Florida State University

Action Report

HIV/AIDS:
An Analysis of Best Practice Prevention
Education Programs for African Americans

Master of Public Administration
Reubin O’ D. Askew School of Public Administration and Policy

By
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Mrs. Emma J. Brown  
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4105 Lake Bradford Road  
Gainesville, Florida 32609

Dear Mrs. Brown:

My name is Cavette Rose and I am a candidate for the Master’s of Public Administration at Florida State University. It is my pleasure to submit to you HIV/AIDS: An Analysis of Best Practice Prevention Education Programs for African Americans. This document is the result of research and analysis of prevention education programs. There is an enormous problem with the rise of HIV/AIDS in the African American community. This is a problem that can be prevented, so your organization is strongly urged to implement these programs for effective education.

I have enclosed the results of this study as well as recommendations that have the potential to benefit your organization. These are programs that the Center for Disease Control (CDC) has strongly recommended for implementation in your organization. Your organization has a high potential of receiving funds from the CDC if you insert them in your proposal for the upcoming fiscal year. This is especially important for the state of Florida nonprofit organizations because of the rise in new cases in this state.

The recommendation will likely decrease the amount of newly diagnosed cases by African Americans in Alachua County. Prevention Education programs is the key to reducing HIV/AIDS cases.

If you have any questions or concerns about this study, please do not hesitate to call me at (850) 575-5788. Thank you for your time.

Sincerely

Cavette Rose
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EXECUTIVE SUMMARY

PROBLEM: Increase in new HIV/AIDS cases for African Americans
HIV/AIDS cases have been increasing in African Americans between the ages of 25 and 44. This is a problem that can be prevented by behavior changes but it is on the rise with newly diagnosed cases. This study looks at prevention education programs that are specifically for the target population which are African Americans.

PROS AND CONS OF PROGRAMS
The programs that were implemented before were trying to use a one size fits all approach when educating individuals. The prevention programs that were implemented before were not culturally sensitive to African Americans. The programs that are offered now are effective if the right programs are chosen for the proper target population. Some programs are giving out supplies which some African Americans could not or would not seek.

METHODS
Information for this report was collected using two methods. First, library databases and newspaper articles were reviewed to provide background information on what programs were being effective in providing education about HIV/AIDS for African Americans. Second, I interviewed two directors of nonprofit organizations that specialize in HIV/AIDS prevention education.

HIV/AIDS PREVENTION PROGRAM OPTIONS
This report describes and evaluates three options for prevention education programs on HIV/AIDS for African Americans
- **Outreach Intervention** is the visitation of educators to the community by going door to door or talking to individuals that is on the street corner. Outreach programs focus on meeting the community in their neighborhoods by going into the community and giving out education information on the prevention of HIV virus.
- **Group-level Intervention** programs are presentations that are intended for groups of people who are assembled together at one time. These programs have the potential to reach large numbers of the target population. They are done more often than not because they are cost effective.
- **Individual-level Intervention** Individual interventions are one on one life saving skill building sessions that teach individuals how to use condoms and safe sex negotiation skills. This intervention focuses on those people who are afraid to talk in groups but are at high risks for contracting the HIV virus.

Each option was evaluated against three criteria: **theoretically sound program structure, accessibility/availability** and **staff**.

RECOMMENDATIONS
Outreach intervention is the recommended action for providing education prevention programs. It is an education prevention program that is done in a place that is
comfortable for the individual which usually means they are more willing to listen and try to make changes in their lives. The structure of this program makes it easy to get the education message out. Being very accessible and available to the community has an impact on the success of the program. The staff of outreach intervention program are individuals from the community in which they are educating about HIV/AIDS prevention. This is a vital tool because these individuals care about the community they are educating so they will do their job to the best of their ability. The programs are also implemented using African American educators on the frontlines. They are more responsive to an educator if they are from the same ethnic background and in some cases the same gender.
Problem Statement

AIDS is an epidemic that has killed 2.9 million people in the world in the year 2003. It is estimated that 37.8 million people in the world are living with HIV/AIDS. In high income countries, HIV is still rising rapidly because more people have access to the antiretroviral treatment (WHO 2003). The low income countries contain 95 percent of the people living with HIV. People are not keeping up with the changes in prevention, so there is evidence that there is a shortcoming among the immigrants and refugees contracting the virus.

In the United States, HIV/AIDS affects minorities because there is a growing shift of AIDS cases during the 1990s from men who had sex with men (MSN) toward African Americans, Hispanics and women. Statistics show that of the people living in the United States with HIV/AIDS, 42 percent were black, 37 percent were White and 20 percent were Hispanics (CDC 2003). HIV/AIDS is a significant social problem that is facing today’s generation of African Americans. This problem is important because it is rising rapidly and it can be prevented.

