UNIT 5  BEST PRACTICES IN HIV/AIDS PREVENTION AND EDUCATION

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5.0 OBJECTIVES

After reading this chapter the reader will be able to identify the historical roots of HIV prevention methods in the United States with a clear understanding of how and why these interventions began. Furthermore, the reader will be familiar with US experience with empirically supported prevention interventions for high-risk populations, with particular emphasis on understanding of “what works”. Building on the initial ideas regarding interventions presented from the Western perspective, we will emphasize the emerging context in India and consider guidelines for best practices there. The goal here is to evaluate the intersection of these techniques, adapting successful strategies for the unique population and cultural characteristics in India. Finally, the learner will be able to identify the population most at risk for HIV in India and will begin generating ideas for social work supported prevention interventions.

5.1 INTRODUCTION

HIV prevention programs have been developed and tested worldwide since the onset of the epidemic, beginning in North America and spreading across the globe. As we will see in this unit, much has been learned through trial and error about best practices, and so now, the exchange of information is bidirectional, as social workers from around the world strive to learn from each other, on how best to serve their clients. In every country, a primary challenge has been determining what is needed, and adapting methods responsive to the specific cultural, social, economic, and political climates, in which they must be implemented.

In the previous units on HIV/AIDS, we have explored the basics of viral transmission and examined how certain segments of any population come to be seen as at “high risk” for acquiring the virus. Here, we will examine how evidence-based techniques for helping such persons understand their risk and how to minimize it, have been identified and applied. We will note specific techniques developed for women, drug
users, men who have sex with men (MSM), and youth. Briefly, we will overview their origins, use, and demonstrated effectiveness in the United States and India, appreciating the similarities and differences across cultures. Additional readings are identified for those seeking further detail.

5.2 A BRIEF HISTORY OF HIV PREVENTION PROGRAMS IN THE UNITED STATES

In 1981, the first cases of what is now known as HIV were reported in the United States. The populations hit hardest in the United States were men-who-have-sex-with-men (MSM), intravenous drug users (IDU), women (especially commercial sex workers and partners of IDUs), and ethnic minorities. Because of the stigma associated with risk factors for infection, there were (and continue to be) great barriers to overcome in developing effective prevention programs. In the beginning, the Centers for Disease Control and Prevention (CDC) worked to identify the cause of the infection, developed and disseminated treatment guidelines for infection, and worked to prevent the spread of further infections. Historically, these efforts focused on three approaches (Wolitski et al., 2006):

1. prevention activities directed at persons at high risk for contracting HIV;
2. HIV counseling, testing, and referral services, and
3. prevention activities directed at improving the health of persons living with HIV and preventing further transmission

Primary Prevention

In the United States, prevention activities directed at those most at-risk for HIV started as grass-roots efforts among gay men in large metropolitan areas. The goals of these programs were to increase awareness about HIV/AIDS, dispel myths and ease fears about the spread of the disease, and most importantly, impart knowledge about how people can take precautionary measures against infection.

The CDC followed these efforts in the mid-1980’s by generating public health messages tailored to youth, persons at increased risk for HIV including MSM and IDU, racial and ethnic minority populations, pregnant women, as well as health-care workers. These messages stressed the importance of abstinence, the consistent and correct use of condoms, avoiding sharing needles when injecting drugs, perinatal testing and treatment, and universal precautions in the medical field. While these messages were essential in initiating behavior change, infection rates continued to increase among those most at risk for infection. As a result, behavioural interventions were subsequently developed and refined to provide more intensive and targeted prevention techniques. In 1999, the CDC developed the Compendium of HIV Prevention Interventions with Evidence of Effectiveness (revised in 2003), to disseminate effective prevention methods to community agencies. The present unit would expose the reader to a brief overview of techniques studied and reported in the Compendium, and compares them to current efforts being carried out in developing nations. While each study reviewed here varies on the research methodology, each meets a standard of scientific rigour of best available evidence.

