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Assessing the Landscape of HIV Prevention for Youth

This month's *Bulletin* focuses on HIV prevention for youth. For many reasons, it can be difficult to effectively address the HIV prevention needs of young people. Discussions about youth and sexuality, in particular the ongoing debate around abstinence-only programs versus comprehensive sexuality education, remain politically charged. In addition, communication and collaboration with state education agencies, as well as internally among various health department branches, remains an enormous challenge.

Prioritizing youth can also be a challenge. In comparison with other demographic groups, the rates of HIV infection among youth are relatively low. According to the CDC Fact Sheet, [HIV/AIDS among Youth](#) (last updated May 10, 2006), an estimated 38,490 young people in the U.S. have received a diagnosis of AIDS. They accounted for about 4 percent of the 929,985 total estimated AIDS diagnoses.¹ However, combining youth-specific HIV/AIDS data with surrogates such as STD data and data on the sexual experiences and behaviors of youth would provide a more comprehensive picture of their risk. The lack of comprehensive epidemiological data, compounded by the inherent challenges of engaging and working with youth, including recruitment and retention, transportation issues, and additional costs incurred for youth-specific activities, have all been barriers to understanding the HIV prevention risks and service needs of youth.

Often, the result of these myriad challenges is that youth-focused HIV prevention efforts may fall through the cracks. Yet, in a recent NASTAD survey of health department HIV prevention activities for youth, respondents overwhelmingly indicated an interest in addressing youth issues and indicated the need for more information about activities and strategies being implemented in other jurisdictions for youth-specific HIV prevention.

This issue of the *Bulletin* provides an overview of HIV prevention for youth, highlighting current trends and developments and examining issues from the perspectives of health departments, the Centers for Disease Control and Prevention (CDC) Division of Adolescent and School Health (DASH) and national organizations.

Reference:

1. CDC. *HIV/AIDS Surveillance Report, 2003*. Vol. 15. Atlanta : US Department of Health and Human Services, CDC; 2004:1–40.

CDC Division of Adolescent and School Health: Perspectives and Activities

Provided by CDC/DASH

Young people in the U.S. are at persistent risk for human immunodeficiency virus (HIV) infection. This risk is especially notable for youth of minority races and ethnicities. Continued prevention outreach and education efforts are necessary as new generations replace the generations that benefited from earlier prevention strategies. To address this problem, the CDC's Division of Adolescent and School Health (DASH) has worked with State and Local Education Agencies and National Non-Governmental Organizations (NGOs) since 1988 to help them provide HIV prevention education for school-aged youth.

School-based programs are crucial for reaching youth before behaviors are established. Because risk behaviors do not exist independently, topics such as HIV, sexually transmitted diseases (STDs), unintended pregnancy, tobacco, nutrition, and physical activity should be integrated and ongoing for all students in kindergarten through high school. The specific scope and content of these school health programs should be locally determined and consistent with parental and community values. Evidence of prevention success can be seen in trends from the *Youth Risk Behavior Survey* conducted over a 12-year period, which show both a decline in sexual risk behaviors and an increase in condom use among sexually active youth. The percentage of sexually experienced high school students decreased from 54 percent in 1991 to 47 percent in 2003, while condom use among sexually active students increased from 46 percent to 63 percent. These findings represent a reversal in the

trend toward increased sexual risk among teens that began in the 1970s and point to the success of comprehensive prevention efforts to both delay first intercourse among teens and increase condom use among young people who become sexually active.

DASH contributes to CDC's efforts to reach out-of-school-youth by supporting national non-governmental agencies that help build the capacity of youth-serving community based programs, many which serve the needs of adolescents who are most vulnerable to HIV infection, such as homeless or runaway youth, juvenile offenders, or school drop-outs.

