VERMONT YOUTH HIV PREVENTION NEEDS ASSESSMENT

Project Summary - February 2005

Vermont Department of Education
Safe and Healthy Schools
(802) 828-0570

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I. Background Information

Population Definition

The target population is defined as people between 13 and 24-years-old who are currently either out of school (e.g., stopped attending school or graduated from school), enrolled in an alternative educational program, or enrolled in public school.

Interviewees

Phase I: Interviewees included service providers who work in some capacity with youth who are currently out of school. A total of 118 service providers were interviewed.

Phase II: Interviewees included health educators of alternative educational programs. These programs included approved and recognized independent schools, recognized schools, state-approved tutorials, state-approved programs, and state-operated facilities listed in the Vermont Education Directory. A total of 46 health educators were interviewed.

Phase III: Interviewees included health educators of public schools. A total of 28 health educators were interviewed.

A total of 192 phone interviews were conducted across all 3 phases of this project.

Number of Students

Interviewees were asked to estimate how many youth (aged 13-24) their organization, program, or school had served in the past year.

Phase I:	Organizations serving out of school youth	62,087
Phase II:	Alternative educational programs	5,053
Phase III:	Public Schools	16,236
	Total	83,376 youth served

NOTE:

This number includes all youth reported by interviewees, even if they are younger than 13 or older than 24 (i.e., outside the population definition for this report).

II. Overall Summary of Interviewees' Responses

Several items of interest were asked of interviewees in all 3 phases of this project:

A. Which HIV prevention interventions do you provide to youth?
B. Which HIV risks do you address with youth?
C. What resources would you need to improve HIV education?
D. Are there any (e.g., not limited to HIV) services lacking for the youth you serve?

The phone interviews for each phase were modified to fit the settings in which the interviewees were working with youth. Because the interviewees in Phases II and III were working in educational settings, the interviews used in those phases were quite similar. The interview for Phase I, however, differed more significantly from the other two, because it was geared toward a wide variety of service providers, some of whom might not provide HIV education of any sort to the out of school youth with whom they were working. This project summary focuses on those content areas that are similar across all three projects, in order to have an overview regarding how 13-24-year-olds in Vermont are being provided with HIV education and prevention.

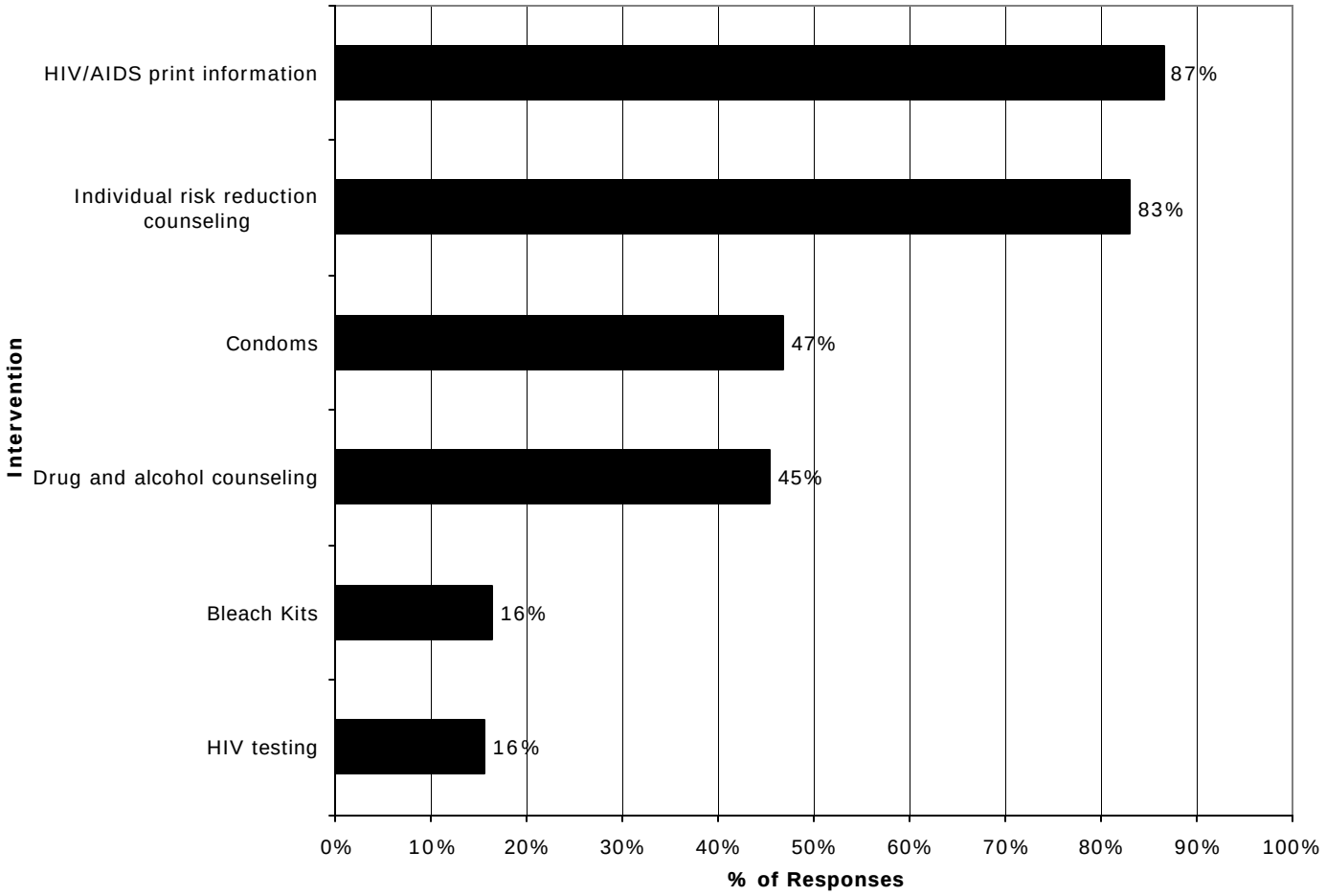
Given that this report is a summary of three phases of a project looking at HIV prevention for youth in Vermont, not every response from the original phases is included. For instance, charts, unless otherwise noted, only include responses from 10% or more of all interviewees. For a full view of more responses, see the individual reports for each phase, at:

www.state.vt.us/educ/new/html/pgm_coordhealth.html

Unless otherwise noted, the percent of responses is based on a total of 192 interviewees. Several questions, however, were not asked of every interviewee. For instance, several items for Phase I were only asked of service providers who stated that they do provide some sort of intentional HIV education or prevention to youth.

HIV Prevention Provided

Interviewees were asked about which types of HIV interventions they provide to the youth with whom they work.



NOTES

HIV/AIDS print information: this response occurred equally across all three phases

Individual risk reduction counseling: this response occurred equally across all three phases

Condoms: 74% of these responses were from interviewees in out–of school settings (Phase I)

Drug and alcohol counseling: 91% of these responses were from interviewees in either alternative educational programs (Phase II) or public schools (Phase III)

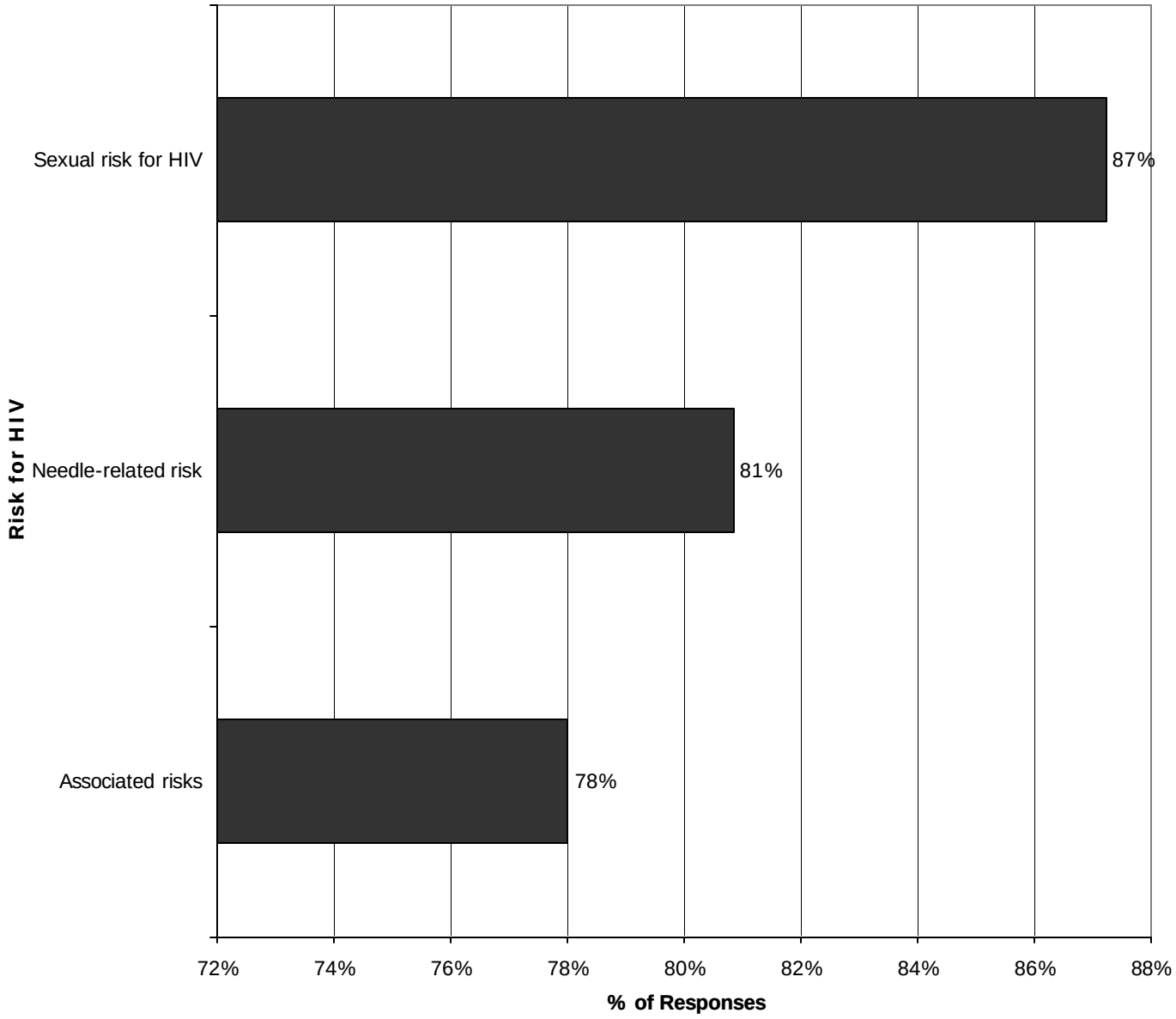
Bleach kits: 97% of these responses were from interviewees in out-of-school settings (Phase I)

HIV testing: 68% of these responses were from interviewees in out-of-school settings (Phase I), and 32% were from interviewees in alternative educational settings (Phase II)

Note: A total of 141 interviewees responded to this question. Not all interviewees for Phase I were asked this question, only those who stated that they provide some sort of HIV education for youth.

HIV Risks Addressed with Youth

Interviewees were asked about which HIV risk factors they addressed with youth.