African Americans have outnumbered Caucasians in new AIDS diagnosis and in the number of deaths. Many young African Americans between the ages of 25 and 44 are still having unprotected sex. Although condoms are given out freely at most health care and educational facilities, it appears that many African Americans choose not to use them. Many believe that they are immune to the HIV/AIDS disease and will not contract it. HIV/AIDS is becoming more complex to treat and it requires a well trained physician to deliver good and quality cost effective care. One theory suggests that areas where
African Americans reside are not receiving the necessary prevention education programs and are more likely to have a higher percentage of HIV/AIDS cases.

The rise in HIV/AIDS among African Americans has been potentially linked to the lack of education, denial, social behaviors and low income levels. These indicators can provide nonprofit organizations and policy makers with valuable information on where to focus on prevention education programs. This will also help some organizations to reach their target population and hopefully will result in more successful education prevention programs about HIV/AIDS. The Center for Disease Control (CDC) spends forty percent of its total budget of $744 million dollars on activities in the African American communities about prevention (CDC, 2001).

The purpose of this report is to provide nonprofit organizations in the state of Florida with options for better prevention education programs about HIV/AIDS for African Americans by examining procedures, policies, and current education methods that are being used, otherwise known as best practices. This report will describe and examine specific prevention education programs for nonprofit organizations in Florida focusing on African Americans. They may implement these best practices in their organization’s program and use them as a guide to reach the target populations which are African Americans in the communities of Florida. An implication that can be made is that success with education prevention interventions programs will result in a decrease in HIV/AIDS cases.
Literature Review

History

Human Immunodeficiency Virus (HIV) is assumed to have developed from a form of SIV found in chimpanzees in West Africa. No one really knows exactly where and when the virus first emerged but the infection developed into the epidemic disease AIDS (Acquired Immunodeficiency Syndrome) in the middle of the twentieth century. HIV was first said to be found in humans in 1959 when a plasma sample was taken from an adult male living in the Republic of Congo. HIV was later found in a tissue sample of an American teenager who died in 1969. These samples were studied in 1998 and the study suggested that HIV was introduced into humans in the 1950s. The epidemic of AIDS started to spread suddenly because of international travel, blood transfusions and drug use. A Canadian flight attendant, who traveled worldwide, indirectly or directly through sexual contacts, infected many others with the virus. Paid donors, including Intravenous drug users’ blood was collected and then distributed worldwide (Bailes et al., 1999).

World

According to UNAIDS (Kmietowicz Z. 2003), it was estimated that in 2003 14,000 people around the world were newly infected with HIV every day. 40 million people are living with HIV/AIDS including 2.5 million children in the world. Around the world many countries are responding to the need to fight HIV/AIDS. They are recognizing the importance of the fight. In Brazil, the average treatment costs for patients have been reduced to $1200 and they also gave away ten million condoms during the carnival season. This time of year is when people are more likely to indulge in risky
sexual behaviors. The AIDS epidemic can extend to any person in the world. The president of Malawi’s brother died from AIDS in February of 2004. AIDS does not discriminate against anyone no matter how rich or poor someone is. Status does not matter to this disease either. In Sub-Saharan Africa, an expert group reaffirmed that unsafe sexual practices are responsible for most of the HIV infection cases. The rate of new infections has been decreasing and may be stabilizing in Sub-Saharan Africa. This success is due to vaccine development and prevention programs that were implemented in this region (Democratic Policy Committee, 2001).

In Uganda, HIV infection rates have been reduced by 70 percent since the 1990s. In 2004 it was estimated that a half million people were HIV positive compared to 1.5 million ten years ago. The cause for reduction was that people in Uganda reduced the amount of sexual partners that they had and many who were already infected perished. They also utilized the community prevention efforts that were in place in the local communities. Some of the techniques that they used were local care groups, nongovernmental organizations, care networks and religious movements. Friends, neighbors and families talked about sexually transmitted diseases instead of pretending that the diseases do not exist.

