Advocates For Youth
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Guide to Implementing TAP

(Teens for AIDS Prevention)

A Peer Education Program to Prevent HIV and STI

2nd Edition

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Advocates for Youth – helping young people make safe and responsible decisions about sex.

> Advocates for Youth is dedicated to creating programs and advocating for policies that help young people make informed and responsible decisions about their sexual and reproductive health. Advocates provides information, training, and strategic assistance to youth-serving organizations, youth activists, policy makers, and the media in the United States and the developing world.

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The Need for HIV/STI Prevention Peer Education <<<

The Rationale for Peer Education

Peer education programs can be a powerful approach to educating youth and changing their attitudes. Some studies indicate that teenagers receive most of their information about sexual expression from other youth and the media and that peer influence becomes increasingly important as adolescents mature.[8,9] Peers are an important aspect of an adolescent's transition to adulthood. As youth move away from dependence on the family, closer ties with their peers give youth the social support they need during these transition years. In other words, the peer group assumes increasing importance as teens move to establish independence from their families. Peers provide a stabilizing influence and a source of behavioral support and standards within the safety of a group. Studies show that adolescents who believe that their peers are practicing safer sex are more likely to do the same.[10]

The peer group is highly important in influencing adolescents' values and behaviors. In one study, urban youth said they would be more likely to listen to and believe information about AIDS from an HIV-infected youth than from an older or even a famous person.[11] Research suggests that when HIV/STI prevention information comes from their peers, adolescents are more likely to participate in discussions about infection and are also more likely to see HIV infection and AIDS as personal dangers than when the same information is presented by adults.[10] One study on condom use among adolescents found that teens' perceptions of other teens' condom use was the best indicator for determining their own condom use.[12]

Peer-based interventions can enhance HIV knowledge and reduce risk behaviors. One study found that peer-based interventions decrease the incidence of unprotected sexual intercourse, the frequency of sexual intercourse, and the number of teens' sexual partners. The study also found that peer-based interventions increase teens' acquisition and use of condoms.[13]

Peer-based programs will work in a variety of settings. One evaluation of a family planning clinic's program found that peer counselors were more effective with teenage clients than were adult counselors in delivering educational and counseling services to prevent unwanted teenage pregnancy. Between the initial and return visits, teenage clients' contraceptive use increased 40 percent among those counseled by their peers. Among teenage clients served by adult professionals, the increase was only ten percent.[14] Peer education is also a good way to reach the youngest and least educated teens. In one study, teens who actively sought out peer counselors were often younger and had lower levels of education compared to other teenage clients.[14] Another study found that peer counselors were more effective than nurses in improving sexually active adolescents' use of oral contraception.[9]

Social learning theory emphasizes that similarities in age and interests between those giving and those receiving educational messages will increase the persuasiveness of the messages. Empathy and a perception that peers share similar life experiences may also be critically important in the success of strategies to change attitudes and behaviors.[10] Thus, peer educators can have genuine advantages over professionally trained adults in dealing with teens.

When the peer educators in Advocates for Youth's original TAP program were asked why they believed peer education to be an effective approach to HIV/STI prevention with adolescents, they responded that peer educators:

- *Relate to other teens on their own level*
- *Talk about problems that affect teens*
- *Make new friends*
- *Explore new frontiers with their peers*
- *Let people in power know youth's point of view*
- *Have fun*
- *Bring essential information to other youth*
- *Help adults understand the way teens think and act.*

This guide presents an HIV/STI prevention peer education program (hereafter, TAP).[4]

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The Need for HIV/STI Prevention Peer Education <<<

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Chapter II.

Building Support for a Peer Education Program

Peer education is widely recognized as a useful and credible way to reach young people with important information. While peer education does not usually cause much concern among adults, young people's involvement as HIV/STI prevention educators may cause concern and provoke controversy. Those planning any HIV/STI prevention peer education program, including TAP, should remember that some individuals within the school, faith community, or agency may feel concern about utilizing youth as HIV/STI prevention educators of their peers.

The issues or concerns about youth's involvement may differ, however, depending upon the setting. For example, adults working in schools may have different concerns than those working in religious institutions, youth groups, shelters, or other community-based organizations. Adults working in different settings may also have varying ideas about the feasibility of a TAP program. This chapter can help planners to develop a solid rationale for a TAP program as well as to anticipate and respond to the concerns of members of the particular community that will host a TAP program. The chapter presents

A. **Guidelines for building support**
B. **Nine reasons why TAP meets teens' need for HIV/STI prevention education**
C. **Convincing arguments to counter possible opposition to the program.**

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Building Support for Peer Education <<<

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Building Support for Peer Education <<<

also need the skills to enable them to act on those attitude changes. TAP members deliver information and skills to other teens through creative, interactive exercises and activities that have the power to change youth culture in a school or in a community.

4. AIDS cases have been reported in every state. While not every community has been dramatically affected by HIV or AIDS, it is highly probable that a parent, teacher, or youth – or someone well known to them – has been or will be infected with HIV. Adults and youth must be prepared to deal with the situation when it happens. TAP helps educate youth and staff.

- The saying that an ounce of prevention is worth a pound of cure is nowhere more relevant than in the world of HIV prevention. Yet, human nature means that many people will not feel compelled to take precautions against HIV until personally affected by the consequences of not taking them. For example, a former Director of the United States Office of Personnel Management released a workplace policy on HIV/AIDS only after her son was greatly touched by getting to know a teacher with AIDS.
- HIV infection and AIDS will affect every school or agency – even if they haven't yet. All agencies and schools should have a policy setting forth a compassionate, caring response to HIV seropositivity in staff, students, and clients. The policy should also emphasize a commitment to HIV/STI prevention education. Implementing TAP means that a school or agency is powerfully committed to HIV/STI prevention education for young people.

5. HIV/STI prevention education is currently the only way to curb the spread of HIV among youth.

There is no cure for HIV infection or for AIDS. Experts estimate that the world is years away from development and approval of a viable preventive vaccine. However, we do know how to prevent infection with HIV. Everyone who has significant contact with any young person should make sure that youth receives both

- Correct information about HIV and other STIs, including ways to protect against infection
- Opportunities to practice and improve skills in communication, negotiation, and refusal as well as in how to use condoms.

6. One of the most effective approaches for communicating essential HIV/STI prevention information to youth is teens talking with other teens.

- Teens often ask their friends health questions before—or instead of—asking their parents, teachers, or other adults in their lives. In fact, many teens have said that they would most likely seek HIV/STI prevention information from someone their own age.[6]

7. TAP builds self-esteem among TAP members who earn their peers' respect because of the work they are doing.

- When youth participating in TAP perform street theater or make educational presentations on HIV/STI prevention before their peers, they earn other youth's respect. They become leaders. As TAP leaders receive positive reactions from their peers, their self-esteem increases. This enhanced self-esteem is most often noticeable among the youth having the least self-confidence when they entered the program.[6]

8. Through teens, parents may become more knowledgeable about HIV/STI and AIDS, and communication between adolescents and parents may improve.

A TAP program involves parents in several ways. Parents may:

- Grant permission for teens to participate in the program
- Participate in at least one training exercise when teens interview their parents or other family members on their knowledge and attitudes about HIV/STI
- Learn more about HIV/STI and AIDS when teens share the information that they have learned during the program
- Attend presentations by the TAP members.

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Building Support for Peer Education <<<

C. Ten Common Arguments Against Implementing TAP and Suggested Responses

In order to advocate effectively for a TAP program, planners must be able to anticipate and respond to objections. Ten commonly heard objections and possible responses are listed here.

Objection 1 – Sexuality education encourages teens to have sexual intercourse.

Response – Research does not support this commonly heard and hotly argued point. In 1993, an extensive review of existing research found that sexuality education did not lead to earlier or increased sexuality activity.[7] In fact, the study found sexuality education that included information about contraception actually delayed the onset of sexual activity, decreased overall sexual activity, and/or increased the adoption of safer practices by sexually active youth.[7] Moreover, prominent scientific and medical organizations, such as the Institute of Medicine, flatly refute this argument.[8]

Objection 2 – Adolescents are not at risk for developing AIDS. It's a disease of adults.

Response – It is true that only a small percentage of AIDS cases occurs among teens. However, the real danger to teens is infection with HIV, the virus that attacks the immune system and eventually causes AIDS. Approximately 17 percent of AIDS cases are among those ages 20 to 29.[9] The lengthy period between HIV infection and onset of AIDS – as much as 10 years – means that many of the young people in their twenties who are living with AIDS were probably infected with HIV when they were teens.

Objection 3 – Parents will not support this program. It's too controversial.

Response – A 1999 Advocates for Youth/SIECUS poll found that 93 percent of adults support the teaching of sexuality education in high schools, while 84 percent support sexuality education in middle/junior high schools.[10] Another study showed that 79 percent of adults favor television advertising to promote condoms for HIV/STI prevention.[11]

Objection 4 – This school already provides ___ (fill in the blank) hours of HIV/STI prevention education in ninth grade health class. Therefore, we have no need for this program.

Response – The majority of adolescents receive some form of sexuality education in school, yet very few receive comprehensive sexuality education, which is proven to be more effective. Students need to learn HIV/STI prevention education within a larger context that includes making decisions, setting goals, and exploring values and gender roles. Students also need factual information about reproduction, physiology, contraception, and sexually transmitted infections. They cannot get this in one, two, or a few hours. The TAP training component provides the larger context and provides ongoing reinforcement of important HIV/STI prevention skills and information. Adults wouldn't expect youth to receive all they would ever need to know about writing in a one-hour class in ninth grade. Why should anyone expect it about HIV/STI prevention?

As TAP members develop and implement educational activities for their fellow students, members and other youth receive both encouragement and support in avoiding risk behaviors for HIV infection.

Objection 5 – This organization provides _____ (outdoor, recreational, sports, etc.) activities for youth. It is not in the business of offering other types of programs.

Response – Community-based organizations are ideally situated to reach and engage youth who are frequently overlooked by other institutions – such as homeless youth, immigrant youth, and youth whose culture, race/ethnicity, or sexual orientation puts them at a disadvantage in dealing with local institutions. All youth need education about how to prevent HIV/STI because prevention directly relates to their physical well being. Wherever possible,

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Building Support for Peer Education <<<

Planners should include youth in the planning from the beginning. Then, the youth will participate in crafting an exciting, exuberant, creative program.

