

A Focus on Kids Intervention

FOCUS ON YOUTH WITH IMPACT

**An HIV Prevention Program
for African-American Youth
with a Complementary Program for Parents**



An Evidence-Based Curriculum

ImPACT Facilitator's Guide



Focus on Youth with ImPACT

(Informed Parents and Children Together)

A Focus on Kids Intervention

**An HIV Prevention Program
for African-American Youth
with a Complementary Program for Parents**

ImPACT Facilitator's Guide

ETR Associates
Santa Cruz, California

ETR Associates (Education, Training and Research) is a nonprofit organization committed to fostering the health, well-being and cultural diversity of individuals, families, schools and communities. The publishing program of ETR Associates provides books and materials that empower young people and adults with the skills to make positive health choices. We invite health professionals to learn more about our high-quality publishing, training and research programs by contacting us at 1-800-321-4407 or visiting our website at www.etr.org.

Focus on Youth with Informed Parents and Children Together (ImPACT) was supported by Grant/Cooperative Agreement Number U65/CCU924904 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

© 1998 by ETR Associates. Revised edition © 2005.
Focus on Youth with ImPACT edition © 2008.
All rights reserved.

Produced by ETR Associates, 4 Carbonero Way,
Scotts Valley, CA 95066-4200.

Contents

Acknowledgments	v
Introduction and Overview	1
About ImPACT	9
ImPACT Session Information Form	13
Activity 1. Introduction to Focus on Youth with ImPACT	14
Activity 2. HIV 101	18
Activity 3. The ImPACT Parent/Guardian DVD	22
Activity 4. Effective Communication	24
Activity 5A. Condom Demonstration	25
Activity 5B. Condom Card Activity	29
Activity 6. Talking with Your Youth Roleplays	35
Activity 7. Ending the Session	39
Appendix A. CDC Fact Sheets	41
HIV/AIDS Among African Americans	41
HIV-Related Risk Behaviors Among African-American Youth	48
Appendix B. CDC Materials	53
Male Latex Condoms and Sexually Transmitted Diseases	53
CDC Statement on Study Results of Product Containing Nonoxynol-9	59
Nonoxynol-9 Spermicide Contraception Use—United States, 1999	61
The ABCs of Smart Behavior	65
Guidelines on Content of HIV Education Materials	67

Acknowledgments

This edition of *Focus on Youth with ImPACT* was updated and packaged from *Focus on Kids* and from *Informed Parents and Children Together (ImPACT)* to provide new information and tailor activities to increase the relevance of the program for African-American youth between ages 12 and 15 who are at risk for HIV infection. This edition addresses the critical role of parents in their youth's decision-making and behavior. Including *ImPACT* helps parents work with their youth to guide them toward responsible decision making.

Eight agencies were selected to participate in a pilot of the Focus on Youth package. Over a 6-month period, each of the agencies piloted the new package with 8–10 youth. Their feedback has been incorporated in the final version.

We are grateful for the commitment of the original researchers, Bonita Stanton, MD, PhD, and Jennifer Gailbraith, PhD, the writers, all of the youth, their parents and the youth service providers who helped to focus-group test and pilot *Focus on Youth with ImPACT*. We would also like to thank:

- Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention, Diffusion Team Members: Winifred King, PhD, MPH; Ivory Kimbrough, MPH; Patricia Patrick; Lashaun Polk, MPH; and Harneyca M. Hooper, MPH
- *ImPACT* Video Community Partners:
 - Gresham Parks and Recreation Center, Atlanta, Georgia
 - Ray of Hope Christian Church, Decatur, Georgia
 - Grady Memorial Hospital Teen Services Program, Atlanta, Georgia
 - ASA Academy & Community Science Center, Oakland, California
 - CAL-PEP (California Prevention and Education Project), Oakland, California
 - Berkeley Mount Zion Missionary Baptist Church, Berkeley, California
 - Wannetter Terrell
 - Marie Mitchell, RN

Acknowledgments

- Deborah Harris, RN, MSN, MBA
- Sharon Sanders
- Yolanda Lane Smith
- Tovi Scruggs, MEd
- Sharon Morrison Parker
- *ImPACT* Video Production Team:
 - Only Movies Productions
 - Tracy Taylor—Director, Executive Producer and Writer
 - Maurice Dwyer—Assistant Director/Camera Operator
 - Chun Ming Huang—Cinematographer and Camera Operator
 - John Savedra—Cinematographer and Camera Operator

The Focus on Youth with ImPACT Team

Cherri Gardner, MA

Pam Drake, PhD

James Walker

Scott Martin

Tereé Jerome

Suzanne Schrag

Sarah Stevens

Charlene Foster

Acknowledgments from the Original Focus on Kids

Over a period of more than a decade, we had a wonderful and exciting time working with hundreds of youth, parents and organizations from Baltimore to develop, implement and evaluate the *Focus on Kids* HIV prevention curriculum. Everyone with whom we worked was committed to a common goal: to prevent our adolescents from becoming infected with HIV. It appears our efforts have paid off. Youth participating in the *Focus on Kids* programs are less likely to engage in HIV risk behaviors than youth who have not participated in this program. We are proud of this curriculum and hope that every one of the individuals and organizations with whom we have worked will share in this pride.

Since this curriculum was first developed, it has been implemented in a variety of school and community settings around the nation and the world. In addition to the Baltimore research, versions have been evaluated in West Virginia, Washington, D.C., Washington State, the Bahamas, Namibia, China and Vietnam. Adaptation to new settings is always exciting, fun and fulfilling—and at times complex and even perplexing. The process has resulted in strong bonds among members of the implementation team, and between the program and our community partners.

We wish to thank all the youth and their parents who worked with us throughout the curriculum development and evaluation in each of these places. We also wish to thank the community interviewers and group leaders who worked with us and enabled us to evaluate the curriculum, as well as the staff of the many community recreation centers, the schools and the countless local, state and national organizations and other agencies that helped us along the way.

The *Focus on Kids* team adapted the work of many individuals and programs in developing this curriculum. We appreciate their fine work and their commitment to the well-being of youth. These include:

- Center for Experiential Education
- Center for Population Options
- Ross Ford, for the Family Tree Activity
- Patricia Kramer
- Planned Parenthood of Bergen County, Inc., The Center for Family Life Education

- Planned Parenthood of Maryland STARS (Students Talking About Responsible Sexuality)
- S. Schinke, A. Gordon and R. Weston, for the SODA Decision-Making Model

The curriculum would not have been possible without the aid and funding of the National Institute of Mental Health, the National Institute of Child Health and Development, and the Agency for Health Care Policy and Research. The Child Health Foundation supported our efforts to turn the results of this work over to Baltimore communities. Finally, we thank ETR Associates for helping us reach a much greater audience of youth.

We dedicate this manual to the youth and families in communities all over the country and the world who helped make the success of *Focus on Kids* possible.

The Original Focus on Kids Team

Bonita Stanton, MD	Carole Harris, PhD
Maureen Black, PhD	Linda Kaljee, PhD
George Cornick	Xiaoming Li, PhD
Lesley Cottrel, PhD	Robert Pack, PhD
Lynette Devieux	Izabel Ricardo, PhD
Susan Feigelman, MD	Yvonne Summers
Jennifer Galbraith, PhD	Ying Wu, PhD

Introduction and Overview

Overview of Focus on Youth with Informed Parents and Children Together (ImPACT)

Focus on Youth with Informed Parents and Children Together (ImPACT) is an HIV, STD and pregnancy prevention intervention for African-American youth ages 12–15. The intervention was updated from *Focus on Kids*, a community-university linked research and intervention program. The goal of *Focus on Youth with ImPACT* is to reduce the risk of HIV infection among youth. The researchers, led by principle investigator Bonita Stanton, M.D., worked with community members from recreation centers, housing developments, schools and government agencies in settings throughout the U.S. to reach this goal.

The evaluation of the combined *Focus on Kids* and *ImPACT* interventions^{1,2} met the necessary criteria for the interventions identified as interventions with best evidence of efficacy by the Centers for Disease Control and Prevention's (CDC) HIV/AIDS Prevention Research Synthesis (PRS) Project. *Focus on Kids* alone was identified as an intervention with promising evidence.^{3,4}

This *Focus on Youth with ImPACT* edition provides updated information and more tools to facilitate implementation and increase the relevance of the program for African-American youth between ages 12 and 15 who are at risk for HIV infection.

ImPACT is a 90-minute HIV prevention program for parents of African-American adolescents used in combination with *Focus on Youth*. *ImPACT* is delivered to parents/guardians and youth, one family at a time, by a health educator. It consists of basic HIV information, a culturally appropriate video documentary that stresses parental monitoring and communication, a discussion with the health educator, two guided roleplays, a parent/guardian

¹ Wu, Y., Stanton, B., Galbraith, J., Kaljee, L., Cottrell, L., Li, X., et al. (2003). Sustaining and broadening intervention impact: A longitudinal randomized trial of three adolescent risk reduction approaches. *Pediatrics* 111 (1): 32-38.

² Stanton, B., Cole, M., Galbraith, J., Li, X., Pendleton, S., Cottrell, L., et al. (2004). A randomized trial of a parent intervention: Parents can make a difference in long-term adolescent risk behaviors, perceptions and knowledge. *Archives of Pediatrics and Adolescent Medicine* 158:947-55.

³ Lyles, C. M., Kay, L. S., Crepaz, N., Herbst, J. H., Passin, W., Kim, A., et al. (2007). Best evidence interventions: Findings from a systematic review of HIV behavioral interventions for U.S. populations at high risk, 2000-2004. *American Journal of Public Health* 97 (1): 133-143.

⁴ Centers for Disease Control and Prevention. 2006. HIV/AIDS Prevention Research Synthesis Project. Retrieved June 21, 2006, from www.cdc.gov/hiv/topics/research/prs/index.htm.

resource guide, and a condom demonstration. It was guided by parental monitoring theory and theory of parenting (passive, authoritarian and authoritative).

What Makes *Focus on Youth with ImPACT* Different?

It is a community-based program. The original *Focus on Kids* was developed for use in recreation centers as opposed to schools or clinics. This community basis for the program helped reach higher-risk youth who were already truant from school or had high absenteeism rates, as well as youth who did not go to clinics or were not connected with health care professionals. It also allowed the program to be closer to where youth were making decisions about high-risk activities—in their neighborhoods and social networks. *Focus on Kids* has also been used successfully in classroom and school settings.

It features community involvement. Another unique aspect is the emphasis on community involvement in the project on many different levels. Initially, several recreation club directors worked as consultants to help the research team better understand the youth and the best way to reach them. A community advisory board was formed and has been an invaluable aid in survey and curriculum development, as well as the overall project design.

Focus on Kids also tried to use community members in as many roles as possible—as interviewers, group leaders and research assistants. Through work with the community, the program developers were able to gain insight into the needs and perceptions of urban youth and their parents.

It uses natural friendship groups. The program is unique in its use of “natural friendship groups.” Each young person enrolled in the original *Focus on Kids* program was asked to invite 1 to 3 same-gender friends to join the program, forming natural friendship groups. As a result, the young people were able to reinforce the positive, healthy decisions of their friends.

It actively involves parents. Most adolescent risk reduction programs do not specifically include parents, even though it is generally known how important parents are in the health decisions their children make. Inclusion of the evidence-based program, *ImPACT*, in this edition, empowers parents to stay connected with their youth as the youth face difficult decisions during their teen years.

It has a comprehensive focus. Although the primary goal was to reduce HIV infection, the team was aware that there are many things that lead to risk behaviors among youth, and therefore it was important to make the curriculum holistic and comprehensive. It became obvious from talking with parents, youth and community leaders who work with youth that the curriculum would need to be broadened to cover many topics, including decision making, values clarification, communication, and knowledge about risk behaviors associated with HIV infection, other STD, teen pregnancy, violence, alcohol, drug selling and other drug use.

Target Audience for *Focus on Youth with ImPACT*

Focus on Youth is designed for African-American youth between the ages of 12–15. The program uses “natural friendship groups,” or groups of youth who already spend time together. When possible, HIV prevention efforts are most effective when youth are reached before becoming sexually active.

ImPACT is specifically designed for the parents and/or guardians whose children are or will soon be participating in the *Focus on Youth* intervention.

