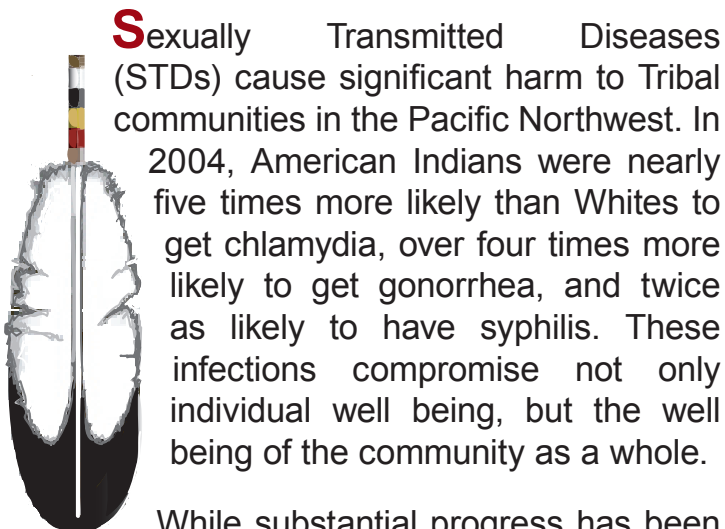


Sexually Transmitted Diseases:

An Advocacy Kit for Tribal Leaders

For many of us, talking about sex is an uncomfortable topic. For some of us, we were not taught by our elders how to discuss sexuality. For others, we were not shown by our community how to form healthy relationships. Because of this, we have remained silent, and in turn, our children and grandchildren have also grown up without knowing the words needed to talk about these issues.

Unfortunately, Sexually Transmitted Diseases are now causing significant physical, social, and economic harm to Tribal communities -- And our silence will not stop their devastating impact. Together, we must find the courage to stand up and have a voice. As gifts from the Creator, we cannot be afraid to discuss Sex and Sexuality with our children, and take the steps that are needed to protect future generations.



Sexually Transmitted Diseases (STDs) cause significant harm to Tribal communities in the Pacific Northwest. In 2004, American Indians were nearly five times more likely than Whites to get chlamydia, over four times more likely to get gonorrhea, and twice as likely to have syphilis. These infections compromise not only individual well being, but the well being of the community as a whole.

While substantial progress has been made in preventing and treating certain STDs, experts estimate that 19 million infections occur each year in the United States, with almost half of them contracted by young people.

In addition to the physical and psychological consequences, these diseases also take a tremendous toll on the Indian healthcare system. Nationally, direct medical costs associated with STDs are estimated at \$13 billion annually.

Because of factors such as rural geography, early sexual debut, close-knit sexual networks, and high rates of hepatitis C, substance use, and sexually transmitted diseases, many experts now believe that HIV/AIDS is a "time bomb" that may reach epidemic proportions among Native communities. The number of American Indians and Alaska Natives diagnosed with AIDS has grown more rapidly than in any other ethnic group, increasing almost 800% from 1990 to 1999.

In response, Tribes in Oregon, Washington, and Idaho have joined together to address this common concern by forming the Red Talon STD/HIV Coalition. Valuing the role of tribal decision-makers, this group has identified you as an important resource for encouraging healthy community discussion and outreach, and for implementing strategies to prevent sexually transmitted diseases. **We look forward to working alongside you on this important endeavor!**

Provided by Project Red Talon, a project of the Northwest Portland Area Indian Health Board

For more information, call toll free 877-955-5519 or visit us on the web: www.npaihb.org (Funded by CDC grant U183/CCU024369-01)



Sexually Transmitted Diseases: What You Can Do...

As decision-makers, you play a significant role in the health and welfare of your Tribe. Your opinions are heard and respected. Your actions are observed and influence others. Your policies and decisions will shape the lives of future generations. With this power, comes responsibility...

Know the Facts

Educate, Motivate, and Mobilize against Sexually Transmitted Diseases!

What You Can Do...