Planners should also remember that youth have serious practical concerns and little money. After school, they are hungry, and the program should provide them with drinks and food. If youth have to travel to the program, they may need immediate reimbursement to cover their travel expenses. If interested youth need to work at a paying job after school and on weekends, then creative planners will build in flexibility to meet the time and energy constraints on the youth. Having other teens do the recruiting – through presentations, by word of mouth, or by developing creative flyers – will also encourage other teens' interest. Personal testimony from one teen to another is very powerful. Teens can always explain why becoming involved in TAP is worth another teen's valuable time.

Objection 10 – Teens will not listen to other teens because they have no authority.

Response – Some teens may initially think, "Why should I listen to you? You don't know any more than I do." But when teens have been trained in HIV/STI prevention and in public speaking, other teens listen. Confident teens quickly gain respect and attention when they speak directly to other teens and give them correct information. Teens gain more from HIV/STI prevention education that is peer-led than from education led by adult.[12]

Endnotes:

1. Youth risk behavior surveys. *Morbidity and Mortality Weekly Report, CDC Surveillance Summaries*. [Annual report] Atlanta, GA: Centers for Disease Control and Prevention.
2. Alan Guttmacher Institute. *Sex and America's Teenagers*. New York: The Institute, 1994.
3. _____. Trends in sexual risk behaviors among high school students, 1991-1997. *MMWR* 1998;47:749-752.
4. Graves KL, Leigh BC. The relationship of substance abuse to sexual activity among young adults in the United States. *Family Planning Perspectives* 1995;84:1116-1120.
5. Kann L, Kinchen SA, *et al*. Youth risk behavior surveillance, United States, 1997. *MMWR CDC Surveillance Summaries* 1998;46(SS-3):1-89.
6. Center for Population Options. *Focus Group Research Results: Adolescent HIV Knowledge, Attitudes, Behavior*. Washington, DC: Advocates for Youth, 1988, and Advocates for Youth. *Research results*. Washington, DC: The Author, 1998.
7. Baldo M, Aggleton P, Slutkin G. *Does Sex Education Lead to Earlier or Increased Sexual Activity in Youth?* Presentation to the IXth International Conference on AIDS, Berlin, 6-10 June, 1993. Geneva, Switzerland: World Health Organization, 1993.
8. Committee on HIV Prevention Strategies in the United States, Institute of Medicine. *No Time to Lose: Getting More from HIV Prevention*. Washington, DC: National Academy Press, 2000.
9. Centers for Disease Control & Prevention. *HIV/AIDS Surveillance Report* 1999;11(1):1-42.
10. Hickman-Brown Public Opinion Research. *Overview of Research Results [on Sex Education, Report to SIECUS and Advocates for Youth*].Washington, DC: Hickman-Brown, 1999.
11. Buchta RM. Attitudes of adolescents and parents of adolescents concerning condom advertisements on television. *Journal of Adolescent Health Care* 1989;10:220-223.
12. Stevens J. *Peer Education: Promoting Healthy Behaviors*. [The Facts] Washington, DC: Advocates for Youth, 1997.

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Chapter III

Planning the Program and Finding Funding

From the outset, young people should participate in designing the program and should be consulted about all aspects of the program and its intended outcomes. Only youth themselves can answer the fundamental question as to whether a TAP program is something youth really want and want to do? Forming youth-adult partnerships – in which young people are equal team members with adults – is vital to the success of a TAP program.

Once support for TAP has been established within the school, community, or organization, it is time to plan the program itself and to plan for its implementation and administration. Planners – including youth – will need to focus at this point on four major objectives:

1. **Developing a comprehensive working plan for TAP**
2. **Identifying and achieving support and funding for TAP**
3. **Selecting and training staff**
4. **Recruiting youth to become peer educator TAP members.**

This chapter concentrates on the first two of the objectives. It provides guidelines for the individual(s) or group(s) responsible for each objective. Chapter IV focuses on objectives three and four – selecting and training staff and recruiting youth to become TAP members.

Before you begin planning the program, be sure to read chapters I, II, III, IV, and VII in their entirety. Reading these chapters *first* will help you understand the planning process and avoid pitfalls to creating a successful peer education program.

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Planning the Program and Finding Funding <<<

Steps to Success: The Community-Based Needs and Assets Assessment

- Carefully define the parameters of the community. Is the community defined by geographical area (e.g., zip code, neighborhood, town, or county) or by non-geographical characteristics (e.g., culture, language, age, socioeconomic status, or grade level)?
- Determine the availability and specificity of baseline data. Is data available for the specific community? If not, can the team assess the extent of needs and assets in other ways?
- Actively engage community members, including formal and informal leaders among the youth, parents, teachers and/or program workers into the needs and assets assessment process. Community members will help to identify the critical questions that the assessment will aim to answer, develop approaches to data collection, and gather the information.
- Use a variety of data collection strategies, including existing community data sources as well as complementary qualitative approaches – focus group research and in-depth interviews – to assure a comprehensive picture of the community the TAP program will serve.
- Enlist skilled, trained individuals to conduct the assessment process and interpret the data. Graduate students in a local university may be willing and able to assist with this phase of planning.
- Obtain the cooperation of key individuals, such as parents, school administrators, and school board or agency staff, in collecting the information.
- Be sensitive to concerns about confidentiality of the information. Be sensitive and wary about the potential negative uses of the information gathered.
- Ensure that the needs assessment is broad in scope and reaches beyond HIV prevention itself to include youth development and the community context of young people's lives.

Source: Brindis CD, Pittman K, Reyes P, *et al. Adolescent Pregnancy Prevention: A Guidebook for Communities*. Palo Alto, CA: Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, 1991.

In regard to the community's youth, the following questions can help the assessment team to identify important needs and/or assets of the youth that the TAP program will target. They may also help the team determine which youth in the community the program will target.

Who Are the Youth TAP Will Serve?

- What is the ethnicity of the youth in the targeted community?
- What is their general economic status?
- What are their ages? Will the program target a specific age group (such as those ages 13 to 15) or a general age group (such as all teenagers)?
- How many of the target audience are enrolled in school? In other words, what proportion of the youth are out of school?
- What are the out-of-school youth doing? Are they working? Are they unemployed?
- What is the ratio of females to males?
- Do all of the youth attend the same school, church, or youth group? Are they all residents of the same neighborhood or of the same shelter?
- What percentage of the youth openly self-identify as gay, lesbian, bisexual, or transgender?
- Are many of the youth homeless or living on the street? Who serves the homeless youth?
- Is survival sex (prostitution) a common source of income for the community's street youth and homeless youth?
- Is the use of alcohol and other drugs a problem among the youth? Which drug(s) are most commonly used?

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Planning the Program and Finding Funding <<<

Outcome and impact objectives specify the results the program intends to obtain, with respect to the TAP members and/or the teenage audience of the TAP members' activities. Planners should keep in mind the overall goal of TAP, the goals of the TAP members' campaign, and the particular needs of the targeted youth.

Outcome objectives attempt to measure the short-term achievements of the program. Short-term could mean post-testing immediately after a program or activity, or it could mean assessment within 30 days to six months after a program or campaign.

Examples:

- The TAP members will demonstrate significantly increased knowledge regarding HIV/STI prevention immediately after the conclusion of their training. Their post-test scores will have improved by at least 20 points over pretest scores. At the same time, TAP members will demonstrate improved skills in making decisions, communicating, and negotiating, shown by at least a 20 point increase in post-test scores over pretest scores.
- Immediately after TAP members have finished their campaign, teens targeted by the campaign will increase by at least 10 points their post-test score as compared to the pretest scores in their knowledge regarding HIV/STI. At the same time, post-testing will show that teens have significantly more positive attitudes about safer sexual behavior, demonstrated by a 20 point increase in their attitudes scores.

Impact objectives relate to the long-term objectives of the program. Long-term usually means one year or more. These objectives would relate to changes in knowledge, attitudes, and/or behaviors over time and would also relate to TAP's overall goal of changing youth's norms around sexual behavior.

Examples:

- After one year, sexually active TAP members will report more consistent use of condoms and fewer new sexual partners when compared to non-participating sexually active youth.
- After one year, significantly more youth in the target community will report positive attitudes about condom use when compared to baseline data in the target community.
- After three years, sexually active youth in the target community will report significantly more consistent use of condoms when compared to baseline data in the target community and fewer new sexual partners when compared to sexually active youth in surrounding communities.
- After five years, the incidence of adolescent pregnancy and reportable STI will have decreased by 20 percent among the entire student body of Hometown High School when compared to statistics available for the school year immediately preceding the inception of the program.

Objectives indicate areas in which data must be collected for process, outcome, and impact evaluation. Objectives direct the program and limit it. For example, a program that expects to improve attitudes about condom use *must* include activities about condoms and their use. At the same time, the program would probably not include an activity centered on choosing a college. Chapter VII, Evaluating the Peer Education Program, offers additional information that may help planners to formulate specific, achievable objectives to guide the program to meet the needs of targeted youth. Chapter VII also provides suggestions for conducting a simple process evaluation.

C. Developing the Comprehensive Plan for the TAP Program

The comprehensive plan will address four major program stages:

Stage 1. Preparing

Stage 2. Training

Stage 3. Developing and Conducting Activities

Stage 4. Assessing and Modifying the program.

Stage 1. Preparing – Chapter III provides a step by step guide to preparation. In it, planners will also find information on identifying budgetary and

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need. In this volume, *budget* is used in regard to *all* resource needs.

Budget planning is essential. The first step in budgeting for a TAP program is estimating the cost of program components. The program's timeline and plans for training, conducting activities, and performing an evaluation – based on the program's objectives – will provide a useful overview for considering resource needs. Needs from one program to another will vary due to the program structure, objectives, timeline, and specific activities. *Before* completing the budget, the planning team should talk with youth in the target community to get ideas of the kinds of activities they enjoy and find worthwhile.

