A *Focus on Kids* Intervention

FOCUS ON YOUTH WITH IMPACT

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

An Evidence-Based Curriculum

Implementation and Technical Assistance Guide

Focus on Youth with ImPACT

(Informed Parents and Children Together)

A *Focus on Kids* Intervention

An HIV Prevention Program for African-American Youth

with a Complementary Program for Parents

Implementation and Technical Assistance Guide

ETR Associates
Santa Cruz, California

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

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

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Purpose of This Guide

This Implementation and Technical Assistance Guide has been designed for Executive Directors, Program Directors and Managers, Technical Assistance/Capacity-Building Providers and Program Evaluators. The purpose of this guide is to enable agencies to better plan, implement and monitor *Focus on Youth with Informed Parents and Children Together (ImPACT)*.

It also serves the purpose of giving agencies the necessary information to address any challenges or barriers that may be encountered during implementation of *Focus on Youth with ImPACT.*

Acknowledgments

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

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

We are grateful for the commitment of the original researchers, Bonita Stanton, MD, PhD, and Jennifer Galbraith, PhD, the writers, all of the youth, their parents and the youth service providers who helped to focus-group test and pilot *Focus on Youth with ImPACT.* We would also like to thank the Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention, Diffusion Team Members: Winifred King, PhD, MPH; Ivory Kimbrough, MPH; Patricia Patrick; Lashaun Polk, MPH; and Harneyca M. Hooper, MPH.

The Focus on Youth with ImPACT Team

Cherri Gardner, MA
James Walker
Tereé Jerome
Sarah Stevens
Pam Drake, PhD
Scott Martin
Suzanne Schrag
Charlene Foster

Acknowledgments from the Original Focus on Kids

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

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

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

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

- Center for Experiential Education
- Center for Population Options
- Ross Ford, for the Family Tree Activity
- Patricia Kramer

- Planned Parenthood of Bergen County, Inc., The Center for Family Life Education
- Planned Parenthood of Maryland STARS (Students Talking About Responsible Sexuality)
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The curriculum would not have been possible without the aid and funding of the National Institute of Mental Health, the National Institute of Child Health and Development, and the Agency for Health Care Policy and Research. The Child Health Foundation supported our efforts to turn the results of this work over to Baltimore communities. Finally, we thank ETR Associates for helping us reach a much greater audience of youth.

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

The Original Focus on Kids Team

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

Introduction and Overview

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

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

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

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

ImPACT is a 90-minute HIV prevention program for parents of African-American adolescents used in combination with F*ocus on Youth*. *ImPACT* is delivered to

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

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

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

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

parents/guardians and youth, one family at a time, by a health educator. It consists of basic HIV information, a culturally appropriate video documentary that stresses parental monitoring and communication, a discussion with the health educator, two guided roleplays, a parent/guardian resource guide, and a condom demonstration. It was guided by parental monitoring theory and theory of parenting (passive, authoritarian and authoritative).

What Makes *Focus on Youth with ImPACT* Different?

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

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

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

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

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

stay connected with their youth as the youth face difficult decisions during their teen years.

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

Target Audience for *Focus on Youth with ImPACT*

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

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

Focus on Youth with ImPACT Essentials

Maintaining Fidelity

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

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

Key Characteristics are important, but not essential, attributes of an intervention's recommended activities and delivery methods. They may be modified to be culturally appropriate and fit the risk factors, behavioral determinants, and risk behaviors of the target population and the unique circumstances of the venue, agency, and other stakeholders. Modification of key characteristics should not compete with or contradict the core elements, theory, and internal logic of the intervention. (McKleroy, et al., 2006)

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

Core Elements and Key Characteristics of *Focus on Youth*

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

Implementation core elements:

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

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

Content core elements:

- **Core Element 4:** Use culturally appropriate interactive activities proven as effective learning strategies to help youth capture the important constructs in the theory.
- **Core Element 5:** Include a "family tree" to contextualize and personalize abstract concepts, such as decision making and risk assessment.
- **Core Element 6:** Enable participants to learn and practice a decision-making model such as SODA (Stop, Options, Decide, Action).
- **Core Element 7:** Train participants in assertive communication and refusal skills specifically related to negotiation of abstinence or safer sex behaviors.
- **Core Element 8:** Teach youth proper condom use skills.

Key characteristics:

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

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

Core Elements and Key Messages of *ImPACT*

Implementation core elements:

- **Core Element 1:** Delivering intervention **one-on-one** to parents/guardians and youth in well-located community-based setting

(such as CBO, church, recreation center, or school) or their home at a time and place that is convenient for parent/guardian.

- **Core Element 2:** Use of a facilitator whom the parents/guardians find credible. The facilitator should be skilled at building rapport with parent and youth at the beginning of the session.
- **Core Element 3:** Ideally, *ImPACT* should be delivered prior to the youth beginning the *Focus on Youth* intervention.

Pedagogy core elements:

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

Content core elements:

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

Video/DVD Key Messages

The following messages have been identified as the “heart and soul” of the video/DVD. Before viewing the video/DVD with parents and youth, be sure to have reviewed these key messages. This will help you engage in discussions during the parent/youth sessions. These key messages were

derived from an intensive formative evaluation, including ethnographic research and a review of the literature.

1. It is important to talk to your youth about sex before they start having sex.
   - Best time to influence is before youth start having sex.
   - Find a good time for you (parent/guardian) and youth.
   - You can't wait for them to ask about sex.
   - Don't wait until he/she is in the situation, because you are not going to be around.
   - Parents need to talk with their youth about STDs and pregnancy.
2. Parents should talk to their children about abstinence.
   - Talking to youth about abstinence and making sure to correct the misperception that "everybody's doing it" will allow them to make better sexual decisions.
3. It is important to know whom your youth is with, what he/she is doing and where he/she is.
   - Hang out with your youth. Know his or her friends, know what he/she is facing.
4. It is important for youth to know how they would respond if they were in a situation in which they might be pressured into having sex (even when the pressure might be positive, such as a boyfriend or girlfriend saying how much he/she loves them).
5. There are serious consequences to risky sexual behavior.
   - Fifteen to 30% of all HIV infections occur among people younger than age 25.[7]
   - African Americans are disproportionately affected by HIV, accounting for 55% of all HIV infections reported among young people ages 13 to 24.
   - Although treatment is now available that allows people to live much longer with HIV, there are still many difficulties with being HIV infected, including serious treatment side effects and stigma.

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

- Sex can make it difficult for a young person to reach their goals.
- The decisions youth make when young have an impact on their future.

6 Parents should talk to their youth about proper condom use.
- Talking to youth about condoms and making sure they know how to use condoms is not the same thing as encouraging them to have sex.

7 Communication goes both ways.
- Be approachable. A parent's negative reaction to a youth coming to talk can stop future conversations.
- It is important to listen to your youth.
- Often youth are happy that parents talk to them about sex. It shows them you care.

8 Talking with your youth is difficult but it gets easier over time.
- Both parents and youth often feel awkward about these discussions.
- Be prepared. Do the best you can do as a parent and for yourself.
- It is OK to tell your youth you don't know the answer to a question and to find out the answer later.
- Parents and youth are having these difficult conversations successfully. It can be done!

9 If you feel you cannot talk to your youth about sex, it is important to find someone else to talk to him/her. Find someone who shares your values and has a good rapport with your youth so the youth respects and enjoys talking with this person.

10 Allow youth to grow toward independence, but set guidelines too.
- Ultimately, youth are going to make their own decisions, but it is parents' job to give them information and prepare them as much as possible.

Pilot Study and Lessons Learned

A four-day training session for facilitators of the *Focus on Youth* pilot was held in Oakland, California, in November 2006. Eighteen participants representing CBOs and local health jurisdictions from six cities were in attendance each day.

The purpose of the pilot study was to ascertain the usefulness and appropriateness of the activities associated with the *Focus on Youth* intervention. This determination was made by the achievement of the following objectives:

- Training facilitators to implement the *Focus on Youth* intervention.
- Providing ongoing technical assistance to facilitators.
- Implement the pilot of the *Focus on Youth* intervention in community-based venues nationally.
- Collect process data from youth participants and facilitators to support the refinement of the *Focus on Youth* intervention.

Some of the objectives of the training session were for participants to be able to:

- Explain the historical perspective of *Focus on Youth*.
- Understand curriculum core elements and increase their ability to maintain fidelity by being able to identify examples that would violate those core elements.
- Increase their familiarity with the curriculum and Evaluation Manual by experiencing as youth and participating in discussions about how the curriculum relates to the lives of the youth in their communities.
- Gain a clear understanding of current HIV/STD information.
- Increase their comfort, competence and confidence in facilitating groups of at-risk African-American youth ages 12–15 by delivering, as facilitators, some of the curriculum content.
- Enhance their understanding of the Capacity Building Assistance services available as they undertake this pilot project, including assistance with *Focus on Youth* and assistance with other assessed program needs related to HIV prevention for African-American youth ages 12–15.
- Understand and commit to their *Focus on Youth* pilot recruitment, retention, implementation and follow-up responsibilities as agencies and facilitators.

Participants had several opportunities to provide feedback on the training sessions, all of which was overwhelmingly positive. The participants returned home to develop and implement the marketing and recruitment strategies and the *Focus on Youth* intervention. The intervention was well

received by both youth and facilitators. Intervention experiences were documented in order to improve the flow of the intervention.

A 4-tiered approach was used for obtaining information from both youth and pilot participants:

Pilot Observation Logs and Interviews: The logs were used by outside observers to evaluate youth engagement and facilitator fidelity and skill to determine if modifications need to be made in training sessions or the curriculum manual. All observations were accompanied by an interview of the session facilitator to follow up on changes observed in the session and determine additional Capacity Building Assistance (CBA) needs.

Facilitator Implementation Log: This log was used by session facilitators to document fidelity, as well as youth engagement and facilitator comfort with each session. For each program activity in a session, facilitators indicated whether it was "taught as suggested," "taught with changes," or "not taught." They also provided a description of changes made to the session as well as a description of any situations that may have had and impact on implementation.

Youth Outcome Survey: This self-report survey was used to evaluate attainment of youth outcomes. The survey covered the attitudes, skills, knowledge and behaviors addressed in the *Focus on Youth* program.

Follow-Up Telephone Interviews: Telephone interviews were conducted one month and three months after the end of the pilot. They were used to gather post-pilot feedback, determine intent to implement *Focus on Youth* and assess sustainability.

Some of these experiences are highlighted below as lessons learned.

Recruitment:

- To achieve the highest level of success with youth groups, recruitment should begin 6– 8 weeks prior to when the start of the session is anticipated.
- Agencies should draft letters to parents and guardians early on, including language that prepares the parents for the *ImPACT* session. Sample letters can be found in Section 6 of this guide.
- Agencies were most successful with gathering resources for their program when they develop the community outreach letter several weeks

prior to implementing the sessions. A sample letter can be found in Section 6 of this guide.

- In terms of identifying appropriate youth for the intervention, it has been found that utilizing youth who have participated in other programs offered by your agency is particularly useful, as the existing rapport only adds to the success of the program.

Pre-implementation:

- Agencies should have resources to allocate the appropriate time for facilitators to implement this intervention (approximately 4 hours per week). In many instances, that may mean shifting selected duties while preparing for and implementing the program.
- Each facilitator should know the community. Explore who in the community may be willing to provide donations.
- To insure success, facilitators should have completed HIV 101 courses, and have knowledge and a clear understanding of the various types of contraception.
- Facilitators must have group facilitation experience and skills in order to successfully complete this program.
- Selecting youth-friendly facilitators, who are comfortable with facilitating sensitive discussions, are respected by the parents and have the trust of the youth is critical to program success.
- It is important for agencies to allow the two facilitators time prior to the session to prepare together. It is equally important that the facilitators make space to candidly discuss each other's strengths and weaknesses, as well as debrief after each session regarding the challenges and successes encountered to allow for greater support of each other during future sessions.

During implementation:

- Facilitators should consider the normal, regularly occurring events happening around them. What season is it? What weather conditions could affect the implementation of the program? Make sure to account for daylight savings time, etc.
- Facilitators should think out transportation logistics. How are youth getting to the site? bus? friends? carpool with other youth?

- When choosing a space, it is imperative to think about the physical space needed for some of the activities. The space should be large enough for participants to move around.
- Note that Sessions 5 and 7 provide the option for facilitators to utilize a rape crisis counselor (Session 5) and an HIV-positive speaker (Session 7). If you choose to utilize speakers, it is imperative that the facilitator begin working on securing the speaker prior to implementing any of the sessions.

Focus on Youth with ImPACT Intervention Package

For those who choose to implement *Focus on Youth with ImPACT* and send staff to be trained in the intervention, a comprehensive intervention package will be provided for participants to take back to their sites. The materials participants will receive at their training include the following:

1. Curriculum.
2. Implementation and Technical Assistance Guide. The Implementation and Technical Assistance Guide serves as a resource to provide technical assistance to agencies that are implementing *Focus on Youth with ImPACT.* It provides key information and addresses frequently asked questions associated with the intervention.
3. Evaluation Manual. This manual provides detailed guidance in how to plan for your evaluation, along with copy-ready instruments that can be used for conducting your evaluation activities.
4. Ten (10) Youth Workbooks. Each youth workbook contains all handouts and fact sheet your youth will need while participating in the Focus on Youth intervention.
5. *ImPACT* Facilitator's Guide. This guide provides step-by-step instruction on conducting the *ImPACT* intervention with parents and guardians.
6. Ten (10) *ImPACT* Parent/Guardian Resource Guides. This Resource Guide is provided to parents and guardians who participate in *ImPACT.* This Resource Guide also provides tips for parents/guardians for opening communication with their youth, especially around discussing topics related to HIV prevention.
7. *ImPACT* DVD. This DVD is a documentary of parents and youth engaged in dialogue about abstinence, effective communication, parental

monitoring and condom efficacy. The DVD accompanies the *ImPACT* facilitator's guide and provides step-by-step instruction for facilitators to implement the parent session.

8. *Focus on Youth with ImPACT* CD. This CD contains Word documents of all sample letters, permission slips and other resources, as well as PDF files of the *Focus on Youth* curriculum.
9. Job Aids. These laminated job aids are provided to assist with presenting key content information and signs to post for particular activities.

With the exception of the Implementation and Technical Assistance Guide, the materials above are only available to those who attend a *Focus on Youth* training. In some instances, however, appropriate Health Department or School staff may obtain a preview package from ETR or AED.

II Getting Started—Pre-Implementation

Your ability to effectively assess your agency's capacity to implement the *Focus on Youth with ImPACT* intervention prior to actually implementing the intervention will be critical to your success. Because *Focus on Youth with ImPACT* has multiple layers of involvement and engagement of its participants, parent/guardians and the community at large, it will be important to think about the following factors: assessing readiness, budgeting, conducting focus groups, and staff training and development.

Agency Capacity and Readiness

It is critical to effectively assess your agency's capacity to implement an intervention. The assessment of agency capacity can help identify areas of development that can lead to the success of the intervention. In most cases, the optimal time to do this type of assessment is prior to beginning to implement the intervention

Assessing Agency Readiness for *Focus on Youth with ImPACT*

When assessing your agency's readiness to implement *Focus on Youth with ImPACT,* here is a checklist of things to consider:

- ❑ What are your desired outcomes/goals for your *Focus on Youth* program? What population of youth are you trying to reach?
- ❑ What has your agency previously done in this area? What made it effective/ineffective?
- ❑ Are there others in your area working with African-American youth around HIV, STD and pregnancy prevention? What's made them effective/ineffective?
- ❑ What are the natural alliances between your agency and other community stakeholders (e.g., businesses, community-based organizations, media, etc.)? How might that relationship be leveraged?
- ❑ What resources will be required to see your *Focus on Youth* intervention through to its successful completion? Think about both financial and non-financial resources (human capital, space and other donations).
- ❑ How will you recruit youth for your *Focus on Youth* intervention?

- ❑ How will your target population best receive messages or learn about your Focus on Youth program?
- ❑ Is the community aware of the impact of HIV among African Americans, and specifically African-American youth? If so, do you have a gauge of their willingness to be engaged in the process?
- ❑ How prepared is your organization? Is there training that needs to happen? Is there agency buy-in?

Organizations interested in arranging training or technical assistance for *Focus on Youth with ImPACT* can contact your CDC project officer or ETR Associates at 510-645-1047, tereej@etr.org, jamesw@etr.org.

Budgeting for *Focus on Youth with ImPACT*

As your agency prepares to implement the *Focus on Youth with ImPACT* intervention, it is important to assess its fiscal obligations during your formative evaluation process. *Focus on Youth with ImPACT* is a relatively inexpensive intervention to implement. The following information and two sample budget sheets (Start-Up Costs and Maintenance Costs) are provided to help your agency create or refine a budget for *Focus on Youth with ImPACT*. The sample start-up budget covers the participation of two facilitators at the *Focus on Youth with ImPACT* Training of Facilitators, preparation and one 8-session cycle of *Focus on Youth with ImPACT.* (One "cycle" consists of 1 parent session with each parent/guardian of a participating youth and the 8-session *Focus on Youth* intervention.)

The justification of the line items found on both sample budgets is as follows:

Program manager (5% FTE): The program manager's responsibilities are to provide direct oversight to the two facilitators, and to ensure that the intervention is implemented with fidelity.

Two (2) facilitators (10% FTE): To conduct *Focus on Youth with ImPACT,* your agency will need two experienced group facilitators for each group of youth, who will complete the *Focus on Youth with ImPACT* training and implement the *Focus on Youth with ImPACT* intervention.

Fringe Benefits: For employee benefits; calculated at 25% per FTE.

Facility costs: Facility expenses have been included to ensure that adequate space can be provided for the implementation of the intervention.

FOY equipment: Audio and video equipment is needed to facilitate activities (e.g., if an agency uses a video instead of a speaker). A portable DVD player is needed for parent sessions.

Other equipment: Includes equipment to conduct office work such as a computer.

Office supplies: Includes pens, paper, newsprint, paper clips, staples, markers, tape, Post-its, etc.

Other expenses: Includes printing, copying, educational materials (e.g., health brochures, intervention flyers, etc.) and guest speaker honorarium for Session 7.

Incentives: Non-cash incentives (e.g., gift cards, transportation vouchers and nutritional incentives) have been identified to assist in the successful recruitment and retention of youth participants throughout the course of the intervention.

Travel: This line item is designated to support staff who will travel to complete the FOY Training of Facilitators course. Depending on your agency, staff may be eligible to receive support for per diem, lodging, transportation and other expenses.

Focus on Youth with ImPACT Sample Start-Up Costs

Personnel Cost	FTE%	Salary	Time on Project	Cost	Total
Program Manager (1)	5%	$42,000.00	5 months	$875.00	
Facilitators (2)	10%	$32,000.00	4 months	$1,066.66	
Fringe Benefits (25%)				$485.42	
					$2,427.08
Facilities Cost	**FTE%**		**Time on Project**	**Cost**	
Office Space					
$2.29/sq. ft @ 48 sq. ft/day (30) x FTE	25%		4 months	$3,297.60	
Meeting Space	N/A				
$2.29/sq. ft. @ 144 sq. ft/day x 2 days			16 hours	$659.52	
					$3,957.12
FOY Equipment			**Time on Project**	**Cost**	
Television				$500.00	
Portable DVD player				$150.00	
Easel				$75.00	
					$725.00
Other Equipment	**FTE%**		**Time on Project**	**Cost**	
Computer					
$200/month x FTE	25%		4 months	$200.00	
					$200.00
Office Supplies				**Cost**	
Paper, pens, stapler, staples, newsprint, markers, etc.				$200.00	
					$200.00
Other Expenses				**Cost**	
Copying & Other Printing					
100 copies @ $.10/copy				$10.00	
Postage & Mailing				$25.00	
Guest Speaker Honorarium				$100	
Educational Materials				$100.00	
					$235.00
Incentives					
Non-Cash Incentives					
$25 gift card x 10 youth				$250.00	
Transportation Vouchers					
$3/week x 10 youth x 8 sessions				$240.00	
Nutritional Incentives					
$5 x 10 youth x 8 sessions				$400.00	
					$890.00
Travel	**FTE%**			**Cost**	
Air travel to *FOY with ImPACT*					
$600/ FTE	2			$1,200.00	
Lodging					
$89/night x 6 nights x 2 FTE	2			$1,068.00	
Per Diem					
$50/day x 6 days x 2 FTE	2			$600.00	
					$2,868.00
TOTAL					**$ 11,502.20**

Focus on Youth with ImPACT Sample Maintenance Costs

Personnel Cost	FTE%	Salary	Time on Project	Cost	Total
Program Manager (1)	5%	$42,000.00	3 months	$525.00	
Facilitators (2)	10%	$32,000.00	3 months	$1,599.96	
Fringe Benefits (25%)				$531.24	
					$2,656.20
Facilities Cost	**FTE%**		**Time on Project**	**Cost**	
Office Space					
$2.29/sq. ft. @ 48 sq. ft/day (30) x FTE	25%		3 months	$3,297.60	
Meeting Space	N/A				
$2.29/sq. ft. @ 144 sq. ft/day x 2days			16 hours	$659.52	
					$3,957.12
Other Equipment	**FTE%**		**Time on Project**	**Cost**	
Computer					
$200/month x FTE	25%		3 months	$150.00	
					$150.00
Office Supplies				**Cost**	
Paper, pens, stapler, staples, newsprint, markers, etc.				$200.00	
					$200.00
Other Expenses				**Cost**	
Copying & Other Printing					
700 copies @ $.10/copy				$70.00	
Postage & Mailing				$25.00	
Guest Speaker Honorarium				$100	
Educational Materials				$100.00	
					$295.00
Incentives					
Non-Cash Incentives					
$25 gift card x 10 youth				$250.00	
Transportation Vouchers					
$3/week x 10 youth x 8 sessions				$240.00	
Nutritional Incentives					
$5 x 10 youth x 8 sessions				$400.00	
					$890.00
TOTAL					**$ 7,258.32**

Working with Logic Models

Logic models are used to describe how the materials and steps of an intervention connect to address the targeted behavioral issue. In the *Focus on Youth with ImPACT* intervention, the goal is to increase youth condom use, delay the onset of youth sexual activity and increase parental monitoring and communication. The *Focus on Youth with ImPACT* logic model illustrates how successful outcomes can be attained through the facilitation with fidelity of the youth and parent/guardian activities. Agencies are encouraged to use the format of the logic model to create a logic model that reflects specific components and goals unique to your agency.

