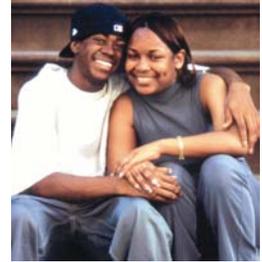


HIV Prevention for Young People in Developing Countries: Report of a Technical Meeting



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The Institute for Youth Development (IYD) is a nonpartisan, nonprofit organization that promotes a comprehensive risk avoidance message to youth for five harmful risk behaviors that are inextricably linked: alcohol, drugs, sex, tobacco, and violence. IYD believes that children and teens, provided with consistent and sound messages, are capable of making positive choices to avoid these risk behaviors altogether, especially if they are empowered by strong parent and family connections.

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Introduction

On July 24, 2003, the U.S. Agency for International Development (USAID), the Institute for Youth Development, and YouthNet/Family Health International cosponsored a technical meeting in Washington, DC called “HIV Prevention for Young People in Developing Countries.” Approximately 150 HIV/AIDS, reproductive health, and youth development experts from a diversity of organizations and backgrounds participated. The meeting consisted of plenary presentations followed by question-and-answer sessions, a youth panel, eight smaller “breakout” discussion groups on specific topics, and a wrap-up and synthesis session.

Dr. Nancy Williamson, director of the YouthNet program, introduced the day, explaining the dual objectives of the meeting: to share state-of-the-art research and programmatic experiences relating to HIV prevention among young people, and to provide an opportunity for dialogue across groups from different academic disciplines and philosophical perspectives on strategies for HIV prevention among youth.

Dr. Anne Peterson, assistant administrator for the USAID Bureau of Global Health, gave a brief backdrop to the scope of the problem: 12 million young people under age 25 infected with HIV. Young people are the key to HIV/AIDS prevention, she said, and the unprecedented attention U.S. President George W. Bush has given this global public health issue offers opportunities to strengthen HIV prevention programs for youth. USAID has moved from an emphasis on condoms to a new, more balanced “ABC” approach – combining **A**bstinence, **B**eing faithful or partner reduction, and **C**ondom use. She said she appreciated having so many faith-based organizations at the meeting, since both her personal view as well as that of the administration is that efforts to combat the epidemic cannot succeed without the involvement of these groups.

Shepherd Smith, president of the Institute for Youth Development, put the issue of HIV/AIDS for young people in the broader context of youth avoiding involvement in five types of risky behavior: alcohol, drugs, sex, tobacco, and violence. The earlier a young person participates in any of these behaviors, the more negative the outcomes, he said. The goal is to help young people develop the skills to make better decisions and avoid those risky behaviors.

This report summarizes the presentations and discussions at the meeting. All of the plenary presenters used PowerPoint slides, which are available on-line through YouthNet at: www.fhi.org/en/Youth/YouthNet/NewsEvents/HIVprevenmeeting.htm; USAID at: http://www.usaid.gov/pop_health/aids/News/conferences.html, and the Institute for Youth Development at: www.youthdevelopment.org. Please refer to these slides, especially for quantitative data.

Session I: Should Youth Be a High Priority for HIV Programming?

This session addressed contextual factors, including the extent to which AIDS affects young people and the major influences on youth behaviors, with particular attention to cultural factors. Dr. Ward Cates of Family Health International introduced the three presentations and guided the discussions.

Patterns of HIV Prevalence and Risky Behaviors among Youth

Dr. Roeland Monasch, UNICEF

Dr. Monasch noted that his presentation would draw heavily on the UNICEF report, “HIV and Young People: Opportunity in Crisis.” He began by describing both global and country patterns of HIV prevalence among youth, reminding the audience that 42 million persons worldwide are currently living with HIV. Comprehensive interventions, he said, could avoid 29 million new infections in the near future. Targeting adolescents ages 13 to 19 is clearly the “window of opportunity” to slow the spread of the HIV/AIDS pandemic because of the current low rate of infection in that age group.

Dr. Monasch noted a frequently cited statistic: one-half of new HIV infections worldwide occur in youth ages 15 to 24. Girls are especially vulnerable to infection because of biological and social reasons. Biologically, their immature reproductive tracts are susceptible to viral infection, and girls’ low social status throughout much of the developing world leaves them vulnerable to coercion by both older men and boys their own age.

Different kinds of HIV epidemics have young people at their center. *Generalized* epidemics spread HIV in the population at large through heterosexual transmission. For example, in Swaziland, from 1992 to 2002, the prevalence of HIV infection increased from 4 percent to 46 percent among pregnant women 20 to 24 years old. *Concentrated* epidemics spread HIV throughout a specific population, usually groups engaging in high-risk behaviors. In Russia, the reported number of new HIV infections among adolescents who inject drugs increased from 333 in 1998 to almost 10,000 in 2000. Another example of a concentrated epidemic is found in Myanmar (Burma), where two of every three sex workers are women ages 15 to 24; the HIV infection rate among sex workers is 40 percent.

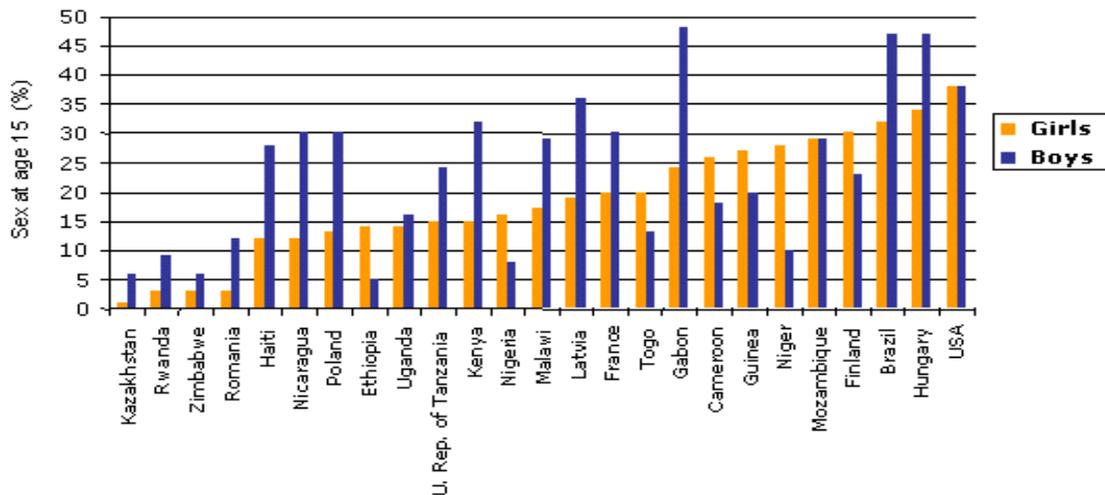
While many adolescents have heard of HIV, most are still unaware of how to protect themselves from the virus. Many also harbor serious misconceptions about HIV and their own personal risk. Whether willingly or through coercion, most people begin sexual activity during adolescence. Those adolescents who initiate sexual activity the earliest have the greatest risk of HIV infection due to biological immaturity, a sense of invincibility, and an increased length of time between sexual initiation and marriage, when they are more likely to have multiple sexual partners. Younger, sexually active adolescents are also less likely to use condoms. In the KwaZulu Natal region of South Africa, almost 90 percent of sexually active 14-year-old girls did not use condoms at first sexual intercourse. Finally, the presence of other sexually transmitted infections (STIs)

also increases the likelihood of HIV infection; while STI infection rates are high among young people, few seek treatment for STIs.