Focus on Youth with ImPACT Essentials

Maintaining Fidelity

All CDC-Identified Effective Behavioral Interventions have what is referred to as “core elements” that make that intervention effective. **Core Elements** are required elements that embody the theory and internal logic of the intervention and most likely produce the intervention’s main effects. Core elements are identified through research and program evaluation. Core elements essentially define an intervention and must be kept intact (i.e., with fidelity) when the intervention is being implemented or adapted, to ensure the best prospect that the program will produce outcomes similar to those demonstrated in the original research.⁵

Key Characteristics are important, but not essential, attributes of an intervention’s recommended activities and delivery methods. They may be modified to be culturally appropriate and fit the risk factors, behavioral

⁵ McKleroy, V., Galbraith, J., Cummings, B., Jones, P., Harshbarger, C., Collins, C., et al. (2006). Adapting evidence-based behavioral interventions for new settings and target populations. *AIDS Education and Prevention* 18 (Suppl. A): 59-73.

determinants, and risk behaviors of the target population and the unique circumstances of the venue, agency, and other stakeholders. Modification of key characteristics should not compete with or contradict the core elements, theory, and internal logic of the intervention. (McKleroy, et al., 2006)

When making changes to *Focus on Youth with ImPACT*, activities should continue to capture the identified intent or theoretical construct. Activities can be changed so long as they continue to reflect the identified constructs of Protection Motivation Theory (PMT). In Section 5 a chart can be found that lists all activities and which constructs of the theory the activity captures.

Core Elements and Key Characteristics of *Focus on Youth*

The core elements of *Focus on Youth with ImPACT* have been organized in three sections: content, pedagogical and implementation. Content core elements are the essential elements of *what* is being taught by the intervention that is believed to change risk behaviors. Pedagogical core elements are the essential elements of *how* the intervention content is taught. Finally, implementation core elements are the essential characteristics of an intervention that relate to some of the logistics that set up a positive learning environment.⁶

Implementation core elements:

- **Core Element 1:** Deliver intervention to youth in community-based settings.
- **Core Element 2:** Use two skilled facilitators to model communication, negotiation and refusal skills for the youth.
- **Core Element 3:** Use “friendship” or venue-based groups (i.e., a basketball team, a scout troop, church group, an existing youth group) to strengthen peer support.

Content core elements:

- **Core Element 4:** Use culturally appropriate interactive activities proven as effective learning strategies to help youth capture the important constructs in the theory.

⁶ Education, Training and Research Associates and CDC. (In press). *Adaptation guidance for science-based pregnancy, STD and HIV prevention education programs for adolescents*. Scotts Valley, CA: ETR Associates.

- **Core Element 5:** Include a “family tree” to contextualize and personalize abstract concepts, such as decision making and risk assessment.
- **Core Element 6:** Enable participants to learn and practice a decision-making model such as SODA (Stop, Options, Decide, Action).
- **Core Element 7:** Train participants in assertive communication and refusal skills specifically related to negotiation of abstinence or safer sex behaviors.
- **Core Element 8:** Teach youth proper condom use skills.

Key characteristics:

- The program is implemented with between 6 and 10 youth.
- New members should not join after the third session.
- Participants meet for at least 100–145 minutes.
- Culturally and linguistically based activities are embedded for your target population.
- Groups contain members of the same gender and age group.
- Parents/guardians must be told what the program is about and should sign a permission slip.
- At least one facilitator matches the ethnicity of the majority of the participants.

Any modification of key characteristics should be done with great care, and should not compete with or contradict the intent, theory and internal logic of the intervention.

Core Elements and Key Messages of *ImPACT*

Implementation core elements:

- **Core Element 1:** Delivering intervention **one-on-one** to parents/guardians and youth in well-located community-based setting (such as CBO, church, recreation center, or school) or their home at a time and place that is convenient for parent/guardian.
- **Core Element 2:** Use of a facilitator whom the parents/guardians find credible. The facilitator should be skilled at building rapport with parent and youth at the beginning of the session.

- **Core Element 3:** Ideally, *ImPACT* should be delivered prior to the youth beginning the *Focus on Youth* intervention.

Pedagogy core elements:

- **Core Element 4:** Use of a documentary that shows the challenges and importance of parents monitoring and talking to their children ages 12–15 about sex, abstinence, STDs, HIV and condoms.
- **Core Element 5:** Facilitator must sit down and watch the video with the parent/guardian and youth. Youth and parent/guardian must watch the video together.

Content core elements:

- **Core Element 6:** Enabling parent/guardian and youth to learn and practice communication skills.
- **Core Element 7:** Teaching parent/guardian and youth proper condom use skills.
- **Core Element 8:** Distributing and guiding parent/guardian and youth through a Resource Guide that includes the following topics:
 - Basic components of good communication and how to talk to your youth
 - Importance of parental monitoring
 - Steps for proper condom use
 - STD and HIV facts, including prevalence data among young African Americans

Video/DVD Key Messages

The following messages have been identified as the “heart and soul” of the video/DVD. Before viewing the video/DVD with parents and youth, be sure to have reviewed these key messages. This will help you engage in discussions during the parent/youth sessions. These key messages were derived from an intensive formative evaluation, including ethnographic research and a review of the literature.

- It is important to talk to your youth about sex before they start having sex.
 - Best time to influence is before youth start having sex.
 - Find a good time for you (parent/guardian) and youth.

- ▶ You can't wait for them to ask about sex.
 - ▶ Don't wait until he/she is in the situation, because you are not going to be around.
 - ▶ Parents need to talk with their youth about STDs and pregnancy.
- 2** Parents should talk to their children about abstinence.
- ▶ Talking to youth about abstinence and making sure to correct the misperception that “everybody's doing it” will allow them to make better sexual decisions.
- 3** It is important to know whom your youth is with, what he/she is doing and where he/she is.
- ▶ Hang out with your youth. Know his or her friends, know what he/she is facing.
- 4** It is important for youth to know how they would respond if they were in a situation in which they might be pressured into having sex (even when the pressure might be positive, such as a boyfriend or girlfriend saying how much he/she loves them).
- 5** There are serious consequences to risky sexual behavior.
- ▶ Fifteen to 30% of all HIV infections occur among people younger than age 25.⁷
 - ▶ African Americans are disproportionately affected by HIV, accounting for 55% of all HIV infections reported among young people ages 13 to 24.
 - ▶ Although treatment is now available that allows people to live much longer with HIV, there are still many difficulties with being HIV infected, including serious treatment side effects and stigma.
 - ▶ Sex can make it difficult for a young person to reach their goals.
 - ▶ The decisions youth make when young have an impact on their future.
- 6** Parents should talk to their youth about proper condom use.
- ▶ Talking to youth about condoms and making sure they know how to use condoms is not the same thing as encouraging them to have sex.

⁷ Morris, M. (2006) Prevalence of HIV Infection Among Young Adults in the United States: Results from the Add Health Study. *American Journal of Public Health* 96 (6): 1091-1097.

- 7** Communication goes both ways.
 - ▶ Be approachable. A parent's negative reaction to a youth coming to talk can stop future conversations.
 - ▶ It is important to listen to your youth.
 - ▶ Often youth are happy that parents talk to them about sex. It shows them you care.
- 8** Talking with your youth is difficult but it gets easier over time.
 - ▶ Both parents and youth often feel awkward about these discussions.
 - ▶ Be prepared. Do the best you can do as a parent and for yourself.
 - ▶ It is OK to tell your youth you don't know the answer to a question and to find out the answer later.
 - ▶ Parents and youth are having these difficult conversations successfully. It can be done!
- 9** If you feel you cannot talk to your youth about sex, it is important to find someone else to talk to him/her. Find someone who shares your values and has a good rapport with your youth so the youth respects and enjoys talking with this person.
- 10** Allow youth to grow toward independence, but set guidelines too.
 - ▶ Ultimately, youth are going to make their own decisions, but it is parents' job to give them information and prepare them as much as possible.

About *ImPACT*

Welcome to Focus on Youth with ImPACT! This parent session, *Informed Parents and Children Together (ImPACT)*, and the accompanying DVD were designed specifically for the parents and guardians of the youth participating in your *Focus on Youth with ImPACT* program. The session is guided by parental monitoring theory and the theory of parenting (passive, authoritarian and authoritative). It will guide important future discussions between parents/guardians and their youth around HIV, STD and teen pregnancy prevention.

ImPACT is made up four components:

- 1** A documentary that shows the challenges and importance of parents monitoring and talking to their youth about sex, abstinence, STDs, HIV and proper condom use
- 2** A one-on-one guided roleplay where facilitators walk parents and youth through a practice “mock communication” about monitoring, communication, abstinence, sex, condoms, STDs and HIV.
- 3** A Parent/Guardian Resource Guide with factual information about HIV, STDs and correct condom use, as well as the importance of monitoring and communicating with young people
- 4** A condom demonstration, followed by the opportunity for both parent and youth to practice if they are comfortable.

The objectives of ImPACT are as follows:

- Parents/guardians will be reminded that they continue to play a critically important role in the lives of their children as youth mature through adolescence.
- Parents/guardians will increase their knowledge of basic facts about HIV transmission, prevention and testing. They will have an increased awareness of HIV risk factors associated with African Americans and African-American youth.
- Parents/guardians will learn skills to increase monitoring and communication and to enhance parent-child relationships.
- Parents/guardians will understand the importance of affording their youth increased independence and yet providing sufficient structure and guidance to assure their safety and well-being.

- Parents/guardians will understand the importance of listening to and acknowledging the perspectives of their youth while simultaneously reinforcing the importance of youth understanding parental expectations and parents' need to monitor their adolescents.
- Parent/guardians will learn correct condom use skills by observation and practice.

About the ImPACT Parent/Guardian Resource Guide

This guide was designed to accompany the viewing of the *ImPACT* DVD, and is provided as a tool to facilitate communication between parents/guardians and youth. It should be stressed that it is not a how-to-parent guide, but, rather, a tool to assist parents/guardians in effectively communicating with their youth around difficult topics such as abstinence, sex, condom use, HIV and other STDs. Steps to effective condom use are included in this Resource Guide and parents should be strongly encouraged to participate in this section with their youth.

The Resource Guide also provides tips to help parents monitor their youth in loving and supportive ways during this challenging time of adolescence as youth develop their social skills and test their independence.

How and When to Make Contact with Parents

While the *Focus on Youth* intervention is effective in reducing unprotected sex among youth, it is more effective when combined with the *ImPACT* parent component. *ImPACT (Informed Parents and Children Together)* encourages parents/guardians to be engaged in the learning process as their children take part in *Focus on Youth*. Research has also shown that by being an active force in the lives of their children, parents/guardians can have a profound impact.

Here are some useful tips to help you arrange for the ImPACT sessions with the parents/guardians of the youth in your program:

- Find out from participating youth who their parents/guardians are. In some cases, the person you will be conducting the *ImPACT* session with may be an aunt, uncle, older sibling, grandparent or mentor.
- When contacting the parent/guardian, introduce yourself *and* your agency.

- Provide the parent/guardian with a brief overview of *Focus on Youth with ImPACT*.
- Explain that you would like to request an opportunity to meet with them and their child in their home to share *ImPACT* with them.
- Inform them that the session will take 90 minutes.
- Refer to the *ImPACT* Session Agenda on page 16 as a guide to provide an overview of what will take place during the 90 minutes.
- Schedule a date and time to meet with the parent/guardian and youth. Make sure this meeting occurs prior to Session 3.
- Inform them that you will be providing a Parent/Guardian Resource Guide. Let them know that it contains a significant amount of written material. Ask the parent/guardian: Are there any special needs you may have regarding this written material (e.g., English is a second language, poor eyesight, difficulty reading, etc.)? If they say yes, mark the applicable box on the *ImPACT* Session Information Form (see page 13) and note what those needs are so that the facilitator who conducts the *ImPACT* session is aware of this. During the session, the facilitator should be sure to summarize fact sheets and other information from the Parent/Guardian Resource Guide and to read roleplays aloud.
- After scheduling the meeting, confirm by sending written correspondence. Mail this letter 1–2 weeks prior to the *ImPACT* session.
- Two days prior to the session, reconfirm your meeting by telephone.
- The morning of your meeting with the parent/guardian and youth, reconfirm the time and location of the session.

Logistics

- Use the *ImPACT* Session Information Form found on page 13 to collect the information you need and ensure that you have all relevant materials for the session.
- If you will be using your own laptop to play the DVD, make sure that the laptop is fully charged prior to your meeting with the parent/guardian and youth.

Please review your Implementation and Technical Assistance Guide for Frequently Asked Questions regarding the *ImPACT* session.