United States

In the United States, it is estimated that between 800,000 and 900,000 Americans are living with HIV/AIDS. Globally Americans have ranked AIDS as the most urgent health issue. It is ranked second in the United States. AIDS is an epidemic that apparently started in 1978. It killed 31 people by 1980 and another 203 by 1981. AIDS started off as a vast disease and is still going strong today. In 1982, there were a total of 853 known deaths and during this time the Center for Disease Control (CDC) linked the
disease to blood. AIDS was a topic that was not discussed in public because of the unknown. There is no cure for AIDS so people do not talk about the issues that Americans are facing with this disease. In 1985 the Food and Drug Administration (FDA) approved the first HIV antibody test and then President Ronald Reagan mentioned the word AIDS in public for the first time when he was asked a question by a reporter. HIV/AIDS was said to be a “gay men disease”, so many heterosexuals thought that they were not at risk for contracting the virus. In 1991 there were over a million people in the United States with the HIV virus and Professional basketball player Magic Johnson announced that he had HIV. In 1996 the first anti-HIV drug Nevirapine was approved for use in the United States. The number of known deaths has risen to 34,947. In 1997 the CDC reported that AIDS deaths dropped. They also reported the first case of probable transmission of HIV through kissing. In 2002 the cumulative deaths in the United States totaled 501,669. In 2000, the United States spent over $10.8 billion on HIV/AIDS. Young people are being affected with HIV/AIDS at a higher rate than older Americans. It is estimated that individuals under the age of 25 account for half of all the new infection cases (AEGIS 1998).

African Americans

African Americans make up 12 percent of the total United States population, but they represent 41 percent of the reported HIV/AIDS cases. As of December 2003, the National Institute of AIDS and AIDS research has included to addressing the needs and concerns of the minority population on their agenda (U.S. Dept. of Health and Human Services 2003). The institute is trying to ensure that minority patients have access to clinical trials and the latest information on treatment and prevention. They are also trying to improve the effectiveness of outreach and education programs because African
Americans are disproportionately affected with the AIDS epidemic. Many African Americans are at high risk for HIV infection because of the risk behaviors that they engage in. They are not at a high risk because of their race or ethnicity, it's not who they are, but what they do that puts them at this risk.

Theories

Social Cognitive Theory defines human behavior as a triadic, dynamic and reciprocal interaction of personal factors, behavior and the environment (Bandura, 1977a; 1986; 1989). According to this theory, an individual’s behavior is uniquely determined by each of these three factors. While the SCT upholds the behaviorist notion that response consequences mediate behavior, it contends that behavior is largely regulated antecedently through cognitive processes. Therefore, response consequences of a behavior are used to form expectations of behavioral outcomes. It is the ability to form these expectations that give humans the capability to predict the outcomes of their behavior, before the behavior is performed. This theory posits that most behavior is learned vicariously.

According to the Health Belief Model there are two factors that influence the likelihood that one will take preventative action. First a person must believe that the benefits of performing the behavior outweigh the costs. There should be more positive than negative outcomes. Second the person must have a sense of personal agency or self-efficacy with respect to performing the preventative behavior. They have to believe that they have the skills and abilities necessary for performing the behavior under different circumstances.
The Theory of Gender and Power is a social structural theory that accounts for gender-based power differences in male-female relationships. It examines by gender the division of labor and the distribution of power and authority within relationships and gender-based definitions of sexually appropriate conduct. It also considers the impact of a woman’s willingness to adopt and maintain sexual risk-reduction strategies within heterosexual relationships as it pertains to her lack of power, her commitment to the relationship and her role in the relationship (CDC 2004).

**Practices for HIV/AIDS Prevention Education**

Sex education seeks to reduce the risks of potentially negative outcomes from sexual behavior. It also tries to develop young people's skills so that they make educated decisions about their sexual behavior. Prevention programs started with the emphasis on abstinence. With the realization that abstinence is not working efficiently, education programs started to emphasize the use of condoms for protection against the HIV virus. Many people are using condoms incorrectly or not using them at all, so the emphasis now for African Americans is having sexual relations with one individual at a time.

Monogamy means having relations with one person at a time. The emphasis that is now put towards the prevention of HIV is being monogamous. Some HIV prevention programs include: school based education, screening of blood supply, perinatal prevention programs and access to sterile drug injection equipment. These programs have been proven to be effective but not particularly with African Americans.

Successful prevention education programs in schools have key qualities. These key qualities are: provision of information, exercises to encourage an appraisal of values and role play rehearsal to teach sexual negotiation skills. Programmes that aim to reduce specific sexual risk-taking behaviors and which reinforce group norms against
unprotected sex and discuss social pressures to have unprotected sexual activity have been shown to be successful (HIV/AIDS Education and Young People, 2004).

Services that are provided to young children outside of school should be available on the weekends, in the evenings, accessible by public transport, and have staff whom the young people are not afraid to approach. Services may be provided through specialized clinics, youth advisory services, general practitioners, physicians, and through local outreach work. Peers are also a very good source of information and support for one another. Peer-led education programs have clear objectives, provide support, referral to appropriate services and provide training. Sometimes it is easier to take advice from peers of one’s own age than from an older person that is older. Youths tend to believe that a young adult who has been through some of the same situations that they have, will know what they are talking about.