Logic Model Definitions

Logic model: A model of logical connections showing the main elements of an intervention and how they work together. Usually depicted as a graphic, it shows the relationship and theory of action among the various components of a program or intervention. It articulates the relationships and linkages to ensure achievement of anticipated benefits.

Problem statement: A statement that describes the factors that put a population at risk or create some other problem to be addressed by a program. These factors may be related to knowledge, attitudes, beliefs, behaviors, skills, access to services and information, policies or environmental conditions.

Long-term outcomes: What are the expected long-term results (e.g., maintenance of protective behaviors, skills, access, policies and/or environmental conditions) from this intervention? The long-term outcomes should reflect the problem statement—the changes that are anticipated subsequent to engaging in the activities of an intervention. Anticipated outcomes must be supported by a theoretical or experiential foundation that indicates that is reasonable to expect that the planned activities will affected the desired outcomes.

Intermediate outcomes: What results (e.g., changes in behaviors and environmental conditions) are expected to occur some time after the intervention is completed? What needs to happen in order for long-term outcomes to be realized?

Immediate outcomes: What will be the immediate results (e.g., changes in knowledge, attitudes, beliefs, and skills) among participants at the conclusion of the intervention? These outcomes are necessary to realize the intermediate outcomes.

Activities: Based on what is known about the target population and the intervention, what are the activities that will most likely have the desired effect on outcomes? Describe the services that will be provided to accomplish the desired outcomes (e.g., materials distribution, outreach events, group sessions, referrals, peer facilitator training). There is a direct relationship between activities and outcomes that must be supported by a theoretical or experiential foundation.

See the chart on pages 22–24 for more detail.

Conducting Focus Groups

A focus group is a small group whose members represent the target population.

Local youth-serving agencies are encouraged to hold focus groups around curriculum content before implementing a program. Focus groups can be useful in helping you discover strategies for adapting the curriculum and materials to reflect the cultural nuances of the target population.

Recruitment and Size

Recruitment of focus group members consists of gathering a sample of the target population to meet for no longer than one and a half hours. Focus group members can be recruited by simply asking if someone would be willing to meet for an hour or so to answer some questions about youth. You may need to offer incentives while recruiting. Focus group size is important. Select a focus group that is large enough to gather a variety of opinions, yet not so small that a few participants are pressured to respond to all of the questions. An ideal size for a focus group is between 8 and 12 participants.

Parent/Guardian Permission

Parent/guardian permission is required for youth under age 18 to participate in a focus group. Develop a permission form that includes the purpose,

Focus on Youth with ImPACT Behavior Change Logic Model (Draft)

Problem Statement

Target Population: ***Focus on Youth with ImPACT*** is community-based HIV/STD risk reduction intervention designed for high-risk African-American youth ages 12 to 15 and their parents.

Risk Behaviors: This **population** is at risk for unwanted pregnancies, HIV and other STDs due to having unprotected sex.

Major risk and contextual factors for HIV/STD include: *Young people often engage in unprotected sex because of*:

- Perception that peers are engaging in behavior
- Underdeveloped and/or under-used decision making skills
- Underdeveloped and/or under-used sexual negotiation skills
- Lack of refusal skills
- Lack of condom use skills
- Lack of knowledge and skills to use a range of protection strategies
- Lack of parental monitoring
- Inability and/or unwillingness of parents to discuss HIV, STDs, and safer sex with their teens
- Lack of parent knowledge regarding condom use skills

FOY Behavior Change Logic

Behavioral Determinants ***Corresponds to risk or contextual factors***	Activities ***To address behavioral determinants***	Outcomes ***Expected changes as a result of activities targeting behavioral determinants***	
		Immediate Outcomes	Intermediate Outcomes
• Lack of knowledge about how decisions impact one's future • Lack of decision-making skills regarding risk behavior • Lack of knowledge about HIV/STD and methods for protection against disease • Low self-efficacy for abstinence and condom use	FOY is an 8-session (90 -120 minutes each), interactive, small group-based intervention. The activities developed for each of the sessions are designed to address the behavioral determinants or risk factors among youth. • Discuss how decision making occurs in a social context and that decisions made while they are young can have an impact on their future.	**Increases in**: • Knowledge that the decisions made while you are young can have an impact on your future • Confidence about making good decisions for protecting themselves from HIV/STD • Perceived vulnerability to HIV/STD infection • Knowledge of HIV/STD testing	**Increases in:** • Confidence to refuse sexual intercourse • Confidence to negotiate and use male condoms • Refusal skills • Condom negotiation skills

(continued)

Focus on Youth with ImPACT Behavior Change Logic Model (Draft) (continued)

• Low response efficacy for abstinence and condom use
• Perception of high response costs for using a condom or being abstinent
• Perceived intrinsic and extrinsic rewards of risk behaviors
• Low perceived peer norms supportive of abstinence or condom use
• Low perceived severity and vulnerability related to outcomes of sexual risk behaviors
• Lack of skills for:
    • refusal of unsafe sex
    • condom use
    • negotiation
• Low perceived parental monitoring
• Low communication with parents
• Low parental knowledge of HIV/STD transmission and safer sex practices
• Low parental self-efficacy for condom use skills
	• Learn skills for better decision making through the SODA Decision-Making Model
	• Examine their risk behaviors and why they may feel invincible or invulnerable in order to understand how this can place them at risk for HIV/STD or unplanned pregnancy.
	• Identify and use personal values to make decisions.
	• Identify a variety of behaviors that do and do not put young people at risk for HIV infection through reading fact sheets and participating in a risk continuum activity.
	• Discuss reason teens engage in risky behaviors
	• Identify and rank their personal values about relationships and sexuality
	• Identify ways to obtain information in order to make healthy decisions by applying the decision-making model.
	• Develop skills for decision making while considering the options of those choices
	• Develop skills for gathering information about options and resources from trusted adults, fact sheets and other sources
	• Discuss and weigh the positive and negative consequences of options as they make decisions
	• Explore how many young people are protecting themselves through a game (peer norms)
	• View demonstration of correct use of male condoms
	• Practice correct use of male condoms
		• Personal responsibility for safer sexual behavior
		• Knowledge about puberty, sexual function and reproduction
		• Knowledge and skills on how to use condoms effectively and correctly
		• Knowledge and skills for showing you care without having sex
		• Refusal skills
		• Skills to influence and negotiate with partners to use protection
		• Skills to reduce vulnerability for forced sex
		• Skills to refuse unsafe sex
		• Knowledge of safer sex practices
		• Ability to talk about sex and safer sex practices
		• Ability to identify strategies for protecting oneself and one's community from HIV/STD.
		• Parent's ability to monitor youth
		• Parent knowledge and skills re HIV, STDs and safer sex
		• Parental monitoring and communication
		• Perceived parental monitoring and communication
			• Use of alternative strategies for protection (outercourse, mutual HIV testing, refusal, leaving a relationship or not starting one because of concerns about safer sex)
			• Consistent condom use with partner(s)
			• Peer norms supportive of abstinence
			• Peer norms supportive of condom use
			• Parental monitoring
			• Parental and adolescent communication
			• Reduction of sexual intercourse
			• Reduction of sexual partners

(continued)

Focus on Youth with ImPACT Behavior Change Logic Model (Draft) (continued)

<table>
<tr>
<td>Revised version: August 5, 2008</td>
<td>
• Practice communication and negotiation skills to assist in carrying out responsible decisions.
• Discuss how poor communication can lead to compromising situations and identify ways to avoid them through a story
• Explore various ways to show they care without having sex through brainstorming and roleplay
• Develop awareness of how quickly HIV and other STDs can be spread and how they can be prevented
• Obtain information about safer sex and contraception through discussion and fact sheets
• Develop attitudes and skills that support sexual health through listening, roleplaying and negotiation skills
• Listen to or view a video of a person living with HIV/AIDS to better understand how the disease can change a person's life
• Identify long-term goals themselves and describe short-term goals that can help them achieve these long-term goals
• Analyze their concerns and discuss how they can take responsibility about protecting themselves and their community from HIV/STD
ImPACT Session (Parents)
• Build monitoring and communication skills with viewing video, discussion, practice and roleplay
• Increase knowledge about HIV/STD, condom use and other safer sex practices via viewing of video, condom demonstration and practice
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general content of the questions, and the date and time of the focus group. Also describe any incentives that will be offered to the youth.

Content

Focus groups can be used for a variety of reasons. They can be used to test marketing materials or activities, gather ideas or ask questions regarding curriculum content. To compile questions for the focus group, think about which aspects of the program could use the input of the target population to increase the chances of that target population relating to the material. Rather than beginning with a blank slate, it is often helpful to list a few ideas and then have the focus group respond these and add additional ideas that better resonate with local youth.

Examples of items that could be focus-group tested for Focus on Youth with ImPACT include:

- **Names of family tree story members:** Instead of using the family names in the curriculum, have focus group members create names that would best resonate with local youth.
- **Local hang-out areas for youth:** List a few local gathering places for youth in your community and have focus group members comment on those locations, add more to the list, and vote to select the most popular hang-out areas. Use these locations in the material when discussing situations with the group members.

Incentives

It can be useful to offer food, drink and a small incentive (e.g., a gift certificate to a local music store) for participating in a focus group. Local businesses are usually very willing to donate such incentives.

Training the Team to Deliver Focus on Youth with ImPACT

Focus on Youth with ImPACT is designed to work well for group leaders and teen participants alike. The material has been extensively field tested and evaluated. The instructions are thorough, clear and easy to follow. Most of the materials needed for the program are included in this publication.

In planning for the implementation of your *Focus on Youth* program, you should consider the following: qualifications for group leaders, confidentiality of youth and parents, cultural competency of staff, and facilitation skills of staff.

Qualifications for Group Leaders

The qualifications for effective group leaders are the same as those for any youth-specific HIV, STD and teen pregnancy prevention program:

- Understanding of adolescent development.
- Ability to reach young people by communicating clearly and demonstrating respect and caring.
- Knowledge of how to manage youth groups in a positive way and maintain structure without resorting to punishment or criticism.
- Professional standards about being prepared and on time for all sessions, and being available to group members or their parents as necessary between sessions.
- Ability to work collaboratively with other leaders, members of a school or organization, and members of the broader community.
- Comfort in addressing issues of sexuality and sexual health.
- Ability to set appropriate boundaries.
- Reasonable mastery of the informational aspects of the program (e.g., the risk behaviors for HIV and other STD, effective steps for prevention).
- Ability to present these materials in a forthright and nonjudgmental manner.
- Commitment to the purpose of the program—reducing youth risk for HIV—and a belief in its effectiveness.
- Previous experience in facilitating youth groups.

Group leaders who have these qualities are likely to do an excellent job with the program. It is also true that virtually all facilitators can improve their efficacy through training.

Confidentiality

It is important for the staff implementing *Focus on Youth with ImPACT* to keep the information regarding the youth in their program confidential and in a safe place. This may include any baseline assessment surveys, post-behavioral surveys, and other information that may contain personal information.

Cultural Competency

Staff should also be culturally competent and sensitive. Cultural competency is taking into consideration the values and beliefs (culture) of the client and those of the agency and its employees, while developing services and shaping current organizational policies to effectively validate the lived experience of those individuals (clients) served.

Cultural competency includes:

- Awareness of one's own cultural values
- Awareness and acceptance of cultural differences
- Understanding that people of different cultures have different ways of communicating, behaving and problem solving
- Having basic knowledge about a client's culture
- Ability and willingness to adapt the way one works to fit the client's cultural background

Cultural competency is not simply:

- Decorating
- Having displays
- Sharing diverse foods
- Attending special classes
- Participating in special ceremonies
- Reciting phrases from historical figures
- Knowing a few individuals of a specific ethnicity

Culturally appropriate programs:

- Demonstrate sensitivity to and understanding of cultural differences in design, implementation and evaluation
- Acknowledge culture as a predominant force in shaping behaviors, values and institutions
- Acknowledge and accept that cultural differences exist and have an impact on service delivery
- Believe that diversity within cultures is as important as diversity between cultures
- Respect the unique, culturally defined needs of various client populations
- Recognize that concepts such as "family" and "community" are different for various cultures and even for subgroups within cultures

In Focus on Youth with ImPACT, culturally specific approaches can be used for:

- Board recruitment and training
- Staff recruitment, hiring and training
- Recruitment of youth
- Parent/guardian sessions
- Development of materials (e.g., roleplays)

Agencies implementing Focus on Youth with ImPACT should regularly review their policies and procedures regarding:

- Valuing diversity
- Having the capacity for cultural self-assessment
- Being conscious of the dynamics inherent when cultures interact
- Having institutionalized cultural knowledge
- Adapting service delivery based on understanding of cultural diversity

Here's why community engagement is so important:[8]

- Cultural competence extends the concept of self-determination to the community.
- Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g., neighborhood, civic and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social and religious organizations; and spiritual leaders and healers).
- Communities determine their own needs.
- Community members are full partners in decision making.
- Communities should economically benefit from collaboration.
- Community engagement should result in the reciprocal transfer of knowledge and skills among all collaborators and partners.

National statistics indicate that the HIV/AIDS epidemic is disproportionately affecting culturally diverse minority populations in the United States. The manner in which we (health care providers, teachers, community members) recognize and respond to this diversity are critical to the development of effective cultural appropriate health care, prevention and intervention programs.

Facilitation Skills

What is facilitation? Group facilitation is the art and science of managing group sessions and the group developmental process. It involves guiding a group of people through a series of phases—forming, storming, norming, performing and adjourning—while using a specific set of skills and tools, as identified by Bruce Tuckman in 1965.

What makes a good facilitator? Good facilitators create an environment in which group members share ideas, opinions, experiences and expertise in order to achieve a common goal. Good facilitators possess a variety of qualities and skills. Some of the qualities spring from innate personality traits such as being able to recognize one's own biases while remaining neutral, enjoying interaction with diverse groups, and inspiring trust among

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[8] Taylor, T., and Brown, M. (1997). Georgetown University Child Development Center (GUCDC), University Affiliated Program.

group members. Although some people possess a natural talent for facilitation, most develop their skills through formalized training, hands-on experience with groups, and guidance from experienced facilitators.

What are good facilitation skills? Listed below are some basic skills that many people use when they facilitate groups. These are organized according to Tuckman's theory of group development, which describes the evolution of groups from their beginning to their ultimate conclusion, and are based on the activities of successful group level interventions.

1. Establishing Group Orientation
   - Getting the Group Acquainted
   - Encouraging Group Participation
2. Developing Group Structure
   - Determining Group Interactions
   - Managing Group Conflict
3. Maintaining Group Agreements
   - Setting Group Norms
   - Building Group Cohesion
4. Accomplishing Group Tasks
   - Meeting Group Objectives
5. Providing Group Closure
   - Engaging Group Feedback and Next Steps
   - Acknowledging Group Work and Session Wrap-Up
6. Time Management
   - Maintaining Awareness of Time Allotted for Activities
   - Helping Participants Stay on Topic

Tips on Facilitating

- **Make sure you have a comfortable, private space** for the group to meet.
- **Stand where everyone can see you.** A semicircle works well.
- **Watch the time:**
  - Know how much time you want to devote to each activity.
  - If conversations get off track, help guide youth back on task.
  - Try to limit interruptions (phone calls, recreation center business, etc.).
- **Be aware of your audience.** Do they look bored? Do they need a break? Do they understand? Are they offended/scared/overwhelmed?
- **Be FIRED UP!!!!** Attitude is everything! Keep your voice exciting, use body language, walk around when you talk—keep them listening!
- **Get to know names** of the youth and use them.
- **Change names in activities if necessary.** If a roleplay character is named "Jermaine," and you have a Jermaine in your group, change the character's name.
- **Make sure everyone is participating.** Don't call on the same people all the time. Try to help more reserved youth join in the discussions.
- **Integrate previous lessons** when applicable. (Example: What else might Malcolm want to think about while he makes his decision? How about his values? Remember when we talked about values last week? How would values be important when you are making a decision?)
- **Keep it interactive.** Don't lecture too much. For example, when discussing invulnerability, do not define it right away, instead ask the group participants to define it.
- **When youth are in small groups** go around and check in with each group.
- **Use examples often** when explaining things.
- **Define words** (or have youth define them) as you go along.
- **Use open-ended questions** that encourage participants to provide more than "yes" or "no" answers. For example, questions that start with the words how, why, what, who, when or where can trigger a response to enrich a discussion.

- **Use statements that engage youth** and encourage them to take part in discussion. For example, you might say, “That sounds interesting, tell us more about it.”
- **Use positive and corrective feedback** that provides a safe environment for youth to participate freely in open discussion. Positive feedback can come in forms of affirmative nods, smiles or statements such as, “Thank you for sharing that experience with us.” Corrective feedback should be given as soon as incorrect information is given or an inappropriate behavior is shared with the group. The correct information or an alternative behavior or solution should be immediately offered.
- **Always figure out what’s really being asked.** Ask youth to clarify what they are saying when local phrases are being used.
- **Allow anonymity for questions.** By allowing youth to write down and submit questions anonymously, you encourage them to get answers that might be vital to their decisions about HIV prevention behaviors.
- **Be honest;** don’t bluff. If you don’t know an answer, say so. Commit to finding it and getting back to the youth who asked the question. If you make a mistake, admit it.
- **Create a “safe” climate** for group participation. Be careful not to patronize, condemn or trivialize the experiences and feelings of the youth. Don’t preach, although a little personal testimony may enhance the learning.
- **Be open to suggestions** and recommendations. Allow the youth to freely share how the group discussions or activities can be enhanced. Don’t quickly say, “We can only do it this way.” As the youth learn from you, learn from them.
- **Remain flexible.** If you don’t have time to finish a session, go overtime, add a session, or shorten some of the games. You don’t need to be rigid.
- **Remember,** many of the above tips are easier to implement if you have 2 group leaders who are able to work well together.

Tips on Managing Behavior

Behavior is a form of communication. When a youth misbehaves or breaks one of the rules agreed upon by the group, that youth is communicating something to the group and the group leaders.

The message could be anything, ranging from "I don't understand the rule" to "I'm bored" to "This topic is embarrassing, and I have to move the focus off me" to "I'm being ignored and I want more attention." There are endless possible messages and numerous responses available to facilitators.

Here are some tips to ensure that the sessions stay on track.

Define Group Agreements.

- You and the group should define the Group Agreements everyone agrees to follow.
- These Group Agreements should help to guide behavior, and will give you a framework for addressing behaviors and consequences.

Provide reinforcements.