Prevention efforts can work, as evidenced by young people in Thailand, Cambodia, Senegal, Zambia, and Uganda. In Cambodia, HIV prevalence among sex workers younger than age 20 decreased from 41 percent in 1998 to 19 percent in 2002. In Kampala, Uganda, HIV among young pregnant women ages 20 to 24 decreased from 35 percent in 1990 to 7 percent in 2001. Reports of abstinence increased sharply in Uganda from 1988 to 2000, with 66 percent of 15- to 17-year-olds reporting they were not sexually experienced in 2000, compared to 50 percent in 1988. Condom use increased in Uganda; 53 percent of 15- to 17-year-olds reported using a condom the last time they had sex, compared to 27 percent in 1988.

Young people are the greatest hope in the struggle against HIV/AIDS, concluded Dr. Monasch. The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) set a goal in 2000: by 2005, reduce HIV by 25 percent among young people in the most affected countries. Yet with current intervention efforts, HIV levels will remain the same or will likely increase in many countries by 2005. Dr. Monasch showed preliminary findings from modeling exercises suggesting that major increases in investments in youth prevention programs could result in significant reductions in HIV prevalence.

Table 1. Percent of Youth Having Sex before Age 15



DHS, 1998-2001; Health Behaviour in School-aged Children Surveys (HBSC), 1998.

Adolescent Development and Risk and Protective Factors for HIV

Dr. Robert Blum, University of Minnesota

Dr. Blum reported findings from the study he is conducting for the World Health Organization (WHO) on risk and resilience in adolescent sexual and reproductive health (ASRH). The analysis drew from a number of databases including Medline, Popline, and the WHO library. More than 11,000 relevant articles published after 1990 were identified, which focused on young people ages 10 to 24 in developed and developing countries and used multivariate analysis to identify risk and protective factors. Dr. Blum noted that the world of young people today is very different from that of their parents, with many new influences on behavior, including mass communication, the Internet, television, and radio. And, this is the first generation to grow up in a world with AIDS.

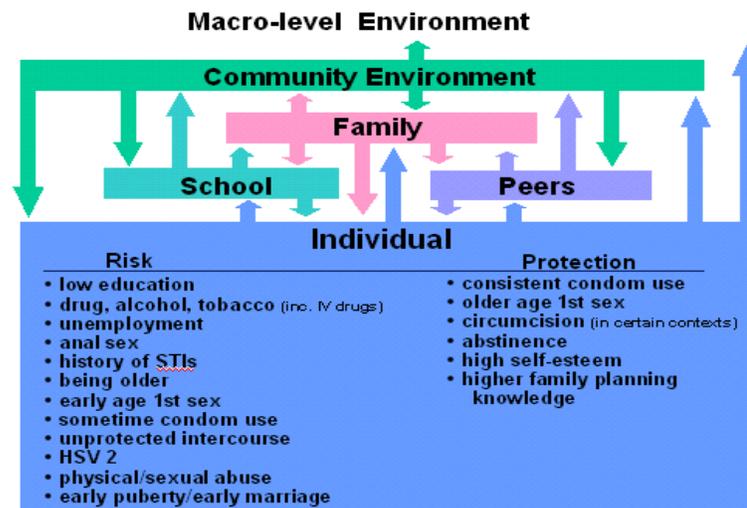
Risk and protective factors for sexual initiation, number of sexual partners, HIV infection, pregnancy, condom use, and related issues were identified at the community, family, peer, school, and individual level. All of these factors interact in the context of political realities, economic issues, and historical events.

- *Community level.* Risk factors included single-parent households, child-headed households, rural to urban migration, and percent unemployed. Protective factors included rural residence and receiving family planning from a health care provider.
- *Family level.* Risk factors were: mother opposed to contraception, a non-nuclear family structure, frequent conflict between parents, low education of father or mother, the death of the mother, and not living with parents. Protective factors consisted of living with parents, the interest of the mother in schooling, education of the mother, higher income, mother or mother-in-law discussing family planning, husband approving of contraception, parents exerting behavioral control, and parental connectedness. Dr. Blum noted at this juncture that there were cultural differences in the role of discussion as a protective factor; in some cases dialogue increases risk behavior.
- *Peers and partners* often have great influence over the behavior of young people. However, Dr. Blum noted that the *perception* of peer behavior is especially powerful in influencing the decisions made by young people. Risk factors included having multiple sexual partners, sex with prostitutes, greater number of lifetime partners, and friends using drugs or alcohol. Protective factors were being engaged to be married, having a boyfriend who approved of contraception, and perceiving that peers use contraceptives.
- *School environment.* Risk factors were school failure and attention deficit hyperactivity disorder. The protective factors were attending family life education (FLE) programs, having higher educational aspirations, completing secondary school or higher, attending school regularly, and school connectedness. Overall, young people performing poorly at school were often at higher risk. Dr. Blum

noted in some cases school was a source of vulnerability, as some young women in Africa may be at risk of sexual exploitation by male teachers.

- *Individual level.* Risk factors were low education, unemployment, anal intercourse, history of STIs, being older, early age at first sex, inconsistent condom use, unprotected intercourse, physical or sexual abuse, early puberty, early marriage, and drug/alcohol/tobacco use. The protective factors were consistent condom use, older age at first sex, circumcision, abstinence, high self-esteem, and sound knowledge of family planning.

Figure 1. An Ecological Model of Resilience



Dr. Blum then discussed a study in the Caribbean that identified risk and protective factors associated with early sexual debut, lifetime sexual partners, condom use, and pregnancy. Consistent risk factors included rage, skipping school, and physical or sexual abuse. Consistent protective factors were family connectedness, religion or religiosity, and school connectedness. Dr. Blum presented a series of matrices of risk and protective factors, which clearly indicated school connectedness was the strongest variable in predicting sexual risk-taking.

Consistent protective factors for ASRH risk behaviors were family, school, partners and beliefs. Connectedness to parents was found to be crucial as a protective factor, including parental expectations regarding school completion, age at marriage, and sexual behaviors. Protective factors associated with schools included: feelings of school connectedness, FLE education, academic performance, number of years of education, and the safety of the school environment. Protective factors related to partners include expectations of partners, low number of lifetime partners, support for contraception and condoms, and fidelity. At the level of the individual, beliefs were central as protective factors, especially the belief that condoms and contraception work, the belief that peers

contracept, and the idea that one has control over one's own sexual and reproductive future.

Cross-Cultural Issues in HIV Prevention Messages for Youth

Patricia Ware, U.S. Department of Health and Human Services, and Martin Ssempe, Makerere University, Uganda

Ware introduced the idea of culture, shared personal experiences about the importance of culture, suggested criteria for how culture affects program development, and asked Martin Ssempe of Uganda to share several specific examples from his experience. Ware explained that culture intersects with various types of agencies and assistance programs. While cultural traditions are essential to understand, it is important to connect and feel committed to others regardless of background, she said.