HIV Counseling, Testing, and Referral Services

In 1985, the US Food and Drug Administration (FDA) implemented wide spread testing for HIV-antibodies in blood banks, health departments and health clinics.
throughout the United States. Testing of individuals includes anonymous or confidential screening, risk reduction counselling and, on HIV+ results being available, referral for treatment. Originally, testing required two visits. First, the individual was screened for risk factors, counselled on risk reduction, and a blood sample was drawn. In about two weeks, the individual would return for results. This two week long delay, often resulted in attrition, with as many as 50 per cent of the individuals failing to return for their test results (Branson et al., 2006). Since that time, many developments in testing procedures have occurred. Most promising is the development of rapid testing. An oral swab collected during the screening, allowed results to be provided within 20 minutes. During the 20 minute wait, risk reduction techniques are discussed. While this new test has greatly reduced attrition in testing and screening, there was still concern that not all individuals at risk for HIV, were being screened. To address this concern, the CDC has recommended that HIV screening be adopted into routine medical care for all individuals. Recommendations further support the development of programs to make HIV testing and counselling more attractive to those at highest risk. This often involves testing in non-traditional settings such as juvenile detention centers, churches or temples, and on the street through mobile health education.

**Prevention with HIV Positive Individuals**

Historically, prevention efforts in the United States focused on educating those at risk for infection, aiming to reduce their risk and further prevent the spread of HIV. Public health campaigns and messages were directed to individuals who were not infected, but at risk for infection; gay men, intravenous drug users, and women, for example. However, in 2003, the CDC made recommendations to shift prevention efforts to HIV+ people. Often referred to as secondary prevention, these efforts aim to reduce transmission of infection among those at highest risk for infection (the known partners of HIV positive individuals) and to also reduce the risk of re-infection among positive individuals. The impetus for this change was that despite twenty years of prevention efforts, diagnosis of new infections in the United States held steady at an estimated 55,000 individuals per year for the last decade (Hall et al., 2008). Furthermore, evidence revealed that while individuals reduced their risk for infection after receiving prevention messages and counseling, the change in behavior was not sustained over time (del Rio, 2003). The goals of secondary prevention are to promote self-protection, partner protection, and disclosure to partners, and the early detection and referral for treatment. While studies suggest that prevention with positives is possible in India (Mcgrath et al., 2007) overcoming stigma to implement this type of intervention is a challenge.

**Check Your Progress I**

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1. In the United States, what three targeted approaches have prevention guidelines focused on?

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2. What is the difference between primary and secondary prevention?

5.3 PREVENTION WITH WOMEN

United States

Prevention efforts in both the United States and in developing nations have targeted women for many reasons. Women often live in situations that do not afford them the same power as men. Furthermore, women are biologically at higher risk for HIV infection than men, due to more accessible permeable membranes during sexual penetration. Finally, to reduce mother to child transmission, prevention interventions target women who are pregnant or may become pregnant.

Interventions with women in the United States vary. The most frequently employed intervention involves group level cognitive-behavioral risk-reduction skills training. Group interventions that stress gender pride, personal responsibility, sexual assertiveness and communication, condom use, and coping skills showed improvement in consistent condom use among African American women (DiClemente & Wingood, 1995). The most notable of these interventions is the Sisters Informing Sisters About Topics on AIDS (SISTA) intervention. Participants in the SISTA program increased condom use and assertiveness with partners (DiClemente & Wingood, 1995). The overwhelming evidence supporting this intervention has resulted in the CDC adopting and promoting this intervention.

Research demonstrated that group sessions with inner-city, single, pregnant women also resulted in an increase of condom (Hobfoll, Jackson, Lavin, Britton, & Shepherd, 1994) and a decrease in unprotected sex (Kelly et al., 1994). These group interventions incorporated role playing and viewing short videos, and stressed skill building and behaviour change. Baker et al (2003) demonstrated that skills training is more effective in reducing sexually transmitted infections than health education alone.

