

# **Dangerous Inhibitions:**

## How America Is Letting AIDS Become An Epidemic Of The Young

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By Chris Collins

monograph series  
occasional paper #3  
February 1997

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**M A R K E T I N G   H I V   P R E V E N T I O N**

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*Quotes appearing in italics throughout this paper are  
from young people interviewed over the last year.*

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## PREFACE

AIDS is increasingly a disease of the young in the United States. This situation is unacceptable. The numbers of new infections are skyrocketing among African-Americans and Latinos. This is also unacceptable. Clearly, our prevention programs are failing.

This monograph challenges everyone to do something about the HIV epidemic among young people. We believe:

- prevention paradigms must change;
- our research methods are missing the mark;
- government cannot do this work itself — it is too encumbered;
- the private sector needs to step forward and contribute additional expertise and resources to existing HIV prevention efforts.

This monograph is a call to action on these fronts. We urge you to read it, distribute it, and act upon it.

Thank you.

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## EXECUTIVE SUMMARY

AIDS prevention efforts are failing America's young people. New hope in the treatment of AIDS has overshadowed the fact that the epidemic continues, and that the rate of AIDS reported among younger Americans continues to escalate. Today, one-half of all new HIV infections in the United States occur in people under the age of 25.

We need an emergency, targeted effort to reach young people at highest risk with sustained interventions tailored to specific needs. We must stop trying to fight an epidemic driven primarily through sexual activity without fully accepting the diversity of sexual desires of young people. And we must correct misguided prevention policies which are literally costing lives.

A new paradigm of prevention is needed to fight an epidemic in youth which increasingly affects the poor and people of color. We need to build on the foundations of our HIV prevention efforts — provision of information and skills training — to include an emphasis on addressing the myriad external forces challenging young people, and to instilling self-value in those young people who are most vulnerable in society. HIV prevention must be delivered in a way which reaches adolescents in the context of their daily lives.

Simply counseling abstinence or rational sexual behavior won't stop the epidemic amongst young people. Most young people choose to have sex. Those at greatest risk — young men who have sex with men, young women, young people of color, homeless and runaway youth — must confront an array of personal and external social factors in order to protect themselves.

It is increasingly apparent that for a young person who becomes infected with HIV, the social problems of racism, homophobia, sexism, and poverty are also deeply personal experiences which can affect self-esteem, the ability to talk about sex openly, and the confidence to insist on personal protection.

Young people living on the street, perhaps the group at highest risk, lack fundamental security in their lives. Many are forced to trade sex for money or shelter. Significant numbers of young people have been sexually abused or coerced, and a history of these experiences is associated with increased unsafe sex.

We can decrease new HIV infections by providing prevention education that enhances a sense of belonging for young gay men and lesbians, and empowers young women to assert their needs, and by providing housing and counseling to those children who have been forced to live on the streets. As well, we must address the sexual coercion of children and teens.

Teaching self respect — particularly to those young people in the most vulnerable groups — is just as important as demonstrating condom use. We need the courage to talk more openly about sexuality: gay sex, straight sex, and specifics of how to use, and insist upon a condom.

Better prevention demands the creation of more culturally appropriate interventions, and increased emphasis on targeted funding to those young people most at risk. Yet we fail to effectively target resources and our laws and policies often serve to cut off the young people most affected by the epidemic. One recent example is the 1996 Welfare Reform Bill incentive for abstinence-only curricula — in the face of research that indicates the clear limits of abstinence-only approaches.

Government AIDS prevention efforts are burdened by financial and political constraints. Public schools are a center of controversy over issues involving sexuality education. Yet the expectation that the public sector can fund, develop and implement effective prevention programs has masked the urgent need for private sector expertise and resources in the battle against HIV among youth.

Each day, young people are deluged with advertising, movies, and music that promote sex without addressing the possible consequences of unprotected sex or providing education on safer sex skills. Private sector media professionals — with extensive knowledge about how to reach young people, and access to the channels that communicate to youth — are largely absent from fighting the epidemic.

Health promotion has not caught up with a new generation that is exposed to ever expanding media influences. Community based organizations have made valiant efforts to reach young people with effective prevention messages, but they, too, have been hampered by inadequate funding and other constraints.

Behavioral research should be pointing the direction toward more effective prevention interventions. Yet there remains an enormous communication gap between behavioral research in the academy and prevention interventions on the street. And much of prevention research is founded on behavioral theories which assume accurate perception of risk will lead to self-protection. Too often, interventions evaluated by researchers take a cognitive approach to health promotion with the age group which most typifies cognitive dissonance. Relatively limited attention is paid to the external forces which influence decisions around safer sex. Government and private sector research funders have not provided the resources to adequately focus on the prevention needs of young people of color.

## **AN EPIDEMIC GETTING YOUNGER**

A recent study from the National Cancer Institute warns that, “while the rate of new AIDS cases reported among people born before 1960 appears to be reaching a plateau, the rate among younger Americans [born after 1960] continues to escalate.” One in four new HIV infections in the United States occur in people under the age of 22; one-half of all infections occur in people under age 25. AIDS is already the sixth leading cause of death among 15 to 24 year olds in the United States and the leading cause of death among 25 to 44 year olds.

- Twenty-five percent of sexually active adolescents get a sexually transmitted disease (STD) in any given year.
- In young people more than any other age group, HIV is spread sexually. Two groups of young people at risk for sexual exposure to HIV account for roughly three-quarters of the adolescent epidemic: men who have sex with men (MSM) and women infected through heterosexual sex.
- The HIV epidemic in young men is concentrated among men who have sex with other men, whether or not they identify as gay. MSM account for nearly three-quarters of infections among young men. Injection drug use and heterosexual sex play lesser roles in HIV among young men.
- The rate of HIV infection appears to be growing faster among young women than any other group. The proportion of U.S. adolescent AIDS cases who are female has tripled from 14% in

1987 to 46% of the reported cases in the year preceding July 1996. Heterosexual sex accounts for three quarters of cases in young women.<sup>1</sup>

- Race is an even more important factor in the HIV epidemic among adolescents than it is among adults. Sixty-one percent of cumulative AIDS cases in Americans age 20 to 24 are among people of color, particularly African-Americans and Latinos. A 1996 study reported that, “HIV continued to spread near peak rates into the 1990s among younger birth cohorts, especially among young African-American men who have sex with men.”
- Self-reported condom use is at 63% in 9th grade and steadily declines with each grade to 50% for high school seniors, probably because young women begin to use the pill as an alternate birth control method.
- Experimentation and risk-taking are fundamental aspects of adolescence.
- The pattern of infection among American youth is consistent with the evolving global epidemic. Jonathan Mann and Daniel Tarantola have written that, “in each society, those people who were marginalized, stigmatized and discriminated against — before HIV/AIDS arrived — have become over time those at highest risk of HIV infection.”

## **RISK FACTORS**

Social vulnerability, the need to gain love and respect through sex, and power differentials within relationships are particularly important risk factors in the subgroups of young people most affected by the epidemic — young gay men, sexually active young women, and young people of color. These vulnerability factors should more closely inform HIV prevention efforts.

- All teens may have personal needs and desires that can make them particularly vulnerable, but some factors are particularly relevant for those at highest risk for HIV. To a large extent, these risk factors are a product of the marginalization of these groups in the larger society.
  - socially based vulnerability, including homophobia, sexism, poverty, homelessness;
  - the need to find acceptance, respect and love through sex;
  - the discovery phase of sex, gay and straight;
  - power dynamics with older partners;
  - coercion and force;
  - difficulty in communicating personal needs; and,
  - sex work.
- HIV prevention programs also must consider risk factors that affect most young people — conditions which are simply a product of being young (or human). These include:
  - perceived lack of peer support for condom use;
  - faulty perception of one’s personal risk and the riskiness of one’s partner;
  - the need for adequate information and ready access to condoms;
  - drug and alcohol use, and the unplanned nature of many sexual encounters; and
  - the difficulty many parents have discussing sexuality issues with their children.

## RETHINKING THE HIV PREVENTION MESSAGE AND ITS DELIVERY

Simply advising young people to practice abstinence and avoid risks at all costs are dangerous foundations for HIV prevention. Simplistic, fear-based messages are not working. Many sexually active teens can be reached more effectively with an emphasis on having satisfying intimate experiences, good sexual encounters, improving interpersonal communications, and maintaining control over their sex lives.

- Young people today identify AIDS as one of the most serious threats facing the nation in the next century. Yet they often do not perceive themselves to be *personally* at risk.
- The percentage of American youth who are taught about HIV in school increased from 54% to 86% between 1989 and 1995, for an increase of 59%. During the same period, the condom usage rate has increased only 17%.
- Among health education teachers, 87% taught the basic facts about HIV/AIDS and 84% taught how HIV is and is not transmitted. But only 37% of these teachers taught correct use of condoms and only 56% taught information on HIV testing and counseling.
- Over the last decade, prevention providers have learned important lessons to guide prevention programming, including:
  - skills training in condom use and negotiation skills, in addition to provision of basic HIV prevention information, is essential;
  - the earlier HIV prevention efforts begin in a person's life, the more likely they are to be successful;
  - peer education approaches show particular promise at reaching youth;
  - proper "dosing" (length or duration of the intervention) is an important factor in delivering effective prevention;
  - successful school-based HIV prevention interventions have common characteristics which should be used to guide programming;
  - tailored interventions for specific groups are essential, including programs for gay youth, African-American and Latino/a youth, and homeless and runaway youth;
  - interventions that address compelling needs in addition to HIV prevention can be particularly effective;
  - training young people to "decode" portrayals of sexuality in the media can help them better understand their social environment.
- Social marketing attempts to utilize the expertise of advertising and marketing to motivate behavior change and can also contribute to controlling the epidemic among adolescents.

## WHAT IS STANDING IN THE WAY?

Most Americans support efforts to inform young people about how to protect themselves from HIV, and to give them the skills and tools to do so. But numerous policies set by schools, television stations, the U.S. Congress and federal agencies impede HIV prevention efforts.

Are we misplacing efforts by focusing primarily on governmental reforms which may not come? As an alternative, some of our focus should be on tapping private sector expertise, re-

sources, creativity, and access to communication channels in a way that can radically improve our ability to prevent HIV among youth.

### **Public and Private Education**

- **Limits on school-based education/sex education:** Thirteen states do not require schools to provide either sexuality or STD/HIV education, including several southern states where many new HIV infections in young people are occurring. Even when HIV education is presented in classrooms, it often neglects essential issues, such as condom use. State sex education curricula tend to emphasize abstinence even though research shows abstinence-only programs have limited impact.
- **Limits on school-based education/homophobia in the classroom:** Eight states require or recommend teaching that homosexuality is not an acceptable lifestyle.
- **Limits on school-based education/condoms:** Only a small minority of high schools make condoms readily available to their students. Because some of the young people at highest risk have dropped out of school, we must also find alternative and creative ways to reach these youth with condoms and prevention messages.
- **Access to Testing:** Many young people at higher risk for HIV do not have ready access to HIV testing and counseling.

### **Government**

- **Missing the point:** Government-sponsored HIV prevention media has often failed to directly address key at-risk groups and provide information on condom use. AIDS education must not simply address the biology of transmission, but also engage young people in thinking about vulnerability factors — including power relationships with partners and societal status — which can put them at higher risk for infection.
- **Missing the populations:** Continued failure to target funding to groups of young people most affected by the epidemic has greatly damaged the effectiveness of HIV prevention efforts.
- **Research that informs prevention:** The public prevention enterprise still has much to learn from private sector marketing research. Marketers track trends, attitudes, values and channels of communication. They place a premium on up-to-the-minute information which can help them reach youth.
- **Needle exchange:** The ban on federal funds for needle exchange programs remains in place even though six government-sponsored reports have concluded that needle exchange programs help reduce HIV infection and do not lead to increased drug use.

### **The Private Sector**

- **Doing what government can't (or won't) do:** Government cannot fight the HIV epidemic among young people on its own. Private sector media professionals have valuable expertise which must be partnered with government's resources to more effectively fight HIV. Churches, local TV stations, supermarkets, health care professionals, and other businesses, can all play a role in more effective HIV prevention.

- **Invisibility on the airwaves:** All the major television networks (excluding Fox TV) have restrictions on condom advertising. Sex is an almost ubiquitous theme in TV shows popular with teens, but condoms are too often not visible nor discussed on these programs.

### **The Research Community**

- **Gaps in programming & research:** There is a paucity of research on effective prevention programs for young people of color, including young men who have sex with men.
- **Direct connection to programming:** Research should be more directly applicable to prevention delivered on-the-street and researchers need to build closer ties with prevention providers. Research should assist in the development of culturally appropriate prevention interventions which reach young people at-risk in the context of their daily lives. More qualitative research tracking attitudes, trends, knowledge and beliefs is needed.

## I. INTRODUCTION

*“It all depends on how confident you are that nothing bad can happen.”*

There is health crisis among America’s young people, and prudishness, politics, and lack of focused resources is damaging our ability to respond. The salient facts are these: one in four new HIV infections in the United States occur in people under the age of 22; one half of all infections in people under age 25.<sup>2</sup> AIDS is already the sixth leading cause of death among 15 to 24 year olds in the United States<sup>3</sup> and the leading cause of death among 25 to 44 year olds. In the 12-month period preceding July, 1996, two thousand, six hundred and sixty-seven people aged 13 to 24 were diagnosed with AIDS.

A recent study from the National Cancer Institute warns that, “while the rate of new AIDS cases reported among people born before 1960 appears to be reaching a plateau, the rate among younger Americans [born after 1960] continues to escalate.”<sup>4</sup> And AIDS threatens to become endemic among particularly vulnerable American adolescents. Young people of color, gay youth, and young women who have sex with HIV positive men are at the center of this expanding epidemic. The National Academy of Sciences has reported that the United States has the highest rate of sexually transmitted diseases of any developed country and that, “an effective national system for STD prevention currently does not exist.”<sup>5</sup>

It is no surprise that HIV prevention programs are failing many young people. First, our approach to promoting self-protection is missing the mark. Risk-avoidance and prudishness about sex wouldn’t sell many tennis shoes or attract young people to a love story. Ironically, these are the cornerstones of HIV prevention messages targeted to young people.

The importance of taking risks — in sports, in business, in love — is virtually a national mantra. The thrill of risk underlies advertising messages, movie plots, and popular music lyrics. The only theme that bombards us more is sex. Young people today are growing up in world in which tangible risks are part of daily life. One in five high school students has carried a weapon to school. Drug use (primarily marijuana) is on the increase. Every year, three million American teens acquire an STD.