- Learn more about STDs/HIV and their impact on your community.
- Adopt a Resolution supporting your tribe's participation in the Red Talon STD/HIV Coalition and use of the Red Talon Tribal Action Plan.
- Work with local schools and educators to strengthen school-based curricula preventing STDs and teen pregnancy.
- Work with the Tribal Clinic to improve clinic-based policies.
- Encourage community awareness by participating in community observances, and by implementing the Red Talon STD/HIV Media Campaign.
- Protect yourself against STDs and HIV infection. Know the risks associated with sex and drug use.
- Get tested - and encourage others to do the same. It's important to know your STD and HIV status to protect yourself and others. Blood, urine, and saliva tests are available for different STDs. Most infections can be treated or cured!
- Educate others about STDs and HIV/AIDS -- They listen and learn from you.
- Volunteer with your tribe's STD/HIV Prevention Program.
- Get medical care and support if you're living with HIV. Effective treatments exist.
- Help someone living with HIV/AIDS by being a friend.
- Help end the stigma associated with HIV/AIDS.



Sexually Transmitted Diseases: The Numbers



It has been recognized for some time that American Indians and Alaska Natives are disproportionately impacted by high rates of sexually transmitted diseases (STDs). In 2004, American Indians were nearly five times more likely than Whites to have chlamydia, four times more likely to have gonorrhea, and twice as likely to have syphilis.

Chlamydia:

When comparing rates by ethnicity, American Indians have the second highest chlamydia rate in the United States. From 2000-2004, the chlamydia rate among American Indian and Alaska Native women was nearly five times higher than the rate reported among white women. Among Native men, the chlamydia rate was 4.75 times higher than the rate reported among white men. In Idaho, Oregon, and Washington, American Indians make up nearly 2.5% of the total population, and account for approximately 3% of all reported chlamydia cases.

Age Distribution: Nearly three-quarters of all chlamydia cases occur among 15-24 year olds.

Year	White, Non-Hispanic	Black, Non-Hispanic	Hispanic	Asian/Pacific Islander	American Indian/Alaska Native
2000	105.9	978.2	384.7	129.2	590.2
2002	126.9	1,087.80	423.4	140.4	644.8
2004	143.6	1,209.40	436.1	133.7	705.8

Gonorrhea:

In 2004, American Indians and Alaska Natives had the second-highest gonorrhea rate, with 117.7 cases per 100,000, a rate that was four times higher than rate reported among whites. From 2000 to 2004, gonorrhea rates increased 19.4% among American Indians and Alaska Natives.

Age Distribution: In 2004, AI/AN gonorrhea rates were highest among 20-24 year olds.

Year	White, Non-Hispanic	Black, Non-Hispanic	Hispanic	Asian/Pacific Islander	American Indian/Alaska Native
2000	27.8	778.1	68.7	26.7	98.6
2002	31	713.7	69.2	21.4	112.5
2004	33.3	629.6	71.3	21.4	117.7

Syphilis:

Between 2003 and 2004, the rates of primary and secondary syphilis increased 14.3% among American Indians and Alaska Natives. During this period, the number of reported syphilis cases decreased among AI/AN men (from 50 to 42), but increased among AI/AN women (from 19 to 35).

Age Distribution: In 2004, AI/AN syphilis rates were highest among 35-39 year olds.

Year	White, Non-Hispanic	Black, Non-Hispanic	Hispanic	Asian/Pacific Islander	American Indian/Alaska Native
2000	0.5	12	1.6	0.3	2.2
2002	1.2	9.5	2.5	0.8	2.1
2004	1.6	9	3.2	1.2	3.2

Sexually Transmitted Diseases: The Numbers

HIV/AIDS:

AIDS has steadily increased in recent years, becoming the ninth leading killer of Native people between the ages of 15 and 44 -- approximately 3,084 AI/ANs have been diagnosed with AIDS since the disease was first encountered in 1980.

In 2004, the rate of HIV/AIDS diagnosis for Native men (20.8 per 100,000) was 1.1 times higher than that for whites. Among Native women, the rate (at 7.7 per 100,000) was 2.4 times higher than that for whites. When compared by ethnicity, AI/AN men and women both had the third highest HIV/AIDS rate in 2004.

Among AI/AN males, the HIV/AIDS case rate increased 2.4% from 2001 to 2004, the most significant increase observed among any reported racial/ethnic group. And among females, the rate increased 4.8%, an increase that was second only behind Asian/Pacific Islanders (A/PI).