NOTES

Sexual risk for HIV: includes both opposite-sex and same-sex sexual activity

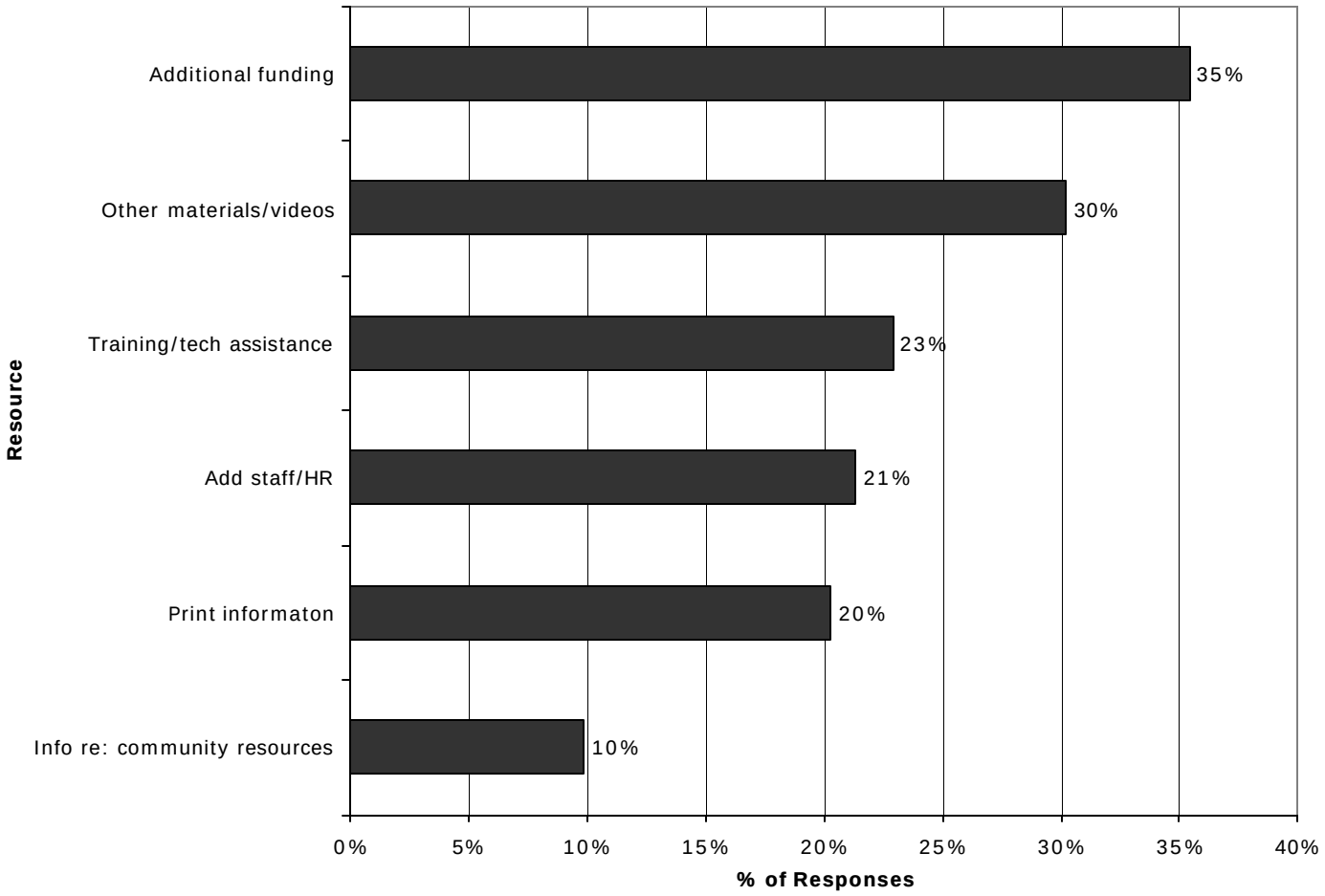
Needle-related risk: includes injecting drugs or steroids, tattooing, and piercing

Associated risks: includes indirect risks for HIV, such as low self-esteem and being under the influence of drugs or alcohol

Note: A total of 141 interviewees responded to this question. Not all interviewees for Phase I were asked this question, only those who stated that they provide some sort of HIV education for youth.

Resources Needed to Improve HIV Education

Interviewees were asked which resources they would need to improve their ability to provide HIV prevention to the youth with whom they work.



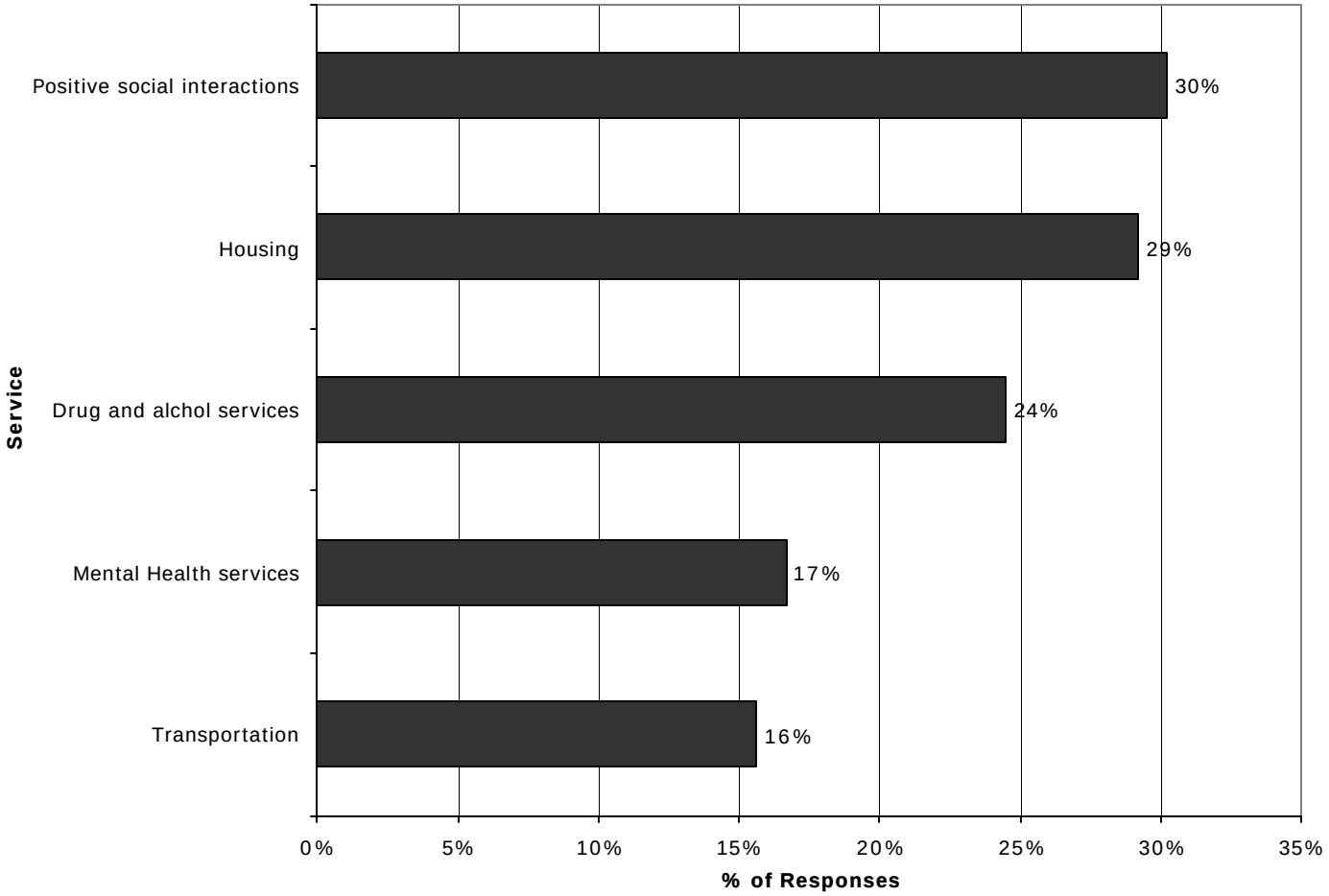
GENERAL NOTE

Interviewees from Phase I (out-of-school settings) were responsible for the majority (52-88%) of responses to this survey question, across all categories.

Interviewees from all three phases responded more equally in terms of wanting "Other materials/Videos," with "Videos" being the most common response.

Services Lacking for Youth

Interviewees were asked whether they noticed any services lacking for youth. This question refers to any service, and is not limited to HIV-related services.



EXAMPLES/NOTES

Positive social interactions: teen centers, after school activities, healthy social and recreational choices

Housing: transitional housing, group homes, half-way houses, housing for at risk youth

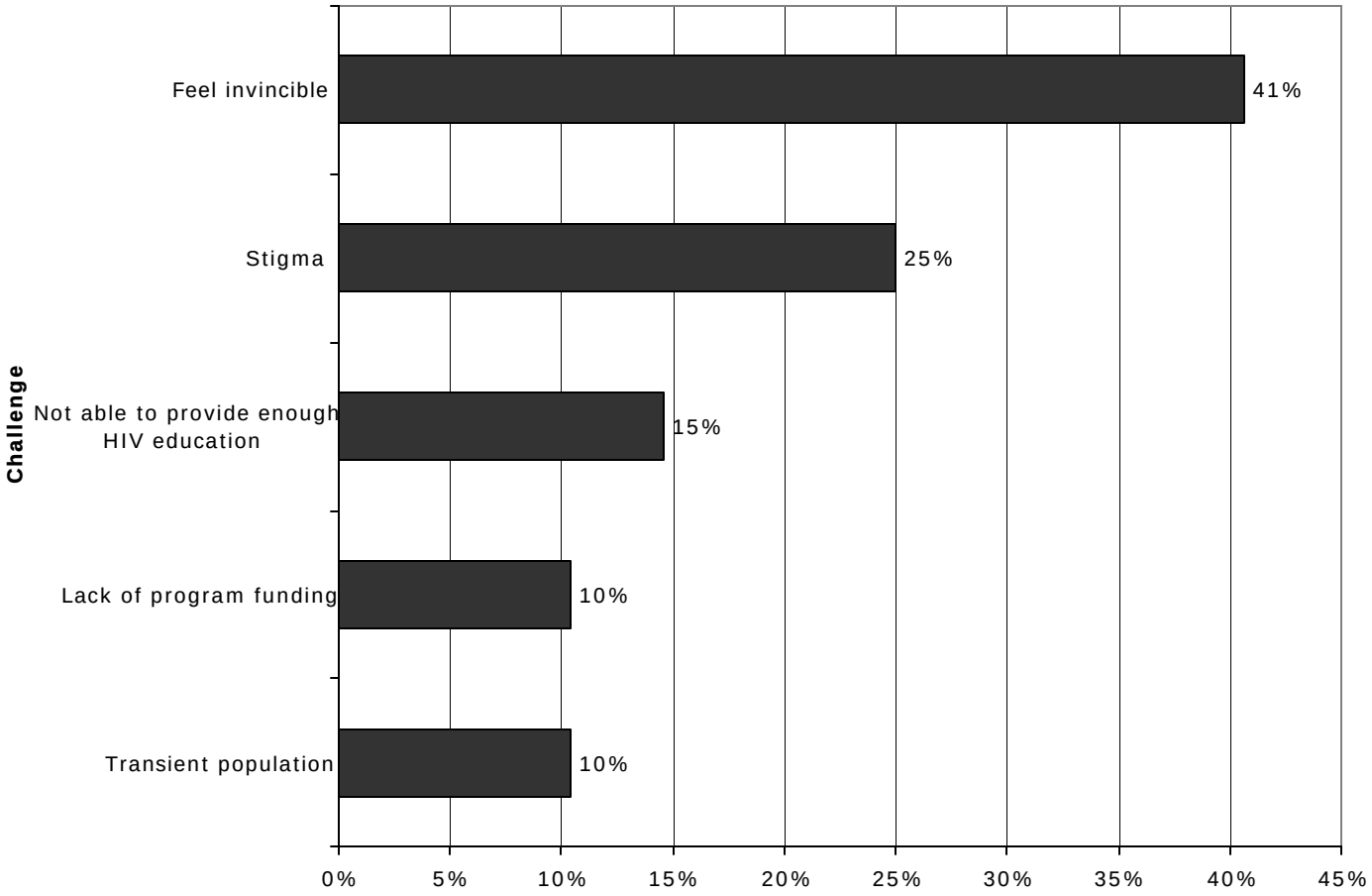
Drug and alcohol services: drug rehabilitation, drug and alcohol counseling, drug abuse services aimed at teens, support groups for drug and alcohol prevention

Mental health services: mental health services for low-income youth, crisis counselor for youth, more mental health counselors, community mental health services

Transportation: particularly mentioned as an issue in rural areas

Challenges to HIV Prevention?