The list of resource needs should include *anything* that the program must purchase or receive as an in-kind (non-cash) contribution. After the list is complete, planners can check off each item for which the program will not have to pay at all. This might include things like paper supplies, the meeting space, heating, and light for a program that is sponsored and housed in a community center. It might also include coordinator's salary, telephone, Internet access, and photocopy services for a program that will operate within a school or agency setting. Many local businesses may be willing to provide services, including food and other products.

Examples:

- A local sports store donates popular shirts popular to one TAP program for youth completing the TAP training.
- Airlines sometimes provide complimentary tickets to nonprofit groups traveling to conferences.

So, planners should keep such alternatives in mind when budgeting for the program. The program will need funds for all the items that remain on the list. [Note: Planners may find it easier to list items according to the planning timeline, and later, to group similar items together for the actual budget.]

The budget should include items necessary for the initial planning phase, including the needs and assets assessment. During this phase, the program will need office supplies, postage, information about HIV/STI prevention, resources for HIV/STI prevention information, photocopying services, and a telephone. If the planner(s) will be paid for time spent planning the TAP program, the budget must include salaries. If the planners are volunteers, the budget should include reimbursement for travel or other expenses. The budget should also include money for stipends and expenses for the youth involved in the planning phase.

During the training of TAP members, the program will require office supplies, copying services, educational materials, and supplies for the activities. Budgeting for this phase of the program may be difficult. However, the program will certainly need some cash and/or donated professional services. In particular, planners should consider budgeting for stipends or salaries for the peer educators. Successful TAP programs often *hire* peer educators. Many teenagers work part-time.

The budget should include funds for drinks and food for the peer educators. Most youth eat their meals at home, and many youth lack the money to eat in restaurants when their commitment to the TAP program makes them miss meals at home. Moreover, TAP training for peer educators often occurs after school or in the evenings when teens' energy levels are low. Free food and soft drinks for the peer educators can assist in keeping the training on track.

Costs for a simple process evaluation can be kept to a minimum – some office supplies and services as well as some staff time. Costs for an outcome evaluation may be considerably more, and costs for an impact evaluation may be as much as two to three times the cost of the program itself. If planners intend to conduct an outcome and/or impact evaluation, information in Chapter VII, Evaluating the Peer Education Program, will help them locate an evaluator who can assist them in estimating the costs for either type of evaluation.

Planning for staffing is critical. The two largest items in most TAP budgets are usually staffing and

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- Salaries or stipends for youth (minimum wage) x (# of students) x (# of hours)

- **Recruitment and Program Administration**
  - Photocopying
  - Office supplies
  - Office equipment (word processor, computer, or typewriter)
  - Reimbursement for program-related transportation
  - Telephone
  - Meeting room
  - Storage space for materials and records
  - Postage
  - Printing/photocopying of recruitment flyers, application forms, permission slips, etc.
- **Meetings**
  - Food and drinks ($10 to $25) x (# of meetings)
  - Reimbursement to youth for transportation
  - Training supplies
  - Newsprint
  - Markers
  - Tape
  - Office supplies
  - Photocopying
  - Educational materials (pamphlets and reference books)
  - Videos (to rent, purchase, or borrow)
  - Handouts for training sessions
  - VCR and TV (to rent, purchase, or borrow)
  - Guest speakers' fees.
- **Activity Development**

Costs in this category will depend on the activities selected by the youth; however, the budget should be flexible enough to allow for different types of activities, including:

- Producing videos
- Engaging in advocacy
- Designing and producing pamphlets and/or posters
- Producing advertisements
- Designing and producing tee shirts
- Designing and producing buttons
- Producing dramas or musicals
- Traveling to places where TAP members will perform or present their activities.

- **Evaluation**
  - Survey development and administration
  - Pre- and post-test development
  - Photocopying
  - Survey analysis and reports
  - Pre- and post-test analysis and reports
  - Publicizing the results.

E. Planning for Evaluation

Chapter VII, Evaluating the Peer Education Program, outlines the steps necessary for evaluating TAP activities and the program. Evaluation must be planned at the same time that the rest of the program is planned. Otherwise, administrators may want to evaluate a program based on an agenda that it was never designed to meet. For example, difficulties could arise if the program was designed to increase condom use among sexually active teens while the oversight agency later wanted to assess whether it raised the age at which teens initiated sexual intercourse.

Many evaluation difficulties can be avoided by proper prior planning at this early stage. For instance, administrators may be frustrated later if evaluation is impossible because there is no baseline data for the necessary comparisons. The evaluation concept may match poorly with the actual activities of the program. Or, the activities may not support the original objectives and goals of the program. Early planning permits staff to determine whether the activities will support the objectives and how to assess the accomplishments of the TAP program. To save time, avoid frustration, and get results that will help build a stronger TAP program, please read Chapter VII before beginning comprehensive program planning.

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before they will receive a proposal. Some foundations insist that they initiate the request for a proposal. Grants officers in other foundations may be willing to meet with individuals, and, if the grants officer feels that the program may dovetail with his/her foundation's interests, the officer will ask for a formal proposal. Planners should *never* guess as to a foundation's requirements and should not send a proposal before they have contacted the foundation. Speaking first to a grants officer, board member, or other officer at a foundation will mean a much higher probability of success. It will also mean that the ensuing proposal will comply with the individual foundation's protocols. Even when invited to submit a proposal, the TAP planner should first obtain written guidelines from the specific foundation, calling the foundation for clarification of the guidelines, if needed.

Tips on Finding Foundation Sources of Funding

- Talk with people running HIV/STI prevention education programs in the community to explore funding ideas. Ask about local corporate funding sources as well as about foundations and government sources.
- Call the Foundation Center in New York City 212.620.4230 or in Washington, D.C. 202.331.1400, or visit http://fdncenter.org. The Center can help identify appropriate foundations for the program's area. It also produces The Foundation Directory, which provides information on the nation's largest foundations.
- The local public library's reference desk should be able to provide books listing funding sources and their requirements. *AIDS Funding: A Guide to Giving by Foundations and Charitable Organizations* is published by the Foundation Center.This resource lists over 600 funding sources committed to supporting HIV/STI prevention programs and AIDS service organizations.
- A short list follows of major foundations that give to HIV/STI prevention programs and AIDS service organizations. Remember that many more organizations than are listed here support HIV/STI prevention programs and AIDS service organizations.

1. Elton John AIDS Foundation focuses on funding direct patient care services and HIV prevention education, and often works with the National AIDS fund when providing funding in North America. The Elton John AIDS Foundation can be contacted by phone at 310.535.1775 or online at www.ejaf.org.
2. The Gill Foundation concentrates on gay, lesbian, bisexual, and transgender and HIV/AIDS organizations that are located in Colorado, the non-urban U.S., and national organizations. The Gill Foundation can be contacted by phone at 303.292.4455 or online at www.gillfoundation.org.
3. The Ittleson Foundation funds innovative HIV prevention programs and also has a special interest in funding programs that focus on youth. The Ittleson Foundation can be contacted by phone at 212.794.2008 or online at www.ittlesonfoundation.org.
4. The Magic Johnson Foundation funds community-based HIV education and prevention programs that serve youth in inner-city communities. The Magic Johnson Foundation can be contacted by phone at 888.MAGIC.05 (888.624.4205) or online at www.magicjohnson.org.
5. The Public Welfare Foundation funds projects that provide HIV prevention education and advocacy programs to disadvantaged youth. The foundation has funded local organizations and peer education programs in the past. The Public Welfare Foundation can be contacted by phone at 202.965.1800 or online at www.publicwelfare.org.

Tips on Finding Corporate Sources of Funding

- Identify which local corporations have given grants to schools and youth-serving agencies by talking with local agencies.
- Investigate whether any friends and business associates have connections to corporate funding sources and are willing to provide introductions or advice.

A Peer Education Program to Prevent HIV and STI >>>>>>>>>>>>>>>>>>>>

Planning the Program and Finding Funding <<<

Chapter IV.

Selecting and Training Staff and Recruiting TAP Members

This chapter addresses the two final objectives (first listed at the beginning of Chapter III) necessary to successfully implement a TAP program:

- **Objective 3. Selecting and training staff**
- **Objective 4. Recruiting youth who will become peer educator TAP members.**

Remember that the entire planning process should actively and meaningfully involve youth. Youth can and should be involved in both of the processes discussed in this chapter – selecting a program coordinator and recruiting and selecting TAP members. In particular, youth can and should participate in the selection of criteria for a coordinator and in the interviews of candidates for coordinator. Youth can and should participate actively in the recruiting and selection of TAP members.

Objective 3. Selecting and Training Staff

Selecting Staff

A TAP program must have a coordinator – an adult who is responsible for the overall integrity and continuity of the program. The coordinator may actually be the person who initiated the move to establish a TAP program and/or the one who has taken primary responsibility for planning the program up to this point. However, the coordinator may instead be a different individual, recruited and selected at this time. This section deals with selecting and hiring or enrolling the coordinator and additional staff.

educating youth, planners should remember that particular qualities are especially important in a TAP coordinator and that only one of these focuses on knowledge base. Some are experiential. Others have to do with interpersonal skills or other intangible assets. Look for the following qualities when recruiting volunteers or hiring staff for TAP:

Because many of the most important attributes are experiential and/or interpersonal skills, the planning team will need to devise careful strategies for recruiting and interviewing. The strategies will need to allow interviewers to assess qualities that may not be easily captured in a resumé or standard interview techniques.

Knowledge	Experience	Interpersonal Skills
Knowledge of HIV and other STIs	Ability to motivate adolescents	Ability to communicate well with adolescents
	Commitment to HIV/STI prevention	Creativity
	Experience in teaching sexuality education	Flexibility
	Ability to work with youth of varying cultures, socioeconomic status, race/ethnicity, and sexual orientation	Sense of humor Ability to enjoy people and situations
	Willingness to allow youth to make program decisions Ability to work in partnership with youth	Willingness to empower youth to educate their peers

Additional staff may be highly valuable to a TAP program. At the very least, two TAP coordinators can share responsibilities and generate more enthusiasm and ideas than can one coordinator. For TAP, as for any other program that focuses on and works with youth, success rests heavily on the attributes of the adults involved in the program.

