDS treatment

____*People are encouraged to refer their sex and drug-using partners to counseling and treatment*

____*People are encouraged to tell health care providers why they suspect they have STD/HIV, what parts of their bodies they think were exposed, and when they think the contact took place*

____*People are encouraged to ask health care providers when they can resume having sex and ways they can protect their partner if they have an incurable STD*

____*People infected with STD/HIV are encouraged to practice sexual abstinence or low-risk behavior and never to share injecting drug needles and equipment*

____*People diagnosed with STD/HIV are encouraged to communicate their infection status to past, current, and possible future sex or injecting drug partners*

____*People with negative test results are encouraged to practice behaviors that prevent or reduce their chances of infection*

30. STD/HIV Treatment

____A number of STD treatments exist

____HIV/AIDS has no cure

____New HIV treatments exist

____Treatments for AIDS are available

____The future outlook for HIV/AIDS treatment is improving

____*People who are infected are encouraged to follow medical advice and seek support/counseling*

____*People are encouraged not to use home remedies, mail/Internet-order products, or drugs from friends*

31. Support for People with STD/HIV

____Value and need exists for the support of family and friends

____Support groups and Internet chat rooms can help people infected with STD/HIV

____Other sources exist for finding support groups

**Partner HIV/STD Tests and Treatment**

32. Importance of Asking Partners to See a Health Care Provider

____It can prevent serious illness in the partner

____It can prevent re-infection

____It can control the spread of STD/HIV

____*People having sexual contact with infected partners should not resume sexual contact until all people have been cured or should practice risk-reduction if sexual contact does resume*

33. Ways of Getting Partners to Tests and Treatment

____Take the partner to the clinic

____Inform the partner of the infection

____Seek the help of an STD/HIV public health specialist

____*People who are infected are encouraged to make certain that their sex and needle-sharing partner(s) have tests/counseling*

____*People who suspect they are infected are encouraged to take their sex or injecting drug use partner with them to the health care provider*

____*People who suspect they are infected are encouraged to be honest with their partner, to not blame anyone, to be supportive, and to remain calm and positive*

____*People are encouraged to cooperate with public health specialists in locating partners*

## PRESENTATION OF STUDENT MATERIAL

**Theoretical Approach**

34. Theoretical "behavior change"models

____Several constructs of empirically tested "behavior change" models are used in determining content and learning opportunities

**Learning Domains Approach**

35. Cognitive

____The major emphasis is on health-enhancing behaviors related to avoiding STD/HIV, recognizing STD/HIV symptoms, finding STD/HIV medical help, following treatment directions, getting partners to treatment, and individual efforts to help control STD/HIV

____The STD and HIV messages are integrated

____There is minimal emphasis on biomedical/technical information

36. Affective

____Health-enhancing attitudes are reinforced and supported

____Learning opportunities related to attitudes are provided

37. Skill

____Learning opportunities that require rehearsal of skills related to STD/HIV prevention and risk-reduction are provided

**Learning Enhancement**

38. Repetition

____Major concepts are presented several times

39. Feedback/Reinforcement

____Opportunities are provided for students to test their learning with prompt feedback and reinforcement

40. Involvement

____Learning opportunities are provided that require a student's involvement and use of major concepts

41.Relevance

____Information is specifically geared to teenagers based on developmental principles

42. Vocabulary

____Definitions and pronunciations of technical and possible unknown/unfamiliar terms are provided

____Terminology familiar to teenagers is used

43. Sensitive to Diversity

____Material is congruent with cultural diversity

____Material is not condescending or prejudicial toward diverse groups

**Verbal Quality**

44. Readability

____Reading level is junior high school level; this includes minimal use of words with more than three syllables as well as minimal use of long and complex sentences