- Use frequent opportunities to reinforce youth for what they are doing RIGHT. In other words, catch them being good! Some youth may not be used to praise and might feel uncomfortable at first, especially if they get teased by other youth, or interpret it as being singled out.
- Remember that praise can be given verbally, nonverbally or tangibly (openly or discreetly).

  Verbal Reinforcement

  - Youth can be verbally reinforced for behaviors or things they do: "That's a good point." "It was very considerate when you shared your materials." "You must feel proud of yourself for getting such good grades." "I really like the way you're sitting—it shows that you're paying attention."

  Nonverbal Reinforcement

  - Attention and recognition can be given in very subtle and unobtrusive ways. A look, a smile or a handshake are all ways of acknowledging another individual without saying a word or calling attention to that person.

- Nonverbal reinforcement can be very useful if you notice that someone is beginning to drift from the group's activities or needs to be brought back into the group. It is particularly effective for the second group leader to use, since it doesn't disrupt the verbal flow of the group or the material being presented by the other group leader.
- You may choose to start off by pairing a nonverbal reinforcement with a verbal one (e.g., shake someone's hand while saying, "I like the way you acted out that character in the roleplay").
- Later, if you use just the nonverbal, the youth will be able to associate it with the verbal statement you made earlier.

Tangible Rewards

- Some people like to use tangible rewards, such as raisins, candy, or paper tokens which can later be traded in for a small prize.

Consequences

- Have youth participate in defining the consequences as well as the rewards for their actions. That way, no one will be surprised when a consequence is implemented.
- Make sure that consequences are reasonable. Youth tend to be very strict with themselves when talking about consequences in more abstract terms.
- Be realistic. Choose consequences you're likely and willing to implement.

Give clear instructions.

- Instructions are ways of letting youth know what you expect of them. They are most effective if they have been discussed beforehand, so that everyone knows the expectations.
- Instructions should be short and to the point. Sometimes parents make the mistake of giving a string of commands at one time (e.g., "Go upstairs, wash your hands, pick up your clothes, do your homework, then come downstairs and fix the hamburgers.") and then get upset when kids, particularly younger ones, only do the first or the last thing. Kids are more likely to follow rules that they understand, so be brief and to the point.
- Always remember to reinforce a youth for following your instructions.

Sometimes ignore behavior.

- Sometimes, the most effective thing to do is simply to ignore certain behaviors. If a youth is doing something that is relatively harmless to the group process, ignore it, and reinforce someone else in the group for something he or she is doing right.
- Continue to monitor the first youth's behavior. As soon as he or she does something right, reinforce what was just done.
- Do not get into a power struggle with youth. You are the adult and the person in charge, so you always have options. There is never a need to put a youth down.

Plan and take breaks.

- Plan to take a break about halfway through the session. An hour and a half can be a very long time to sit in a group, especially if youth have already been sitting in a classroom all day long.
- Usually, it works well to provide snacks during the break, so that snacks become reinforcers for having accomplished the tasks of the first half of the session.
- The group's behavior may indicate they are ready for a break before the planned time, especially if they are feeling tired, bored or lacking energy.
- Sometimes, a youth may ask for a break. If you think it is a reasonable request, reinforce that youth for being self-aware and give the group a minute to stretch.

Ask for feedback.

- Be open to feedback and attentive to what your audience is telling you.
- Youth may have suggestions about activities, preferences and dislikes, which may actually make the group more enjoyable for everyone.

Provide positive limit setting.

- Part of establishing autonomy is testing limits. Know that youth may be likely to test your limits.
- Try to remain positive. There are so many Don'ts in the world, especially for youth, so try to emphasize the Do's.
- For example, when youth are first defining the rules of the group, help them phrase things in a positive way—I will respect the opinions of other

members of the group—rather than negatively—No making fun of other people's opinions.

Establish and respect confidentiality.

- Talk about confidentiality when setting Group Agreements. In these groups, confidentiality means that youth and leaders will not reveal personal information shared by youth during the sessions. The only exception is when a participant discloses behaviors or circumstances that endanger the self or others, (e.g., someone reports being abused physically or sexually, says he or she is feeling suicidal, or is carrying a weapon and plans to use it in a fight later that day). In these instances, youth should let the leaders know what they have heard. The leaders may be required to make a report to authorities.
- Let youth see you modeling an appropriate respect for confidentiality. Avoid discussing participants' personal information outside of the group.
- Familiarize yourself with your organization's policies concerning confidentiality, and be sure to follow them.

Take a youth aside when necessary.

- Sometimes, you may notice that a youth is preoccupied or withdrawn, or acting out in an uncharacteristic way. Without reinforcing the behavior, you still have the option to take that youth aside to talk individually while the other group leader continues to work with the rest of the group.
- This method may be the best way to get at what is on the youth's mind, and may be quite relevant to something being discussed in that session.
- Make yourself available to talk after group, if necessary.
- Coordinate with the other group leader beforehand so you both understand what is taking place when you walk out of the room with a youth and leave the other leader alone with the group for a while.

Using Instructions

- State your instruction clearly and succinctly: "Please sit down."
- State your instruction again, followed by a statement of the consequence for noncompliance: "Please sit down. If you don't sit down, I will stop the video."
- If the group member complies, reinforce him/her for following the Group Agreements: "Thank you."
- If the group member does not comply, follow through on the consequence: Stop the video. Then, give the instruction again: "Please sit down."
- If the group member complies this time, reinforce him/her and continue with the activity. If the group member does not comply, let him/her know the consequence: "Please sit down. If you do not sit down, you will have to step out for 5 minutes."
- If the group member complies, reinforce him/her. If not, enforce the consequence: "You need to step out for 5 minutes."
- Make sure that consequences are reasonable and match the degree of the misbehavior. Never threaten a group member with a consequence that you aren't willing to follow through on. It will put you in a corner and detract from your credibility.

Instead of Discipline

1 **Suggest a way to be helpful.**

"Instead of playing with the paper, I'd like you to help me collect everyone's papers."

2 **Express your feelings strongly, without criticizing character.**

"I'm upset that I am constantly interrupted, and I can't finish telling this story."

3 **Say what you expect.**

"I expect that group members will express their thoughts to the whole group rather than carry on private conversations."

4 **Suggest ways to correct the situation.**

"The popcorn scattered all over the floor will need to be picked up before we go on to the next activity."

5 **Offer a choice.**

"You can either remain in your seat and participate, or you can leave the room until we've completed the discussion."

6 **Problem solve.**

"How can we make sure that no more juice gets spilled?"

7 **Choose appropriate consequences and take action.**

"Since the group is not following directions, we will stop this video."

8 **Allow the group members to experience consequences.**

Don't try to protect them from discomfort. "Since you are unable to stop disrupting the group, you need to step out for the next 5 minutes."

Information for Group Leaders

This section provides a wealth of information to increase skills in youth facilitation, including: background information on adolescent development, tips for talking about sexuality, answering sensitive questions, responding to reports of abuse, working with HIV-positive speakers, criteria for video selection and resources for leaders. Agencies are encouraged to use this information in basic youth facilitation skills trainings designed to prepare youth facilitators to lead discussions in topics related to sexuality and HIV/STD prevention.

Background Information on Adolescent Development

Adolescence is a time of change and transitions. Many things are happening at the same time, which may be confusing both to adolescents and the adults around them.

Biological Development

Adolescents go through many important transitions as their hormones begin to signal changes in their development. Hormonal changes trigger the development of secondary sex characteristics (changes in voice, hair growth, etc.) Hormones also are related to emotional changes, characterized by rapid mood swings or what may appear to be overly emotional reactions. These reactions may be confusing to teens themselves as well as to those around them.

Physical Development

Individual adolescents experience growth spurts at different times. While one 12-year-old boy may suddenly grow tall and muscular, his friend of the same age may still be short and slight in build. One girl may have begun her menstrual cycle and have developed a mature-looking body while her same-age friend may still look more like a little girl.

These changes become important to a young person's self-image, and to her or his status among peers. Adults need to be sensitive to these issues, since adolescents are sensitive to them and may react to them quite strongly.

Adults also need to keep in mind that physical growth and changes in the way youth think do not always keep pace with each other. It may be necessary to remember that the tall and muscular boy is not necessarily more mature or advanced cognitively and emotionally than his small friend. Expectations of what is age-appropriate behavior should not be guided by a teen's physical appearance.

Psychological Development

Cognitive skills. As young people go from preadolescence into adolescence, their ability to think about situations and concepts develops considerably. Preadolescents are more likely to think about things concretely, and need many examples before they can grasp the meaning of a concept. As adolescents mature, they gain the ability to think more abstractly. They begin to enjoy thinking and talking more about abstract concepts, and to consider possibilities and hypothetical situations.

This becomes an exciting time for them as they become more aware of their own mental abilities. If you can capture their imaginations, it will make the sessions much more interesting to them.

Identity. During the course of development, adolescents may fall on different points along the continuum from dependence to autonomy, as they try to negotiate their way toward becoming young adults. However, this is not a smooth process, and the same adolescent may be at either extreme of dependence or autonomy within a matter of moments.

Adults' task is to assist adolescents in negotiating this transition, while recognizing that they may sometimes need to take a few steps back before taking a full stride forward.

Interpersonal Development

Relationship with parents. Issues of power and control can be difficult for adolescents and may be a source of conflict with parents. Adolescents seem to develop best in situations where there are moderate levels of control (neither total freedom nor excessive control), with adults who communicate an atmosphere of emotional support and caring.

Relationships with peers. Relationships with peers are extremely important during adolescence as part of identity formation. Adolescents often look to friends for feedback, for example, about their looks, behaviors and choices.

Saving face is extremely important, especially since adolescents are easily embarrassed. It is important to recognize that one reason for misbehavior may be the need to save face or to maintain a favorable perception in friends' eyes.

Talking About Sexuality

It is natural to feel some awkwardness when talking about sexuality with young people. Like all skills, this one improves with practice and experience. Here are some guidelines that can help build your comfort and enhance your ability to reach young people effectively.

Most Important: A Positive Tone

The most important thing you can offer is a positive tone in your response to their questions. Let them know by your voice, gestures and facial expressions, as well as the things you say, that you welcome their questions and appreciate their curiosity and opinions.

General Guidelines

Practice the language ahead of time. If you're not used to speaking to groups about sexuality, practice saying the words ahead of time. Speak in front of a mirror, or have a conversation with family or friends about the program. Say the words *sexual intercourse, anal intercourse, semen, penis, vulva, erection,* etc. This will make it easier when you talk about these things with the group.

Expect some embarrassment. You or the group members may be embarrassed at times. As everyone becomes more accustomed to the conversations, the embarrassment will diminish or disappear.

Use respectful, appropriate language. Young people often use slang to refer to a sexual act or sexual anatomy. This may be the only language they know, or simply the language that is most comfortable for them, but it is helpful for them to learn standard terms as well. If they're seeking health

care, writing an article for a newsletter, negotiating safer sex with a partner, or talking to a counselor or parent, they may be able to communicate better if they know standard terminology. Without being critical of the language they use, you can rephrase some of their questions. ("Ron asked a question about a 'boner.' A more standard term for this is 'erection.' And yes, it is normal for a man to wake up with an erection in the morning.")

Welcome their questions. Let the group know that you want to hear their questions, are interested in their thoughts and experiences, and are committed to helping them make the best possible choices in their lives.

Provide a prevention message. Frame information and discussions about sexuality within an overall prevention message. You might focus on the importance of assessing risks, the ways young people can give and get support from friends, or the benefits of making a choice to be abstinent or use condoms.

Focus on capabilities and positive norms. Young people hear a lot about teens who aren't doing things "right." A focus on young people who fail, make mistakes, or have suffered terrible consequences tends to make these problems sound like the norm. Instead, place the emphasis on young people who make healthy choices and want their peers to do the same. Whenever possible, give answers that emphasize norms that are positive, health-affirming and responsible.

Respect the group. Respect the gravity of the issues young people deal with, and the talents and capabilities they can bring to their concerns. This is one of the best ways to establish a positive alliance.

Talk about skills. Follow up answers with suggestions about choices group members can make and skills they can practice. For example, after a discussion about the risks of impulsive or unsafe sex, you might ask, "What are some things you could say or do if someone was pressuring you to have sex?"

Avoid using "you" in general answers. If you're talking about general issues, not personal ones, avoid language that makes risks seem expected. For example, say, "If a person has unprotected sex, he or she will be at risk for HIV," instead of "If you have unprotected sex, you'll be at risk for HIV."

Support Abstinence

Abstinence is a good choice for young people. Those who postpone sexual involvement are more likely to complete high school, less likely to become pregnant, and more likely to make better health choices in general. Support for abstinence is an expression of care for young people.

Leaders affirm this perspective through the activities and discussions in *Focus on Youth with ImPACT*. Most teens can see both the benefits of abstinence and the risks posed by sexual activity, but it is vital that this message be presented in an informed and balanced way, rather than being preachy, punitive or moralistic.

While emphasizing abstinence, leaders should not ignore the fact that some young people are choosing to be sexually active. Communicate the same quality of caring and concern when supporting group members to take steps to ensure safe and healthy sexual experiences and to make thoughtful, informed decisions about sexuality. They should use condoms and contraception. They need to pay attention to their emotions, and get help if they feel troubled in their relationships.

Keep Appropriate Boundaries

It is natural for group leaders to be drawn to certain group members, and even to develop special relationships with them. Sometimes, however, this can lead to problems. A leader who wants to be friends with a young person may miss some important opportunities to provide guidance, support and modeling.

When leaders stay in role, they maintain a hierarchical relationship with the group. They are adults, not peers. As adults, their expectations, suggestions, concern and involvement have a different kind of impact and meaning. This sort of support can be very helpful, especially for group members who don’t have other strong, positive adult role models in their lives.

Good boundaries also help protect leaders—group members are less likely to misconstrue your interactions. Young people need leaders who can act as role models and mentors much more than they need another friend or “buddy.”

Enjoy the Adventure

It is impossible to predict what will come up when youth groups discuss sexuality and sexual health. There are always surprises. The curiosity, intensity and authenticity young people bring to this topic can be refreshing, inspiring and exciting. The group will learn from you, and you will certainly learn from them.

Answering Sensitive Questions

As you prepare to answer group members' questions about sensitive topics such as sexual behavior and sexual orientation, use the following guidelines to form answers that are accurate, appropriate and complete.

Questions may be grouped into five broad categories which, of course, overlap:

- Requests for information
- Values questions
- "Am I normal?" questions
- Permission-seeking questions
- Shock questions

Requests for Information

This type of question is generally posed when youth are genuinely seeking information regarding a particular subject to help increase their knowledge regarding it.

- If you know the answer, fine. If not, it is OK to say, "I don't know," and then refer the youth to an appropriate source.
- Are there some value issues within the context of the question? If yes, make sure various points of view are presented.
- Is the question, although informational, one which you consider inappropriate for classroom discussion? Problems can be avoided if you have established in the context of the group ground rules, an agreement such as: "All questions are valid. However, I will have to make the final decision about the appropriateness of each question for total class discussion. If you turn in a question anonymously which I choose not to

answer, it is not because it is a bad question. I may feel that it is not of interest to everyone or that I'm not prepared to lead a class discussion around that issue. Please see me at the end of class if ever this happens so that I can try to answer your question privately."

Values Questions

These questions are posed when youth are seeking clarity about facilitators' values with the goal of potentially helping them define their own values. A great way to begin to answer this kind of question is to stress that "For some, ____ is true; for others, _________ is true, and, for me, _________ is true."

If there are value issues involved in the question, for example, "Is it all right for teens to have sex?," provide a synopsis of the different points of view regarding the issue. Refer participants to people in their lives who may help them resolve their questions about the issue.

Youth sometimes ask a question about the group leader's values. Opinions about how or whether to respond to these questions differ. Some feel it is important to respond while others believe their role as group leader gives their response to much weight. If you share your opinion, emphasize that it is only one of many and recommend that youth ask their parents/guardians about family values and beliefs. Avoid sharing information about personal sexual practices.

"Am I Normal?" Questions

These questions generally focus on adolescent concerns about their bodies and the emotional and physical changes they're experiencing.

- Validate their concerns, e.g., "Many young people worry that..." and provide information about what they can expect to happen during the adolescent years.
- Refer them to parents/guardians, clergy, family physician, community resources or a counselor for further discussion, if appropriate.

Permission-Seeking Questions

These come in two common forms—“Is it normal to ...?” or “Did you ... when you were growing up?” Youth may be asking your permission to participate or not participate in a particular behavior.

Avoid the use of the word normal when answering questions. What is “normal” for some is morally unconscionable for others. Present what is known medically, legally, etc.—the facts—and discuss the moral, religious and emotional implications, making sure all points of view are covered. Refer youth to parents/guardians, clergy or another trusted adult for discussion of moral/religious questions.

Establish, in the context of group ground rules, an agreement related to discussion of personal behavior, such as: “No discussion of personal behavior during class.” If and when you (the group leader) get a question about your personal behavior, you can remind youth of this ground rule and redirect the discussion to one of the pros and cons (religious, moral, medical, emotional, legal, interpersonal, etc.) of the particular behavior in question. Again, refer youth to parents/guardians and clergy for further discussion of moral/religious questions.

Shock Questions

Shock questions often catch a facilitator off guard due to the context or content of the language used in asking the question. Remind youth about the ground rules related to appropriate questions for classroom discussion.

Sometimes the shock comes not from the content of the question, but the vocabulary used. You can re-word the question to defuse it, especially if you have previously established a groundrule related to vocabulary, such as: “In this class, I want to teach the proper vocabulary for body parts and functions, and I also want to communicate with you. Sometimes you may not know the correct word for something you have a question about. Use whatever word you know to ask that question and I will answer using the correct (acceptable) word.”

It is important to understand and feel comfortable with the guidelines for answering sensitive questions. When you are presented with a sensitive question, stay calm and follow these 3 steps:

1. **Listen to the question.** Determine what information/response the youth seems to be seeking. Pause for a moment or two if needed.
2. **Paraphrase the question.** Change slang to correct terminology, convert "me" or "you" pronouns in questions to general terms such as "a young person" or "people." Paraphrasing questions also helps check your understanding of the question.
3. **Respond to the question based on the guidelines.** While answering the question, clear up any misinformation and provide an objective, fact-based response.

Responding to Reports of Abuse

Whenever young people are learning about sexuality, it is possible that reports of physical or sexual abuse will emerge. Group members may share rumors they have heard, express concern for a friend who is facing these problems, or ask directly for help themselves. They may exhibit signs or symptoms of abuse. They may describe a personal experience without realizing it constitutes abuse.

There are laws prohibiting the sexual and physical abuse of minors in every state. These laws require that abuse be reported immediately to the appropriate authorities. Your organization should have clear policies and procedures in place that describe how to respond to any allegations of abuse. Be sure you are familiar with these guidelines. Review the written policies and procedures manual, and know to whom you can turn at the agency for assistance if you are unsure about a situation or need guidance.

Here are some points to keep in mind:

- **Know state laws and your organization's policies** on mandated reporting concerning suspected abuse, neglect, sexual abuse or statutory rape.
- **Discuss these requirements with the young people in your program** so they understand exactly what must happen if they describe a situation you are required to report.
- **Be clear about the limits of confidentiality.** Don't negotiate with group members, promise not to tell or provide assurances you may not be able to keep. Sometimes a situation seems benign on first telling, but as a group member fills in details it becomes clear that a report is mandated.

- **If an activity causes youth to self-disclose,** the facilitator should carefully end the disclosure and talk to the youth in private after class.

Working with HIV-Positive Speakers

Meeting and hearing the personal story of a person with HIV often has a significant impact on young people. Speakers are likely to be most effective when they resemble the group members in some way—especially when they are young and have a clear understanding of the world teens in your community cope with every day.

When the speaker tells his or her personal story, group members can begin to identify with the speaker's appearance, feelings, values and how this person came to engage in risky behaviors. Speakers help to put a human face on HIV, touching young people at a personal and emotional level, and making the risks real to them.

Finding a Speaker

- Contact local HIV agencies for help in finding a speaker. Many areas have organized speakers' bureaus that provide single speakers or panel discussions for classrooms, youth programs and other groups.
- Most speakers are trained to reinforce basic information about HIV transmission and prevention, and to deal with lifestyle issues in a manner that does not advocate particular sexual attitudes or practices.
- Ask the speakers' bureau about their policies, training and experience to be sure they are a good match for your program.

An Interview Questionnaire for prospective speakers can be found on page 50.