Following is a list that describes significant DASH activities to help prevent HIV infection among our nation's youth:

Workgroup on Adolescent Sexual Health (WASH)

Dr. Janet Collins, Director of the National Center for Chronic Disease Prevention and Health Promotion, has established a workgroup on youth issues with staff representing four divisions (Division of HIV and AIDS Prevention, Division of Adolescent and School Health, Division of STD Prevention, and Division of Reproductive Health). WASH was formed to:

1. foster increased communication and collaboration across CDC programs striving to prevent sexual risks among youth,
2. determine the extent to which CDC is addressing the most important issues and activities related to preventing youth sexual risks, and
3. identify gaps and unnecessary duplication in CDC efforts.

The first major effort of the working group was to develop an analysis of CDC's efforts related to the prevention of sexual risk among youth. WASH implemented an online assessment of funded programmatic and research activities that address youth (defined as young people ages 10-21), their families, or institutions that serve youth. WASH also is reviewing CDC guidance documents (e.g., program announcements, guidelines, and fact sheets) on prevention of sexual risk among youth to analyze the messages that CDC delivers to address sexual risk among youth and to determine whether this guidance consistently reflects the current science base and best practices. Future activities include convening a panel of experts who will be asked to provide feedback on CDC's activities to prevent sexual risk among youth.

Providing effective HIV prevention programs for youth will continue to be a high priority for CDC. This emphasis is reflected in CDC's ongoing funding of state and local education departments, community-based organizations (CBOs), capacity building assistance providers (CBAs), and school health programs. CDC strongly encourages CBOs serving youth to work with their education and health departments to determine the best way to meet the HIV prevention needs of young people, their families, and their communities. CDC will continue to strengthen its long-standing partnerships with CBOs, health departments, CBAs, state/local education agencies, and other key organizations to help at-risk youth stay healthy, reduce their risk, and remain free of HIV infection. CDC also works to help young people already infected with HIV to access the care, treatment, and support they need to live with the infection and avoid transmitting the virus to others.

State and Large City School HIV Prevention Programs

DASH supports 48 state, seven territorial, and 18 large city education agencies for school health programs to provide young people with skills and information that prevent sexual risk behaviors putting them at risk for HIV infection.

National Organizations

DASH provides funding to national NGOs to help implement HIV prevention programs among youth in schools and youth in high-risk situations in communities, colleges, or universities.

Research Synthesis & Evaluation

DASH is currently working on a new initiative that may more effectively address the needs of schools and communities by providing assistance in selecting health education curricula based on the best evidence available. The initiative is composed of two complementary tools: the Health Education Curriculum Analysis Tool (HECAT) which is under development, and the Physical Education Curriculum Analysis Tool (PECAT), which is currently available.

Monitoring School Health Programs and Policies

The *School Health Policies and Programs Study* (SHPPS) monitors the quality and quantity of school health programs and policies nationwide. Findings from SHPPS 2000 revealed that the vast majority of schools (86 percent) require instruction on HIV prevention. Additionally, the School Health Profiles helps state and district education and health agencies monitor the current status of school health education; school health policies related to HIV infection/AIDS, tobacco use prevention, unintentional injuries and violence, physical activity, and food service; physical education; asthma management activities; and family and community involvement in school health programs. State and local education and health agencies conduct the survey biennially at the middle/junior high school and senior high school levels in their states or districts, respectively.

Surveillance of Risk Behaviors

The Youth Risk Behavior Surveillance System (YRBSS), first implemented in 1991, provides national, state, and local data on six categories of priority health-risk behaviors among youth and young adults – behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and STDs, including HIV infection; unhealthy dietary behaviors; and physical inactivity – plus overweight. Since 1991, the *Youth Risk Behavior Survey* has shown a promising trend: fewer adolescents report they have ever had sexual intercourse and more sexually active adolescents report they used a condom at last intercourse. While this trend is encouraging, there are still many adolescents engaging in behaviors that put them at risk for HIV infection.

For more information, visit [DASH's website](#).

Perspectives from the Field: Youth HIV Prevention in Missouri

*Interview with Brad Hall, Chief Administrator, Section for Disease Control & Environmental Epidemiology
Missouri Department of Health & Senior Services*

NASTAD: What does the HIV/AIDS epidemic look like among youth in Missouri?