Yet our strange ensemble of youth-oriented media, advertising, and health promotion strategies adds up to a single dangerous mixed message: explore, risk, experiment, and be attractive — except when it actually comes to sex. Then our messages are more muddled. Condoms, gay sex, and dynamics within relationships are often not explicitly discussed. Both antidrug and HIV prevention health messages using scare tactics and overdramatization are summarily discarded by young viewers. Stern warnings to teens to avoid taking risks at all costs and “just say no” are speaking a language that is unlikely to succeed with adolescents in the 1990s.

There are obvious reasons why government has fallen short in its responsibility to fight the epidemic in youth: funding is limited and political salvos from right and left stifle development of innovative programs. And AIDS is not Legionnaire’s disease — many of the people it affects are members of socially stigmatized populations. Historically, government has had difficulty reaching these groups. How can government target resources to stigmatized populations when political expediency demands a mainstream focus? How can it deliver sensitive interventions to gay people in the face of pervasive homophobia? How can it build trust with the poor and people of color?

Community-based organizations have made valiant efforts to reach young people with effective prevention messages, but they, too, have been hampered by inadequate funding and other constraints. Much of the expertise needed to reach young people with powerful and effective messages is vested in the private sector, but we have failed to form large scale, sustained, public-private alliances to fight HIV. There are numerous examples of innovative and effective HIV prevention programs for young people at the local level. But the sum is less than the parts — as a nation, we are failing to reach too many young people at high risk for HIV.

Our society has a moral responsibility to do better. The public and private sectors must work together to use the resources and expertise at their disposal to fight the HIV epidemic among youth. But to do this, we must be honest about the realities of the epidemic and the lives of young people in America.

We must develop new approaches to prevention education which are culturally relevant and which arm young people to deal with the power dynamics in relationships that make demanding safer sex feel like an enormous risk. Fresh messages and marketing ideas that speak to the needs of youth need to be developed. And existing obstacles — from policies about condom availability and the content of health education in schools, to prohibitions on what is shown on the airwaves — need to be removed.

This report presents an update on the epidemic of HIV among America's young people. For purposes of the report, "youth" is defined as people in early adolescence through early adulthood, ages 11 through 24. Where noted, the discussion will frequently focus particularly on adolescents aged 13 to 19. The report takes a close look at what epidemiology can tell us about the changing nature of the epidemic, including who is getting infected, and what factors are involved in sexual risk taking among the young. It surveys some of the lessons learned from prevention programs targeted to young people. Finally, it proposes a new thematic approach to reach beyond traditional prevention efforts to those at highest risk, and provides a list of policy impediments that must be overcome.

This report on HIV and young people does not attempt to present all the facts, raise all the questions, or suggest all the potential improvements which could advance our efforts against HIV. It does try to lay out some of the key national issues which must be confronted in order to end the HIV epidemic among the young.

## II. AN EPIDEMIC GETTING YOUNGER

*“You need a condom the first time, but not after. Once you get comfortable with each other, the responsibilities for birth control shift to the woman.”*

*“I don’t use condoms if I feel secure that there are not extra activities going on. If I have complete trust, honesty.”*

- Charting Risk
- A Sexual Epidemic

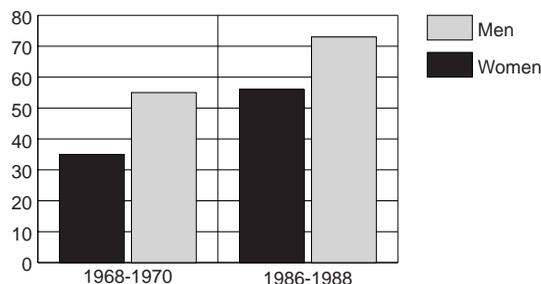
### CHARTING RISK

Experimentation defines adolescence. During their teen years, each new generation of Americans sets lifetime records for itself in overall numbers of sexual partners and incidence of sexually transmitted diseases. Sex is a normal step in the human development process, a step which is most often first taken during adolescence. Today, more than any time in memory, there are real risks associated with these first steps.

The centrality of risk in the lives of youth has even spawned its own government tracking network, the Youth Risk Behavior Surveillance (YRBS) system, which biannually measures everything from bicycle-helmet use to sexual activity to attempted weight loss. The 1995 YRBS tells us that in the last 30 days one in four high school students has smoked marijuana, one in five carried a weapon to school, half used alcohol, and one in three have been in a car with a driver who was drinking. Over the last year, one-quarter of high school students has seriously considered suicide.<sup>6</sup>

More young people are having sex in their teen years than ever before. In the mid-1950’s, just over a quarter of women under 18 had had sexual intercourse. In 1968, 35% of young women and 55% of young men had had sexual intercourse by age 18. Twenty years later, these numbers were 56% of young women and 73% for young men.<sup>7</sup> And as the Sexuality Information and Education Council of the United States (SIECUS) points out, “almost all adolescents participate in sexual activity of some kind. Overall, 90% have kissed...72% have participated in touching ‘above the waist.’”<sup>8</sup>

Percentage of Young Men and Women  
Who Have Sex by Age 18



Source: Sexuality Information and Education Council of the United States (SIECUS)

Sex starts early for many young people. Nearly four in ten (37%) 9th graders have had intercourse, and by 12th grade this becomes nearly seven in ten (66%). One in four (25%) 12th graders say they are currently abstinent, and another quarter (23%) say they have had sex with four or more partners.<sup>9</sup>

## Do young people protect themselves?

Do young people protect themselves from HIV and other STDs? Self-reported condom use is at 63% in 9th grade and steadily declines with each grade to 50% for high school seniors, probably because young women begin to use the pill as an alternate birth control method.<sup>10</sup> One in four sexually active adolescents acquire an STD in any given year.<sup>11</sup> This adds up to three million adolescent STD cases annually, one-quarter of annually reported STDs in the country. Experimenting with sex and drugs is a rite of passage for many young people, but this synergy of risks has consequences. The fact that one-quarter (25%) of all high schoolers combined drugs or alcohol with sex the last time they had intercourse increases the likelihood they will not take adequate steps to protect themselves against HIV.<sup>12</sup>

It is possible to read news reports of the latest YRBS or national drug use surveys and imagine an “average” teen with a mean risk profile. In fact, of course, HIV, STDs and drugs all have their areas of concentration, and those too are reflected in government statistics. We know, for example, that rates of gonorrhea among 15 to 19 year olds in 1995 were more than four times higher among African-Americans than the average, and highest among African-American young women. Gonorrhea rates overall have declined 24% from their peak in 1992, but have dropped twice as fast among 15 to 19 year-old men as among young women. Rates have actually increased 3% among Latinos in the same age group, and mirroring the dynamics in other ethnic groups, young women were disproportionately affected. Latina gonorrhea rates increased by 7% over the period as compared to a 5% drop for 15 to 19 year-old male Latinos.<sup>13</sup> STD rates are two to three times higher in inner-city populations than in the general population.<sup>14</sup>

The Centers for Disease Control and Prevention (CDC) reports most of its STD and risk data by race, age or grade in high school, and state (including many larger cities). Men who have sex with men, one of the groups most at-risk for HIV and other STDs, are *invisible* in this statistical portrait.

## A SEXUAL EPIDEMIC

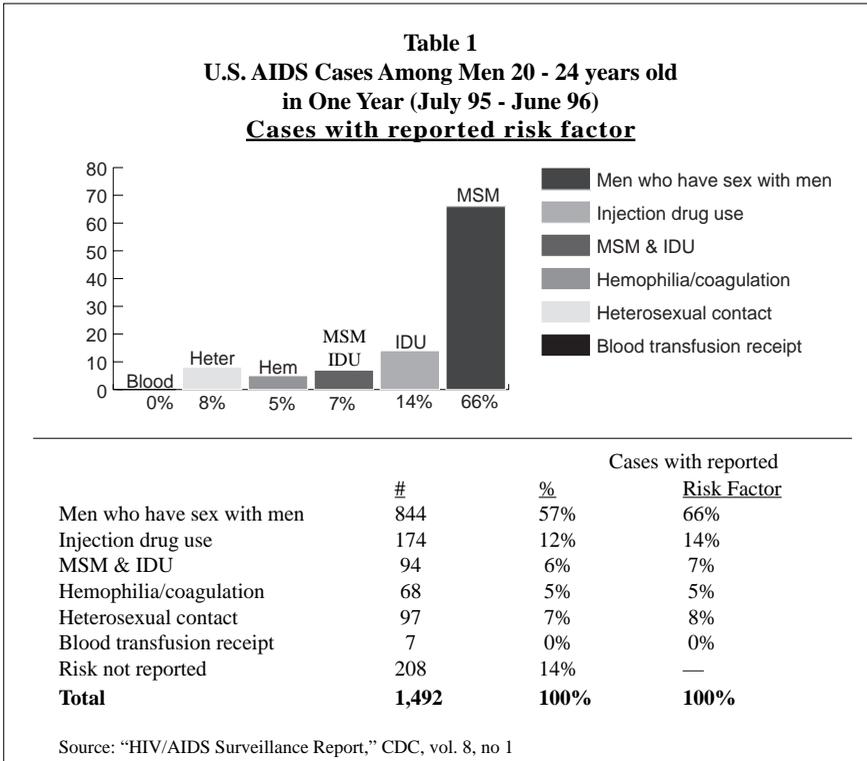
In young people more than any other age group, HIV is a disease spread sexually. While injection drug use accounts for about half of new infections among the population as a whole, the youth epidemic is primarily driven by sexual activity, and the two most at-risk subgroups of young people acquire HIV primarily through sex.

Two portraits capture a large percentage of current and future of HIV cases in the young. One is of a young man who is beginning to act on his desire to have sex with other men. The other is of a young woman having sex, often with an older man who injects drugs. With every passing year, both these young people are more likely to be African-American or Latino/a, to come from communities outside of big cities, and to live in the South.

### Young men

Primary causes of infection are very different among young men and young women. The HIV epidemic in young men is concentrated among gays (or men who have sex with men). In 20 to 24 year-old men, most of whom would have been infected in their teens, two-thirds (66%) of all AIDS cases were men who have sex with men. Table 1 presents 1996 surveillance data on AIDS cases among men in their early twenties. Because AIDS cases reported in 1996 represent infections that occurred up to a decade ago, these figures fail to capture the current number and distribution of infections.<sup>15 16</sup>

Another 7% of infections were in men who have sex with men *and* inject drugs, meaning that three quarters (73%) of AIDS cases among young men are among young gay men. Heterosexual injection drug users represented 14% of cases and heterosexual contact accounted for 8% of cases among men. While HIV incidence has fallen dramatically among older gay men, many young gay men continue to put themselves at risk. According to researcher Susan Kegeles, “various studies report that 33% to 43% of young gay men report unprotected anal intercourse in the past two to six months.”<sup>17</sup>

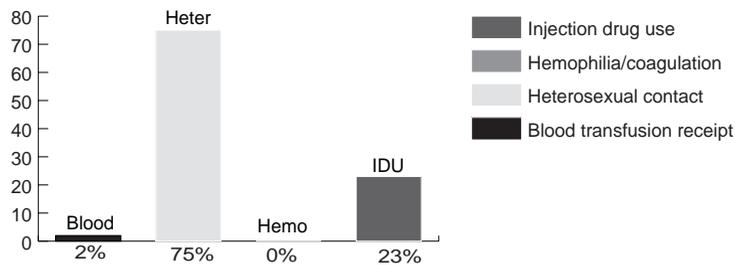


**Young women**

The rate of HIV infection is growing faster among young women than any other group. The proportion of young women among U.S. adolescent (ages 13-19) AIDS cases has tripled from 14% in 1987 to 46% of the reported cases in the year preceding July 1996. Heterosexual sex accounts for three-quarters (75%) of cases in young women ages 20-24 (Table 2).<sup>18</sup> Forty-one percent of women in this age group who were infected heterosexually identified the risk category of their partner; 79% percent of them were injection drug users (IDUs). Injection drug use was the risk factor in 23% of reported AIDS cases among women in this age group. Heterosexual sex represents an increasing percentage of the epidemic among young women, while injection drug use is falling as a share of cases.

Some of these young men and women, gay or straight, are also homeless, which substantially increases their risk for acquiring HIV. Estimates of seroprevalence among homeless and runaway youth range from 5.4% to 7%.<sup>19</sup>

**Table 2**  
**U.S. AIDS Cases Among Women 20 - 24 years old**  
**in One Year (July 95 - June 96)**  
**Cases with reported risk factor**



	#	%	Cases with reported <u>Risk Factor</u>
Injection drug use	130	16%	23%
Hemophilia/coagulation	2	0%	0%
Heterosexual contact	414	52%	75%
Blood transfusion receipt	9	1%	2%
Risk not reported	239	30%	—
<b>Total</b>	<b>794</b>	<b>100%</b>	<b>100%</b>

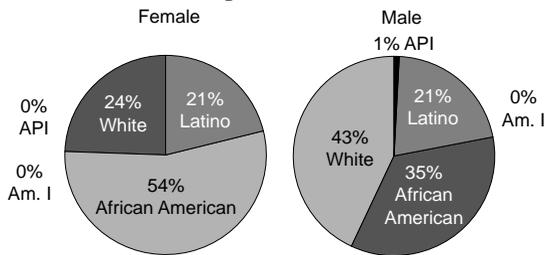
Source: "HIV/AIDS Surveillance Report," CDC, vol. 8, no 1

## Ethnicity

There is a growing racial disparity in the AIDS epidemic among youth. Race is an even more significant factor in the adolescent HIV epidemic than among adults. Sixty-one percent of cumulative AIDS cases in Americans age 20 to 24 are among people of color. In the population as a whole, 53% of cumulative AIDS cases are among people of color.<sup>20</sup> Table 3 shows that both African-Americans and Latinos are overrepresented among cumulative AIDS cases in the 20 to 24 year-old age bracket. African-Americans represented 35% of AIDS cases among men and 54% of cases among women reported in the year preceding July 1996. Although Asian American/Pacific Islanders and Native Americans represent comparatively smaller numbers in these figures, it is important to note that young people in these groups are also at-risk for HIV, and that they represent a significant part of the epidemic in some geographic areas.