____Syntax is sound, with precise and simple presentation of concepts

45. Accuracy

____Information is accurate according to contemporary understanding

**Visual Esthetics**

46. Layout

____Pages have ample "white space"

____Print is an adequate size;layout has a logical,natural flow; and a variety of typeface fonts and colors are used

47. Graphics

____Photos, graphs, and illustrations are used to enhance student interest and understanding

____No negative, confusing, or prejudicial effects are produced

**Tone of Messag e**

48. Health-promoting

____Material emphasizes self-directed, health-enhancing behavior, including responsibility for the health of others

49. Objective

____Material does not make moral judgments, use emphatic adjectives or adverbs, contain any obtrusive style, or use offensive material

____Material includes anxiety-alleviating information

## BACKGR OUND FOR TEACHERS

**School STD/HIV Pr evention Education**

50. Teenagers as a Critical Prevention Target Group

____Prevalence of teen sexual and drug-use risk behaviors is described

____Teenage STD/HIV-related attitudes and knowledge are described

51. Effectiveness of STD/HIV Prevention

____Common characteristics of most successful prevention programs are provided

52. Goal and Rationale

____The major instructional emphasis includes preparing individuals to avoid STD/HIV; to recognize STD/HIV symptoms; to access STD medical care; to follow treatment instructions, if infected; to refer all partners to medical care; and to help control the STD/HIV problem

____Desired behavioral outcomes are stated

____The value of integrating STD/HIV prevention messages is provided

____Teenagers' opinions of their need for STD/HIV information and services is given

____Parental support for school STD/HIV education and for instruction about specific topics is given

53. Curriculum Development

____Material describes rationale for conducting curriculum preparation studies, process evaluations, program effectiveness assessments, and program refinements

____Material describes local, state, and national resources that can assist in curriculum development,implementation, and evaluation

____Material lists the traits of the most successful prevention education programs and encourages their use in curriculum development

____Suggestions are provided for working effectively with the local community, such as with an advisory committee

____Material describes the composition of an advisory committee and encourages the inclusion of student members from diverse communities

____Suggestions for gaining support and resolving conflict relative to STD/HIV prevention education content are provided

____Resources are given that can provide accurate STD/HIV information

**School STD/HIV Prevention Education Implementation**

54. Administration/School Board Acceptance

____Importance and value of administrative and School Board approval and support of HIV/AIDS prevention education are stated

____Importance and value of establishing a school policy for STD/HIV prevention education is given

____Suggestions for securing approval and support are provided

55. Placement within the Cur riculum

____Material describes the rationale for STD/HIV prevention education as part of a comprehensive, kindergarten through twelfth grade health science education program that also includes comprehensive sexuality education

____Material provides suggestions on how to integrate STD/HIV prevention education into the curriculum

56. Lesson Plans

____A lesson plan for the curriculum that suggests daily

activities is provided

____Materials needed to implement the curriculum are listed

57. Learning Environment

____Material describes and encourages the creation of a safe classroom environment in which students can discuss STD/HIV without the fear of censorship or ridicule

____Material allows students to decline participation in activities that violate their personal values

58. Presenting STD/HIV Prevention Education in Diverse Settings

____Importance of instruction addressing the entire range of needs among diverse groups is stated

____Suggestions for presenting culturally appropriate instruction are given

____Suggestions for dealing with various religious and moral views toward STD/HIV-related issues are provided

59. Instructor Qualities

____Material describes teacher competencies required to provide quality STD/HIV instruction

____The importance of the instructor communicating with students with ease, sensitivity, and tact in an objective, factual manner is stressed

____Material encourages the use of a qualified classroom teacher for STD/HIV instruction as well as the use of carefully selected outside authorities only as supplemental speakers

____Material encourages schools to provide in-service education for people assigned to provide STD/HIV instruction

**STD/HIV Instructional Activities**

60. Learning Opportunities

____Learning opportunities provide maximum student participation, reflect theoretical behavior change models and the three learning domains, and emphasize health-enhancing behaviors