While the numbers are very small among 13-18 year-olds, the cases we do have are 2.5 times as high among Blacks as among Whites, evenly split between males and females, and almost entirely in St. Louis. Cases among males were MSM, while females were reported from heterosexual contact.

In 2004, the highest incidence rate in Missouri was among 19-24 year-olds at 16.8 cases per 100,000 people. In comparison, Missouri's overall incidence rate is 7.0 cases per 100,000. Cases among 19-24 year-olds were only slightly higher among Blacks than Whites, but were 6 to 1 male, and 85 percent were in St. Louis and Kansas City (compared to about 75 percent of the total incidence in the state). Cases among males were almost exclusively MSM, while the females were evenly split between heterosexual contact and IDU. Overall,

HIV/AIDS among youth is disproportionately urban, Black, and MSM.

NASTAD: What sparked your jurisdiction's commitment to youth issues and how have you ensured that youth issues remain a priority?

When I first became involved in HIV prevention, what I saw were programs that were focused on changing the risky behaviors of people in various high-risk population groups based on epi data of who was already infected. To me, that seemed like the story of the guy who was walking along and found a person floating down a river in trouble. He stopped to pull the person out, only to find another person, and another, and soon there were more people than he could possibly help himself and he had to find more help. So, he was faced with the dilemma of continuing to pull people out of the river or going upstream to find out why and how people were falling in the river in the first place and solving the real underlying problem.

I knew then that I wanted to focus significant attention on HIV/STD prevention for youth, but wasn't exactly sure how to do it. About that time, I was invited to participate in the regional stakeholders' collaborative, which gave me an opportunity to team up with our state's adolescent health coordinator and representatives of the state's education department. It was that opportunity to hear what other states were doing, to learn about the issues in reaching youth, and to really begin to brainstorm ideas on how to collaborate and join forces that really started the youth movement in our state.

NASTAD: Describe the current prevention programs and initiatives specifically targeting youth being implemented in your jurisdiction.

The plan is to implement a multi-tiered statewide prevention education program that includes:

- a. educating those studying education in graduate school on health and prevention messages so that by the time they graduate and begin teaching they will be able to effectively do prevention education in schools;
- b. recruiting and training education majors to serve internships in which they will act as "peer" prevention educators for middle- and high-school students;
- c. providing to the schools a menu of prevention programs and messages that will reach every variety of student population and the materials, training, and ongoing support to implement the programs locally; and
- d. identifying and working with various community-based youth service organizations to implement appropriate prevention programs and messages for the youth they serve.

Coming up with the concept was the easy part, getting there has been much more difficult:

We began a work group that included members of the state HIV Prevention Community Planning Group, the state Committee on Adolescent and School Health, STD and HIV prevention programs, Ryan White Title IV programs, and a wide variety of state and local agencies and community-based programs – anyone who we could find that works with youth. We began to meet to learn about each others' programs, how we could collaborate and how we could use existing programs and models to effectively get prevention messages to youth, especially those at highest risk.

We hired a consultant to research existing programs around the country that have been proven effective and to compile a matrix that the work group could use as a guide to where we wanted to take our program and the programs/messages we wanted to offer the schools and community-based organizations.

We are currently trying to hire a state youth prevention educator/program coordinator jointly funded by HIV Prevention and STD grant funds, who will also work closely with the Adolescent Health Program and the Office

of Minority Health.

NASTAD: What have been some of the major challenges and barriers to implementing youth prevention programs in Missouri?

Time. Having gone through two reorganizations, shifting of positions, and expansion of duties over the past year, we have had little time to move forward as quickly as I would like, but we will eventually get there. Additionally, it has been difficult to find just the “right” person for the job who can readily build effective working relationships with youth.

Funding. Like I said before, you can’t stop pulling people out of the river – fixing the bridge takes additional resources. Initial program start-up funding has been available from the HIV prevention grant. We have requested new state funding to fully implement the program statewide, which we were not able to obtain this first year, and are exploring foundation funds and will again request new state dollars to get us there.