Protecting Yourself

It is important as you prepare to meet with youth and their parents/guardians in their homes for you to consider your own safety and well-being, as well as the communities you may be visiting. You may want to do the following:

- **Map your area.** It is important to know where your youth live, routes in and out of their neighborhoods, if there is any illegal activity that might occur there and if there is certain clothing that would not be considered appropriate (e.g., certain colors may be affiliated with gangs).
- **Their turf, their time.** Remember that you are entering the youth and parent/guardian's social domain and requesting their time. Be mindful and respectful by showing up at your scheduled time and finishing at the appropriate time.
- **Remember: safety first!** Always keep safety in mind. If possible, wear name badges, etc., as a form of identification. Try not to wear fancy jewelry, carry large amounts of cash or schedule appointments too late in the evening.
- **Know your role.** Be clear about what your purpose is when conducting the parent session. You are there simply to conduct the ImPACT intervention and possibly offer additional resources, if solicited.

ImPACT Session Information Form

Directions: Complete this form for each family you will visit before conducting the *ImPACT* session.

Parent/Guardian Name: _____ Visit Date: _____

Youth Name: _____ Visit Time: _____

Address: _____

Telephone: home _____

cell _____

DVD Player
available?

Yes No

Special needs around
written material?

Yes No

Directions:

Checklist

- | | |
|-------------------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Facilitator's Guide | <input type="checkbox"/> Parent/Guardian Resource Guide |
| <input type="checkbox"/> <i>ImPACT</i> Session Agenda | <input type="checkbox"/> <i>ImPACT</i> Parent/Guardian DVD |
| <input type="checkbox"/> Condoms | <input type="checkbox"/> Penis model |
| <input type="checkbox"/> Antibacterial hand cleaner | <input type="checkbox"/> Water-based lubricant |
| <input type="checkbox"/> Laptop/Portable DVD player
(if no DVD player available) | <input type="checkbox"/> Condom Cards |

I.

Introduction to *Focus on Youth with ImPACT*

- | | |
|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  Objective: | This activity will familiarize parents/guardians with the agenda for the session, increase safety for discussion and increase understanding of the <i>Focus on Youth with ImPACT</i> program. |
|  Time: | 5 minutes |
|  Materials: | ImPACT Session Agenda , <i>Focus on Youth with ImPACT</i> Parent/Guardian Resource Guide |

Notes for Facilitator:

This session may be your first opportunity to interact with both the parent/guardian and youth in a structured setting. It's important to be as prepared as possible so that you can address concerns that may come up for youth and parents/guardians during the discussion. This encounter can be useful in building much-needed support for the youth's participation in *Focus on Youth with ImPACT*. Building rapport with parents/guardians during this session will help enlist them as allies as their child goes through the program.

Procedure

- 1 Start by thanking both the parent/guardian and the youth for taking time out of their busy schedules and spending it with you in their home.
- 2 Even if they may already know it, please (re)state the following:
 - your name
 - the agency you represent
 - your role in the implementation process of *Focus on Youth with ImPACT*
- 3 Next, ask how both the parent/guardian and the youth would like for you to address them. Use those names from this point on.
- 4 Build rapport by making small talk before jumping into the session. You could comment on something (e.g., a painting or picture) you like in their home, discuss a current event or the weather, or ask the youth about school or an after-school activity.

- 5** Let the participants know that today's session is designed to help them talk about issues that can help prevent HIV. Explain that you want to create an environment that will feel mutually safe and comfortable for discussions. Make sure that parents/guardians and youth understand the following:

 - Confidentiality: What is said here, stays here.
 - Right to pass: You don't have to answer a question if you don't want to.
 - No judgment: Try to put yourself in one another's shoes.
 - Create a safe space: Be mindful of your body language and the words you use as you communicate about these difficult topics.
- 6** Distribute the **ImPACT Session Agenda** to both the parent/guardian and the youth. Explain that you would like to briefly outline what you'll cover in the session. Next, walk them through the agenda. Explain that they already may know some of what you will cover. Tell the youth that you will need his/her opinion on the DVD and during the roleplays.
- 7** Ask if there are any questions about the agenda. Address any relevant questions quickly. If the questions don't currently apply, explain that you will answer their questions where most appropriate during your discussion.
- 8** Distribute the Parent/Guardian Resource Guide and have them turn to the **Focus on Youth with ImPACT Fact Sheet** on page 3. Explain that you will now provide a synopsis of the *Focus on Youth with ImPACT* program. Use the **Fact Sheet** as a guide during this part of the discussion, highlighting the key points, but remember not to read verbatim.
- 9** Ask if there are any questions, and answer relevant ones quickly.
- 10** Briefly explain the purpose of today's session. Explain that you are here to share a little about what their youth is learning in the *Focus on Youth with ImPACT* program and to help them learn strategies and skills to keep their youth safe from HIV, the virus that causes AIDS. Explain that HIV is 100% preventable, but to succeed in this fight to prevent it certain things are necessary, such as:

 - effective communication
 - clear understanding of where to get information or resources
 - skills for decision making, negotiation and properly using a condom if necessary
- 11** Close by stating that you are now going to move into the first discussion.

Informed Parents and Children Together (ImPACT) Session Agenda

Introduction to <i>Focus on Youth with ImPACT</i>	5 minutes
HIV 101	10 minutes
The <i>ImPACT</i> Parent/Guardian DVD	30 minutes
Effective Communication	15 minutes
Condom Demonstration OR Condom Card Activity	10 minutes
Talking with Your Youth Roleplays	15 minutes
Ending the Session	5 minutes

Focus on Youth with ImPACT

- ❑ *Focus on Youth with ImPACT* is a HIV, STD and pregnancy prevention program for African-American youth between ages 12 and 15. It gives young people the knowledge and the skills they need to protect themselves from getting HIV or another STD.
- ❑ *Focus on Youth with ImPACT* has 8 sessions. These sessions help youth:
 - Build trust among the group
 - Think about their values and the risks they take
 - Know where to get information about HIV and other issues
 - Learn skills for good communication
 - Look at the consequences of their behaviors
 - Take care of their sexual health
 - Express affection without having sex
 - Get involved with the community
- ❑ *Focus on Youth with ImPACT* is adapted from *Focus on Kids*, a program originally developed in Baltimore to reduce the risk of HIV among urban youth. The university researchers worked with community members from recreation centers, housing developments, schools and government agencies in settings throughout the U.S. and the world to reach this goal.
- ❑ Because many things can lead to risk behaviors among youth, it became clear from talking with parents, youth and community leaders that the program would need to cover many topics, including decision making, values, communication, and knowledge about risk behaviors associated with HIV, other STD, teen pregnancy, violence, alcohol and other drug use, and drug selling.
- ❑ Parents, guardians and other caregivers are a very important part of this effort. This Resource Guide is a tool to assist parents and guardians in talking to their youth around difficult topics such as abstinence, sex, condom use, HIV and other STDs. It gives you information about HIV and other STD, including the impact on the African-American community; tips for good communication with your youth; and information about using condoms.



2.

HIV 101

 Objective:	Parents/guardians will increase their knowledge of basic facts about HIV transmission, prevention and testing. They will have an increased awareness of HIV risk factors associated with African Americans and African-American youth.
 Time:	10 minutes
 Materials:	Parent/Guardian Resource Guide

Notes for Facilitator: In this activity you facilitate a brief conversation with the parent/guardian about HIV—in general and in their community. Be sure to pause after each question to give the parent/guardian a chance to answer. Your role is to clarify misconceptions and prepare them to watch the DVD. Follow the parent/guardian’s lead in terms of language and communication style. Involve the youth in the conversation as well. The information you provide needs to be simple and direct. Refer them to their *Focus on Youth with ImPACT Parent/Guardian Resource Guide* for more detailed information.

Procedure

- 1 Ask the parent/guardian to turn to **Talking to Your Youth About HIV/AIDS** on page 5 in the Parent/Guardian Resource Guide.
- 2 Explain that all of the things you will be discussing about HIV are also in their Resource Guide so they can read more about it later or talk about it later with their youth.
- 3 Begin a dialogue with the parent/guardian about what he/she knows about HIV. Encourage the adult and not the youth to answer the questions, but be cautious about putting parents/guardians on the spot or making them feel they aren’t knowledgeable. Let them say what they know then add any additional information. Some questions you can ask:

- What do you know about HIV?
HIV stands for Human Immunodeficiency Virus. It's a virus that attacks the body's immune system and weakens the body's ability to fight off infection. If left untreated, HIV will eventually weaken the immune system so much that the person will become sick from certain types of infections. When the person gets these infections, he or she is said to have AIDS (Acquired Immune Deficiency Syndrome). Not everyone with HIV has AIDS, and AIDS is not the same as HIV.
- What do you know about how people get HIV?
HIV is passed from one person to another through unprotected sex. It can also be passed by sharing needles for injecting drugs, steroids or hormones, or for tattooing or piercing, with someone who has HIV, and from an HIV-positive mother to her child during pregnancy, delivery or breastfeeding.
- Which body fluids must be exchanged for someone who already has HIV to give it to someone else?
Blood, semen, vaginal fluids, breast milk or any other body fluids that contain blood.
- What do you think are some ways to make sure you don't get HIV?
The best way to make sure you don't get HIV is to not have sex (abstain) and to not use injection drugs or share needles for any other reason. Having sex with only one uninfected person who only has sex with you will also protect you. If you do have sex, have one faithful partner and always use a latex condom.

Notes for Facilitator:

Keep in mind that this is a conversation rather than a presentation. Let the parents/guardians tell you what they know about HIV. Your role is to clarify misconceptions and add information if there are any knowledge gaps.

- 4** Explain to the parent/guardian that after talking a little about HIV in general, you now want to take a couple of minutes to talk about how HIV is affecting the African-American community in general, and especially African-American youth.

- 5** Tell the parent/guardian that, in a moment, you are going to share some facts about HIV and the impact it has had on both the African-American community and on African-American youth. Let them know that what they'll be seeing will have a lot of numbers and charts. For some people, this type of information can be a little overwhelming. Ask the parent/guardian what his or her comfort level is in reviewing data or numbers. If the parent/guardian says he or she is comfortable reviewing data, proceed to step 6.

If parents/guardians express discomfort in reviewing data, explain that it might be easier to understand the information if they focus on the “who, what, when, where and why” of the data or number samples they are viewing.

- **Who:** Who is described in the data? Who is collecting the information? And who is the intended audience for the information?
- **What:** What do the numbers say about the people?
- **When:** How long has it been since the numbers were collected? If the numbers are old, do they still mean anything? Most numbers are good for about 5 years.
- **Where:** Knowing where the information was collected can help you understand how big the area studied was (e.g., if the information was collected in one neighborhood, it could be difficult to say that this is how most people in a city feel about a particular issue, versus having information from people in several communities who participated in the same study).
- **Why:** Why data has been collected is sometimes the most difficult to explain. Often you may be able to get a feel for this by reflecting on the “who” and “what” tips.

Once you have presented the tips, ask the parent/guardian to keep these tips in mind as you begin to review the information with numbers in the Resource Guide.

- 6** Ask the parent/guardian to turn to the CDC handouts **HIV/AIDS Among African Americans** and **HIV-Related Risk Behaviors Among African-American Youth** in Appendix A of the Parent/Guardian Resource Guide (pages 17–28). Explain that the fact sheets are in case they want to know more about how HIV is affecting the African-American community and African-American youth.

- 7** Using the fact sheets as a guide, briefly share the following facts:
- Half of ALL the people living with AIDS in the United States are African American.
 - African Americans are diagnosed with AIDS 10 times more often than white people.
 - Almost 3/4 of the new AIDS cases among young people were among young African Americans.
- 8** Explain that there is a crisis in the African-American community and that one of the goals of the *Focus on Youth with ImPACT* program is to reduce the rate of HIV infection among African-American youth. Tell parents/guardians that their participation is key because research has shown that when parents were involved, their youth had lower rates of sex or sex without condoms and even lower rates of alcohol and cigarette use.

3.

The *ImPACT* Parent/Guardian DVD

 Objective:	Parents/guardians and youth will increase their mutual understanding of: <ul style="list-style-type: none">• Effective and non-effective communication strategies.• The pressures that exist for parents/guardians as their youth grow toward more independence.• The perceived risk of HIV for youth.
 Time:	30 minutes
 Materials:	Television, DVD player, <i>ImPACT</i> Parent/Guardian DVD

Notes for Facilitator: Remember to check with the parent/guardian ahead of time to find out if they have a DVD player you can use. If the family doesn't have one available, then using a portable DVD player may be an option if your agency has one.

- Procedure**
- 1 Explain that you will now show a brief film to help address some of the goals you mentioned earlier.
 - 2 Tell them the DVD is about 25 minutes long. Explain that after viewing the DVD you would like to go over some additional discussion questions with them.
 - 3 Play the DVD.
 - 4 After the DVD, lead a discussion by asking both the parent/guardian and the youth the following questions:
 - What did you think of the DVD? Was there anyone in the documentary whom you connected with? Why?
 - Do you have any questions about what you saw in the DVD?