**Prevention Education Programs for African Americans**

Programs that are designed specifically for African Americans are: Outreach, group level interventions and, individual level interventions. Educators from the various organizations go into low income neighborhoods and give out information to anyone whom they see. The health educator has to mirror the population they are serving. Group level interventions are programs that reach large numbers of the African American population. Individual level interventions are programs designed for individuals who are at high risk for contracting the HIV virus but might not voluntarily seek prevention information. Some culturally successful programs facilitate learning through videotapes, games, exercises and other materials. The Center for Disease Control has issued a
procedural guidance for organizations to help with effective educational and intervention programs.

**Barriers to Prevention**

In order to stop the spread of HIV among African Americans, prevention must be the main priority. The social, cultural, economic, and religious contexts that impact the lives of African Americans must be taken into consideration when dealing with prevention. Age appropriate prevention, culture and linguistics are needed for the diverse populations of African Americans. African Americans are under-represented in the HIV prevention community planning process in order for programs to be effective. African Americans have to be included in the decisions of which prevention programs to use in a certain community. Persons from an affected community are often best able to tell what that community needs are. They can also provide valuable perspectives in designing programs to fulfill those needs.

Funding is another barrier to HIV Prevention for African Americans. The CDC has a budget of $353 million in 1999 for HIV/AIDS, but only $96 million of it was targeted to African Americans. African Americans are the group that has the most cases of HIV/AIDS (41% in the United States) but they are getting only 27.2 percent of the budget to help with prevention. The CDC says that the level of program support that is directed to racial and ethnic minority communities is significantly less than that the current trends indicate is necessary. Organizations that provide prevention services to African Americans are under-funded, so they are not able to meet needs in the local communities. African Americans are not receiving the level of prevention that is needed because the funding level that the organizations have to work with is not high enough (Maldonado, Miguelina 1999).
An article written by Fullilove, Gasch and Paulson, (1991) about shaping AIDS education and prevention in the midst of community decline, talked about two distinct features of the AIDS epidemic. The first is that AIDS is part of a broad-spectrum of excessive risk and mortality that is observed among African Americans. AIDS has joined a long list of health problems for African Americans and it is lowering the life expectancy for this group. The second distinct feature is that HIV is preventable. The choices that people make about their sexual behavior are alterable. The author says that although organizations are teaching prevention and promoting good health behaviors, the community is still not responding. Many African American men do not feel it is critical that they use protection when engaging in risky behaviors. Consequently, prevention programs are trying to teach women how to protect themselves from contracting the disease. The article suggested that women are trying to be strong in saying yes to condom use no matter what the consequences and men are trying to be more responsible and use condoms and not sell drugs in their community.

Fullilove, Gasch and Paulson, (1991) also identified three assumptions as to why the African-American community is having such a high mortality rate. One is that the community in which we live in has a significant impact on our behavior. Another is that African-American men are losing their place in the workforce because of the lack of education. The next thing is that African-Americans believe that the government is conspiring against them. One report from New York Times says that a survey was done and it concluded that there was a widespread belief that AIDS and drugs are part of a White conspiracy to commit genocide against blacks (DeParle 1990).
Fullilove (2001) discussed the fact that many presentations on HIV prevention never make its way to being printed meaning that they are not printed in a newsletter form and distributed in the communities. African-Americans are exposed to the information about HIV but they do not have the recognition of how it is affecting their community. Some are not seeing how it affects someone around them that they care about, know or love. A few African Americans believe that HIV/AIDS is a disease that only affects Caucasians, specifically gay men. The article argued that HIV/AIDS disease is not a white disease anymore but it is now colored. This means that HIV/AIDS is not specific to the white man but more and more African Americans are being affected by it daily. Many African American men who have sex with men (MSM) are not paying attention to the gay prevention methods because they believe within themselves that they are not gay. Many of these men have been in prison and while incarcerated have had sex with other men. When they are released they go back to being heterosexual but they are already infected and most of the times do not even know it. Our community is biased towards gay men so most of the times they do not let anyone know about what they have done (Wright 2001). The brothers hide their bisexual behavior—“the brothers who are on the DL (down low).” (CDC 2001; Wright 2001) Fullilove (2001) also talked about how crack and heroin were the two drugs that were the down fall of many African-Americans.

“The war on drugs put a lot of African-Americans in jail, where coincidentally, the highest prevalence of HIV infection in the US is to be found.” Nowhere in the national HIV prevention program agenda for African-American community do we ever confront “the elephant in the room.” This refers to a significant, critical element of a
problem or conflict confronting a particular group that is so huge it cannot possibly be ignored but is, in fact, never acknowledged by group members (AIDScience Vol.1 2001).

Jemmott, Jemmott, and Fong (1998) are concerned about who the African Americans are at risk for contracting HIV/AIDS. The African-Americans at risk are the ones doing homosexual/bisexual activities which make up 38% of the cases and injection drug users which make up 35% (CDC 1998). What puts African-Americans at risk are the amount of injection drug users, the unemployment and poverty rates, and the high rates of risk behaviors.