Finding “champions” and buy-in. We have been able to get some great enthusiasm and buy-in from some CPG members, but overall the group has not yet fully embraced the concept enough yet to change the priority setting from epi-based to a more proactive “pre-epi-based” and shift funding from existing health education/risk reduction (HERR) programs to more broad-based youth efforts.

NASTAD: What are some of the lessons learned in trying to target youth populations in your jurisdiction?

Get the support and buy-in from management up front. It makes a world of difference.

Cast your net as far and wide as you can to bring as many people to the table as possible. There are way more people out there working with youth and reaching youth than I ever imagined. The more people you work with, the more likely you are to find those “champions” for your programs. Also, don’t be discouraged when people don’t jump on board or you can’t get them to commit.

Look for the epi data to tell your story. You may need to change age breakdowns or reporting formats to really see the true picture clearly. We broke our “youth” age groups into 13-18 (primarily high school ages) and 19-24 (primarily college or new to the workforce ages) in order to better target outreach/educational efforts.

For more information about Missouri’s efforts, contact [Brad Hall](#).

Youth Involvement in Community Planning

Interview with Loretta Dutton, Research Scientist, New Jersey Department of Health and Senior Services Division of HIV/AIDS Services

Meaningful youth involvement has proven a challenge for many health departments for several reasons, including high turnover rates among youth participants, costs incurred for training and transportation of youth participants and different communication styles. In April 2006, NASTAD coordinated technical assistance (TA) for New Jersey to assist them in increasing youth involvement in their HIV Prevention Planning Group.

NASTAD: What was the impetus for this TA request?

The New Jersey CPG has historically struggled with a lack of youth involvement. Over the years, the group maintained a Youth Committee that was dedicated to just that purpose. But New Jersey tried a number of projects that could not sustain youth input and meaningful participation. Several members have relentlessly sought avenues, venues, and ideas to solicit youth participation. Examples of attempts over the past three years include: promoting an HIV Prevention Club as an after-school activity; contacting Rutgers University for

volunteer public health majors and/or student interns, and holding focus groups in south, central, and northern New Jersey. A variety of reasons have prevented consistent outcomes, from transportation needs to the costs associated with these activities. Understandably, this has resulted in a level of frustration reaching a fever pitch in recent months.

A committee member who heard about the Pennsylvania Young Adult Roundtables (PA YARTS) presented the concept to the full CPG, and the idea was embraced. Once this was accomplished the committee wrote a grant proposal to the AIDS Partnership for funding to support the endeavor (pending). Through NASTAD's peer TA program, key CPG members discussed their TA needs with Michael Shankle, Director of the PA YARTS, which is based at the University of Pittsburgh. The end product was a NASTAD-supported TA presentation by Michael detailing the round-table program design.

NASTAD: How was this TA helpful?

The TA gave the CPG a blueprint for what it would take to successfully replicate the PA YARTS in New Jersey. The level of implementation that Pennsylvania has achieved was a little overwhelming to some members. Michael, however, was able to put the task into perspective in relation to available resources and the extent of manpower hours required to sustain such a project. Realistically, New Jersey may need to start small and evolve over time.

NASTAD: How will you use what you learned from the TA as you move forward?

The next step is for the committee to take the Pennsylvania design and adapt it to New Jersey's geography and resources. Ideally the plan would include a staged implementation process to make the most of limited resources. Once the plan is approved by CPG it will be forwarded to the state for review.

NASTAD: Is there any follow-up that needs to happen?

We are strong advocates for mentoring and benefiting from lessons learned, so the answer yes. The committee will prepare a next step scenario and will keep communication open for further suggestions from NASTAD and Michael.

For more information, contact [Loretta Dutton](#). For more information about NASTAD TA, visit [NASTAD's website](#).