In 2004, HIV was newly diagnosed for an estimated 206 American Indians and Alaska Natives.

Hepatitis A:

Historically, hepatitis A rates differed by race, with the highest rates occurring among American Indians and Alaska Natives. AI/AN rates, which were greater than 60 cases per 100,000 prior to 1995, have decreased dramatically as a result of widespread vaccination. In 2003, vaccination levels for children aged 24-35 months were 43% in Idaho, 33% in Oregon, and 27% in Washington.

Hepatitis B:

In the U.S., Hepatitis B is most commonly acquired by adults through sexual transmission. In 2002, the Hepatitis B rate among AI/ANs was second only to non-Hispanic blacks.

Hepatitis C:

Hepatitis C virus (HCV) infection is the most common chronic bloodborne infection in the United States; an estimated 2.7 million persons are chronically infected. Data indicates that sexual transmission of HCV accounts for up to 20% of HCV infections. Hepatitis C rates have declined in all racial groups since 1995, but non-Hispanic blacks and AI/ANs continue to have higher incidence rates than other racial/ethnic groups.

Impact:

Given the greater proportion of young people in many of our Native communities, high STD rates are particularly troubling to those concerned about HIV prevention. Research now shows that those infected with STDs are 2 - 5 times more likely to acquire HIV when exposed through sexual contact. Consequently, elevated STD rates among Native youth and adults put us at higher risk for the transmission of HIV.

These statistics were obtained from STD Surveillance 2004 [www.cdc.gov/std/stats] and HIV/AIDS Surveillance Report, CDC 2004, Volume 16.



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Sexually Transmitted Diseases: The Social Impact



Sexually Transmitted Diseases (STDs) cause a number of physical, mental, and social consequences. Sexually transmitted infections can cause pain, infertility, cancer, and death. This pain impacts individuals and the tribe as a whole.

Health Consequences:

Chlamydia - Chlamydia is a bacterial infection that can easily be cured with antibiotics, but it is usually asymptomatic and often undiagnosed. Untreated, it can cause severe health consequences for women, including pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. Up to 40% of females with untreated chlamydia infections develop PID, and 20% of those may become infertile. In addition, women infected with chlamydia are up to five times more likely to become infected with HIV, if exposed. Complications from chlamydia among men are relatively uncommon, but may include epididymitis and urethritis, which can cause pain, fever, and in rare cases, sterility.

Gonorrhea - While gonorrhea is easily cured, untreated cases can lead to serious health problems. Among women, gonorrhea is a major cause of PID, which can lead to chronic pelvic pain,

ectopic pregnancy, and infertility. In men, untreated gonorrhea can cause epididymitis, a painful condition of the testicles that can result in infertility. In addition, studies suggest that the presence of gonorrhea infection makes an individual three to five times more likely to acquire HIV, if exposed.

Syphilis - Syphilis, a genital ulcerative disease, is highly infectious, but easily curable in its early stages. If untreated, it can lead to serious long-term complications, including nerve, cardiovascular and organ damage, and even death. Congenital syphilis can cause stillbirth, or physical deformity and neurological complications in children who survive. Syphilis, like many other STDs, facilitates the spread of HIV, increasing transmission of the virus at least two- to five-fold.

Women's Health:

Because of differences in anatomy, women are biologically more susceptible than men to the transmission of STDs and HIV—and adolescent girls are at even higher risk. At all ages, women are more likely than men to contract genital herpes, chlamydia or gonorrhea. Women are twice as likely as men to acquire chlamydia in a single act of unprotected intercourse with an infected partner, and are three times as likely to acquire gonorrhea in such circumstances. Because symptoms are harder to detect among women, it is also more likely that infections will go untreated.

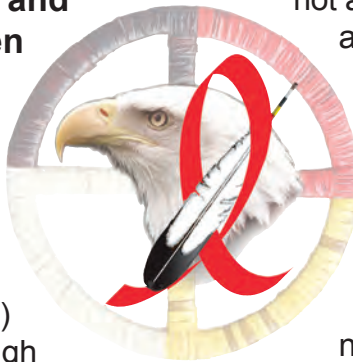
This information was obtained from the STD Surveillance 2004, the National Campaign to Prevent Teen Pregnancy, and the HIV/AIDS Surveillance Report, CDC 2004.