She described culture as the shared values, norms, traditions, customs, arts, history, folklore, music and institutions of a group of people. Values from a group can offer mutual support and trusting relationships, which help people to be able to succeed, to be rewarded and praised, and to have a promising future. A connection to one's culture can help a person take advantage of opportunities as they arise. At the same time, understanding differences in culture is important for those working in programs to develop shared values with the potential "clients" involved. To be culturally competent is to understand and appreciate cultural differences while avoiding stereotypes.

Ssempe gave several examples to illustrate the themes Ware had discussed. For example, he discussed the word "like," which could have multiple meanings in a Ugandan context, including romantic love and "let's have sex." When a well-meaning western counselor had suggested to young people that they communicate more openly about their feelings and tell someone if they like them, the word "like" led to many misunderstandings because of the multiple possible meanings. A general theme that is important to keep in mind about culture is the illusion created by urbanization. Young people may appear to be living in a global context, with access to television and other international influences. However, as Ssempe quipped, "You can take the African out of the village, but you can't take the village out of the African." Traditional cultural roots run very deep.

Discussion

Several audience members raised issues regarding the data reported by Dr. Monasch, for example, the complexities of measuring the prevalence of coerced sex and differences between data from focus groups and population-based surveys. One participant expressed caution about the widely used figure of 50 percent of new infections being among youth, especially since relatively few males are infected between ages 15 to 24. While many countries in Africa may have such an infection pattern, this observer reads the data to show a global figure closer to 35 percent or 40 percent of new infections among youth. This figure may need more scrutiny, as it has come to be used widely based on United Nations reports.

Several questions related to the risk and protective factors discussed by Dr. Blum. Programs tend to focus more on risk factors, it was pointed out. How can we focus more

on protective factors such as school retention? Regarding HIV orphans who lack the key protective factor of at least one parent, it is important to build connections to other caring adult mentors, said Blum.

Several questioned how programs might move toward the ABC approach. One thought that more emphasis on “B” (being faithful) was needed. Another asked whether faith-based groups in Uganda, which currently focus only on A (abstinence) and B are required to add C (condoms) in order to access USAID and other donor agency funds. Finally, regarding cultural competence, one audience member emphasized the importance of a paradigm shift from “helping” to “empowering” people.

Session II: What Do We Know about Preventing Risk-Taking among Youth?

This session addressed issues of behavior change in the general youth population as well as a discussion about reaching high-risk youth. Anita Smith of the Institute for Youth Development introduced the two presentations and guided the discussions.

Changing Youth Behavior: Findings from U.S. and Developing Country Research

Dr. Douglas Kirby, ETR Associates

Dr. Kirby introduced his presentation with a quotation: “We should be dedicated to the lives of young people, not our own ideologies.” He stressed the need to base our decisions regarding youth on research and data. In his presentation, he responded to three questions: 1) Can individual programs have a significant impact on A, B, and C? 2) Is it possible to have a countrywide impact on A, B, and C? 3) Did these changes in A, B, and C significantly affect important reproductive health outcomes? Using data from the United States and developing countries, Dr. Kirby shared evidence that led him to answer yes to all three of his questions. Lastly, he discussed the topic of “disinhibition” or the belief that increasing one protective behavior reduces perceived risk, subsequently increasing a different risk behavior.

Reproductive health and HIV/AIDS education programs for adolescents have demonstrated impact on A, B, and C. In a preliminary reanalysis of sex and HIV education programs in developing countries, many of which were reviewed in the FOCUS on Young Adults end of program report, Dr. Kirby found significant outcomes. Some programs targeted A, B, and C, while others targeted only one or two of these approaches. Nine studies were designed to delay sexual initiation, and two of them resulted in a delay in first sex. Five studies sought to decrease the number of sexual partners, and two were successful at this B goal. And, of five studies seeking to increase condom use, two showed increased condom use among sexually active youth. Dr. Kirby’s analysis of U.S. sex and HIV education programs, summarized in *Emerging Answers*, yielded similar findings. About one-third of the 28 programs designed to increase age of sexual initiation achieved this goal. Similarly, three out of 10 programs that aimed to decrease the number of sexual partners and 10 of 18 programs that sought to increase condom use were successful in doing so.

Regarding countrywide impact, Dr. Kirby summarized what has happened in Uganda, based on a review of survey data and his own recent visit to Uganda, where he interviewed various key informants.

He concluded that multisectoral interventions in Uganda during the late 1980s and 1990s demonstrated a countrywide impact on A, B, and C, contributing to sharp declines in HIV infection rates. In the late 1980s, A and especially B primarily contributed to the decline, while in the 1990s, C also contributed.

Table 2. The Number of Programs with Different Effects on Sexual and Contraceptive Behaviors

	Sex & HIV Education Programs in U.S.	Sex & HIV Education Programs In Developing World**
Initiation of Sex		
• Delayed initiation	9	2
• Had no sig. impact	18	7
• Hastened initiation	1	0
Total	28	9
Frequency of Sex		
• Decreased frequency	5	1
• Had no sig. impact	13	0
• Increased frequency	1	0
Total	19	1
No. of Sexual Partners		
• Decreased number	3	2
• Had no sig. impact	7	3
• Increased number	0	0
Total	10	5
Use of Condoms		
• Increased use	10	2
• Had no sig. impact	8	3
• Decreased use	0	0
Total	18	5
Use of Contraception		
• Increased use	4	1
• Had no sig. impact	7	2
• Decreased use	0	0
Total	11	3

** These are preliminary numbers that will be updated shortly.

In the United States, Kirby pointed out that programs to promote A and C have contributed to improvements in A, B, and C, and in turn contributed to a steady decrease in pregnancy rates among 15- to 19-year-olds. To reduce high STI rates, there should be greater emphasis on B. The data in Uganda and the United States indicate that programs addressing A, B, and C can affect key reproductive health indicators, answering Dr. Kirby's third question.

Regarding disinhibition, Dr. Kirby addressed whether programs designed to improve only A, B, or C might have a negative effect on the other goals. Specifically, does reducing the number of sexual partners and increasing the length of each relationship (focus on B) reduce the use of condoms? He found the answer to be yes in both the United States and Uganda. Young adults are less likely to use condoms after having sex multiple times with the same partner. In the case of condom or contraceptive disinhibition, results from the United States show that modest programs that emphasize abstinence while encouraging and even facilitating condom or contraceptive use did not increase sexual behavior. However, when contraceptives became much more widely available to young people in the United States in the 1970s, sexual activity significantly increased. Known as the “sexual revolution,” this phenomenon also was a case of contraceptive disinhibition. Similarly, when condoms became more widely available in Uganda, some people used condoms to reduce risk of HIV instead of avoiding sex – that is, C led to less A and B. Consequently, disinhibition should be addressed and accurately measured rather than ignored, denied, or overstated.

He concluded that policies and programs should encourage A, B, and C, not just one or two of the approaches; that programs should give young adults a balanced, accurate message; that it is not a question of either/or but that all three need to be promoted; and that programs should try to prevent promotion of one approach (A, B, or C) from undercutting promotion of the others.

Working with High-Risk Youth: Lessons from Program Experience

Dr. Arletty Pinel, Global Fund to Fight AIDS, Tuberculosis, and Malaria

Dr. Pinel opened her presentation with a challenging question for the audience: Do we tell the truth as young people experience it or as we want it to be?