In October 1996, the Harvard AIDS Institute estimated that by the year 2000 more than half of all U.S. AIDS cases will be among African-Americans. By that time, according to the Institute, an African-American will be nine times as likely to have AIDS as someone who is not African-American. Young African-Americans are at particularly high risk. A 1996 study from Los Angeles County reported that, "HIV continued to spread near peak rates into the 1990s among younger birth cohorts, especially among young African-American men who have sex with men."<sup>21</sup>

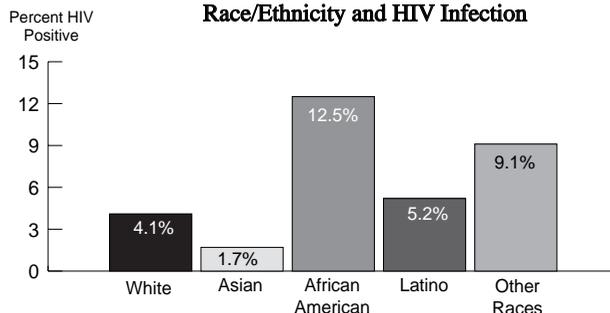
**Table 3**  
**Cumulative U.S. AIDS Cases by Race and Sex**  
**20 - 24 Year Olds**  
**(through June, 1996)**



Source: "HIV/AIDS Surveillance Report," CDC, vol. 8, no 1

A study released in January 1997 of gay and bisexual men ages 15-22 years old, in the San Francisco Bay Area, showed that 12.5% of young gay African-American men were infected with HIV, far greater than Latinos (5.2%) whites (4.1%), or Asian/Pacific Islanders (1.7%) (see Table 4).<sup>22</sup> (Infection rates for Native Americans were not reported separately). The ethnic breakdown was similar in a study of young women entering the Job Corps between 1988 and 1993. Seroprevalence was more than seven times greater among African-Americans than among whites.<sup>23</sup>

**Table 4**  
**Young Men's Survey, 1994-1995**  
**Race/Ethnicity and HIV Infection**



**Region**

The epidemic is also geographically dynamic. Initially, HIV was concentrated in large metropolitan areas. Yet more recently the epidemic has been moving into smaller communities, especially in the South. A CDC publication from 1995 notes that,

Comparing two recent reporting periods, 1988-90 and 1991-93, shows significant changes in the geography of AIDS cases reported among young MSM. AIDS cases in rural areas increased about 6% over the two periods. The largest increase —13%— occurred in metropolitan statistical areas (or MSAs) with populations of 250-499,000. The increases in these two areas (rural and metropolitan) were mostly caused by large jumps in cases reported among African-Americans in the South -- cases rose 79% among African-American MSMs in Southern rural areas and 67% in cities of 250-499,000 in the South...<sup>24</sup>

The picture is similar among young women. Scott Holmberg of the CDC reported that a, "worrisome sub-epidemic involving young heterosexual women — and in parallel but less evident, heterosexual men — is emerging...particularly in the Southeast..."<sup>25</sup> The Job Corps study of young women noted above also found that "seroprevalence was higher among those entering from the South and Northeast."<sup>26</sup>

A 1995 survey of HIV infection rates among teenagers attending health clinics around the country found that median HIV infection rates were 0.2% overall; 0.3% in correctional facilities; and 0.5% in STD clinics. The study also found that the “highest rates among young men reporting sex with men. Excluding men who identified themselves as having sex with other men, “rates in women were similar or somewhat higher than rates in men.”<sup>27</sup>

Susan Sugerma and colleagues have drawn on a variety of sources to provide seroprevalence rates among different populations which reveal the class effect of HIV-prevalence: 0.2% among college students, 0.34% for teenage youths applying for military service, 0.41% among Job Corps entrants (who are generally poorer than military recruits); and, as noted above, 5.4% to 7% among homeless and runaway youth.<sup>28</sup> Within these groups, HIV seroprevalence differs widely by race. In white military applicants the rate is 0.17 per 1000, while among African-Americans it is 1.0/1000. Among gay youth, the rate for whites is 81/1000 and 212/1000 among African-Americans.<sup>29</sup>

### Targeting resources

Anyone *can* get AIDS, as national education campaigns have been telling us for over a decade. Yet the statistics make it clear that the AIDS epidemic has different contours in young people, those among us living through the riskiest time of their lives. While HIV infection rates stabilize or decrease in older populations, “the rate (of AIDS) among younger Americans continues to escalate.”<sup>30</sup>

The epidemic is gaining a foothold in specific population groups; race and economic status are importantly associated with risk exposure. Two groups — young women infected through heterosexual sex and young gay men — account for roughly three-quarters of the adolescent epidemic in youth (based on reported AIDS cases among 20-24 year olds in the year preceding July 1996).

**“in each society, those people who were marginalized, stigmatized and discriminated against — before HIV/AIDS arrived — have become over time those at highest risk of HIV infection.”**

The pattern of infection among American youth is consistent with the evolving global epidemic. Jonathan Mann and Daniel Tarantola have written that, “in each society, those people who were marginalized, stigmatized and discriminated against — before HIV/AIDS arrived — have become over time those at highest risk of HIV infection.”<sup>31</sup>

Of course, if we were to dedicate prevention resources only to these groups, we would miss many infections, and risk the epidemic accelerating elsewhere. There is also the danger that by focusing our attention on the populations most intensely affected by the epidemic, we will risk stigmatizing individuals in those populations and give others an excuse not to protect themselves from HIV. But it is equally true that if we don’t improve our ability to focus resources and target effective interventions where they can reach those at greatest risk, HIV threatens to remain endemic and accelerate in these populations. We must learn how to strike this difficult balance.

### III. UNDERSTANDING RISK

*“I don’t feel I’m at risk because I read a book that tells you how to pick up the signs of a bisexual. Sex is about trust.”*

*“I don’t think I have anything to worry about. I assume they are negative, if they are positive, they wouldn’t put you at risk. You can tell a lot by appearance.”*

- The personal and interpersonal context of sex
- The territory of being young

Young people who consistently make choices to protect themselves often have an array of resources and supports. The Center for Substance Abuse and Prevention (CSAP) has compiled a list of “Resilience/Protective Factors” associated with young people’s ability to avoid “alcohol, tobacco, and other drug problems.” It would be tempting to broadcast these factors as a shopping list of values to instill in young people, except that most of the checklist has more to do with achieving social equity than changing individuals. Among the resilience factors are: “...middle/ upper class status, low unemployment, adequate housing, pleasant neighborhood...structured and nurturing family, parents promote learning...few chronic stressful life events...adequate early sensorimotor and language development, high intelligence, physically robust, no emotional or temperamental impairments...”<sup>32</sup>

Suggesting that all teens join a stable middle-class family is not a realistic strategy. Instead, we can recognize the complexity within which decisions about risk and self-protection are made and arm young people accordingly. One single message or delivery strategy is unlikely to work for young people in vastly different circumstances. An effective prevention approach will acknowledge that the moment at which risky sex occurs is preceded by two personal histories with many influencing factors, including peers, personal needs, social influences, and the situation of the moment.

**It is no accident that HIV is gravitating toward young people who are particularly vulnerable in society.**

#### THE PERSONAL AND INTERPERSONAL CONTEXT OF SEX

Forces related to safer sex decision-making are at once deeply personal and related to interpersonal and broader social influences. Sometimes, low self-esteem clouds a young person’s ability to insist on a condom, or damages the sense of self value necessary to choose condom use. Other times, unequal power dynamics between sexual partners leads to unsafe sex. All teens may have personal needs and desires that can make them particularly vulnerable, but the factors discussed below are particularly relevant for those at highest risk for HIV — young gay men, young heterosexual women, and young people of color. To a large extent, these risk factors stem from the marginalization of these groups in the larger society.

#### Vulnerable Groups

It is no accident that HIV is gravitating toward young people who are particularly vulnerable in society. Any social condition that damages self-esteem, eliminates choices and a sense of control, makes it harder to stand up for yourself, or reduces the time line along which you imagine your life is also likely to affect your ability to insist upon safe sex.

Social forces such as homophobia work against young gay men asserting their needs. Recent data indicates that HIV infection among young gay men is associated with internalized homopho-

bia and weaker gay self identity.<sup>33</sup> George Lemp summarized a number of studies that found that, “young homosexual and bisexual men often feel isolated and alienated, have inadequate social skills, and have difficulty communicating their desires regarding safe sex.”<sup>34 35</sup> Half of all lesbian and gay youth report that their parents reject them due to their sexual orientation.<sup>36</sup> Advocates for Youth in Washington, D.C. reports that, “Significant numbers of lesbian, gay male and bisexual youths report having been verbally and physically assaulted, raped, robbed and sexually abused.”<sup>37</sup>

Young women often find themselves in similarly vulnerable interpersonal situations. The CDC’s Prevention Marketing Initiative (PMI) is designed to test and develop social marketing approaches in five communities in the United States. PMI-sponsored focus groups among women of different races and in different parts of the country reveal the power differential between young men and women. In one group, young women reported believing their partners had cheated on them, and that they felt “stupid” to have let their boyfriends treat them badly.<sup>38</sup> Young women in another group reported a distrust of the opposite sex, and said they felt “used” for sex.<sup>39</sup> Incentives for childbirth may translate into disincentives for safer sex protection. Daniel Romer has observed that young women in low-income neighborhoods have more opportunities to see others achieving status outside of the labor force and, “to seek other sources of status such as childbirth.”<sup>40</sup>

Poverty is yet another factor related to vulnerability for HIV. In a study of high risk sexual behavior and condom use among adult gay and bisexual African-American men, John Peterson reported that “men who practiced unprotected anal intercourse were more likely to be poor.”<sup>41</sup> Poverty is also listed as a primary risk factor for alcohol and drug problems by the Center for Substance Abuse and Prevention.<sup>42</sup>

Sex work is another obvious high-risk activity in which it may be difficult for young people to take precautions against HIV and other STDs. One-quarter of runaway youth in New York City have said they have engaged in trading sex for money or drugs.<sup>43</sup> Other vulnerable populations, such as emotionally disturbed adolescents, are likely at increased risk for HIV and should also receive appropriate, targeted prevention interventions.<sup>44</sup>

## Love

The traditional view is that sex should be an outgrowth of a loving relationship. Yet, in the absence of strong self-protection instincts, love (or the desperate need for it) can sometimes disable a young person’s willingness to insist on safer sex. Many adolescents in the groups most affected by HIV share a common outlook on sex as a means to gain love, affection, or respect. Multiple, complex needs are brought to relationships, and these needs can complicate a young person’s ability to insist on safer sex.

A Kaiser Family Foundation survey of teens found significant differences between young men and women in their perceptions of love as a reason to have sex. Twenty-eight percent of young men and 45% of young women named love as often a reason to have sex.<sup>45</sup> Another survey of American teens found that 71% of high school girls said they were “in love” with their last sexual partner, while only 45% of boys described themselves as being in love with their last partner.<sup>46</sup>

In the paper, “What Leads to Sex,” Stephen Eyre and Susan Millstein also found significant differences in what attracts 16 to 20 year-old men and women to a potential sexual partner. “Arousal” was the chief antecedent to attraction for both African-American and white heterosexual young men. (For African-Americans, arousal was significantly associated with finding the potential partner “attractive,” while for white men arousal was linked with “drinking.”) African-

American young women, on the other hand, named the following factors as leading toward sex with a potential partner: the person respects me, is intelligent, has a sense of humor, is good looking, or has a nice body. The main reason to have sex named by these young women was “you love/care about the person.”<sup>47</sup>

A 1996 government report found that, “Many women at risk for STDs use contraceptive methods that offer no protection from the diseases...Of the...women who reported having a main partner, 56% said that they had not used condoms the last time they had intercourse. Among the ...women with a casual partner, 29% said they had not used condoms the last time they had intercourse.”<sup>48</sup>

In their study of young gay men, Robert Hays and colleagues found that young men engaged in high-risk sex were more likely to have a boyfriend or lover than men who do not engage in high risk sex. And the authors note that, “Using sex as a way to attract a partner or gain affection must also be addressed [in prevention efforts]. As one HIV-positive respondent wrote, ‘gay youths are...incredibly in need of love and attention. I have a lot of bitterness over the fact that as a gay teenager all I wanted was to be loved and all I got was dick up the butt and the HIV infection.’”<sup>49</sup>

Sex that occurs in the context of a loving relationship presents special challenges in HIV prevention. The same researchers found that a safer sex intervention they implemented among young gay men in Eugene, Oregon, “led to a sizable decline in unprotected anal intercourse with casual partners, but risk-taking behavior with lovers remain[ed] at unacceptably high levels.”<sup>50</sup> It is certainly possible that someone will choose to have unprotected sex because of an accurate assessment that his or her partner is HIV negative and that the relationship is mutually monogamous. But the finding that only approximately one quarter of HIV positive young gay men know their HIV status complicates this risk assessment process.<sup>51</sup>

The need to prove love — or not risk losing it — can lead some young people toward greater risk. So much is invested in relationships, it feels dangerous to put that connection at risk. In her study of homeless and runaway youth, Susan Sugarman found that 26% of those surveyed said it was important not to use a condom with a sexual partner in order to prove you love and trust him or her.<sup>52</sup>

### **Discovering Sex**

Young people need to know about sex before they engage in it. Though HIV education is essential at all stages of young adulthood, research shows that the earlier young people are reached in their sexual careers, the better the results. Janet St. Lawrence found that among African-American young people, those who used a condom at first intercourse were more likely to be consistent condom users.<sup>53</sup>

For young gay men, many of whom have been bottling up their sexual desires for years, there are special risks associated with the discovery period of sex. In their sample of predominantly white gay men in San Francisco, Ron Stall found that among gay men under 30, shorter length of residence in San Francisco was correlated with risk-taking behavior, suggesting that the initiation period into a relatively open gay environment is a particularly dangerous period for young gay men.<sup>54</sup> Young gay men who participated in PMI focus groups noted that they were less likely to use condoms immediately after coming out, and that this was likely to be a period of multiple partnering.

### **Older Partners**

Many young people find older partners attractive. All the young men and women participating in one series of PMI focus groups said that they prefer their sexual partners to be at least five years

older than them. But the power dynamics of these relationships can be highly risky, particularly for young women and gay men.

In a summary of research, Ralph DiClemente reports that having a sex partner more than five years older was one of several predictors of less condom use among adolescents.<sup>55</sup> Advocates for Youth reports that, “A national study shows that adult men father over 50% of babies born to teen women aged 15 to 17. A study on California births indicates that seven in 10 births among teenagers are fathered by men older than age 20.”<sup>56</sup> Young gay men participating in PMI focus said that when they are with an older partner who does not want to use a condom, they probably won’t use one.<sup>57</sup>

Kim Miller found that “for young women who are sexually active...the age of their first sex partner may influence their risk of transmission. Young women whose first sex partner was an older man were less likely to use condoms and possibly at higher risk for HIV infection than young women whose first partner was the same age.” Miller also suggests that the difference in age between the two partners may make it difficult for the young women to negotiate condom use with her partner.<sup>58 59</sup>

### **Coercion and Force**

Coercion and forced sex play a significant role in HIV infection in youth, both as situations in which transmission occurs, and as a past psychological wound that increases the chances someone will fail to protect themselves. Twenty-two percent of teens in the Kaiser Family Foundation survey said that being forced against one’s will was “often” a reason teens have sex. Fifty-three percent said they thought force was “sometimes” a reason.<sup>60</sup> Kaiser also reports that of the girls who report having had sex before age 15, 60% say they had sex involuntarily.<sup>61</sup>

Young women in PMI focus groups said that rape and coercive sex are an issue for many young women, and that in these situations they are unable to insist on using a condom. And in The Scapegoat Generation: America’s War on Adolescents, Mike Males notes that, “Most ‘sexually active’ girls under age 15 were victims of sexual abuse and rape by older males.”<sup>62</sup>

George Lemp reported that, “Our data...[among young gay men] show that a lifetime history of forced sex predicts unprotected anal intercourse in the past six months.”<sup>63</sup> Advocates for Youth note that, “National estimates indicate that 15% of males have been sexually abused as children compared to the estimate of 28% for females,” and that, “male victims of childhood sexual abuse are at twice the risk of HIV infection as male non-victims and are at increased risk of substance abuse.”<sup>64</sup> Samuel Jinich has reported that, “Childhood sexual abuse is associated with continued high-risk sexual behavior of gay and bisexual men, particularly among men who recall their experience as coercive.”<sup>65</sup>

### **Communication**

Learning to communicate effectively with sexual partners is one of the most valuable lessons for young people, gay or straight. Ralph DiClemente reported that “the best predictor of condom use was communication with a sex partner requesting condom use.”<sup>66</sup> In a study of young gay men, Robert Hays found that young gay men who did not communicate about sex with their partner were more likely to have risky sex.

