On December 1, 1997 the President of the United States issued a directive on youth and HIV, encouraging the nation to focus attention on adolescents in the battle against AIDS and citing the statistic that one half of all new HIV infections occur in people under 25 years of age. This statistic—cited over and over in reports, brochures, and news stories—suggests that there is a monolithic youth epidemic and an effective prevention strategy to respond to it. But neither of these conclusions is true.

Who Is at Risk?

Everyone agrees that there are a large number of seropositive youth, but beyond this statement, the details become fuzzy. Different cities use different methods—seroprevalence studies or consensus figures that are the result of estimates from agencies serving youth—to determine the extent of the epidemic among a population, called “youth,” but defined inconsistently from study to study and agency to agency by different age ranges. Nationally, the Centers for Disease Control and Prevention (CDC) reports that more that 22,000 cases of AIDS have been diagnosed in youth ages 13 years old to 24 years old.

The only way to develop a true sense of the number of youth who are HIV-infected is through HIV antibody testing. But youth have not sought testing for several reasons, including a failure to perceive their vulnerability to HIV, inadequate access to testing, concerns about confidentiality, and a lack of understanding of the importance of counseling and testing. In addition, many youth report that test results are irrelevant to them, indicating that they do not know about early treatment options or do not believe they will have access to them if they test seropositive.

A standard part of HIV service planning has always been to identify people involved in high-risk behavior and to eliminate the risky behavior. These behavioral interventions have met with some success, for instance, lowering new infection rates among gay men in many localities. As an intervention for adolescents, however, this strategy is problematic.

Adolescence is a period marked by specific developmental tasks, including defining self, establishing new relationships, creating independence, and forging new support systems. It is a time of examination, rebellion, and change. By definition, adolescence is about risk-taking and experimentation,1 and it is important to acknowledge this factor in order to incorporate it into HIV intervention design.

But simply defining risk-taking as harmful has never worked to respond to the dangers it poses. We have “just said no” since the early 1980s, and adolescent substance abuse continues to escalate. We have encouraged sexual abstinence for more than a decade, and in most localities the rates of sexually transmitted diseases (STD) and HIV infection continue to grow. Instead, we need to understand the motivation for risk-taking behavior in order to make it easier to talk to young people about the consequences of their choices and about options that will meet developmental needs for experimentation in ways that reduce the likelihood of harm.

A Glossary of Subpopulations

The specific subpopulations of youth at risk for HIV mirror adult populations: gay and bisexural youth, drug-using youth, and...
youth of color. But, each of these subpopulations faces different risks and levels of risk. Young gay and bisexual men are at the top of the list. In San Francisco, the combined risk groups of young gay men and young gay male injection drug users account for more than 80 percent of the adolescent HIV cases.

Young gay and bisexual men have traditionally not accessed health care, mental health, or substance abuse services, and they often distrust the health care system. During adolescence, gay and bisexual youth seek to come to terms with their sexual orientation, grappling with whether and how to disclose to parents and others. For a young person who is coming out, health care systems, with their data forms and many questions, pose a major challenge, and studies indicate that issues of confidentiality are significant barriers to care for this population.²

It is particularly important to reach out to young gay men to introduce these youth to systems of primary care in supportive ways that respond to and nurture this fundamental process of identity formation. This approach has the added potential to prepare these youth for compliance with complex HIV prevention, testing, and treatment interventions.³ But, it is important to avoid sending the message that youth are important enough to get the attention of society only when they are ill.

Substance abuse among gay and bisexual youth is another major risk. Traditionally, limited opportunities for socialization have meant that gay youth congregate in bars and clubs where alcohol and "designer" drugs are common. In San Francisco, the use of methamphetamine (speed) is widespread. The preliminary results of a study of young injectors indicate that more than half of those seen in city clinics test positive for hepatitis C, possibly indicating risky needle sharing behavior. In addition, drugs such as ketamine (Special K), gamma-hydroxy-butyrate (GHB), and MDMA (Ecstasy), which gay youth in the "club culture" believe to be non-addictive, are widely used to enhance social and sexual encounters. But, these drugs also diminish the ability to make healthy decisions about sex.⁴

Risk through heterosexual contact is rapidly increasing among young women of color. A variety of programs deliver abstinence-only messages and seek to delay the onset of sexual activity. Teen pregnancy rates have been decreasing, yet Black teens still have babies at twice the rate of...
A hungry man is probably not interested in learning to fish, and theory tells us that learning cannot occur if the student is malnourished.