Some community groups or schools may choose a TAP coordinator because of his or her experience in HIV/STI prevention education. However, many outstanding candidates for TAP coordinator will have excellent skills for working with youth but need additional training in HIV/STI prevention education.* Because many people normally focus first on the educational background of adults entrusted with

The TAP coordinator is responsible for the overall management of the TAP program. This includes planning and budget management, training TAP members to become peer educators, and helping them to implement their chosen activities. Two coordinators can share these duties. A coordinator can also delegate some of the responsibilities to interns, other volunteers, and TAP members. Planners should develop a clear list of specific duties for the TAP coordinator and other adults involved in the TAP program.

Example:

- Develop support for the project in the community, school, and/or agency by presenting the program to the PTA, board of directors, and other appropriate groups.

* *Training programs are available in the community or through national, regional, or local HIV/STI conferences. The American Red Cross or local AIDS service organizations will be helpful in identifying resources to further train adults.*

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- Select youth to participate in the project and secure parental permission for each young person under age 18.
- Attend each TAP meeting, provide and coordinate training to TAP members, and arrange logistics for the meetings.
- Empower and assist youth to conduct HIV/STI prevention projects, such as making presentations, conducting assemblies, writing newspaper articles, and producing educational materials, within the community or school.
- Serve as program liaison between youth and parents, staff, and other adults involved with the project.
- Manage evaluation of the TAP program.
- Oversee the budget.
- Secure funding by writing grant proposals for submission to foundations as well as letters requesting donations from local businesses.

Training Staff

Teaching youth about HIV and other STIs is a professional and personal challenge for many educators and other program leaders. Each TAP coordinator will have his/her own feelings and values about the HIV epidemic, and may not be completely comfortable with some of the issues that youth are likely to raise. In particular, leaders may feel uncomfortable in presenting sexuality-related information and in dealing with controversy. If planners have found an otherwise outstanding candidate for TAP coordinator who is uncomfortable with sexual health issues and sexuality education in general, the candidate may need additional sexuality training. Contact Advocates for Youth at 202.347.5700 for assistance in identifying a source for comprehensive sexuality education training.

Please be aware that some 'sexuality education' programs refuse to teach youth about partner negotiation or about proper use of condoms and other contraception for the prevention of sexually transmitted infections and unintended pregnancy. These programs are typically unable to provide the skills and comfort level necessary to enable the coordinator to deal honestly and respectfully with many sexual health issues important to a TAP program.

This section focuses on preparing the TAP coordinator for the professional and personal challenge of teaching youth about HIV and other STIs. In particular, this section discusses the following points:

1. **All teens are not alike.**
2. **Cultural issues matter.**
3. **Reaching members of all populations of youth is critical to being effective.**
4. **Creating a safe and hospitable environment is essential.**
5. **Using appropriate language can help ensure the program's success.**
6. **Empowering youth means assisting youth in developing their leadership skills.**

1. All Teens Are Not Alike.

The TAP coordinator must understand that teens are unique individuals. The coordinator will need to acknowledge the wide range of sexual experience within a group of young people. Some youth will have had sexual intercourse; some will not yet have exchanged romantic kisses with anyone. Some youth will have had heterosexual experience; some teens will have had homosexual experience. Some youth will have chosen to initiate sexual intercourse; some will have had sexual intercourse or other sexual contact forced upon them. Some will be dating; some may not yet be interested in dating. Some teens may have good reason to believe that they have been exposed to HIV/STI; some may incorrectly believe they can contract HIV from a drinking fountain. Some teens may have friends or relatives who are living with HIV; some of the youth may be living with HIV.

The leader must address and include all young people in the group. One suggestion is to begin by saying something like *We are going to be discussing HIV/STI infection. HIV is a national emergency. All of us need to know more about HIV, the virus that causes AIDS, and how it is transmitted as well as*

about other STIs. We will be talking later about prevention. Some of you may not need this information now, but it is important for everyone to listen so that you can help yourself or be helpful to a friend or family member in the future.

Many young people are afraid of STIs, especially HIV. That fear may keep them from protecting themselves. Leaders can reduce this fear by explaining that HIV/STI infection can be prevented. Many teens will feel powerful when they learn that they have the ability to behave in ways that will prevent them from ever becoming infected.

2. Cultural Issues Matter.

Effective education to prevent infection with HIV and other STIs demands frank discussion of sexuality. However, sexual health attitudes, beliefs, and behaviors are sensitive subjects in many communities and among many people. Moreover, sexuality attitudes, beliefs, and behaviors vary widely among cultures. Understanding cultural beliefs about a range of sexuality issues is critical to providing effective prevention education.

A useful definition of culture is *the body of learned beliefs, traditions, principles, and guides for behavior that are commonly shared among members of a particular group*. With this important definition in mind, it is easy to understand why health educators must take cultural issues into account. It is easy to understand why they must acknowledge and understand culture when presenting information to young people. This means acknowledging and understanding youth's language and ethnic background, sexual orientation, and youth culture itself.

This is why peer education is often so much more successful than more traditional teaching styles. The presenters are the peers of the audience. They understand and frequently share the beliefs and attitudes of their audience. Ideally, peer educators will be about the same age and from the same culture as the members of their audience. They will *speak the same language*. In a multicultural setting, a team of peer educators could represent the various cultural backgrounds of the audience. In all cases, peer educators need to be culturally sensitive to the audience. Participants can more easily understand HIV/STI prevention messages when they hear them from someone who uses the dialect, phrases, and examples familiar to them. This is why planners must consider cultural factors *early* in planning programs.

The Importance of Culture

Increasingly today, people come into regular contact with others from different cultures. It is important to learn to talk with people who do not share a common "language," even when all are speaking English or French or Spanish.

Each person participates in at least one culture, and most are products of several cultures. Each culture has its own language and its own spoken and unspoken rules of conduct. These rules define what is and is not accepted as the norm. The first step in dealing competently with people of different cultural backgrounds is to be clear about one's own cultural background – one's own particular parameters and how they affect, define, and **limit** one's worldview.

Issues that cloud and complicate discussions of culture include age, gender, political differences, geographic boundaries, religious differences, language, speech patterns, sexual orientation, immigration status, and racial/ethnic distinctions. These complicated issues are woven into the fabric of culture and may complicate people's attempts to understand one another. Yet, understanding and valuing cultural differences is critical to success in health education. In fact, health educators – whether adults or teens – need more than cultural awareness or cultural sensitivity; they need cultural competence.

Being culturally competent is far more than being sensitive to ethnic differences. It is more than the warm, fuzzy feeling of loving and caring for neighbors. In the context of health education for youth, acquiring cultural competence can be considered as a four-step, ongoing model of learning about:

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- Culture and important cultural components
- One's own culture and its cultural assumptions and values as well as one's perspectives on them
- Individual youth with whom one works
- The cultural backgrounds of these youth.

Cultural competence is a long-term goal. In the end, a culturally competent person exhibits particular beliefs and attitudes, knowledge, and skills.

Why is cultural competence important? Culture serves as a road map both for perceiving and for interacting with the world. Because each culture has its own understanding of health, including sexual health, recognizing and dealing appropriately with cultures is a vital part of any successful effort to influence the sexual health beliefs and behaviors of youth.

Each culture has its own images, stories, myths, and traditions that can contribute to effectively imparting important information. Lack of sensitivity to cultural norms can embarrass and offend an audience and can sabotage HIV/STI prevention education efforts. In particular, important components of communication which may help or hinder HIV/STI prevention education include language, slang, body language, communication styles, health beliefs, family relationships, gender roles, religion, degree of acculturation, immigration status, political power, poverty, economic status, racism, and a history of oppression.

Dealing honestly with sexuality is central to any effective discussion of HIV and other STIs, but it must be done in a way that is culturally appropriate for the audience. In other words, appropriately presenting information and leading discussions requires identifying and considering the characteristics of participants' cultures. Participants' gender and sexual orientation, as well as their racial/ethnic differences will all have an impact on the presentation – how it is made, how it is heard, and what it accomplishes or fails to accomplish. Therefore, those involved in HIV/STI prevention education will be more effective when they understand the interplay of the cultures in the community.

Take, for example, the issue of condoms and some cultural roadblocks to their use in different communities:

- Some young men – seeing their ranks decimated by violence, death, and prison and feeling hopeless about the future – see no reason to use condoms.
- Some young women – having little power in negotiating sexual relationships, and having few options socially, sexually, and economically – see themselves as having no power to insist on condom use.
- Some gay, lesbian, bisexual, and transgender (GLBT) young people – seeing themselves

Cultural Competence

Culturally Competent Beliefs and Attitudes

- Being aware of and sensitive to her/his own cultural heritage
- Respecting and valuing different heritages
- Being aware of her/his own values and biases and how they affect perceptions of other cultures
- Feeling comfort with differences between cultures' values and beliefs
- Being sensitive to circumstances (personal biases, ethnic identity, political influence, etc.) that necessitate assistance from a member of a different culture when interacting with another member of that culture.

Culturally Competent Knowledge

- Understanding the power structure in society and how non-dominant groups are treated
- Having specific knowledge and information about the particular group(s) with which she/he is working
- Being aware of institutional barriers that prevent members of disadvantaged groups from using organizational and societal resources.

Culturally Competent Skills

- Generating a wide variety of verbal and nonverbal responses when dealing with differences
- Sending and receiving both verbal and nonverbal messages (body language) accurately and appropriately
- Intervening appropriately and advocating on behalf of people from different cultures.

condemned by church, community, and family – have a sense of worthlessness and disregard life-affirming and lifesaving behaviors, such as condom use.

- Some ethnic groups – seeing the group as attacked by the dominant culture – see the dominant culture's insistence on condom use as attempts at genocide.

Oppression: Racism and Homophobia

Any program that attempts to deal responsibly with issues of culture must also confront racism and homophobia (hatred based on sexual orientation). Racism and homophobia are two types of oppressive prejudice that can have a tremendously negative impact on young people in any program. Research shows that racism seriously harms young people who are its targets – especially if their families do not help them cope with racism. Homophobia seriously harms youth who are gay, lesbian, and bisexual. These youth frequently contend with verbal and physical abuse, with being ignored and/or ostracized, with violence and discrimination – all of which adversely affect their self-esteem, self-confidence, and hope for the future. Research also shows that racism and homophobia negatively affect youth who feel and act in racist and homophobic ways but who are targets of neither racism nor homophobia. For example, youth who have homophobic attitudes may fail to protect themselves during sexual intercourse because they believe HIV only affects gay males.