____Purpose, objective, and utilization procedures are included for learning opportunities

____Cognitive learning opportunities stress major health-enhancing concepts related to STD/HIV transmission and prevention

____Affective learning opportunities stress, for example, personal examination of attitudes,perceptions,confidence of self-efficacy, beliefs related to STD/HIV-related health behaviors and other issues

____Directions for utilization of affective learning opportunities suggest following standard procedures for values-related activities, including optional and anonymous student participation

____Skill-learning opportunities provide practice and simulation of STD/HIV prevention behaviors, such as decision-making, problem-solving, communication, resistance to negative peer pressure, finding help using the local health board and the Internet,and refusal skills

61. Learning Opportunities Worksheets

____Any student worksheets required for the learning opportunities are included and are printed in a format that permits easy duplication

62. Student Content Supplement

____Any material that may be determined too controversial for students (for example, directions for condom use) is given in a format which can be distributed to students based on local discretion

**STD/HIV Education Evaluation**

63. Classroom Test Questions

____Several types of questions that evaluate cognitive learning are included

____Questions that assess cognitive levels beyond memory are included

# POLITICIANS URGED TO RISE ABOVE PREJUDICES AND EMBRACE HIV/AIDS PREVENTION STRATEGIES

**William Smith**
SIECUS Public Policy Director

> *"But AIDS is a perfect illness because it is so alien to human nature and has as its function to destroy life in the most cruel and systematic way. Never before has such a formidable calamity affected mankind."*

These words were written by the Cuban-born writer and revolutionary Reinaldo Arenas shortly before his death in 1990 from complications associated with AIDS. The words strike hard at the heart of the personal cost and devastation of HIV/AIDS. Yet, Arenas gained from his own personal account a fuller understanding of what it means for all humanity.

To this extent, HIV/AIDS knows no borders; it recognizes no class, gender, nationality, or race. Nor does it take into account the political realities that accompany its relentless attack. The challenge for policymakers, therefore, is to rise above the conventions of human society that the disease does not recognize.

## PREVENTION AND ABSTINENCE

On the whole, politicians have found it difficult to embrace prevention strategies that fall outside their realm of comfort. For example, demonstrating the proper use of condoms and making available clean needles and bleach kits run against the grain of what most politicians feel is appropriate.

Yet, it is precisely these types of interventions—specifically targeted to populations with increased risk factors for HIV infection—that are culturally appropriate and seek to deal with the reality of the epidemic in America.

In this column, SIECUS recently reported on the increasingly intense scrutiny under which federally-supported HIV/AIDS prevention programs are operating. Audits of HIV/AIDS prevention funds are now commonplace.

In some sense, this is good news. These are federal tax dollars, and accountability is vital if funding is to continue. On the other hand, many advocates fear that the audits are politically motivated and designed to root out progressive prevention efforts that are anathema to the current Administration's goal to have abstinence-only-until-marriage programs as the centerpiece of the federally-funded prevention portfolio.

There is also a very clear trend within the Administration to name abstinence-only-until-marriage proponents to the groups who advise and recommend HIV/AIDS policy to the President.

For example, the Advisory Committee on HIV and STD Prevention of the U.S. Centers for Disease Control and Prevention (CDC) increasingly includes individuals who support abstinence-only-until-marriage programs. A recent appointee, Gale Grant, helped create such a program in the state of Virginia (with the support of Claude Allen, the Deputy Assistant Secretary of Health and Human Services).

In another instance, Scott Evertz, director of the White House Office of National AIDS Policy, was recently shifted to the U.S. Department of Health and Human Services and replaced by the more politic Dr. Joseph O'Neill. This shakeup was reportedly the result of Evertz's philosophical differences with the Administration.

## THE BOTTOM LINE

The Bush Administration's approach to HIV/AIDS policy is profoundly affecting the bottom line of prevention efforts.