Gaps in the Literature

The main gap in this literature review is that there seem to be few, if any case studies that have documented successful prevention programs. Not a lot of research has been done about the needs of African Americans in regards to prevention. Researchers do not know what is needed in this community to help stop the spread of HIV/AIDS.

Methodology and Evaluative Criteria

Methodology

Data for this analysis was collected by using: review of academic literature and research, personal experiences, and personal interviews with directors of organizations that concentrate on HIV/AIDS prevention. Academic research was collected by using the following databases: JSTOR (1982-present), Cambridge Scientific Abstracts (1990-present), ERIC (1970-present).

Personal interviews were attended and collected by the researcher. A structured personal interview with Lamar Douglas, Director of Education Services at Big Bend Cares was completed on November 8, 2004. This meeting lasted approximately one hour and was held at the Big Bend Cares office in Leon County. The purpose of this interview
was to gain expert opinion on the prevention education programs that are currently in place and the effectiveness of these programs of African Americans. The second interview was a structured telephone interview with Emma Brown, the Director of the Coalition for the Health and Advocacy of Rural Minorities (CHARM Inc) in Gainesville, Florida. This interview took place on November 15, 2004 and lasted approximately three quarters of an hour. The purpose of this interview was to determine what preventative education programs other area nonprofits are using and the effectiveness of the programs.

I did my undergraduate internship at a nonprofit organization that specializes in HIV/AIDS prevention, so some of this research came from personal experience.

Evaluative Criteria

This analysis will describe and evaluate three policy options by using the following criteria: a theoretically sound program structure, availability/accessibility and staff training. Each criterion will be given a score of high, medium, or low with high being positive and low being negative. A rating of high means there is a thorough accomplishment of the criteria; a medium rating means that there is an average accomplishment of the criteria; a rating of low means there is no accomplishment of the criteria.

A theoretically sound program structure is an essential element of an effective prevention education program. Program structures encompass what activities and services the program offers. Program structure is determined by area representatives. Typically, these persons convene yearly to review what the needs of the communities are and to shape a prevention plan for the upcoming fiscal year. A program structure rates
high if the structure is theoretically sound, and if they use the prevention plan that is recommended and it produces results.

- Accessibility/availability of programs is determined by when and where these programs are being offered. Are program delivery sites on a bus route where low income families without vehicles are able to attend the sessions? It is essential the programs are offered at times that are accessible to persons in need. If those in need are not receiving the information, then a program is not very effective. If a criterion scores in the medium or average range, then it will be evaluated by looking at measures that could be changed within the program without discarding of the entire program.

- Staff are important aspects to determining successful prevention education programs. The staff has to be trained and proficient in delivering these interventions. They have to develop a rapport with the clients in the communities that they are serving. The staff must be persons with whom the community is able to relate to. If a criterion rates low then it will not be used as an intervention for further practice in the different organizations.

**Management Policy Options**

**Option One: Outreach Intervention**

Outreach intervention is the visitation of educators to the community by going door to door or talking to individuals that is on the street corner. Outreach programs focus on meeting the community in their neighborhoods by going into the community and giving out education information on the prevention of HIV virus.

The two programs that will be evaluated under this policy option are MPowerment Project and Real AIDS Prevention Project (RAPP). MPowerment Project
is a community-level HIV prevention program that is run by a “Core Group” of 12-20 young gay/bisexual men from the community and paid intervention staff. The Project mobilizes young gay/bisexual men to shape a healthy community for themselves, build positive social connections, and support their friends to have safer sex. The next program is the Real AIDS Prevention Project (RAPP). It is a community-level HIV prevention intervention designed to help low-income women (aged 15-34) and their partners reduce their risk for HIV infection (CDC 2004).

Theoretically Sound Program Structure: The structure for outreach programs can be either informal or formal. MPowerment Project is an outreach program that is designed to teach young gay/bisexual men in communities about how to reduce the rates of unprotected anal intercourse. It is conducted both formally and informally (CDC2004). In formal outreach, teams of young gay men go to different locations that are frequented by young gay men to discuss and promote safer sex, distribute condoms and deliver educational information literature. This formal outreach helps to build community and provides social opportunities for young gay men and it is scheduled regularly. Informal outreach uses peer influence to change behavior. It is achieved by using supportive and non-judgmental peer interactions. It diffuses a norm of safer sex and testing for HIV.