HIV/AIDS Among African American Youth

Although the number of young people (ages 13-24) in the U.S. with AIDS is still relatively low, the number of these youth receiving an AIDS diagnosis has increased over time. In 2003, an estimated 7,081 young people were living with AIDS. This represents a 37 percent increase since 1999.¹ When one also considers that AIDS has been cited as one of the leading causes of death among certain groups within the 25-34 age category (namely African American women), it becomes clear that the HIV prevention needs of young people cannot be ignored. Young people represented about 12 percent of all persons receiving an HIV/AIDS diagnosis in 2003.¹

African American youth are disproportionately impacted by HIV/AIDS. According to the Centers for Disease Control and Prevention (CDC), African American youth represent the largest group of young people affected by HIV, accounting for over half (56 percent) of all HIV infections reported among their age group.¹ African Americans accounted for 66 percent of reported HIV infections among youth ages 13-19 according to the CDC's *2002 HIV/AIDS Surveillance Report*.² Alarming rates of HIV infection have also been documented among African American men who have sex with men (MSM). In the seven cities that participated in a CDC *Young Men's Survey* during 1994-1998, 14 percent of the African American MSM aged 15-22 in this study was infected

with HIV.¹

So what is driving the HIV/AIDS epidemic among African American youth? While some studies have documented declines in the number of U.S. high school students reporting that they have had sexual intercourse and an increase in condom use, young people still report some of the highest STD rates in the country. This becomes a significant issue given the increased risk of HIV transmission due to the presence of certain STD's. African Americans bear a disproportionate burden of the STD transmission among youth. According to a 2004 CDC report on STD trends in the U.S., females aged 15 to 19 had the highest chlamydia rate, with the rate among Black females being 7.5 times higher than that of white females.³ The report also states that the rate of gonorrhea for Black men was 26 times higher than the rate for whites, with the gonorrhea rates overall being highest among African Americans aged 15-24 across all racial, ethnic, and age categories.⁴ The CDC cites limited access to quality health care, poverty and a background of higher disease prevalence as being factors contributing to the elevated rates of STD's among African Americans and other ethnic minorities.⁴

Other factors contributing to an elevated risk of HIV infection among youth include high rates of alcohol, tobacco and other drug use. Research has shown that a large proportion of youth do not see themselves being at risk for HIV. CDC has found that early parent-child communication regarding values and expectations about sex can be beneficial in helping youth make responsible decisions regarding their sexual behavior.¹ Schools can also serve as an important mechanism for reaching youth regarding high-risk behaviors. When looking to address the HIV epidemic among youth of color, there are additional factors that must be considered including structural racism that can lead to greater levels of poverty and drug use among minority youth, particularly among youth in urban settings. According to Advocates for Youth, there is a need for more "focused, gender sensitive, and culturally appropriate prevention programs that will build the skills of youth, enhance self-esteem, and promote positive behavior change."²

References:

1. Centers for Disease Control and Prevention. (2005). *HIV/AIDS among Youth* [Fact Sheet]. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Also available at: <http://www.cdc.gov/hiv/pubs/facts/youth.htm>.
2. Advocates for Youth. (2003). *Adolescents and HIV/AIDS*. Also available at: <http://www.advocatesforyouth.org/publications/factsheet/fshivaid.htm>.
3. Centers for Disease Control and Prevention. (November 2005). *Trends in Reportable Sexually Transmitted Diseases in the United States, 2004* [Fact Sheet]. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Also available at: <http://www.cdc.gov/std/stats/04pdf/trends2004.pdf>.
4. Centers for Disease Control and Prevention. (2005). *STD Surveillance 2004- Special Focus Profiles, Racial and Ethnic Minorities* [Fact Sheet]. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Also available at: <http://www.cdc.gov/std/stats/minorities.htm>

Highlighting Health Department Youth Initiatives in the South

North Carolina Profile: *Project Commit to Prevent*

by Kim Hoke, Manager, HIV Prevention & Community Planning Unit NC DHHS - Division of Public Health

In 2003, the NC HIV/STD Prevention and Care Branch launched *Project Commit to Prevent* (PC2P) and partnered with eleven of North Carolina's twelve Historically Minority Serving Colleges/Universities to assist each institution to expand HIV/STD prevention/risk reduction educational programs on campus; enhance the

capacity of the health services on each campus to provide HIV/STD risk reduction services; and strengthen linkages between each institution and other HIV/STD service providers near the campus, particularly those providing HIV/STD counseling and testing.