Preparing for the Speaker

- **Make arrangements in advance.** *Make arrangements for scheduling the guest speaker during the first 1–2 weeks of the intervention.* If you choose to use a speaker, his or her participation should be secured well before you present Session 7. Find out what application procedure is required for requesting a speaker and be sure you have enough time to follow through.

- **Review policies and procedures.** Be sure to review any policies your agency has that may limit the speaker's remarks or responses to student questions, and let the speaker know of any restrictions. Also, be sure to follow any required procedures for notifying parents/guardians about outside speakers and sensitive subjects.
- **Inform the speaker.** Let the speaker know what information the group has covered in the *Focus on Youth* sessions, and briefly discuss the proposed content and length of the presentation. You might suggest that the speaker plan to spend the first half of the time sharing his or her experience with HIV and leave the remaining time for questions.

What the Speaker Will Talk About

Most speakers will address some or all of the following issues:

- **Life before the diagnosis.** By sharing information about life as a teen, speakers build rapport with the group and discuss the decisions, attitudes and behaviors that put them at risk for HIV.
- **Finding out they had HIV.** Speakers may share the events leading up to their diagnosis and their thoughts and feelings at learning they had HIV.
- **The impact of HIV on their lives.** Speakers can discuss the impact of HIV on their daily lives, including personal relationships, health, and long-term goals, and describe their treatment regimens.
- **Prevention messages.** Throughout their presentations, most trained speakers include prevention messages based on their personal stories. They may share what they would have done differently knowing there was a risk of getting HIV, and encourage the listeners to protect themselves.
- **Questions and answers.** Session 7 includes group discussion of the presentation after the speaker has left. But you may also include—and most speakers are prepared for—a question-and-answer session with the speaker. This allows the speaker to address specific issues or concerns about HIV.

Focus on Youth with ImPACT HIV-Positive Speaker Interview Questionnaire

1. Would you please share your experience in telling your personal story in a group setting?

2. Have you ever shared your story with a youth audience before?

3. Have you ever participated in a HIV-positive speaker's bureau before?

   If so:

   - What kind of training did you receive (e.g., certifications) in preparation?

   - How long have you worked with the speaker's bureau?

4. Is there someone you've worked with who can provide a reference? (Please provide his or her contact information.)

5. Could you please briefly share what you consider the top 3 factors that contributed to you contracting HIV?

6. What are 3 or 4 key messages you feel are important to convey to youth about your story as it pertains to HIV?

Criteria for Video Selection

In the event that an HIV-positive guest speaker is not available for Session 7, you can show a video that communicates key messages about living with HIV as a replacement. Here are some criteria for selecting such a video.

Does the video:

- **Demonstrate cultural and contextual relevancy** to the youth population you are serving?
- **Use visual images** that resemble the youth in your group?
- **Relate accurate information** about HIV, including transmission, prevention, risk reduction, treatment and testing?
- **Communicate key messages** using age-appropriate content?
- **Incorporate skills** aimed at reducing risk for HIV infection and show youth demonstrating these skills?
- **Have at least a 5-year shelf life,** i.e., could be viewed for the next 5 years without becoming outdated?

Resources for Leaders

These websites offer further information about teen sexual health, HIV and STD risk, youth risk behaviors, or other matters related to adolescent health.

Youth Risks

Youth Risk Behavior Surveillance System
www.cdc.gov/nccdphp/dash/yrbs
Online analysis of Youth Risk Behavior Survey results.

Centers for Disease Control and Prevention (CDC)
www.cdc.gov
Federal agency whose mission includes protecting the health and safety of people at home and abroad by providing credible information to enhance health decisions and promote health. Check out the Division of Adolescent and School Health section (www.cdc.gov/HealthyYouth) and the Divisions of HIV and STD Prevention (www.cdc.gov/hiv/dhap.htm and www.cdc.gov/std).

Child Trends

www.childtrends.org
Nonprofit, nonpartisan research organization dedicated to conducting research and providing science-based information to improve decisions, programs and policies that affect children. Provides excellent research summaries and other useful materials.

Answers to Teens' Questions About Sexuality

Go Ask Alice!

www.goaskalice.columbia.edu
This website developed and maintained by Columbia University's Health Education Program uses a question-and-answer format to provide information on a broad range of issues concerning relationships, sexual behavior and sexual health. Explicit and frank.

Sex, Etc.

www.sexetc.org
Sponsored by Answer at Rutgers University, includes articles by and for teens on a variety of issues related to healthy sexuality.

Healthy Sexuality

Sexuality Information and Education Council of the U.S. (SIECUS)

www.siecus.org
National organization has been providing positive and accurate information about sexuality since 1964. Offers special websites for teachers and schools, teens and parents, and publishes reports, curriculum guidelines, bibliographies, a monthly newsletter and other valuable materials for sexuality educators.

The Guttmacher Institute

www.guttmacher.org
Nonprofit organization focuses on sexual and reproductive health research, policy analysis and public education. Publishes reliable surveys and reports on teen sexuality, many of which can be downloaded from the website.

The Kaiser Family Foundation

www.kff.org
The Henry J. Kaiser Family Foundation addresses a wide variety of health issues, including reproductive and sexual health. Publishes studies and surveys addressing sexuality education, and provides some of the most in depth data to date on attitudes of teachers, students, administrators and parents.

Pregnancy Prevention

The National Campaign to Prevent Teen Pregnancy

www.teenpregnancy.org
National nonprofit whose mission is to improve the well-being of children, youth and families by reducing teen pregnancy. Offers many useful publications that can be downloaded from the website.

Resource Center for Adolescent Pregnancy Prevention (ReCAPP)

www.etr.org/recapp
Nonprofit website provides tools and information for teachers and health educators working with teens. Designed to act as a bridge between researchers and educators, ReCAPP provides up-to-date suggestions on responsible sexuality and teen pregnancy prevention.

Supporting Gay-Lesbian-Bisexual-Transgender Youth

Gay, Lesbian and Straight Education Network (GLSEN)

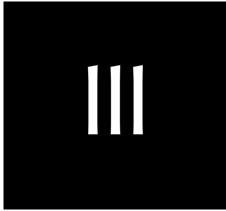
www.glsen.org
National organization dedicated to the end of anti-gay harassment in K–12 schools provides teaching guides, hosts conferences, and advocates for appropriate school policies.

Parents, Families and Friends of Lesbians and Gays (PFLAG)

www.pflag.org
National group promotes the health and well-being of gay, lesbian, bisexual and transgendered (GLBT) persons, their families and friends. The “Safe Schools” program focuses on making schools safe for GLBT youth. Website describes the program, presents current issues, and provides updates on legislative actions on a state-by-state basis.

Gay & Lesbian Alliance Against Defamation (GLAAD)
www.glaad.org
Advocacy organization monitors portrayals of the GLBT community in the press and popular media, and lobbies for accurate and balanced presentations. Website includes both recent and archived press reports.

***Note:* CDC does not take any ownership of the content found on external non-federal websites that link back to the CDC. Information or services detailed on external sites are not endorsed, warranted or guaranteed and are not necessarily representative of the views of CDC or the U.S Department of Health and Human Services.**



Putting *Focus on Youth with ImPACT* to Work—Implementation

Now that you have completed the prerequisites for implementing *Focus on Youth with ImPACT,* you can shift your focus toward the implementation phase of the intervention. In doing so, it will be important to consider the following areas: recruitment and retention of youth, monitoring and evaluating your program, adapting the program, and the theoretical applications of *Focus on Youth with ImPACT.*

Recruitment and Retention of Youth

Focus on Youth with ImPACT uses “natural friendship groups” or youth who already spend time together. The hope is that if youth are friends, they can help support each other with the skills they are being taught. Working with groups of friends also may make youth more likely to come to the group meetings.

Recreation clubs (e.g., drama club), arts and crafts, dance groups, church clubs, scouting groups or sports teams might be a way to find friendship groups. You also could approach several youth and suggest they get some of their friends together to form a group. Groups can also be put together by a presenter or a hosting organization.

Top 8 Recruitment Strategies for Youth

1. **Map your area.** It is important to know where youth may congregate in order to maximize your recruitment efforts. Therefore, it is useful when identifying recruitment areas to survey the “lay of the land,” optimal times for recruitment, etc.
2. **Identify key stakeholders.** It may be useful to identify individuals within your youth social networks who may be able to assist you in finding an “in.”
3. **Their turf, their time.** Remember to be respectful that you are entering youth’s social domain and requesting their time. This can be useful for minimizing power dynamics.
4. **Have a hook.** Think about how you plan to connect with the young people prior to actually meeting them, i.e., what will be your angle?

5. **Remember: safety first!** Always keep safety in mind. Recruit in pairs. If possible, wear name badges, etc., as a form of identification. Always ask permission when approaching groups or soliciting the participation of young people.
6. **Know your role.** Be clear about what you can and cannot provide to young people. Make sure that you articulate this to them as well.
7. **Keep it real.** Be authentic.
8. **Guest pass.** Remember that you are a guest in their community and/or social setting. Treat it with respect.

When planning youth recruitment there are a few key points to consider:

- **Identify key leaders.** As part of your recruitment effort, you will want to recruit a core group of youth who display both traditional and nontraditional leadership qualities. These young people often tend to have influence (positive or negative) over many of their peers. Use these young people as spokespersons. Spend time beforehand preparing them to introduce the program and to answer questions their peers may have.
- **Map locations.** Before conducting outreach to youth, it is critical to identify locations where young people congregate. This may require you to go to those places ahead of time to determine when youth gather there and what times are most appropriate to recruit.
- **Work in pairs.** Work in pairs when recruiting youth for the program. If at all possible, pair an adult with a youth. This can help ease situations that could be perceived as intimidating or awkward by youth who are approached by the adult.
- **Use marketing materials.** Be sure to work with youth to create materials they will resonate with, including coming up with a group name, if needed. Materials such as flyers, brochures and posters should have a youth feel and be placed in locations that young people frequent, such as community centers, Boys & Girls Clubs, YMCAs, libraries, clinics, athletic events and community events. Be sure to include bright colors and bold writing, and be as concise as possible. Also mention things such as incentives, transportation (if provided) and food in the marketing materials. *ALL marketing materials should contain the* Focus on Youth *logo, even if you have renamed your program.*

In terms of retention, there are various ways to help ensure that youth enjoy the program and keep coming back.

- First, make the group meetings fun; keep them upbeat and active.
- You may want to introduce some incentives such as snacks, certificates or small gifts. (See Section VI for Tips on Soliciting Donations.)
- Call and remind youth about the program, do home visits, send out postcards and have youth remind each other.
- Finally, engage parents and guardians. If parents support the program through *ImPACT,* the youth are more likely to remain in the program.

In the original *Focus on Kids,* financial incentives were used with success as a method for ensuring retention of youth throughout the 8 sessions. Other incentives used included a "group bank account" in which a dollar per person was contributed for each session and accumulated. The youth decided together how to use the money for an ending activity. There was a "graduation" requirement to attend at least 6 sessions (make up sessions were held as well), and graduates had a ceremony with cake and certificates. Raffles were held with small gifts (e.g., CD players, gift certificates), and youth received a slip to put into the lottery for each session they attended. Use of friendship groups was also an incentive, as youth were able to spend time with their friends.

Conducting the Parent/Guardian Session

The parent/guardian session, Informed Parents and Children Together (*ImPACT*), and the accompanying DVD are designed specifically for the parents and guardians of the youth participating in your Focus on Youth program. The session is guided by parental monitoring theory and the theory of parenting (passive, authoritarian, and authoritative). It will enable important future discussions between parents/guardians and their children around HIV, STD and teen pregnancy prevention. Ideally, parent/guardians should participate in the *ImPACT* session prior to their youth beginning the *Focus on Youth* intervention. If that is not possible, it should take place no later than Session 3 of the *Focus on Youth* intervention.

Please refer to the *ImPACT Facilitator's Guide* for more information and guidelines on contacting parents/guardians and preparing for the *ImPACT* session.

IV Monitoring and Evaluating Your Program

Once you have a *Focus on Youth with ImPACT* program up and running, it is important to periodically monitor or evaluate the program. An evaluation may be required by a funder or may be a necessary step to show the impact of your program so you can obtain funding to keep it going. You also want to ensure that the program continues to be implemented with the same fidelity (i.e., is implemented as outlined in the curriculum manual) year after year.

Evaluation Questions

Depending upon the resources available and your goals, your evaluation can be very formal and structured or informal and loosely structured. Evaluations are typically designed to answer a series of outcome and process questions. These questions, as they pertain to *Focus on Youth with ImPACT,* are described below.

Outcome Questions

It is important to determine whether the intended outcomes of your program have been achieved. Outcomes may be immediate outcomes or long-term outcomes. Long-term outcomes reflect intended behavior change. However, because behavior is difficult to change, immediate outcomes typically reflect the specific knowledge, skills and attitudes the program covered. Depending upon the length of follow-up with youth, intensity of the intervention, and unique participant characteristics (such as level of behavior prior to participating in the intervention), it may be unrealistic to expect to see much, if any, change in youth behavior immediately after participation in the program.

Often, outcome questions are answered by comparing performance of program participants to that of groups of similar individuals who did not participate in the program. The best studies randomly assign potential participants to either receive the program or to receive another program or no program. However, this is typically costly and difficult logistically. An alternative is to find groups of youth who are very similar to program youth and also have them respond to the evaluation instruments. If this is not possible, often the best that can be done is to evaluate youth performance on

outcomes prior to participating in the program and then again after program completion.

Questions that could be answered through an outcome evaluation include the following:

- **Immediate outcomes.** At the conclusion of *Focus on Youth with ImPACT,* can participating youth:
    - State correct information about HIV/AIDS and other STDs, including modes of transmission and prevention?
    - State their own personal values and understand how these relate to pressures to engage in sexual risk behaviors?
    - Demonstrate skill in decision making, communicating and negotiating with other youth regarding sexual topics and drug topics?
    - Use a condom correctly?
    - Indicate intention to use a condom or abstain from sex?
- **Long-term outcomes:**
    - Do *Focus on Youth with ImPACT* participants report higher rates of abstinence, more condom usage, and more HIV/STD testing than youth who did not participate in the program?
    - Do *Focus on Youth with ImPACT* participants report lower rates of HIV/STD infection than youth who did not participate in the program?

Process Questions

The answers to process evaluation questions help program implementers determine why the outcome results may have occurred and what changes may need to be made to the program to improve outcome performance. These questions focus on the program activities, materials and resources; the performance of program facilitators; and participant satisfaction. It is important to determine whether the program actually being evaluated reflects the program that was intended, what factors had an impact on delivery, and whether participants would recommend participation in the program to others.

Questions that could be answered a part of a process evaluation include the following:

- Did facilitators deliver the program as intended? Did they use the materials correctly? Did they skip any key concepts? What changes did they make? What difficulties did they encounter?
- Were youth engaged in the sessions? Did youth enjoy the program and program facilitators?

Evaluation Instruments

Process and outcome evaluation of *Focus on Youth with ImPACT* can be accomplished through multiple methods. These include session-embedded facilitator-led questions, youth surveys, session observations and facilitator implementation logs. For example, the *Evaluation Manual* includes the following instruments:

- **Youth Feedback Survey:** This is a paper-and-pencil instrument for youth to complete at the end of each session. It asks how much they enjoyed the session, how much they learned, the most important thing they learned, and questions related to the content of each session to assess retention. It also asks youth if they have any concerns or other issues they would like to share. The primary purpose is for the facilitator to gauge youth engagement and learning to determine if he/she needs to make adjustments in teaching style, emphasis, etc. The instrument also can be used as part of a process and outcome evaluation. One possible way to use this instrument as part of an outcome evaluation is to have youth respond to the retention questions prior to a corresponding session and then again after the session.
- **Facilitator Implementation Log:** This log is intended for use by session facilitators to document fidelity as well as youth engagement and facilitator comfort with each session. It is filled out as soon as possible after the end of a session. For each program activity in a session, facilitators indicate whether it was ‘taught as suggested,’ ‘taught with changes,’ or not taught. They also provide a description of changes made to the session as well as a description of any situations that may have impacted implementation (e.g., youth resistance, noise or other distractions, late arrivals or early departures, lack of attention, etc.).

- **Youth Outcome Survey.** This paper-and-pencil self-report survey is intended to evaluate attainment of youth outcomes. The survey covers the attitudes, skills, knowledge, and behaviors addressed in the *Focus on Youth with ImPACT* program. This survey can be administered prior to program implementation (baseline), at the end of implementation, and at various follow-up points (e.g., 3 months, 6 months, 12 months) as part of an outcome evaluation.

Coordinating Your Evaluation

The coordinator of the evaluation should be someone who values evaluation, understands the need for careful data collection, is able to help staff use the evaluation data and can devote time to the project. Depending on the type and magnitude of your evaluation, you can use existing staff or hire an outside evaluator (if resources are available) to coordinate and conduct the activities.

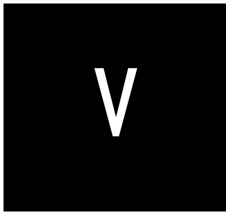
Internal staff with proper training could:

- Assist in designing and pilot-testing data collection instruments.
- Assist in data entry and data analysis.
- Provide ideas for improving the program based on findings.
- Determine sample size and how to select the sample.

It is best to get help from an outside evaluator to:

- Design complex outcome evaluations.
- Oversee collection and analysis of complex data from multiple sources at multiple times in a project's lifetime.
- Oversee analysis and interpretation of long-term outcome data.

If a staff member will be conducting the evaluation, it is important to be aware that it can be challenging to separate one's role as evaluator from other established roles.



Making It Work for Your Community—Adapting the Program

Adapting Focus on Youth with ImPACT

Assess Program Needs

Before initiating the process of adapting *Focus on Youth with ImPACT* for a special population, ensure that your agency has the necessary resources to conduct and adapt the intervention for the special population of African-American youth you have identified. In particular, make certain that:

- Your agency has an adequate budget to conduct the intervention.
- Your agency is able to commit the additional time and staff resources.
- There are appropriate staff, both in terms of personal characteristics and skills, and staff are culturally sensitive to the subpopulation.
- All staff members who will be involved in *Focus on Youth with ImPACT* have been fully trained in how to conduct the intervention.
- Your agency possesses sufficient linkages and access to the subpopulation of African-American youth to maximize recruitment and retention success.
- You gain the support of the agency administrator, and he or she reviews this section and the Pre-Implementation section of this Technical Assistance Guide.

7-Step Process for Adaptation

1. **Who?** Understand the target population.
    - What are the HIV exposure behaviors?
    - What personal, environmental and societal factors influence the continuation of those behaviors?
2. **What?** Understand the intervention.
    - What risk behaviors are targeted by the intervention?
    - What are the core elements and key characteristics of the intervention?
3. **Where and who?** Assess agency capacity.
    - Where is the agency located?

- What is the agency's experience with the targeted population in the community?
- What is the level of experience and expertise among agency intervention staff?

4 **Does it match?** Match the target population, intervention and agency.

- Determine if targeted behaviors match those the intervention is designed to affect.
- Determine if influencing factors are consistent with the theoretical constructs on which the intervention is based.

5 **How and when?** Preparation.

- What level of funding is needed?
- What is the timeline for pre-implementation, implementation and maintenance?
- Are staff expectations realistic?

6 **Do it.** Implement the intervention as planned.

7 **Is it working?** Evaluation.

- Conduct process monitoring and process evaluation.
- Conduct outcome monitoring.
- Compare changes to those realized by the intervention study.
- Make appropriate adjustments.
- Stabilize program.
- Monitor process and outcomes.

Examples of Adaptations

When making changes to *Focus on Youth,* activities should continue to capture the identified intent or theoretical construct (see Theoretical Applications section below). Activities can be changed so long as they continue to reflect the identified constructs of Protection Motivation Theory (PMT).

For example, in the original curriculum, the parent roleplay activity was scored as operationalizing self-efficacy, response efficacy and response costs. Several examples of how various implementing organizations have changed the parent roleplay activity illustrate how this process can be completed to

maintain fidelity and how certain types of changes no longer keep fidelity to the original intent:

- One organization changed the parent roleplay activity to a discussion on parent vs. youth communication styles. This program did not reflect the original constructs (self-efficacy, response efficacy and response costs) because a conversation about different communication styles did not give youth the opportunity to practice the skill and the confidence that such a conversation was possible (response efficacy), or the belief that they could do it (self-efficacy), and did not exemplify problems that might occur during the conversation (response costs).
- Another organization had participants practice the parent roleplay activity at home. Again, this reinvention does not reflect the three PMT constructs, as there is no way to ensure that youth complete the assignment and there is no opportunity for feedback.
- A third program in a juvenile justice facility changed the roleplay activity to talking to probation officers instead of parents to adapt the activity for participants. This group still reflected the PMT constructs (response-efficacy, self-efficacy and response costs) since the youth seemed to receive the same skills from the altered activity.