But clear and honest communication with sexual partners is the exception.<sup>67</sup> In-depth interviews conducted in 1996 by Michaels Opinion Research of New York found that gay and straight couples in their adolescence or early 20s consistently fail to communicate with each other about fundamental issues such as past sexual history and current feelings about the health of the relation-

ship. Many of those interviewed indicated that they were worried that insisting on condom use would be interpreted by their partner as an explicit lack of trust which would threaten to undermine the relationship. Not talking about the issue was the path of least resistance.

Part of being able to communicate is having the skills and self-assurance to assert your own personal needs. A wealth of research indicates that these are vital protective assets when it comes to avoidance of HIV. A study of 1,920 tenth and eleventh grade students found that “adolescents who have high self-efficacy to insist on condom use were 8.8 times as likely to be consistent condom users.”<sup>68</sup> In a study of African-American adolescents residing in high-risk urban environments, Ralph DiClemente also reported that young people with “high assertive self-efficacy to demand condom use” were more likely to report consistent condom use.<sup>69</sup>

## **THE TERRITORY OF BEING YOUNG**

HIV prevention program designers also must consider risk factors that affect the vast majority of young people — conditions that are simply a product of being young (or human).

### **“What do my friends think? What do they do?”**

Many young people feel as if they are putting themselves at *social* risk when they take steps to protect themselves from risk for HIV. Young people do not use condoms because they are embarrassed to buy them, use them, or ask their partner to use them (and because they may not be readily accessible). Concern with peer approval is the great equalizer in condom use among youth — gay and straight. George Lemp found that, “a lack of peer support for safe sex was the strongest predictor of unprotected anal intercourse,” among young gay and bisexual men in the San Francisco Bay Area. Ralph DiClemente reported that “perceived peer norms ...supporting condom use” was one of the most significant factors in condom use among African-American adolescents living in “high-risk urban environments.”<sup>70</sup> Peer pressure is also an important factor in drug use. An October 1996 survey by the National Center on Addiction and Substance Abuse reports that “the main reason teens use drugs is because their friends do.”<sup>71</sup>

### **“It can’t happen to me (or my lover)”**

Accurate perception of risk is not a hallmark of youth. This is particularly true in the case of risk for HIV infection. It is a testimony to the power of denial that adolescents of color and gay adolescents — two of the groups at highest risk for HIV -- can identify AIDS as “someone else’s” problem. Researchers have concluded that, “in comparison with their white peers, minority adolescents report less perceived vulnerability to AIDS, perhaps because they tend to view AIDS as a disease affecting white gay men.”<sup>72</sup>

Many young gay men assume that AIDS is an “older man’s disease,” and hence they can be less cautious when they have sex with others their own age.<sup>73</sup> At the center of the HIV epidemic, many gay men seem to have developed a code of limited accuracy for managing and interpreting risk. In a study of gay men aged 18 to 39, Eva and Ross found that “there is not a close match between what is epidemiologically accepted as risk behavior and what respondents regarded as risk behavior.” They also found that gay men relied upon several external factors to make a determination about their partners’ risk, such as age, appearance, diction, and HIV knowledge, and whether they were the insertive partner.<sup>74</sup>

Faith in a *partner’s* lack of risk is equally dangerous. Overby’s study of high-risk female minority adolescents found that “most participants perceived themselves to be at low personal risk owing to current monogamy, lack of intravenous drug use, and implicit trust in their partner’s safety.”<sup>75</sup> In a study on sexual anticipation and practice in adolescents, Kim Miller notes that

“adolescents with one (steady) partner...may discount safe sex or HIV prevention messages because they may feel safe in what they think is a monogamous relationship.” She also points out that 72% of these adolescents with a steady partner are female.<sup>76</sup> Leslie Clark reported at the 1996 International AIDS Conference that among adolescents, “confidence in one’s ability to determine a potential partner’s HIV status was significantly associated with lack of condom use.”<sup>77</sup>

This faith in a partner’s safety is all the more troubling when you consider that many of these partners, regardless of their intention to tell others about their HIV status, do not know that status themselves. As noted earlier, in a San Francisco Bay Area survey, only approximately one quarter of HIV positive young gay men knew their HIV status.<sup>78</sup> A paper by the AIDS Policy Center for Children, Youth, and Families in Washington, D.C. reports that relatively few young people have ever taken the HIV antibody test and that, “in a study of publicly funded test sites, only 45% of all teenagers who were tested for HIV returned to learn their results.”<sup>79</sup>

### **Knowledge and condoms**

Knowledge about HIV is the essential first step to protecting oneself. DiClemente’s review of the literature includes a study finding that AIDS knowledge is associated with condom use.<sup>80</sup> The 1995 Youth Risk Behavior Surveillance report tells us that 86% of all high school students had been taught about AIDS in school. Nearly two thirds (63%) of all high school students nationwide had talked about AIDS or HIV with a parent or other adult family member.

But superficial knowledge can be a risk factor in itself. Like knowledge about the dangers of tobacco or drinking and driving, education alone does not solve the problem. Ralph Hingson found, “little relation between adolescents’ knowledge about HIV infection and risky sexual practices primarily because most adolescents knew the principal modes of HIV infection.”<sup>81</sup> In a study of African-American youth, Stevenson found that “those teenagers who perceived themselves as highly knowledgeable scored lower on reliable AIDS Knowledge and Prevention Beliefs measures.”<sup>82</sup>

### **Drugs, alcohol and unplanned sexual encounters**

If experimentation with drugs and alcohol is part of many people’s adolescent years, so are rushed and unplanned sexual encounters. Both make safer sex more difficult to prepare for and negotiate. A CSAP article notes that, “...adolescents and young adults may be novices at both drinking and sexual activity...their risky behavior may reflect the limited knowledge and experience of beginners in any endeavor.”<sup>83</sup> One-quarter of all high school students report combining sex and drugs or alcohol. White males have by far the highest rates (36%) while African-American young women have the lowest (11%).<sup>84</sup> In their survey of gay adults, Lowy and Ross reported that “respondents complained that alcohol and drugs, often integral features of a central city gay social lifestyle, accounted for some of the difficulty in maintaining safe sex standards.”<sup>85 86</sup>

According to researchers Ralph Hingson and Lee Strunin, “Many adolescent sexual encounters are unplanned, and alcohol or drug use may cloud judgment...of adolescents.”<sup>87</sup> The CDC’s Prevention Marketing Initiative (PMI) focus group research among a predominantly African-American group of adolescents in one city found that sex was often not planned, and was often accompanied by drugs. Another focus group reported that young women felt that the lack of planning around sexual encounters explained much of the unsafe sex that occurs.<sup>88</sup>

AIDS educators cannot make society more equitable, sexual encounters less furtive, and self-esteem easily acquired. But they can frame messages and create interventions which address special issues of vulnerability among youth. Resources can be focused on enabling young people at particularly high risk to understand that risk, anticipate situations that put them at risk, and help them take precautions to protect themselves and seek help when necessary.

## IV. RETHINKING THE MESSAGE

“When I had sex ed, the movies we watched were very old. Some of them were so old that for the diseases they said had no cure, now we have a cure.”

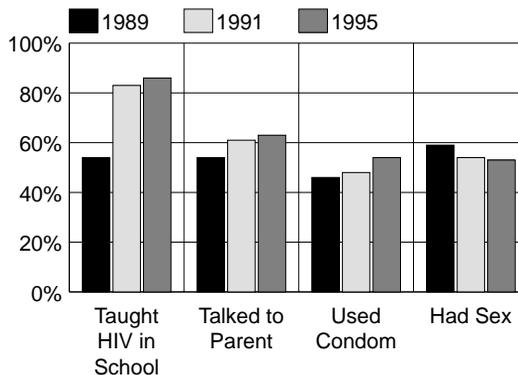
- Getting the word out
- Key lessons learned
- Less Risk or Better Sex?
- Social Marginalization and HIV Prevention
- Social Marketing

### GETTING THE WORD OUT

Young people know about AIDS. The vast majority are taught about AIDS in school; most talk to their parents about it; all of them see media coverage. The multiple communication channels that reach young people are bringing home the message that AIDS is a terrible national problem, and, as a result, young people today identify AIDS as equal to crime and violence as the most serious threat facing the nation in the year 2000.<sup>89</sup> The pressing question is, how many identify HIV as serious *personal* threat — personal enough to take steps to protect themselves?

AIDS education efforts have clearly had their successes. As Table 5 shows, the percentage of young people receiving education about HIV in school has increased markedly in the six years between 1989 and 1995. More young people are talking to their parents about HIV (though we don’t know what they are saying to each other). But it is significant that while reported condom usage rates have also followed an upward slope over these years, that slope is far less steep, and today has reached a point far too low to end the epidemic in young people. The percentage of American youth who are taught about HIV in school has increased 59% over the years shown, while the condom usage rate has increased only 17%.<sup>90</sup>

**Table 5**  
**HIV Education, Communication**  
**with Parents, Condom Use and**  
**Sexual Activity**



Source: Youth Risk Behavioral Survey, 1990-91, 1993, and 1995, CDC

Note: The 1989 condom rate shown was actually for the year 1990

The first thing to ask ourselves is what we mean by “AIDS education.” A CDC study published in September 1996 found that in 1994 HIV-prevention education was required in 79% of states and 83% of school districts. Yet when surveyors asked teachers responsible for HIV education of students about the actual subject matter covered in classes, the results were alarming. Among teachers of courses that focus primarily on health education topics, 87% taught the basic facts about HIV/AIDS, 83.8% taught how HIV is and is not transmitted, and 78% taught “reasons for choosing sexual abstinence.” But only 37% of these teachers taught the correct use of condoms and only 56% taught information on HIV testing and counseling.<sup>91</sup> Maybe this is part of the reason why a 1996 survey found that nearly half (47%) of teens say they want more information about how to prevent AIDS or other STDs.<sup>92</sup>

Failure to tailor health education to the realities of young people is not unique to HIV prevention. An article in the *New York Times* reported that the school based antidrug DARE program — used in almost 75% of US school systems — “employs trained police officers to come to classrooms and teach students how to resist drugs. The system has pleased teachers, parents and police officers, but academic researchers say the program does not make a lasting impact on students’ behavior...”<sup>93</sup>

HIV prevention strategies for young people are often similarly mismatched with the target population. Much of youth-focused HIV prevention is fear based, even though young people are known for believing themselves to be invincible and for thinking on short time lines. It often urges teens to avoid risk, when risk and disobeying helpful advice are the currency of youth. It takes a cognitive approach to health promotion with the age group which most typifies cognitive dissonance. And it ignores the multiple motivations for sex and the external forces which can affect whether someone insists upon safer sex.

**Profound discomfort about adolescent sexuality is one of the most basic and important impediments to more effective HIV prevention efforts.**

Why the strategic mismatch? The most obvious explanation is fear of dealing openly and honestly with teen sexuality in its myriad forms: the multiple healthy motivations for sex, the urge of some young people to be with older partners, the coercion and power dynamics that often plays a role in sex, attraction to same-sex partners, even the very fact that young people have sex at all. For over a decade, HIV prevention has been disabled by these constraints, both in its message, and in its ability to put the tools of prevention — most notably condoms — into the hands of more teens. Profound discomfort about adolescent sexuality is one of the most basic and important impediments to more effective HIV prevention efforts.

There are many examples of HIV prevention programs which have transcended these restraints and honestly addressed adolescent HIV prevention needs. By and large, they share the characteristics of being intense, sustained over time, providing necessary skills training, and being carefully designed to match the specific cultural, age, sex role, and sexual preference characteristics of the populations targeted. To improve our HIV prevention efforts to adolescents we need to expand and build upon the high quality prevention programs already implemented. But we also need to consider new thematic approaches to prevention for young people, and address specific policy roadblocks to improved prevention efforts. First, a review of findings which can help inform a new generation of HIV prevention messages to youth.

## SOME KEY LESSONS LEARNED

Following is a brief review of some of the key lessons learned from quality adolescent HIV prevention programming.

- **Information is just part of the picture:** HIV educators know that young people need to learn skills — such as condom use and assertiveness — in addition to basic information about AIDS. Ross and Rosser have noted that education without skills training or modification of attitudes, beliefs, or situational determinants of risky behavior is not sufficient for behavior change among adolescents.<sup>94</sup>
- **Early and often:** In a comprehensive review article, Kyung-Hee Choi and Thomas Coates found that provision of “explicit HIV prevention programs prior to the time that adolescents are sexually active can have greater impact than programs initiated after the initiation of sexual activity.”<sup>95</sup> Successful interventions must be sustained and intense in nature.
- **Peer education:** Use of peers to deliver prevention messages is often noted as an important ingredient of successful prevention efforts. Peer-directed interventions can help change the perception of social norms around condom use, and peers may be able to deliver messages which are more readily accepted by young people.<sup>96</sup>
- **Dosing:** Like a medication, “proper dosing” is an important factor in effective HIV prevention. A summary paper published by the Office on AIDS, National Institute of Mental Health, observes that, “There is a threshold which varies according to group, below which significant change is unlikely to occur.” Among homeless runaway youth, 10 to 14 intervention sessions emerged as a full dose. In an intervention among gay men, 12 session programs produced “substantive behavioral change.”<sup>97</sup>
- **Specific populations; young African-Americans:** There has been a dearth of research on HIV prevention focusing on young African-Americans. But a few studies of programs that integrate knowledge and skills in a culturally appropriate manner have demonstrated success. St. Lawrence found that an eight-week intervention combining education with behavior skills training — including “correct condom use, sexual assertion, refusal, information provision, self-management, problem solving, and risk recognition” was effective in helping African-American adolescent participants lower their risk for HIV infection.<sup>98 99</sup>
- **Specific populations; young gay men:** A review paper prepared by Robert Hays notes that, “The myth that the gay community has been saturated with AIDS prevention services is in serious need of debunking. New young men will come out each year who have not been exposed to prevention campaigns of previous years, thus HIV prevention for young gay men must be ongoing and dynamic...[prevention programs should incorporate] issues of self-esteem, coming out, substance use and interpersonal and social needs.”<sup>100</sup>
- **Effective prevention in schools:** In a review of school based risk reduction programs, Kirby identified nine common characteristics of effective curricula, including a narrow focus on reducing sexual risk-taking behaviors that may lead to HIV/STD infection or unintended pregnancy, program length of at least 14 hours or use of small groups, addressing social pressures on sexual behaviors, and providing modeling and practice of communication and negotiation skills.<sup>101</sup> The three million adolescents who drop out of school annually<sup>102</sup> are among the youth at highest risk for HIV, and they also need outreach programs to address their special needs.