Interviewees were asked what they thought the challenges or barriers were to reaching youth with HIV information or prevention.



EXAMPLES/NOTES

Feel invincible: HIV does not feel relevant to students, students think they already know all the information, students feel immortal, invincible, and invulnerable (generally speaking)

Stigma: school and/or community resistance to HIV prevention, embarrassment about discussing HIV, homophobia and stereotypes, fear of being stigmatized for asking about HIV

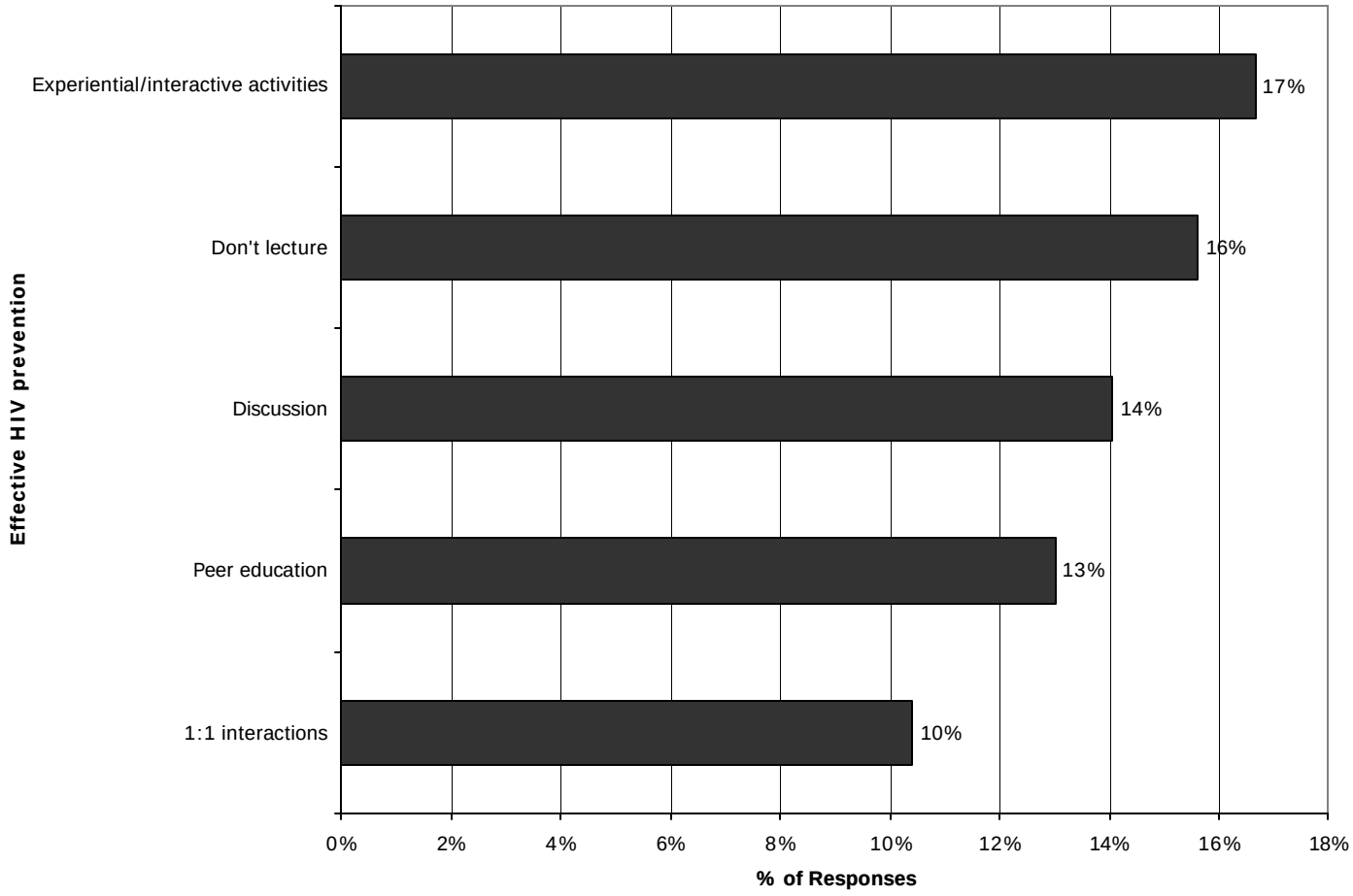
Not enough HIV ed: educators need more training to keep current with HIV education, lack of early HIV education, lack of time to cover HIV with youth

Lack of funding: lack of program funding, lack of resources and staff *[only reported in Phase I]*

Transient population: youth are hard to keep up with, scattered *[only reported in Phase I]*

Effective HIV Prevention?

Interviewees were asked what they had found was effective in terms of reaching youth with HIV prevention messages.



EXAMPLES/NOTES

Experiential/interactive activities: interactive, hands-on activities, role playing, skills-building

Don't lecture: don't try to change behavior, non-judgmental attitude, not preaching – just delivering information, youth should feel listened to

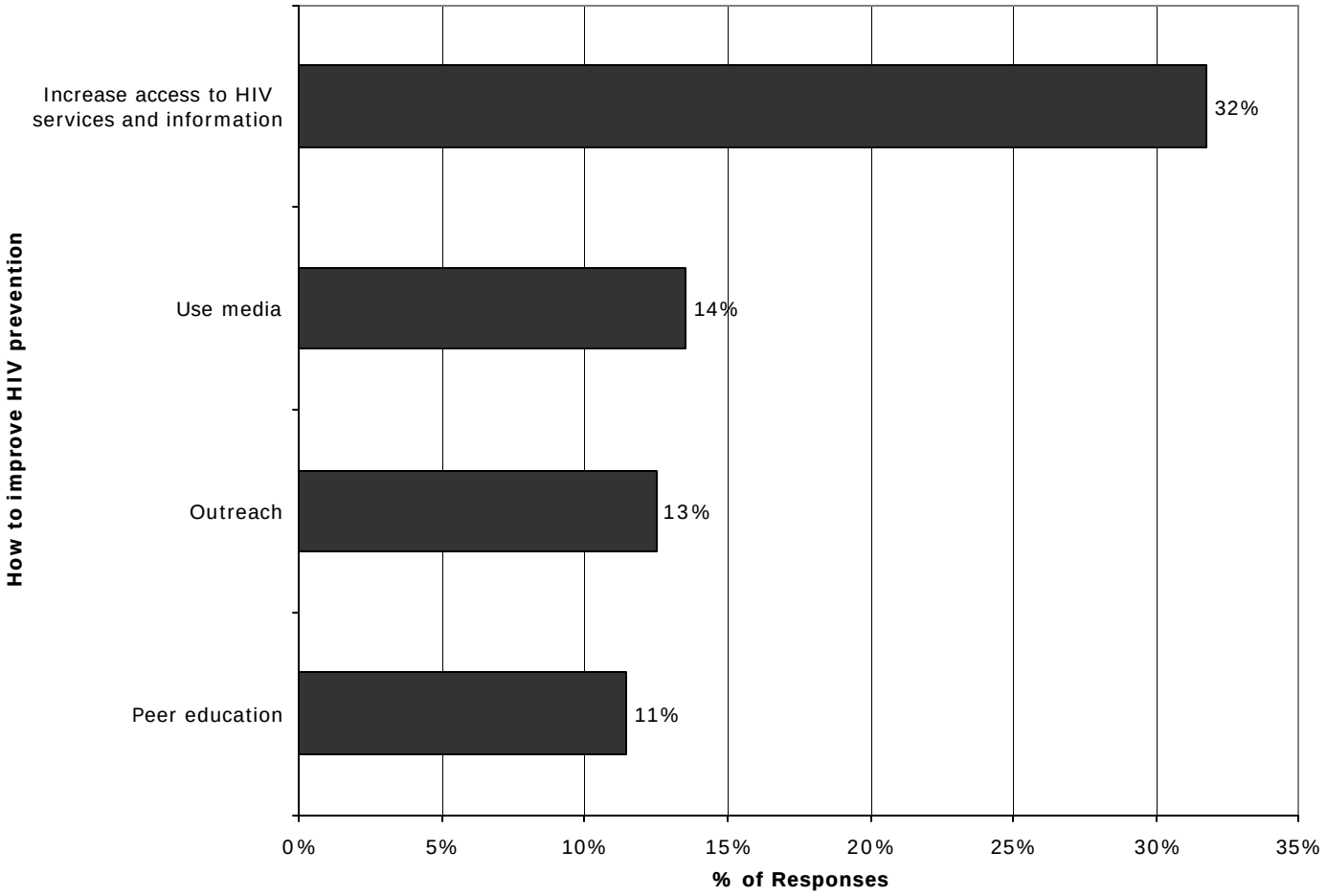
Discussion: teen focus group, dialogue nights, open discussion, group format, work hard to have an open dialogue among students

Peer education: speakers with experience - especially peers, peer speakers who are HIV+, student-to-student presentations

1:1 interactions: establishing individual relationships, knowing students well, one-on-one counseling with youth

How to improve HIV Prevention?

Interviewees were asked for their opinion on how to improve HIV prevention for youth in Vermont.



NOTES

Increase access to HIV services and information: provide HIV services to youth when they access [other] services, integrate HIV with existing curricula, free condoms, make syringe exchange accessible to people under 18, make HIV information available to students 24/7, need access to kid-friendly websites on HIV, have recreational/social programs which also provide HIV information, have a drop-in or mobile clinic with birth control, HIV info, and HIV testing

Use media: radio, TV, posters, literature, succinct visual messages, use media to increase public awareness and promote discussion, use internet or media to reach students with HIV information

Outreach: on-street programs, talking to kids where they are, creative outreach strategies - beyond just providing the information *[only reported in phase I, out-of-school youth]*

Peer education: having young people with experiences with HIV/AIDS share with other young people, use peer educators as guest speakers, HIV+ peer guest speakers, have high school students teach HIV to their peers

III. Summary of Interviewees' Responses, Phases II and III: Formal HIV Education and School/Community Coordination

Phases II and III were focused on youth in educational settings and involved interviewing health educators in alternative educational settings and in public schools, respectively. Due to interviewing health educators, both phases included more specific questions about formal HIV education as well as questions about school/community coordination regarding serving students. The responses to these questions are summarized below.