As mentioned previously, core elements must be implemented with integrity and fidelity to increase the likelihood that prevention providers will have program outcomes similar to those in the original research. These are elements of the intervention that *cannot be changed, modified or adapted.*

Below you will find the rationale for the *Focus on Youth with ImPACT* core elements, as well as examples of changes, adaptations and modifications that reflect either adherence to or violation of selected core elements.

Core Element 1: Deliver intervention to youth in community-based settings.

Rationale: Focus on Kids was originally conducted in recreation centers and other community-based settings to capture youth at the highest risk who may be chronically truant from school and who do not access services at health clinics. The community setting also was considered to be closer to the social context in which youth risk taking occurs.

Core Element 2: Use two skilled facilitators to model communication, negotiation and refusal skills for the youth.

Rationale: The original evaluation of *Focus on Kids* implemented the intervention with two facilitators per group. This strategy allowed facilitators to model communication, negotiation and refusal skills for the youth. It also allowed one facilitator to deal with individual issues of youth without disrupting the group. Although the core element was use of two facilitators, those organizations that use more than two facilitators are considered to be implementing with fidelity as they still meet the intent of the core element.

Core Element 3: Use "friendship" or venue-based groups (i.e., a basketball team, a scout troop, church group, an existing youth group) to strengthen peer support.

Rationale: The original *Focus on Kids* was implemented with naturally formed friendships groups. The rationale for using friendship groups was to influence peer norms positively. The developers posited that if groups of friends went through the program together they could support each other in the development of new skills and could also facilitate peer norms in support of healthy behaviors.

A subsequent *Focus on Kids* evaluation formed groups with youth who utilized common community centers, the approached used by many implementing organizations contacted for a fidelity study. The intervention remained efficacious,[9] thus providing an empirical basis for expanding the core element beyond friendship groups to also include venue-based groups.

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

Rationale: Focus on Youth with ImPACT includes interactive activities including games, roleplays and community projects to help the youth capture the important lessons of the constructs in the theory. It was believed that youth would learn more quickly if they enjoyed what they were doing and had fun. A lot of practice exercises are included with the belief that the more youth practice new skills, the more developed the skills become.

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

This core element is something of a catch-all, and many of the activities can be changed to still capture the intent. The activities thought to be most key are captured in Core Elements 5, 6, 7 and 8. (Please refer to the Theoretical Applications chart at the end of this section.)

Core Element 5: Include a "family tree" to contextualize and personalize abstract concepts, such as decision making and risk assessment.

Rationale: The "family tree" is a unique activity of *Focus on Youth with ImPACT.* In this activity, youth are given a skeleton of a family tree and asked to create the circumstances of and the relationships between the family members. The characters in the family are used throughout the curriculum to put decision making into a personal context for the youth.

The original "family tree" was culturally appropriate for an urban, African-American target audience. Therefore, group leaders are given specific instructions in the facilitators' manual and during training on modifying this activity for their target audience. References for specific resources to assist in the modification of the activity to another target audience are provided. The results of a fidelity study of the original showed that the specific instructions seemed to aid group leaders in successfully adapting the activities for their own use target audience without losing the objectives of the activity.

Activities making up Core Element 5:

- Family Tree
- All of the SODA activities (see Core Element 6)
- Roleplay (see Core Element 7)

Examples from the field:

- Changes adhering to the core element:
  - Changing the names and relationships of the characters to reflect the cultural norms of the community.
  - Adding a character who made positive decisions as an adolescent (maybe an uncle or aunt of the main youth characters).
- Changes violating the core element:
  - Providing specific details about the main characters (male and female youth characters that are the same age as the youth in the group).

- Taking away the multi-generational component of the story that allows youth to see that decisions made as an adolescent have an impact on later life.
- Dictating the decisions made by the main characters as they face new challenges. (The purpose of the exercises is to allow the youth to make the decisions.)

Core Element 6: Enable participants to learn and practice a decision-making model such as SODA (Stop, Options, Decide, Act).

Rationale: An important skill for HIV-prevention is making sound decisions. The original *Focus on Kids* wanted youth to learn an easy decision making model that enabled them to choose healthy behaviors. SODA stands for Stop, Options, Decide and Act. Each step is taught in a separate interactive activity, using scenarios with characters from the family tree. In order to implement this core element with fidelity, all four activities must be completed.

Activities making up Core Element 6:

- SODA Decision-Making Model—Step 1: Stop
- SODA Decision-Making Model—Step 2: Options
- SODA Decision-Making Model—Step 3: Decide
- SODA Decision-Making Model—Step 4: Action

Examples from the field:

- Changes adhering to the core element:
  - In Namibia, changed SODA acronym to POWER—Problem (state); Options; Weigh options; Elect best option; Reflect and act—since SODA is not a word in Namibia.
- Changes violating the core element:
  - Several CBOs implementing some parts of *Focus on Kids* just had one discussion that explained how decision making worked. (This change did not give youth an opportunity to practice the various skills in the SODA exercises which is really how the self-efficacy and response efficacy constructs were reflected.)

Core Element 7: Train participants in assertive communication and refusal skills specifically related to negotiation of abstinence or safer sex behaviors.

Rationale: Although making healthy decisions is an important part of HIV prevention, youth also need the skills to carry out healthy choices. Communication and negotiation are some of the skills needed. Through interactive activities, youth are taught about good listening and verbal and nonverbal effective communication. A roleplay allows youth to practice all the acquired communication skills together. Four activities constitute this communication core element. All four activities have to be completed to implement Core Element 7 with fidelity.

Activities making up Core Element 7:

- Communication Game: Communicating Without Words OR Changing Messages
- Communication Styles: Aggressive, Assertive and Nonassertive
- Sex: A Decision for Two
- Roleplay: Saying NO or Asking to Use a Condom

Examples from the field:

- Changes adhering to the core element:
    - Discussing how poor communication skills may also lead to unprotected sex.
    - Including more roleplays that allow youth to practice assertive communication.
- Changes violating the core element:
    - Just having a discussion about communication styles without allowing the youth an opportunity to practice.
    - Bringing in a rape crisis speaker as a substitute for the Sex: A Decision for Two activity, as this may not allow youth to understand the ways they can prevent date rape themselves.

Core Element 8: Teach youth proper condom use skills.

Rationale: Aside from communication and negotiation skills, using condoms correctly is another skill needed to carry out healthy choices. *Focus on Youth* was designed to foster positive attitudes and norms towards consistent condom use for sexually active youth and to provide appropriate instructions for condom use.

Activities making up Core Element 8:

- Condom Demonstration
- Condom Race

Examples from the field:

- Changes adhering to the core element:
  - Instead of a race, have a condom competition that stresses correct use of condoms instead of how quickly one can be put on.
- Changes violating the core element:
  - Only doing the Condom Cards Activity. (This takes away the response efficacy of the condom demonstration because youth cannot see the strength and size of the condom.)

Adaptations for GLBTQ Youth

Currently, the *Focus on Youth with ImPACT* curriculum contains session-specific materials for facilitators who are adapting *Focus on Youth* activities for gay, lesbian, bisexual, transgender or questioning youth. This information is included below for the convenience of Executive Directors, Program Managers and others who work with these facilitators and who plan and develop interventions with alternative populations.

Adapting Family Trees

The Family Tree is an important activity in *Focus on Youth with ImPACT.* The exercise gives group members an opportunity to think about the ways social environments, especially families, influence young people's decisions. This awareness can enhance their ability to make positive decisions now and in the future.

The Family Tree activity is most effective when the group can relate to it. It needs to sound like their own family, or the families they know. The family situations and relationships should be believable. If group members can imagine and fill in the details of these characters' lives and feelings, they can learn more about their own experiences and values in the process.

The second version of the Family Tree included in the curriculum provides an example that can be used with GLBTQ youth. This is just one example of the wide range of possible family trees. One of these designs may work well for your

program. However, you are also *strongly* encouraged to work with a community advisory board to develop a family tree for your specific setting. There can be a fine line between credibility and stereotype. The input of community members can help you develop a family tree that is realistic, believable and respectful of the youth participants.

Meet with the advisory board, explain the purpose and function of the Family Tree activity in *Focus on Youth with ImPACT* and ask the following or other questions:

- What are some of the strengths of families in this community?
- What are some of the challenges that face families here?
- What are the values that are most important to families here?
- Are there ways families in this community seem similar to, or different from, families in other communities?
- What are some of the influences in our families or community that can lead young people to make positive health choices?
- What are some of the influences that might lead young people to make negative health choices?

Based on the feedback, develop some sample family trees. Have the board review these and choose one they believe will be most effective with the young people participating.

Session 1: Alternate Activity 5—Family Tree: Story 2

Malik & Kenya

Note: Refer to the diagrams on the next page as you tell the story.

Let me introduce you to Malik and Kenya, who are brother and sister about your age. Right now, Malik lives with his dad, James, and Kenya lives with their mother, Teresa, and their grandma, Juanita, whom they call Nichee. But let's start by going back a few years and learning more about Malik and Kenya's family.

Teresa, their mother, met James when she was in junior college. Soon after, they got married and Teresa got pregnant with Malik. A couple of years later, they had Kenya. **(Draw diagram 1 while you tell this part of the story.)**

Before James and Teresa were married, James had been married to Donna. He and Donna had one child, Darrell. **(Add Donna and Darrel to the Family Tree. See diagram 2.)**

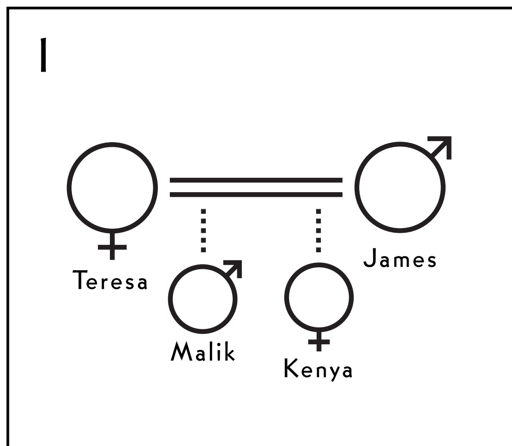
When Teresa and James separated, she moved in with her mother, Juanita. She took Kenya with her. Malik stayed in the old house and lives with his Dad.

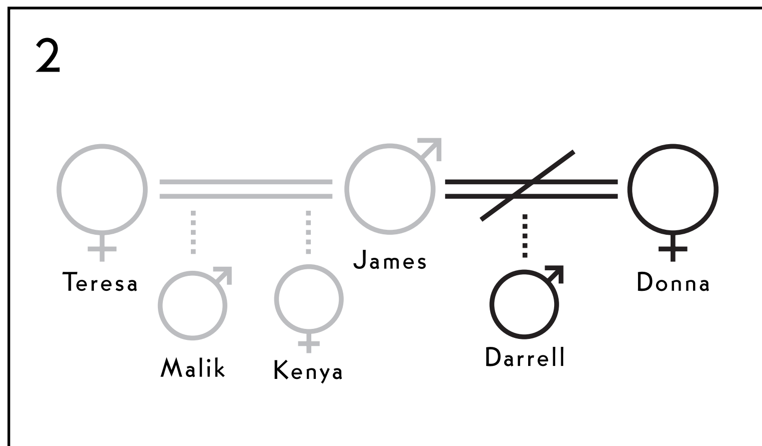
After James tells Teresa he wants a divorce, Teresa doesn't let Kenya go spend the weekends with her Dad and Malik anymore. Malik starts to skip school and to come home late at night. **(Add Nichee and draw a line across the double lines joining Teresa and James to signify the end of their relationship. See diagram 3.)**

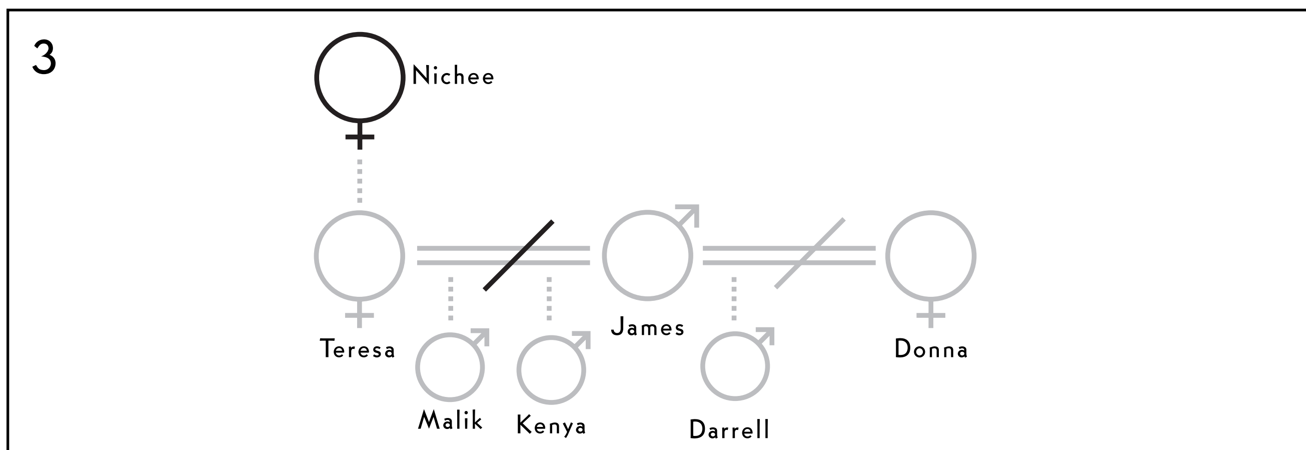
Kenya is worried about her brother. They don't talk like they used to. Malik is also starting to spend a lot of time playing ball with an older guy named Lamont. Finally, Malik tells Kenya that he thinks he likes Lamont, but he doesn't want her to tell his father, James. **(Add Lamont to the Family Tree. See diagram 4.)**

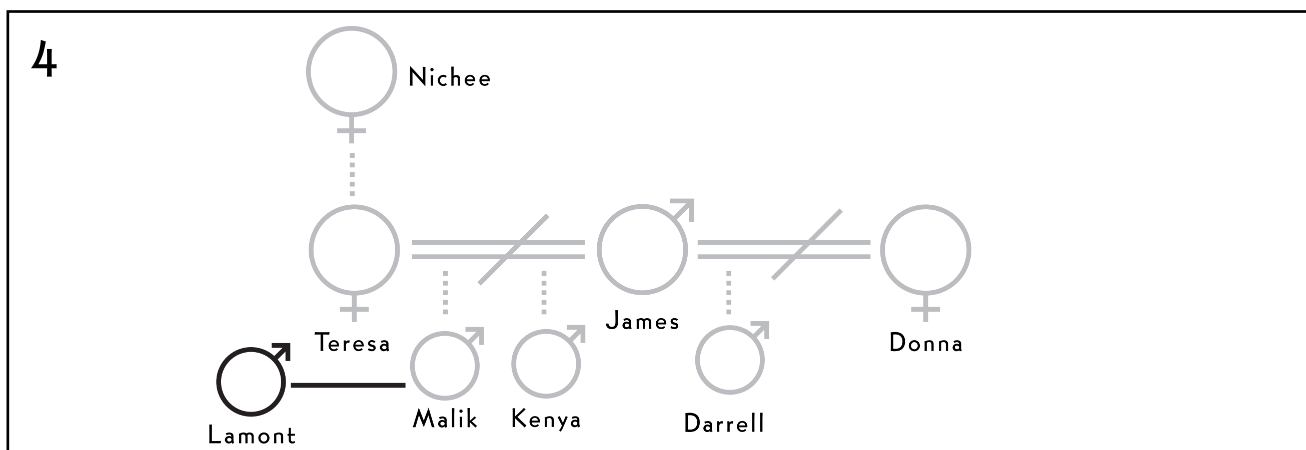
(continued)

Family Tree Diagrams
Story 2









(*Note:* Final Family Tree Chart will look like diagram 4.)

Discussion Questions Story 2

Tell the group that you want them to think about the teens in the story and imagine what their lives are like. Remind them that it's OK to make up and imagine details that are missing from the stories. Since Story 2 introduces the subject of same-gender attraction, take time to engage the group members in some discussion about this relationship.

Questions

- Think a little bit more about Malik:
  - Who do you think his friends are?
  - What does he do in his spare time?
  - How is he doing in school?
- What can you tell me about his sister Kenya?
  - Who do you think her friends are?
  - What does she do in her spare time?
  - How is she doing in school?
- What can you tell me about Malik's relationship with other relatives, both inside and outside the household? (Ask about a few specific individuals, such as his father, James, and his sister, Kenya.) Examples:
  - How does Malik feel about his father? Do you think his father is hard on him?
  - Does Malik know Kenya's worried about him?
  - Malik says he think he likes Lamont. What do you think that means?
- What pressures might Malik be feeling, if he has to hide his feelings for Lamont from his father?
- What do you think society's perceptions are of people who have same-gender attractions? What is the perception in your community of youth with same-gender attractions?
- When Malik has a problem, whom does he talk to? Why does he choose this person?

- What kinds of decisions does Malik have to make now? What kinds of decisions might he have to make in the future?
- Are the decisions Malik is making now going to allow him to do what he wants to do when he grows up?
- When Kenya has a problem, whom does she talk to? Why does she choose this person?
- What kinds of decisions does Kenya have to make now? What kinds of decisions might she have to make in the future?
- Are the decisions Kenya is making now going to allow her to do what she wants to do when she grows up?

Detailed Questions for Supplemental Character Information (if needed)

Note: These questions are intended to guide youth in building the story of Malik and Kenya and should be used only if the youth are having difficulties moving the story along.

Malik

- How old is Malik?
- Is Malik older or younger than his sister, Kenya? How much older or younger?
- What grade was Malik in when his parents separated?
- How did he take it and how did it affect his behavior at school and at home?
- Right now, is Malik close or not so close to his sister, Kenya? Was their relationship always like this?
- What does Malik do to get rid of his stress?
- How does Malik's dad feel about Malik's dreams? What does his dad want to see Malik do?
- What is Malik's relationship like with his dad?

James

- When did James meet Teresa? What was he doing with his life when he met her?
- Was James married before he met Teresa? If so, what was his wife's name? Did they have children? What is (are) their name(s)?
- If James has other children, what does supporting two families do to him?
- How long were he and Teresa together before they separated? Why did they separate?
- How does James feel about Malik? What does he wish for Malik? What does he want Malik to become?

Kenya

- How has Kenya's parents' separation affected her?
- How does she feel about her dad and brother not being around? How often does she see them?
- How does Kenya feel about living with Nichee, adjusting to new school and making new friends?
- Does Kenya know about how Malik deals with his stress? If she found out, how would she feel? Since they don't live together anymore, how do they talk to each other?
- How much freedom does Malik have now that he lives with his dad? What effect is that having on Malik? Does Kenya know about this? How does she feel about it?
- What does Kenya know about how her dad disciplines Malik? Does she agree with how Malik and their dad talk to each other?
- What does Kenya dream about? What kind of student is she? How much studying does she do? How does the amount of studying she does or doesn't do prepare or not prepare her for her dreams?

(continued)

Detailed Questions for Supplemental Character Information *(continued)*

Teresa

- When did Teresa meet James? What was she doing with her life when she met him?
- How long were Teresa and James together before they separated? Who left whom?
- Is there still love between Teresa and James? Why did their relationship fall apart?
- Even though they're separated, does either of them want a divorce?

Lamont

- How did Lamont and Malik meet?
- How do they hook up now? How often?
- How old was Lamont when he "came out"? How long ago was that?
- How many guys has Lamont been with? How comfortable is he with his sexuality?
- How does Lamont feel about Malik? Does that make him look forward to seeing Malik each time or not?

Adapting "SODA Decision-Making Model—Step 2: Options"

Session 3: Addition to Activity 2

For sexually diverse teens who are sexually active (Story 2):

Malik has never dated anyone seriously before and has never had sex. He started hanging out with Lamont 2 months ago. They play ball together every Friday and Malik always looks forward to seeing Lamont. He knows that Lamont has been with several other guys. Some of Malik's friends have been teasing him about being a virgin and telling him to go "get some."

One evening, Lamont invites Malik over to his house. Malik already has plans with his friend Erica and asks if he can invite her too. Lamont sounds disappointed, and says he wanted it to be just the two of them. Lamont says that the two of them can have some time alone.