- **Homeless and runaway youth:** Mary Jane Rotheram-Borus studied the effects of an intervention involving homeless and runaway youth in up to 30 HIV intervention sessions which addressed general knowledge about HIV/AIDS, coping skills, access to health care and other resources, and individual barriers to safer sex. The intervention successfully increased consistent condom use among those receiving the intervention.<sup>103</sup>

**“the beliefs outlined in the health belief model accounted for only 10-15% of the variance in condom use.”**

## LESS RISK OR BETTER SEX?

Most young people choose to be sexually active, and they need to know how to protect themselves as they experiment in the real world of intimacy and sexuality. HIV prevention needs to encourage these young people to get what they need — safely — from intimate relationships, whether that be good and safe sexual experiences, close platonic relationships, or an affirmation of being respected and loved in a way that is satisfying and safe.

The classic standards for health promotion have only limited effectiveness with HIV prevention among adolescents. For an age group in which risk-taking is so closely intertwined with self-definition, simple messages about risk avoidance cannot be wholly successful.

A paradigm shift in our thinking is urgently needed. Many health and HIV education programs are founded on the *health belief model* which emphasizes information (about risk and severity of an event) and skills (to avoid that event) as essential tools for self-protection. But the health belief model will work only for some people, young or old. One study tested several components of the health belief model in adolescents, including perceived susceptibility to HIV infection, severity of HIV, effectiveness of condoms, and barriers to condom use. The authors report that when condom usage rates were measured, “the beliefs outlined in the health belief model accounted for only 10-15% of the variance in condom use.”<sup>104</sup>

## Selling intimacy

From a marketing standpoint, the promoter of HIV prevention starts with a considerable advantage over an advertising firm trying to sell a new car. The former has an appealing product (intimacy and sex) which directly fulfills a basic need. The latter has an automobile which has to be made to appear sexy. Unfortunately, for over a decade HIV prevention has squandered this advantage by focusing on selling risk avoidance rather than satisfying a desire.

The savvy, unshackled HIV prevention marketer would have started promoting personal satisfaction as central to intimacy — sexual and platonic — years ago. She would have defined good sexual experiences in terms of personal satisfaction with an emphasis on affection, enjoyment, and personal control. She would have understood that the theme of personal satisfaction offers choices: individuals can choose to have enjoyable sex, take a break after being sexual for the first time, or remain abstinent. The theme argues for the importance of valuing yourself, avoiding situations in which you may be at risk, taking precautions to protect yourself, and clearly conveying your needs and desires to your partners.

For many young people with questionable risk perception skills and an orientation to the present rather than the future, the immediate promise of a good sex life in which they are in control and satisfying their own self-identified needs is far more captivating than a life free of long-term health risks. The Academy for Educational Development has concluded that to encourage young people to use condoms we, “may need to go beyond the obvious health advantages of protecting oneself from pregnancy and protecting oneself from HIV...every time to address non-health benefits, such as decreased worry, feeling safer, and having better sex.”<sup>105</sup>

Transforming the risk aversion message into one that emphasizes good intimate relationships is particularly appropriate for the adolescent groups most affected by the epidemic. Young women of color, gay youth, and homeless or runaway youth bring a complex variety of needs and vulnerabilities to sex. For many, self-esteem, self-assertiveness (particularly with older, more experienced partners) and communication skills are critical issues. Having a good sex life in which they are in control may be an empowering message for many young people who are the most likely to place themselves at risk.

The traditional risk aversion interventions have proven useful for young people who respond quickly and consistently to public health messages. Those who are harder to reach need a new approach. The theme discussed above may be powerful for many young people, but the essential point is that we must look more broadly at a variety of motivating themes which can reach a diverse and constantly changing audience.

### Related lessons

Other lessons from the first decade and a half of HIV prevention can readily inform a revitalized message:

- **Addressing other real needs:** Information and skills are the foundation of HIV prevention, but to reach many high-risk youth, these tools must address self-perceived individual needs and be presented in a way that allows them to be integrated into the cultures in which people live. For example, interventions offered in the context of social events or community mobilizations may reach many young people who would be uninterested in an educational session on HIV.
- **Young men, young women:** Janet St. Lawrence has proposed that because young men and women have different levels of knowledge and different attitudes about sex, intervention programs should be tailored differently for each group. For young men, “content that conveys girls’ expressed preference for contraception may help make condoms more acceptable by ‘normalizing’ their use, taking the onus off the boy.” Young women, on the other hand, need, “skills building interventions that promote self-expression, assertiveness in sexual situations, problem-solving, and ‘empowerment’ in relationships...”<sup>106</sup>
- **Media savvy:** Even the media-savvy generation may benefit from help in decoding the sex-laden messages being sent their way. In his review of youth-oriented prevention programming, Douglas Kirby observed that, “effective programs included activities that address social or media influences on sexual behaviors...for example, how sex is used to sell products and how television shows often suggest that characters have unprotected intercourse but don’t experience the consequences.”<sup>107</sup>

## SOCIAL MARGINALIZATION AND HIV PREVENTION

We should never expect simple provision of information and skills to end an epidemic when social marginalization plays an important role in transmission. Society’s homophobia, racism and sexism all express themselves on the individual psychological level, and as they do each becomes a factor in disease transmission. AIDS education must not simply address the biology of transmission, but also engage young people in thinking about vulnerability factors — including power relationships with partners and societal status — which can put them at higher risk for infection. Individuals who can anticipate some of these risk dynamics may have a greater chance to be able to insist upon safer sex. And to deliver this message, youth-oriented prevention funding must be targeted to young people from sub-populations most profoundly affected by the epidemic.

Teaching self-respect — particularly to those young people in the most vulnerable groups — is just as important as demonstrating condom use. Part of achieving personal satisfaction in sexual experiences is being able to navigate the many motivations involved in sex. Each issue identified in the “Understanding Risk” section has corollaries here. If love is your goal in being sexual, then you need to think about distinguishing love from being forced to risk your health for someone else’s pleasure. If you prefer older partners, you should be prepared to negotiate the sometimes challenging power dynamics of the situation. Young women need to be urged to think clearly about satisfying their own needs. Young gay men need to be taught that they are not pariahs. All young people need to be encouraged to make personal choices based on valuing themselves, and to understand and anticipate the risk involved in not valuing their own needs.

## **SOCIAL MARKETING**

The advertising industry knows about motivating young consumers, and spends \$1 billion annually to reach children.<sup>108</sup> This investment produces annual teen expenditures of \$65 billion in the United States.<sup>109</sup> These marketing efforts ultimately do more than sell products; they play a pivotal role in the culture of adolescence in the 1990’s. Peter Zollo, a marketing researcher who specializes in reaching young people, says that, “teenagers look to advertising for what’s cool.” Zollo’s assertion that advertising actually *defines* popular culture for many young people may overstate the case. But it is certainly true that there is a powerful synergy of youth culture and advertising which helps define the world for young people.

Social marketing attempts to bring advertising and marketing expertise to motivate healthy behavior change. It has been used to discourage smoking, promote low fat foods, and urge pregnant women to seek prenatal care. If social marketing can reach the young people most affected by HIV with highly effective messages, it can also contribute to controlling the epidemic among adolescents.

Social marketing has the potential to turn the tables on traditional health education efforts. It also offers an excellent opportunity to develop the sex-positive messages that have been so effective with gay adults. One of the first steps in developing a social marketing campaign is determining what target audience members think they need, and then creating a campaign that promotes a product as meeting that need. Critical to the success of this approach is starting with an understanding of the consumer; what he or she wants, what he or she thinks is important.

Population Services International, which has developed numerous social marketing campaigns for developing countries, created perhaps the first such campaign focused on HIV prevention in the United States. PSI’s “Project Action” was based in Portland, Oregon and combined advertising spots, condom vending machine placement in stores, and an intensive community mobilization campaign. An evaluation of the program found that condom use with new and casual partners increased sharply, but that it was more difficult to change condom use behaviors with steady partners. The designers of the program stress that media needs to use diverse channels, be sustained over time and be responsive to changes in the market.<sup>110</sup> (As noted earlier, the CDC has launched their Prevention Marketing Campaign, designed to test and develop social marketing approaches in five communities in US.)

Another way to use media to influence positive behavior change is through the mouths of characters on popular TV shows. At Harvard’s Center for Health Communications, Jay Winsten works to encourage Hollywood television producers to incorporate antiviolence messages into productions such as *Beverly Hills 90210*. Winsten and Charles Rosin, formerly Executive Producer of *90210*, have worked together to include social messages into *90210* scripts. Rosen argues

that, “Fifteen million people a week watch *90210*. If you can lay out a positive, proactive message without preaching, you can have a big impact.”<sup>111</sup>

Is vulnerability to HIV infection similar to susceptibility to participate in consumer culture? It remains to be seen whether approaches that can make a certain type of athletic shoe seem essential to life can also influence someone to, in a moment of passion, insist on a condom with a partner whom they fear may not want to use one. These questions are especially important when we think about the subgroups of teens getting infected with HIV most often. Can major media outlets reach young men who are questioning their sexuality with an appropriate, targeted, and motivating message? Can it help people at-risk of coercive sex think about how to protect themselves from (and in) these situations? What about homeless and runaway youth?

The question is equally difficult among other populations deeply affected by HIV. In The MEE Report, Ivan Juzang details the multiple difficulties of reaching African-American intercity teenagers. He writes that, “Mainstream society has virtually no credibility with these young people; they are alienated from their own heritage, and their subculture tolerates self-destructive behavior and encourages taking risks.” The Report urges those trying to reach this group through the media to be authentic, avoid being preachy, and go beyond giving advice to telling young people specifically how to insist upon safer sex.<sup>112</sup>

Social marketing may be a valuable new tool in the fight against HIV in young people, but its success requires listening to young people’s specific needs, providing culturally appropriate, targeted messages, and the willingness to acknowledge the important role of sex in the lives of young people. Creative uses of media which rely primarily on traditional fear-based, cognitive approaches to prevention instead of new and compelling messages are unlikely to have a lasting impact.

## V. WHAT IS STANDING IN THE WAY?

*“I think that schools should have condoms available to students. Because high school kids are going to have sex — why not make sure it is safe? I also think adults need more education.”*

- Public and Private Education
- Government
- The Private Sector
- The Research Community
- Reassessing Goals

It would be difficult enough if HIV educators had only to find effective messages which would resonate with young people and help them protect themselves from disease. Unfortunately, the impediments to effective HIV prevention among youth are far more complex. Whether it is discussing how to use a condom in schools, or mentioning their existence on television, social prohibitions stymie the prevention efforts necessary to end the epidemic among youth. Limitations on school-based sex education are at the forefront of Religious Right activism in cities across the country. A new survey reports that 65% of school board members describe themselves as, “political conservatives,” and 44% as “religious conservatives.”<sup>113</sup>

It is relatively easy to make a list of the public sector’s strategic missteps in the effort to prevent HIV in young people. The question is whether we can reasonably expect school districts and local and federal governments to overcome political and other hurdles and set more rational policy in the future.

Are we misplacing efforts by focusing primarily on governmental reforms which may not come (or come too slowly)? Can we tap private sector expertise, resources, creativity, and access to communication channels in a way that can radically improve our ability to prevent HIV among youth? Can we call on local TV stations, funders, churches, health care workers, businesses and others to help improve our efforts?

Below is a short list of public and private sector actions which could make HIV prevention more effective. It is, of course, only a partial list, one that focuses on broad areas of education and health policy.

### **PUBLIC AND PRIVATE EDUCATION**

#### **Limits on school-based education: sex education**

Approximately nine out of ten parents want their children to have sex education in school.<sup>114</sup> A 1996 Kaiser survey of Americans found overwhelming support for school-based AIDS education. Thirteen percent of those interviewed said this education should be begin at ages 7 to 9; 49% felt it should begin at ages 10 to 12 ; and 25% would begin AIDS education at ages 13 to 15.<sup>115</sup> Education policy should not be set simply by polling data, but it is important to note when the public sector may not be taking an opportunity to provide sex ed even with broad agreement that this education is needed. SIECUS reports that 13 states do not require schools to provide either sex or STD/HIV education,<sup>116</sup> including several southern states where many new HIV infections in young people are occurring. And, as noted earlier, when HIV education is presented in classrooms, it often neglects essential issues, such as condom use.

It is sometimes argued that, in the name of good values and disease control, the primary goal of sex education in the schools should be to encourage abstinence as the only acceptable option. Yet Kirby's review of school-based programs concluded that, "abstinence programs do not have a positive impact upon delaying the onset of intercourse."<sup>117</sup> At least one study has found that an "abstinence only" program *increased* the level of sexual activity in young people.<sup>118</sup> Even so, a 1993 SIECUS study found that, "state curricula emphasize abstinence."<sup>119</sup> The organization further reports that, "of the 26 states that require abstinence instruction, only 14 also require the inclusion of other information on contraception and pregnancy and disease prevention."<sup>120</sup>

Neither research nor public sentiment support these restrictive policies. In 1995, the North Carolina State Legislature enacted a law requiring public schools in the state to restrict classroom discussion of sex to "abstinence only." The American Social Health Association then commissioned a poll of state residents, and found that 65% of voters believed schools should educate students about condoms as a way to prevent STDs.<sup>121</sup>

**Recommendation:** All children should be offered honest, age-appropriate sex and STD/HIV education as a part of their schooling. This education should include information on condoms and other tools necessary to protect oneself from HIV and other STDs and include themes addressed elsewhere in this report, including acceptance of homosexuality, and issues concerning power dynamics in relationships. State legislatures should revise state law as appropriate to ensure that this education is provided. Equally important is providing opportunities for parents to improve their ability to talk with young people about sexuality and self protection.