*The Washington Post* published an editorial on September 12 that was aptly titled "Retreat on AIDS." It began by describing the initial support of longtime critic Senator Jesse Helms (R-NC) to increase U.S. funding of international HIV prevention efforts to the tune of $500 million targeted for programs focusing on mother-to-child transmission of HIV/AIDS.

While advocates greeted the apparent conversion of the ultra-conservative Senator Helms with some degree of joy, they were critical of the fact that the funding was not enough and that, while needed, it skirted the fundamental issue of unprotected sex among heterosexuals, which is responsible for the spread of most of the AIDS cases in Africa.

The editorial went on to detail how—to date—the federal government has not spent a single cent of this money and that Congress, in attempting to fund programs related to mother-to-child transmission, must cut funds for other programs. In other words, there is no new money for the much-heralded initiative—it must come from the funds of current programs.

An Administration's priorities are most clearly spelled out

each year when the White House releases its budget blueprint for the coming fiscal year. For 2003, there is a chasm between President Bush's "wartime" budget blueprint and the one released by HIV/AIDS advocates through National Organizations Responding to AIDS (NORA), an umbrella organization of which SIECUS is a member.

The President's budget flat-funds every aspect of domestic HIV prevention, care, and treatment, including all interventions within the CDC and all programs receiving funds through the enormously popular Ryan White CARE Act. The only area that is designated to receive increased funds is research.

At press time, the appropriations process for fiscal year 2003 is in an unprecedented state of disarray. The U.S. House of Representatives has all but given up on trying to bridge differences over spending priorities with the White House and with most conservative elements of the Republican Party.

It appears that most domestic funds for HIV/AIDS programs will come from the President's budget when conservatives force its introduction as the Republican bill—bypassing the House subcommittee that usually has responsibility for such appropriations. Thus, the current House bill flat-funds everything.

The U.S. Senate, on the other hand, has listened to recommendations made by NORA and other advocates and provided for increases in vitally needed programs. For example, the current Senate bill funds the Ryan White CARE Act at $2.07 billion, an increase of $116 million over fiscal year 2002. Domestic HIV/AIDS programs at the CDC also received an increase of $2.7 million, bringing the total to $691 million.

While these numbers do not meet the recommendations set forth by NORA or meet the needs of programs in communities across the country, they are a significant improvement over the numbers proposed by the Administration and those in the current House bill.

Tellingly, even though the President and his conservative allies in the U.S. Congress argue that the current war on terrorism and its accompanying domestic security concerns mean less spending on other domestic programs, there is an exception: both the President and conservative legislators are pushing for a $33 million increase in the Special Project of Regional and National Significance—Community-Based Abstinence Education (SPRANS-CBAE) program for fiscal year 2003.

## CONCLUSION

Money talks. It spells out where the growth is foreseen in our country's prevention initiatives geared toward HIV/AIDS, other sexually transmitted diseases, and unintended pregnancy. The pre-eminence of abstinence-only-until-marriage funding speaks loud and clear.

In mid-September, individuals gathered in California for the annual U.S. Conference on AIDS. In an unfortunate replay of the heckling of Tommy Thompson, the U.S. Secretary of Health and Human Services, at the International Conference on AIDS in Barcelona this past summer, White House Advisor O'Neill was similarly booed and heckled in San Diego. O'Neill rose above the clatter, arguing for abstinence saying, "We have not made a dent in the annual number of infections in years."

The arguments around the role of abstinence-only-until-marriage programs in the federal funding portfolio are sure to continue. Yet, even if these programs eventually demonstrate a delay in sexual activity, we know that they are statutorily prohibited from presenting young people with information on proper contraception for the day when they do become sexually active.

Such a strategy merely postpones the unfortunate and irresponsible fallout of a policy that keeps young people in the dark. And at risk for HIV/AIDS.

## HIV PREVENTION OBJECTIVES DECLARATION OF COMMITMENT ON HIV/AIDS

This is the Declaration of Commitment on HIV/AIDS voted by the United Nations (U.N.) Special Session on HIV/AIDS in June 2001.