Another program that is used by organizations for African Americans is the Real AIDS Prevention Project (RAPP). The structure of this program is designed to help low-income women ages 15-34 to help reduce their risk for HIV infection. The purpose of this program is to increase consistent condom use by women and their partners to change community norms and practices and to get community involvement. This program
structure is designed for a specialist to do outreach in the community and do an assessment to identify best places and ways to reach the community members. The specialist has to find out what the people think about HIV prevention and what they see the barriers to change are for the community. One section to RAPP is the role model stories that women with real experiences go out into the communities and share with others about how they change their behaviors. The role models post flyers in the communities and they recruit people who are willing to tell about their experiences. This criterion scores high because of how the people are able to understand the information that is being given to them. The members of the community are being trained and going back into these communities to deliver the message as an educator would do (CDC 2004).

Accessibility/availability: This intervention is very accessible and available because the educators are going out to meet the individuals who are at risk. This criterion scores very high because is the educators are going into the communities to educate individuals at risk. This type of program is comfortable and safe for the individuals receiving the information. The core group meets regularly and analyzes different parts of the project to see what needs improvement or what they can change to make the project work efficiently.

RAPP is very accessible because the specialist is going into the communities to the women. They are having one-on-one, mini-interviews with women to help them think about changing a risky behavior. One aspect of RAPP is the community network that is established with business in the area. Examples of businesses are nail and hair salons, barbershops, welfare offices, drug stores and convenient stores. These businesses
are frequented by African Americans, so they have a way to getting the education on HIV/AIDS (CDC 2004). The more awareness in the community, the better the effectiveness.

**Staff:** The MPowerment Project staff consists of 12-20 gay/bisexual men (core group) from the community, volunteers and paid intervention staff coordinators (CDC 2004). This criterion rates high because the staff and the core group are from the community so they usually know who to talk to and how to talk to them about protecting themselves. It is easier to develop a rapport with someone that you know than someone who we do not know at all. The core group’s members have racial, ethnic and socioeconomic diversity. They support and encourage each other about safer sex.

The staff members for RAPP are trained individuals from the neighborhoods. Peer Volunteers are individuals who like to talk to people on the street and are comfortable with discussing HIV and other sensitive issues. The staff are made up of different age groups and genders and race based on the community being served. The influence from community leaders is very important and ranked highly because the theory behind RAPP is based on behavior change. If the community women see their leaders’ behavior then they will want to follow in their footsteps.

In conclusion, outreach intervention programs are effective, have good structure, trained staff and are very accessible. Program structure, accessibility/availability and staff/leader influence all are criterions that scored high. They are thoroughly accomplishing the goal of the criterion. This intervention is a positive program in the African American communities. Members of the communities are usually accepting of
their own people coming into the neighborhoods and delivering education information that will better the African American community.

**Option Two: Group Intervention**

Group intervention programs are presentations that are intended for groups of people who are assembled together at one time. These programs have the potential to reach large numbers of the target population. They are done more often than not because they are cost effective.

The two programs that will be evaluated under the group intervention policy option are Sisters Informing Sisters About Topics on AIDS (SISTA) and Community Promise which is Peers Reaching Out and Modeling Intervention Strategies. SISTA is a program that applies both the Theory of Gender and Power and the Social Cognitive Theory. It is a social skill training intervention that was developed for African American women at high risk. It consists of five two-hour sessions that is given by peer staff. It is geared toward letting women know that they have the power to tell their partners that they must use condoms when engaging in sexual behaviors. Community Promise is community level intervention to promote progress toward consistent HIV prevention through community mobilization and distribution of small-media materials and risk reduction supplies such as condoms and bleach.

**Theoretically Sound Program Structure:** Sisters Informing Sisters about Topics on AIDS (SISTA) is a program that is set up to have group discussions, lectures, role playing, and a video and take home exercises. SISTA intervention is a program that is designed for African American women to reduce their HIV risk behaviors (DiClemente, Wingwood 1995). This program is theoretically sound because it incorporates the theory
of gender and power in the design of the program. If a woman is convinced that she has some control in her relationship, then she is more willing to assert this power on her partner to wear a condom. This program structure of the group intervention is rated at a medium because it only incorporates women and not men. Men should also be aware of the behaviors that they need to change and what women would like to have happen when they are engaging in risky behaviors.

The next program community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) is a community-level intervention program that is created to a specific population at time of implementation. It was developed to help local health departments and service organizations. Peers from at risk communities provide the content from their own experiences on how to reduce their risk of contracting the HIV virus. Community PROMISE is based on the social cognitive theory which states that persons learn by observing other people successfully practice a new behavior. Community PROMISE has four elements that are responsible for the intent and design of this interventions' effectiveness (CDC 2004).