Sexually Transmitted Diseases: The Social Impact

Teens and Young Adults:

Early sexual debut, multiple sex partners, and infrequent condom use puts Native youth at heightened risk for STDs, HIV, and teen pregnancy. The data are compelling:

- **1 out of every 4 sexually active teens will get an STD this year, and Native youth may be at even higher risk.** According to a 2001 survey involving a nationally-representative sample of 8,500 BIA high school students, Native youth were more likely to have had sex than the national average. Slightly more than half (52.3%) of Native American female high school students reported having had sex, compared to 42.9% of all female high school students, and 65.5% of Native American male students reported having had sex, compared to 48.5% of all male high school students.
- **1 in 10 sexually active adolescents has chlamydia.** Because adolescent women are physically more susceptible to infection and 75% of infections produce no symptoms, adolescent women are at particularly high risk.
- **2 U.S. teens are infected with HIV every hour of every day.** Increasing their risk for



HIV and other STDs, female Native American students report less condom use than the national average (45.0% vs. 51.3%).

- **1 of every 5 sexually active teen females will get pregnant this year.** While teen pregnancy rates for Native American youth are not available from national data sets (due to a lack of available abortion data), in 2002 the birth rate for Native American 15- to 19- year olds was 53.8 per 1,000, much higher than the national rate of 43.0 per 1,000. In 2001, only 8.3% of BIA high school students reported using birth control pills, compared to 18.2% of high school students nationally.
- **Among all populations, chlamydia and gonorrhea rates are highest among 15 to 24 year olds.**

Social Consequences:

Elevated STD rates among American Indians and Alaska Natives put us and our youth at heightened risk for HIV transmission. Rural geography, low rates of condom use, and risky sexual norms could further contribute to an epidemic of HIV among our NW Tribes. **It is vitally important that we unite to address this concern!**

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Sexually Transmitted Diseases: The Economic Impact



In addition to the physical and social consequences of sexually transmitted diseases, STDs impose a substantial economic burden on our NW Tribes. Nationally, direct costs associated with STDs, including HIV, amounted to \$9.3 to \$15.5 billion in the year 2000. Assessing the economic burden of STDs can help estimate the cost of treating STDs, and can help quantify the impact they have on your medical services.



In the following figures, estimated medical costs include the direct medical expenses associated with treating each STD and the sequelae that result from untreated or inadequately treated infections. This includes the cost of clinician visits, hospitalization, diagnostic testing, drug treatments, and therapeutic procedures. These lifetime costs assume that the infection was incurred between the ages of 15-24, as is most often the case. Other expenses associated with STDs, including transportation costs, lost wages, and pain and suffering are not included in these figures.

Chlamydia: Based on the cost of diagnosing and treating acute infections, screening tests that yield positive results, and sequelae resulting from untreated acute infections, the expected cost per case of chlamydia was \$20 for men and \$244 for women. This analysis assumed that acute infections were asymptomatic or untreated in 78% of men and 32% of women. In women, 82% of the estimated cost per case was attributable to sequelae, whereas in men, 78% of the estimated cost per case was attributable to acute infection.

Gonorrhea: Similarly, the expected cost per case of gonorrhea was \$53 for men and \$266 for women, based on the cost of diagnosing and treating acute infections, positive screening tests, and sequelae resulting from untreated infection. This analysis assumed that acute infections were asymptomatic or untreated in 29% of men and 27% of women. In women, 81% of the cost per case was attributable to sequelae, whereas in men, 92% of the cost per case was attributable to acute infection.

Syphilis: Reflecting the probability of and costs associated with syphilis treatment in the primary, secondary, or early latent stage, the estimated cost per case was \$444.

Sexually Transmitted Diseases: The Economic Impact

HIV/AIDS: Assuming that, on average, persons with HIV live for 16 years after becoming infected; each infected person is unaware of his or her infection in the first two years and begins viral load monitoring in the third year; and in years 4-16, the person receives antiretroviral therapy, prophylaxis, and treatment for opportunistic infections, as well as other medical care associated with progression to AIDS, the estimated lifetime cost of each HIV infection was \$199,800 in the year 2000.