Racism

Racism couples **prejudice** and **power**. Prejudice is having a negative attitude about other people and cultures based simply on the difference between them and one's own group. All people should guard and contend against their own prejudiced attitudes. However, racism is prejudice that is specifically linked with power. Coupling prejudice with power creates an effect that is far greater than that arising when an individual feels prejudiced against people of other cultural groups.

When *any* one cultural group dominates other cultural groups, that group inevitably sets up procedures and defines what is good, normative, appropriate, and civilized through its cultural lens.The dominant group informally maintains some standards through social custom, common practice, and ritual, while it maintains others formally and legally through laws and institutions of power, such as the police and the armed forces.

In the United States, the largest population group throughout the 20th century was descended from northern European whites. This group defined and set cultural norms, usually to the exclusion and detriment of other racial/ethnic groups and cultures. Cultural dominance and the resulting subordination of other cultures has meant great hardship and suffering for Native Americans, African Americans, Latinos, and Asian Americans. Successfully designing a health education program involves honestly considering the impact of racism *and* building equitably upon the cultures of *all* the youth targeted by the program.

Homophobia

A second area of conflict and confusion in U.S. culture today, with which TAP coordinators *must* be prepared to deal, is homophobia – hatred and fear of people based on their sexual orientation. Bigots sometimes blame gay people in the United States for the HIV/AIDS epidemic and instigate violence against GLBT individuals. The United States' largely heterosexual culture at times promotes intolerance of GLBT individuals.

The TAP coordinator should be aware that some of the young people in the group may self-identify as GLBT or may be questioning their sexual orientation. These youth are extremely vulnerable to emotional damage from homophobic statements by their peers and/or from adults as well as to the verbal and physical abuse that such statements may encourage. The TAP coordinator should support *all* youth by refusing to tolerate homophobic statements. Adults can also help GLBT youth and young people who are questioning their sexual orientation by providing information about appropriate community resources. Additionally, discussing sexual orientation and homophobia will help teens to clarify their personal values and bring

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their actions into consonance with those values. The teen, for example, whose personal values include caring about and respecting *all* people, will be able to understand that homophobia violates his/her own personal values. The TAP coordinator also needs to emphasize consistently that one's behavior – not one's sexual orientation – puts one at risk for HIV/STI infection.

Building a successful HIV/STI prevention education program means acknowledging, addressing, and confronting the darker side of human behavior – prejudice and oppression, racism and homophobia. Even more, building a successful HIV/STI prevention education program means acknowledging and building upon the positive health beliefs and attitudes of the cultures of *all* the young people participating in the program. By valuing, incorporating, and celebrating cultures' positive health beliefs and attitudes, and by confronting and addressing racism and homophobia, program coordinators can help youth achieve better health and create better programs for their peers.

3. Reaching Members of All Populations of Youth Is Critical to Being Effective.

The TAP coordinator must address and tailor his/her educational approach to the needs of the group. Youth embody a range of cultural backgrounds and sexual orientations, and the TAP training must directly address the needs of each TAP member. In addition, some youth will represent multiple minority categories (e.g., gay Latino immigrant). These youth may feel as if they must choose between these groups. They need to know that is not so – their distinct needs as gay youth, Latino youth, and immigrant youth, for example, will all be met.

GLBT Youth

A national survey by the Kinsey Institute estimated that about 10 percent of the population is gay. The survey of 6,000 adolescents and adults discovered that 37 percent of the male population had at least some overt homosexual experience and that 10 percent of these males were exclusively homosexual.[1] GLBT youth are perhaps one of the most hidden and most scorned of youth groups. Many GLBT youth who are *out* about their sexuality face conflict with their families and friends. Those who are *closeted* face internal conflict over their self-identified sexual orientation and their pretended heterosexuality. Few schools or community-based youth-serving agencies provide programs designed specifically for GLBT youth. Since many of these institutions remain ignorant about and fearful of GLBT people, these youth remain isolated and silent in society. The TAP coordinator's job is to educate him/herself first, then to educate TAP members, and finally to educate his/her colleagues about what being a GLBT youth means.

Due to the general homophobic atmosphere of many American cultures, GLBT youth are at greater risk than other youth for a variety of health and social problems, including physical and emotional abuse, suicidal thoughts and attempts, suicide, and drug use.

- Gay youth are two to three times more likely to attempt suicide than other young people.[2]
- Many GLBT youth face rejection from their families. In a runaway shelter in San Francisco, gay and lesbian youth reported a high incidence of verbal and physical abuse from their parents, siblings, and peers.[2]
- In a survey of 29 gay and bisexual male teenagers, the majority of youth experienced school problems related to sexuality, substance abuse, and/or emotional difficulties that warranted mental health intervention. Half of those surveyed reported a history of sexually transmitted diseases, running away from home, or conflicts with the law.[3]
- Many GLBT youth turn to drugs and alcohol as a coping mechanism to deal with the social isolation they experience. Approximately 30 percent of lesbian and gay youth have problems with alcoholism.[2]
- Gay and lesbian youth comprise as many as 25 percent of all youth living on the streets in the United States.[2]

It is particularly important to reach young men who have sex with men (YMSM) with HIV/STI prevention activities. Some of these youth self-identify as gay or as bisexual; some do not. They are especially vulnerable to HIV/STI infection because social stigma and the lack of a peer group often lead them to

socialize with older men who have higher rates of infection. The TAP coordinator should consider inviting an expert from the community to conduct a session on homophobia and HIV/STI prevention issues specifically relating to YMSM.

Latino Youth

Latino youth represent a variety of cultural and linguistic heritages, and for this reason, it is important for the TAP coordinator to understand how language, culture, acculturation, and religion may interact with the TAP approach to HIV/STI prevention education. The TAP coordinator should not assume that all Latinos speak Spanish – many come from families that have resided in the United States for many generations. Many speak only English. Others speak several languages that may or may not include Spanish. On the other hand, Latino youth whose families have quite recently immigrated to the United States may be able to communicate best in Spanish. The TAP coordinator should also not assume that all Latinos speak the same dialect of Spanish – Mexicans, Puerto Ricans, and El Salvadorans, for example, all speak different and distinct Spanish dialects. Thus, the TAP coordinator must learn the linguistic needs of the TAP members and choose appropriate educational materials, pamphlets, posters, and videos for the group. TAP groups located in Latino communities should design materials in a form of Spanish that will be clearly and easily understood by the youth in the target community.

Approximately 85 percent of Latinos are Catholic. Catholic youth may have difficulty discussing topics like safer sex, sexuality in general, and homosexuality. Some Catholic youth may feel comfortable and open-minded about these issues. However, they may return after the TAP session to families where these topics are not discussed. The TAP group should reach consensus on the prevention messages it will communicate to other youth in the community. During this process, the group should also agree to respect differing opinions.

Latino youth urgently need to understand that HIV/AIDS is a problem for Latino communities. Latinos in the United States disproportionately number among HIV/AIDS cases. For example, while Latinos constitute about 11 percent of the U.S. population, they account for about 18 percent of all reported AIDS cases.[4] The TAP coordinator should encourage Latino TAP members to design educational activities that will reach their Latino friends. Currently, culturally sensitive and age-appropriate HIV/STI prevention materials for this community are scarce.

African American Youth

African American youth, like Latino youth, represent diverse cultural and socioeconomic backgrounds. Thus, the TAP coordinator may need to assess the needs of these youth in order to implement an appropriate educational approach to the TAP training. African American youth vary as much as do white and Latino youth. For example, those from different geographic locations will have different needs. African American, inner-city youth will probably experience violence and drug- and gang-related pressures while their suburban and rural counterparts may not. Some African Americans are immigrants, and for many immigrants, English is not their first language. The TAP coordinator should identify HIV/STI prevention materials that best meet the needs of African American youth in the TAP group.

The role of the church and/or mosque is central in many African American communities. In some communities, churches and mosques are important partners in HIV/STI prevention education. However, many African American faith communities have yet to become fully involved in prevention and education efforts. Some African American youth may feel uncomfortable with open discussion of sexuality issues, including topics such as sexual orientation, gender identity, contraceptives, and effective HIV/STI prevention methods. The Values Clarification activity (Session 2, Activity B) will allow all participating youth

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to discuss their feelings and beliefs about these issues as well as help them to recognize the diversity of values held by their peers.

African Americans disproportionately number among HIV/AIDS cases. While African Americans constitute 13 percent of the total population, they account for 36 percent of all reported AIDS cases. Because many African Americans perceive AIDS to be a disease of white, gay males, they have been slow to respond to the epidemic with effective HIV/STI prevention programs. Many African Americans, with strong memories of the infamous Tuskegee syphilis study of the mid-1900s, suspect that HIV prevention is a white conspiracy to limit black births and/or that AIDS is a genocidal disease unleashed on African Americans by whites. The TAP coordinator must be sensitive in dispelling young people's misconceptions and should reaffirm his/her concern for the youth and their safety in order to build their trust. Nevertheless, the TAP coordinator will need to recognize and address current beliefs and myths among African American youth if they are to become effective HIV/STI prevention peer educators.

Asian Pacific Islanders and Native American Youth

Asian Pacific Islanders (API) and Native Americans in the United States have lower numbers of AIDS cases than African Americans and Latinos. However, within certain risk behavior categories, their AIDS case rates are increasing. API and Native American youth represent diverse cultural backgrounds. Members of either group may speak any of a large number of languages, or they may speak only English.

Reaching these populations is especially important. A study of API college students found that 87 percent reported not using a condom during each act of sexual intercourse.[5] While most HIV/STI prevention programs targeted towards API populations focus on youth,[6] few build sexual negotiation skills, in part due to cultural discomfort with frank discussions about sex and illness within API communities.[7] In addition, acculturation status plays a major role in risk behavior and access to health services and information. API youth who have recently immigrated to the United States often have difficulty accessing information and services.

Research demonstrates that many Native American youth are not using condoms and that Native American males are more likely to have had sex than are non-Native American teenagers.[8,9] Current prevention programs for Native American youth may be less effective than in other communities, and Native American youth urgently need culturally specific prevention programs.