Answer their questions. If they have none, prompt them with the questions below.

- As a parent/guardian, what main points from the DVD stand out for you?

It's important for parents to talk to their child about sex, STD and pregnancy. It's important to know with whom children are socializing, what they are doing, and where they are. If parents feel they can't talk to their children about sex, it's important for them to find someone else to do this who shares the parent's values and has a good rapport with the youth. Parents should talk to their kids about abstinence and proper condom use. Parents should allow youth to grow toward independence but set guidelines that help them.

- Did you see anything in the DVD that might make you change the way you discuss sex or HIV with your youth and/or your parent/guardian?
- Were there any strategies you think could be useful in your communication with your youth or parent/guardian? What were they?
Parents should spend time with their children, know their children's friends, and know what their children are facing. Parents should be approachable because communication involves listening to youth as well as talking to them. You can use humor to make these conversations a bit easier, especially in the beginning.
- Have there been circumstances that have made it more difficult to talk to each other about sensitive issues such as HIV/AIDS, abstinence, sex, etc.?

5 Clarify any misinformation that comes up as part of the discussion.

Notes for Facilitator:

If your agency has prepared a handout of local resources, provide that to parents/guardians at this time.

- 6** Close by thanking them for allowing you to use their TV and DVD player. Explain that you would now like to practice some of the skills you've all been discussing.

4.

Effective Communication

 Objective:	Parents/guardians will understand the importance of communicating with and monitoring their youth.
 Time:	15 minutes
 Materials:	Parent/Guardian Resource Guide

Procedure

- 1** Incorporating the DVD into your discussion, begin a brief dialogue around communicating with their youth about sex, abstinence and HIV. Refer to **Tips for Talking with Your Youth** on page 7 in the Parent/Guardian Resource Guide. Remind parents/guardians about what they saw in the DVD and ask them to think about similarities in their own lives. Pose the following questions:
 - What are conversations around sex like between you and your son/daughter/niece, etc.? Is it challenging? Does he/she talk to you?
 - What do you know about his/her girlfriends/boyfriends?
 - Have you talked to him/her about abstinence? about safer sex?
- 2** Refer parents/guardians to **The Importance of Monitoring Your Youth** on page 9 in the Parent/Guardian Resource Guide. Explain that this section offers ideas for ways to learn more about young people’s communication and ideas for non-intrusive ways to monitor their youth. Ask parents/guardians which of these things they already do and which they might like to try.

5A.

Condom Demonstration

 Objective:	Parent/guardians will learn correct condom use skills by observation and practice.
 Time:	10 minutes
 Materials:	Penis model, condoms, water-based lubricant, antibacterial hand cleaner, Parent/Guardian Resource Guide

Procedure

- 1** Explain to the parent/guardian that in addition to helping youth learn healthy communication and negotiation skills, the *Focus on Youth with ImPACT* program will also teach how to correctly use a condom. It's important to emphasize that not all young people are having sex, and that reviewing proper condom use with them doesn't mean you are suggesting that their youth is engaging in sexual behavior. Stress that discussing condom use doesn't send a message to youth that their parents are giving them permission to have sex. Instead they are supporting the idea that, if and when a young person makes the decision to be sexually active, it's important to protect himself or herself from HIV and other STD.
- 2** Acknowledge that it may be awkward to teach their youth how to use a condom. Explain that you hope this discussion and practice will ease the awkwardness. Offer these points for them to consider:
 - Studies have shown that *talking* to youth about condoms and *making sure they know how to use condoms* is not the same as **encouraging** them to have sex.⁸
 - Although abstinence—not having sex—is always the safest choice, condoms can help prevent HIV, other STD and unwanted pregnancy.

⁸ Smoak, N., M. A. Scott-Sheldon, B. Johnson, M. Carey and the SHARP Research Team. 2006. Sexual risk reduction interventions do not inadvertently increase the overall frequency of sexual behavior: A meta-analysis of 174 studies with 116,735 participants. *Journal of Acquired Immune Deficiency Syndrome* 41 (3): 374-384.

- The goal is to foster positive norms and attitudes toward consistent condom use for youth who are sexually active (similar to wearing a safety belt when in a car).
- For condoms to help, they must be used properly.

Notes for Facilitator:

Be sure to convey that carrying and using condoms is not gender specific. Both men and women need to be prepared to protect themselves.

- 3** Ask parents/guardians if they have any objections to you demonstrating the correct way to use a condom. *If the answer is YES, stop and do activity 5B instead.*
- 4** Tell parents/guardians that, before they talk to their youth about condom use, they must feel comfortable with the proper way to use a condom. This practice will help them do that. Using the penis model, demonstrate the correct way to use a condom, using the steps below.
 1. Once people decide to have sex and use condoms, they should discuss using condoms with their partners.
 2. Once they and their partner have agreed to use condoms, they'll need to buy or get latex condoms. Condoms are easy to find in drug stores and many grocery or convenience stores. Young people can often get them for free at health clinics.
 3. Check the expiration date and examine the package. Do not use a condom if it's past its expiration date, or if the package is torn or damaged.
 4. Open the package carefully. Handle the condom with care. Teeth, fingernails or sharp objects can damage the condom.
 5. Get ready.
 - Determine which way the condom unrolls. (Don't unroll the condom before putting it on.)
 - Pinch the top of the condom between your thumb and first finger to keep the air out.
 - Leave about 1/2 inch of room at the tip. This allows space to catch the semen, so the condom won't break.

6. Put the condom on.
 - Continuing to hold the tip of the condom, place it against the head of the erect penis (the end of the penis where the urethral opening is).
 - Use your other hand to carefully unroll the condom over the penis, all the way down to the base (the end of the penis next to the body).
 - When it's put on properly, the condom should stay on the penis during intercourse.
 7. After ejaculation:
 - Hold the rim of the condom around the base of the penis.
 - Pull the penis out while it is still erect (hard).
 - Be careful not to spill any semen.
 8. Take it off.
 - Make sure the penis is away from the partner's body before removing the condom.
 - Throw the used condom away. (Wrap it in toilet paper and throw in a trash can. Do not flush it down the toilet.)
 - Never use a condom more than once.
- 5** Explain to parents/guardians that you would like to have them practice the condom demonstration. Acknowledge that this might feel a bit awkward, but practice will help reinforce the information they just learned.
- Provide parent/guardian and youth with condoms.
 - Explain that you would like them to go through the steps of putting on a condom using the penis model or their fingers. (*Note: If they are uncomfortable with this, use the Condom Card Activity (5B) as an alternative.*)
 - Give them 5 minutes to complete the condom demonstration.

Notes for Facilitator:

If participants are struggling with the activity, provide appropriate prompts to assist them through the process.

6 Provide additional information:

- Use latex condoms. These can be found in drug stores, many grocery and convenience stores, and are often free at health clinics. Don't use lambskin condoms, because these don't protect against HIV.
- Polyurethane condoms, sometimes called "plastic" condoms, are a good choice for people who are allergic to latex.
- Use only water-based lubricants, such as KY Jelly™, with latex condoms. Oil-based lubricants, such as petroleum jelly, massage oils or lotions will cause the condom to break.
- When condoms are used properly, they rarely break or fall off.

Point out the **How to Use a Condom** information sheet on page 11 in the Parent/Guardian Resource Guide and tell them they can refer to this sheet to review the steps later.

Ask if the parent/guardian has any questions before you move into the roleplays. Address any questions or concerns.

5B.

Condom Card Activity

 **Objective:** Parent/guardians will learn accurate information about condom use.

 **Time:** 10 minutes

 **Materials:** **Condom Cards**, Parent/Guardian Resource Guide

Notes for Facilitator: This activity is an alternate to use if you are not able to do an actual condom demonstration. It's not necessary to do this activity if you have done the condom demonstration. The condom demonstration is a much stronger activity so you are encouraged to do it if at all possible.

Procedure

1 Explain to the parent/guardian that in addition to helping youth learn healthy communication and negotiation skills, the *Focus on Youth with ImPACT* program will also teach how to correctly use a condom.

It's important to emphasize that not all young people are having sex, and that reviewing proper condom use with them doesn't mean you are suggesting that their youth is engaging in sexual behavior. Stress that discussing condom use doesn't send a message to youth that their parents are giving them permission to engage in sex. Instead they are supporting the idea that, if and when a young person makes the decision to be sexually active, it's important to protect himself or herself against HIV and other STD.

2 Offer these points for them to consider:

- Studies have shown that *talking* to youth about condoms and *making sure they know how to use condoms* is not the same as *encouraging* them to have sex.⁹

⁹ Smoak, N., M. A. Scott-Sheldon, B. Johnson, M. Carey and the SHARP Research Team. 2006. Sexual risk reduction interventions do not inadvertently increase the overall frequency of sexual behavior: A meta-analysis of 174 studies with 116,735 participants. *Journal of Acquired Immune Deficiency Syndrome* 41 (3): 374-384.

- Although abstinence—not having sex—is always the safest choice, condoms can help prevent HIV, other STD and unwanted pregnancy.
 - The goal is to foster positive norms and attitudes toward consistent condom use for youth who are sexually active.
 - For condoms to help, they must be used properly.
- 3** Explain that there are 3 important skills for people to learn concerning condom use:
- How to use a condom—how to put it on and discard it afterwards.
 - How to bring up the topic with a partner.
 - How to cope with or handle a partner’s reaction regarding condom use.
- 4** Explain that they’ll be learning about the first step—how to use a condom. They’re going to start by finding out how much they already know. Explain that you’ll be handing out cards that describe the steps for proper condom use. Their task will be to arrange the cards to show these steps in the correct order.
- 5** Hand out the **Condom Cards**. (Be sure the cards are shuffled before handing them out.) There are 13 cards.
- 6** Ask the parent/guardian to arrange the cards in the correct order. When they have settled on their arrangement, review the steps one at a time and explain each one carefully. If the cards are in the correct order, praise the parent/guardian for how much he/she already knows. If there are errors, affirm that people often get confused about these steps, which is why it’s important to review this information carefully.

The condom card steps, in order:

1. Talk with your partner about using condoms.
2. Buy or get latex condoms.
3. Check the expiration date and package.
 - Do not use past expiration date.
 - Do not use if package is torn or damaged.
4. Open package carefully. Handle the condom with care.
5. Determine which way the condom unrolls. (Do not unroll the condom before putting it on.)
6. Pinch the top of the condom to squeeze air out.

7. Leave about 1/2 inch of room at the top to catch the semen.
8. Continuing to hold the tip of the condom, place it against the head of the erect penis.
9. Use your other hand to carefully unroll the condom over the penis, all the way down to the base.
10. After ejaculation, hold the rim of the condom around the base of the penis.
11. Take the penis out while it is still erect (hard).
12. Make sure the penis is away from the partner's body. Remove the condom.
13. Throw the used condom away. Never use a condom more than once.

7 Provide additional information:

- Use latex condoms. These can be found in drug stores, many grocery and convenience stores, and are often free at health clinics. Don't use lambskin condoms, because these don't protect against HIV.
- Polyurethane condoms, sometimes called "plastic" condoms, are a good choice for people who are allergic to latex.
- Use only water-based lubricants, such as KY Jelly™, with latex condoms. Oil-based lubricants, such as petroleum jelly, massage oils or lotions will cause the condom to break.
- When condoms are used properly, they rarely break or fall off.

Point out the **How to Use a Condom** information sheet on page 11 of the Parent/Guardian Resource Guide and tell them they can refer to this sheet if they want to review the steps later.

Notes for Facilitator:

Go over the steps for condom use in some detail. The cards provide basic information, but this can be expanded on. Be sure the parent/guardian understands the anatomy of condom use (for example, which end of the penis is the head, which end is the base).

Condom Cards

Directions: Copy and cut apart the cards. Or print each step on a piece of 8-1/2" x 11" paper. Be sure to shuffle the cards well before using them in the activity.

Talk with your partner
about using condoms.

Buy or get latex condoms.

Check the expiration date and package.

- Do not use past expiration date.
- Do not use if package is torn or damaged.

Open package carefully.
Handle the condom with care.

Determine which way the condom unrolls.
(Do not unroll the condom before putting it on.)

Pinch the top of the condom
to squeeze air out.

Leave about $1/2$ inch of room
at the top to catch the semen.

Continuing to hold the tip of the condom,
place it against the head of the erect penis.

Use your other hand to carefully unroll the condom
over the penis, all the way down to the base.

After ejaculation, hold the rim of the condom around the base of the penis.

Take the penis out while it is still erect (hard).