The first stage is the community identification process in which an up to date assessment of the target population is conducted. This gives the general idea of what are the behaviors in that risk group community, the location of the risk group and the environments where the risky behaviors are taking place. This assessment includes a focus group that elaborates on the information that is received to incorporate in the intervention plan. The second stage is finding members from this community to distribute the information that is needed in this community to reduce their risk behaviors. Training the peers is a part of this process that is very important because they are
distributing the information. They have to feel confident and comfortable with talking to this high risk population about their behavior and how to change it. The third stage is to create role model stories based upon individuals from that particular community who have changed their risky behaviors. The final stage is to distribute the role model stories and risk reduction supplies by the peers. This theory is theoretically sound because many people learn from others by observing their behavior. Usually when we as humans see that something works well for someone else, then we try to imitate to also receive the benefits.

**Accessibility/availability:** SISTA is geared toward women only so this criterion is rated at a low level. It is not available to the whole target population, which are both African American men and women. It should be facilitated in an area where at risk women are able to access public transportation to attend the sessions and there should be no distractions around. The area should also be secure to protect the women's confidentiality.

The next program community PROMISE is scored low with this criterion of accessibility because everyone in this community that needs the intervention to change their risky behaviors will not have access. The peer educators are able to reach places to talk to at risk individuals that an outreach staff would not be able to go. A problem with this intervention in the African American community is where and when are these interviews being conducted? The time of day that these interviews are held might also be a problem for this intervention. Usually the people with high rates of sexually transmitted diseases are at work during the day or at school.
Staff: The staff of SISTA should be peer health educators of which one should be a full time employee (DiClemente, Wingwood 1995). Many of the nonprofit organizations are having a difficult time with funding so this criterion would be scored medium because of this important element of the program structure. The peer educator should be of the same race, gender, and ethnicity of the target population which are African American women. The staff should also be very knowledgeable about the transmission of HIV and methods of prevention and they should have a non-judgmental attitude.

The next program being discussed is a project called community-level PROMISE. Peers from the PROMISE project are trained to talk about the experiences of the role models and tell about their stories. They go out into the community in groups and tell of things that this population can do to change their risky behaviors. Some reasons why this criteria is considered to be low or negative are: the peer staff are the individuals who are collecting the information about the role model stories and keeping track of them and they have to keep a numbered count of all the materials that they distribute and this is not always accurate. Another reason that this criterion is a negative aspect to this program is that the staff must keep the individuals who they are using as role models' identity confidential. This is not always feasible. There is medium influence from the community leaders in this process.

**Option Three: Individual Intervention**

Individual interventions are one on one life saving skill building sessions that teach individuals how to use condoms and safe sex negotiation skills. This intervention focuses
on those people who are afraid to talk in groups but are at high risks for contracting the HIV virus.

The two programs that will be evaluated under the individual intervention are Popular Opinion Leader (POL) and Street Smart. POL is a four session 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. Street Smart is designed for runaway and homeless youth. It consists of eight two-hour sessions. It draws on the social cognitive theory that describes the relationship between behavior change and a person’s belief.

Theoretically Sound Program Structure: Popular Opinion Leader (POL) project is designed to have one on one conversation with peers in different social networks. A trained peer educator speaks one on one with peers in the community and corrects any misperceptions that they have about HIV and AIDS. They also discuss the importance of HIV prevention and what they can do to reduce their risk of contracting the disease. The peer educators give them examples of things they can do to reduce their risk like: keeping condoms close, avoid sex when drunk, trying not to fall into peer pressure of unsafe sex, and getting tested (CDC 2004). This criterion scores high because many individuals prefer one on one attention. People feel more comfortable speaking one on one about an issue than in a group.

The next program structure that is being discussed is Street Smart. It is an intensive prevention program for runaway, gay and homeless youths. It rates high because it gives the youths a chance to talk about their feelings, thoughts and attitudes about changing their sexual behavior on a one on one level. Having someone there to
listen without judging is very important for this target population. They are in the experimental stages of their lives, so this is the time to educate them on their actions and the consequences from it.

**Accessibility/availability:** POL program is scored low because from my experience, individuals are not willing to just stand around and listen to information about HIV/AIDS. Many people are not available during the day and when they are at home many have signs of "no soliciting" because they do not want to be bothered after a long day at work. Another issue is finding peers that are willing to be trained to go out and do the one on one intervention. No one wants to be the outcast of the group and that is what they will be if they go to the club or to a party discussing HIV prevention.

The next program is Street Smart in which it would rate a low for the criteria. When youths run away, they usually do not go to a place where they know that they will have to attend sessions or get lectures. They go to a friend’s house where they can do what they want or the things that they were not able to do at home. How will this program find the teens that are engaging in the sexual activities that are putting them at risk before they reach a shelter? A shelter is for some the last resort of someplace to go when they run away.