White (91.7 per 1000 versus 48.4 per 1000); Hispanic teens have the highest rates (101 per 1000). What programs overlook is that many young women get pregnant to satisfy the need for love, to leave a legacy, or to respond to other emotional and religious factors. Program planners might design interventions that seek ways to help young women fulfill these needs or at least understand that, in the long run, pregnancy alone will not fulfill these needs. Further, it does not make sense to identify as a risk group young women engaged in heterosexual activity without also targeting their male partners, who, despite the notion that these partners are being served by other program options, are not receiving HIV-related services.

Adolescence, a time of experimentation, movement towards independence, and growth, has always been a time for learning about alcohol and other drugs. The challenges of poverty, and domestic and community violence facing today’s youth lead many to self-medicate with substances that are readily accessible on the street in urban, suburban, and rural settings.

Yet, a review of local service directories reveals the glaring omission of adolescent substance abuse services. For example, in Boston there is currently no residential substance abuse program for adolescents, and in San Francisco there is only one. Treatment options limited to hospital detoxification, outpatient therapy, and community-based abstinence-only programs may not provide enough options to meet the specific needs of adolescents; residential stabilization may be useful and some type of supported housing is essential. The lack of treatment options is a serious problem not only because it fails to reduce adolescent substance use, but also because sobriety is often a requirement for youth who want to participate in other educational, social service, and health care programs. Youth who are clean and sober gain increased access to such programs and their benefits, and sobriety enhances the likelihood that young people will comply with commitments they make as participants in these programs.

Despite their obvious differences in risk and demographics, at-risk youth share one crucial characteristic: their goals and expectations often differ from those of adults who design and deliver programs and care for them. Frequently these differences shade all aspects of program design and implementation and can erect barriers to care that diminish motivation and the self-esteem necessary to remain healthy and make healthy choices.

For example, gay youth, beginning to think about and experiment with sex, get messages that amount to aversion therapy, telling them all the things they should not do or cannot do. For many of these young people, being gay is about sex, love, and intimacy. Portraying this emergence only as a series of risky, potentially harmful experiences is not only contradicted by their experiences, it is irrelevant to their lives and may be harmful to their psychological development. Similarly, teen mothers seeking love and stability in their young lives are told to wait, to abstain, and to finish their education. Life has already taught them plenty, and their plans may be much more compelling than the expectations prevention planners might establish for them.

Creating Partnership

HIV education and prevention efforts, generally designed by adults, are focused on the future. “If you do——, you will live longer.” “If you stop doing——, you will stay healthy.” How real are these messages for youth? In REALITY, a magazine by and for seropositive youth, editor Bill Barnes states that “For many HIV-positive youth the future is kinda not the first thing on our minds.” This statement is a powerful bit of information for those of us delivering services.

We tell young people not to do drugs and they will live longer, and we tell them not to have sex and they will have healthier futures. The fact is youth have always engaged in sex and have always experimented with alcohol and other drugs. As uncomfortable as this makes most adults, it is a reality. Youth do these things because they feel good, they satisfy a need, or they medicate a “problem.” Young people do these things because in the communities in which they live, they perceive these behaviors as their only options to respond to these goals.

If youth are doing drugs to battle hopelessness or having sex to bridge isolation or to shield themselves from violence, this information is crucial to HIV prevention efforts. These problems take precedence over the possible transmission of HIV and the eventual health implications of transmission. In order to reduce HIV
risk, prevention programs must address solutions to hopelessness, isolation, and violence. Criminalizing or forbidding behaviors that satisfy basic human needs will not reduce risky behaviors or the resulting HIV transmission.

In the sixties Bobby Kennedy used to quote an old proverb, “If you give a man a fish, he eats today; if you teach a man to fish, he can eat forever.” The fact is that a hungry man is probably not interested in learning to fish, and theory tells us that optimal learning cannot occur if the student is malnourished. We need to understand that the man is hungry and get him fed. Once we have indicated in this way that we understand his basic human need, he may engage with us in a conversation about future job training.

The programs that work best to educate young people about HIV prevention and to bring young people into care are those programs that are based on youth/adult partnerships. In the context of effective partnerships, adults listen respectfully to youth, and youth participate in goal-setting and outcome measurement. Such partnerships also require adults to speak honestly and clearly. Adults who lived through the 1960s have little credibility delivering “Just say no” or abstinence-only messages in the 1990s. However, adults can share the powerful knowledge that drugs and sex are, at best, temporary solutions to isolation and hopelessness, because this insight is based on experiences they share with youth.

Youth/adult partnerships also take advantage of the particular strengths of each partner. Young people have energy, passion, determination, and a hunger for knowledge. Adult providers have experience, technical knowledge, and concern. Effective partnerships will honor the struggles that are native to youth—to be individuals, to be independent, to do things in their own way—allowing for experimentation and growth, while informing these experiences with information and approaches that reduce harm.