A. Formal HIV Education

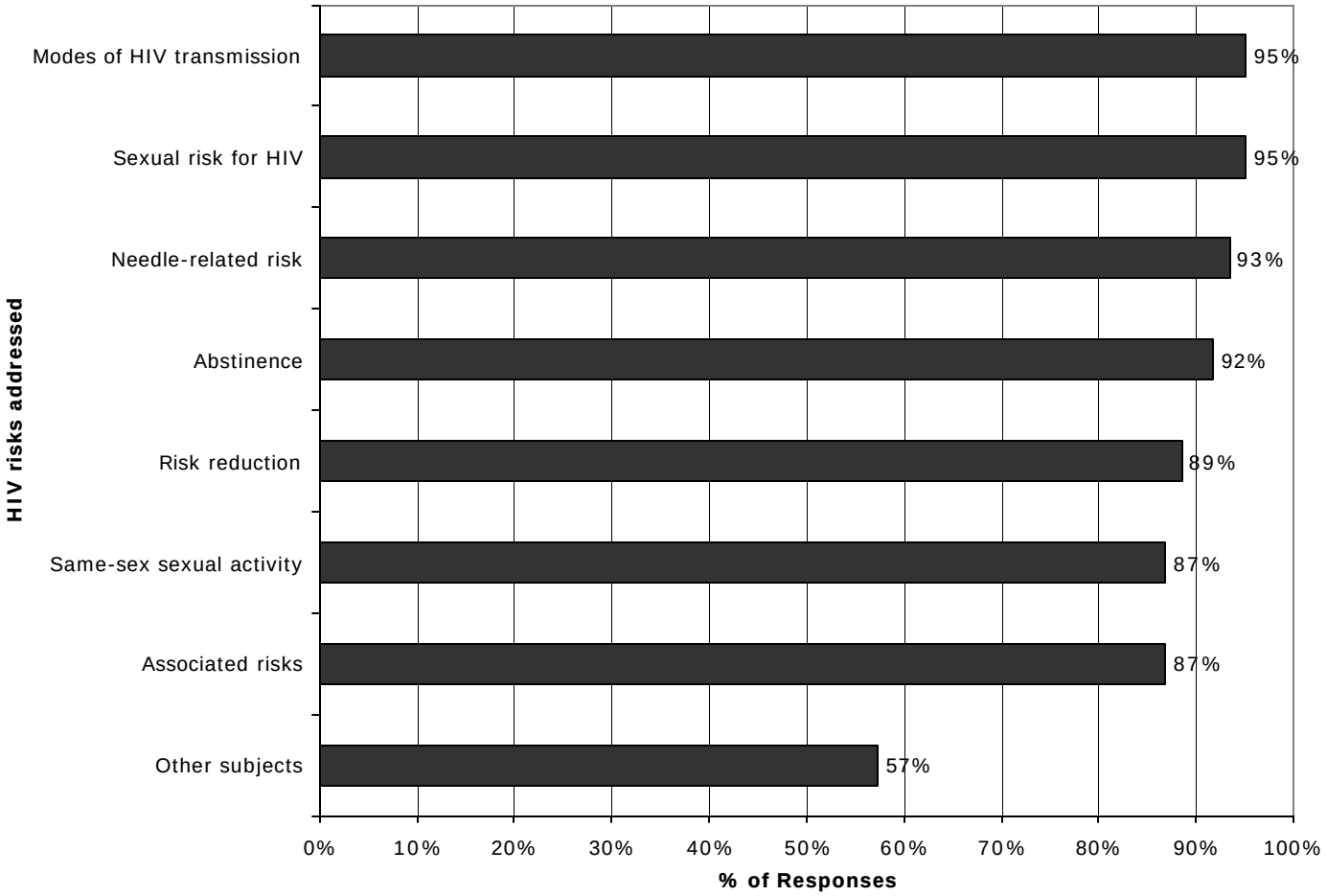
A total of 61 interviewees from Phases II and III responded to more specific questions about HIV education. Interviewees were asked the following questions:

1. Which risks for HIV do you address with students as a part of formal HIV education?

2. Which teaching approaches do you use as part of teaching students about HIV?

For both of the above questions, interviewees were presented with a list of possible answers; a summary of their responses is included in the following two charts.

HIV Risks Addressed

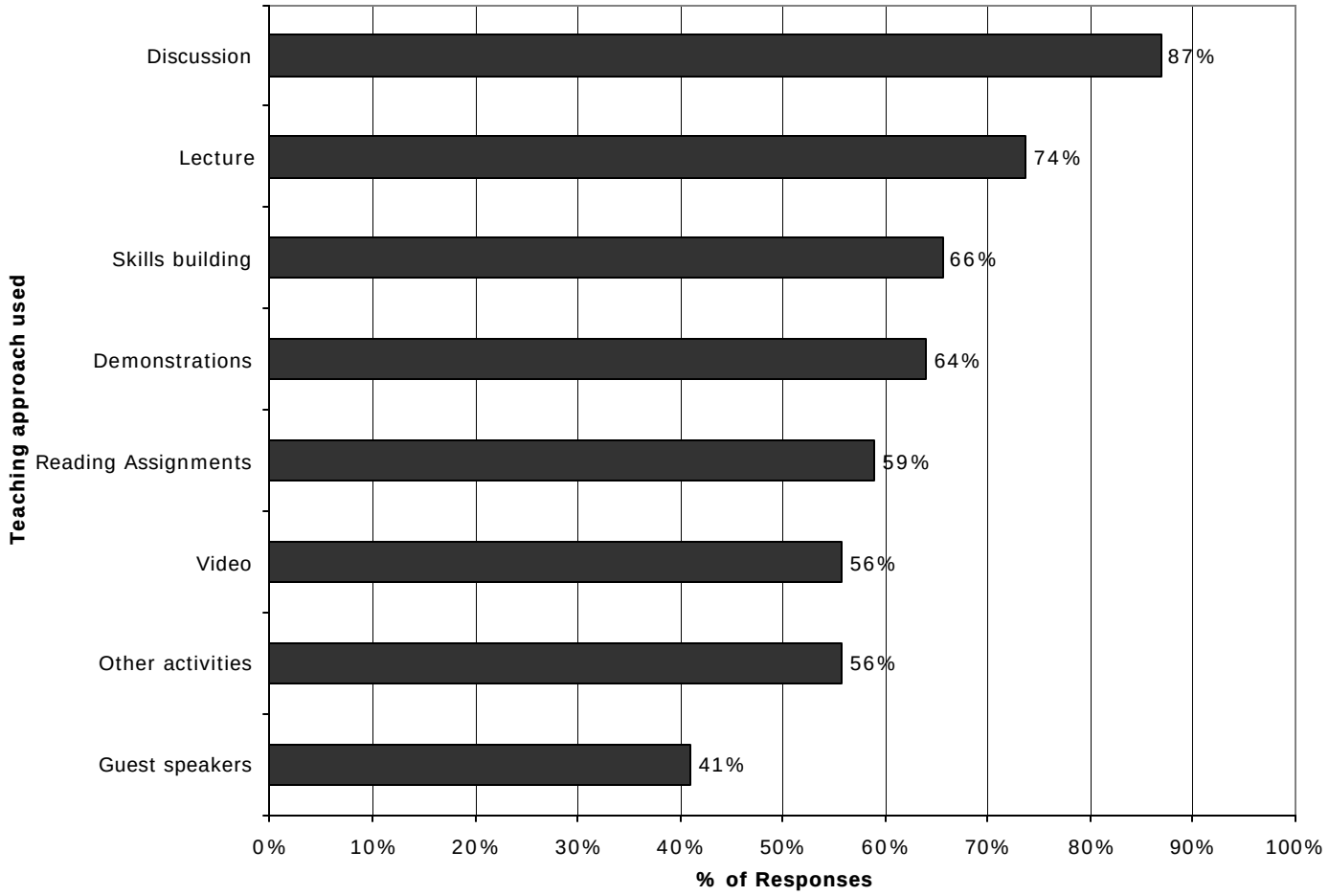


NOTE

The above chart represents responses from a total of 61 participants in Phases II and III.

Teaching Approaches Used for HIV Education

Interviewees were asked which teaching approaches they used for HIV education.



NOTE

The above chart represents responses from a total of 61 participants in Phases II and III.

B. School/Community Coordination

Interviewees in Phases II and III were asked several questions about school/community coordination. Questions about school/community coordination were not limited to the area of HIV prevention, but were intended to include coordination of any type that was meant to address students' needs. These questions reflect an underlying value inherent in this study, regarding collaboration between various organizations, community and educational. Interviewees were asked a series questions:

1. a) Do you see a need for increased school/community coordination?

   b) If so, what do you see as the obstacles to that coordination?

   c) How could those obstacles be overcome?

2. a) Have you noticed successful school/community coordination?

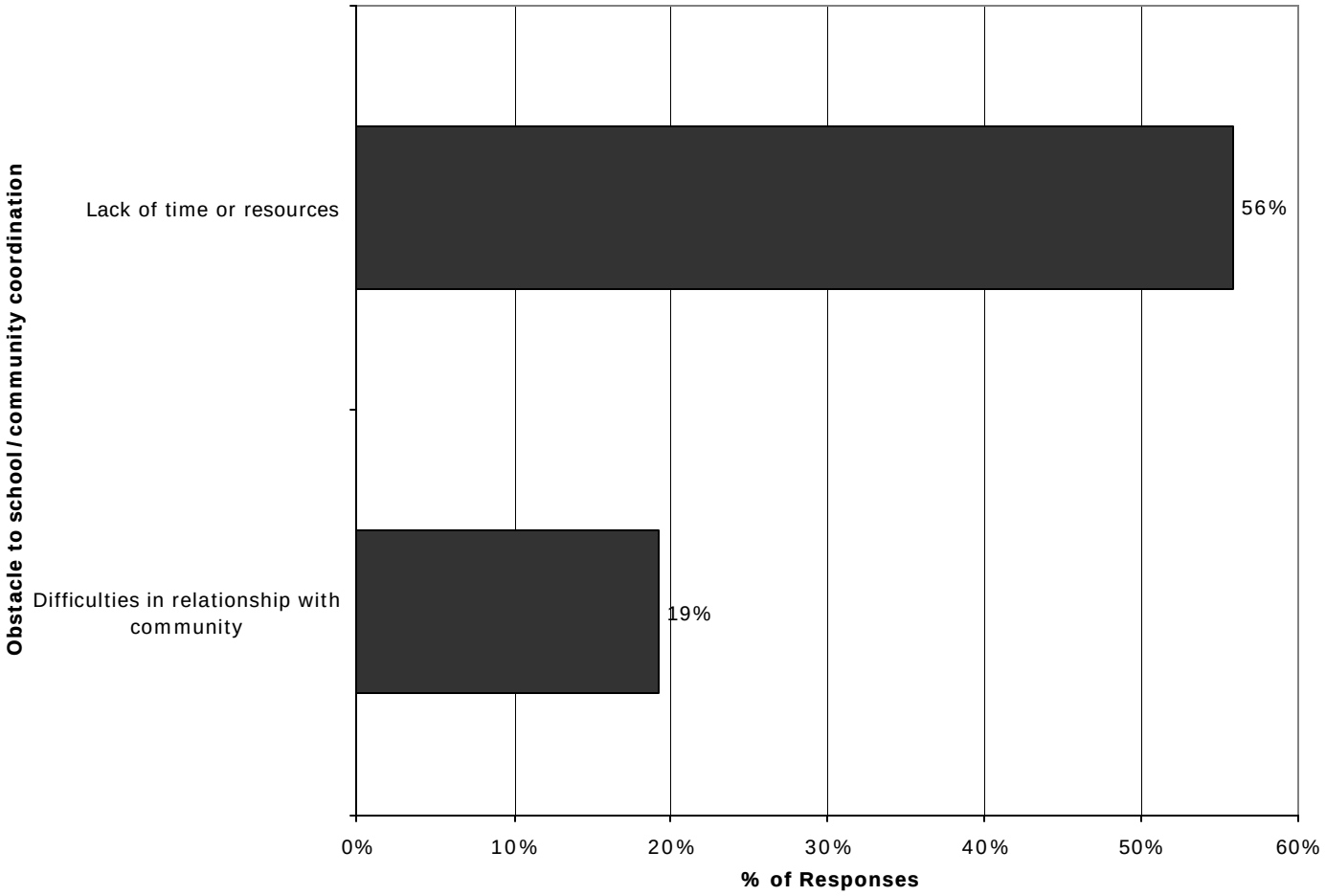
   b) If so, what helped facilitate that coordination?