India

Many socio-economic factors contribute to increased risk for HIV among women in India. Strict gender roles that limit a woman’s power in sexual relationships can lead to violence and sexual exploitation. Women in India have limited control in negotiating safer sex practices. Furthermore, women may have limited access to information regarding HIV, and preventive and protective resources, such as condoms and health care. Women living in rural areas of India are not utilizing prenatal testing for HIV (Sinha et al., 2008). Reasons include lack of information and inadequate resources for HIV testing. Another concern is the social costs incurred by women who test positive for HIV. Women are often blamed for spreading HIV to family members and face exclusion from their husband’s household. Clearly, the stigma
associated with an HIV diagnosis for women can be devastating. Pant Pai et al (2008) highlighted the barriers to HIV testing, and intervened by providing on-demand rapid testing to all women who appeared at one rural hospital for delivery. Rapid testing was available 24 hours a day, seven days a week. Ninety-eight percent of the women approached for this study accepted HIV testing, with 15 women testing positive. These women were provided with prevention of mother-to-child HIV transmission (PMTCT) measures. As a result, 13 infants were HIV negative at birth, and at one and four months follow-up. Two infants were HIV positive at birth and died within a month of delivery. The implication here is that HIV prevention counselling and testing with pregnant women is essential for the prevention and control of HIV infection among the unborn children. While this most recent study demonstrates that testing of pregnant women in rural hospitals is feasible, The Prevention of Parent to Child Transmission of HIV/AIDS (PPTCT) programme was started in India in 2002. It offers counselling and testing to pregnant women in 11 major hospitals in the five high HIV prevalence states (NACO, Prevention of Parent to Child Transmission section, para. 1).

The National AIDS Control Organization (NACO) in India, has identified female sex workers (FSW) as one of the populations at highest risk for infection, and has developed targeted interventions. These aim to provide awareness of HIV and promote safer sex techniques, through peer-led community outreach and referral for STI treatment; as well as through empowerment involving advocacy, education, crisis management, and “ownership” of prevention services by FSWs.

The most notable intervention with FSW in India is the Sonagachi Project (Jana, Basu, Rotheram-Borus, & Newman, 2004). Based in Calcutta since 1991, the Sonagachi Project addresses community, group, and individual factors. Community level interventions identified sex workers as key stakeholders and stressed political advocacy. Group-level interventions employed peer-outreach workers who develop social relationships with FSW. The outreach workers inquired about the immediate health problems of the FSWs, assisted in resolving them, disseminated HIV information as well as distributed condoms, as well as provided medications to FSW for STIs. Individual interventions emphasize skills and competencies, social cognitive perceptions, and social service delivery to eliminate barriers (e.g. illiteracy and financial stress).

The skills and competencies stressed by the Sonagachi Project include HIV and STI awareness and prevention techniques, including correct and consistent condom use. Outreach workers modelled positive outcomes, most importantly, self-respect. Empowerment of FSW is the foundation for success. Changing perceptions involved adopting a set of rights for FSW. These include the right to speak out, good health, freedom of movement, fulfillment in a relationship, and the right to educate their children (Jana et al., 2004). Changing the FSWs’ self-image resulted in enhanced hope, as well as empowerment to change high-risk behaviors.

Program designers stress that effective prevention efforts, must be cost effective, useful, realistic, evolving, and sustainable (Jana et al., 2004). Until treatment for STIs is more common and available, efforts such as the Sonagachi Project are rare, but essential in changing risk behavior for HIV infection.
5.4 PREVENTION WITH DRUG USERS

United States

Considering the fact that drug users are at an increased risk for HIV infection, studies have evaluated prevention interventions tailored for them. Though still dramatically stigmatized in the United States, substance abuse treatment is available. Treatment frequently entails inpatient detoxification and psychological counselling. It is during this treatment that HIV counselling and screening may be undertaken. However, many drug abusers do not seek this treatment, limiting opportunities for HIV prevention interventions and requiring creative alternatives. One early study (Des Jarlais, Casriel, Friedman, & Rosenblum, 1992) employed group sessions to non-injection heroin users in a community store front located in a high drug trafficking area. The groups presentations and role playing that ensued, resulted in the participants being less likely to inject drugs. Other effective group interventions include women in methadone maintenance programs (El-Bassel & Schilling, 1992). The five-session curriculum entails HIV transmission and prevention, condom use, and assertiveness training. Assertiveness training advocates for the expression of the right to refuse sexual advances and to negotiate safer sex practices. At the end of the sessions, women reported increased condom use with their partners. While this model may not be appropriate for women living in India, there are components that can be adapted in a culturally sensitive manner to those most at risk.