A good place to begin the partnership, is with dialogue, as adults begin to share their histories of risk and adolescent struggle. Once the partners acknowledge common ground, this can form the platform on which to build programs, services, treatment options, and research studies that will interest youth and with which they might comply and from which they might benefit. The involvement of youth in program planning can also bring to planning agencies an energy and insight that may be unfamiliar and welcome.

**Conclusion**

Could it be that focusing on high-risk youth is too narrow a target? All youth are sexual, and bursting with new emotions (and hormones). Many young people experiment with drugs and alcohol. Many in our cities face violence and poverty. Many in rural and suburban areas face isolation and alienation. All youth deserve to be listened to and engaged. All youth deserve to have options from which to make the healthiest choices possible. In full partnership with caring adults, adolescents can develop programs that have the best chance of responding to their real needs and risks. In this enterprise, youth deserve the wisdom of adult experience, and adults need the passion and insight of youth.

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**Clearinghouse: Youth and HIV**

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**References**


While Latinos and Latinas have always been over-represented among people with HIV disease, they comprise almost a majority of HIV infections among teenagers. According to the San Francisco Department of Public Health AIDS Office, as of December 1997, 43 percent of AIDS cases among youth ages 13 to 19 were among Latinos or Latinas: 44 percent of these cases were Latino, and 33 percent were Latina. Facing language barriers, cultural taboos, or religious boundaries, Latino communities have lacked appropriate HIV information, making individuals easy targets for this disease.

Program Goals and Design
It is fitting, then, that a program designed to address this situation should come from a Latino-identified agency rather than from an HIV-identified organization. In the spring of 1997, the Mission Neighborhood Health Center (MNHC) in San Francisco developed and implemented a program focused on HIV, sexually transmitted disease (STD), and pregnancy prevention among Latino youth ages 13 to 18. The goals of the “Latinos en Extasis” program are to:

- Increase the perception of susceptibility to HIV infection, STDs, and pregnancy;
- Improve self-esteem;
- Improve communication skills for negotiating condom use and other birth control.

The youth-focused, peer intervention program is based on Diffusion of Innovation Theory (DIT). This type of intervention builds on the social influence of community leaders to change the socially acceptable norm for a given behavior. The theory suggests that information and learning flow through natural social networks: Latino youth are more likely to adopt new behaviors if these behaviors are introduced by someone who is similar to them in age and culture and is perceived to be a role model. Since peer norms are well-known to exert a particularly strong influence on adolescent behavior, peer education can be particularly effective in changing the sexual behavior associated with HIV and STD risk.

It is important to the program design for the teens to feel ownership of Latinos en Extasis. They named the program and selected the logo and slogan: “Felices sin riesgo” (Happy and risk free). Applying DIT, peer leaders seek to diffuse concepts related to the slogan to group members. After completing the four-session course, peer leaders assure further diffusion by asking participants to discuss these concepts with five other teens: friends, siblings, neighbors, relatives, or strangers. Participants are encouraged to integrate “risk free” into every day life, making it a “catch phrase” within their peer groups, an acknowledgment of pride about the decisions they and their peers are making.

When recruiting peer educators, program staff select teens who are perceived as leaders among youth. The peer educators who are chosen are outspoken, have good communication skills, and have a desire to give back to the community, to work with other teens, and to be community activists. Program staff go to high schools, community agencies, health fairs, and other community events. Peer leaders travel to other locations to attend conferences, workshops, and other events. A “catch phrase” that is repeated by the youth is “Fellaces sin riesgo” (Happy and risk free). The program is designed to make young people feel empowered and ready to face challenges.

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See also references cited in articles in this issue.
and street fairs, and conduct further street outreach. Currently, there are eight peer educators and two alternates (five men and five women), whose nationalities are as diverse as the city in which they live, including people born in: El Salvador, Mexico, Nicaragua, Peru, Puerto Rico, and the United States. Some of the peer educators are monolingual—speaking only Spanish—and some are bilingual.

Peer educator training includes education on HIV, STDs, reproductive anatomy, and health education. The training also emphasizes communication styles, creativity in facilitation skills, team building, how to address peer pressure around issues of sex, and program development.

**Filling and Leading Groups**

Peer educators recruit participants from the target population who reflect the diversity of the San Francisco Latino community. This includes people from different socioeconomic classes, with different education levels, and with different backgrounds: youth involved in gangs, youth from the gay, lesbian, bisexual, and transgender community, homeless youth, teen parents, and recent immigrants as well as second or third generation citizens. Teens participate in four weekly group discussions. The program repeats with new participants several times a year: during its first nine months, Latinos en Extasis completed four cycles of the course, a total of 16 groups.