N = 61	**Interviewees reporting a need to increase school/community coordination**
Phase II Alternative Educational Programs	31
Phase III Public Schools	21
Total	52

The above table summarizes the responses of 61 interviewees in Phases II and III, who responded that they see a need for increased school/community coordination.

Obstacles to Successful School/Community Coordination

A total of 52 interviewees responded that they saw a need for increased school/community coordination. They were then asked a follow-up question about what they thought were the obstacles to this sort of collaboration.



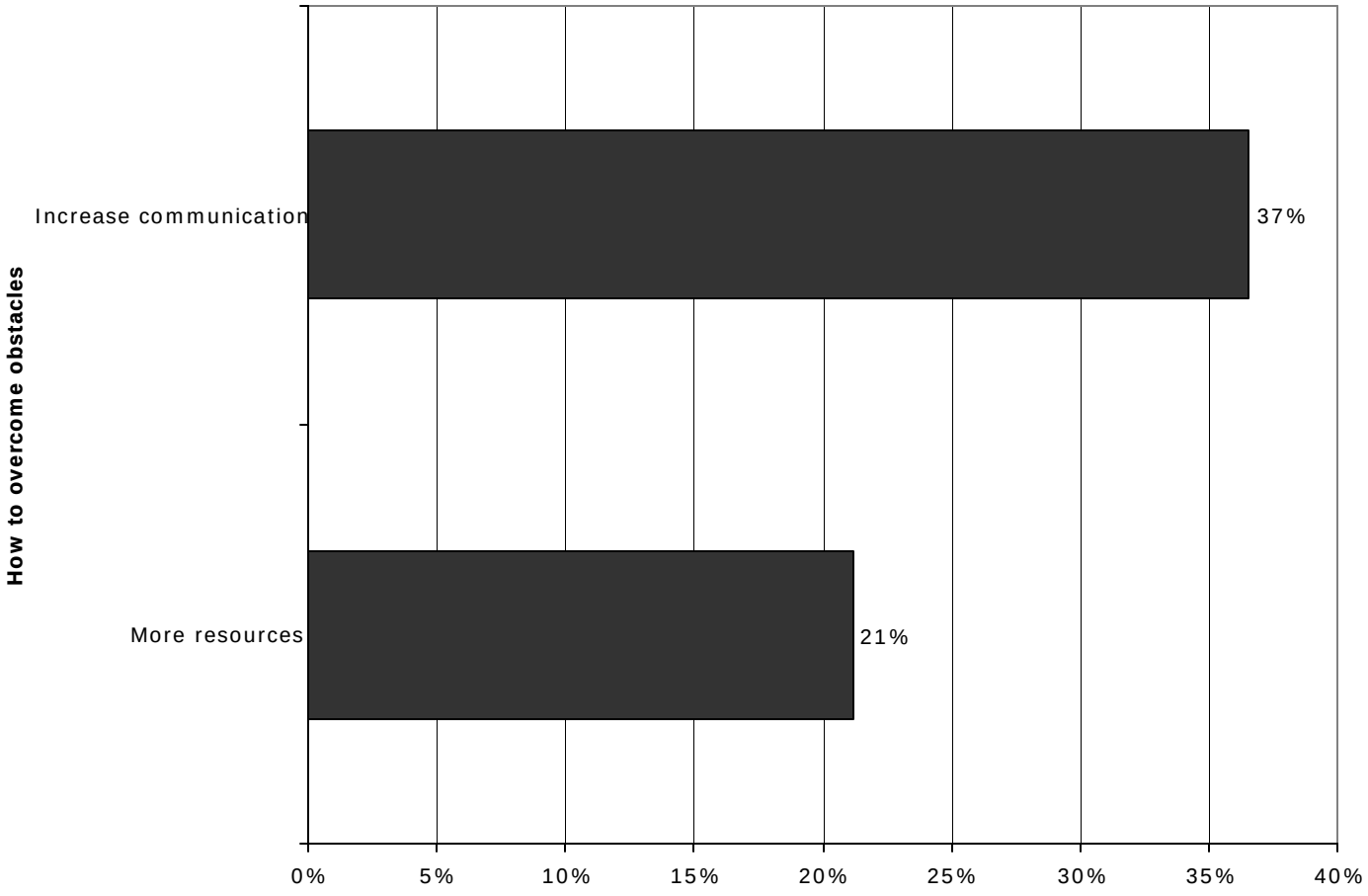
NOTES

Lack of time or resources: Lack of time and funding, lack of a school health coordinator, not enough money, lack of staffing, lack of time related to high caseloads, too busy dealing with crises, people being too busy leads to communication barriers

Difficulties in relationship with community: lack of responsiveness from community organizations, traditional or conservative beliefs as a barrier, red tape, lots of hoops to jump through to get services, bar too high for accessing services, some federally funded agencies not allowed to serve students with criminal records (esp. re: housing), bureaucracy and politics

How to Overcome Obstacles to School/Community Coordination

The same 52 interviewees who noted that there were obstacles to school/community coordination were also asked how those obstacles could be overcome.



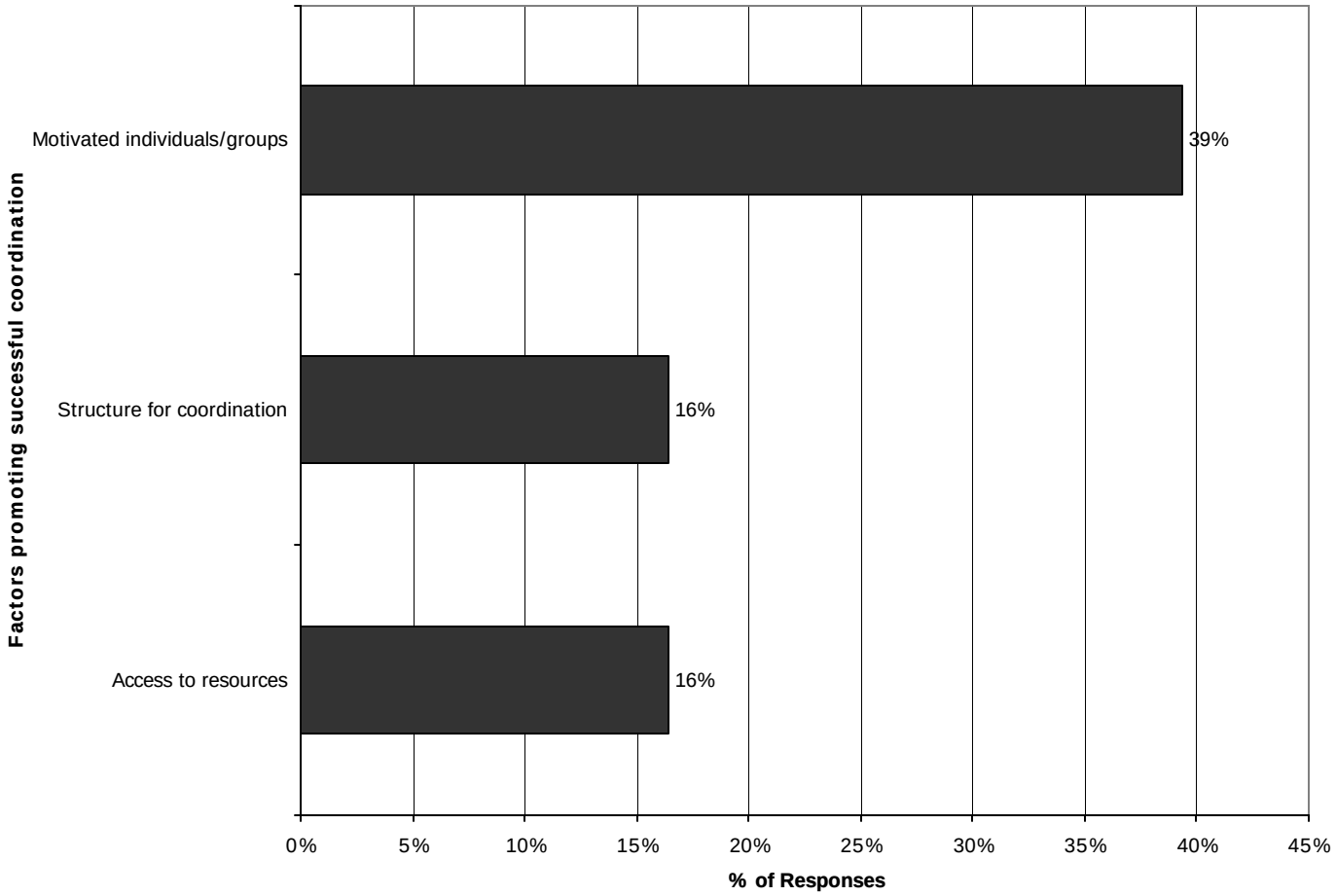
NOTES

Increase communication: increase avenues for communication; have interagency meetings; create forum for increasing communication among service providers, make collaboration a funding requirement, develop better connections between people, educate community about needs of high risk kids, communities and schools need to understand one another and the issues better, more people from school to represent the school in the community, outreach involving school, community organizations, and parents

More resources: more staff, more funding, fund positions specializing in school/community collaboration, have a school health coordinator

Effective School/Community Coordination

A total of 61 interviewees reported that they had noticed examples of effective coordination between the school and the community. Those 61 interviewees gave the following examples of what makes successful coordination possible between the school and the community**.**



NOTES

Motivated individuals/groups: when everyone is behind a particular issue, dedicated staff, community investment in the school, a certain individual has made these collaborations happen, a specific community leader has gotten people involved in these collaborations, when the community organizations/groups approach the school, committed individuals, certain people in the community are motivated to collaborate in this way, having vocal community members and a responsive school board and administration, high levels of concern around certain issues, when someone takes the initiative

Structure for coordination: having particular staff who are responsible for school/community collaboration, having school/community coordinators who can address students' needs holistically, having a community program which comes into the school and then follows students once they return to the community

Access to resources: having adequate funding and resources available to find and utilize community resources, having funding and support from state-level leadership for certain collaborations, good long term funding has made collaboration with a local community center successful, funding is available for a particular collaborative program, community resources available on-site at school, funding available from outside school, when community groups are very visible, accessible and inclusive.