Make sure the penis is away from the partner's body. Remove the condom.

Throw the used condom away. Never use a condom more than once.

6.

Talking with Your Youth Roleplays

 Objective:	Parents/guardians and youth will increase and enhance skills for communication around the topics of healthy decision making and sexuality.
 Time:	15 minutes
 Materials:	Parent/Guardian Resource Guide

Procedure

- 1** Tell the parent/guardian that now they will have an opportunity to think about how they could apply some of the tips you've shared and the discussions in the DVD about sexual decision making.
- 2** Explain that they will practice some of the skills they learned by acting out a conversation using 2 stories you will provide. The stories address some typical issues that may arise between parents/guardians and youth. They will have a few minutes to practice each conversation.
- 3** Acknowledge that sometimes it's easier to practice communication skills in a pretend situation. This is often called a roleplay. Explain that they will play the part of the parent in the story. Remind them that they are playing a role. The situation is pretend, but they can use all the skills they have been learning about to help them have the conversation.
- 4** Determine if the parent/guardian and youth are comfortable with performing a roleplay. If any parents/guardians or youth decline to participate in the roleplay, reassure them that they have the right to pass and say that, with their permission, you would like to play the role they would have played. Let them know that you will ask them for their perspective on the roleplay. Once there is clarity on who will perform the roleplay, have both parties choose fictional names for their "characters."

Notes for Facilitator:

You can refer parents/guardians to the **Roleplays: Talking with Your Youth** worksheet on page 13 of the Parent/Guardian Resource Guide if they want to read the stories beforehand and write down their responses to the questions.

5 Read the first roleplay story:

Your son/daughter has been a bit distant with you lately. You've noticed that he/she has been spending more time on the phone in his/her room with the door shut, has been listening to love songs on the radio, or has been speaking about one or more of his/her peers a lot. You ask what's going on, and he/she says, "Nothing." In the next week or two you see more of the same behavior and notice that he/she seems to be having emotional mood swings.

6 Ask the parent/guardian if he/she has any questions about the scenario you just read. Address any questions, and allow some time for the roleplayers to practice, if desired. Stress to both parent/guardian and youth that this is a roleplay and that they are acting. When they are ready to begin, say "Action!"**7** Once the roleplay is complete, say, "Cut!" Ask the following questions:

- Is this a reason to be concerned?
- When would be a good time to have this discussion? (*At a time that's convenient for both; when both are calm; when there are no outside distractions*)
- What would you want to discuss? (*Whom he/she is talking to on the phone; what kind of relationship they are having.*)
- Would you as the parent want to communicate your concerns about a potential sexual relationship? Would you want to communicate your expectations around abstinence and sex?
- Besides having this conversation, what other things might you as the parent want to do (*Would you want to meet the friend(s) your youth is spending time talking to on the phone? Would you want to meet the parents of these friends?*)
- What questions would you ask?
- What information would you want to make sure your youth has?

8 Now read the second roleplay story:.

Your son/daughter tells you that he/she feels grown up and has found real love. He/she has come very close to having sex with his/her partner and has recently been thinking about going all the way.

Ask if they are ready to get back into their characters. When they are ready, say, “Action!” and have them begin the roleplay.

9 Once the roleplay is complete, say, “Cut!” Ask the following questions:

- How did it feel acting out that situation? (*Did you feel awkward or embarrassed? Was it easy or hard? How do you think you would feel if this situation was really happening?*)
- What would you do if your child approached you with a similar story? (*Would you ask what made him/her feel ready to go all the way? Would you discuss the consequences of pregnancy or getting an STD?*)
- What messages would you want to convey? (*Your preference is that he/she remain abstinent. If people have sex, they need to be sure to use a latex condom every time.*)
- What information would you want to share? (*Your own experience with feeling in love; the emotional consequences of having sex; the risks of having sex too soon.*)

10 Thank the parent/guardian and youth for participating in the roleplays.**11** Review some basic tips about communicating about abstinence, sex, HIV and condoms.

- Choose a convenient time to talk in a private spot when you won't be interrupted, and will have time to finish the discussion.
- Know what you're going to say ahead of time.
- Listen to your youth.
- Wait through the silence. Sometimes you may have to be quiet for a while before your youth will talk.
- Your youth (and you) may feel embarrassed or anxious. This is to be expected. You can say that it's difficult but very important that you talk about this topic.
- Show and tell your youth that you are concerned.

- If your youth is NOT having sex (or says he/she is not having sex) first let him/her know that you are glad because waiting to have sex is the best way to be protected 100%. Then explain that you still want to talk about sex because it's important for every young person to know certain things.
- Remember, this doesn't have to happen in one conversation. You will be opening the door to future communication with your youth.

7. Ending the Session

 Objective:	Parents/guardians will be guided to sustain the information learned in the session using resources in the community.
 Time:	5 minutes
 Materials:	Parent/Guardian Resource Guide

- 1 As you near the end of the session, parents/guardians may want to know how to sustain the information you've discussed using resources available in the community. The **Where Do I Go From Here?** information sheet on page 16 of the Parent/Guardian Resource Guide is designed to help them find resources in the community and develop other safety strategies with their youth. Direct parents/guardians to this sheet and walk them through the two sections.
- 2 Explain that this is the end of the session, and thank the parent/guardian and the youth for their time. Remind them when and where the *Focus on Youth with ImPACT* meetings are, and emphasize the importance of the youth attending all of the sessions. Let the parent/guardian know where to call for more information if they have questions after you leave.

CDC HIV/AIDS FACT SHEET

HIV/AIDS among African Americans



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

Revised June 2007

In the United States, the HIV/AIDS epidemic is a health crisis for African Americans. At all stages of HIV/AIDS—from infection with HIV to death with AIDS—blacks (including African Americans) are disproportionately affected compared with members of other races and ethnicities [1, 2].

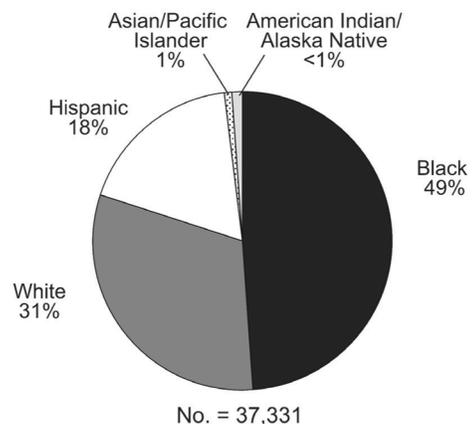
STATISTICS

HIV/AIDS in 2005

- According to the 2000 census, blacks make up approximately 13% of the US population. However, in 2005, blacks accounted for 18,121 (49%) of the estimated 37,331 new HIV/AIDS diagnoses in the 33 states with long-term, confidential name-based HIV reporting [2].*
- Of all black men living with HIV/AIDS, the primary transmission category was sexual contact with other men, followed by injection drug use and high-risk heterosexual contact [2].
- Of all black women living with HIV/AIDS, the primary transmission category was high-risk heterosexual contact, followed by injection drug use [2].
- Of the estimated 141 infants perinatally infected with HIV, 91 (65%) were black (CDC, HIV/AIDS Reporting System, unpublished data, December 2006).
- Of the estimated 18,849 people under the age of 25 whose diagnosis of HIV/AIDS was made during 2001–2004 in the 33 states with HIV reporting, 11,554 (61%) were black [3].

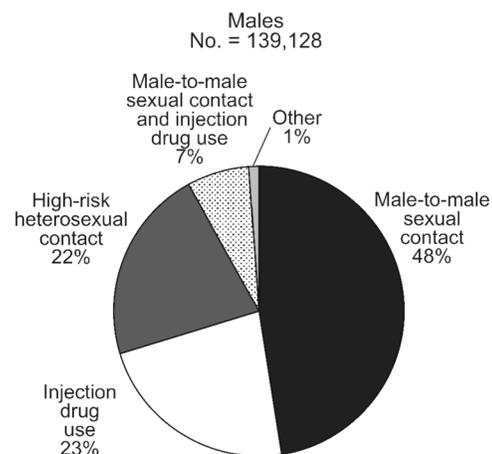
*See the box (before the References section) labeled Understanding HIV and AIDS Data for a list of the 33 states.

Race/ethnicity of persons (including children) with HIV/AIDS diagnosed during 2005



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

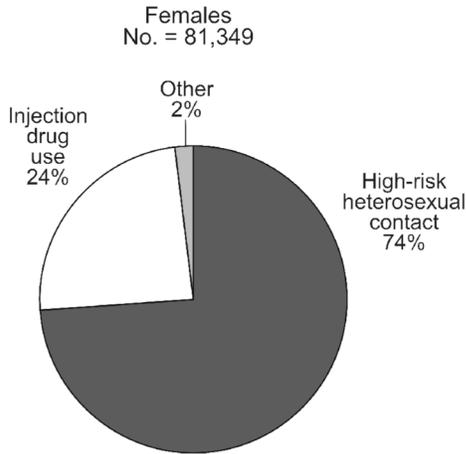
Transmission categories for black adults and adolescents living with HIV/AIDS at the end of 2005



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

HIV/AIDS AMONG AFRICAN AMERICANS

Transmission categories for black adults and adolescents living with HIV/AIDS at the end of 2005 (cont.)



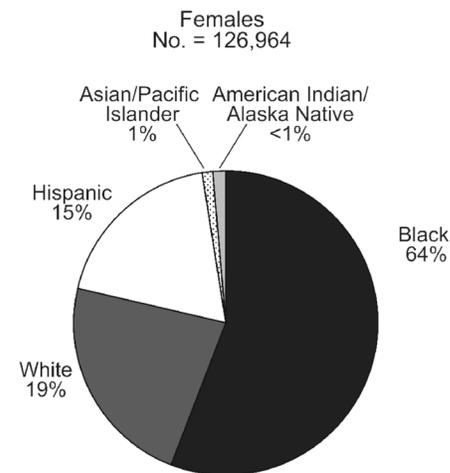
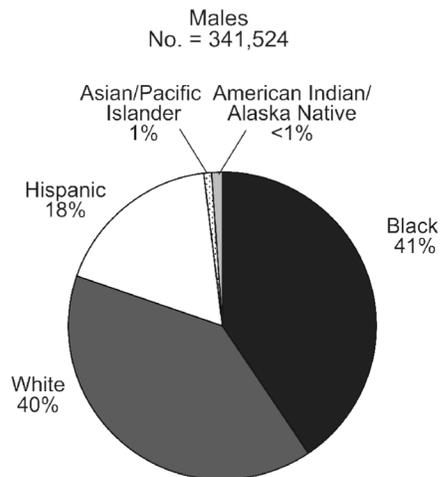
Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

AIDS in 2005

- Blacks accounted for 20,187 (50%) of the estimated 40,608 AIDS cases diagnosed in the 50 states and the District of Columbia [2].
- The rate of AIDS diagnoses for black adults and adolescents was 10 times the rate for whites and nearly 3 times the rate for Hispanics. The rate of AIDS diagnoses for black women was nearly 23 times the rate for white women. The rate of AIDS diagnoses for black men was 8 times the rate for white men [2].
- The 185,988 blacks living with AIDS in the 50 states and the District of Columbia accounted for 44% of the 421,873 people in those areas living with AIDS [2].
- Of the 68 US children (younger than 13 years of age) who had a new AIDS diagnosis, 46 were black [2].
- Since the beginning of the epidemic, blacks have accounted for 397,548 (42%) of the estimated 952,629 AIDS cases diagnosed in the 50 states and the District of Columbia [2].
- From the beginning of the epidemic through December 2005, an estimated 211,559 blacks with AIDS died [2].

- Of persons whose diagnosis of AIDS had been made during 1997–2004, a smaller proportion of blacks (66%) were alive after 9 years compared with American Indians and Alaska Natives (67%), Hispanics (74%), whites (75%), and Asians and Pacific Islanders (81%) [2].

Race/ethnicity of adults and adolescents living with HIV/AIDS, 2005



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

HIV/AIDS AMONG AFRICAN AMERICANS

RISK FACTORS AND BARRIERS TO PREVENTION

Race and ethnicity, by themselves, are not risk factors for HIV infection. Even though HIV testing rates are higher for blacks than for members of other races and ethnicities [4], rates of undetected or late diagnosis of HIV infection are high for black men who have sex with men (MSM) [5].

Blacks are also more likely to face challenges associated with risk factors for HIV infection, including the following.