#### **Limits on school-based education: Homophobia in the classroom**

Of all the insults young people use against each other, "fag" and "dyke" are among the most potent. Good public health practice would have schools attempt to counteract the damaging effects of homophobia. After all, to avoid HIV, young gay men need to be able to accept their sexuality and understand the need to protect themselves. And, as noted earlier, internalized homophobia in young gay men is associated with HIV infection. (page 16)

Yet eight states require or recommend teaching that homosexuality is not an acceptable lifestyle,<sup>122</sup> and SIECUS found that the topics least likely to be covered in state sex education curricula are sexual identity and orientation.<sup>123</sup> The federal Center for Substance Abuse and Prevention warns that, "Although [gay, lesbian and bisexual youth and adults] ...comprise more than 10% of people at risk for problems, alcohol and other drug programs generally do not address their prevention needs."<sup>124</sup>

**Recommendation:** School-based sexuality curriculum should present gay, lesbian and bisexual sexual preferences as healthy and valid identities. Young people should learn that homophobia, like other forms of bigotry, has severe human costs.

#### **Limits on school-based education: condoms**

Many Americans support condom availability in high school. A 1991 national survey found that "65% of the American adult population supports condom availability in schools to prevent the transmission of HIV."<sup>125</sup> A 1996 Kaiser study titled Americans and AIDS/HIV found that 46% of adults agreed that condoms should be provided in high schools.<sup>126</sup> According to the study, 62% of 18 - 29 year olds support condoms in high schools.

Despite this widespread support for condom availability, today it is easier for many young people to get drugs than it is to get condoms. A September 1996 *New York Times* article reported that, "teenagers from inner-city, working-class and suburban neighborhoods said marijuana can be

as easy to buy as beer or cigarettes, often from schoolmates...’It takes one phone call,’ said Matt, a 16-year old in Gloucester, Mass.”<sup>127</sup>

It often takes much more effort than a phone call for an adolescent to get a condom. A study by Douglas Kirby and Nancy Brown found that only 2.2% of all public high schools and 0.3% of high school districts made condoms available. Even at these schools, 45% of the students obtained an average of less than one condom per student per year. “Only 5% of the schools made condoms available through baskets or bowls, the most barrier-free and nonrestrictive approach to condom provision,” the researchers noted.<sup>128</sup>

Outside of school there are impediments too. Advocates for Youth did a study in 1988 examining the accessibility of family planning methods in drug stores and convenience stores in Washington, D.C., and found, “one-third [of the stores] kept condoms behind the counter forcing teens to ask for them...only 13% clearly marked where contraceptives were shelved...adolescent girls asking for help encountered resistance or condemnation from clerks 40% of the time.”<sup>129</sup> Teens may get help accessing condoms from the marketplace before schools or public health programs make them more available. Supermarkets are beginning to prominently display condoms again, with the English condom manufacturer Durex focusing on the youth market with advertisements on MTV.<sup>130</sup> Almost one-third of teens (28%) say they want more information about where to get birth control.<sup>131</sup>

**Recommendation:** High schools should make condoms and birth control information readily available to students.

### Access to Testing

Knowledge of serostatus can help young people get earlier access to treatment and may encourage them to protect their partners from infection. Yet a recent survey found that only 24% of HIV-positive young gay men in the San Francisco Bay Area knew of their serostatus.<sup>132</sup> The AIDS Policy Center for Children, Youth and Families notes that, “...information about HIV counseling and testing options should be an important part of broad-based HIV education and prevention programs offered through schools and community based organizations.”<sup>133</sup>

**Recommendation:** Discussion of HIV counseling and testing options should be included in school based HIV prevention education.

## GOVERNMENT

### Missing the point

Through three presidential administrations, the CDC has made a variety of efforts to use national media to educate the population about HIV. In the late 1980s there was the *America Responds to AIDS* campaign of television spots, posters, and other media. More recently, the *Respect Yourself, Protect Yourself* television spots have sought to reach young people at risk for HIV. These latter spots show marked improvements in their candor and quality and in the diversity of the individuals appearing. But serious questions remain about the character of government-sponsored TV ads.

In a content analysis of HIV prevention television public service announcements sponsored by CDC and National Institutes of Drug Abuse which aired nationally between 1987 and June 1996, Robert Cameron Wolf found important deficits in the educational messages being presented. Wolf reported that although 61% of the ads address people under 21, the ads “ignored..the needs of high-risk populations such as gays/bisexuals and injection drug users.” In fact, only 4% of the ads

during this period specifically addressed themselves to gay men. In addition, only 9% of the ads focused on condoms, and “these ads fail to address important barriers to use, such as potential embarrassment...”<sup>134 135</sup>

This analysis is eerily consistent with criticisms of another national campaign aimed at changing the behavior of young people. Like the CDC ads, Partnership for a Drug Free America messages have identified the problem, but failed to provide a realistic portrayal of that problem or its potential solutions. Erica Weintraub Austin has noted that the Partnership, “has been rightly criticized for identifying problems but offering no resolutions; portraying improbable rather than most probable consequences...and making use of shock-value techniques, which can backfire.”<sup>136</sup>

AIDS education also needs to more explicitly tackle external social and interpersonal risk factors such as: avoiding and negotiating coercive encounters; how to handle various situations in which the other partner is more

“powerful” in the relationship; instilling self value; separating the need to receive love and affection, from the obligation to put oneself at risk; and, accepting one’s own sexual preferences, needs and desires.

**“The emphasis on the broad reach of disease has virtually ensured that precious funds won’t go where they are most needed.”**

If government agencies are unable to develop and distribute media which effectively reaches those groups at highest-risk, then public funding needs to be distributed to private groups which can more effectively develop targeted, appropriate messages.

**Recommendation:** The CDC and other government agencies must identify strategies to deliver HIV prevention media which address critical audiences (including young gay men) and critical issues (such as condom use). If it is politically impossible for these agencies to focus in these areas, government should contract with private organizations to provide appropriately targeted media or otherwise promote candid prevention messages.

### Missing the Populations

We are spending too many prevention dollars on low risk populations, while ignoring the urgent need for culturally appropriate, targeted messages to young people at higher risk. In a 1996 article on federal HIV prevention spending, the *Wall Street Journal* noted that, “The emphasis on the broad reach of disease has virtually ensured that precious funds won’t go where they are most needed.”<sup>137</sup>

Of course, political concerns often stand in the way of effectively targeting resources. But as a society, we must find a way to overcome these concerns and target culturally appropriate prevention where it is urgently needed.

**Recommendation:** CDC, working with local prevention planning groups must ensure that prevention spending more equitably addresses needs of young men who have sex with men, African-Americans, Latinos, and young women at higher risk of infection.

### Research that informs prevention

Government agencies have excelled at providing essential information on the national epidemiology of AIDS. The Youth Risk Behavioral Survey and annual HIV/STD epidemiologic reports are prominent examples. Yet the public prevention enterprise still has much to learn from private sector marketing research. Marketers track trends, attitudes, values and channels of communication. They place a premium on up-to-the-minute information which can help them

reach youth. They don't just count consumers, but try to understand their targets. They also seek to continually renew that understanding.

The CDC's PMI is an example of new public initiatives that seek to understand what motivates young people in order to produce more effective prevention campaigns. Private sector marketers have worked with government officials and researchers to make PMI a unique and promising endeavor. More of this kind of collaboration is urgently needed. Projects like PMI need further reach and adequate funding to produce interventions on a timely basis.

**Recommendation:** Collaborative projects like the Prevention Marketing Initiative — which seek to gain in-depth knowledge of young people's values, concerns and attitudes — should comprise an increased share of CDC educational efforts.

### **Needle Exchange**

Young people who are at risk for HIV through needle use suffer from the ban on federal funds for needle exchange programs. This ban remains in place even though six government-sponsored reports have concluded that needle exchange programs help reduce HIV infection and do not lead to increased drug use.<sup>138</sup> Young people also need access to youth-friendly substance abuse programs.

**Recommendation:** The Department of Health and Human Services should follow the advice of government-funded reports and fund needle exchange programs.

## **THE PRIVATE SECTOR**

### **Doing What Government Can't (or Won't) Do**

Government cannot fight the HIV/STD epidemic among young people on its own. It faces constraints in the areas of politics, marketing knowhow, and financing. The private sector has a moral responsibility to be more actively involved in HIV prevention among youth. Private sector media, advertising, marketing, and public relations professionals have valuable expertise which must be partnered with government's resources to more effectively fight HIV. Other areas of the private sector have important opportunities to help prevent HIV in youth, for example:

- local TV producers can air more HIV prevention spots, particularly segments which address young people in high risk groups, including young men who have sex with men;
- TV writers and producers can make condoms more visible in youth-oriented programs;
- supermarkets and pharmacies can ensure that condoms are easy to purchase and that the young people who do purchase them are not harassed;
- all businesses can agree to sponsor or support community-based HIV prevention activities, and to make HIV prevention literature visible and available;
- more churches can provide HIV prevention services which are sensitive to the needs of young people;
- physicians, nurses and other health care personnel can deliver prevention messages to their young (and old) clients.

**Recommendation:** The private sector has a responsibility to offer its expertise in research, campaign design, and media production to improve our society's HIV prevention efforts. Government and the private sector must work together in a manner that enhances our ability to gain in-depth understanding of young peoples' knowledge, attitudes and values. Churches, local TV stations, supermarkets and other businesses, can all play a role in more effective HIV prevention.

### **Invisibility on the airwaves**

Social marketers are beginning to develop bold new television and radio spots to reach young people. Condom manufacturers are moving towards more visible advertising (though they have historically avoided associating their product with gays or STD prevention). Self-imposed restrictions by broadcasters — not laws — stand in the way of more HIV prevention programming reaching a broad television audience. The 1996 Kaiser survey on Americans and HIV/AIDS found broad support for condom visibility on television. Seventy-two percent of those interviewed said the major TV networks should accept condom ads, while 63% agreed that television should have more references to condoms.<sup>139</sup> All the major television networks (except Fox TV) have policies banning condom advertising except in public service announcements that emphasize disease prevention rather than pregnancy prevention. On the local level, 70% of station managers responding to a Harris poll said they believed contraceptive commercials would offend many people.<sup>140</sup>

Innovative HIV prevention television spots targeted to high-risk populations fall victim to an apparent double standard for public service advertisements. Broadcasters have few reservations about airing the aggressive antidrug messages offered by the Partnership for a Drug Free America. TV networks, bus companies, and other media outlets have donated *over \$2 billion* worth of public service advertising space to the Partnership. But ads that talk about sex — particularly those that address gays — have found far less success with placement.

When they launched their BBDO-designed "There's Life After Sex" campaign, AIDS Project Los Angeles found it was difficult to place many of their gay-youth-oriented television spots before midnight, though they had greater success with TV cable affiliates and with radio spots. APLA was informed that their next series of ads, focusing on women, would likely find more and better free placements because they were more "mainstream."<sup>141</sup> Even the CDC had difficulty convincing some local TV stations to air the complete set of *Respect Yourself, Protect Yourself* ads.<sup>142</sup>

**Recommendation:** Local television stations and national networks should remove their restrictions on television condom advertising. Community-based HIV prevention organizations, working with public health leaders, should pressure local and national television producers to air HIV prevention public service announcements that are appropriate to the many populations affected by the epidemic. Network producers and writers must make a concerted effort to integrate more condom and safer sex messages into popular television shows which reach youth.

## **THE RESEARCH COMMUNITY**

### **Gaps in programming and research**

Another major shortfall in HIV prevention for young people is the lack of programming and research on some of the populations that are most intensely affected by the epidemic. A 1993 study conducted by the US Conference of Mayors reported that, "Primary HIV prevention programs for adolescent males of color who have sex with other...males are virtually nonexistent in most cities..."<sup>143</sup> And behavioral researcher Barbara Marin noted in October 1995 that, "Research focusing on AIDS prevention among minority populations has lagged behind research on other groups, despite the high and worsening rate of HIV infection among Blacks and Latinos...Almost

no targeted work has been done with African-American or Latino gay men or drug users...”<sup>144</sup> Other researchers have noted the challenges of doing research on young gays and lesbians because of the difficulty of getting parental consent for such studies.<sup>145</sup>

A second challenge is to more closely link behavioral science research with prevention practice. Researchers and community based planners and providers of prevention often operate in very different environments, with conflicting definitions of what information sources are valid, and different vocabularies with which to express their ideas.<sup>146</sup> The CDC’s Prevention Community Planning (PCP) process is an opportunity to bring researchers and prevention practitioners closer together.

**Recommendation:** The National Institute of Mental Health, the CDC, private foundations, and other funders of behavioral and policy research must target sufficient resources to prevention research in those communities that are most affected by the HIV epidemic, including African-Americans, Latinos, and youth. The CDC and PCP technical assistance providers should continue to develop methods to assist local planning groups make use of behavioral science. CDC should also develop a mechanism to inform behavioral researchers about the PCP-identified deficits in HIV prevention research.

## REASSESSING GOALS

It’s hard to fight an infectious agent that is spread sexually when we are afraid to be honest about the realities of sexuality in the population. This is often the situation with the HIV epidemic among young people in America. To craft better prevention interventions, we need to consider promoting good sexual experiences in addition to offering the safety of “abstinence-only” or the promise of good health a decade in the future. To reach the subgroups at the center of the epidemic, we need to tailor our interventions to their needs rather than to the needs of adults. To give young people the information and tools they need, we must undo policy impediments created to appease a minority of the population. And, one to one, parents, teachers, and friends must be willing to talk honestly with young people about their sexual concerns and desires.