Human Papilloma Virus:

Accounting for costs associated with cervical abnormalities in women and external anogenital warts in both men and women, the expected cost of HPV per infection was \$1,228 for women and \$27 for men in 2000.

Genital Herpes: The lifetime cost of genital herpes (excluding neonatal herpes) among those who were 15-24 at the time of infection, was estimated to be \$417 for women and \$511 for men, including suppressive therapy for some patients.

Trichomonas vaginalis: An estimated 20-50% of infections are symptomatic. Assuming that 40% of cases would be treated, and that 60% would not be treated and would incur no costs, the average cost per case was \$18.



Hepatitis B: If it is conservatively assumed that the average latent period before chronic liver disease onset is 20 years, the average lifetime cost of Hepatitis B was \$779 per case in 2000.

Given the very limited health service budgets available to our NW Tribes, Sexually Transmitted Infections can pose a sizable economic threat if not adequately prevented.

Reference: HW Chesson, JM Blandford, TL Gift, G Tao and KL Irwin. The Estimated Direct Medical Cost of Sexually Transmitted Diseases Among American Youth, 2000. Perspectives on Sexual and Reproductive Health, Volume 36, Number 1, January/February 2004.

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Sexually Transmitted Diseases: The Tribe's Role in Prevention



There are many benefits to investing in STD and HIV Prevention. The estimated lifetime cost of care and treatment for just one HIV+ person is about \$200,000. By keeping people from becoming infected, STD/HIV Prevention Programs not only save lives, but also reduce the number of people needing expensive medical treatments.

Cost Effectiveness of Prevention:

All things being equal, research suggests that interventions targeting high-risk and high-seroprevalence populations tend to be more cost-effective than un-targeted interventions.

While convenient, low cost and broad reaching interventions are not necessarily cost-effective. Giving everyone a brochure produces little behavior change, whereas working intensively to help high-

risk clients use condoms correctly, communicate with their partners, and learn to recognize and avoid high-risk situations can result in pronounced behavior change.

Community-Based Strategies:

Community-level STD and HIV prevention interventions have proven to be cost-effective, even with resource-intensive components such as personnel, renting space, and running social events. Effective programs can avert 5-6 HIV infections over five years, with a cost of \$14,600-18,300 per case averted.

School-Based Strategies:

School-based HIV, STD, and pregnancy prevention programs have achieved a 15% increase in condom use and an 11% increase in contraceptive use among sexually active students. By preventing cases of STDs and teen pregnancies, the program saved \$2.65 in medical and social costs for every dollar spent on the program.

Sexually Transmitted Diseases: The Tribe's Role in Prevention

Clinic-Based Strategies:

CDC recommends annual chlamydia screening for sexually active women under the age of 26, and for older women with risk factors such as new or multiple sex partners. A simple change in clinical procedures -- coupling chlamydia tests with routine Pap testing -- can sharply increase the proportion of women screened. Likewise, research suggests that Expedited partner therapy (EPT) using patient-delivered partner therapy (PDPT) is a cost-saving and cost effective partner management strategy. Implementing clinic-based policies such as these is a critical step in preventing the transmission of sexually transmitted diseases.



Cost Effectiveness of HIV Prevention for HIV-Positive Persons:

Studies regarding the effectiveness of HIV prevention interventions for HIV-positive persons have assessed interventions with varying intensity. If HIV transmissions are permanently prevented and lifetime medical costs are avoided in an HIV-negative partner, then monthly counseling sessions (even at moderate levels of effectiveness), may be cost-saving to society. At higher transmission rates and effectiveness, research suggests that dozens of sessions per client could be cost-saving.

Working together, we must bridge Community, School, and Clinic-Based prevention strategies!

Reference: www.caps.ucsf.edu/costeffectiverev.html

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STD Prevention: Clinic-Based Strategies

High quality, accessible medical and laboratory services are essential elements in the prevention of sexually transmitted diseases. Because our community members are often reliant on Tribal or IHS clinics to obtain most of their health services, it is critical that they integrate high quality STD screening, diagnosis, and treatment services. If these services cannot be provided by the local clinic, clinic practices must ensure that patients are referred to other available services.