Sexual Risk Factors

Black women are most likely to be infected with HIV as a result of sex with men who are infected with HIV [2]. They may not be aware of their male partners' possible risk factors for HIV infection, such as unprotected sex with multiple partners, bisexuality, or injection drug use [6, 7]. Sexual contact is also the main risk factor for black men. Male-to-male sexual contact was the primary risk factor for 48% of black men with HIV/AIDS at the end of 2005, and high-risk heterosexual contact was the primary risk factor for 22% [2].

Substance Use

Injection drug use is the second leading cause of HIV infection both for black men and women [2]. In addition to being at risk from sharing needles, casual and chronic substance users are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol [8]. Drug use can also affect treatment success. A recent study of HIV-infected women found that women who used drugs, compared with women who did not, were less likely to take their antiretroviral medicines exactly as prescribed [9].

Lack of Awareness of HIV Serostatus

Not knowing one's HIV serostatus is risky for black men and women. In a recent study of MSM in 5 cities participating in CDC's National

HIV Behavioral Surveillance System, 46% of the black MSM were HIV-positive, compared with 21% of the white MSM and 17% of the Hispanic MSM. The study also showed that of participating black MSM who tested positive for HIV, 67% were unaware of their infection; of participating Hispanic MSM who tested positive for HIV, 48% were unaware of their infection; of participating white MSM who tested positive for HIV, 18% were unaware of their infection; and of participating multiracial/other MSM who tested positive for HIV, 50% were unaware of their infection [10]. Persons who are infected with HIV but don't know it cannot benefit from life-saving therapies or protect their partners from becoming infected with HIV.

Sexually Transmitted Diseases

The highest rates of sexually transmitted diseases (STDs) are those for blacks. In 2005, blacks were about 18 times as likely as whites to have gonorrhea and about 5 times as likely to have syphilis [11]. Partly because of physical changes caused by STDs, including genital lesions that can serve as an entry point for HIV, the presence of certain STDs can increase one's chances of contracting HIV infection 3- to 5-fold. Similarly, a person who has both HIV infection and certain STDs has a greater chance of spreading HIV to others [12]. A recent CDC literature review showed that high rates of HIV infection for black MSM may be partly attributable to a high prevalence of STDs that facilitate HIV transmission [5].

Homophobia and Concealment of Homosexual Behavior

Homophobia and stigma can cause some black MSM to identify themselves as heterosexual or not to disclose their sexual orientation [13, 14]. Indeed, black MSM are more likely than other MSM not to identify themselves as gay [5]. The absence of self-identification or the absence of disclosure presents challenges to prevention programs. However, data suggest that these men

HIV/AIDS AMONG AFRICAN AMERICANS

are not at greater risk for HIV infection than are black MSM who identify themselves as gay [14, 15]. The findings of these studies do not mean that black MSM who do not identify themselves as gay or who do not disclose their sexual orientation do not engage in risky behaviors, but the findings do suggest that these men are not engaging in higher levels of risky behavior than are other black MSM.

Socioeconomic Issues

Socioeconomic issues and other social and structural influences affect the rates of HIV infection among blacks [16]. In 1999, nearly 1 in 4 blacks were living in poverty [17]. Studies have found an association between higher AIDS incidence and lower income [18]. The socioeconomic problems associated with poverty, including limited access to high-quality health care, housing, and HIV prevention education, may directly or indirectly increase the risk factors for HIV infection.

PREVENTION

In the United States, the annual number of new HIV infections has decreased from a peak of more than 150,000 in the mid-1980s and has stabilized since the late 1990s at approximately 40,000. Populations of minority races and ethnicities are disproportionately affected by the HIV epidemic. To reduce further the incidence of HIV, CDC announced the Advancing HIV Prevention (AHP) initiative in 2003 (http://www.cdc.gov/hiv/topics/prev_prog/AHP/default.htm). This initiative comprises 4 strategies: making HIV testing a routine part of medical care, implementing new models for diagnosing HIV infections outside medical settings, preventing new infections by working with HIV-infected persons and their partners, and further decreasing perinatal HIV transmission.

CDC has also established the African American HIV/AIDS Work Group to focus on the urgent issue of HIV/AIDS in African Americans. The work group developed a comprehensive response

to guide CDC's efforts to increase and strengthen HIV/AIDS prevention and intervention activities directed toward African Americans. Already, CDC is engaged in a wide range of activities to involve community leaders in the African American community and to decrease the incidence of HIV/AIDS in blacks.

For example, CDC

- Funds demonstration projects evaluating rapid HIV testing in historically black colleges and universities as well as projects to improve the effectiveness of HIV testing among black women and MSM.
- Conducts epidemiologic research focused on blacks, including
 - Brothers y Hermanos, a study of black and Latino MSM conducted in Los Angeles, New York, and Philadelphia that aims to identify and understand risk-promoting and risk-reducing sexual behaviors
 - Women's Study, a study of black and Hispanic women in the southeastern United States that examines relationship dynamics and the cultural, psychosocial, and behavioral factors associated with HIV infection.
- Addresses, through the Minority AIDS Initiative (<http://www.cdc.gov/programs/hiv08.htm>), the health disparities experienced in the communities of minority races and ethnicities at high risk for HIV infection. Funds are used to address the high-priority HIV prevention needs in such communities, including funding community-based organizations (CBOs) to provide services to African Americans. Examples of the programs that CBOs carry out are
 - A program in Washington, DC, that provides information to, and conducts HIV prevention activities for, MSM who do not identify themselves as homosexual. The activities include a telephone help line; Internet resources; and a program in

HIV/AIDS AMONG AFRICAN AMERICANS

- barbershops that includes risk-reduction workshops, condom distribution, and training barbers to be peer educators.
- A program in Chicago that provides social support to help difficult-to-reach African American men reduce high-risk behaviors. This program also provides women at high risk for HIV infection with culturally appropriate, gender-specific prevention and risk-reduction messages.
 - A program in South Carolina that is focused on changing the behaviors of adolescents to reduce their risk of contracting HIV infection and other STDs.
- Creates social marketing campaigns, including those focused on HIV testing, perinatal HIV transmission, and the reduction of HIV transmission to partners.
 - Disseminates scientifically based interventions, including
 - SISTA (Sisters Informing Sisters About Topics on AIDS), a social-skills training intervention in which peer facilitators help African American women at highest risk reduce their risky sexual behaviors.
 - Many Men, Many Voices (3MV), an STD/HIV prevention intervention for gay men of color that addresses cultural and social norms, sexual relationship dynamics, and the social influences of racism and homophobia.
 - POL (Popular Opinion Leader), which identifies, enlists, and trains key opinion leaders to encourage safer sexual norms and behaviors within their social networks. POL has been adapted for African American MSM and shown to be effective in that population.
 - Healthy Relationships, a small-group intervention for men and women living with HIV/AIDS.
 - WILLOW (Women Involved in Life Learning from Other Women), to be disseminated in 2007, is a small-group, skills-training intervention for women living with HIV. WILLOW enhances awareness of the risky behaviors associated with HIV transmission, discredits myths regarding HIV prevention for people living with HIV, teaches communication skills in negotiating safer sex, and reinforces the benefits of consistent condom use. WILLOW also teaches women how to recognize healthy and unhealthy relationships, discusses the effect of abusive partners on safer sex, and provides information about local shelters for women in abusive relationships.
- CDC also supports research to create new interventions for African Americans and to test interventions that have proven successful with other populations for use with African Americans. Additionally, CDC funds agencies through ADAPT (Adopting and Demonstrating the Adaptation of Prevention Techniques) to adapt and evaluate effective interventions for use in communities of color.
- In addition, CDC
- Provides intramural training for researchers of minority races and ethnicities through a program called Research Fellowships on HIV Prevention in Communities of Color.
 - Established the extramural Minority HIV/AIDS Research Initiative (MARI) in 2002 to create partnerships between CDC epidemiologists and researchers who are members of minority races and ethnicities and who work in communities of color. MARI funds epidemiologic and preventive studies of HIV in communities of color and encourages the career development of young investigators. CDC invests \$2 million per year in the program and since 2003 has funded 13 junior investigators at 12 sites across the country [19].

HIV/AIDS AMONG AFRICAN AMERICANS

Understanding HIV and AIDS Data

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

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

HIV/AIDS: This term is used to refer to 3 categories of diagnoses collectively: (1) a diagnosis of HIV infection (not AIDS), (2) a diagnosis of HIV infection and a later diagnosis of AIDS, (3) concurrent diagnoses of HIV infection and AIDS.

REFERENCES

1. LCWK2. Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 10-year age groups, by race and sex: United States, 2003. Available at http://www.cdc.gov/nchs/data/dvs/lcwk2_2003.pdf. Accessed January 29, 2007.
2. CDC. *HIV/AIDS Surveillance Report, 2005*. Vol. 17. Rev ed. Atlanta: US Department of Health and Human Services, CDC; 2007:1–46. Available at <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>. Accessed June 28, 2007.
3. CDC. Racial/ethnic disparities in diagnoses of HIV/AIDS—33 states, 2001–2004. *MMWR* 2006;55:121–125.
4. Anderson JE, Chandra A, Mosher WD. *HIV Testing in the United States, 2002*. Hyattsville, Md: National Center for Health Statistics; 2005:1–32. Advance Data from Vital and Health Statistics, No. 363.
5. Millett GA, Peterson JL, Wolitski, RJ, Stall R. Greater risk for HIV infection of black men who have sex with men: a critical literature review. *American Journal of Public Health* 2006;96:1007–1019.
6. Hader SL, Smith DK, Moore JS, Holmberg SD. HIV infection in women in the United States: status at the millennium. *JAMA* 2001;285:1186–1192.
7. Millett G, Malebranche D, Mason B, Spikes P. Focusing “down low”: bisexual black men, HIV risk and heterosexual transmission. *Journal of the National Medical Association* 2005;97:52S–59S.
8. Leigh BC, Stall R. Substance use and risky sexual behavior for exposure to HIV: issues in methodology, interpretation, and prevention. *American Psychologist* 1993;48:1035–1045.
9. Sharpe TT, Lee LM, Nakashima AK, Elam-Evans LD, Fleming P. Crack cocaine use and adherence to antiretroviral treatment among HIV-infected black women. *Journal of Community Health* 2004;29:117–127.
10. CDC. HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—five US cities, June 2004–April 2005. *MMWR* 2005;54:597–601.
11. CDC. *Sexually Transmitted Disease Surveillance, 2005*. Atlanta: US Department of Health and Human Services, CDC; November 2006. Available at <http://www.cdc.gov/std/stats/toc2005.htm>. Accessed January 28, 2007.
12. Fleming DT, Wasserheit JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections* 1999;75:3–17.
13. CDC. HIV/AIDS among racial/ethnic minority men who have sex with men—United States, 1989–1998. *MMWR* 2000;49:4–11.
14. CDC. HIV/STD risks in young men who have sex with men who do not disclose their sexual orientation—six US cities, 1994–2000. *MMWR* 2003;52:81–85.
15. Hart T, Peterson J. Predictors of risky sexual behavior among young African American men who have sex with men. *American Journal of Public Health* 2004;94:1122–1123.
16. National Minority AIDS Council. African Americans, health disparities and HIV/AIDS: recommendations for confronting the epidemic in black America. November 2006. Available at http://www.nmac.org/public_policy/4616.cfm. Accessed January 31, 2007.

HIV/AIDS AMONG AFRICAN AMERICANS

17. US Census Bureau. Poverty: 1999. Census 2000 Brief. May 2003. Available at <http://www.census.gov/prod/2003pubs/c2kbr-19.pdf>. Accessed January 28, 2007.
18. Diaz T, Chu SY, Buehler JW, et al. Socioeconomic differences among people with AIDS: results from a multistate surveillance project. *American Journal of Preventive Medicine* 1994;10:217–222.
19. Trubo R. CDC initiative targets HIV research gaps in black and Hispanic communities. *JAMA* 2004;292:2563–2564.

For more information . . .

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

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

CDC National HIV Testing Resources
<http://www.hivtest.org>
Location of HIV testing sites

CDC National Prevention Information Network (NPIN)
 1-800-458-5231
<http://www.cdcpin.org>
CDC resources, technical assistance, and publications

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



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION



HIV-Related Risk Behaviors Among African-American Youth

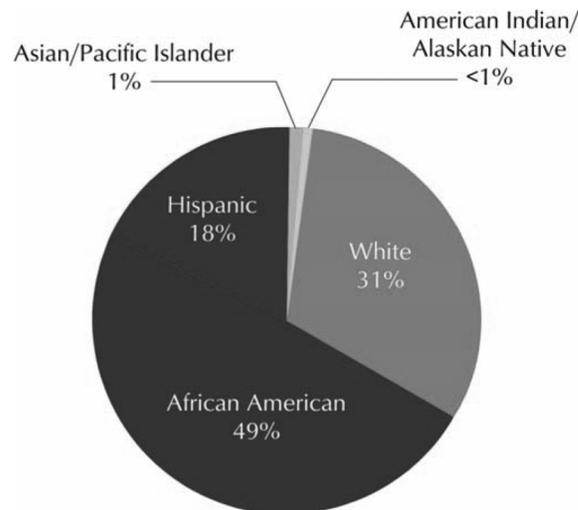
“It is time for all of us to take action to protect ourselves and our young people against HIV/AIDS. . . [W]e must educate our children about HIV prevention. They need to know that it is OK to talk about AIDS, because illness, like injustice and inequality, cannot be eliminated by remaining silent.”