## NOTES

- 1 In this report, most decimals have been rounded.
- 2 Rosenberg, P., et al, "Declining Age at HIV Infection in the United States," letter in *New England Journal of Medicine*, March 17, 1994, vol. 330, p.789.
- 3 Centers for Disease Control and Prevention, "Adolescents and HIV/AIDS," fact sheet, Dec. 1995.
- 4 Quoted from press release, "National Cancer Institute Study Fact Sheet: New Study Refines Estimates of HIV in the United States: Reveals Sobering Trend for Young Americans," National Cancer Institute, Nov. 1995; based on the article, "Scope of the AIDS Epidemic in the United States," by Rosenberg, P, *Science*, Nov. 24, 1995, vol. 270, p. 1372-1375.
- 5 Committee on Prevention and Control of Sexually Transmitted Diseases, Institute of Medicine, The Hidden Epidemic: Confronting Sexually Transmitted Diseases, National Academy Press, Washington, D.C., 1996.
- 6 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in *Morbidity and Mortality Weekly Report*, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 8-19.
- 7 The Alan Guttmacher Institute, Sex and America's Teenagers, The Alan Guttmacher Institute, New York and Washington, D.C., 1994, p. 20.
- 8 Sexuality Information and Education Council of the United States, "Adolescence and Abstinence," Fact Sheet on SIECUS web site.
- 9 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in *Morbidity and Mortality Weekly Report*, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 64.
- 10 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in *Morbidity and Mortality Weekly Report*, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 67.
- 11 The Alan Guttmacher Institute, Sex and America's Teenagers, The Alan Guttmacher Institute, New York and Washington, D.C., 1994, p. 38.
- 12 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in *Morbidity And Mortality Weekly Report*, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 19.
- 13 Division of STD Prevention, "Sexually Transmitted Disease Surveillance, 1995," Centers for Disease Control and Prevention, Sept. 1996, Atlanta.
- 14 Jemmott, JB, Jemmott, LS, Fong, GT, "Reductions in HIV Risk-Associated Sexual Behaviors Among Black Male Adolescents: Effects Of An AIDS Prevention Intervention," *American Journal of Public Health*, March 1992, vol. 82, no 3, p. 372.
- 15 The average ten year lag between infection with HIV and development of clinical symptoms of AIDS makes it difficult to track the epidemic. AIDS cases are reported to the CDC, but they represent infections occurring approximately a decade before, not where the epidemic is today. To protect confidentiality, 22 states do not require reporting of HIV infection itself. Even if they did, the large number of individuals who are not tested until they become ill would make these figures of dubious value. Still, by looking at current AIDS reporting and comparing it with previous years, we can get a sense of where the epidemic is concentrated and where it is heading.
- 16 These and other epidemiological figures are from the Centers for Disease Control and Prevention, "HIV/AIDS Surveillance Report. U.S. HIV and AIDS Cases Reported Through June 1996," Centers for Disease Control and Prevention, midyear edition, 1996, vol. 8, no.1.
- 17 Kegeles, SM, Hays, RB, Coates, TJ, "The Mpowerment Project: A Community-Level HIV Prevention Intervention for Young Gay Men," *American Journal of Public Health*, August 1996, vol. 86, no 8, p.1129.

- 18 As in the previous table, these figures likely underrepresent the number of young women currently being infected annually.
- 19 Sugerman, ST, et al, "Acquired Immunodeficiency Syndrome and Adolescents," *American Journal of Diseases of Children*, April 1991, vol. 145, p. 431.
- 20 Centers for Disease Control and Prevention, "HIV/AIDS Surveillance Report. U.S. HIV and AIDS Cases Reported Through June 1996," Centers for Disease Control and Prevention, midyear edition, 1996, vol. 8, no.1.
- 21 Greenland, S, et al., "Evidence For Recent Growth Of The HIV Epidemic Among African-American Men And Younger Male Cohorts in Los Angeles County," *Journal of AIDS and Human Retrovirology*, April 1, 1996, vol. 11, no. 4, p. 401-409.
- 22 McFarland, W, et al, "HIV Seroprevalence Among Young Men Who Have Sex with Men in the San Francisco Bay Area: The Young Men's Survey III," San Francisco Department of Public Health, Santa Clara Valley Health and Hospital Systems, Alameda County Health Care Services Agency, and Division of HIV/AIDS, Centers for Disease Control and Prevention, presented January, 1997.
- 23 The figures were: 0.52% among African-Americans, 0.09% among Latinas, and 0.07% in whites. From, Valleroy, L, et al, "HIV Seroprevalence Among Disadvantaged Out-of-School Young Women," HIV Infect Women Conf, Feb 22-24, 1995, S54.
- 24 Centers for Disease Control and Prevention, "Information for HIV Prevention Community Planning Groups (#2); HIV/AIDS Among Young Gay and Bisexual Men," fact sheet, Sept. 1995.
- 25 Holmberg, SD, "The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas," *American Journal of Public Health*, May 1996, vol. 86, no. 5, p. 650.
- 26 Valleroy, L, et al, "HIV Seroprevalence Among Disadvantaged Out-of-School Young Women," HIV Infect Women Conf, Feb 22-24,1995, S54.
- 27 Sweeney P, Lindegren ML, Buehler JW, Onorato IM, Janssen RS, "Teenagers At Risk Of Human Immunodeficiency Virus Type 1 Infection. Results From Seroprevalence Surveys In The United States," *Arch Pediatric Adolesc Med*, May 1995, vol. 149, no. 5, p. 521-8.
- 28 Sugerman, ST, et al, "Acquired Immunodeficiency Syndrome and Adolescents," *American Journal of Diseases of Children*, April 1991, vol. 145, p. 431. The military's epidemiological data are likely skewed lower because potential recruits know the military will not accept HIV positive personnel.
- 29 Kirby, D, "A Review of Educational Programs Designed to Reduce Sexual Risk-Taking Behaviors Among School-Aged Youth in the United States," ETR Associates, Aug. 5, 1996.
- 30 Quoted from, "National Cancer Institute Study Fact Sheet: New Study Refines Estimates of HIV in the United States: Reveals Sobering Trend for Young Americans," National Cancer Institute, Nov. 1995; based on the article, Rosenberg, P, "Scope of the AIDS Epidemic in the United States," *Science*, Nov. 24, 1995, vol. 270, p. 1372-1375.
- 31 Mann, J, Tarantola, D, *AIDS in the World II*, Oxford University Press, 1996, p. 464.
- 32 Center for Substance Abuse Prevention, "Resilience/Protective Factors," fact sheet from CSAP web site.
- 33 McFarland, W, et al, "HIV Seroprevalence Among Young Men Who Have Sex with Men in the San Francisco Bay Area: The Young Men's Survey III," San Francisco Department of Public Health, Santa Clara Valley Health and Hospital Systems, Alameda County Health Care Services Agency, and Division of HIV/AIDS, Centers for Disease Control and Prevention, presented January, 1997.
- 34 Lemp, GF, "Seroprevalence of HIV and Risk Behaviors Among Young Homosexual and Bisexual Men," *Journal of the American Medical Association*, Aug. 10, 1994, vol. 272, no.6, p.453.
- 35 A.H. Grossman has written that, for gay people, "Having to cope with a disparaging and oppressive society creates unique stressors and developmental variations in identity development that are cofactors for HIV infection and disease," in, "Homophobia: A Cofactor Of HIV Disease

- In Gay And Lesbian Youth,” *Journal of the Association of Nurses in AIDS Care*, Jan-Feb 1994, vol. 5, no. 1, p. 39-43.
- 36 Remafedi, G., “Male Homosexuality: The Adolescent’s Perspective,” *Pediatrics*, 1987, vol. 79, p. 326-330, quoted in SIECUS, “Adolescence and Abstinence,” Fact sheet on web site.
- 37 Savin-Williams RC, “Verbal and Physical Abuse as Stressors in the Lives of Lesbian, Gay Male and Bisexual Youths: Associations with School Problems, Running Away, Substance Abuse, Prostitution and Suicide,” *Journal of Consulting Clinical Psychology*, 1994; vol. 62, p. 261-269; quoted in, Advocates for Youth, “Adolescent Males: Sexual Attitudes and Behavior,” fact sheet, Advocates for Youth, Washington, D.C. , Aug. 1995.
- 38 Communication Sciences Group, Results of Phase Two Formative Research in Phoenix, Arizona, Oct. 10, 1995, p. 6.
- 39 Blatner Associates Inc., Audience Research for HIV Prevention Planning, Newark, 1996, p. 33.
- 40 Romer, D, Kim, S, “Health Interventions for African-American and Latino Youth: The Potential Role of Mass Media,” *Health Education Quarterly*, May 1995, vol. 22, no 2, p. 176.
- 41 Peterson, JL, “High-Risk Sexual Behavior and Condom Use among Gay and Bisexual African-American Men,” *American Journal of Public Health*, Nov 1992, vol.82, no.11, p. 1490.
- 42 Center for Substance Abuse Prevention, “Risk Factors,” fact sheet from CSAP web site.
- 43 Susan Tucker Sugerman found that 19% of runaway and homeless youth at a shelter in Houston, Texas had practiced sex work. Sugerman, ST, “Acquired Immunodeficiency Syndrome and Adolescents,” *American Journal of Diseases of Children*, April 1991, vol 145, p. 431.
- 44 Athey, JG, “Emotionally Disturbed Adolescents and AIDS: An Introduction,” in Woodruff, JO., ed., Troubled Adolescents and HIV Infection, CASSP Technical Assistance Center, Georgetown University Child Development Center, Washington, D.C., October 1989, p. 5.
- 45 Kaiser Family Foundation, “The 1996 Kaiser Family Foundation Survey on Teens And Sex: What They Say Teens Today Need to Know, And Who They Listen To,” Kaiser Family Foundation, Menlo Park, CA, June 1996, p. 14.
- 46 Roper Starch, Teens Talk About Sex: Adolescent Sexuality in the 90’s: A Survey of High School Students, commissioned by Rolanda in association with Sexuality Information And Education Council Of The United States, p. 6.
- 47 Eyre, SL, (UCSF), and, Millstein, SG, “What Leads to Sex? Adolescent Preferred Partners and Reasons for Sex,” in press.
- 48 Centers for Disease Control and Prevention, “Contraceptive Method and Condom Use Among Women at Risk for HIV Infection and Other Sexually Transmitted Diseases — Selected US Sites, 1993-1994,” *Morbidity And Mortality Weekly Report*, Sept 27, 1996.
- 49 Hays, RB, Kegeles, SM, Coates, TJ, “High HIV Risk-Taking Among Young Gay Men,” *AIDS*, 1990, vol. 4, no. 9, p. 905.
- 50 Kegeles, SM, Hays, RB, Coates, TJ, “The Mpowerment Project: A Community-Level HIV Prevention Intervention for Young Gay Men,” *American Journal of Public Health*, August 1996, vol. 86, no 8, p.1135. The researchers reported that 44.7% of those in the study self-reported unprotected anal intercourse with a boyfriend after the intervention (p.1133).
- 51 McFarland, W, et al, “HIV Seroprevalence Among Young Men Who Have Sex with Men in the San Francisco Bay Area: The Young Men’s Survey III,” San Francisco Department of Public Health, Santa Clara Valley Health and Hospital Systems, Alameda County Health Care Services agency, and Division of HIV/AIDS, Centers for Disease Control and Prevention, presented January, 1997.
- 52 Sugerman, ST, et al, “Acquired Immunodeficiency Syndrome and Adolescents,” *American Journal of Diseases of Children*, April 1991, vol. 145, p. 433.
- 53 St. Lawrence, JS, “African-American Adolescents’ Knowledge, Health-Related Attitudes, Sexual Behavior, and Contraceptive Decisions: Implications for the Prevention of Adolescent HIV Infection,” *Journal of Consulting and Clinical Psychology*, 1993, vol. 61, no.1, p. 108.
- 54 Stall, Ron, “A Comparison of Younger and Older Gay Men’s HIV Risk-Taking Behaviors: The Communication Technologies 1989 Cross-Sectional Survey,” *Journal of AIDS*, 1992, vol. 5, p. 682-687.

- 55 DiClemente, RJ, "Psychosocial Determinants of Condom Use Among Adolescents," in DiClemente, RJ, ed, Adolescents and AIDS, Sage Publications, Newbury Park, 1992, p. 48.
- 56 Advocates for Youth, "Adolescent Pregnancy and Childbearing," Fact Sheet, Advocates for Youth, March 1996, quoting from, Facts at a Glance. Washington, D.C.: Child Trends, 1996; and, Males M. "School-age Pregnancy: Why Hasn't Prevention Worked?" *Journal of School Health*, 1993; vol. 63, p.429-432.
- 57 Communication Sciences Group, Results of Phase Two Formative Research in Phoenix, Arizona, Oct. 10, 1995, p.22.
- 58 Quoted in press release from the Centers for Disease Control and Prevention, "New CDC Data on Youth HIV/AIDS Risk: Wide Range of Prevention Messages Needed," issued by CDC Press Office, July 9, 1996; abstract at International AIDS Conference, Vancouver: Miller, K, et al, "Sexual Involvement with Older Men: HIV Related Risk Factors for Adolescent Women."
- 59 In an abstract presented at the 1996 International AIDS Conference, Julie Fraser argues that educational campaigns need to address "power differentials between men and women...Helping redefine trust in relationships, promoting men's responsibility, and placing greater emphasis on specific knowledge gaps....should also be considered." Fraser, JM, et al, "Re-Creating Risk: Youth and Adolescent's Constructions of Safe Sex," abstract presented at International AIDS Conference, Vancouver, July 1996.
- 60 Kaiser Family Foundation, "The 1996 Kaiser Family Foundation Survey on Teens and Sex: What They Say Teens Today Need to Know, And Who They Listen To," Kaiser Family Foundation, Menlo Park, CA, June 1996, p. 15.
- 61 Kaiser Family Foundation, "Emerging Issues in Reproductive Health," Fact Sheet, June 24, 1996.
- 62 Males , MA, The Scapegoat Generation: America's war on adolescents, Common Courage Press, 1996.
- 63 Lemp, GF, "Seroprevalence of HIV and Risk Behaviors Among Young Homosexual and Bisexual Men," *Journal of the American Medical Association*, Aug. 10, 1994, vol. 272, no.6, p. 453.
- 64 Advocates for Youth, "Adolescent Males: Sexual Attitudes and Behavior," Fact Sheet, Advocates for Youth, Washington, D.C., August 1995; quoting, Zierler, S, et al, "Adult Survivors of Childhood Sexual Abuse and Subsequent Risk of HIV Infection," *American Journal of Public Health*, 1991; vol. 81, p. 572-575.
- 65 Jinich, S, et al, "The Effect of Childhood Sexual Abuse on HIV Risk-Taking Behavior Among Gay and Bisexual Men," in press, Fall, 1996.
- 66 DiClemente, RJ, "Psychosocial Determinants of Condom Use Among Adolescents," in DiClemente, RJ, ed, Adolescents and AIDS, Sage Publications, Newbury Park, 1992, p. 36.
- 67 In another study of high-risk female minority adolescents in urban areas, Overby and Kegeles found that "discussion with their partner about actual risk and awareness of the importance of past behaviors was generally lacking." Overby, KJ, Kegeles, SM, "The Impact of AIDS on an Urban Population of High-Risk Female Minority Adolescents: Implications for Intervention," *Journal of Adolescent Health*, May 1994, vol. 15, no. 3, p. 216-27.
- 68 DiClemente, RJ, "Psychosocial Determinants of Condom Use Among Adolescents," in DiClemente, RJ, ed, Adolescents and AIDS, Sage Publications, Newbury Park, 1992, p. 46.
- 69 DiClemente RJ, et al, "African-American Adolescents Residing in High-Risk Urban Environments Do Use Condoms: Correlates and Predictors of Condom Use Among Adolescents in Public Housing Developments," *Pediatrics*, Aug 1996, vol. 98, p. 269-78.
- 70 DiClemente RJ, et al, "African-American Adolescents Residing in High-Risk Urban Environments Do Use Condoms: Correlates and Predictors of Condom Use Among Adolescents in Public Housing Developments," *Pediatrics*, Aug. 1996, vol. 98, p. 269-78.
- 71 *USA Today*, Oct. 22, 1996, p.1D.
- 72 St. Lawrence, JS, "African-American Adolescents' Knowledge, Health-Related Attitudes, Sexual Behavior, and Contraceptive Decisions: Implications for the Prevention of Adolescent HIV Infection," *Journal of Consulting and Clinical Psychology*, 1993, vol. 61, no.1, p. 105.