Group leaders conduct each round of sessions at MNHC as part of the health center's Teen Clinic. (Recently, Latinos en Extasis ran a group at a community youth agency, and this experience has opened up the possibilities of offering groups at other community agencies and high school health centers.) The groups provide a safe and confidential environment to discuss HIV, STDs, and pregnancy, and related issues such as communication, negotiating skills, boundary settings, safer choices, sexuality, and prevention strategies.

While recruiting participants, and during their presentations, peer leaders are especially aware of the importance of establishing personal connections with group participants. Expressing friendliness, sincerity, and interest, they invite teens to attend the group at least once, and then lead the group through a pre-set agenda. Group leaders also share personal experience to establish common bonds with participants and to inspire trust.

The group curriculum was inspired by reducing the Risk by Richard Barth, who focuses on building skills to prevent HIV, STDs and pregnancy. It includes material on both abstinence and consistent and effective use of protection. The peer leaders utilize activities such as role-plays, dyads, and icebreakers to enhance participation among their group members. They adapt games to fit educational models: for example, in Pictionary, the participant is given a word or phrase related to health education and is asked to draw or, in some other creative way, communicate the concept. Peer leaders may also design games of their own, integrated into each session, ease the flow and help leaders when participants become unfocused.

**Conclusion**

Latinos en Extasis has made great strides. Many of the youth that have come to the groups have stated in their evaluations that they have enjoyed the groups because teens ran them and the groups were fun. They said they liked the interactive approach and games peer educators used to facilitate and educate the participants.

One of the peer educators shared her personal experience as a member of Latinos en Extasis: "I am a 16-year-old sophomore. I was born in Puerto Rico and moved to the United States when I was 8 years old. Latinos en Extasis has taught me many things. I have been able to gain information and pass it on to the teenagers who come to the groups. I have learned to communicate better with others and provide a safe environment by building a certain communication and trust. Our groups are unique and fun because we communicate HIV prevention education through games and activities. Latinos en Extasis is a great way to help others, and at the same time help yourself by learning from different people's experiences. This way we can live Felices Sin Riesgo."

**Correction**

An error in the March 1998 issue of *FOCUS* may have caused confusion regarding the authorship of both articles. "A Tale of Two Epidemics: HIV and Stimulant Use," is by Michael Gorman, PhD, MSW, a University of Washington research scientist and clinical social worker. The second article, "Stimulant Abuse Treatment and HIV," is by Michael D. Siever, PhD, a University of California, San Francisco psychologist. The biography of each author is otherwise correct.
Recent Reports

Condom Use among Heterosexual Teens

Contradicting the research literature, a recent study found that skill-based interventions were not sufficient to induce high-risk heterosexually active teenagers to use condoms consistently. However, the interventions—including a comic book, videotape, and group skill training—did achieve moderate changes in attitudes toward condom use, reported ability to talk about condoms with partners, and beliefs about the efficacy of condoms in protecting against sexually transmitted diseases (STDs).

Participants included 228 youths (ages ranging from 13 to 18) from a juvenile detention facility and 168 youths sampled (ages ranging from 14 to 19) in STD and other public health clinics. There were equal numbers of African American and European American male and female youth. Each participant completed a survey before testing, after the interventions, and after three- and six-month follow-ups. The interventions focused on negotiating skills: the 16-page comic book provided basic information about HIV and other STDs and presented condom use negotiating skills; the 27-minute videotape demonstrated these skills; and the eight-hour group skill training focused on rehearsing the skills. Researchers divided subjects into three groups: a comic book group; a comic book plus video group; and a group that received all three interventions.

After three and six months, there were fewer significant differences between the interventions than would be expected by chance alone. However, there were some notable differences between the two populations studied. Participants in the detention sample indicated significant gains in self-efficacy at six months, while there was no change for the clinic group. Results from the clinical group show changes in beliefs that condoms protect against STDs, but show no change in beliefs that condoms protect against pregnancy. Conversely, results from the detention sample show changes in beliefs that condoms protect against pregnancy, but show no change in beliefs that condoms protect against STDs.

The researchers conclude that while the relatively brief skill-based interventions may suffice for teens at lower risk than those in the study, they are not effective enough to motivate condom use among adolescents at high risk. They suggest researching interventions that personalize becoming infected with HIV or another STD, perhaps involving role playing or writing down consequences of infection.