Coretta Scott King

HIV/AIDS Among African Americans

- At the end of 2003, an estimated 1,039,000 to 1,185,000 persons in the United States were living with HIV/AIDS.¹ In 2005, more than 38,000 cases of HIV/AIDS were diagnosed in the 33 states with confidential, name-based reporting of HIV and AIDS cases.²
- African Americans make up approximately 13% of the U.S. population, but in 2005 they accounted for 49% of the estimated number of HIV/AIDS cases diagnosed.² Among youth, while only 15% of teens (ages 13–19) are African American, they accounted for 73% of new AIDS cases reported in 2004.³
- In 2005, the rate of AIDS cases for African-American adults and adolescents was 10 times the rate for whites and almost 3 times the rate for Hispanics. The rate of AIDS diagnoses for African-American females was 24 times the rate for white females; for African-American men it was 8 times the rate for white males.²
- During 2001–2004, among women, 68% of the HIV/AIDS diagnoses were among African Americans and, among men, 44% of the HIV/AIDS diagnoses were among African Americans.⁴
- During 2001–2004, of the estimated 18,849 people aged 25 years or younger diagnosed with HIV/AIDS in the 33 states with confidential, name-based reporting of HIV and AIDS cases, 61% were African American.⁴

Race/ethnicity of persons (including children) with HIV/AIDS diagnosed during 2005*



* Based on data from 33 states with confidential name-based HIV infection reporting.

SAFER • HEALTHIER • PEOPLE™

HIV-Related Risk Behaviors Among African American Youth

- In 2002, HIV/AIDS was the number one cause of death for African-American women aged 25–34 years and the number two cause of death for all African Americans aged 35–44.⁵ Of the more than half a million people with AIDS who have died in the United States, 38% were African American.²
- African Americans have the highest rates of sexually transmitted diseases (STDs). In 2005, rates of gonorrhea were 18 times higher among African Americans compared to whites and rates of syphilis were five times higher among African Americans compared to whites.⁶ The presence of certain STDs can increase one's chances of contracting HIV two to five-fold.⁷

Go to www.cdc.gov/hiv/topics/aa/index.htm for more information on HIV/AIDS among African Americans.

HIV-Related Risk Behaviors

- HIV transmission occurs among adults and adolescents primarily through unprotected sexual contact and injected drug use. HIV-related risk behaviors are often established during adolescence and extend into adulthood.
- The primary modes of HIV transmission among African-American adult or adolescent males are male-to-male sexual contact (48%), followed by injection drug use (23%) and high-risk heterosexual contact (22%). The primary modes of HIV transmission among African-American adult or adolescent females are high-risk heterosexual contact (74%), followed by injection drug use (24%).²

HIV-Related Risk Behaviors Among African-American Students, 2005

The following data are from the CDC's 2005 National Youth Risk Behavior Survey (YRBS), which has been conducted every other year since 1991 and provides data representative of 9th through 12th grade students in public and private schools throughout the United States.⁸ National YRBS data apply only to youth who attend school and so are not representative of

all youth. In 2004, approximately 4% of youth aged 16–17 years were not enrolled in high school and did not have a high school credential.⁹

Black students have higher rates of some HIV-related risk behaviors than white students and Hispanic/Latino students.

- 67.6% of black students had ever had sexual intercourse, compared with 43.0% of white students and 51.0% of Hispanic/Latino students.
- 47.4% of black students were currently sexually active (i.e., had sexual intercourse with 1 or more persons during the 3 months preceding the survey), compared with 32.0% of white students and 35.0% of Hispanic/Latino students.
- 16.5% of black students had had sexual intercourse before age 13 years, compared with 4.0% of white students and 7.3% of Hispanic/Latino students.
- 28.2% of black students had had sexual intercourse with 4 or more persons during their life, compared with 11.4% of white students and 15.9% of Hispanic/Latino students.

Black students have lower rates of some HIV-related risk behaviors than white students and Hispanic/Latino students and black students are more likely to have been tested for HIV.

- Among students who were currently sexually active, 31.1% of black students did not use a condom during last intercourse, compared with 37.4% of white students and 42.3% of Hispanic/Latino students.
- Among students who were currently sexually active, 14.1% of black students reported drinking alcohol or using drugs before last sexual intercourse, compared with 25.0% of white students and 25.6% of Hispanic/Latino students.
- 0.3% of black female students reported illegal injection drug use, compared with 1.3% of white female students and 1.4% of Hispanic/Latino female students.
- 21.0% of black students had been tested for HIV, compared with 10.2% of white students and 12.0% of Hispanic/Latino students.

HIV-Related Risk Behaviors Among African American Youth

Black male students have higher rates of some HIV-related risk behaviors than black female students. Black female students are more likely to have been tested for HIV.

- 74.6% of black male students had ever had sexual intercourse, compared with 61.2% of black female students.
- 51.3% of black male students were currently sexually active, compared with 43.8% of black female students.
- 26.8% of black male students had had sexual intercourse before age 13 years, compared with 7.1% of black female students.
- 38.7% of black male students had had sexual intercourse with 4 or more persons during their life, compared with 18.6% of black female students.
- 3.1% of black male students reported illegal injection drug use, compared with 0.3% of black female students.
- 24.1% of black female students had been tested for HIV, compared with 17.9% of black male students.

See Table 1 for more information on HIV-related risk behaviors by race/ethnicity and sex among high school students.

12th grade black students have higher rates of some HIV-related risk behaviors than 9th grade black students.

- 80.0% of 12th grade black students had ever had sexual intercourse, compared with 55.4% of 9th grade black students.
- 62.9% of 12th grade black students were currently sexually active, compared with 33.7% of 9th grade black students.
- 43.8% of 12th grade black students had had sexual intercourse with 4 or more persons during their life, compared with 18.4% of 9th grade black students.
- 46.7% of 12th grade black students who were currently sexually active did not use a condom during last intercourse, compared with 18.2% of 9th grade black students who were currently sexually active.

Between 1991-2005, rates of some HIV-related risk behaviors among black students varied. Some behaviors declined while others declined and then leveled off. The percentage of black students reporting illegal injection drug use increased since 1991, but remains small.

- The percentage of black students who were currently sexually active declined from 59.3% in 1991 to 47.4% in 2005; the percentage who had had sexual intercourse before age 13 years declined from 28.2% in 1991 to 16.5% in 2005; and the percentage who had had sexual intercourse with 4 or more persons during their life declined from 43.1% in 1991 to 28.2% in 2005.
- The percentage of black students who had ever had sexual intercourse declined from 81.5% in 1991 to 60.8% in 2001; since 2001, however, it has leveled off. In 2005, 67.6% of black students had ever had sexual intercourse.
- The percentage of black students who did not use a condom during last sexual intercourse (among those who were currently sexually active) declined from 52.0% in 1991 to 30.0% in 1999; since 1999, however, it has leveled off. In 2005, 31.1% of currently sexually active black students did not use a condom during last intercourse.
- The percentage of black students reporting illegal injection drug use increased from 1.1% in 1995 to 1.7% in 2005.

See Table 2 for more information on trends in HIV-related risk behaviors among high school students.

HIV-Related Risk Behaviors Among African American Youth

Table 1. HIV-Related Risk Behaviors Among U.S. Students in Grades 9–12, by Race/Ethnicity* and Sex, Youth Risk Behavior Survey, 2005

	Black Students			Hispanic Students			White Students		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Ever had sexual intercourse	67.6 ±3.1**	74.6 ±3.7	61.2 ±4.6	51.0 ±4.3	57.6 ±4.4	44.4 ±5.0	43.0 ±4.1	42.2 ±4.4	43.7 ±4.6
Were currently sexually active (Had sexual intercourse with ≥1 person during the 3 months preceding the survey.)	47.4 ±2.6	51.3 ±4.5	43.8 ±3.1	35.0 ±3.9	36.3 ±4.0	33.7 ±4.2	32.0 ±3.3	30.6 ±3.4	33.5 ±4.2
Had sexual intercourse before age 13 years	16.5 ±2.4	26.8 ±3.5	7.1 ±2.0	7.3 ±1.9	11.1 ±3.2	3.6 ±1.2	4.0 ±0.8	5.0 ±1.0	2.9 ±0.8
Had sexual intercourse with 4 or more persons during their life	28.2 ±2.6	38.7 ±4.2	18.6 ±3.3	15.9 ±2.4	21.7 ±3.5	10.4 ±2.1	11.4 ±1.8	11.6 ±2.1	11.1 ±2.2
Did <u>not</u> use a condom during last sexual intercourse (among currently sexually active students)	31.1 ±3.6	24.5 ±4.4	37.9 ±6.1	42.3 ±4.1	34.7 ±7.3	50.2 ±4.3	37.4 ±2.5	29.9 ±3.7	44.4 ±3.2
Had drunk alcohol or used drugs before last sexual intercourse (among currently sexually active students)	14.1 ±3.1	15.4 ±3.7	12.8 ±3.8	25.6 ±4.7	32.2 ±7.3	18.7 ±3.8	25.0 ±2.8	29.9 ±4.3	20.5 ±2.6
Lifetime illegal injection drug use	1.7 ±0.9	3.1 ±1.8	0.3 ±0.3	3.0 ±1.0	4.6 ±1.6	1.4 ±0.7	1.9 ±0.4	2.5 ±0.7	1.3 ±0.6
Had been tested for HIV	21.0 ±2.4	17.9 ±3.2	24.1 ±3.6	12.0 ±1.4	12.7 ±1.8	11.2 ±2.0	10.2 ±1.1	8.8 ±1.2	11.6 ±1.8

Table 2. Trends in HIV-Related Risk Behaviors Among U.S. Students in Grades 9–12, by Race/Ethnicity,* Youth Risk Behavior Survey, 1991-2005

	1991	1993	1995	1997	1999	2001	2003	2005	Changes from 1991–2005
Ever had sexual intercourse									
All Students	54.1 ±3.5**	53.0 ±2.7	53.1 ±4.5	48.4 ±3.1	49.9 ±3.7	45.6 ±2.3	46.7 ±2.6	46.8 ±3.3	Decreased, 1991–2005
Black Students	81.5 ±3.2	79.7 ±3.2	73.4 ±4.5	72.7 ±2.8	71.2 ±8.1	60.8 ±6.6	67.3 ±3.3	67.6 ±3.1	Decreased, 1991–2001 No change, 2001–2005
Hispanic Students	53.1 ±3.5	56.0 ±4.1	57.6 ±8.6	52.2 ±3.6	54.1 ±4.8	48.4 ±4.5	51.4 ±3.2	51.0 ±4.3	No change, 1991–2005
White Students	50.0 ±3.2	48.4 ±2.8	48.9 ±5.0	43.6 ±4.2	45.1 ±3.9	43.2 ±2.5	41.8 ±2.7	43.0 ±4.1	Decreased, 1991–2005
Were currently sexually active (Had sexual intercourse with ≥1 person during the 3 months preceding the survey.)									
All Students	37.5 ±3.1	37.5 ±2.1	37.9 ±3.5	34.8 ±2.2	36.3 ±3.5	33.4 ±2.0	34.3 ±2.1	33.9 ±2.5	Decreased, 1991–2005
Black Students	59.3 ±3.8	59.1 ±4.4	54.2 ±4.7	53.6 ±3.2	53.0 ±8.9	45.6 ±5.4	49.0 ±2.9	47.4 ±2.6	Decreased, 1991–2005
Hispanic Students	37.0 ±3.6	39.4 ±3.7	39.3 ±7.1	35.4 ±3.9	36.3 ±4.0	35.9 ±3.2	37.1 ±2.8	35.0 ±3.9	No change, 1991–2005
White Students	33.9 ±2.8	34.0 ±2.1	34.8 ±3.9	32.0 ±3.1	33.0 ±3.3	31.3 ±2.2	30.8 ±2.0	32.0 ±3.3	No change, 1991–2005
Had sexual intercourse before age 13 years									
All Students	10.2 ±1.6	9.2 ±1.3	8.9 ±1.4	7.2 ±0.9	8.3 ±1.2	6.6 ±0.9	7.4 ±1.2	6.2 ±0.8	Decreased, 1991–2005
Black Students	28.2 ±2.8	28.0 ±2.8	24.2 ±3.4	21.7 ±2.3	20.5 ±4.8	16.3 ±2.6	19.0 ±2.4	16.5 ±2.4	Decreased, 1991–2005
Hispanic Students	8.9 ±1.7	9.7 ±2.0	8.8 ±2.9	7.7 ±1.4	9.2 ±1.3	7.6 ±2.0	8.3 ±1.4	7.3 ±1.9	Decreased, 1991–2005
White Students	6.7 ±1.1	5.6 ±1.0	5.7 ±1.1	4.0 ±0.8	5.5 ±0.7	4.7 ±1.1	4.2 ±0.9	4.0 ±0.8	Decreased, 1991–2005