The following services, policies, and practices should be used by Tribal and IHS clinics to prevent the transmission of Sexually Transmitted Diseases:

Range of Services

- The clinic provides STD and HIV Testing
- The clinic provides STD and HIV Treatment

Clinic Policies and Procedures

- The clinic follows current recommended treatments for STDs.
- When appropriate, the clinic encourages Patient-Delivered Partner Therapy or EPT.
- The clinic allows minors to access services without parental consent.

Clinician Performance Standards - Clinicians and clinic managers attend at least one STD/HIV update course every two years.

Case Reporting - Clinic procedures ensure that morbidity reports are promptly submitted following the diagnosis of a reportable STD, to the state or county Health Department.

Partner Services - Clinic practices ensure that one of three strategies are used to notify partners of possible exposure to STD or HIV infection: Provider, Self, or Contract referral.

Disease Intervention Services - At least one clinic staff person is responsible for providing Disease Intervention Services, or connecting patients to the County's DIS system.

Lab Services - If STD services are provided by the clinic, the clinic has an on-site stat laboratory or capacity to perform stat tests.

Screening - Clinic practices ensure that:

- All sexually active females less than 26 years old are screened for chlamydia and gonorrhea at least once per year.
- All young, sexually active men are screened routinely for chlamydial and gonococcal infections.
- Older males and females with known risk factors are screened for chlamydia and gonorrhea at least once per year.
- All persons with known risk factors receive serologic screening for syphilis.
- Routine, voluntary HIV screening occurs for all persons 13-64 (not based on risk or local prevalence rates.) Repeat HIV screening occurs at least annually for all persons with known risk.
- Sexually active, HIV-infected persons are screened at least annually for STDs.
- All pregnant women are tested for chlamydia, gonorrhea, hepatitis B, hepatitis C, bacterial vaginosis, syphilis, and HIV at the first prenatal visit.

STD Prevention: School-Based Strategies

Evidence shows that comprehensive sexuality education programs that provide information about both abstinence and contraception can help delay the onset of sexual activity in teenagers, reduce their number of sexual partners, and increase contraceptive use when they become sexually active - thus preventing STDs and teen pregnancy.

Sex and Pregnancy Among Teenagers

- By their 18th birthday, 6 in 10 teenage women and nearly 7 in 10 teenage men have had sexual intercourse. A sexually active teenager who does not use contraception has a 90% chance of becoming pregnant within a year. One quarter of sexually active teens will get an STD this year, and Native youth may be at even higher risk.

Sexuality Education in the Classroom

- Sexuality education teachers are less likely to provide students with information on birth control, how to obtain contraceptive services, sexual orientation, and abortion than they were 15 years ago.
- Despite the decline, the majority of U.S. parents, teachers, and students overwhelmingly favor broader sex education -- and 94% of parents say that sex education should cover contraception. At least 40% of students report that topics such as STDs and HIV, birth control, how to use and where to obtain birth control, and how to handle pressure to have sex were not adequately covered in their most recent sexuality education course.

State Sex and STD/HIV Education Policy								
State	Sex Education			STD/HIV Education			Parental Role	
	Mandated	If Taught, Content Required		Mandated	If Taught, Content Required		Consent Required	Opt-Out Permitted
		Abstinence	Contraception		Abstinence	Contraception		
Idaho								X
Oregon		Stress	Cover	X	Stress	Cover		X
Washington				X	Stress	Cover		X

State Policy - Idaho, Oregon, and Washington laws require academic instruction about HIV/STDs, but do not require sex education. Thirty states require local school districts to teach about abstinence: Oregon requires that it be “stressed,” and requires that contraception be “covered.” No states requires that birth control information be emphasized.

Local Policy - Even when a state policy on sex education exists, significant latitude and oversight is left to local school districts. A national survey of school superintendents found that more than two-thirds (69%) of U.S. school districts have a policy to teach sex education. The remaining 31% leave the decisions about whether to teach such curriculum to individual schools.

Reference: http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf; http://www.guttmacher.org/pubs/fb_sex_ed02.html and <http://www.kff.org/womenshealth/3224-index.cfm>.

STD Prevention:

Community-Based Strategies

Research suggests that interventions targeting high-risk and high-seroprevalence populations tend to be more cost-effective than un-targeted interventions. The following projects have been rigorously evaluated by the Centers for Disease Control and Prevention, and have been effective at reducing the spread of STDs and HIV, and promoting healthy behaviors.