Each participating college is awarded \$9,000-\$14,000 to implement a campus project, a small percentage of which is used for program staff salary. During our last funding cycle, NC HIV/STD Prevention and Care Branch committed \$100,000 to PC2P. Approximately 80 percent of funding received by participating colleges and universities is spent on the actual program, for items such as incentives, brochures and travel. Designated peer educators from each participating campus and NC HIV/STD Branch staff meet on a quarterly basis for a Student Advisory Council Meeting to discuss challenges and barriers and provide updates on ongoing activities. These meetings also provide Branch staff the opportunity to deliver ongoing HIV education and prevention messages to participants. All participating campuses are required to submit activity reports once per semester which capture data including the number of participants enrolled in the program and the number of trainings delivered.

During the first year of operation each college and/or university was responsible for:

- Assessing campus needs related to HIV/STD prevention, which included a HIV knowledge, behavior, and attitude random survey of students.
- Designing and implementing a campus-based HIV/STD prevention and risk reduction project under the supervision of the NC HIV/STD Prevention and Care Branch.
- Assuring the participation of student representatives in the design and implementation of the project.
- Receiving training and assistance to establish campus-based HIV counseling and testing services.
- Assuring that every student enrolled at the institution had access to information about HIV/STD prevention/risk reduction and HIV/STD community services near the campus
- Identifying one or two students to represent the college/university on the Student Advisory Committee with the responsibility of planning student forums on HIV/AIDS/STDs.
- Working collaboratively with the other participating institutions to prepare a final report summarizing the *1st Year of Project Commit to Prevent*

A primary outcome of the first phase of PC2P was the formation of the *Statewide College/University Stomp Out HIV/STDs Student Leadership Planning Committee* comprised of student leaders from the twelve NC Historically Minority Colleges/Universities. This committee coordinated a conference which was attended by over 450 student leaders, faculty, and staff from each of the twelve campuses and lead to the development recommendations to assure on-going enhancement of HIV/STD prevention and risk reduction efforts. As the project moved into its second contract period, emphasis was placed on sustaining student involvement and enhancing administrative support.

One of the major initial challenges of implementing PC2P was identifying the right avenue to approaching the administration at participating colleges. The administration at some colleges were concerned that involvement in the initiative to could be perceived as an indication that there is an HIV epidemic on their campuses, which could ultimately result in a decrease in enrollment.

Several exciting activities have taken place this year. All campuses coordinated projects for National Black HIV Awareness Week, including activities such as a movie night, an awareness dinner, and literature distribution drive. A retreat for approximately 150 youth participants was held this spring which provided them the opportunity to creatively share information about best practices on their campuses through various formats including drama and spoken word. A key topics of discussion at the retreat, chosen independently by the youth participants was "Sexual Responsibility in a Sexually Irresponsible Society".

For more information, contact [Kim Hoke](#) (919) 733-9560.

South Carolina's *Between Brothers*

by Matt Jenkins, Youth Activity Coordinator, South Carolina HIV/AIDS Council

The *Between Brothers Project* is an HIV prevention and health education program that targets young men between the ages of 13-24, serving Richland and Lexington counties. The program offers HIV prevention and health education through Individual Level Intervention (ILI) and Group Level Intervention (GLI), and also offers referrals for HIV testing and syphilis screenings. GLIs are offered through the *Between Brother's* program include:

Be Proud! Be Responsible! is a six-module curriculum that provides adolescents with knowledge, motivation and skills necessary to change their behaviors in ways that will reduce their risk of contracting HIV and other sexually transmitted diseases. This curriculum is currently being facilitated primarily in partnership with the Department of Juvenile Justice (DJJ) for males ages 13-24.