HIV-Related Risk Behaviors Among African American Youth

	1991	1993	1995	1997	1999	2001	2003	2005	Changes from 1991–2005
Had sexual intercourse with 4 or more persons during their life									
All Students	18.7 ±2.1	18.7 ±2.0	17.8 ±2.7	16.0 ±1.4	16.2 ±2.6	14.2 ±1.2	14.4 ±1.6	14.3 ±1.5	Decreased, 1991–2005
Black Students	43.1 ±3.5	42.7 ±3.9	35.6 ±4.4	38.5 ±3.6	34.4 ±10.3	26.6 ±3.7	28.8 ±2.5	28.2 ±2.6	Decreased, 1991–2005
Hispanic Students	16.8 ±2.6	18.6 ±3.1	17.6 ±3.7	15.5 ±2.4	16.6 ±3.6	14.9 ±1.7	15.7 ±2.2	15.9 ±2.4	No change, 1991–2005
White Students	14.7 ±1.8	14.3 ±2.1	14.2 ±2.4	11.6 ±1.5	12.4 ±2.1	12.0 ±1.4	10.8 ±1.5	11.4 ±1.8	Decreased, 1991–2005
Did not use a condom during last sexual intercourse (Among currently sexually active students.)									
All Students	53.8 ±3.3	47.2 ±2.7	45.6 ±3.5	43.2 ±1.6	42.0 ±4.2	42.1 ±2.2	37.0 ±2.5	37.2 ±2.1	Decreased, 1991–2005
Black Students	52.0 ±3.8	43.5 ±3.8	33.9 ±4.8	36.0 ±2.8	30.0 ±5.4	32.9 ±3.5	27.2 ±3.7	31.1 ±3.6	Decreased, 1991–1999 No change, 1999–2005
Hispanic Students	62.6 ±6.2	53.9 ±4.4	55.6 ±11.1	51.7 ±5.6	44.8 ±6.8	46.5 ±5.1	42.6 ±5.3	42.3 ±4.1	Decreased, 1991–2005
White Students	53.5 ±4.6	47.7 ±3.9	47.5 ±4.0	44.2 ±2.0	45.0 ±5.1	43.2 ±3.0	37.5 ±3.1	37.4 ±2.5	Decreased, 1991–2005
Lifetime illegal injection drug use									
All Students	NA***	NA	2.1 ±0.4	2.1 ±0.5	1.8 ±0.4	2.3 ±0.4	3.2 ±1.2	2.1 ±0.3	No change, 1995–2005
Black Students	NA	NA	1.1 ±0.6	1.0 ±0.7	0.9 ±0.5	1.6 ±0.7	2.4 ±1.1	1.7 ±0.9	Increased, 1995–2005
Hispanic Students	NA	NA	2.2 ±0.9	2.2 ±0.6	1.8 ±0.8	2.5 ±0.7	3.9 ±2.1	3.0 ±1.0	No change, 1995–2005
White Students	NA	NA	2.0 ±0.6	1.8 ±0.5	1.6 ±0.4	2.4 ±0.5	2.5 ±1.3	1.9 ±0.4	No change, 1995–2005

*Data are presented only for non-Hispanic black, non-Hispanic white, and Hispanic students because the numbers of students from other racial/ethnic populations were too small for meaningful analysis.

**The 95% confidence interval provides the range of values within which the "true" percentage lies. A 95% confidence interval means that if the survey were repeated many times, the "true" value would fall within the interval 95% of the time. When the confidence interval is relatively narrow, the estimate is more precise. Wider confidence intervals diminish the ability to report results with precision. For example, if the confidence interval ranges from a low of 82% to a high of 98%, the "true" estimate of the behavior 95% of the time could be as low as 82% or as high as 98%.

***NA = Not available.

For more information on the YRBS, go to www.cdc.gov/yrbs.

References

- Glynn M, Rhodes P. *Estimated HIV Prevalence in the United States at the End of 2003*. National HIV Prevention Conference; June 2005; Atlanta. Abstract T1-B1101.
- CDC. *HIV/AIDS Surveillance Report, 2004*. Vol. 17. Atlanta: U.S. Department of Health and Human Services, CDC; 2006:1–54.
- CDC. *HIV/AIDS Surveillance in Adolescents and Young Adults (through 2004) Slide Set [internet]*. Available: www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm [2007, February]
- CDC. Racial/ethnic disparities in diagnoses of HIV/AIDS —33 states, 2001–2004. *MMWR* 2006;55(5):121–125.
- Anderson RN, Smith BL. Deaths: Leading causes for 2002. *National Vital Statistics Reports* 2005;53(17):1–92.
- CDC. *Sexually Transmitted Disease Surveillance, 2005*. Atlanta, GA: U.S. Department of Health and Human Services, 2006:1–160.
- Fleming DT, Wasserheit JN. From epidemiological synergy to public health policy and practice: The contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections* 1999;75:3–17.
- CDC. Youth risk behavior surveillance— United States, 2005. *MMWR* 55(SS-5):1–108, 2006.
- Laird J, DeBell M, Chapman C. *Dropout Rates in the United States: 2004*. Washington, DC: U.S. Department of Education, National Center for Education Statistics, 2006:1–61. (NCES 2007-024).



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

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

Fact Sheet for Public Health Personnel:

Male Latex Condoms and Sexually Transmitted Diseases

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

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

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

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

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

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

Sexually Transmitted Diseases, Including HIV

Sexually transmitted diseases, including HIV

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

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

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

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

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

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

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

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

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

HIV / AIDS

HIV, the virus that causes AIDS

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

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

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

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

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

Discharge Diseases, Including Gonorrhea, Chlamydia, and Trichomoniasis

Discharge diseases, other than HIV

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

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

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

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

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

Genital Ulcer Diseases and Human Papillomavirus

Genital ulcer diseases and HPV infections

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

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

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

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

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

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

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

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

Department of Health and Human Services

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

CDC Statement on Study Results of Product Containing Nonoxynol-9

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

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

Reference

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

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

Nonoxynol-9 Spermicide Contraception Use— United States, 1999

From *Morbidity and Mortality Weekly Report* 51 (18): 389-392.

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (1), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (2–4); one trial showed an increased risk (3). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (5,6), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%–18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%–5% of all women attending Title X clinics reported using N-9 contraceptives (other than condoms) as their primary method of contraception (Table 1). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9—lubricated (Table 2). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that N-9—containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

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

Editorial Note:

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

Spermicidal gel is used in conjunction with diaphragms (1); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical

barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year (1).

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

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

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

References

1. Trussell J. Contraceptive efficacy. In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology: 17th Revised Edition*. New York, New York: Ardent Media, 1998.
2. Roddy R, Zekeng L, Ryan K, Tamoufe U, Weir S, Wong E. A controlled trial of nonoxynol-9-film to reduce male-to-female transmission of sexually transmitted diseases. *N Engl J Med* 1998;339:504—10.
3. Kreiss J, Ngugi E, Holmes K, et al. Efficacy of nonoxynol-9 contraceptive sponge use in preventing heterosexual acquisition of HIV in Nairobi prostitutes. *JAMA* 1992;268:477—82.
4. Van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9—14, 2000, Durban, South Africa.

5. Louv WC, Austin H, Alexander WJ, Stagno S, Cheeks J. A clinical trial of nonoxynol-9 for preventing gonococcal and chlamydial infections. *J Infect Dis* 1988;158:513—23.
6. Roddy RE, Zekeng L, Ryan KA, Tamoufe U, Tweedy KG. Effect of nonoxynol-9 gel on urogenital gonorrhea and chlamydial infection, a randomized control trial. *JAMA* 2002;287:1117—22.
7. CDC. Sexually transmitted diseases treatment guidelines 2002. *MMWR* 2002;51(RR-6).
8. Moran JS, Janes HR, Peterman TA, Stone KM. Increase in condom sales following AIDS education and publicity, United States. *Am J Public Health* 1990;80:607—8.
9. Henshaw SK. Unintended pregnancy in the United States. *Fam Plann Perspect* 1998;30:24—9,46.

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

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

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

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

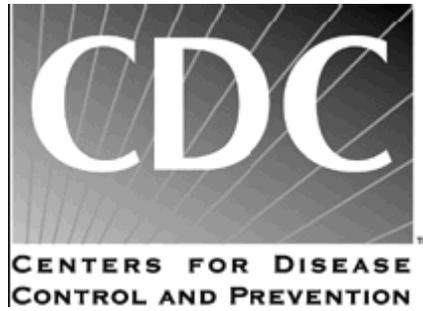
TABLE 2. Number of nonoxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/territories, 1999

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

* Not available.

† 41 of 61 grantees responded.

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



The ABCs of Smart Behavior

To avoid or reduce the risk for HIV

A stands for abstinence.

B stands for being faithful to a single sexual partner.

C stands for using condoms consistently and correctly.

Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs

Interim Revisions June 1992

1. Basic Principles

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

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

SEC. 2500. USE OF FUNDS.

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

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

- (d) CONSTRUCTION. - Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to, or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene.“
 - c. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.
 - d. Messages provided to young people in schools and in other settings should be guided by the principles contained in „Guidelines for Effective School Health Education to Prevent the Spread of AIDS“ (MMWR 1988;37 [suppl. no. S-2]).
2. Program Review Panel
- a. Each recipient will be required to establish or identify a Program Review Panel to review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or another CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:
 - (1) Understand how HIV is and is not transmitted; and
 - (2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.
 - 2. The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or

procedure of the recipient organization or local governmental jurisdiction.

3. Applicants for CDC assistance will be required to include in their applications the following:
 - (1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review panel, except as provided in subsection (d) below. In addition:
 - (a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either through representation on the panels or as consultants to the panels.
 - (b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a State or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.
 - (c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.
 - (d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.
 - (2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:
 - (a) Concurrence with this guidance and assurance that its provisions will be observed;
 - (b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.
4. CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multi state), or

statewide in scope, or that plan to distribute materials as described above to other organizations on a national, regional, or statewide basis, must establish a single Program Review

Panel to fulfill this requirement. Such national/regional/State panels must include as a member an employee of a State or local health department, or an appropriate designated representative of such department, consistent with the provisions of Section 2.c.(1). Materials reviewed by such a single (national, regional, or state) Program Review Panel do not need to be reviewed locally unless such review is deemed appropriate by the local organization planning to use or distribute the materials. Such national/regional/State organization must adopt a national/regional/statewide standard when applying Basic Principles 1.a. and 1.b.

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

A Focus on Kids Intervention

FOCUS ON YOUTH WITH IMPACT



Protect High-Risk Youth

This community-based program gives youth the skills and knowledge they need to protect themselves from HIV and other STD.

- Written specifically for African-American youth
- Stories and discussion topics for and about African-American youth
- Gives youth real skills to deal with real, high-risk situations

Focus on Youth with IMPACT:

- Builds skills in decision making, communication, assertive refusal, advocacy and accessing resources.
- Empowers youth to resist pressures, clarify personal values, communicate and negotiate around risk behaviors, and learn to use a condom correctly.
- Includes a variety of interactive activities—games, roleplays, discussions and community projects.
- Makes use of naturally occurring “friendship groups” to strengthen peer support of alternatives to risky behaviors.
- Addresses HIV and other STD, abstinence and condom use.
- Offers a parent session to strengthen parental involvement and family support for avoiding risky behaviors.

Research Proves It Works!

Focus on Youth with IMPACT:

- Increased condom use and intention to use condoms among sexually active youth.
- Lowered rates of sex, sex without a condom, and alcohol and tobacco use among youth in the parental monitoring group.
- Has been successful in both school and community settings across cultures, throughout the United States and internationally.



ETR
Associates

1-800-321-4407
www.etr.org

A nonprofit organization