- What is the decision? *(whether or not to go to Lamont's house, whether or not to have sex)*
- How does Malik feel? How does Lamont feel? *(Possible answers: confused, scared, excited, upset, nervous)*
- What does Malik need to know before he makes his decision? *(Possible answers: What are the consequences of having sex? of not having sex? What are his parents' rules and expectations about him having sex? How can he tell Lamont he isn't ready? What kind of protection would he need if he was ready?)*
- What are Malik's options? *(Possible answers: Go to Lamont's house, but make sure they don't have sex; tell Lamont he's busy; invite Erica anyway; suggest an alternate activity—go to a movie, a bookstore or coffeehouse, a friend's house.)*

Adapting "Resources: Finding Information for Good Decisions"

Session 3: Additions to Activity 3

3 Assign team tasks as follows:

Team 4: Use the phone book or Internet to find gay, lesbian, bisexual, transgender and questioning (GLBTQ) support services for teens that include HIV and STD testing and rape crisis.

Notes for Group Leaders: The Team 4 exercise can focus on identifying services for GLBTQ teens. Members of this team need to be advised to be sensitive to the issue of sexual diversity as previously discussed and be prepared to discuss any differences in getting information as a straight teen or as a GLBTQ youth. For example, was the information on the GLBTQ website significantly different from the info on a non-GLBTQ site?

GLBTQ Resources

You may want to add these additional resources to **Getting the 411: Resource Guide for Teens.**

OutProud: National Coalition for Gay, Lesbian, Bisexual & Transgender Youth

www.outproud.org

Offers resources and information for GLBT youth, their friends and educators.

PFLAG: Parents, Families and Friends of Lesbians & Gays

www.pflag.org

National organization that supports gay, lesbian, bisexual and transgender (GLBT) people and advocates for equality, dignity and respect for all.

Adapting "Sex: A Decision for Two"

Session 5: Alternate Activity 5—Malik's Story

Notes for Group Leaders: If you (or your agency) are unable to provide a rape crisis counselor to be present for this session, make sure that one of the facilitators is available during the activity to talk to any youth who may become upset. Have your local rape crisis center's contact information available for youth, should they need it. Often, rape crisis centers will have informational brochures for youth who have been sexually assaulted. Check with your center to see what resources they can provide you.

Be sure to familiarize yourself with the story, discussion questions and suggested answers. In addition to helping the group understand how empowering assertive communication can be, the goal is to create a safe space so that youth feel comfortable talking about this topic and are able to have their questions answered, and to dispel common myths about rape that often blame the victim. It is important to use safe, validating language throughout this activity, and to give consistent, supportive messages.

(*Note:* Follow steps 1 through 3 of the procedure in Session 5, Activity 5.)

4 Read Malik's Story.

5 After the story, ask for some initial reactions or thoughts about the story. Acknowledge that this is a serious subject and that the story they just heard presented a complicated situation.

6 When the group is ready, lead a discussion using the following questions:

- What could have happened at the end of this story? *(Malik could have left. Lamont could have listened to Malik when he said no to having sex. Lamont could have forced Malik to have sex anyway.)*
- If Lamont had managed to have sex with Malik, would that have been an instance of date rape? *(Yes. Even though Malik is attracted to Lamont and wanted to spend time with him, he did not give him permission to have sex. If Lamont had sex with Malik anyway, that would be rape.)*
- What form of communication did Malik use to express that he was uncomfortable in the situation? *(When he initially tried to leave, his communication was passive. Toward the end, he became more assertive.)*

- What role did alcohol play in this situation? How did it affect Malik? How did it affect Lamont? *(It's harder to think clearly and evaluate a potentially dangerous situation when you've been drinking. If you've been drinking a lot, it can be harder to resist sexual advances, because your thinking is impaired and your reflexes are slower. Drinking makes some people act more aggressively. If you've been drinking, you may not be able to pick up on subtle communication or the other person's body language. Drinking too much causes blackouts and this can leave a person vulnerable to assault or rape.)*

7 Explain that some people have misunderstandings about what rape is or how it happens. Tell them you'd like to clarify any misunderstandings they may have by asking if certain statements are myth or fact.

Choose 4–7 of the statements below and ask youth to state whether they are myth or fact. Correct any misinformation.

- Men cannot be sexually assaulted. *(Myth. Men can be, and are, sexually assaulted every day. Any man can be sexually assaulted regardless of his size, strength, appearance, occupation, race or sexual orientation.)*
- If a male gets an erection during sexual assault, it means he "really wanted it" or consented to it. *(Myth. This is one of the things that can cause a lot of confusion and guilt for male rape survivors if they don't understand that an erection means only that the body responded how it is set up to do. It's a normal physical response that can have nothing to do with desire. This part of the body has nerve endings that respond to touch, and that "touch" can be wanted or not wanted, pleasurable or not pleasurable. It's the same as when the body responds to someone tickling you. You will probably laugh, even if the tickling is done by a person you don't want to tickle you or at a time you don't want to be tickled. The body will respond, but this doesn't mean you wanted to be tickled.)*
- A woman can't rape another woman. *(Myth. Although the majority of rapes are committed by men, women can and do rape. As with sexual assaults committed by men, the perpetrator may be a partner, an acquaintance, or a stranger, and it can happen to any woman, regardless of her sexual orientation.)*
- You can't be raped by someone you've already had consensual sex with. *(Myth. You have the right to say "no," even if you've had sex with someone before. Each time you're asked to have sex, you have the right to say "no.")*
- Rape is committed by strangers. *(Myth. Over half of all reported rapes are committed by a person known to the victim.)*

- If you're forced to have sex by a boyfriend or girlfriend, even if you love each other, it's rape. *(Fact. Any nonconsensual sex is rape.)*
- Rape most often occurs at gun or knife point and somewhere outdoors, such as in a dark alley. *(Myth. Most rapists do not use a weapon to force someone to have sex. Over half of all rapes occur in the home.)*
- Date rape is just as serious as being raped by someone you don't know. *(Fact. Rape is rape. Both forms of rape are equally illegal, and people can go to jail for "date rape.")*
- Rape is caused by the way a person dresses or acts. *(Myth. Rape is an act of violence. It is not about sex—it's about power or one person trying to control the other. No one has the right to have sex with anyone against his or her will, no matter what the situation.)*
- Rape only happens to girls. *(Myth. Rape happens to boys, girls, children, the elderly, men and women. In 2002, 1 out of 8 rape victims was male.)*
- Someone who is raped deserves it, especially if they have been drinking and/or making out. *(Myth. No one deserves to be raped. Drinking with someone or making out with him or her doesn't mean you are agreeing to have sex.)*
- Rape is common among teens. *(Fact. About 44% of rape victims are under age 18.)*
- It's better not to tell anyone if you're raped. *(Myth. Whether a person decides to report to the police or not, the services of a sexual assault center are available in most communities 24 hours a day. It's important for victims of rape to receive medical care and emotional support immediately. It also may help keep the rapist from finding another victim.)*
- Child sexual abuse is rare, happens out of the blue and is usually an extreme form of child abuse. *(Myth. This form of abuse develops gradually over a period of time and usually will be repeated until it is stopped. Although the forms of abuse may become more serious as time goes on, the majority are not the torture/murder types seen on TV.)*
- It is your own fault if you couldn't stop a rape. *(Myth. Rape is an act of violence. It's usually performed by someone who has found a way to overpower the victim either mentally through threats—to hurt you, to break up with you, to not like you—or by calling you a tease or saying you asked for it, or with physical violence. It is never your fault if you get raped.)*

(*Note:* Continue with steps 8 and 9 of the procedure in Session 5, Activity 5.)

Group Leader

Session 5

Malik's Story

"Come on man, drive to the hoop," yelled Lamont.

Lamont, the college junior from State was yelling at Malik, a high school senior, to score during their weekly pick-up game. Lamont and Malik had been playing this weekly game for the past three months and they both looked forward to it every Friday after Malik got out of school. Although Lamont was bigger and taller, Malik was able to hold his own because he'd played for years with his taller friends.

As they scored the last points and beat their opponents, they both high-fived and "man-hugged" in victory. Malik learned a lot from playing with Lamont, but most of all he liked the sportsmanship. Secretly though, Malik was aware of his growing attraction to Lamont. He noticed that during the week he was thinking a lot about Lamont. He enjoyed the weekly pick-up game for the sport, but also because he was able to spend time with Lamont.

"Hey, you got anything planned? Want to head back to my place? I have some cold ones in the fridge," Lamont asked Malik as they were gathering up their belongings.

"Yeah, I'm out of juice and I'm thirsty." Malik knew that Lamont lived not far from the hoop court, near the college campus. They'd hung out at Lamont's place after games before. Malik was excited about the invitation even though Lamont had never given any indication that he was interested in Malik outside of basketball.

"Make yourself comfortable, I'll grab those drinks," Lamont said, as Malik looked around the apartment. Lamont came back with two cold beers. "When you said cold ones, I thought you meant Gatorade," Malik shot back at Lamont as he grabbed the beer and looked back for a response. "Yeah, Gatorade is great, but after a great game, there's nothing like a cold beer." Lamont winked at Malik and took a big gulp from his bottle. Malik didn't really drink beer but he was thirsty, and he didn't want to seem uncool to Lamont, so he took a drink. They started to watch a game on TV.

When he finished his drink, Lamont asked Malik, "You want another one?" as he got up and headed to the kitchen. He didn't really want any more, but Malik responded "Yeah," and sat back on the sofa watching the game. He was feeling a little nervous

(continued)

Group Leader

but happy to be hanging with Lamont, who was older, cooler and had a mad big-screen TV with surround sound.

When Lamont came back, he sat much closer to Malik on the sofa. This excited Malik. They talked about Lamont's major (business) and Malik's desire to go to college and study architecture. Eventually, Malik started feeling really buzzed from the beers and thought he should probably go. He was worried that his attraction to Lamont was going to show. He had never felt like this and he wanted some time to think more clearly about his feelings.

"I think I'd better get going," Malik said as he got up. As he did, he realized he was more buzzed than he thought and stumbled a little as he rose. Lamont caught him, and steadied him so he wouldn't fall. Malik got a little uncomfortable and tried to play it off by stepping away as he laughed at himself.

Lamont laughed, "Why don't you chill and finish watching the game?" and playfully pushed Malik back onto the sofa. They both laughed as Malik fell backward and collapsed on the sofa. Lamont got up and went into the kitchen for some more beer when his phone rang.

It was Larry inviting himself over. Lamont said to Larry, "No. It's not cool for you to come over today, Larry." When Lamont came back with more chips and beers Malik asked, "What's up with that?" "Nothing," Lamont responded. As Lamont set the beers and chips down, he sat on the sofa close to Malik. Lamont put his hand on Malik's thigh and said "I didn't think you would mind if he didn't come over. You seem to like things the way they are. Am I wrong?" Malik didn't know what to say. He knew he liked Lamont, and now he knew Lamont liked him too. But all that alcohol was getting to him and he wasn't feeling that well. Plus, with Lamont all up on him like this, he was nervous and confused. "Man, I think I need to leave," Malik finally said.

As he tried to stand to leave, Lamont held him down. "Come on, man, we can just kick it for a while. I know you want to," Lamont said as he moved closer. "No, I really better go. This is a lot for me right now," Malik said, trying again to get up. Lamont stopped him. "Man, don't act like a punk. You dig me, I know you do. I dig you too. Now come on, let's just relax." Convinced that Malik really wanted it, Lamont made his move, ignoring Malik when he muttered, "No, stop."

Theoretical Applications and National Health Education Standards

The overall goals, sessions and individual activities within the *Focus on Youth with ImPACT* sessions are based on Protection Motivation Theory, a type of social cognitive theory. Understanding the activities' links to this theory and to the National Health Education Standards (NHES) can help guide any changes made to the curriculum to ensure that it still addresses all of the constructs of the theory and the NHES.

About Protection Motivation Theory

Protection Motivation Theory (PMT) is a social cognitive theory that emphasizes the balance between pressures to engage in a risk behavior (social and personal rewards), risks involved (severity of the undesired outcome, vulnerability), and considerations of the alternatives (how well the alternatives help avoid undesirable outcomes; ability of the youth to employ the alternative behavior; and social, personal or other costs associated with employing the alternative).[10]

In simpler terms, this can be seen as an appraisal of threat (e.g., What are the dangers of having unprotected sex?), balanced with an appraisal of coping (e.g., What are the benefits of abstinence or using a condom?). Self-efficacy plays a role in this appraisal process (e.g., Do I have the skills and knowledge I need to choose abstinence or use a condom?).

PMT recognizes the influence of culture, family and peers in the identification and recognition of risks. If culture, family and peers all consider the threat of unprotected sex significant, chances are the individual youth will as well.

When an individual makes an appraisal of threat, the following constructs come into play:

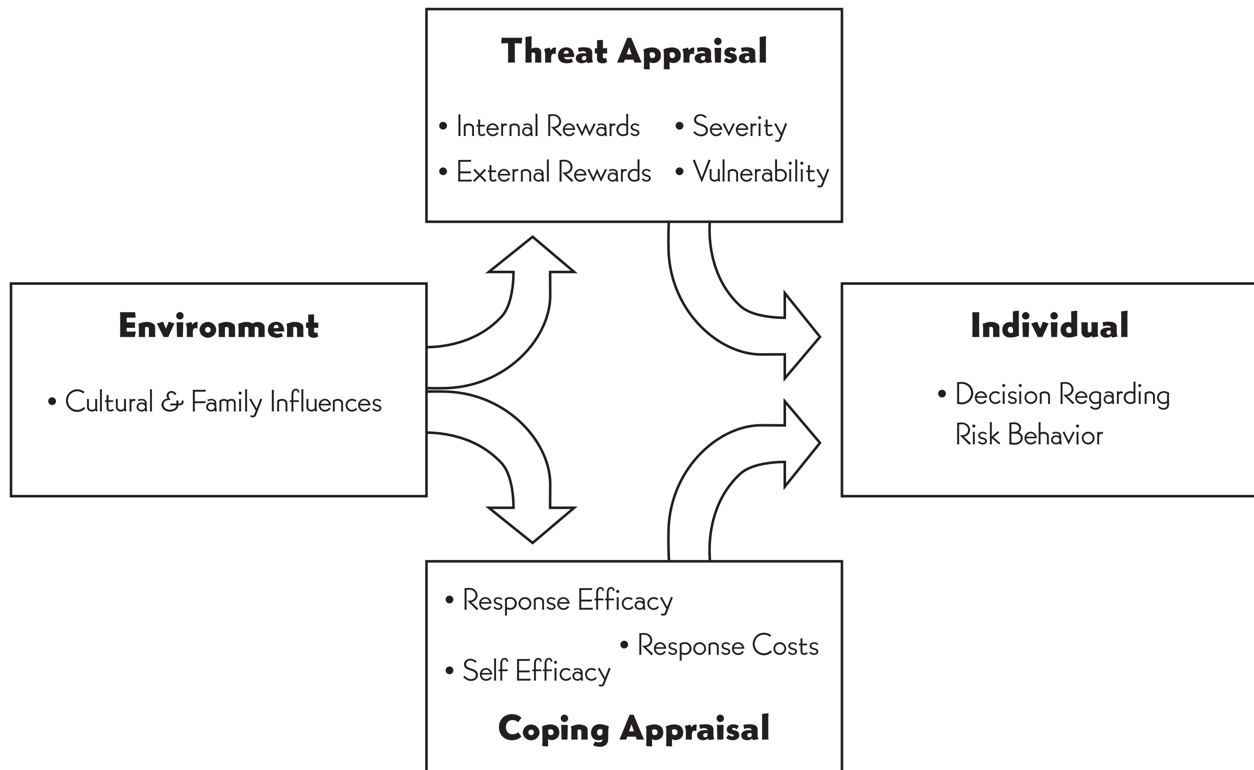
- **Internal rewards:** Positive personal feelings in response to a threat (e.g., a young person might see rewards in unprotected sex if he or she feels it will strengthen a romantic relationship or raise his or her status among peers).

[10] Rogers, R. W. 1983. Cognitive and physiological processes in fear appraisals and attitude change: A revised theory of protection motivation. In Social Psychology, ed. T. Cacioppi and R. E. Petty, 153-176. New York: Guilford Press.

- **External rewards:** Positive personal feelings in response to others' feedback or reactions (e.g., a young person might see rewards in unprotected sex if friends are all encouraging him or her to have this experience).
- **Severity:** A belief about how severe the outcome of the risky behavior could be (e.g., how serious would it be to have unprotected sex and become infected with HIV?).
- **Vulnerability:** A belief about how likely the negative outcome is (e.g., how likely am I to become infected with HIV if I engage in unprotected sex?)

When an individual engages in coping appraisal, the following constructs come into play:

- **Response efficacy:** The belief that it's possible to protect oneself from the negative outcome of the risky behavior (e.g., by choosing abstinence or using condoms).
- **Self-efficacy:** The individual's belief that he or she is capable of using the protective behavior (e.g., Do I have the necessary knowledge and skill to choose abstinence or use a condom?).
- **Response costs:** A belief about the disadvantages of the protective behavior (e.g., drawbacks to using a condom).



About the National Health Education Standards

Health teachers are familiar with the National Health Education Standards (NHES), but providers outside the health education field may not know about these guidelines. They were developed by the Joint Committee on National Health Education Standards, a national committee of health education specialists, and first published in 1995. Since that time, they have become widely accepted and applied in public and private educational settings. The revised Standards were published in 2007.[11]

The current NHES outline 8 general standards, then describe specific performance indicators for these standards for students from kindergarten through grade 12.

1 Students will comprehend concepts related to health promotion and disease prevention to enhance health.

[11] Joint Committee on National Health Education Standards. 2007. *National health education standards: Achieving excellence.* 2d ed. Atlanta, GA: American Cancer Society.

2. Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
3. Students will demonstrate the ability to access valid information and products and services to enhance health.
4. Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
5. Students will demonstrate the ability to use decision-making skills to enhance health.
6. Students will demonstrate the ability to use goal-setting skills to enhance health.
7. Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
8. Students will demonstrate the ability to advocate for personal, family and community health.

Applications to *Focus on Youth*

The following chart provides a summary of how *Focus on Youth with Impact* activities meet the National Health Education Standards and performance indicators for Grades 6–8. The chart also indicates which constructs of PMT are at work in different activities. Some activities (for example, those that build trust among group members or review a previous session's learning) do not meet any specific standards or theoretical constructs, but do provide an overall sense of cohesion and movement for the program.

Session 1: We're All in This Together

Activity	NHES Standards/Performance Indicators	PMT Constructs
1. Introduction Game: Flying Objects		
2. *Focus on Youth with ImPACT.* Program Overview		
3A. Group Cohesion Activity: Crossing the River 3B. Group Cohesion Activity: The Box 3C. Group Cohesion Activity: The Human Knot	Standard 4.1: Apply effective verbal and nonverbal communication skills to enhance health. Standard 5.3: Distinguish when individual or collaborative decision making is appropriate. Standard 5.5: Predict the potential short-term impact of each alternative on self and others.	
4. Establishing Group Agreements		
5. Family Tree		Severity, internal rewards, external rewards, vulnerability, response costs
6. SODA Decision-Making Model—Step 1: Stop	Standard 5.2: Determine when health-related situations require the application of a thoughtful decision-making process.	