Interventions Targeting Injections Drug Users:

A number of intervention strategies have shown to be cost-effective for injection drug users: needle exchange programs, HIV testing and counseling, and drug treatment.

The Holistic Health Recovery Program (HHRP) is a 12-session, manual-guided, group-level program for HIV-positive and HIV-negative injection drug users. The primary goals are harm reduction, health promotion, and improved quality of life. Core Elements:

- Teaches skills to reduce harm of injection drug use and unprotected sexual activities.
- Teaches negotiation skills to reduce unsafe sexual behaviors with sexual partners and teaches skills to heal social relationships.
- Teaches decision making and problem solving skills using cognitive remediation strategies.
- Teaches goal setting skills.
- Teaches skills to manage stress.
- Teaches skills to improve health, health care participation, and adherence to treatments.
- Teaches skills to increase clients' access to their own self-defined spiritual beliefs.



Interventions Targeting

Men who have Sex with Men:

Many Men, Many Voices (3MV) is a 6- or 7-session, group level STD/HIV prevention intervention for gay men of color. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia. Core Elements:

- Educates clients about HIV and personal risk.
- Develops risk reduction strategies.
- Trains in behavioral skills.
- Trains in partner communication and negotiation.
- Provides social support and relapse prevention.

The Mpowerment Project is a community-level STD/HIV prevention intervention run by and for young gay and bisexual men. This intervention uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages. Core Elements:

- Recruiting a core group of young gay men to design and carry out project activities
- Establishing a project space where many of the project activities can be held
- Conducting entertaining, venue-based (e.g., bars, community events) outreach
- Sponsoring social events to promote community-building among young gay men.
- Convening peer-led, one-time discussion groups
- Conducting a publicity campaign about the project within the community.

Interventions Targeting Sexual Networks:

Popular Opinion Leader is a community-level intervention that involves identifying, enlisting, and training key opinion leaders to encourage safer sexual norms and behaviors within their social networks through risk-reduction conversations.

Core Elements:

- Intervention is directed to an identifiable target population in well-defined community venues.
- Ethnographic techniques are systematically used to identify segments of the target population and identify those persons who are most popular, well-liked, and trusted .
- Popular Opinion Leaders (POLs) are taught to share risk reduction messages with friends and acquaintances during everyday conversations.
- POLs meet weekly in sessions that use instruction, facilitator modeling, and extensive role play to help refine skills.
- POL's set goals to engage in risk reduction conversations with friends and acquaintances between weekly sessions.

Interventions Targeting Women:

Real AIDS Prevention Project is a community mobilization program, designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. This intervention relies on peer-led activities, including: outreach/one-on-one brief conversations with brochures, referrals, and condom distribution; small group safer sex discussions and presentations. Core Elements:

- Conducting community outreach using peers.
- Having one-on-one, safer sex discussions based on the client's readiness to change.
- Using printed stories about community members and safer sex decisions (role models).
- Sponsoring small group activities, such as safer sex parties and presentations.

Interventions Targeting the Community:

Community PROMISE is a community-level intervention that can target any population, since it is created and implemented in collaboration with the community. The intervention has been tested with African American, White, and Latino communities, including intravenous drug users and their sex partners, non-gay identified men who have sex with men, high risk youth, female sex workers, and high risk heterosexuals, among others. Core Elements:

- Community identification process to collect information about the community, including HIV/STD risk behaviors and influencing factors.
- Creating role model stories based on personal accounts from individuals in the target population who have made positive behavior change.
- Recruiting and training peer advocates from the target population to distribute role model stories and prevention materials.
- Continuous formative evaluation to capture behavior change within the target population.

VOICES (Video Opportunities for Innovative Condom Education & Safer Sex) is a group-level, single-session video-based intervention designed to increase condom use among heterosexual men and women who visit a health clinic.

- Viewing culturally-specific videos portraying condom negotiation;
- Conducting small group skill-building sessions to work on overcoming barriers to condom use;
- Educating program participants about different types of condoms and their features; and
- Distributing samples of condoms identified by participants as best meeting their needs.

Additional Interventions at: www.effectiveinterventions.org