When working with high-risk youth to prevent HIV infection, this question is especially pertinent. The reality is that some youth are engaging in high-risk behaviors – i.e., injecting drug use (IDU), commercial sex work, and unprotected sexual activity – but programmers often are not considering these populations when designing programs to prevent HIV infection. At-risk youth have multiple needs and require comprehensive programmatic approaches, not isolated interventions.

For example, adolescents who engage in commercial sex work may also tend to engage in behaviors such as drug use or other activities that also put them at risk for HIV. In Svetlogorsk, Belarus, 62 percent of IDUs were found to be HIV positive in 2000. More than one-third of the HIV-positive population in Argentina injects drugs. In order to prevent HIV infection in high-risk youth, programmers need to be accepting, realistic, and make services readily available to youth.

The primary focus of programming for HIV prevention in youth is often on heterosexual transmission within premarital relationships, although there are other significant modes of transmission. These include boys or young men who have sex with men, transactional sex, sexual coercion and violence, sex trafficking, and early marriage. Unfortunately, youth do not fall into neat categories when it comes to HIV prevention; all of these types

of transmission require careful prevention planning. Mother-to-child transmission complicates the picture as well. There are young people growing up who were born with HIV and now have sexual and reproductive health needs of their own.

Programs should also focus on those youth who are living with HIV/AIDS and promote acceptance of their status. HIV-positive youth face both stigma and discrimination and require access to treatment, care, support, and prevention in order to keep themselves healthy and prevent the spread of the virus to others.

Few data exist on high-risk youth and HIV infection. When data are collected, persons involved in the study are often grouped into two age brackets: 0 to 14 years, and 15 to 49 years. Clearly, a 16-year-old has different reproductive health needs than a man of 47 years, yet statistically they are often grouped together. Also, most of the information reported focuses on program process, rather than on impact. Changes in the way in which information is recorded and reported will help identify ways to improve programs for high-risk youth.

Other factors that distort HIV prevention programming include: programs that neglect to incorporate knowledge of cultural factors that determine vulnerabilities; program planners who perceive vulnerabilities through their own personal, professional, and ethnic biases; programs that limit prevention to intermittent communication activities without addressing contextual issues; programs that dissociate HIV prevention and care; and programs that artificially separate sexual and nonsexual risks.

Currently, most programs rely upon condoms, voluntary counseling and testing, and access to antiretroviral treatment. While these methods are what adult professionals believe are the essential elements of HIV/AIDS programming, they may not be what young people need. Youth know how to identify and express their needs, but programs are often planned from adult perspectives. Sometimes youth are consulted, but rarely are they involved in prevention programs.

Because HIV/AIDS is here to stay, Dr. Pinel concluded, HIV/AIDS programming for high-risk youth ought to start looking at the world from the perspectives of young people. Successful HIV/AIDS programming for youth requires that we address their long-term needs in a more comprehensive way and that we treat young people with the same understanding, support, and love that we would give to our own children.

Discussion

The questions and responses from the panel focused on three main areas, with other miscellaneous comments. Several audience members went back to an issue from the first session: the theme of assertiveness of females in terms of girls in Uganda and cross-cultural sensitivity. One person was interested in findings about the impact of any projects that led to females being more assertive with males. Another participant pointed out the importance of changes in norms among both males and females, that “gender” did not refer only to females.

Questions about designing messages for youth focused on the role of fear, which Dr. Kirby mentioned as a potentially motivating factor. Early in the AIDS epidemic, fear was often used as part of AIDS awareness campaigns, but this approach lost the support of many who thought that the emphasis should be on positive motivations. One speaker contrasted fear as a primal emotion with risk perception as a cognitive process. Another argued that fear is a continuum: Extreme fear may lead to paralysis or hopelessness while more moderate fear may lead to behavior change.

Dr. Blum said that while fear may be a short-term motivator, no evidence suggests that fear leads to behavior change. Dr. Kirby responded that fear can be a motivator if combined with a positive message. A related question was the point Dr. Kirby made that the most effective sex education programs had a clear message. The concern was raised that given the great diversity of young people, various types of messages are required. Dr. Kirby agreed that programs need to target messages by age and other appropriate characteristics. But, within a segmented audience, a clear, directive message has more impact, according to research, he said.

Several participants discussed issues related to condoms. One asked if there is evidence that social marketing programs work. Another responded that a recent study suggests there is no evidence that wide-scale condom distribution through social marketing programs has been effective in bringing down HIV infection rates. A third person emphasized that condom social marketing has worked to make condoms more widely available where public-sector distribution is weak. Condom marketing targeted at high-risk groups has also worked to reduce HIV prevalence in concentrated epidemics, such as Thailand.

Youth Panel: Perspectives on HIV

Arie Passov, YouthNet

Lan Tsubata, WAIT program

Neema Mbonela, YouthNet

Sun Gil Taylor, WAIT program

Shanti Conly, USAID/Office of HIV/AIDS, introduced the four panel members and guided the questions and discussion. Each of the young panel members spoke briefly of their personal experiences regarding HIV and why they are involved in this area. This was an informal discussion with no slides or PowerPoint presentations.

Arie Passov, a YouthNet summer intern, is a medical student in Estonia. He first learned about HIV through a poster with a danger-type symbol that his brother put on his bedroom wall when he was a kid, then learned more in high school years, and then as a medical student, saw the virus spread through selected populations – specifically injecting drug users and the Russian-speaking minority in his country. He has seen how the epidemic is beginning to cross into the general population in Estonia and wants to continue working on HIV issues as a doctor.

Lan Tsubata introduced herself as being part of Washington AIDS International Teens, or “the WAIT team.” WAIT is a subproject of a parent organization, the Washington AIDS International Foundation. She explained that WAIT uses skits, plays, dancing, and drama to help educate peers on how HIV infects the body, how best to protect and prevent HIV infection, and the importance of getting tested. WAIT team members often give testimonials of their own virginity and vows to remain abstinent. The members act as a support group to reinforce these choices.

Neema Mbonela, a YouthNet summer intern from Tanzania, now in college in the United States, described the strong taboo against talking about sex in her country. Those who are sexually active lack any support system, as it goes against the stated values of many families. She got involved with AIDS as a volunteer at an AIDS orphanage while at boarding school in Kenya. She began to see the impact the disease has on many levels. One major issue is intergenerational sex, with so-called “sugar daddies” exchanging school fees and other income for sex with teenage girls. She sees HIV/AIDS among young people linked closely with livelihood and income issues.

Sun Taylor of the WAIT team described how the group uses performing arts in the Washington, DC schools. He shares with other students his choice to remain abstinent and why he has made this choice. There is nothing cool about getting HIV, he said; HIV is nothing to play around with. HIV is a lifestyle decision. Instead of choosing that lifestyle, kids can choose to do positive things. Guys have an extra responsibility because girls are more at risk. Having the support of the WAIT team helps him to remain abstinent.