For more information on culturally specific HIV/STI prevention education, check with the following organizations:

1. Advocates for Youth utilizes the skills and enthusiasm of young Web activists to create communities of GLBT youth, Latino GLBT youth, HIV-positive youth, young women of color, and peer educators. Its Web sites provide online information, assistance, and support. (www.youthresource.com, www.ambientejoven.org, www.youthHIV.org, www.sistahs.org, and www.youthshakers.org or phone 202.347.5700)
2. The Asian and Pacific Islander Wellness Center's mission is to educate, support, empower and advocate for Asian and Pacific Islander communities – particularly Asian and Pacific Islanders living with or at-risk for HIV. (www.apiwellness.org or phone 415.292.3400)
3. The NAACP has a principal objective to ensure the political, educational, social and economic equality of minority group citizens of the United States. The NAACP is committed to non-violence and relies upon the press, the petition, the ballot and the courts, even in the face of overt and violent racial hostility. (www.naacp.org or phone 410.521.4939)

4. The National Association of People With AIDS (NAPWA) advocates on behalf of all people living with HIV and AIDS in order to end the pandemic and the human suffering caused by HIV/AIDS. NAPWA's web site is devoted to its ongoing mission to educate, inform, and empower all people living with HIV and AIDS. (www.napwa.org or phone 202.898.0414)
5. The National Council of La Raza (NCLR) works to reduce poverty and discrimination, and improve life opportunities, for Hispanic Americans. NCLR work towards this goal through two primary, complementary approaches: (1) capacity-building assistance to support and strengthen Hispanic community-based organizations and (2) applied research, policy analysis, and advocacy. (www.nclr.org or phone 213.489.3428)
6. The National Minority AIDS Council is the premier national organization dedicated to developing leadership within communities of color to address the challenge of HIV/AIDS. (www.nmac.org or phone 202.483.6622)
7. The National Native American AIDS Prevention Center's mission is to stop the spread of HIV and related diseases among American Indians, Alaska Natives, and Native Hawaiians and to improve the quality of life for members of our communities infected and affected by HIV/AIDS. (www.nnaapc.org or phone 510.444.2051)
8. The National Youth Advocacy Coalition's mission is to advocate for and with young people who are lesbian, gay, bisexual, or transgender in an effort to end discrimination against these youth and to ensure their physical and emotional well being. (www.nyacyouth.org or phone 202.319.7596)
9. The U.S.-Mexico Border Health Association promotes public and individual health along the United States-Mexico border through reciprocal technical cooperation. It focuses its technical cooperation resources on information dissemination on border health issues and the creation of effective networks. (www.usmbha.org or phone 915.833.6450)

4. Creating a Safe and Hospitable Environment Is Essential.

Creating an hospitable environment begins even before TAP members come to the first session. Indeed, unless the invitation is hospitable, there will be few participants! Advertising should indicate in what language(s) the program will be conducted and whether or not translators will be available. Announcements should include information about the availability of services for those with special physical needs, such as signers for deaf youth.

Using mail may not be the best way to reach and interest parents and young people. In some communities and in some cultures, the TAP coordinator may find that having personal contact with parents and young people is beneficial and even necessary to recruit participants.

When designing a program for HIV/STI prevention education, the TAP coordinator should consider the environment in which the program is to take place. Discussing difficult topics is easier when the participants are in an inviting, comfortable, and safe environment. What helps provide a safe, inviting environment?

- Attractive and easily understood promotional materials
- Adequate notice so prospective participants can arrange their schedules to fit the program
- A telephone number for questions regarding the program
- A private room
- A room large enough for the expected number of participants and for breaking into small groups
- Comfortable temperature and fresh air
- Refreshments – even if this is only fresh water and paper cups
- Nametags, tissues, and other important supplies
- Speaking platform visible to all participants
- Sufficient materials for all participants, such as paper, pens/pencils, copies of program

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- Clear, correct, and understandable visual aids
- Time to permit participants to pursue an activity that is of interest to them, such as creating a closing skit
- A suggestion/comment box to permit individuals to ask questions or give comments anonymously
- Constant awareness that some participating youth may already have been adversely affected by the HIV epidemic.

Taking care of these details will help to ensure that participants are comfortable during the program. Details like these are especially important when participants may be uneasy and/or uncomfortable during discussion of some topics.

Caring about participants' needs is a *plus* that will minimize discomfort and assist receptivity. Other details that will make a program and space more hospitable include:

- Clear signs directing participants to restrooms, telephones, and other amenities
- Quiet spaces for youth to use if they need to be alone or to reflect quietly
- Child care or a parallel track for children during the program to facilitate young parents' involvement in the program
- Transportation vouchers and/or maps and directions to public transportation
- Scheduling that is convenient for the participants
- Attention to special dietary and/or medical needs of participants. (For example, youth who are diabetic may need to eat at very regular times regardless of what is happening in the program at the time.)

Making hospitality a priority will help coordinators to create an environment that enhances youth's ability to learn and to assume responsibility and leadership in the program.

5. Using Appropriate Language Can Help Ensure the Program's Success.

A subtle, yet powerful way to ensure the program's success is to change the language used to define teens' sexual behavior. Traditionally, teens who have had sexual intercourse within the recent past are described as being *sexually active*. Indeed, interviews and surveys designed to discover whether or not a teen is having sexual intercourse often ask – *Are you sexually active?*

This terminology eliminates nearly the entire range of sexual expression, from fantasy and social interaction, to touch and kissing. Sexuality has been narrowed down to <u>only</u> sexual intercourse. All other sexual behaviors become less than *the real thing*. The message sometimes conveyed to teens is that *only* sexual intercourse constitutes the behavior of a sexually active person. Even more, some research suggests that many teens consider only vaginal intercourse to be *the* act that counts. Oral intercourse, for example, is less than *the real thing* to these youth. When information about a youth's sexuality pertains to the specific act of sexual intercourse, that should be the phrase used. In fact, coordinators may want to continually emphasize that "sexual intercourse" is a concept that includes vaginal, oral, and/or anal intercourse.

Reframing and expanding the concept of sexual activity to include the entire spectrum of behaviors and feelings that expresses sexuality and sensuality acknowledges the importance of all these behaviors and feelings. A broader definition of sexual activity permits youth to explore those behaviors that are less risky for teens. The Circles of Sexuality activity has been added to this guide to help youth understand the wide range of feelings, thoughts, and actions that constitute sexuality and that, therefore, describe a sexual being.

Teenagers need clear information about the sexual behaviors that place them at risk for HIV/STI infection. This can be one of the most difficult and important tasks that leaders undertake. Because most teenagers experiment with some types of sexual behavior, however, educators can help teens understand which ones are high-risk, which are low-risk, and which are risk-free.

Throughout the training, this guide uses the term *all types of sexual intercourse*. This phrase refers inclusively to oral, vaginal, and anal intercourse. None of these behaviors in and of itself puts a person at risk for HIV infection. Rather, the behaviors are risky when they involve a partner whose HIV antibody status is positive, unknown, or falsely assumed to be negative. Even when the HIV antibody status of both partners is known and negative, partners still may be at risk of other STIs and/or of unintended pregnancy. Moreover, infection with some STIs which cause open sores, such as herpes and syphilis, can increase an individual's risk for HIV infection.

Although *mutual monogamy* between uninfected partners is generally considered to be a safer sexual behavior, this is an inappropriate prevention message for many teens. Mutual monogamy refers to a situation in which two people have sex *only* with each other within an enduring relationship. However, when teens discuss monogamy, they usually mean something different. They usually mean a mutually faithful relationship which will last anywhere from two weeks to a year or more and will then be followed by another relationship, and that one by another. Many teens rely on the safety of such relationships – *serial monogamy*. This is not the same as *mutual monogamy*, and teens are at risk for HIV/STI if they have unprotected sexual intercourse with a partner who has been infected during another relationship. Mutual monogamy may be difficult to achieve before people reach mature adulthood, and even then it may continue to be an issue of serious concern.

Addressing Sexual Expression

Educators can help teens understand that there are many ways to express sexual feelings. Some of these ways place teens at no risk for an unplanned pregnancy or HIV infection. Talking, kissing, whispering, hugging, singing, dancing, and holding hands are all safe ways to show and receive affection from a partner. Touching, fantasizing, caressing, massaging, and masturbating are also safe ways to express sexual feelings. Teens should know that sexual behaviors that include abstinence from all types of sexual intercourse – oral, vaginal, and anal – are free of the risk of HIV infection. [Some sexual behaviors that include abstinence from all types of sexual intercourse may, however, involve a risk of STIs if they occur with an infected partner. For instance, several STIs can be transmitted during a kiss with a person who has an open chancre (sore) on or in his/her mouth.]

Strategies to encourage youth to delay initiating sexual intercourse are an important component of HIV/STI prevention education. Teens should know that sexual intercourse is not the only way to give or receive pleasure or to share in intimacy. Young people need to feel free to express affection through nongenital activities.

While it is important to encourage youth to defer sexual intercourse until it is right for them, educators need to be realistic about the number of teens in their programs who are already having sexual intercourse. According to national statistics, in a group of 17-year-old teens, less than half of the young people are likely never to have had sexual intercourse. Moreover, according to one recent study, many youth who have had oral and/or anal sexual intercourse define themselves as *virgins* because they have never had vaginal intercourse.[10] In some communities, 12 is the average age at which young males have first sexual intercourse. Any youth that engages in risky sexual behaviors needs explicit information about how to protect him/herself and a partner.

Discussing Safer Sex

Safer sex is a term commonly used to describe the use of a latex condom or other latex barrier (such as a dental dam) to prevent HIV/STI infection during oral, vaginal, or anal intercourse. Leaders can help teenagers who engage in sexual intercourse to understand their risk of becoming infected and how to practice safer sex. Any type of sexual intercourse between two *uninfected* partners is safe from the risk of HIV infection. The difficulty is that most people, teenagers *and* adults, do not know if they are infected with STIs, including HIV. "Knowing someone well"

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or "asking your partner about HIV/STIs" is an unrealistic way for teens to assess potential risk of HIV/STI infection. Teens need to understand that it is impossible to tell if someone is infected with HIV/STIs just by looking at him/her and that many infected people do not know they are infected.