More recent interventions include the Self-help in Eliminating Life-Threatening Diseases (SHIELD) Project (Latkin, Sherman, & Knowlton, 2003), incorporating social networking and peer outreach among both HIV positive and HIV negative...
current drug users. Participants were trained to provide outreach and risk-reduction counselling. SHIELD stresses on developing a sense of community for current drug users, and emphasizes harm reduction aiming to decrease the potential dangers and health risks associated with risk behaviour while at the same time recognizing that the risk behaviour itself may not be eliminated entirely. “Throughout the intervention, participants were encouraged to conduct HIV education and advocate risk reduction among their sex and drug partners, family and friends, and other community members” (Latkin et al., 2003, p. 334). Participants reported less sex and drug risk behaviors six months following the intervention.

India

NACO has identified IDUs as being at highest risk for infection in India, endorsing detoxification and rehabilitation, needle exchange, and access to health services to IDUs to reduce risk and prevent further disease transmission. Partners of IDUs are also at increased risk for infection. A study in Manipur demonstrates how much these individuals are at risk. “Within seven years of the onset of an explosive HIV epidemic among IDUs, 45% of the wives of HIV positive IDUs acquired HIV through sex within monogamous marital relationship” (Panda, Azim, Rehman, Poudel, & Chaudhuri, 2007, p. 896). Clearly, prevention interventions among IDUs are needed. Methods to achieve prevention goals are similar to those employed with FSW; peer led community outreach and information dissemination, referral health services, and community-building. Still, the stigma of substance use is a formidable barrier to effective prevention efforts.

Community building calls for involving key stakeholders, including IDUs, local officials, and health care providers to communicate issues and concerns and developing consensus. Hangzo et al. (1997) developed an intervention with IDU in Manipur. To successfully implement the intervention, researchers first worked with community officials to prevent police and military harassment of outreach workers and IDUs. Next, outreach to IDUs utilising the social networks was undertaken and it included family and friends. Outreach workers from varying ethnic backgrounds were trained to conduct prevention outreach in the community. Outreach workers distributed prevention information and made referral for medical care, meeting IDUs in shooting galleries, drop-in centers, treatment centers, and jails. This study clearly demonstrated that a community level intervention with IDUs can be implemented.

Finally, the Society for HIV/AIDS and Lifeline Operation in Manipur (SHALOM) located in Churachandpur, is a community-based organization that conducts a syringe and needle exchange program (SNEP). Components of SNEP include a facility where IDUs can go to exchange used syringes for new ones and get free condoms, and outreach workers who assess social and medical needs. While this program is effective in reaching those IDUs, more than three-fourths of the users of SNEP were HIV positive and reported engaging in high-risk sexual behavior (Eicher, Crofts, Benjamin, Deutschman, & Rodger, 2000). These researchers encourage SHALOM SNEP to expand their outreach efforts to newer IDUs, and to increase sexual risk prevention education.
Check Your Progress III
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1. What is harm reduction? Can you think of several interventions that successfully incorporate harm reduction?
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2. What are some components of effective community building?
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5.5 PREVENTION WITH MSM

United States
In the United States, HIV first involved men-who-have-sex-with-men. The most common empirically supported methods for interventions include outreach in the community and small, peer-led groups. Kegeles, Hays, and Coates (1996) combined community outreach, a social marketing campaign, and a small peer-led group intervention to demonstrate that participants reduced frequency of unprotected anal intercourse. Small group interventions often employ role-playing and lectures to develop risk reduction skills. HIV risk reduction, behavioural self-management, assertiveness skill training, relationship skills and social support development are components of an effective intervention with MSM, resulting in reported reduction of unprotected anal intercourse and an increase in condom use (Kelly, St. Lawrence, Hood, & Brasfield, 1989).