Discussion

The questions from the audience and discussion addressed motivations for youth regarding sexuality and HIV prevention, the ABC approach, when to start prevention education, and the issue of role models. Several panel members mentioned fear as a motivation for recognizing the problem. Mbonela pointed out that the ABC message might work in Tanzania, but it is important to recognize that targeting an abstinence message to people 22 years old who are sexually active will not work. One of the questioners pointed out that because of taboos around sexuality, young people conceal their sexual activity and often do not get the support they need. Addressing a question about when prevention education should start, Tsubata said that the earlier the better. She added that faith-based organizations have an opportunity to provide prevention messages based on a message of love. The panel responded to comments about hard-to-reach groups. Youth who are not in school are of particular concern, as well as minority groups, such as the Russian-speaking minority in Estonia.

Session III: Sharing Strategies for HIV Prevention among Youth

This session included eight breakout groups with co-facilitators. After the discussion, a facilitator for each group reported priority discussion points to the full conference plenary. Below are the key points shared with the plenary, together with a summary of the supporting discussion.

1. Incorporating Positive Youth Development into Youth HIV Prevention

Co-facilitators: Shepherd Smith and Dr. Robert Blum

- **The benefits of positive youth development go far beyond preventing youth from becoming infected with HIV.** Youth development programs should be inclusive and comprehensive, designed to build on the assets and strengths of young people and to assist them in defining goals, completing school, and planning their futures. Positive youth development can affect whether a young person uses drugs, for example, as well as influence behaviors that can lead to HIV infection. The group also recognized the need for youth to know there is hope for their future. One particularly important protective factor for positive youth development is the connectedness of youth to school, demonstrated by research in many countries.
- **Replicating successful models needs more attention and effort.** The group recognized the need to include positive youth development efforts as part of broader prevention programs, beyond HIV prevention. Where successful models exist, more attention to replication is needed. When seeking to expand successful models, faith-based organizations have much to offer in HIV prevention for youth.
- **Political leadership can contribute to helping youth in many ways.** Leadership is important for youth in communities, in full partnership with families, schools, faith-based groups, advocates, and grassroots organizations. This leadership provides positive role models and promotes positive messages. It can also help expand universal education opportunities and support for other protective factors.

2. Programming to Delay First Sex and Promote Abstinence

Co-facilitators: Gale Grant and Elizabeth Serlemitos

- **Broad family life education programs are essential.** FLE programs should start early because many of the factors associated with the delay of sexual initiation – such as good self-esteem and positive parental relationships – need to be developed early in childhood. These programs need to go beyond biology to emphasize life skills, building not only the skills to refuse sex or negotiate for contraceptive use but also the skills to build relationships and increase self-esteem.
- **Comprehensive support systems from peers, family, and community help in delaying first sex and promoting abstinence.** Social support systems are essential in

providing choices and maintaining behavior. Peer norms often contribute to early sexual initiation, as in Jamaica, where a climate of homophobia and other factors lead young men to feel pressured by friends and even parents into early sexual activity. In such cases, it is necessary to create a climate in which it is acceptable to delay first sex or abstain. The community should offer healthy alternatives to sex, providing opportunities for young people to develop meaningful relationships with partners and peers, to develop talents and skills, and to have fun.

- **Violence and coercive sex affects programming.** Regardless of the individual decision to abstain or delay first sex, violent or coercive sex, including economic, transactional, and transgenerational sex, is a reality. In some cultures, messages of abstinence need to be targeted to adults and policy-makers to help prevent transgenerational or coercive sex.
- **A dialogue for consensus and consistency in terminology is needed.** There is a need to bring together individuals across diverse backgrounds and organizations to agree on standard definitions of terms such as “abstinence” and “sexually active.”
- **Listening to youth within their own cultural context is important.** To effectively promote abstinence and delay first sex, the cultural context must be considered, including understandings and definitions of concepts such as sexuality, femininity, masculinity, and gender roles.

3. Mobilizing Faith Networks for Youth HIV Prevention

Co-facilitators: Shirley Oliver-Miller and Jerry Thacker

- **Education about the role faith-based organizations can play is needed.** Faith-based organizations, an untapped resource for the secular community, typically have an established infrastructure and the ability to reach people at the community level. Faith-based venues can provide a supportive, empowering community setting for youth. U.S.-based faith groups and religious leadership need to be catalysts in getting communities and youth involved in issues of adolescent reproductive health and HIV/AIDS. A dialogue must take place between the secular community and faith-based groups to identify common ground in this area. The secular community needs to respect the identity and integrity of faith groups. Honest compromises must be made to create comprehensive prevention messages. Education for both groups should evolve from this dialogue, and secular groups need to understand the elements of spirituality that faith groups include in viewing sex and sexuality.
- **Obtaining financial resources is a large obstacle for many faith groups; they need funding to expand from care and support programs to prevention.** Traditionally, faith groups have focused on care and support, but they need to be more involved in prevention as well, especially with youth. Funding is a key element in mobilizing faith groups. Many faith-based organizations have the human support and volunteers to participate in programming but need donor assistance to intensify their involvement.

- **Building collaboration and finding common ground are critical in mobilizing faith-based groups.** Once faith groups become engaged in adolescent reproductive health and HIV/AIDS, the faith and public health groups should strive to complement each other's prevention efforts. While different groups retain their distinct identities, interfaith alliances also need to be formed. Sensitive curricula need to be developed that support and use religious texts to talk about sex with youth. Youth within faith communities need to be involved in all aspects of program planning.

4. Best Practices in Curriculum-Based Prevention Programs

Facilitator: Dr. Douglas Kirby

- **The quality of training and supervision of educators needs to be strengthened.** Teachers need to believe in what they are saying and the messages that they are putting across in order for the programs to be effective. Teachers need support and training to provide clear messages.
- **Curricula should provide for participation and support of parents.** Some participants thought improvements are needed in parent-child dialogue about sex. An effective way is to assign homework questions relating to sex and give parents the chance to answer the questions. Some participants felt that young adults prefer to talk to their parents about sex rather than peers; thus it is important to provide parents with the information and skills they need to have an effective dialogue with their children. However, others felt that young people, especially in their earlier teens, still feel uncomfortable discussing sexuality with parents.
- **Services need to be linked among schools, parents, and communities.** Effective programs give a clear message, focus on behavior change, and use health theories to address risk and protective factors. Everyone agreed that for a curriculum to be effective, it must have the support of the community and other stakeholders. Ideally, it would also be linked to youth-friendly services and other out-of-school activities.

5. Using Media to Change Social Norms among Youth

Co-facilitators: Dr. Jane Bertrand and Juliette Davis

- **Coordination among agencies is necessary.** There is a need not only to avoid conflicting messages but also to increase the overall impact of a campaign. This outcome can best be achieved through coordination at the agency level.
- **The target population and key stakeholders should be involved in message development.** The most effective campaigns know their target audience and involve them in developing the campaign. However, given the necessity to balance youth needs with community norms, input from both youth and adult stakeholders are needed for an acceptable end product.
- **It is key to segment youth audiences.** Often youth are perceived inaccurately to be a homogeneous group. The group stressed the need to segment youth beyond age and sex; examples included in- and out-of-school and married and unmarried adolescents.