Session 2: Risks and Values

Activity	NHES Standards/Performance Indicators	PMT Constructs
1. Opening Ritual and Review		
2. How Risky Is It?	Standard 1.1: Analyze the relationship between healthy behaviors and personal health.	Severity, vulnerability
3. Why Do People Feel Invulnerable?		Vulnerability
4. Defining a Value	Standard 2.2: Describe the influence of culture on health beliefs, practices and behaviors.	
5. Rank Your Values	Standard 2.2: Describe the influence of culture on health beliefs, practices and behaviors.	Internal rewards, response costs, self-efficacy, external rewards
6. Values Voting	Standard 2.2: Describe the influence of culture on health beliefs, practices and behaviors.	Internal rewards, response costs, self-efficacy, external rewards

Session 3: Educate Yourself: Obtaining Information

Activity	NHES Standards/Performance Indicators	PMT Constructs
1. Opening Ritual and Review		
2. SODA Decision-Making Model—Step 2: Options	Standard 5.4: Distinguish between healthy and unhealthy alternatives to health-related issues or problems. Standard 5.5: Predict the potential short-term impact of each alternative on self and others.	Response efficacy, self-efficacy
3. Resources: Finding Information for Good Decisions	Standard 3.1: Analyze the validity of health information, products and services. Standard 3.2: Access valid health information from home, school and community.	Self-efficacy, response costs, response efficacy, severity, vulnerability
4. Trusted Guardian/Adult as a Resource	Standard 4.1: Apply effective verbal and nonverbal communication skills to enhance health.	Self-efficacy, response efficacy, response costs
5. The Advice Columnist: What Teens Want to Know	Standard 1.2: Describe the interrelationship of emotional, intellectual, physical and social health in adolescence.	Self-efficacy, response costs, response efficacy, severity, vulnerability
6. Challenge: Check It Out!	Standard 3.2: Access valid health information from home, school and community. Standard 3.5: Locate valid and reliable health products and services.	Self-efficacy, response costs, response efficacy, severity, vulnerability

Session 4: Educate Yourself: Examining Consequences

Activity	NHES Standards/Performance Indicators	PMT Constructs
1. Opening Ritual and Review		
2. Numbers Game: How Many Teens Are Really...?	Standard 2.5: Analyze how messages from media influence health behaviors. Standard 3.1: Analyze the validity of health information, products and services.	External rewards
3A. Condom Demonstration 3B. Condom Card Activity	Standard 3.2: Access valid health information from home, school and community.	Response efficacy, self-efficacy
4A. Hands-On Condom Race 4B. “Let the Music Play” Condom Card Race	Standard 3.2: Access valid health information from home, school and community.	Self-efficacy
5. SODA Decision-Making Model—Step 3: Decide	Standard 5.5: Predict the potential short-term impact of each alternative on self and others. Standard 5.6: Choose healthy alternatives over unhealthy alternatives when making a decision.	Response efficacy, self-efficacy, response costs, severity, vulnerability
6. More Challenges!	Standard 3.2: Access valid health information from home, school and community. Standard 3.5: Locate valid and reliable health products and services. Standard 4.1: Apply effective verbal and nonverbal communication skills to enhance health.	Self-efficacy, response costs

Session 5: Build Skills: Communication

Activity	NHES Standards/Performance Indicators	PMT Constructs
1. Opening Ritual and Review		
2. SODA Decision-Making Model—Step 4: Action	Standard 3.2: Access valid health information from home, school and community. Standard 5.1: Identify circumstances that can help or hinder healthy decision making. Standard 5.5: Predict the potential short-term impact of each alternative on self and others.	Response efficacy, self-efficacy, response costs
3A. Communication Game: Communicating Without Words 3B. Communication Game: Changing Messages	Standard 4.1: Apply effective verbal and nonverbal communication skills to enhance health.	Self-efficacy, response costs
4. Communication Styles: Aggressive, Assertive and Nonassertive:	Standard 4.1: Apply effective verbal and nonverbal communication skills to enhance health.	Self-efficacy, response costs, response efficacy
5. Sex: A Decision for Two	Standard 2.3: Describe how peers influence healthy and unhealthy behaviors. Standard 2.9: Describe how some health risk behaviors can influence the likelihood of engaging in unhealthy behaviors.	Response costs, response efficacy, self-efficacy, vulnerability, severity, internal and external rewards

Session 6: Sexual Health and Showing You Care Without Having Sex

Activity	NHES Standards/Performance Indicators	PMT Constructs
1. Opening Ritual and Review		
2. Ways to Show You Care	Standard 1.5: Describe ways to reduce or prevent injuries and other adolescent health problems.	Self-efficacy, response efficacy, internal rewards, external rewards, severity
3. "Ways to Show You Care" Roleplay	Standard 4.1: Apply effective verbal and nonverbal communication skills to enhance health.	
4. HIV Transmission Game	Standard 1.1: Analyze the relationship between healthy behaviors and personal health.	Vulnerability
5. Safer Sex and Contraception	Standard 1.1: Analyze the relationship between healthy behaviors and personal health.	Response efficacy, self-efficacy, vulnerability, response costs
6. Challenge: Being-a-Parent Interviews	Standard 3.2: Access valid health information from home, school and community.	Response efficacy, severity, vulnerability

Session 7: Attitudes and Skills for Sexual Health

Activity	NHES Standards/Performance Indicators	PMT Constructs
1. Opening Ritual and Review		
2. HIV-Positive Speaker or Video		
3. Goal Setting for My Future	Standard 6.4: Describe how personal health goals can vary with changing abilities, priorities and responsibilities.	Self-efficacy, response efficacy, internal rewards, severity, vulnerability
4. Goal Setting: Obstacles and Support	Standard 1.5: Describe ways to reduce or prevent injuries and other adolescent health problems. Standard 6.4: Describe how personal health goals can vary with changing abilities, priorities and responsibilities.	Self-efficacy, response efficacy, internal rewards, severity, vulnerability
5. Roleplay: Saying NO or Asking to Use a Condom	Standard 4.1: Apply effective verbal and nonverbal communication skills to enhance health. Standard 4.2: Demonstrate refusal and negotiation skills to avoid or reduce health risks. Standard 7.2: Demonstrate healthy practices and behaviors that will maintain or improve the health of self and others.	Self-efficacy, response efficacy, response costs

Session 8: Review and Community Project

Activity	NHES Standards/Performance Indicators	PMT Constructs
1. Opening Ritual and Review		
2. What Are You Concerned About?		Severity, vulnerability
3. What Youth Can Do		Response efficacy, self-efficacy
4. The Knowledge Feud	Standard 1.5: Describe ways to reduce or prevent injuries and other adolescent health problems.	Self-efficacy, severity, vulnerability, response efficacy
5. Pat on the Back	Standard 4.1: Apply effective verbal and nonverbal communication skills to enhance health.	Internal rewards, external rewards
6. Community Projects Discussion	Standard 8.1: State a health-enhancing position on a topic and support it with accurate information. Standard 8.2: Demonstrate how to influence and support others to make positive health choices. Standard 8.3: Work cooperatively to advocate for healthy individuals, families and schools.	External rewards, self-efficacy, response efficacy

VI Commonly Asked Questions

The successful implementation of an intervention such as *Focus on Youth with ImPACT* can appear to be a daunting task. We have identified the most common questions facilitators have and address them below.

Pre-Implementation

How many youth should be in a group?

The curriculum was designed for and works best with groups of 6 to 10.

How do I form a group of youth?

Focus on Youth with ImPACT uses "natural friendship groups" or youth who already spend time together. The hope is that if youth are friends, they can help support each other with the skills they are being taught. Working with groups of friends also may make youth more likely to come to the group meetings.

Recreation clubs (e.g., drama club), arts and crafts, dance groups, church clubs, scouting groups or sports teams might be a way to find friendship groups. You also could approach several youth and suggest they get some of their friends together to form a group. Groups can also be put together by a presenter or a hosting organization.

When planning youth recruitment there are a few key points to consider:

- **Identify key leaders.** As part of your recruitment effort, you will want to recruit a core group of youth who display both traditional and nontraditional leadership qualities. These young people often tend to have influence (positive or negative) over many of their peers. Use these young people as spokespersons. Spend time beforehand preparing them to introduce the program and to answer questions their peers may have.
- **Map locations.** Before conducting outreach to youth, it is critical to identify locations where young people congregate. This may require you to go to those places ahead of time to determine when youth gather there and what times are most appropriate to recruit.
- **Work in pairs.** Work in pairs when recruiting youth for the program. If at all possible, pair an adult with a youth. This can help ease situations

that could be perceived as intimidating or awkward by youth who are approached by the adult.

- **Use marketing materials.** Be sure to work with youth to create materials they will resonate with. This includes adapting the project name (see page ix). Materials such as flyers, brochures and posters should have a youth feel and be placed in locations that young people frequent, such as community centers, Boys & Girls Clubs, YMCAs, libraries, clinics, athletic events and community events. Be sure to include bright colors and bold writing, and be as concise as possible. Also mention things such as incentives, transportation (if provided) and food in the marketing materials. *It is important that the* Focus on Youth *logo be placed on ALL marketing materials, even if your group decides to change the group name.*

How soon before the intervention starts should I begin recruiting youth?

In general, it is wise to begin recruiting as early as possible. A period of between 6 and 8 weeks prior to the anticipated start of your program is an ideal time period.

What key points about the intervention should I highlight when recruiting youth?

It's fun. It's interesting. It's interactive. You'll learn useful skills such as negotiating and different ways to communicate effectively. You'll learn useful facts about HIV prevention and ways to get good, reliable information. *Focus on Youth* can help you learn strategies to help you achieve your goals.

Has the program been implemented in a school setting?

Yes. There have been several adaptations of *Focus on Kids* done in the school setting.

1. "Focus on Teens" was done with small groups over lunch time and after school in Baltimore.
2. In West Virginia, *Focus on Kids* was conducted in classrooms.
3. Adapted versions were done with high school and middle school students after school hours in Namibia, with middle school students in

China, and with elementary school students during class hours and after school in the Bahamas.

Has the program been implemented by churches?

In a 2003 study, two sites were churches.[12] The content of *Focus on Kids* was shared with the churches in advance and did not pose a problem for them. It is essential that any organization and community collaborating to implement *Focus on Youth with ImPACT* be aware of the content. Churches have also been partners with *Focus on Kids* in other countries including Namibia and the Bahamas.

What age should the youth be?

This will depend on the sexual behaviors of young people in your community. *Focus on Youth with ImPACT* was adapted for African-American youth ages 12 to 15. In Vietnam and China, *Focus on Kids* has been used with youth as old as 20. In general, the program has had a greater impact on older youth, but, when possible, it is important to reach youth before they begin to be sexually active. Regardless of the age, it is recommended that there be no more than a 2 to 3 year age gap within the group.

Where can I get free supplies?

Donations are an excellent way to obtain supplies. Ask local stores, companies, restaurants and factories to donate needed items. See Section VI for tips and a sample letter for soliciting donations. Your local health department or other local agencies may be able to supply free condoms or HIV information pamphlets.

How do I make this program relevant for youth in my community?

The curriculum is based on Social Cognitive Theory, and ethnographic and survey research was conducted to ensure that the intervention was developmentally and culturally grounded. The target audience for the original *Focus on Kids* was urban youth, ages 9 to 15, from predominantly low-income areas, all of whom were African American. The curriculum has since proven relevant for many other adolescent groups. This special edition was adapted with African-American youth ages 12 to 15 in mind, and was

[12] Wu, et al., 2003.

pilot tested in six geographically diverse areas of the country. However, it may be necessary to make minor adaptations to best suit the needs of your targeted community.

One strategy that might help when adapting the curriculum is to have an advisory board made up of community leaders (e.g., teachers, recreation club directors, and church leaders), parents and youth. Share the curriculum with the advisory board and listen to their recommendations for adaptations. Another strategy is to conduct a few focus group meetings with groups of 8 to 10 parents and youth to ask what they believe youth need to learn to protect themselves from HIV. Include ideas from the youth in the activities. (See Section 2 for more information on conducting focus groups.) A final strategy is to get survey information, if available, to determine risk behaviors most common among the youth with whom you will work.

For example, drug trafficking was a concern heard frequently from parents and youth when the *Focus on Kids* curriculum was first developed, so some sessions included information on preventing substance use. Minor changes to the curriculum can help ensure you are best addressing the needs of your youth. (See Section 5 for descriptions of core elements and information on how the activities link to the theory on which the original program is based.) Understanding these aspects can help ensure that any changes you make continue to meet the activity objectives while maintaining fidelity to the core elements.

Should I have young men and young women in the same group?

The curriculum was designed for single-sex groups; however, it is a good idea to combine groups occasionally so participants can hear how the other gender thinks and practice roleplaying in mixed-gender groups.

One way to bring young men and young women together is an all-day retreat. The curriculum includes instructions for this option.

Does the program have to be implemented in 8 weekly sessions? Can you conduct it over 2 days rather than 8 weeks?

There were several sites in the 2003 study[13] that conducted the intervention in 2 days. It has also been implemented in 24 “25-minute” sessions during

[13] Wu, et al., 2003.

the school lunch hour, and, although this study was not as rigorously evaluated, the results were promising.

Implementation

Can I run a group by myself?

Probably, but this situation is not optimal. A very experienced facilitator who is quite comfortable with the curriculum might be able to implement on his or her own.

The original *Focus on Kids* program was done with two group leaders, and this seems to work best. Co-facilitators can model good communication and negotiation skills. Also, one group leader is free to deal with a youth who is having behavioral problems while the other can continue with the rest of the group.

Having two group leaders incorporates different styles and personalities, which can enable more youth to be reached. Group leaders might have different strengths (e.g., one might be an older professional with lots of experience, and the other be closer to the age of the group members). Co-facilitating is a core element of the program and is strongly recommended.

Can you use peers to co-facilitate the intervention?

None of the studies have used this method. Young people ages 18–20 were used and paired with older facilitators.

What do I do if my co-facilitator leaves the project?

It would be best to find another co-facilitator. Even if it is not possible for the new co-facilitator to be trained prior to assisting, he or she can still help with youth who are having difficulty participating in the group and with modeling.

How often should I run the groups?

The curriculum was designed for 1 session per week; however, scheduling can be flexible. You might want to meet twice a week, or even do the program as a 2-day or 4-day “workshop.” It is important to meet at a regular time each week, so youth know when the group meeting is.

How should the room be set up?

When setting up the room, consider configurations that will give all of the participants a clear view of both the facilitators and the other participants (U-shape, semicircle, etc.). Every seat should be a great seat! You'll also want to make sure that the room has proper lighting (windows) and ventilation.

What if youth don't come back?

There are various ways to help ensure that youth enjoy the program and keep coming back:

- First, make the group meetings fun; keep them upbeat and active.
- You may want to introduce some incentives such as snacks, certificates or small gifts. (See Section 7 for Tips on Soliciting Donations.)
- Finally, call and remind youth about the program, do home visits, send out postcards and have youth remind each other.

What was retention like in the original study? What percentage of youth completed all 8 sessions?

About two-thirds of the youth completed at least 6 sessions. We do not have data about how many completed all 8.

What were the most effective incentives in getting youth to return back the group?

Financial incentives were used with success. Other incentives used included a "group bank account" in which a dollar per person was contributed for each session and accumulated. The youth decided together how to use the money for an ending activity. There was a "graduation" requirement to attend at least 6 sessions (make up sessions were held as well), and graduates had a ceremony with cake and certificates. Raffles were held for small gifts (e.g., CD players, gift certificates), and youth received a slip to put into the lottery for each session they attended. Use of friendship groups was also an incentive, as youth were able to spend time with their friends.

Were there booster sessions held later on?

Yes. Booster sessions have some benefits, although these benefits seem to be transient. Booster sessions do not seem to have enduring effects but did make a difference for about 6 months.

Some youth in my group want to know more about same-gender sex, others don't. How do I handle this situation?

It is good to begin this discussion with all youth regardless of their sexual orientation, both because some youth will not yet be certain of their orientation and because it helps youth learn to be tolerant of a wide range of sexual orientations and preferences. Facilitators should be aware that there may be youth in the group who are gay, lesbian, bisexual, transgender or questioning, but not out as such. It is important that these youth not be alienated. If you hear another youth make a comment that is derogatory, remind the group of the ground rule about being respectful.

It is essential that parents/guardians and any organization and community collaborating to implement *Focus on Youth with ImPACT* be aware of the content of this intervention. Even if facilitators don't include materials that explicitly address same-gender sex, they should always try and keep the presentation of sexual orientation neutral as much as possible. Some suggestions:

- During the Family Tree activity, instead of asking if Malcolm is interested in dating girls, ask if he is interested in dating *anyone*.
- Try to stay away from using the terms "boyfriend" and "girlfriend."
- Use gender neutral names in vignettes.

What about youth who want to join the group later?

After the second or third session, it is difficult for youth to join and get all the information needed. It is therefore best to close the group at this time and have interested youth wait until you are able to start a new group.

What about parents and guardians?

Parents/guardians need to be told what the program is about and should sign a parent/guardian permission slip. (A Sample Permission Slip is provided in Section 6.) Be sure you are familiar with, and abide by, your organization's policies and procedures concerning parental consent, as well as any state guidelines.

Ensuring that parents and guardians have bought into the program is important. One way of getting their support is to offer an information session where overviews of the youth sessions and information about the

parent/guardian *ImPACT* session are presented. Parents and guardians have also increased their support of the program by experiencing the *ImPACT* parent/guardian session. During this 90-minute session in the home, parents/guardians learn firsthand what the intervention is about and participate in some of the activities used in the curriculum.

How does the all-day retreat work?

In the original *Focus on Kids* program, an all-day retreat was offered during Session 6 as an incentive for youth who had attended 3 or more sessions. Youth were taken to a camp outside the city where they participated in the educational activities in Session 6, as well as recreational activities.

The retreat is an ideal time to bring a speaker in to talk to all of the groups at one time. Possible speakers include a person living with HIV or someone from the community sharing his or her life experiences. Check with your local health department, family planning agencies or HIV organizations to see if they have a speaker's bureau. (*Note:* A speaker is included in Session 7 of *Focus on Youth with ImPACT.* If you use the all-day retreat option and have a speaker during Session 6, you can drop that activity from Session 7.)

The retreat also offers an opportunity for groups of young men and young women to come together to understand the others' perceptions and practice communication and negotiation skills with each other.

For the all-day retreat, be sure to address these challenges:

- Have enough chaperons. A good ratio is 1 adult for every 4 youth.
- Be sure the chaperons have a relationship with the youth so that youth will listen to them.
- You may need an additional release from parents/guardians. Check your organization's guidelines.
- Make sure your organization has appropriate insurance coverage for such an event. Have an emergency contact and medical information on record for all participants.
- Provide plenty of recreational activities along with the educational ones so that youth have structured time to release energy.

If you invite a speaker, it is important to know what she or he will say in advance to ensure it will be an appropriate message for the youth.

How should I end the program?

If time and money allow, it is nice to bring closure with a graduation ceremony. In the original program, youth invited their parents/guardians for a celebration in which they received certificates and refreshments were served. Session 8 presents some options for ending the program and possibly maintaining contact.

Adapting Focus on Youth

Can you include a STD and/or HIV Counseling and Testing component in this intervention?

This was done with the Baltimore study which took place in schools. The intervention was not as rigorously evaluated but seemed to remain efficacious. STD testing could be incorporated after the discussion of STDs.

Does adding this component to the intervention constitute adaptation or reinvention?

It would depend on how structured it was. If it were just referral or letting them know about available resources this would not be reinvention. If it were more structured, e.g., urine-based screening of the whole group, then it would be adding a core element, which would be considered reinvention and would call for further evaluation.

Is it OK to add a session specifically discussing substance abuse to meet the needs of our youth?

If the session is fun and not too long, there should be no problem with this. This session should build on the content that is already in *Focus on Youth with ImPACT,* e.g., decision making, refusal skills, future goals and values.

ImPACT

The *ImPACT* parent/guardian session is a 90-minute session in the home with the youth participant and his or her parent/guardian. During this session, all of the components of the intervention are described and the youth and parent/guardian watch a video/DVD of a short film documentary focused on teaching parents/guardians effective ways to talk to their teenage children about sex and HIV/AIDS. The video stresses the importance of open

communication between parents and teens. It tackles these issues head on in an effort to increase communication with youth *before* they start having sex. The film allows youth, their parents/guardians and experts to talk openly about their feelings about sex and HIV/AIDS. It shows these topics through various points of view, including teens, parents and educators.

Is it OK to not include the parent/guardian component and just conduct the youth groups?

A randomized, controlled trial of *Focus on Kids* (alone) found it to be effective in reducing unprotected sex among youth. However, the program is more effective when combined with the parent component.

Does the adult have to be the legal parent or guardian?

No. But the adult has to be an important adult in the youth's life with whom he or she spends a significant portion of time. This person could be an older sibling, aunt, uncle or grandparent.

If the parent has more than one child in the age range can multiple children participate at the same time?

Yes, although ideally the parent will do separate roleplays with each child.

Can you do the parent/guardian component with groups of parents instead of individually?

See *ImPACT* Core Element Number 1 in Section I to understand why this situation is not ideal. If it is the only option, it is important to break up the roleplays so each parent and youth pair does the practice individually.

What happens if a youth doesn't want to be present for the ImPACT delivery?

Youth are not required to participate, but should be strongly urged to be present. If it is a matter of scheduling, try to reschedule at a time when both the youth and the parent/guardian can be present. If it is because the youth doesn't want to participate, encourage him or her to at least start watching the video. If the youth is not enjoying it, he or she can always leave.

Does ImPACT have to be delivered in the home?