In addition to skills-training, some small group interventions work to promote the social acceptability of safer sex (Valdiserri et al., 1989). Outreach efforts must be creative and adapted for the targeted population and intervention setting. Frequently, interventions take place where MSM socialize. Training gay men to effectively promote HIV risk reduction behaviors followed by disseminating this message to peers proved an effective intervention in gay bars (Kelly et al., 1991).

Other times, individual counselling may be the most appropriate intervention. Because MSM in the United States have been the most frequently targeted population for HIV prevention messages, interventions can become stale. Prevention fatigue has been cited as one possible reason that MSM continue to engage in high-risk behavior. To address this issue, Dilley, et al. (2002) adapted prevention messages during counselling and testing with MSM to create a new intervention with this population.
Participants were asked to keep journals of sexual encounters between counseling sessions, and to indicate reasons for engaging in unprotected anal intercourse. The primary focus was how participants justified unprotected sexual activity. At follow-up, participants reported a decrease in unprotected anal intercourse. Clearly, both group and individual level prevention interventions MSM are feasible and effective in reducing unprotected sexual risk behavior. Determining whether these reduce rates of infection is harder. EXPLORE (Koblin, Chesney, & Coates, 2004) consisted of ten individual counselling sessions focusing on risk behaviour, including sexual and substance abuse. These sessions were highly intensive, and incorporated motivational interviewing and cognitive behavioral therapy (CBT). On completion, participants registered 18.2% fewer new HIV infections (Koblin et al., 2004).

India

Men-who-have-sex-with-men is a description of a sexual activity between two men. It does not address the sexual identity or orientation of the males involved. MSM may see himself as homosexual, bisexual, or heterosexual. He may have both male and female partners regardless of his sexual identity. If he is a sex worker, he may see his sexual activity as merely a means to earn money and support his family. He may perceive sexual activity between men as an expression of his masculinity or femininity. Regardless of how the MSM thinks of his behavior, often times, MSM are stigmatized, discriminated against, and even criminalized. Complex cultural, religious, moral, and political structures impact the lives of MSM. The result is often an invisible population of men at high-risk for HIV.

The frequent discounting of MSM in India may result in inaccurate or conflicting estimates of the rates of HIV infection. For years, researchers have recognized that government estimates of the number of MSM and their HIV prevalence in India are inexact (Godbole & Mehendale, 2005). In response, a randomized cross-sectional analysis was conducted in Chennai in 2001, demonstrating that 5.9% of the men surveyed reported that they have had sex with men and were more likely to be HIV positive than men who did not report same-sex encounters (Go et al., 2004). Other cross-sectional studies demonstrated that in rural regions of India, nearly “10% of single and 3% of married men had had unprotected anal sex with a man” (Verma & Cumbulumbien, 2004, p. 1854).

In addition, there have been very limited empirically supported studies of HIV prevention for MSM, though there are qualitative and ethnographic studies, often focusing on the anthropological phenomenon of identity development, Hijras, and Kothis (Boyce, 2007). Other studies explore the sexual behaviors and experiences of MSM in India (Chakrapani, Newman, Shunmugam, McLuckie, and Melwin, 2007; Sri Krishnan et al., 2007).

NACO nevertheless identifies MSM as a high-risk population. Targeted interventions to MSM are designed to minimize the spread of infection to the general population, as was seen with FSW. Prevention interventions with MSM emphasize the importance of peer educators, promotion of behaviour change, access to and the use of condoms. One organization that has been essential in prevention efforts with MSM in India is Naz Foundation International (NFI). Since its inception in 1996, NFI has worked to assist communities in capacity building for the advocacy for the rights of MSM and HIV prevention.
Best Practices in HIV/AIDS Prevention and Education

While there are other NGOs that conduct prevention and outreach to MSM (e.g., Sahodaran, The Social Welfare Association for Men and The Indian Community Welfare Organization) there are no identifiable evaluations of the efficacy of these agencies and interventions. One possible explanation is that these agencies face many barriers, including harassment from police and other government officials (Safren et al., 2006).