- **When developing messages, programmers need to weigh short-term gains versus long-term consequences.** In the context of social marketing, where the short-term goal is often to sell condoms, messages may have negative long-term consequences. An example is when advertising portrays men using their brand of condoms as more manly or experienced, which propagates a negative gender norm. For long-term impact, strategic messages need to contribute to positive norms.
- **Media can be used to stimulate community dialogue.** The group recognized that media is best used to affect knowledge and attitudes of a specific target group. However, these changes not only occur individually but also as a group. Media can fuel community discussions about sensitive and important issues.
- **It is important to integrate media into multi-level interventions.** To achieve behavior change, media needs to be coordinated with other interventions, such as counseling and other direct contact.

6. Increasing Consistent Condom Use Among Youth

Co-facilitators: Jeffrey Spieler and Nomi Fuchs

- **Condom programs need to work within the ABC approach.** We cannot deal with condoms in isolation from the other messages of abstinence and being faithful. All three components of the ABC message must be emphasized and there should be no undermining of any one message. All three have legitimacy. A recent Zimbabwe study of young people showed that while abstinence was being promoted as the best strategy by policy-makers and leaders, unmarried young people were concealing their condom use in order to avoid being stigmatized. Abstinence, being faithful, and condom use should not be viewed as mutually exclusive but as complementary strategies. Ways to make them more mutually supportive should be found.
- **Programming needs to look at social norms.** There is a need to create a social and policy environment that supports a range of risk reduction strategies, including condom use. More dialogue on issues of condom use and sexuality is needed among policy-makers, leaders, parents, and other groups.
- **Problems of accessibility and availability of condoms, including the role of stigma, need to be overcome.** Access to condoms is an important issue especially among youth, who may be discriminated against when seeking condoms. Condoms must be made accessible and available to youth.
- **Programs need to be appropriate by age and lifestyle.** Programming should be tailored to meet the needs of different age groups among youth. The needs and lifestyle of a 14-year-old are very different from that of a 19-year-old. Issues related to condom use and sexuality should be taught sensitively as differing views exist on whether condom use promotes greater promiscuity.

- **Social marketing is not enough.** Social marketing is not effective if promoted in isolation from a more comprehensive approach, including peer education, counseling, and other approaches. Undertaking this broader approach can help ensure that youth have access to condoms and the related information that they might need. At times, social marketing falls short of ensuring access and availability of condoms.
- **Political commitment and policies can provide a supportive environment and framework for action.** Uganda and Thailand illustrate the impact of political commitment. The campaigns in these two countries had a large impact and led to significant decreases in HIV/AIDS infection rates. Such generalized campaigns create an atmosphere where youth and adults can talk to each other about various issues surrounding HIV/AIDS and an environment that is more supportive of youth services.

7. Special Youth Issues in Voluntary Counseling and Testing (VCT)

Co-facilitators: Dr. Ann McCauley and Dr. Tiffany Hamm

- **Follow-up services need to be added to VCT services.** VCT involves pre-test counseling, the HIV test itself, followed by post-test counseling. Counselors are advised against simply testing their clients without giving them the necessary support that counseling provides. Post-test counseling ideally leads to a personal plan for safer behavior, but several participants with counseling experience expressed concern that behavior change is often short-lived and that the VCT services alone do not lead to a sustained change in behavior. A VCT counselor from Kenya raised the point that the anxiety and stress involved in being tested and waiting are part of the behavior change intervention but alone do not lead to persistent, long-term change. To promote more effective behavior change, it is necessary to provide on-going follow-up services including continued counseling and support. Several such services exist in Kenya and Haiti in the form of post-test clubs, although they are costly to operate and resource-intensive.
- **Parental consent needs attention.** A participant cited an example where young adolescent orphans cannot learn the outcome of their VCT tests because legal age of consent is 18 years and they have no one to provide parental consent. In Botswana, youth cannot get tested without parental consent until they are 21 years old, by which time about half of them are already HIV positive. The group agreed that parental consent policies need to be revised so that they facilitate health, and they identified a need to involve ministries of health to form and implement adequate policies. In several cases, guidelines exist that govern decisions to provide minors with treatment and services, and final decisions are left to the discretion of the service provider. Clear and consistent policies are needed that allow counselors and clinic staff to provide young people with the VCT services they need. Young people are often unwilling to approach parents with reproductive health and HIV concerns.
- **Creativity is needed regarding where VCT is provided.** Participants noted that a recent WHO meeting on VCT concluded that there is no perfect location for VCT services. Different locations appeal to different people. All VCT centers for youth must be staffed with youth-friendly counselors and arranged so that youth do not risk

being seen by an adult who knows them. The centers need to be conveniently located and open at times easily available to youth, i.e., after school hours. Appealing venues might be located near schools, sports facilities, and other such places frequented by young people.

8. Preventing Injecting Drug Use (IDU) among Youth

Co-facilitators: Dr. Gina Dallabetta and Dr. Jacqueline Lloyd

- **High-risk behaviors are interrelated. Interventions addressing broad risk and protective factors are important at multiple levels.** Youth using tobacco and alcohol are more likely to engage in a variety of other risky behaviors. We should address the primary risk factors among peers and families and try to strengthen protective factors.
- **The use of “gateway drugs” should be prevented.** In the majority of cases, the use of “gateway drugs” such a tobacco, alcohol, and marijuana commonly precede injecting drug abuse. These gateway drugs should be identified and their use discouraged.
- **Treatment programs and other services are needed for youth already using “gateway drugs.”** Injecting drug use prevention programs tend to target mainstream youth who are not engaging in risk behaviors, whereas youth already using tobacco, alcohol, and other gateway drugs often lack support and treatment options.
- **Gender differences in drug use need to be recognized.** Although statistically there are more male IDUs, female IDUs often experience greater stigma and have more difficulty accessing services.
- **IDUs and sex workers overlap, amplifying the risk of HIV infection.** A concentrated HIV epidemic has a tendency to become generalized, including through transmission to partners of IDUs and commercial sex workers.
- **The HIV epidemic is diverse, with injecting drug use a major problem in Asia and CIS/EE.** The HIV epidemic in Eastern Europe and the Commonwealth of Independent States is concentrated among injecting drug users. The issue of drug use should be more prominently included in HIV/AIDS conferences and addressed as part of a comprehensive response rather than an isolated issue.

Session IV: Country Case Studies in Reducing HIV Prevalence

This session focused on campaigns in Uganda and Zambia, each of which included more than one element from the ABC strategy. Shepherd Smith of the Institute for Youth Development introduced the two presentations and guided the discussions.

Promoting Healthy Behaviors among Young People in Uganda

Martin Ssempe, Makerere University, Uganda, and Edreda Bampata, Uganda Youth Forum

Ssempe spoke first, providing an overview of the HIV epidemic in Uganda and the factors that contributed to the drop in HIV infection rates from 18 percent in the mid 1990s to as low as 6 percent in 2000. The campaign emphasized abstinence and being faithful, with condoms for those who needed them. In a study in one community, the proportion of boys ages 13 to 16 reporting virginity rose from 40 percent in 1994 to 90 percent in 2001, he said. In the same study, girls of the same age group reporting virginity rose from 80 percent to 98 percent.