IV. Focus Group Summary

Response Overview

The following pages contain aggregated responses from fifteen focus groups conducted during the three phases of this project:

> PHASE 1: Five groups with youth who are (or were) connected to organizations serving out-of-school youth, and youth who are in and out of school. Groups were conducted in Brattleboro, Burlington (2), Montpelier, and St. Johnsbury.
>
> PHASE 2: Four groups with youth in correctional settings. Three groups were conducted with young men at facilities in northern and central Vermont; and one group with young women at a facility in southern Vermont.
>
> PHASE 3: A total of six groups were conducted with students at three public high schools, in central and southern Vermont.

A total of 136 Vermont youth participated in these focus groups.

NOTE:

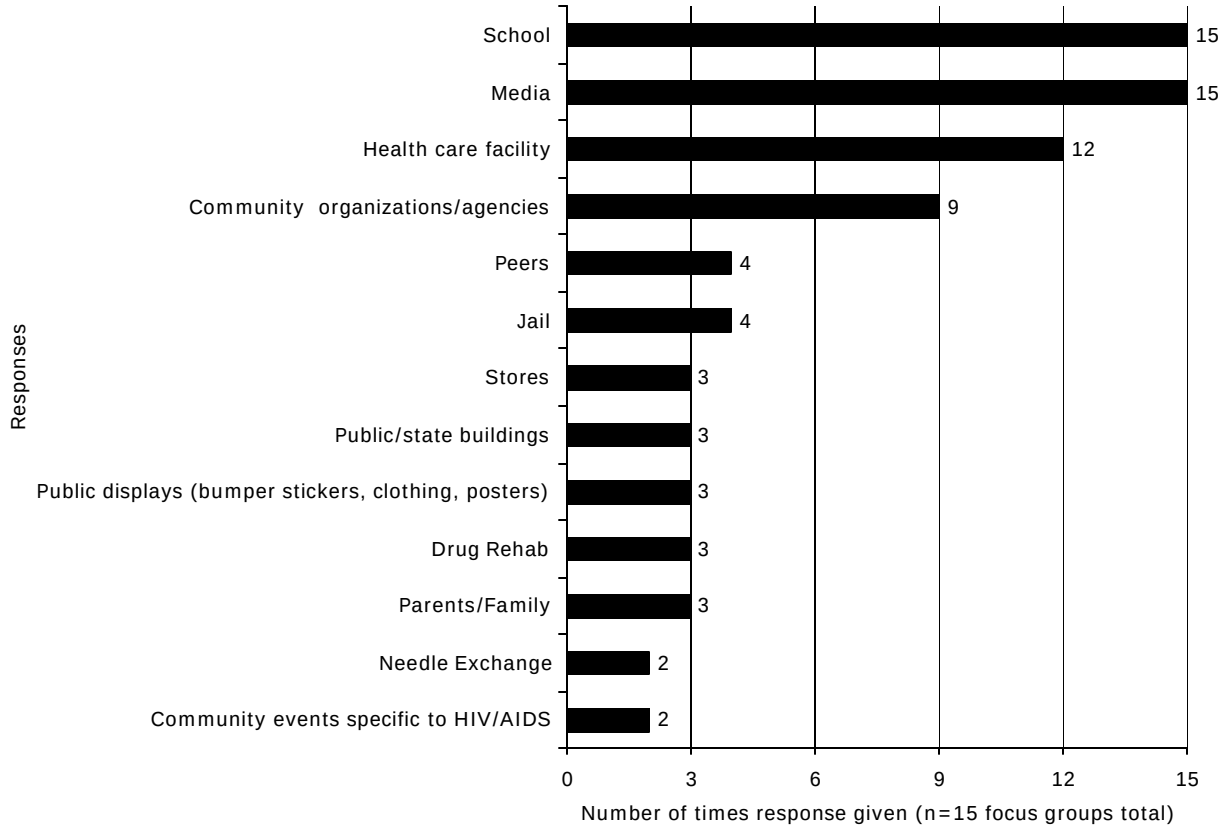
All fifteen focus groups responded to the same six questions. Responses were recorded as given; no attempt was made to correct misinformation inherent in any answer. All of the most frequent responses (i.e., those given in more than one focus group) have been aggregated here, on the following pages.

Because questions were open-ended, some subjectivity was necessary in grouping answers categorically. Some categories also dovetail with one another, and should not be seen as mutually exclusive (example: many youth responded that alcohol is a barrier to HIV prevention; others responded that drug addiction is a barrier. These were grouped as separate responses, though they are certainly related.)

For a more detailed look at participant responses, see the individual reports created for each of the three phases of this needs assessment, available through the Vermont Department of Education and/or their website, at:

www.state.vt.us/educ/new/html/pgm_coordhealth.html

Focus Group Question 1: Where have you seen HIV/AIDS information?



RESPONSE DETAILS/NOTES

School: health class, nurse's office, bulletin boards, posters, etc. All levels were mentioned: high school, middle school, elementary school, in that order of frequency.

Media: Television was the most frequently mentioned media format (particularly, MTV and commercials); followed by magazines, then radio, internet, movies, etc.

Health care facility: Planned Parenthood, doctor's office, clinic, hospital

Community organizations/agencies: teen center, American Red Cross, AIDS service organizations, various human services and youth service providers

Peers: primarily friends

Jail: *Only mentioned in Phase 2 focus groups (held in correctional facilities).*

Stores: Body Shop, grocery store

Public/state buildings: courthouse restroom, library, Department of Health, employment office

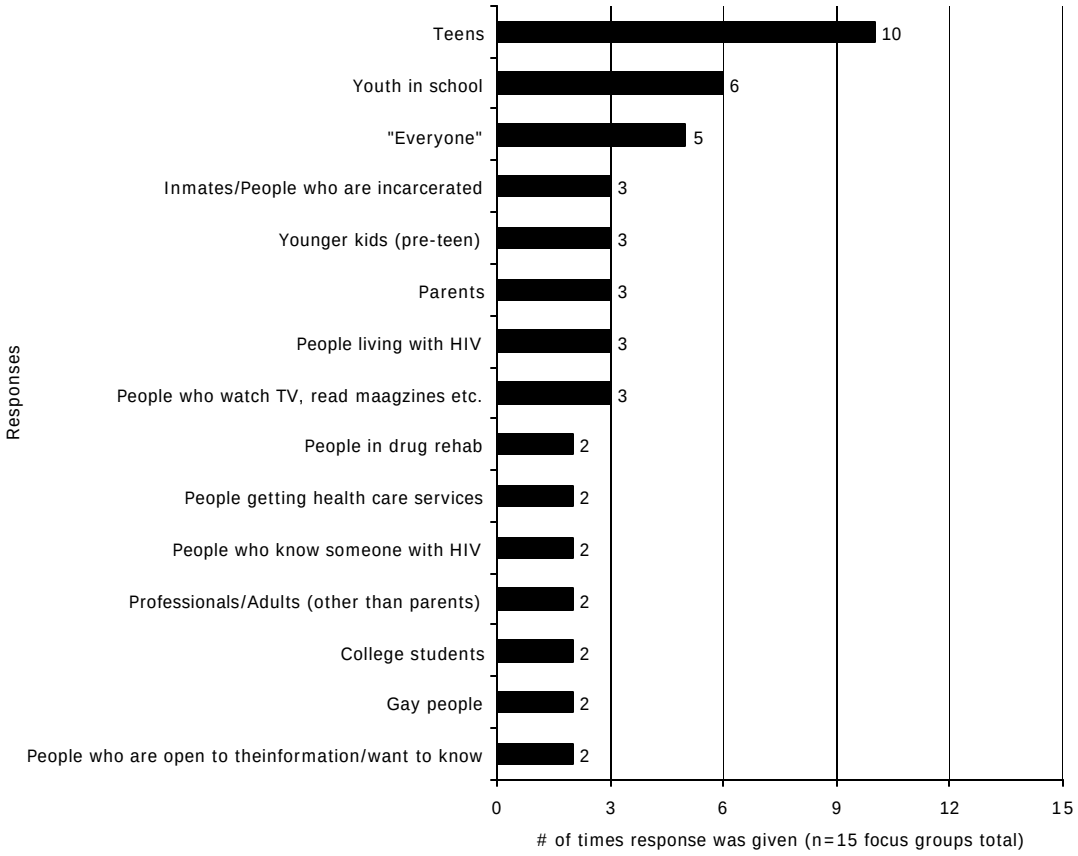
Public displays (bumper stickers, clothing, posters)

Drug Rehab: Serenity House and Huntington House were mentioned (not to the exclusion of others)

Parents/Family

Needle Exchange: Burlington and St. Johnsbury locations were mentioned (not to the exclusion of others)
Community events specific to HIV/AIDS: Including AIDS Walks and AIDS Awareness Day. *Only mentioned in Phase 1 focus groups (out-of-school youth)*

Focus Group Question 2: Who is getting HIV/AIDS information?



RESPONSE DETAILS/NOTES

Teens: Many participants indicated that HIV/AIDS information seems to be targeted at teens and young adults, to the exclusion of youth under 13 and adults.

Youth in school: includes high school, middle school and/or elementary school students, and is specific to those youth who are accessing the educational system, as opposed to homeless, runaway, and other youth not in school. While this response intersects in some ways with others (Teens; Everyone; Younger kids), it was given as a differentiated response in several focus groups.

"Everyone": While some participants felt that HIV/AIDS information is targeted to a limited audience, others contend that it is reaching everyone.

Inmates/People who are incarcerated: *Only mentioned in Phase 2 focus groups (held in correctional facilities).*

Younger kids (pre-teen): There were mixed responses on this point in many groups, about whether or not pre-teens are getting HIV/AIDS education and whether or not it is effective to reach youth at that age.

Parents: Many youth felt that parents had this information; and many responded that parents were specifically NOT getting HIV/AIDS information.

People living with HIV

People who watch TV, read magazines, etc.: This was a common theme in the focus groups, that media (particularly television) is a/the prime way to reach a young audience.

People in drug rehab: *Only mentioned in Phase 2 focus groups (held in correctional facilities).*

People getting health care services: This response dovtetails with others, in the point that some amount of proactive access (to services, to education, to media, etc.) is often necessary for prevention to take place.

People who know someone with HIV: Many participants responded that this information needs to be personalized in order to feel relevant.