Many Men, Many Voices (3MV) is a group level intervention designed specifically for gay men of color to promote behavior change for HIV/STI prevention. Two facilitators lead six, two hour sessions over an established time frame. These sessions take place in a confidential and private setting to help the men feel safe and accepted with positive social support. 3MV is a step-by-step process that relies on real dialogue and participant interactions. The age range for this intervention is 18-29.

Participants for both GLIs are recruited through: (1) established partnerships with youth serving organizations including DJJ, local colleges and recruitment from within the community; (2) recruitment/outreach from various community venues (i.e. night clubs, colleges, community events & health fairs); (3) age appropriate referrals from in-house programs (i.e. testing/counseling and project Life Line); (4) walk-ins and; (5) WIN WIN Project (participants recruit from their social networks and receives compensation for their recruitment efforts).

One of the biggest challenges facing *Between Brothers* has been the overall stigma associated with HIV education. The perception still exists that program participants or those with an interest in HIV education are either at higher risk for contracting HIV or are HIV-positive. Stigma continues to be a very big issue in the South, with parents often hesitant to allow their youth to participate in *Between Brothers* activities fearing it will lead to their youth engaging in behaviors that will put them at risk. Participants of the program, particularly those involved in 3MV, continue to struggle with issues of acceptance and lack of social support from their families, places of worship, and the broader community. Maintaining anonymity has also been a barrier, which to a certain degree has been addressed by taking participants on retreats outside of the state capitol, Columbia. However, these retreats can be cost prohibitive and not always feasible.

Between Brothers cites their work with incarcerated youth as a major success. Working in partnership with DJJ has provided them access to a high-risk youth population often overlooked in the delivery of HIV prevention programming. Another major success was the implementation of *Be Proud! Be Responsible!* with a group of approximately 20 members of a local fraternity, administered in a one day format. *Between Brothers* is actively exploring opportunities to work with other fraternities.

For more information, contact [Matt Jenkins](mailto:Matt.Jenkins@scdhhs.gov) (803) 254-6644.

Lessons Learned from the Regional Stakeholders Meetings

by Danielle Sollers, Program Associate, Association of Maternal and Child Health Programs

From 2003-2005, NASTAD, along with the Association of Maternal and Child Health Programs (AMCHP), the National Coalition of STD Directors (NCSD), and the Society of State Directors of Health, Physical Education and Recreation (SSDHPER) coordinated Regional Stakeholders Meetings (RSM) for 24 state teams to strengthen collaboration between state departments of education and health. The goal of these meetings was to

encourage interagency efforts to support and improve HIV, STD, unintended and teen pregnancy prevention in schools through a capacity-building process that brings together representatives from state departments of education and health.

Over the next five years, the national partners will reach out to the 26 states that have not taken part in the RSMs. The partners will also reconvene the 24 states that participated in the first series of meetings to provide follow-up technical assistance and support.

AMCHP has taken the lead in compiling *Preventing STD, HIV, Unintended and Teen Pregnancy in Schools: State Profiles*, a “lessons learned” document featuring stories from state teams that took part in the RSM process from 2003-2005. Following is an excerpt from the document highlighting the lessons learned in Colorado.

Excerpt from State Profiles document on Colorado

The Colorado team worked to:

- Articulate a shared vision for HIV, STD, unintended and teen pregnancy prevention programs for school-aged youth;
- Identify challenges to achieving the shared vision;
- Describe collaborative strategies for overcoming these challenges; and,
- Create an action plan for enhancing collaboration among programs.

Colorado team members reported several lessons learned:

- Keep an open mind;
- Look at team composition and involve all key stakeholders;
- Strengthen interagency collaboration and come to common ground before including external partners;
- When team members move on, begin one-on-one relationships with new team members that come aboard. Arrange a face-to-face visit to gain their support and show your enthusiasm for the process;
- Allow your team ample meeting time. The process moves at a slow pace in the beginning and is emotionally draining;
- Meet with the meeting facilitator as a planning committee to ensure that everyone is on the same page;
- Share with facilitators the work done at the National Stakeholders Meeting and what path the team is taking; and,
- Agree, as a team, to stick with the action plan and strategies to seek solutions. When the team gets stuck, go back to the future vision where the team agreed on how to address barriers.