Factors contributing to the Uganda success included national leadership from President Museveni and his wife, information education and communication (IEC) materials (“Your next partner could be the very special one who gives you HIV/AIDS”), and cultural and religious teachings. Most tribes in Uganda strongly discourage promiscuity while rewarding virginity; similarly Christianity and Islam, the predominant religions in Uganda, also censure promiscuity. By incorporating faith and cultural solutions, the teachings of abstinence and marital fidelity gained vitality and credibility.

Community dramas and small discussion groups helped spread the messages about the mode of HIV/AIDS transmission, testing for HIV/AIDS, and the importance of delaying sexual activity, while debunking myths about AIDS. Ssempe raised the challenge of promoting condoms without promoting promiscuity. Consistent condom use in a relationship is associated with suspicion of risk within the relationship, and students at Makerere University reported using a condom the first one to three times with one partner but then stopping as trust builds. Ssempe felt condoms are a temporary solution while abstinence and marital faithfulness are long-term solutions.

The Ugandan experience shows the importance of involving national leadership, being open about the consequences of HIV/AIDS, incorporating culture and faith, and emphasizing the A and B parts of the ABC model, not just using condoms. Ssempe also noted behavior change is enhanced when large rallies or drama are followed by small groups or life skills discussions, and that youth need motivation for behavioral change. Ssempe said that the rates of HIV infection in Uganda have begun to rise, which he felt was due to more emphasis on condom promotion.

Edreda Bampata described the work of the Uganda Youth Forum (UYF), a project started in 1992 by Uganda First Lady Janet Museveni to address issues of HIV/AIDS, breakdown of family structure, unparented youth, changing culture and media, condoms and contraception, sex, drugs, alcohol, and street violence. The UYF has focused on

promoting the A and B of the ABC model, in particular the dignity and ability of human beings to choose, especially in making the choice to abstain. The UYF has promoted abstinence through First Lady youth conferences, positive parenting seminars and conferences, life skills and character education programs, training educators, community service projects, and abstinence support groups. More than 40,000 youth have signed “True Love Waits” cards committing themselves to sexual purity until marriage and faithfulness in marriage.

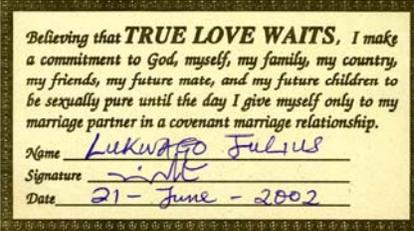
Abstinence Solution in Action

- ✓ First Lady’s Conferences
- ✓ Strong Family Conferences
- ✓ Life-skills Program
- ✓ Training Educators

- ✓ Character Education
- ✓ Community Service Projects
- ✓ Abstinence Support Groups/Clubs

Youth make commitment to ABSTAIN and sign TLW Cards

Over 40,000 have been signed.




*Julius and Fiona, recent graduates
—have been friends for now 5years
and they are abstaining*

In most cases, UYF uses face-to-face activities rather than the media. In school, children as early as age nine begin life skills programs, which emphasize the importance of involving young people. In promoting healthy behavior among young people, Bampata noted physical, emotional, mental, and spiritual needs must be considered, ensuring the health of the entire being. Youth must be treated as unique and handled appropriately. Youth also need positive role models to initiate positive change. Finally, Bampata feels that youth must hear a repeated message about faithfulness and abstinence for greater impact.

The HEART Campaign in Zambia

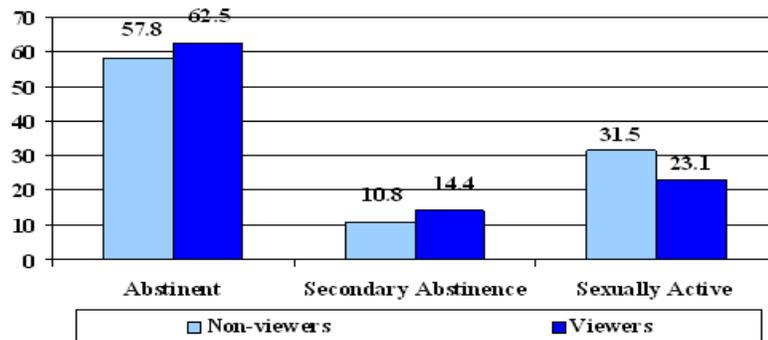
Elizabeth Serlemitsos, ZIHPCOMM

The HEART campaign – HEART stands for Helping Each Other Act Responsibly Together – involved partnerships among the Zambian Central Board of Health, USAID, Johns Hopkins University/Center for Communications Program, Population Services International/Society for Family Health, and a number of youth organizations coordinated by a Youth Advisory Group. The campaign emphasized youth involvement, segmentation of target audiences, focus on gender differences, collaboration among agencies to ensure

consistent messages, and a developmental approach to look holistically at the issues surrounding improved sexual health.

The majority of Zambian youth (84 percent) are sexually active by age 19. By the age of 14, 71 percent of boys and 34 percent of girls have had sex, according to a UNICEF study. In 1999, the government challenged the youth of Zambia to become more involved in HIV prevention programming for their peers. The social context of girls giving sex for love and boys giving love, or tangible representations of love, for sex, made it clear there was a need to change these cultural norms surrounding sex.

Figure 2. Sexual Activity Status of Female Respondents by Campaign Viewership



Taking the challenge, youth, in full-partnership with collaborating agencies, launched a national mass media campaign. Media was thought to be the most effective way to stimulate community dialogue about a taboo subject such as sex. Focusing on safer sex and abstinence, the campaign was designed to promote positive peer pressure and change community norms. The campaign promoted virginity, delayed sexual debut, and condoms. It recommended that youth abstain from sex or use condoms every time they had sex. These messages were then tailored to different target groups, in particular, young people who had not yet initiated sexual activity and those who had already engaged in sex. The campaign did not include a message about reducing the number of partners.

Results from the first two rounds of surveys in August 1999 and August 2000 show significant positive changes for a number of targeted outcomes for urban girls and boys. A significant number of both male and female viewers said they were more likely to use condoms, with female viewers being nearly twice as likely as female non-viewers (49 percent to 25 percent) to use condoms. Viewers were more likely to remain abstinent or to adopt “secondary abstinence” than non-viewers. Television, the primary medium, was found to be an effective way to reach urban Zambian youth.

Lessons and challenges emerged from the campaign. Segmenting girls and boys created difficulties. A piece targeting girls for condom use caused an outcry from the community and was pulled from the air. There was subsequent backlash from youth claiming they

were being denied their right to information. Serlemitsos credited the ability of young people to respond to their level of involvement, which created a sense of ownership of the campaign. Notably, this situation demonstrates the need to balance youth and adult stakeholder inputs during message development. Another recommendation was to ensure complementary messages and strategies among other groups implementing youth programs.

Discussion

Several participants raised issues related to abstinence and the value of delaying sex, such as the long-term result of having fewer lifetime partners. One audience member asked about other forms of sexual expression besides intercourse. Ssempe emphasized the need to plan healthy alternatives in the form of structured activities for youth at times when they might be more likely to engage in sex, such as Saturday nights. He thought this type of approach was better than encouraging other forms of sexual expression that might eventually lead to intercourse.