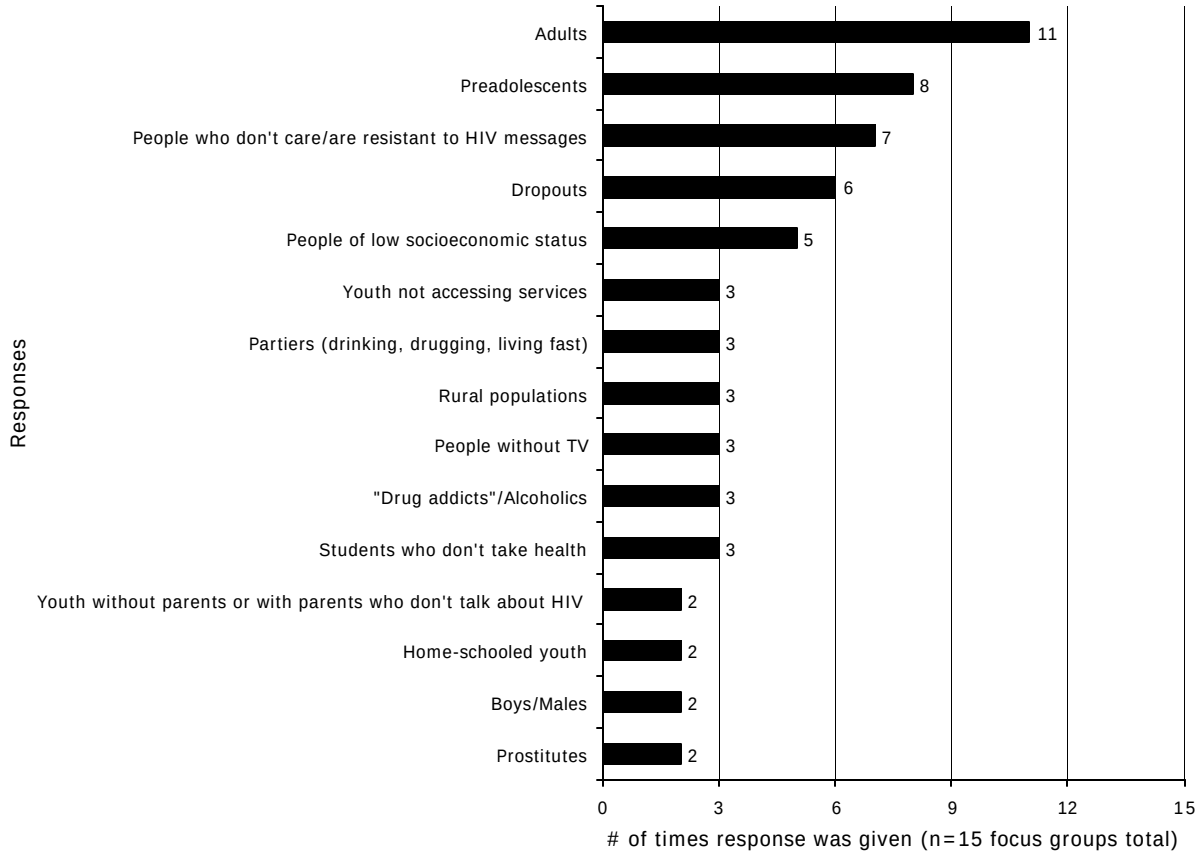
Professionals/Adults (other than parents): doctors, nurses, counselors, teachers

College students: *Only mentioned in Phase 3 focus groups (held in public high schools).*

Gay people: While many participants noted that HIV "isn't just a gay disease," some also indicated that the information is actively targeted to men who have sex with men.

People who are open to the information/want to know: Many participants indicated in some way that the information is "out there" for anyone who wants it, and that some measure of proactive access is key.

Focus Group Question 3: Who is NOT getting HIV/AIDS information?



RESPONSE DETAILS/NOTES

Adults: Also given as a response in Question 2 (Who is getting HIV/AIDS information?). Some felt that HIV/AIDS information is targeted at young people, to the exclusion of adults.

Preadolescents: Also given as a response in Question 2 (Who is getting HIV/AIDS information?)

People who don't care/are resistant to HIV messages: if they think it won't happen to them; people who don't act on the information they know; people in denial. *Also see question 4 (What gets in the way?)*

Dropouts: Many participants indicated that school (and particularly school health class) was the primary or only place they'd gotten HIV/AIDS information.

People of low socioeconomic status: those who lack access to healthcare, to television and other media; homeless people/street people.

Youth not accessing services: people who don't get help with their drug problem; youth who don't access sexual health services. *Only mentioned in Phase 2 focus groups (held in correctional facilities).*

Partiers (drinking, drugging, living fast): This response dovetails with "Drug addicts/Alcoholics" (below) but participants did distinguish between the specific power of addiction, as compared to the social pressures and norms of a partying crowd.

Rural populations: small town kids; people with less access to services (where more information is available). Some participants indicated that HIV/AIDS stigma is higher in the smaller towns and more remote areas.

People without TV: Media, and particularly television, were indicated as the primary way (sometimes the only way) young people get HIV prevention messages.

"Drug addicts"/Alcoholics: *Only mentioned in Phase 1 focus groups (held with out-of-school youth, and youth who are in and out of school).* Participants noted that addiction can be a much stronger force than prevention.

Students who don't take health: *Only mentioned in Phase 3 focus groups (held in public high schools).* Many participants indicated that school (and particularly school health class) was the primary or only place they'd gotten HIV/AIDS information.

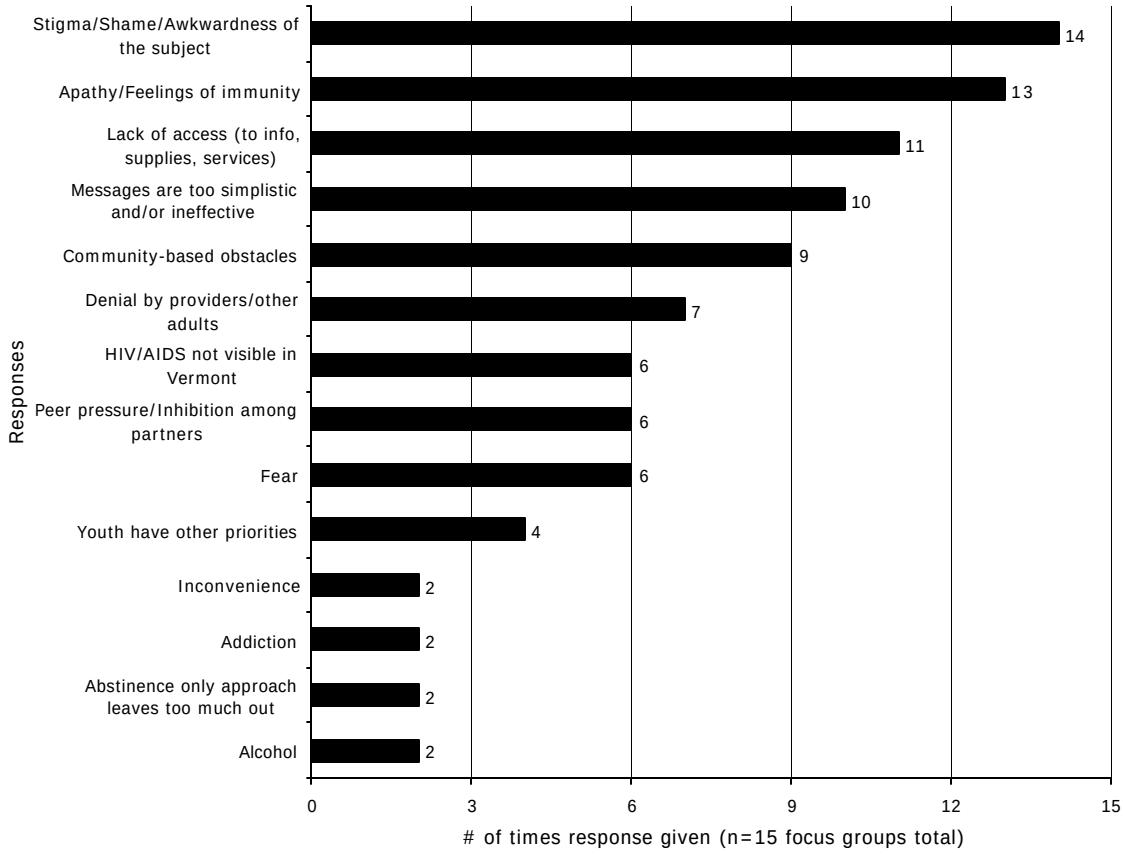
Youth without parents or with parents who don't talk about HIV

Home-schooled youth: This response assumes no health education and/or HIV/AIDS unit.

Boys/Males: Some felt that girls/females were more likely to access sexual health services such as Planned Parenthood, where HIV/AIDS information is available. Others indicated that boys/males are more likely to take risks and/or feel immune to the possibility of HIV infection.

Prostitutes: Named as an at-risk population. Other participants questioned whether or not there were sex workers in Vermont.

Focus Group Question 4: What are the challenges/barriers to HIV prevention?



RESPONSE DETAILS/NOTES

Stigma/Shame/Awkwardness of the subject: Many groups spent a good deal of time on this point. Some specific responses: You don't want to stand up and ask "stupid" questions, so you don't learn; No one wants to admit to unprotected sex or shooting up, or to say "I have AIDS"; We need to open up the sex/AIDS dialogue; GLBT kids have to come out to get information that is relevant to them; No one wants to be seen sitting in the waiting room at Planned Parenthood.

Apathy/Feelings of immunity: sense of invincibility; kids do what they want to even if they know the facts; an attitude of "I'm never going to get it"; rural areas are considered less of a problem

Lack of access (to info, supplies, services): This includes transportation issues; small-town familiarity; lack of service providers; lack of money for condoms and lack of outlets for free condoms, especially where young people can get to them without embarrassment. While the same may be true for needle exchange and/or clean injection equipment, participants did not often mention those items.

Messages are too simplistic and/or ineffective: lack of detailed prevention information; lack of information about how HIV/AIDS actually effects your life and your body; not enough information about HIV and needle use; we know you can get the virus and die, and that's all we know.

Community-based obstacles: includes rural isolation; lack of transportation; difficulty finding and obtaining condoms and clean injection equipment

Denial by providers/other adults: adults assume that youth aren't engaging in risk behaviors; adults/educators are uncomfortable discussing sensitive subjects (sex, drug use). This response dovetails with shame/stigma (above) as well as other factors.

HIV/AIDS not visible in Vermont: We live in Vermont, it's not that prevalent, so we don't expect it around here; HIV focus has fallen off since the 1990's.

Peer pressure/Inhibition among partners: pressure to engage in risk behaviors, and also to not pay attention to prevention messages; partners may be embarrassed or afraid to bring up prevention with one another; we aren't respectful of ourselves.

Fear: includes fear of the virus itself and not wanting to hear about it; fear of learning one's HIV status; fear of asking for information

Youth have other priorities: Includes specific activities and other social factors, but also the fact that other STDs, and pregnancy, are more on the minds of young people than HIV. Many participants indicated that HIV should be covered in conjunction with other STDs, not as a stand-alone topic.