Still, preventative interventions must continue in order to curtail the spread of HIV. One highly effective intervention is male circumcision. Studies have demonstrated that male circumcision is effective in reducing the spread of HIV. Comparing rates of infection between circumcised and uncircumcised men, one study demonstrated that among Indian men, circumcision resulted in a 6.7 fold reduction in the rate of infection (Reynolds et al., 2004). Clearly, there is a demonstrated need for prevention with this population. Despite the overwhelming barriers faced by MSM and MSM outreach workers, there are interventions that are effective. However, it may be the process of tackling the barriers to prevention with MSM that proves to be the most significant task.

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<td>1. Which is more effective in reducing risk among MSM, group or individual level interventions?</td>
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<td>2. According to NACO, what should prevention efforts with MSM include?</td>
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5.6 PREVENTION WITH YOUTH

United States

Prevention efforts with adolescents and young adults in the United States began in the 1980s. A large literature exists on effective interventions designed for youth. Youth are at an increased risk for HIV due to biological, psychological and social factors, including peer pressure and the natural tendency to explore a developing sense of sexuality.
Culturally and ethnically appropriate group interventions are often used. One such intervention for adolescent males held at an inner-city school on a Saturday morning incorporated games, videos, and exercises. Students were taught about safer sex practices including condom use and abstinence, and participants reported more frequent condom use and fewer sexual partners (Jemmott, Jemmott, & Fong, 1992). Other culturally appropriate interventions for low-income African Americans have been implemented in recreation centers in public housing developments (Stanton et al., 1996). One involved peer group learning during multiple group sessions. Discussions focused on values, goal setting, HIV transmission and prevention, human development, and contraception. Storytelling and role playing were also employed, and sexually active adolescents reported greater condom use after participation. St. Lawrence et al. (1995) also studied the effects of a cognitive behavioral intervention with African American adolescents. The Becoming a Responsible Teen (BART) intervention is an eight week intervention for inner city youth at a public health clinic for low-income families. Topics included AIDS education, sexual decisions and values, technical skills, social skills, cognitive skills, and empowerment. Findings showed greater condom use, reduced frequency of unprotected intercourse, and delay in sexual activity onset.

Other interventions include adapting school curriculum. Reducing The Risk (Kirby, Barth, Lelan, & Fetro, 1991) addressed the need for HIV education in large school districts. Based on social learning and cognitive behavioral theories, it develops social skills to reduce sexual risk taking behaviour, and employs role playing activities in the classroom. Students learn how to communicate with partners about delaying sexual activity. Students receiving the intervention were less likely to initiate sexual activity and to engage in unprotected sexual intercourse.

These interventions demonstrate that youth can be reached in a variety of settings, including the school, the health care facility, or the neighborhood. A small group intervention to runaway youth in New York City (Rotheram-Borus, Van Rossem, Gwadz, Koopman, & Lee, 1997) was designed based on social learning theory, and focused on reinforcing positive behaviors. Participants were taught about HIV transmission and prevention, used role playing to develop social skills, explored available resources, and discussed attitudes and norms. Results included less unprotected sexual encounters and a reduction in substance use following this intervention (Rotheram-Borus et al., 1997).

Clearly, designing, implementing, and evaluating interventions for youth is challenging. The following guidelines for interventions targeted to youth have been recommended (DiClemente et al., 2008):

- tailor interventions to meet the needs of the population;
- target those behaviors most amenable to change;
- utilising the family as a behavioral change agent;
- expand the scope of STI/HIV intervention programs, beyond individuals;
- incorporate long-term maintenance strategies into interventions;
- incorporate biological outcomes as a measure of program efficacy; and
- translate and disseminate effective STI/HIV interventions.

These recommendations for best practice are clearly visible in the Sistering, Informing, Healing, Living, and Empowering (SiHLE) Project (DiClemente et al, 2004), serving African American adolescent females recruited from community
health centers. The intervention involved four group sessions which stressed ethnic and gender pride, HIV transmission and prevention, skills building, communication and healthy relationships. Participants reduced new sexual partners, and improved consistent and correct condom use. As a result, SiHLE Project has been adopted by the CDC as a model for effective intervention with adolescent African American females (Wingood & DiClemente, 2006).