No. However, the setting should be quiet and isolated from other people and distractions. For example, a private room in a recreation center could work. The location also needs to be convenient for the parent/guardian and youth.

What if both parents want to participate?

This is fine.

What if the family doesn't own a DVD player? If they're in a hurry, can I just leave the DVD with them?

No. Make certain that you watch the DVD with them. If the family doesn't own a DVD player, see what other options you have. Does your agency have a laptop computer with a DVD player? Is there an alternate location you could use that has a DVD player?

Monitoring and Evaluation

How do I evaluate the program?

Process and outcome evaluation of *Focus on Youth with ImPACT* can be accomplished through multiple methods. These include session-embedded facilitator-led questions (found at the beginning and end of each session in the curriculum), youth surveys, session observations, facilitator implementation logs and facilitator interviews. The *Focus on Youth* Evaluation Manual includes these instruments. Use of the instruments is optional, and individual sites may choose to use all, some, or none of them. Results from these instruments can be used to improve program delivery, provide data for agency reports, determine additional program or service needs, or conduct a formal evaluation of your *Focus on Youth with ImPACT* program.

How do I obtain Technical Assistance?

Agencies directly funded by CDC, can request Capacity Building Assistance (CBA) services through the CBA Request Information System (CRIS). You can access CRIS at www.cdc.gov/hiv/cba . Once your request has been processed, it will be forwarded to both your project officer and the appropriate CBA provider for your focus area. For example, ETR Associates is a CBA provider in Focus Area 2: Strengthening Interventions for HIV Prevention. For additional information and assistance, contact your project officer.

Sample Parent/Guardian Letter

Date ______________________

Dear Parent:

(Name of site) is offering an HIV-prevention program for young people ages 12 to 15. In the program, they will learn how to protect themselves from HIV infection. This will be done by learning information and skills such as decision making, abstaining from sex, condom use, negotiation and communication. They will learn these skills by playing games, doing roleplays and having group discussions.

The program will be held every _______ (day) at _______ (time) for 8 weeks. The young people should enjoy and have fun with the program.

If you would like your child to participate in this program please sign the attached permission slip and return it to ______________________________.

There is also a parental component to this intervention that provides tips for opening communication with your youth, especially around discussing topics related to HIV prevention. These topics can include what HIV is, how it's transmitted and how it can be prevented.

If you have any questions about the program now or any time in the future, please call me at ______________________________.

Sincerely,

Name____

Title____

Name of Center ____

Sample Parent/Guardian Permission Slip

I agree to let my child participate in the *Focus on Youth with ImPACT* program being offered by ________________________________ (name of site).

I understand that if my child participates in the program, she/he will be taught information on decision making, abstinence, condom use, communication skills and learn specific information about HIV and how to avoid it.

I understand that all discussions that my child will have with the group leaders of this project will be confidential and will not be reported to me or anyone else.

I agree to let my child participate in this program. I understand that she/he is free to stop at any time.

Child's name ____

Age ____

Parent/Guardian's signature _______________________________

Date____

Address ____

Phone ____

Group leader's signature __________________________________

Date____

Tips on Soliciting Donations

- Carry donation letters and information about the program with you wherever you go (e.g., movies, restaurants, grocery stores, malls, etc.). It never hurts to ask for a donation.
- Get started early. It may take a long time for a donation to be approved and go through the chain of command, often as long as a month. Also, many organizations have limits on how much they donate each year, and once they've fulfilled their quotas they stop giving donations.
- Use the yellow pages to get ideas. Call an agency or business and ask for the manager. If she or he is not able to help, ask for the corporate headquarters.
- Fast-food chains and well-known franchise restaurants are almost always good for drinks, cups, napkins, cookies, etc.

Sample Donation Letter

Organization name ____
Organization address ____
Date ____

To whom it may concern:

The Youth Development Center at _________________ (name, site) offers youth in the community cultural, recreational, tutoring and health education activities. The center provides after-school, evening and weekend programs designed to address many of the challenges facing young people in our community, including substance use, involvement in crime and violence, truancy and pregnancy. The program goals are to keep our youth off the streets and involved in positive activities.

The Center has established an HIV-prevention program called *Focus on Youth with ImPACT.* The group meets weekly for 8 weeks to focus on decision making, goal setting, communication skills, and factual information about avoiding HIV infection, unintended pregnancy and drug use. The goal of the program is to help youth make healthy decisions about their lives.

It is our hope that your company might be able to provide products that could be used as incentives for young people who successfully participate in this program. Food items for snacks or small gift items would be extremely helpful in ensuring that teens take part in this positive program.

If you have any questions, please do not hesitate to contact me at ___________.

Thank you in advance for your cooperation.

Sincerely yours,
Name ____
Title ____
Name of Center____

Sample Focus Group Consent Form

I ______________________________ (parent/guardian), understand that my child ____________________________ (name) has been asked to participate in a focus group for _______________ __________ (agency name). The focus group will be held at ________________________ (location) on ______________ (date) from _______A.M./P.M. to_______ A.M./P.M.

By participating, my child will be asked to share his or her insight on how to personalize the *Focus on Youth with ImPACT* intervention to our specific population of ____. It has been explained to me that this is not a class, but an opportunity for my child's voice to be heard in a way that will have an impact the growth of the program. I also understand that by participating in the focus group, my child will receive ____ (incentives).

Therefore, I give permission for my child to participate in this project.

____

Parent/Guardian's Name (Print) Date

____

Parent/Guardian's Signature Date

VIII Glossary of Terms

Abstinence: Not having sexual intercourse—oral, anal or vaginal; being celibate.

Acquired Immune Deficiency Syndrome (AIDS): Results from infection with human immunodeficiency virus (HIV) in which the immune system is not able to effectively fight infection. A person is diagnosed with AIDS when his or her CD4 count drops below a certain level or one or when more AIDS-defining illnesses develop.

AIDS: See Acquired Immune Deficiency Syndrome.

Anal sex (also called anal intercourse): Inserting the penis into the anus of a sexual partner.

Anonymous testing: Testing done with no identifying information recorded. Only the person tested can obtain the result.

Antibody: A substance in the blood formed to combat invading disease agents such as viruses, bacteria, fungi and parasites.

Antibody-negative test results: A test result in which no signs of antibodies to HIV are detected. Either the person does not have HIV, or the person has recently become infected with HIV but does not yet have detectable antibodies.

Antibody-positive test result: A test result in which antibodies to HIV are detected in the blood. The person is assumed to have HIV if both the ELISA and Western blot tests show positive results.

Anus: The opening of the rectum that controls the release of waste (feces) from the body.

Bisexual: A person who is sexually attracted to people of the same sex and of the opposite sex (both-sex orientation).

Blood-borne disease: Disease agents that are carried and transmitted through the bloodstream; for example HIV and hepatitis B.

Body fluids: Fluids the body makes, such as tears, saliva, sweat, blood, vaginal fluid, semen and breast milk.

Casual contact: Ordinary social contact; for example, kissing on the cheek, shaking hands, and using a telephone, toilet or swimming pool. Not a means of spreading HIV. Diseases such as the common cold or flu can be spread in this manner.

Casual transmission: Spreading an infection or disease through casual contact. Not a means of transmitting HIV.

Centers for Disease Control and Prevention (CDC): Federal health agency that is part of the U.S. Department of Health and Human Services and provides national health and safety guidelines and statistical data on HIV infection, AIDS and other diseases.

Condom: A sheath made of latex, polyurethane or lamb intestine that fits over the erect penis to catch semen. When used correctly, latex condoms can provide protection against HIV transmission. Lambskin condoms should never be used because they do not protect against HIV.

Confidential testing: Testing in which test results are linked to a person's name and recorded in medical files. State laws limit who can have access to the results and under what conditions people can gain access.

Contaminated needles: Needles that have been used by a person with HIV and have not been properly cleaned. HIV transmission is possible if these needles are shared. Any needle that has already been used is more likely to be contaminated with something.

Core Element: Core elements are required elements that embody the theory and internal logic of the intervention and most likely produce the intervention's main effects. Core elements are identified through research and program evaluation. Core elements essentially define an intervention and must be kept intact (i.e., with fidelity) when the intervention is being implemented or adapted, to ensure the best prospect that the program will produce outcomes similar to those demonstrated in the original research.

Crack: A form of cocaine that is smoked.

Cunnilingus: Mouth-to-vaginal-area sex. See Oral sex.

Disinfectant: A chemical that destroys infection-causing agents; for example, liquid chlorine bleach can be used to clean needles and syringes.

Dry kiss: Kissing that does not involve mouth-to-mouth or open-mouth contact; examples include social kissing and kissing on the cheek.

Ejaculate: To eject semen from the penis during orgasm.

Ejaculation: The spontaneous discharge of semen during orgasm.

Epidemic: A rapidly spreading disease affecting large numbers of people in a population.

Evidence-based intervention: Evidence-based interventions have been proven effective through research studies that showed positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health (e.g., reduction in the number of new STD infections) outcomes. Studies employ rigorous research designs, with both intervention and control groups, so that the positive outcomes can be attributed to the interventions. With input from the researchers, the materials necessary to implement the interventions have been packaged into user-friendly kits. With the appropriate training and intervention package, service providers can increase their opportunities to conduct effective HIV/STD prevention programs in their communities.

Exposure to HIV: Occurs during an exchange of body fluids with someone who has HIV. It can lead to possible HIV transmission.

Fellatio: Mouth-to-penis sex. See Oral sex.

Female condom: A soft, loose fitting polyurethane sheath that lines the vagina and provides a physical barrier that protects against HIV transmission.

French kiss: See Open-mouth kiss.

Genital contact: Contact between the sexual organs of two people.

Heterosexual: Being romantically or sexually attracted to people of the opposite sex; having sexual partners of a different sex.

HIV: See Human Immunodeficiency Virus.

Homosexual: Being romantically or sexually attracted to people of the same sex; having sexual partners of one's own sex.

Human Immunodeficiency Virus (HIV): The virus that causes AIDS and destroys the body's immune system, making it susceptible to life-threatening opportunistic infections or rare cancers.

Immune: Protected from a particular disease.

Immune system: A variety of cells and substances within the body that fight disease agents such as viruses, bacteria, parasites and fungi.

Incidence: The number of new cases of a disease over a period of time.

Incubation: The period of time from the point of infection to the onset of symptoms.

Infection: Invasion of the body by disease agents.

Intercourse: See Sex.

Key characteristic: Key characteristics are important, but not essential, attributes of an intervention's recommended activities and delivery methods. They may be modified to be culturally appropriate and to fit the risk factors, behavioral determinants and risk behaviors of the target population and the unique circumstances of the venue, agency and other stakeholders. Modification of key characteristics should not compete with or contradict the core elements, theory or internal logic of the intervention.

Lesbian: A woman who is romantically or sexually attracted to women and whose sexual partners are women. See Homosexual.

Lubricant: Something wet and slippery used to reduce friction during sex. Lubricant can be put it on the outside of a condom or inside the vagina or anus during sex to keep the condom from getting dry and breaking. There are two kinds of lubricants: water-based and oil-based. Only water-based lubricants are recommended because oil-based lubricants can create holes in condoms.

Masturbation: Massaging the genitals for sexual stimulation.

Monogamy: Having sex with only one person. This can prevent STD if two people test negative for infections before they initiate sex, and then agree to have sex only with each other. Some people interpret monogamy as having sex with only one person at a time, and therefore they end up having many partners, one after another. People are at risk for STD unless they and each new partner are tested and treated for STD before having sex.

Mutual masturbation: Massaging each other's genitals for sexual stimulation. See Masturbation.

Nonlubricated condom: A condom packaged without a lubricant. It may be dry and seem as if it has chalk on it. A nonlubricated condom is safe for

people to use during oral sex to prevent HIV. It can also be cut along the side and the tip cut off to make a square of latex that can serve as a moisture barrier to be used over the anus or vagina during oral sex.

Nonoxynol-9: A chemical that kills sperm. It is used in some contraceptive creams, foams and jellies. According to CDC, nonoxynol-9 is no longer recommended for use with latex condoms for added protection from HIV during vaginal sex. It does not offer added protection against HIV.

Oil-based lubricant: A lubricant made from something that has oil in it. The oil can eat holes in latex condoms used during sex. Then germs that cause STD, including HIV, can go through these holes and enter the body. Vaseline, mineral oil and lotion are some examples of oil-based lubricants.

Open-mouth kiss: A kiss that involves tongue-to-tongue contact.

Oral sex (also called oral intercourse): Contact of the mouth or tongue with a partner's penis, vagina or anus.

Penis: The male sexual organ.

Polyurethane condoms: Condoms made of plastic. Research continues on the effectiveness of polyurethane. Latex condoms continue to be recommended as the most effective barrier.

Positive test result: Findings that show the presence of antibodies; the person tested is assumed to have HIV and be able to infect others.

Pregnancy: The time from when the sperm and egg fuse and implant in the uterus until birth, which takes about 9 months.

A woman can get pregnant even if:
- She is having her period.
- She hasn't had her first period yet.
- She is under age 12.
- It is her first time.
- She doesn't have an orgasm.
- She doesn't have vaginal intercourse very often.
- The man pulls his penis out of her vagina before he ejaculates.
- Her partner only touches the outside of her vagina with his penis.
- She urinated right after sex.
- She douches with anything.
- She jumps up and down after intercourse.

Preseminal fluid: The few drops of semen that leak out of the penis just before a man ejaculates, which contain about 20,000–40,000 sperm. Most men don't feel it coming out, but preseminal fluid can get a woman pregnant. It can also transmit STD.

Puberty: The time when hormones cause the physical changes that turn a young person into a young man or young woman. Puberty doesn't happen to everyone at the same time. For girls it begins to happen between ages 8 and 14. Breasts grow larger and the girl begins menstruating. In boys, puberty starts around age 12. The penis and testicles grow and develop, and the voice also starts to change. Both boys and girls begin to grow pubic hair. They may also grow hair on other parts of their bodies. The physical changes are usually finished by age 20. Puberty also a time where feelings about self, family or other people, as well as moods and emotions, can change. It can be a very frustrating and confusing time for young people.

Pulling out: When a man removes his penis from a sexual partner's vagina, anus or mouth before he ejaculates. It does not prevent the spread of STD, and it will not prevent a woman from getting pregnant. Pulling out is another term for withdrawal.

Rectum: The last portion of the digestive tract, just above the anus.

Risk behavior: Any activity that puts a person at increased risk of contracting HIV.

Safer sex: Sexual practices that involve no exchange of blood, semen or vaginal fluid.

Saliva: The fluid produced in the mouth.

Semen: Whitish fluid ejaculated from the penis during orgasm. It contains sperm from the testes and fluid secreted from several glands to nourish and protect the sperm.

Sex (also called sexual intercourse): Genital contact between individuals; contact with vagina, penis or anus.

Sexual orientation: The attraction people feel or the erotic relationship they develop with others of their own sex, the opposite sex, or both sexes.

Sexually Transmitted Disease (STD): A disease transmitted through genital contact during sex. Gonorrhea, syphilis, herpes, HIV, Chlamydia, and hepatitis B are examples of STDs.

Spermicide: A chemical that kills sperm on contact, such as nonoxynol-9. Spermicide can come in the form of a foam, cream, film, suppository or jelly.

STD: See Sexually Transmitted Disease.

Syndrome: A group of related symptoms or diseases.

T-cell: A type of white blood cell essential to the body's immune system. It helps regulate the immune system and control B-cell and macrophage functions.

Transfusion (blood): The act of receiving blood intravenously.

Vaccine: A substance made from modified or denatured bacteria or viruses that produces immunity to that particular disease.

Vagina: The passageway in a female extending from the vulva to the cervix, which is penetrated during vaginal sex.

Vaginal fluid: Fluid that provides moistness and lubrication in the vagina. Vaginal fluid contains HIV in a woman who has HIV.

Vaginal sex (also called vaginal intercourse): Penetration of the vagina by the penis or a sex toy.

Virus: A disease agent that must live within cells of the body to survive; it often destroys these cells.

Wet kiss: See Open-mouth kiss.

Works: Needles, syringes and other equipment used to prepare, “cook” and inject street drugs.

IX CDC Materials

Important Information for Users

This HIV/STD risk-reduction intervention is intended for use with persons who are at high risk for acquiring or transmitting HIV/STD and who are voluntarily participating in the intervention. The materials in this intervention package are not intended for general audiences.

The intervention package includes implementation manuals, training and technical assistance materials, and other items used in intervention delivery. Also included in the packages are (1) the Centers for Disease Control and Prevention (CDC) factsheet on male latex condoms, (2) the CDC Statement on Study Results of Product Containing Nonoxynol-9, (3) the Morbidity and Mortality Weekly Report (MMRW) article “Nonoxynol-9 Spermicide Contraception Use—United States, 1999,” (4) the ABCs of Smart Behavior, and (5) the CDC guidelines on the content of HIV educational materials prepared or purchased by CDC grantees (Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in CDC Assistance Programs).

Before conducting this intervention in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved, the intervention package materials are to be used by trained facilitators when implementing the intervention.

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

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

Fact Sheet for Public Health Personnel:

Male Latex Condoms and Sexually Transmitted Diseases

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

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

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

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

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

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

Sexually Transmitted Diseases, Including HIV

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

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

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

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

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

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

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

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

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

HIV / AIDS

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

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

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

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

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

Discharge Diseases, Including Gonorrhea, Chlamydia, and Trichomoniasis

Discharge diseases, other than HIV
Latex condoms, when used consistently and correctly, can reduce the risk of transmission of gonorrhea, chlamydia, and trichomoniasis.

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

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

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

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

Genital Ulcer Diseases and Human Papillomavirus

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

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

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

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

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

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

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

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

Department of Health and Human Services

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

CDC Statement on Study Results of Product Containing Nonoxynol-9

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

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

Reference

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

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

Nonoxynol-9 Spermicide Contraception Use— United States, 1999

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

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

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

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

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

Editorial Note:

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

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

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

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

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

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

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

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

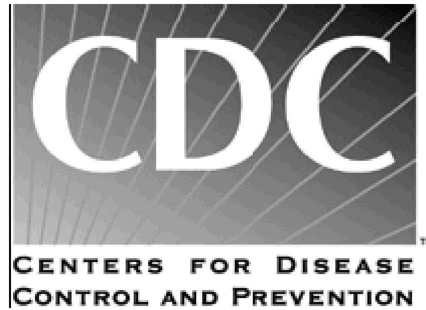
* Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, Virgin Islands; Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky, Mississippi, North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

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

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

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

* Not available.
† 41 of 61 grantees responded.
§ Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.



The ABCs of Smart Behavior

To avoid or reduce the risk for HIV

A stands for abstinence.

B stands for being faithful to a single sexual partner.

C stands for using condoms consistently and correctly.

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

Interim Revisions June 1992

1. Basic Principles

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

   a. Written materials (e.g., pamphlets, brochures, fliers), audio visual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.

   2. Written materials, audiovisual materials, and pictorials should be reviewed by Program Review Panels consistent with the provisions of Section 2500 (b), (c), and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c), and (d), as follows:

      SEC. 2500. USE OF FUNDS.

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

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

(d) CONSTRUCTION. - Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to, or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene."

c. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

d. Messages provided to young people in schools and in other settings should be guided by the principles contained in „Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (MMWR 1988;37 [suppl. no. S-2]).

2. Program Review Panel

a. Each recipient will be required to establish or identify a Program Review Panel to review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or another CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:

(1) Understand how HIV is and is not transmitted; and

(2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.

2. The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or

procedure of the recipient organization or local governmental jurisdiction.

3. Applicants for CDC assistance will be required to include in their applications the following:

   (1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review panel, except as provided in subsection (d) below. In addition:

   (a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either through representation on the panels or as consultants to the panels.

   (b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a State or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.

   (c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.

   (d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.

   (2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:

   (a) Concurrence with this guidance and assurance that its provisions will be observed;

   (b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

4. CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multi state), or

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

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

5. When a cooperative agreement/grant is awarded, the recipient will:

   (1) Convene the Program Review Panel and present for its assessment copies of written materials, pictorials, and audiovisuals proposed to be used;

   (2) Provide for assessment by the Program Review Panel text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals which are under development;

   (3) Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the Program Review Panel specifying the vote for approval or disapproval for each proposed item submitted to the panel; and

   (4) Provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

A *Focus on Kids* Intervention

FOCUS ON YOUTH WITH IMPACT

Protect High-Risk Youth

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

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

Focus on Youth with ImPACT:

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

Research Proves It Works!

Focus on Youth with ImPACT:

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

ETR Associates
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A nonprofit organization