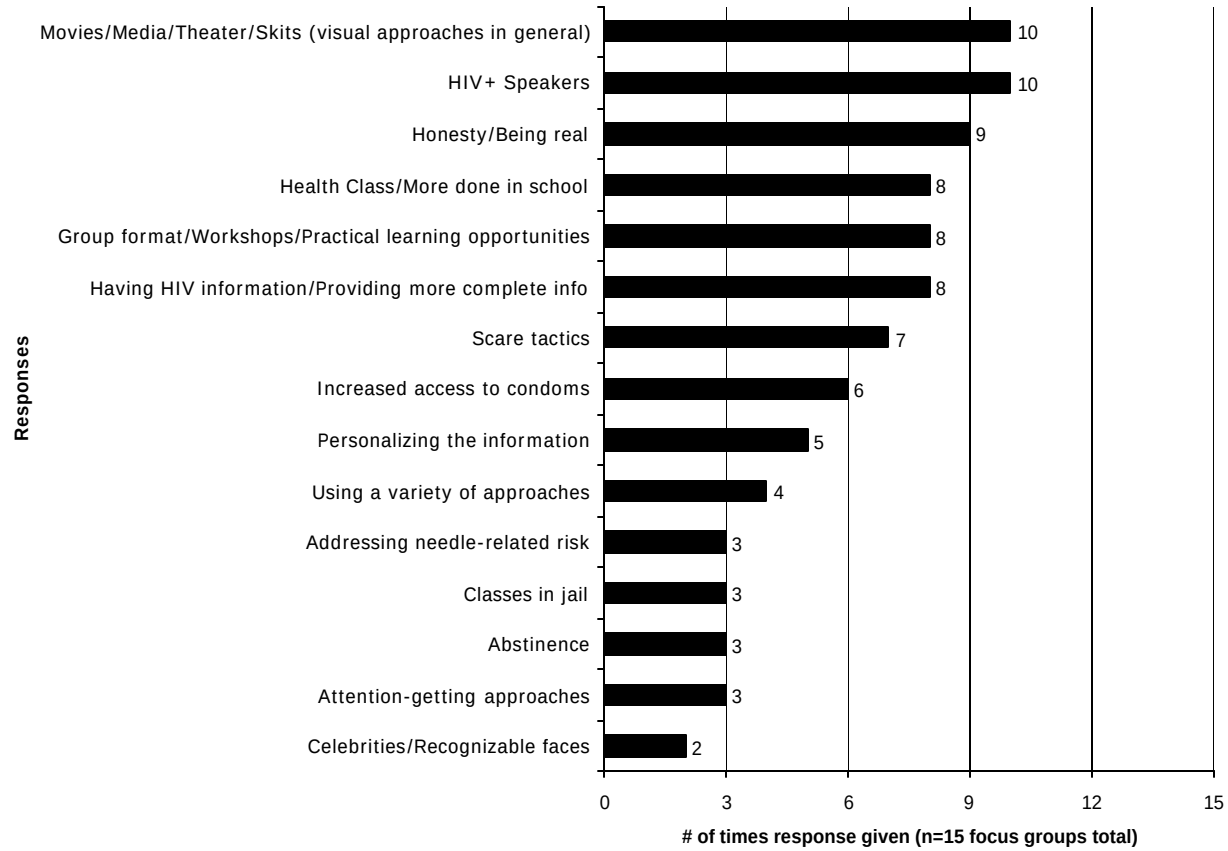
Inconvenience: People don't want to use condoms and/or go get them.

Addiction: *Only mentioned in Phase 2 focus groups (held in correctional facilities).* Participants noted that addiction can be a much stronger force than prevention.

Abstinence only approach leaves too much out: *Only mentioned in Phase 1 focus groups (held with out-of-school youth, and youth who are in and out of school).*

Alcohol: This response dovetails with Addiction (above) but participants did make the distinction that without or without addiction, alcohol can lead to risk behavior.

Focus Group Question 5: In terms of HIV prevention, what is helpful or effective?



RESPONSE DETAILS/NOTES:

General note: Many of these responses intersect around the idea of making HIV/AIDS feel relevant to young people; making the information accessible, more interesting, and at least sometimes interactive; and allowing for a more open, honest dialogue on the subject.

Movies/Media/Theater/Skits (visual approaches in general): Movies mentioned: *Philadelphia; Traffic; Kids; Boys on the Side*; Commercials: "Truth" ads; "Knowing is Beautiful" ads (re: HIV testing); In general, many participants noted the power of a well-told story in whatever format, either with well-known players or with faces they could relate to.

HIV+ Speakers: Participants did not uniformly feel that the speaker needs to be a young person in order to be effective. Hearing about true life experiences was the more strongly emphasized point here.

Honesty/Being real: Many participants felt that the messages they receive are too simplistic and/or that teachers are inhibited from a more complete discussion of HIV and the behaviors that can transmit it.

Group format/Workshops/Practical learning opportunities: "Less writing, more thinking." There was some disagreement about whether group or individual-level intervention was more effective, but many participants felt that interactivity was a key (and often missing) component to effective HIV/AIDS education.

Having HIV information/Providing more complete info: Dovetails with Honesty/Being real (above); also with the often-mentioned theme that access to information and supplies is a key component in prevention.

Scare tactics: fear of dying by not protecting myself; hearing scary stuff about other countries, like the HIV rate in Africa; When you do hear about HIV in Vermont, it's shocking. The only way they'll listen is if it's shocking; HIV+ speakers scare people in an effective way.

Increased access to condoms: Primarily includes more outlets for free condoms, but participants also mentioned a need to decrease the stigma around buying condoms and/or making them available in youth-oriented stores and organizations.

Personalizing the information: hearing from young people who have HIV, and HIV+ speakers in general; if you know someone who has HIV.

Using a variety of approaches: refers to accounting for different learning styles; also, reaching youth in more than one place, and using both group and individual level interventions. *This response was only given in Phase 1 focus groups (held with out-of-school youth, and youth who are in and out of school).*

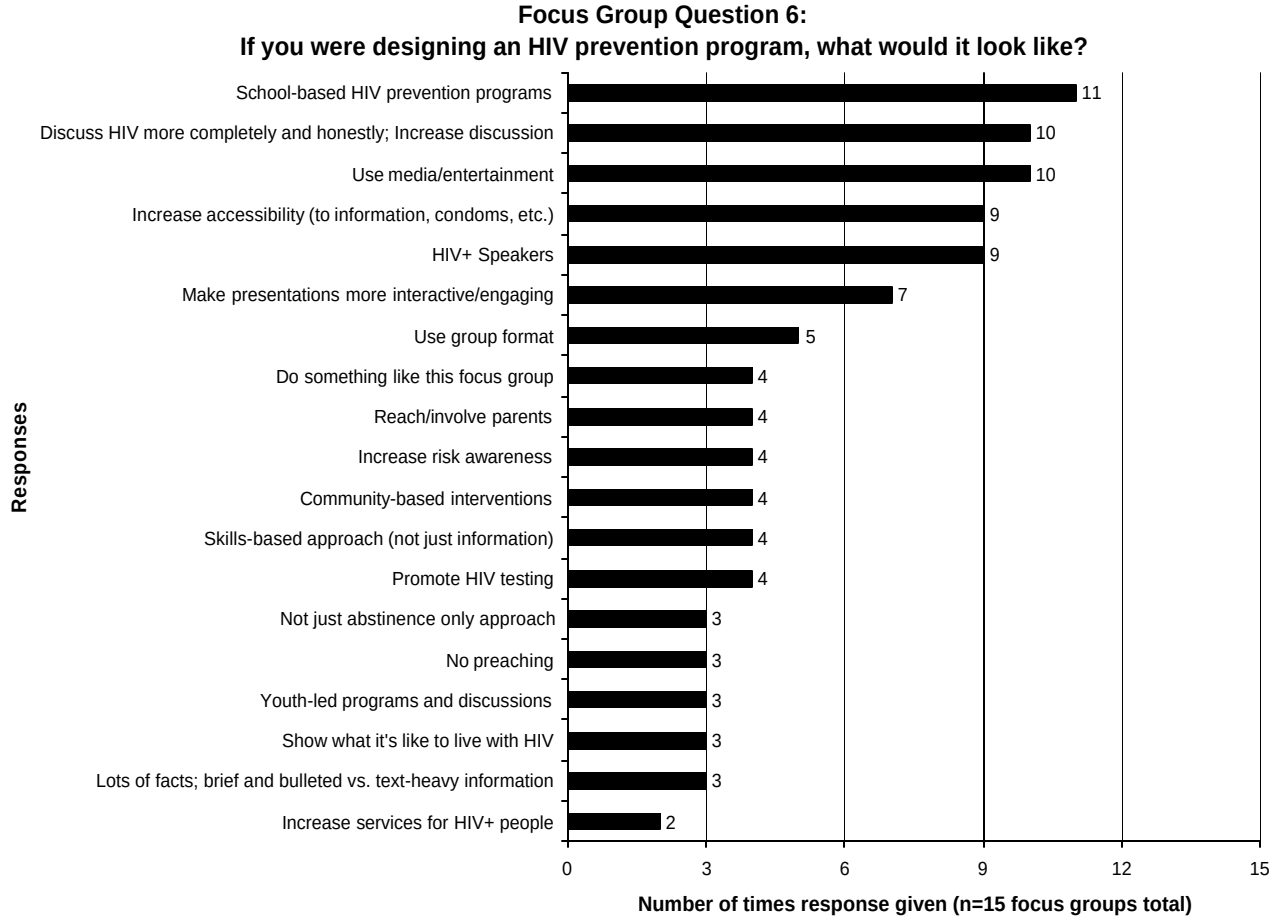
Addressing needle-related risk: Some (but not many) participants noted that needle-related transmission is rarely, if ever, addressed with youth.

Classes in jail: Those participants who had been given HIV/AIDS information while incarcerated felt that it was very effective.

Abstinence: It is notable that abstinence was mentioned relatively infrequently as an effective prevention technique.

Attention-getting approaches: If it doesn't catch your attention, it doesn't work; Includes materials with bright colors, eye-catching images, and short, digestible pieces of information.

Celebrities/Recognizable faces: athletes, music stars, television/film stars.



RESPONSE DETAILS/NOTES

General note: In many ways, the themes in question 6 responses are similar to those in question 5, around open and honest discussion; increased accessibility; and making HIV/AIDS information and prevention feel more engaging, interactive, and/or relevant to the concerns of young Vermonters.

School-based HIV prevention programs: better programs in health class; smaller classes; assemblies; distribute condoms and print information at school; show prevention supplies and how they are used; start earlier.

Discuss HIV more completely and honestly; Increase discussion: have a more discussion-based (vs. lecture or book-based) program; create more comfort around the topic; make it so everyone is talking about it.

Use media/entertainment: TV commercials; movies; famous faces; make it entertaining, in an emotional way.

Increase accessibility (to information, condoms, etc.): create more access to information outside of class; go to where kids hang out; put information in places like waiting rooms where people are bored; put the message everywhere; distribute condoms in places where kids are and where they can take them without embarrassment.

HIV+ Speakers: Participants did not uniformly feel that the speaker need be a young person in order to be effective. Hearing about true life experiences was the more strongly emphasized point here.

Make presentations more interactive/engaging: make it easy to relate to, not just boring fats; anything with energy; not just lecture.

Use group format: There was some disagreement about whether group or individual-level intervention was more effective, but many participants felt that interactivity was a key (and often missing) component to effective HIV/AIDS education.

Do something like this focus group: Participants referred to the interactive, discussion-based (vs. lecture-based) quality of the focus groups.

Reach/involve parents: mass mailing to parents; address kids and parents together at the same event; target adult media outlets

Increase risk awareness: Some participants noted that while HIV/AIDS information is widely available, it doesn't mean anything to most youth, who don't feel that they are at risk for HIV infection.

Community-based interventions: refers to larger, public events where HIV information and/or prevention supplies are available, and where HIV/AIDS may or may not be the primary focus.

Skills-based approach: refers to prevention skills (refusal/ postponement skills; condom usage; safer injection technique)

Promote HIV testing: Many participants noted that much of what is out there about HIV testing does not include information about exactly how to get tested, where to get tested, what the costs might be, etc.

Not just abstinence-only approach;
No preaching: *These responses were only mentioned in Phase 1 focus groups (held with out-of-school youth, and youth who are in and out of school).*

Youth-led programs and discussions

Show what it's like to live with HIV: Participants referred not just to HIV+ speakers, but also to the effectiveness of showing (through video, field trip, etc.) what someone goes through after their infection, how HIV can affect the body, what a medication regimen is like, etc.

Lots of facts; brief and bulleted vs. text-heavy information: While some participants disagreed with this point, others did feel that "you can never give too much information" and that the effective way of doing it is with briefly-stated, compelling facts/factoids.

Increase services for HIV+ people: *Only mentioned in Phase 2 focus groups (held in correctional facilities).*