A young man from Kenya who counsels youth at a VCT center challenged Ssempe on his view that it was important to promote abstinence and delay regardless of the young person's experience. The Kenyan expressed his view that, as a professional counselor, his responsibility is to respond to the client's particular needs, without imposing his personal values or views. Ssempe responded that he felt it was important to promote abstinence among the groups with whom he works, explaining the magnitude of the impact of HIV/AIDS in Uganda and citing personal examples. Such experience results in being more directive in pointing young people toward what is truly safe, i.e., abstinence.

Wrap-Up, Synthesis, and Closing

Dr. Robert Blum of the University of Minnesota presented a wrap-up and synthesis of the day. Dr. Blum began by describing efforts at HIV prevention as inherently political. Among participants with diverse backgrounds, there will always be some disagreement. But the outcome of the day reflected far more convergence than discordance. Important points of agreement were:

- Protective and risk factors for youth are to a large extent consistent across cultures.
- Education and schooling protect youth from harm.
- Leadership makes a difference, such as the national leadership provided by the Ugandan president and first lady.
- Youth-adult relationships are important.
- Prevention does work, exemplified by Cambodia, Uganda, and Senegal.
- ABC does work, demonstrated in Uganda and the United States.
- ABC messages can successfully cohabitate.
- Messages need to be clear and consistent across sectors and funding streams.
- Interventions should be culturally appropriate, respect young people, make a commitment to the community, and involve the target audience.
- Providing hope for the future is important.
- Realistic, achievable opportunities for young people are essential.
- Adults need to provide caring, connectedness, behavioral monitoring, and skills training.

Dr. Blum concluded by echoing a sentiment of Dr. Pinel's presentation, asking if we were going to tell the youth their truth or our own. We know enough to avoid being trapped by our own biases. Yes, we can do better, but do we have the political will to do so?

Closing Remarks

Shanti Conly, Office of HIV/AIDS, USAID

Conly thanked the leadership and key staff at YouthNet and the Institute for Youth Development for putting together the conference.

Roxana Rogers, Office of HIV/AIDS, USAID

Rogers closed the meeting by highlighting the need to:

- Pay greater attention to primary prevention
- Develop a comprehensive approach to ABC
- Build on protective factors such as parents, faith-based organizations, and schools
- Change social norms that put young women at risk
- Provide access to condoms and information on the importance of partner reduction for sexually active young people

We need to let the data and evidence guide us, she said, and to keep an open mind about the most effective interventions. We should learn from Uganda's success, while recognizing that other countries may follow different pathways to address the epidemic. The meeting was an excellent opportunity to exchange ideas and to learn from each other, cutting across different disciplines and perspectives. It is time to bridge research and practice, and for those of us who are parents to go home to work on protective factors with our own kids!

Meeting Agenda

- 9:00 – 9:15 a.m. **Welcome and Introduction**
Nancy Williamson, YouthNet, Family Health International
Anne Peterson, Bureau for Global Health, USAID
Shepherd Smith, Institute for Youth Development
- 9:15 – 10:45 a.m.** **SESSION I: SHOULD YOUTH BE A HIGH PRIORITY FOR HIV PROGRAMMING?**
Moderator: Ward Cates, Family Health International
- 9:15 – 9:35 a.m. **Patterns of HIV Prevalence and Risky Behaviors among Youth**
Roeland Monasch, UNICEF
- 9:35 – 10:05 a.m. **Adolescent Development and Risk and Protective Factors for HIV**
Robert Blum, University of Minnesota
- 10:05 – 10:25 a.m. **Cross-Cultural Issues in HIV Prevention Messages for Youth**
Patricia Ware, Department of Health and Human Services
Martin Ssempe, Makerere University
- 10:25 – 10:45 a.m. **Discussion**
- 10:45 – 11:00 a.m. **Coffee Break**
- 11:00 – 12:15 p.m.** **SESSION II: WHAT DO WE KNOW ABOUT PREVENTING RISK-TAKING AMONG YOUTH?**
Moderator: Anita Smith, Institute for Youth Development
- 11:00 – 11:30 a.m. **Changing Youth Behaviors: Findings from U.S. and Developing Country Research**
Douglas Kirby, ETR Associates
- 11:30 – 11:50 a.m. **Working with High-Risk Youth: Lessons from Program Experience**
Arletty Pinel, Global Fund to Fight AIDS, Tuberculosis, and Malaria
- 11:50 – 12:15 p.m. **Discussion**
- 12:15 – 1:15 p.m. **Luncheon – Youth Panel: Perspectives on HIV Prevention**
Moderator: Shanti Conly, Office of HIV/AIDS, USAID
A panel of four young people offered their perspectives on HIV prevention.
- Arie Passov, YouthNet
Lan Tsubata, WAIT
Neema Mbonela, YouthNet
Sun Gil Taylor, WAIT

- 1:15 – 3:25 p.m.** **SESSION III: SHARING STRATEGIES FOR HIV PREVENTION AMONG YOUTH**
- 1:15 – 2:00 p.m. **Breakout Panels (Round 1):** Each group included two resource persons who briefly introduced the particular topic. Discussion focused on best practices based on research and program experience and on priority research questions and programmatic issues.
- **Incorporating Positive Youth Development into Youth HIV Prevention**
Co-facilitators: Shepherd Smith and Robert Blum
 - **Programming to Delay First Sex and Promote Abstinence**
Co-facilitators: Gale Grant and Elizabeth Serlemitsos
 - **Mobilizing Faith Networks for Youth HIV Prevention**
Co-facilitators: Shirley Oliver-Miller and Jerry Thacker
 - **Best Practices in Curriculum-based Prevention Programs**
Facilitator: Douglas Kirby
 - **Using Media to Change Social Norms among Youth**
Co-facilitators: Jane Bertrand and Juliette Davis
 - **Increasing Consistent Condom Use among Youth**
Co-facilitators: Jeffrey Spieler and Nomi Fuchs
 - **Special Youth Issues in Voluntary Counseling and Testing**
Co-facilitators: Ann McCauley and Tiffany Hamm
 - **Preventing Injecting Drug Use among Youth**
Co-facilitators: Gina Dallabetta and Jacqueline Lloyd
- 2:00 – 2:45 p.m. **Breakout Panels (Round 2):** Participants move to a second panel for an additional 45-minute session.
- 2:45 – 3:25 p.m. **Quick Reports from Breakout Panels:**
Promising practices, challenges, priority research questions
Facilitator: Jeffrey Spieler, Office of Population, USAID
- 3:25 – 3:40 p.m. **Coffee Break**
- 3:40 – 4:50 p.m.** **SESSION IV: COUNTRY CASE STUDIES IN REDUCING HIV PREVALENCE**
Chair: Shepherd Smith, Institute for Youth Development
- 3:40 – 4:10 p.m. **Promoting Healthy Behaviors among Young People in Uganda**
Martin Ssempe, Makerere University, and Edreda Bampata, Uganda Youth Forum
- 4:10 – 4:30 p.m. **The HEART Campaign in Zambia**

Elizabeth Serlemitos, ZIHPCOMM

4:30 – 4:50 p.m.

Discussion

4:50 – 5:05 p.m.

Wrap-Up and Synthesis

Robert Blum, University of Minnesota

5:05 – 5:15 p.m.

Closing Remarks

Shanti Conly, Office of HIV/AIDS, USAID

Roxana Rogers, Office of HIV/AIDS, USAID