Latex condoms, when used consistently and correctly, have been proven to be an effective barrier to HIV transmission in the laboratory. However, condoms can break or leak and, therefore, are not 100 percent effective against the spread of HIV/STIs or for the prevention of pregnancy. It is important to recognize that most condom failure rates are attributed to improper use – human error. Condoms offer the best protection available for people who are going to have intercourse with a partner whose antibody status is unknown.

Teens also need to understand that, for best protection against unintended pregnancy and infection with HIV and other STIs, heterosexual partners should use a dual method – a latex condom *and* another effective contraceptive method, such as the pill, implants, Depo-Provera, or the diaphragm. They must also understand that only condoms provide protection against infection with HIV and other STIs. The pill, implants, Depo-Provera, the diaphragm, and the IUD (intra-uterine device) provide *no* protection against HIV and other STIs.

Use of emergency contraceptive pills, the "morning-after pill," is rising in the United States. Emergency contraception provides pregnancy prevention *after* unprotected intercourse and when a regular contraceptive method fails. However, teens need to be reminded that although emergency contraception can effectively prevent most pregnancies, it offers *no* protection against HIV or other STIs.

Again, in preparing to teach teens about HIV/STI prevention, the leader will have many opportunities to reassess his or her personal beliefs and values. The leader should clarify his/her own beliefs and values and, if necessary, seek outside assistance and support.

6. Empowering Youth Means Assisting Youth in Developing Their Leadership Skills.

In addition to providing information and teaching skills to protect youth from HIV/STI infection, the TAP coordinator will be working to empower youth to feel comfortable in imparting HIV/STI prevention information to their friends and developing educational activities. Young people gain more from an experience when they are actively involved. From the beginning of the program, TAP members should take part in decisions about the program. In addition, involved youth should be aware of the budget as they begin to develop activities that may require funding. This will enable youth to understand how funding relates to programming. Moreover, when the money runs low, they can assume some fundraising responsibilities, such as sponsoring activities to raise money or approaching local businesses for donations.

Effective youth involvement requires serious commitment on the part of all individuals at every level of an organization. Adults who intend to fully integrate involved youth into the program must address the organizational culture and structures that make youth involvement easy or difficult. For example, the organization may need to redefine its business hours or to modify some meeting spaces. Both adults and young people will need to examine their communication styles before they can forge effective partnerships. Effective youth involvement in prevention programming often means changing the rules. However, the rewards are large. When youth are truly involved in decisions about program design, development, implementation, and evaluation, they are able to ensure that the program is relevant and responsive to adolescents' interests and needs.

The essence of youth involvement is a *partnership* between adults and young people. Effective youth/adult partnerships work toward solving community problems. Working partnerships also acknowledge the contributions of all participants – youth and adults. In theory, creating such partnerships sounds good and makes a lot of sense, but putting such a partnership into practice is not always easy.

Power dynamics, usually rooted in cultural norms, may make it difficult for young people and adults to feel comfortable working together. Years of formal instruction in school often teach young people to expect answers from adults. Some youth expect adults to largely ignore, deride, or veto youth's ideas. Adults frequently underestimate the knowledge and creativity of young people. Adults are also accustomed to making decisions without input from youth, even when youth are directly affected by those decisions. Therefore, joint efforts toward solving problems can be difficult, requiring deliberate effort on the part of both adults and young people.

One researcher developed the Spectrum of Attitudes theory and identified three different attitudes that most adults hold toward young people.[11] These attitudes affect adults' ability to believe that young people can make good decisions. These attitudes also determine the extent to which adults may be willing to involve young people as significant partners in decisions about program design, development, implementation, and evaluation. The three attitudes represent seeing youth as 1) objects, 2) recipients, or 3) partners. Page 43 offers a summary of the attitudes.

The TAP coordinator should be aware of how and what he/she communicates to teens about his/her own ideas. Subtly negative reactions may suppress youth's energy and commitment to the project. If the TAP coordinator completely disagrees with a proposal put forward by youth which is a viable, acceptable, and educational approach, he/she should encourage the youth to proceed. For many adults, accepting – even while disagreeing – with youth's ideas can be the most challenging aspect of a peer education project. Overall, the more responsibility youth assume while receiving proper direction from adult leaders, the more successful the TAP program will be.

Objective 4. Recruiting Youth Who Will Become TAP Members

The TAP coordinator can recruit TAP members through a variety of mechanisms, including word of mouth, flyers, applications, and interviews. Outreach should portray the program in a way that will stimulate excitement and interest. During its first year, recruitment may depend on teachers, community members, and youth workers who can identify and enlist youth. After the TAP program has become established, TAP members themselves will be most successful at recruiting other teens into the project. Since they can speak from personal experience, they can interest their peers in the project.

Before beginning recruitment, leaders should consider the requirements for participation. Successful program leaders recommend that planners not limit participation to, nor seek out and recruit, academically high achieving youth because many other teens will not see them as peers. Planners should seek youth who have a variety of abilities, talents, and backgrounds. Some of these youth will be high achieving academically; most will not. During the TAP pilot-test, schools that participated required that members have parental permission and maintain at least a C-average. Youth-serving agencies recruited youth who were interested in HIV/STI prevention and exhibited leadership ability.

Information from the needs and assets assessment will be useful in helping planners identify the target population to reach with the HIV/STI prevention messages. Planners should then recruit youth that resemble the target population in race/ethnicity, gender, language, sexual orientation, and cultural heritage. The circumstances of the sponsoring organization, rather than the urgent needs of a particular population, may define the group to target. For example, in a school, the target population may be as the entire student body or particular grades. A youth-serving agency may target youth from a certain neighborhood or all youth that participate in the programs offered by the agency.

Consider how many youth should be in the TAP group. A group of 10 to 15 will be both flexible and manageable. During the program year, some members will probably dropout for various reasons. This is normal for many peer education groups.

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Spectrum of Attitudes[11]

Youth as Objects –

Adults who have this attitude subscribe to the myth of adult wisdom. They believe adults know what is best for young people. They attempt to control situations in which young people are involved. They believe that young people have little to contribute. Further, they may feel the need, based on their own prior experiences, to protect young people from suffering the potential consequences of mistakes. Adults who see youth as objects seldom permit more than token youth involvement and usually have no intention of meaningfully involving youth. One example might be an adult writing a letter to an elected official about an issue pertinent to youth and using a young person's name and signature for impact.

Youth as Recipients –

Adults who have this attitude believe that adults must assist youth to adapt to adult society. They permit young people to take part in making decisions because they think the experience will be good for them and assume that youth are not yet "real people" and need practice to learn to "think like adults." These adults usually delegate to young people trivial responsibilities and tasks that the adults do not want to undertake. Adults who see youth as recipients usually dictate the terms of youth's involvement and expect young people to adhere to those terms. One example might be adults extending an invitation to one young person to join a board of directors otherwise comprised solely of adults. In such a milieu, a young person's voice is seldom raised and little heard. Adults do not expect the young person to contribute, and the young person knows that adults deliberately retain all power and control.

Youth as Partners –

Adults who have this attitude respect young people and believe that young people have significant contributions to make now. These adults encourage youth to become involved and firmly believe that youth involvement is critical to a program's success. These adults accept youth's having an equal voice in decisions. They recognize that youth and adults both have abilities, strengths, and experience to contribute. Adults who have this attitude will be as comfortable working with youth as with adults and enjoy an environment with both youth and adults. Adults who see youth as partners believe that genuine participation by young people enriches adults' just as adult participation enriches youth and that a mutually respectful relationship recognizes the strengths that each offers. One example might be hiring a young person to participate from the beginning in developing a proposal to be submitted to a funding institution.

After defining the target population, requirements for TAP members, and the number of peer educators needed, planners should circulate flyers, talk with community leaders, pass out applications, and set up interviews. The coordinators and other involved youth and adults should allow at least six weeks for recruitment in a community-based agency and at least two or three weeks in a school or organization with consistent access to the target population.

Permission Slips

Some schools and community-based programs require that participating youth have parental permission. Signed parental permission forms ensure that parents are informed about and approve of young people's participation. Moreover, permission slips protect the program from potential problems with parents who may not understand or approve of a young person's involvement in TAP. For groups that work with undocumented, runaway, homeless, or street youth or with gay, lesbian, bisexual, and transgender (GLBT) youth, parental permission slips may not be needed. A sample permission slip is included at the end of this chapter and in the Appendix.

Endnotes:

1. Remafedi G. Homosexual youth: a challenge to contemporary society. *JAMA* 1987;258:222-225.
2. Remafedi G, French S, Story M *et al*. The relationship between suicide risk and sexual orientation: results of a population based study. *American Journal of Public Health* 1998;88:57-60.
3. Remafedi G. Adolescent homosexuality: psychosocial and medical implications. *Pediatrics* 1987;79:331-337.
4. Centers for Disease Control & Prevention. *HIV/AIDS Surveillance Report* 1999;11(1): 1-42.
5. Soet JE, Dilorio C, Adame D. HIV prevention, knowledge, attitudes, and sexual practices among Asian college students. *Journal of Health Education* 1997;28(6 Supplement):S22-S28.
6. Chng CL, Sy FS, Chois ST, *et al*. Asian and Pacific Islander American HIV community-based organizations: a nationwide survey. *AIDS Education & Prevention* 1995;7:251-263.
7. Office of Research on Women's Health. *Women of Color Health Data Book: Adolescents to Seniors*. Bethesda, MD: National Institutes of Health, 1998.
8. Bureau of Indian Affairs, Office of Indian Education Programs. *1997 Youth Risk Behavior Survey of High School Students Attending Bureau Funded Schools*. Washington, DC: The Bureau, 1998.
9. Edwards S. Among Native American teenagers sex without contraceptives is common. *Family Planning Perspectives* 1992;24:189-191.
10. Schuster MA, Bell RM, Kanouse DE. The sexual practices of adolescent virgins: genital sexual activities of high school students who have never had vaginal intercourse. *American Journal of Public Health* 1996;86:1570-1576.
11. National 4-H Council. *Creating Youth/Adult Partnerships: The Training Curricula for Youth, Adults, and Youth/Adult Teams*. Chevy Chase, MD: The Council, 1997.