For more information, contact [Danielle Sollers](#).

Contribute to NASTAD's *Working for Our Youth* Resource!

NASTAD is compiling a resource tool entitled *Working for Our Youth: A Guide to Health Department HIV Prevention Programs for Youth*. The document is intended for state health departments, state education agencies, and non governmental organizations to better understand the range of HIV prevention programs targeting youth that are funded or directly administered by health departments. *Working for Our Youth* will be posted on [NASTAD's website](#) and printed copies will be distributed to interested partners. For more information, contact [Kellye McKenzie](#).

Capacity Building Calendar

Information on CDC-sponsored Capacity Building Assistance trainings for **June-September** is now available.

Meeting and Planning Calendar

June 4-7, 2006

HIV Prevention Leadership Summit (HPLS), Dallas, TX. For more information, visit the [conference website](#).

June 7-10, 2006

"Building the Movement." National Mental Health Association's Annual Meeting, Washington, D.C. For more information, visit the [conference website](#).

June 21-23, 2006

"HIV & AIDS Research: the Light and the Dark - Then & Now," 14th International Symposium On HIV and Emerging Infectious Diseases (ISHEID), Toulon, French Riviera. For more information, visit the [symposium website](#).

June 22-25, 2006

A National Symposium: Global Health Care Justice, Hiram, OH. For more information, visit the [symposium website](#).

June 27, 2006

National HIV Testing Day. Sponsored by the National Association of People With AIDS. For more information, visit the [event website](#).

August 13-18, 2006

XVI International AIDS Conference, Toronto, Canada. Abstract submissions due February 22, 2006. For more information, visit the [conference website](#).

August 28-31, 2006

The Ryan White CARE Act Grantee Conference and the 9th Annual Clinical Conference Update, Washington, D. C. Workshop and poster presentations will be grouped under six tracks: 1) access to care; 2) quality; 3) program development; 4) coordination and linkages; 5) administration (fiscal and program management); and 6) data evaluation and outcomes. For more information, visit the [conference website](#).

September 12-14, 2006

CDC's 2006 National Health Promotion Conference: Innovations in Health Promotion: New Avenues for Collaboration, Atlanta, GA. For more information, visit the [conference website](#).

September 24-26, 2006

United States Conference on AIDS (USCA), Hollywood, FL. For more information, visit the [conference website](#).

October 15, 2006

National Latino HIV/AIDS Awareness Day. For more information, visit the [event website](#).

November 4-8, 2006

"Public Health and Human Rights," American Public Health Association's 134th Annual Meeting, Boston, MA. For more information, visit the [conference website](#).

November 9 – 12, 2006

Sixth National Harm Reduction Conference, Oakland, CA. For more information, visit the [conference website](#).

December 1, 2006

World AIDS Day. For more information, visit the [event website](#).

April 5-7, 2007

"HIV/STD Prevention in Rural Communities: Sharing Successful Strategies V," the Rural Center for AIDS/STD Prevention national conference, Indiana University, Bloomington, IN. A call for papers will be issued in fall 2006. For more information, visit the [RCAP website](#).

If you have an idea or program relative to any of these topics that you would like to include in the *Bulletin*, please contact [Nyedra Booker](#) (202/434-8090). The NASTAD *HIV Prevention Bulletin* is written and edited by NASTAD staff and participants of community planning and prevention efforts around the country.

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LET US KNOW WHAT YOU THINK! NASTAD welcomes feedback to issues presented in our newsletter. To submit commentary, please e-mail us at NASTAD@NASTAD.org.

Visit our Webpage! Electronic versions of the *Bulletin* are posted along with other information on both NASTAD's prevention and care projects.

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The logo for NASTAD, consisting of the word "NASTAD" in a large, light purple, sans-serif font. To the left of the text are three vertical dots of the same color, arranged in a column.

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