India

The United States President’s Emergency Plan for AIDS Relief (PEPFAR) provides funding for HIV treatment and prevention in developing nations. A key component to PEPFAR funding is implementing the ABC approach to prevention. ABC stands for Abstinence, Be Faithful, and Correct and Consistent Condom Use. While ABC is not an actual intervention or program, it is a fundamental philosophy embraced by PEPFAR to guide population specific interventions globally. The principle components include delaying sexual activity for non-married individuals, ending casual sexual activity, eliminating cross-generational transactional sex, focusing on marital fidelity, adopting correct and consistent condom use and HIV counseling and testing. PEPFAR supports NACO in its prevention efforts, including efforts directed toward youth.

There are a disproportionate number of youth infected with HIV in India; 31% of the identified cases with HIV occur in individuals, between the ages of 15 and 29 years (NACO, Youth section). Young people are faced with many challenges which place them at high risk for HIV including changing bodies, family concerns, social and cultural influences, gender imbalances, economic and financial struggles, and the pressures of a changing world. Globalization and urbanization compete with traditional cultural values and beliefs, and teens are often conflicted. Young girls face different pressures than boys based on differing socially accepted gender norms. Starting at a young age, youth may need to contribute to the family income, be forced to work long hours, and sacrifice formal education for family survival. These contributing factors lead to an increased vulnerability for HIV among youth in India.

To address these needs, several initiatives have been endorsed by the Indian government, including the National Population Policy, the National AIDS Prevention and Control Policy, the National Youth Policy and the Reproductive and Child Health (RCH) Programmes. NACO has created multiple interventions targeted towards youth, both in and out of school, which promote healthy, responsible lifestyles. The Adolescence Education Programme (AEP) incorporates HIV/AIDS prevention education into life-skill training curriculum delivered to school-aged youth. Included in this programme is the School AIDS Education Programme. The curriculum focuses on family life, human growth and development, abstinence, and life skills. Other programs include the Red Ribbon Club, HIV education programmes on college and University campuses, and Youth Unite for Victory on AIDS, providing life skill education and counselling to adolescents.

Recently, a research team conducted brief HIV education intervention in seven villages in Western Rajasthan involving 78 girls between the ages of 12 and 19. Educational sessions consisting of visual aids were presented in local dialects. Topics included HIV transmission, prevention, and management. Myths about HIV were also discussed. A post test revealed significant increases in HIV knowledge among adolescent girls living in rural villages (Trivedi, Joshi, & Levine, 2008).
These examples are just a few of the initiatives and programs designed to address the HIV prevention and education needs of youth living in India. For a more extensive review of these initiatives and other programs not discussed here, please refer to *Young Peoples Sexual and Reproductive Health in India: Policies, Programs, and Realities*, a regional working paper produced by the Population Council (Santhya & Jejeebhoy, 2007). Till date, there are few empirically supported studies evaluating the effects of these education programs, and results vary (Chhabra, Springer, Rapkin, & Merchant, 2008; Ghosh, Chhabra, Springer, & Sharma, 2008). Even fewer identifiable studies examine the efficacy of prevention interventions with high-risk adolescents in India. There is a dire need and great opportunity for social workers to develop, implement, and evaluate prevention interventions with high risk adolescents in India.

Check Your Progress V

**Note:** Use the space provided for your answer.

1. What are the seven guidelines for interventions with youth?

2. What does ABC stand for? What are the components of this policy?

### 5.7 LET US SUM UP

This chapter briefly outlines the history of HIV prevention efforts in the United States, and provides an overview of empirically supported prevention interventions for populations at highest risk for infection. Efforts currently implemented in India are also reviewed. The evaluation of the intersection of Western and Indian techniques provides a basis for adapting successful strategies for the unique population and cultural characteristics in India. You should now be able to identify the populations most at risk for HIV in India and begin generating ideas for social work supported prevention interventions for these people.

### 5.8 FURTHER READINGS AND REFERENCES


Understanding and Responding to Stigma & Discrimination