- Ensure by 2005 access in all countries to a broad array of prevention programs
- Ensure by 2005 that at least 90 percent of young people (15 to 24)—and 95 percent of such people by 2010—have meaningful access to the information, education, and services needed to protect themselves from HIV infection
- Reduce by 2005 the rate of HIV infection among young people by 25 percent and reach this target globally by 2010
- Reduce the proportion of infants born with HIV by 20 percent by 2005 and by 50 percent by 2010
- Strengthen HIV prevention efforts by enacting or strengthening anti-discrimination and other human rights laws, by empowering women and by taking steps to reduce the vulnerability of key populations to HIV

For more information on the United Nations Special Session on HIV/AIDS go to www.un.org/ga/aids/coverage

# Kids need to learn their ABCs

## ...THEN THEIR HIVS AND STDS

**KEEPING A CHILD SAFE AND HEALTHY ISN'T EASY.** That's why it's so important – especially in the age of HIV/AIDS – for parents to talk with their kids about sex.

**TODAY, THAT MEANS MUCH MORE THAN HOW BABIES ARE MADE.** It's also about how to prevent pregnancy, sexually transmitted diseases, and HIV/AIDS. Research shows that the more parents and children talk, the more likely kids are to make healthy choices.

**WE CAN HELP.** Call the experts at the Sexuality Information and Education Council of the United States. We know the tough questions kids ask, the different answers parents can give, and what it all means. We give you time to think – and a game plan to help your children protect themselves.

Talk with your kids about sex. Talk soon. Talk often. Talk again.

Please call 202.819.9770 or visit SIECUS at www.familiesaretalking.org

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**Submitting Articles and Book and Audiovisual Reviews for Publication in the *SIECUS Report***

Each issue of the *SIECUS Report* features groundbreaking articles and commentary by leaders and front-line professionals in the field of sexuality and education, along with news, special bibliographies on varied topics, book and audiovisual reviews, recommended resources, and advocacy updates.All of this comes to members and other subscribers six times each year.

Manuscripts are read with the understanding that they are not under consideration elsewhere and have not been published previously. Manuscripts not accepted for publication will not be returned. Upon acceptance, all manuscripts will be edited for grammar, conciseness,organization,and clarity.

To expedite production, submissions should adhere to the following guidelines:

## PREPARATION OF MANUSCRIPTS

Feature articles are usually 2,000–4,000 words. Book and audiovisual reviews are typically 200–600 words.

Manuscripts should be submitted on 8½ x 11 inch paper, double-spaced, with paragraphs indented. Authors should also send a computer disk containing their submission.

All disks should be clearly labeled with the title of submission, author's name, type of computer or word processor used,and type of software used.

The following guidelines summarize the information that should appear in all manuscripts.Authors should refer to the current issue of the *SIECUS Report* as a guide to our style for punctuation, capitalization,and reference format.

### Articles

The beginning of an article should include the title, subtitle, author's name and professional degrees, and author's title and professional affiliation.

Articles may incorporate sidebars, lists of special resources, and other supplementary information of interest. Charts should be included only if necessary and should be submitted in camera-ready form. References should be numbered consecutively throughout the manuscript and listed at the end.

### Book Reviews

The beginning of a book review should include the title of the book, author's or editor's name, place of publication (city and state), publisher's name, copyright date, number of pages,and price for hardcover and paperback editions.

### Audiovisual Reviews

The beginning of an audiovisual review should include the title of the work, producer's name, year, running time, name and address of distributor, and price.

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## Mission

SIECUS affirms that sexuality is a natural and healthy part of living. SIECUS develops,collects, and disseminates information;promotes comprehensive education about sexuality; and advocates the right of individuals to make responsible sexual choices.


SIECUS sexuality information and education council of the united states

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