HIV Testing among Urban Youth

A study of homeless and gay and bisexual urban youth in Los Angeles, New York, and San Francisco found not only that most subjects had been tested at least once for HIV, but also that, contrary to expectations, more than 90 percent had returned for results. Of the three cities, Los Angeles had the highest rate of testing (90 percent), San Francisco was second (65 percent), and New York third (39 percent).

Researchers recruited youth ages 14 to 22 from community-based agencies serving gay, bisexual, homeless, and runaway youth. Results were based on self-reports regarding testing, sexual activity, and substance use. In San Francisco, 70 percent of the sample were heterosexual; in New York, 50 percent were gay and 45 percent were bisexual; and in Los Angeles, the sample was divided among three orientations.

Youth at highest risk—injecting drug use or gay—and those who were older had the highest rates of testing. In addition, sexually active youth in San Francisco were less likely to use condoms during vaginal or anal intercourse (62 percent) than those from either Los Angeles (76 percent) or New York (80 percent). San Francisco subjects were more likely to have used injection drugs (41 percent) than those in Los Angeles (25 percent) or New York (6 percent). "Anglo" youth had the highest reported levels of vaginal intercourse and injection drug use, while African Americans had the highest reported levels of anal intercourse. Latino youth were least likely to report unprotected intercourse or injection drug use.

Latino youth were also the least likely to have been tested for HIV at each test site. Subjects who were older, those who identified as homosexual, those who reported unprotected anal or vaginal

Brief skill-based strategies may reach teens at lower risk but do not motivate condom use in teens at high risk.
intercourse, and those who reported injection drug use were significantly more likely to have been tested.

**Culture and Risk Behavior among Students**


While Asian/Pacific Islander teenagers have low overall HIV seroprevalence rates, once sexually experienced, their behaviors may be as risky as those of White adolescents, according to a study of 5,793 students.

Researchers analyzed data from the Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey, a questionnaire administered in 1991 to 12,272 U.S. high school students. Of the national sample, the 5,385 students who identified as White and 408 students identified as Asian/Pacific Islander were the focus of this subanalysis. The median age of both groups of students was 16, and Asian/Pacific Islander students rated their academic performance higher than did White students.

After controlling for academic performance, White students were 2.4 times more likely to communicate about HIV and AIDS, 2.7 times more likely to be sexually experienced, and 2.5 times more likely to use alcohol or other drugs before sex than Asian/Pacific Islander subjects. These findings might be explained by the values of family obligation, obedience to rules and roles, and face saving in many Asian and Pacific Islander communities—values that may have engendered personal reticence and conservative attitudes toward sex.

The study shows, however, that Asian/Pacific Islander subjects who were sexually experienced did not differ from their White counterparts in terms of age of first sexual experience, number of lifetime sexual partners, and prevalence of condom use. These students may be influenced more by mainstream American values than by Asian/Pacific Islander values.

**Sexual Behaviors of Gay Youth**


An Australian study of sexual health found no significant differences in HIV-related risk factors between young and older men, contrary to North American and European data, which have repeatedly demonstrated a youth risk phenomenon. The findings challenge the notion that men under the age of 25 are immature, predisposed toward risk-taking, and less capable of responding to safe sex messages.

Data was obtained between 1992 and 1994 from the sociobehavioral arm of the Sydney Men and Sexual Health study, a longitudinal investigation of the impact of HIV on gay and bisexual men. Researchers interviewed 1,038 subjects, 216 of whom were under the age of 25 and 822 of whom were more than 25 years old. There were no significant differences between the younger and older groups in relation to ethnicity, sexual identity, or relationship status.

Despite the fact that the young men in this sample were less likely than the older men to know their HIV serostatus, they were as knowledgeable about HIV transmission, as connected to the Sydney gay community, and as behaviorally cautious as their older counterparts. For example, there were no significant intergenerational differences in anal intercourse with regular or casual male partners.

The discrepancy between these findings and the North American and European data may result from the existence of organized gay communities in Australia and the encouragement of HIV education, safe pleasures, and gay self-expression.

**Next Month**

Psychologist Walt Odets has highlighted the failing of HIV prevention strategies that indiscriminately target both seropositive and seronegative people. In response, his writing has focused on defining the prevention challenges for seronegative gay men. In the June issue of *FOCUS*, Lynda R. Temoshok, PhD, with the Institute of Human Virology in Baltimore, and Ralph R. Frerichs, DVM, DrPH, Chair of the UCLA Department of Epidemiology, take much the same position, but examine instead secondary prevention—preventing transmission from people with HIV to their uninfected partners. They describe the risks, risk relationships, and challenges of secondary prevention.

Also in the June issue, Walton Senterfitt, RN, MPH, an epidemiologist at the Los Angeles Department of Health Services, describes a telephone hotline program for seropositives.
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