- 73 Lemp, GF, "Seroprevalence of HIV and Risk Behaviors Among Young Homosexual and Bisexual Men," *Journal of the American Medical Association*, Aug. 10, 1994, vol. 272, no.6, p.453; also see Communication Sciences Group, Results of Phase Two Formative Research in Phoenix, Arizona, Oct. 10, 1995, p. 19.
- 74 Lowy, E, Ross, MW, "'It'll Never Happen to Me': Gay Men's Beliefs, Perceptions and Folk Constructions of Sexual Risk," *AIDS Education and Prevention*, 1994, vol. 6, no. 6, p.467.
- 75 Overby, KJ, Kegeles, SM, "The Impact of AIDS on an Urban Population of High-Risk Female Minority Adolescents: Implications for Intervention," *Journal of Adolescent Health*, May 1994, vol. 15, no. 3, p. 216-27.
- 76 Miller, KS, et al, "Adolescent Sexual Experience: A New Typology," in press
- 77 Clark, LF, et al, "Confidence in HIV Risk Assessments as a Barrier to Adolescent Condom Use," International Conference on AIDS, Vancouver, July 1996.
- 78 McFarland, W, et al, "HIV Seroprevalence Among Young Men Who Have Sex with Men in the San Francisco Bay Area: The Young Men's Survey III," San Francisco Department of Public Health, Santa Clara Valley Health and Hospital Systems, Alameda County Health Care Services agency, and Division of HIV/AIDS, Centers for Disease Control and Prevention, presented January, 1997.
- 79 AIDS Policy Center for Children, Youth and Families, "Position Statement: Youth and HIV Testing," AIDS Policy Center for Children, Youth and Families, Washington, D.C., April 1996, p. 2.
- 80 DiClemente, RJ, "Psychosocial Determinants of Condom Use Among Adolescents," in Adolescents and AIDS, DiClemente, RJ., ed, Sage Publications, Newbury Park, 1992, p. 38.
- 81 Hingson, R, Strunin, L, "Monitoring Adolescents' Response to the AIDS Epidemic: Changes in Knowledge, Attitudes, Beliefs, and Behaviors," in DiClemente, RJ., ed, Adolescents and AIDS, Sage Publications, Newbury Park, 1992, p. 24.
- 82 Stevenson, HC, et al, "HIV Prevention Beliefs Among Urban African-American Youth," *Journal of Adolescent Health*, April 1995, vol. 16, no. 4, p. 316-23.
- 83 Center for Substance Abuse Prevention, "AIDS," Prevention Primer, on CSAP world wide web site.
- 84 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in *Morbidity And Mortality Weekly Report*, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 67.
- 85 Lowy, E, Ross, MW, "'It'll Never Happen to Me': Gay Men's Beliefs, Perceptions and Folk Constructions of Sexual Risk," *AIDS Education and Prevention*, 1994, vol. 6, no. 6, p. 467-482, p.478.
- 86 Drug use was identified as a risk factor for seroconversion in the HIVNET Vaccine Preparedness Study among gay men. Buchbinder, SP., et al, "The Feasibility of Conducting Preventive HIV Vaccine Trials in Homosexual Men in the United States," *Journal of Infectious Diseases*, 1996, vol. 174, p. 954-961.
- 87 Hingson, R, Strunin, L, "Monitoring Adolescents' Response to the AIDS Epidemic: Changes in Knowledge, Attitudes, Beliefs, and Behaviors," in DiClemente, RJ, ed, Adolescents and AIDS, Sage Publications, Newbury Park, 1992, p.24.
- 88 Blatner Associates, Inc., Audience Research for HIV Prevention Planning, Newark, Centers for Disease Control and Prevention, 1996, p.xi
- 89 Horatio Alger Association, The Mood of American Youth, Horatio Alger Association, Virginia, 1996, p.51.
- 90 Reported condom use during last sexual encounter rose from 46% in 1989 to 54% in 1995..
- 91 "School-Based HIV-Prevention Education — United States, 1994," *Morbidity And Mortality Weekly Report*, Sept. 6, 1996.
- 92 Kaiser Family Foundation, "The 1996 Kaiser Family Foundation Survey on Teens And Sex: What They Say Teens Today Need to Know, And Who They Listen To," Kaiser Family Foundation, Menlo Park, CA, June 1996, p.7.

- 93 Kolata, G, "Experts Are at Odds on How Best to Tackle Rise in Teen-Agers' Drug Use," *New York Times*, Sept. 18, 1996, p. A17.
- 94 Ross, MW and Rosser, BRS, "Education and AIDS Risks: A Review," *Health Education Research*, 4, p. 273-284.
- 95 Choi, K, Coates, TJ, "Prevention of HIV Infection," *AIDS*, 1994, vol 8, no 10, pgs. 1380, 1384.
- 96 Coates, T, and Greenblatt, R., "Behavioral Change Using Interventions At The Community Level," in Holmes, K, et al (Eds.) *Sexually Transmitted Diseases* (2nd ed.), 1990, New York: McGraw-Hill, p. 1075-1080; DiClemente, Ralph, "Confronting the Challenge of AIDS Among Adolescents, Directions for Future Research," *Journal of Adolescent Research*, 1993, vol. 8, no. 2, p. 156-166.
- 97 Office on AIDS, National Institute of Mental Health, and NIMH Consortium on HIV Prevention Research, "AIDS Prevention Strategies that Work: A Review of NIMH-Sponsored Research," 1995.
- 98 St. Lawrence, JS, et al, "Cognitive-Behavioral Intervention to Reduce African-American Adolescents' Risk for HIV Infection," *Journal of Consulting and Clinical Psychology*, 1995, vol. 63, no 2, p. 221-237.
- 99 For a discussion of cultural issues and HIV prevention in the African-American community see, "HIV/AIDS Education and Prevention Among African-Americans: A Focus on Culture," by Airhihenbuwa, CO., et al, *AIDS Education and Prevention*, 1992, vol. 4, no. 3, p. 267-276.
- 100 Hays, R, "What Are Young Gay Men's HIV Prevention Needs," Center for AIDS Prevention Studies, University of California, San Francisco, April 1995
- 101 Kirby, D, "A Review of Educational Programs Designed to Reduce Sexual Risk-Taking Behaviors Among School-Aged Youth in the United States," ETR Associates, Aug. 5, 1996.
- 102 Center for AIDS Prevention Studies, UCSF, "What Are Adolescents' HIV Prevention Needs?," Fact Sheet, Center for AIDS Prevention Studies, University of California, San Francisco, April 1995.
- 103 Rotheram-Borus, Mary Jane, "Reducing HIV Sexual Risk Behaviors Among Runaway Adolescents," *Journal of the American Medical Association*, Sept. 4, 1991, vol 266, no 9, p. 1237-1241.
- 104 Hingson, R, Strunin, L, "Monitoring Adolescents' Response to the AIDS Epidemic: Changes in Knowledge, Attitudes, Beliefs and Behaviors," in DiClemente, RJ, ed, *Adolescents and AIDS*, Sage Publications, Newbury Park, 1992, p.24.
- 105 Academy for Educational Development, "Use of a Theory-Based Semi-Structured Elicitation Questionnaire to Explore Determinants of Consistent Condom Use," *AIDS Prevention: Lessons Without Borders*, flier.
- 106 St. Lawrence, JS, "African-American Adolescents' Knowledge, Health Related Attitudes, Sexual Behavior, and Contraceptive Decisions: Implications for the Prevention of Adolescent HIV Infection," *Journal of Consulting and Clinical Psychology*, 1993, vol. 61, no. 1, p. 110.
- 107 Kirby, D, et al, "School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness," *Public Health Reports*, May-June 1994, vol 109, no 3, p. 354.
- 108 McNeal, JU, *Kids as Customers*, New York: Lexington Books, 1992.
- 109 Transcript of All Things Considered broadcast, Sept. 7, 1996.
- 110 Blair, J, "PSI/Project ACTION: Impact on Teen Risk Reduction," Population Services International, Washington, D.C., August 1995.
- 111 Rubin, AM, "Using Pop Culture to Fight Teen Violence," *The Chronicle of Higher Education*, July 21, 1995.
- 112 Motivational Educational Entertainment, *The MEE Report: Reaching the Hip-Hop Generation*, MEE Productions, Inc., Philadelphia, PA.
- 113 From a National School Boards Association study, reported in, Applebome, P, "Survey Finds Cautious Mood In School Board Members," *New York Times*, Jan. 12, 1997, p.A11.
- 114 Donovan, P, *Risk and Responsibility: Teaching Sex Education in America's Schools Today* (New York: The Alan Guttmacher Institute, 1989), quoted in SIECUS, "Guidelines for Comprehensive Sexuality Education," fact sheet on SIECUS web site.

- 115 Kaiser Family Foundation, "The Kaiser Survey on Americans and AIDS/HIV," March 1996, p.9.
- 116 Sexuality Information And Education Council Of The United States, "Sexuality Education in the Schools: Issues and Answers," Fact sheet on web site.
- 117 Kirby, D, "A Review of Educational Programs Designed to Reduce Sexual Risk-Taking Behaviors Among School-Aged Youth in the United States," ETR Associates, Aug. 5, 1996, p. 36.
- 118 Centers for Disease Control and Prevention, "Facts About...HIV Prevention Messages for Young Adults," December 1995.
- 119 Sexuality Information And Education Council Of The United States, "Adolescence and Abstinence," Fact sheet on web site.
- 120 Sexuality Information And Education Council Of The United States, "Sexuality Education in the Schools: Issues and Answers," Fact sheet on web site.
- 121 American Social Health Association, "ASHA Poll: Most NC Voters Favor Condom Education in Schools," *STD News*, American Social Health Association, Fall 1996.
- 122 Sexuality Information And Education Council Of The United States, "Sexuality Education in the Schools: Issues and Answers," Fact sheet
- 123 Sexuality Information And Education Council Of The United States, "Adolescence and Abstinence," Fact sheet on web site.
- 124 Center for Substance Abuse Prevention, "Gay, Lesbian and Bisexual Youth/Adults," Prevention Primer on web cite.
- 125 Roper Organization, Inc, "AIDS: Public Attitudes And Education Needs," New York, 1991; quoted in Kirby, D, et al, "School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness," *Public Health Reports*, May-June 1994, vol 109, no 3, p. 341.
- 126 Kaiser Family Foundation, "The Kaiser Survey on Americans and AIDS/HIV," March 1996, p. 10.
- 127 Wren, CS, "Youths Confide Buying Drugs as Easy as Beer," *New York Times*, Sept. 10, 1996.
- 128 Kirby, DB, Brown, NL, "Condom Availability Programs in U.S. Schools," in *Family Planning Perspectives*, September/October 1996, p.196.
- 129 Advocates for Youth, "School Condom Availability," fact sheet, May 1995.
- 130 "A Resurgence for Condoms?," *Supermarket Business*, August, 1996, p. 74.
- 131 Kaiser Family Foundation, "The 1996 Kaiser Family Foundation Survey on Teens And Sex: What They Say Teens Today Need to Know, And Who They Listen To," Kaiser Family Foundation, Menlo Park, CA, June 1996, p. 6.
- 132 McFarland, W, et al, "HIV Seroprevalence Among Young Men Who Have Sex with Men in the San Francisco Bay Area: The Young Men's Survey III," San Francisco Department of Public Health, Santa Clara Valley Health and Hospital Systems, Alameda County Health Care Services agency, and Division of HIV/AIDS, Centers for Disease Control and Prevention, presented January, 1997.
- 133 AIDS Policy Center for Children, Youth and Families, "Position Statement: Youth and HIV Testing," AIDS Policy Center for Children, Youth and Families, Washington, D.C., April 1996, p. 2-3.
- 134 Wolf, RC, et al "Enough Already: Reevaluating the Future of the U.S. Government's AIDS Awareness Campaign," poster presentation, International Conference on AIDS, Vancouver, 1996.
- 135 A study by Lynn Miller compared the self-identified goals of at-risk women with the key messages in HIV prevention media. It found that, "those goals mentioned most often in AIDS-prevention messages were not particularly relevant to high risk women." Miller, L, et al, "Selling Safer Sex: Do AIDS Messages Fit the Everyday Goals of High Risk Women?," International AIDS Conference, Vancouver, 1996.

- 136 Austin, EW, "Reaching Young Audiences," in Maiback, E and Parrott, RL, eds., Designing Health Messages: Approaches from Communication Theory and Public Health Practice, Sage Publications, 1995.
- 137 Bennett, A and Sharpe, A, "AIDS Fight Is Skewed By Federal Campaign Exaggerating Risks," *Wall Street Journal*, May 1, 1996, p. A-1, col.6
- 138 Lurie, P, Drucker, E, "An Opportunity Lost: Estimating the Number of HIV Infections Due to the US Failure to Adopt a National Needle Exchange Policy," presented at the International Conference on AIDS, Vancouver, 1996.
- 139 Kaiser Family Foundation, "The Kaiser Survey on Americans and AIDS/HIV," March 1996, p.10.
- 140 Kaiser Family Foundation, "Emerging Issues in Reproductive Health," fact sheet, June 24, 1996.
- 141 Based on conversation with Allen Carrier of AIDS Project Los Angeles; this experience is consistent with that of Dana Van Gorder and David Weisman when they requested air time for HIV prevention spots on network affiliates in the San Francisco Bay Area.
- 142 Based on conversation with Centers for Disease Control and Prevention staff.
- 143 Quoted in, "Information for HIV Prevention Community Planning Groups, #2, HIV/AIDS Among Young Gay and Bisexual Men," Centers for Disease Control and Prevention, September 1995.
- 144 "Minority Groups And Young Gay Men Have High And Worsening Rates Of HIV; Prevention Research Is Lacking, Say UCSF Researchers In New Report," news release from Center for AIDS Prevention Studies, UCSF, Oct. 5, 1996.
- 145 Based on personal conversation with Susan Kegeles, a researcher at the Center for AIDS Prevention Studies, University of California, San Francisco.
- 146 Collins, C, and Franks, P, "Improving the Use of Behavioral Research in the CDC's HIV Prevention Community Planning Process," monograph published by the Center for AIDS Prevention Studies, University of California, San Francisco, July 1996.