Sample Permission Slip

I, _____ , give my permission for my son/daughter
(name of parent/guardian)

_____ to participate in the TAP / HIV/STI Prevention
(name of student)

Peer Education program at _____. I understand that
(agency/school)

he/she will be learning facts about HIV and other STIs and skills for protecting him/herself and that he/she will participate in designing an educational campaign for other youth. I understand that the TAP group will meeting on _____ and _____ each week from _____
(days of the week) (time)
to _____.

_____
(parent/guardian's signature)

_____ yes _____no I am interested in receiving some HIV/STI prevention materials.

_____ yes _____no I may be available and willing to drive TAP members to conferences, meetings, or presentations.

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Session 1, Activity C
Handout

TAP Evaluation Survey: Pretest

HIV and AIDS as well as other STIs are serious problems in the United States. We want to find the best ways to teach youth about HIV/STIs. This survey will help us understand what you know and how you feel about HIV and AIDS. Your answers are important. Please answer each question carefully and honestly. Please note that, in this survey, *having sex* means making love, doing it, or having sexual intercourse. *Having sex* means having vaginal, oral, and/or anal intercourse.

Write your answers directly on this survey. Please, do NOT put them on another sheet of paper. Do NOT write your name on this survey. Your answers will be kept confidential, and no one will know how you answered this survey. You will have 15 minutes for this pretest. When you are finished, please come up and put the survey in this box. Remember NOT to write your name on the survey.

Thank you for your help.

Please mark your answers with a check mark or an answer in the appropriate space on the left.

1. Are you male or female?
   ___ female
   ___ male
2. How old are you?
   ___ years old
3. What is your race?
   ___ Asian/Pacific Islander
   ___ Black/African-American
   ___ Hispanic
   ___ Native American
   ___ White (non-Hispanic)
   ___ Other (please specify)

Please circle your response on the right.

4. Can a person get HIV (the virus that causes AIDS) from any of the following?

a. Going to school with a student who has AIDS or HIV	YES	NO
b. Kissing someone who has AIDS or HIV	YES	NO
c. Sharing needles or "works" with someone who has AIDS or HIV	YES	NO
d. Sharing needles to pierce ears, take steroids, or get tattoos with someone who has AIDS or HIV	YES	NO
e. Having sex without a condom with someone who has AIDS or HIV	YES	NO
f. Being bitten by mosquitoes or other insects	YES	NO
g. Giving blood at a hospital, blood bank or the Red Cross	YES	NO
h. Swimming in a pool with a person who has AIDS or HIV	YES	NO

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Circle #4

Reproduction and Sexual Health - These are a person's capacity to reproduce and the behaviors and attitudes that make sexual relationships healthy and enjoyable.

- **Factual information about reproduction** – Is necessary so youth will understand how male and female reproductive systems function and how conception and/or STI occur. Adolescents often have inadequate information about their own and/or their partner's body. Teens need this information so they can make informed decisions about sexual expression and protect their health. Youth need to understand anatomy and physiology because every adolescent needs the knowledge and understanding to help him/her appreciate the ways in which his/her body functions.
- **Feelings and attitudes** – Are wide-ranging when it comes to sexual expression and reproduction and to sexual health-related topics such as STI, HIV and AIDS, contraceptive use, abortion, pregnancy, and childbirth.
- **Sexual intercourse** – Is one of the most common behaviors among humans. Sexual intercourse is a behavior that may produce sexual pleasure that often culminates in orgasm in females and in males. Sexual intercourse may also result in pregnancy and/or STIs. In programs for youth, discussion of sexual intercourse is often limited to the bare mention of male-female (penile-vaginal) intercourse. However, youth need accurate information about three types of sexual intercourse – vaginal, oral, and anal intercourse.
- **Reproductive and sexual anatomy** – The male and female body and the ways in which they actually function is a part of sexual health. Youth can learn to protect their reproductive and sexual health. This means that teens need information about all the effective methods of contraception currently available, how they work, where to obtain them, their effectiveness, and their side effects. This means that youth also need to know how to use latex condoms to prevent STI. Even if youth are not currently engaging in sexual intercourse, they probably will do so at some point in the future. They must know how to prevent pregnancy and/or disease.

  Finally, youth also need to know that traditional methods of preventing pregnancy (that may be common in that particular community and/or culture) may be ineffective in preventing pregnancy and may, depending on the method, even increase susceptibility to STIs. The leader will need to determine what those traditional methods are, their effectiveness, and their side effects before he/she can discuss traditional methods of contraception in a culturally appropriate and informative way.
- **Sexual reproduction** – The actual processes of conception, pregnancy, delivery, and recovery following childbirth are important parts of sexuality. Youth need information about sexual reproduction – the process whereby two different individuals each contribute half of the genetic material to their child. The child is, therefore, not identical to either parent. [Asexual reproduction is a process whereby simple one-celled organisms reproduce by splitting, creating two separate one-celled organisms identical to the original [female] organism before it split.] Too many programs focus exclusively on sexual reproduction when providing sexuality education and ignore all the other aspects of human sexuality.

Circle #5 - Sexualization

Sexualization is that aspect of sexuality in which people behave sexually to influence, manipulate, or control other people. Often called the "shadowy" side of human sexuality, sexualization spans behaviors that range from the relatively harmless to the sadistically violent, cruel, and criminal. These sexual behaviors include flirting, seduction, withholding sex from an intimate partner to punish her/him or to get something, sexual harassment, sexual abuse, and rape. Teens need to know that no one has the right to exploit them sexually and that they do not have the right to exploit anyone else sexually.

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3. Is encouragement the same as pressure? Where do you draw the line and why?
4. Do many young men think like Darrel? How can they be encouraged to use condoms?
5. What role should Yvonne play in a discussion of condom use?

Role-Play D: Four Male or Females Actors

Scene The teens are in a kitchen at a party. The parents are not at home. Pat takes out some crack and a pipe, asking, "Anyone got a light? Come on, don't be shy, this party is just starting."

Actors

1. *Pat* – Gets acceptable grades and is popular. Isn't sure what she/he will do after high school.
2. *Lee* – Shy, just moved to the neighborhood. Used drugs, but has vowed to stop now that he/she lives in a new place.
3. *Chris* – Soccer and basketball team captain. Drinks on occasion.
4. *Robin* – Plays some sports with Chris, studies and hopes to go to college. Hasn't tried drugs or alcohol and sometimes feels like the only one who hasn't.

Discussion Questions:

1. What might make each character say yes? Or say no?
2. Would this be different if it were heroin and a syringe or would it be the same?
3. If you never knew Pat used drugs, how would you feel if she/he offered it to you?
4. HIV isn't spread by smoking crack or sharing a pipe, so how could smoking crack put one of these characters at risk for HIV?

Role-Play E: Two Female Actors

Scene Anna, age 16, is dating an older guy named Steven, age 21, whom she doesn't know very well but likes a lot. They started having sexual intercourse last week and didn't use a condom or any other form of contraception. Her friend, Julie, age 16, is afraid the man might be using injection drugs and is worried that Anna may be exposing herself to both pregnancy and HIV. She says, "You've got to tell him to use a condom."

Discussion Questions:

1. How important is it for Anna to find out about her boyfriend's past and present – both about his sexual history and his drug use?
2. Why might someone not tell the truth about what they've done in the past – both sexually and about drug use? Would loving someone change this?
3. What might make it difficult for Anna to discuss using a condom with her boyfriend?
4. What should Anna do if her boyfriend says he doesn't like condoms?
5. How did you feel about what Julie was saying to Anna?

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Youth Developing Activities to Educate Their Peers <<<

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Chapter VII.

Evaluating the Peer Education Program

This chapter provides a step by step guide to planning the evaluation of the TAP program. Some program planners and implementers think of evaluation as the collection of a lot of useless information they will never see again. However, when designed correctly, evaluation becomes a practical tool that provides information about program components that work and do not work – giving a basis for modifying and strengthening the program. Evaluation keeps the program on track, identifies problems, and also makes the program credible to funding sources and supporters in the community. Although evaluation can be quite complex, it need not be difficult. This chapter provides some strategies for conducting simple evaluations, even for those with no previous experience. For those who want or need a more sophisticated program assessment, this chapter offers an overview of where to find more information and a trained evaluator to help. The chapter describes how to plan the evaluation, conduct process and outcome evaluations, and get additional information and technical assistance.

Planning for Evaluation

An evaluation plan should be a part of the overall TAP implementation strategy. Planning for evaluation begins at the same time as planning the program. By now, you should have read Chapters I, II, III, and IV. If you haven't, please read them now. Then, read this chapter before you begin program planning. The objectives set for the TAP program will be the same objectives used to structure the evaluation. Making the objectives specific permits evaluation. Measurable criteria for determining accomplishments, such as numbers and percentages, dates and locations, and the kind of activities involved will also guide evaluation.

Evaluation is a means of discovering the achievements of a program. Evaluation will provide feedback on the program's progress and measure the program's impact on the TAP members – the youth trained as peer educators. The following four steps will guide a workable evaluation plan that can be a direct benefit to the TAP program.

Step 1: Review the objectives and decide what to measure.

- Are the program objectives clearly stated?
- Are aspects of the objectives measurable or quantifiable?
- If so, for each objective, how will you know when this objective is met?
- If not, how can the objective be redesigned in order to permit evaluation to see if and when this objective is met?

The answers suggest what you should measure. If an objective does not specify what to measure, consider the objective's purpose in helping to meet program goals. Then reword it so that it specifies what should be measured. For example, if one objective is to increase youth's comfort with condoms and with vocabulary related to sexuality, how will you measure this? If you cannot figure out how to measure an objective, it may need to be reworded or reassessed.

Step 2: Collect measurements (also referred to as information or data). Use simple forms whenever possible, such as field notes and attendance lists. (These are described later in this chapter.) Collect the data when the event or activity actually happens. Many types of information cannot be collected later. For example, to know how many youth attend a TAP presentation, getting a head count at the time is essential. It cannot be done later. In another example, to measure increased knowledge or skill levels, you must have baseline data. Otherwise, there is no way to measure change.

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