**Staff:** POL staff consists of mainly peer educators. The popular opinion leaders for this project must be well-like by their peers. This criterion scores low because it is very hard to find well-like, popular people who are willing to talk to individuals one on one about HIV/AIDS. Individuals in the African American communities do not want to be associated with anything that has to do with this disease called AIDS. In order for this
program to be effective, the peer staff has to recruit others from the community to get them to talk to their friends about their behaviors in terms of HIV and AIDS contraction.

The next program is Street Smart and it scored low under this criteria. There is not enough staff to provide one on one session with these runaway youths. Many of the sessions are done in groups. Each individual youth has different problems and reasons why they are out on the streets and not at home. In a group their problems will not be addressed personally, so they are in the same situations that they start out in.

**Conclusion/Recommendation for Action**

This report found that there are prevention education programs that are suitable for African Americans that can be effective when they are implemented in the right way. Researchers are now realizing that the one size fits all programs were not being effective. The programs that are geared toward African Americans in preventing new HIV cases are now culturally sensitive to this population. The programs are also implemented using African American educators on the frontlines. They are more responsive to an educator if they are from the same ethnic background and in some cases the same gender.

This report has examined three options for effective education prevention programs for African Americans. These options were evaluated by using three criteria: theoretically sound program structure, accessibility/availability and staff/community leader influence. The results are in table 1.
Table 1. Summary of Options and Evaluative Criteria

<table>
<thead>
<tr>
<th>Evaluative Criteria</th>
<th>Option 1 Outreach</th>
<th>Option 2 Group-Level Intervention</th>
<th>Option 3 Individual-Level Intervention</th>
<th>Overall Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretically Sound Program Structure</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Accessibility/Availability</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Staff</td>
<td>High</td>
<td>Medium</td>
<td>Low</td>
<td>Medium</td>
</tr>
</tbody>
</table>

(Scoring: Low, Medium, and High with low being negative, medium being average and high being positive in regards to the evaluative criterion.)

Option one is outreach intervention in which educators go out into the communities and speak to at risk individuals face to face, or in groups. This is done in a place that is comfortable for the individual which usually means they are more willing to listen and try to make changes in their lives. The structure of this program makes it easy to get the education message out. Informal sessions are just as effective as informal sessions as long as the educator is comfortable with talking about the subject of HIV/AIDS. Being very accessible and available to the community has an impact on the success of the program. Humans find excuses to not attend a session about a topic in which they are not too interested in, but if the educator is coming to them, then they are more inclined to listen. The staff of outreach intervention program are individuals from the community in which they are educating about HIV/AIDS prevention. This is a vital tool because these individuals care about the community they are educating so they will
do their job to the best of their ability. The overall result for option one is that the program structure, accessibility/availability, and staff all scored high.

Option two is the group-level intervention in which educators have some programs that are geared to target groups of individuals at one time. This option's overall rating was at a medium level. The program structure was rated medium because not many individuals are willing to get in a group and talk about the risky behaviors of having unprotected sex and what the results might be if they do. HIV/AIDS is not a subject that is typically discussed in everyday conversations among African Americans.

Option three is the individual-level intervention in which educators perform one on one session with at risk individuals. The individual intervention option is limited mainly because of the lack of staff that is available to conduct these sessions. There is usually not enough money in the budget to hire sufficient staff to offer one on one session. The lack of staff leads to a low level of availability. This option's overall rating was average.

In summary, this analysis indicates that outreach intervention ranked the highest in regards to being effective education prevention programs for African Americans. Outreach programs are the recommendation that I would make for being the most effective program. It ranked high when evaluated by each criterion. In my experience, I have witnessed that outreach programs are more accepted because of how the educators approach the at risk individuals. Going to individuals door to door is saying that the educators are willing to do whatever it takes to get the word out about what African Americans can do to protect themselves. People are more responsive when they see someone else taking an interest in their personal lives.
References


Center for Disease Control and Prevention. HIV/AIDS Surveillance Report. 2001; 13(2)


PRESS RELEASE
December 2, 2004

World AIDS day was December 1, 2004. AIDS is an epidemic that started in 1959. It has killed over 500,000 people and 40 million people are now living with the disease in the world. The major concern about this disease in the United States is the rapid pace of new HIV cases in the African American communities. HIV/AIDS cases have been increasing in African Americans between the ages of 25 and 44. This is a problem that can be prevented by behavior changes but it is on the rise with newly diagnosed cases. This study looks at prevention education programs that are specifically for the target population which are African Americans. The programs that were implemented before were trying to use a one size fits all approach when educating individuals about HIV/AIDS. The prevention programs that were implemented before were not culturally sensitive to African Americans. The programs that are offered now are effective if the right programs are chosen for the proper target population. Some programs are giving out supplies which some African Americans could not or would not seek.

The program that is recommended for this specific population is outreach intervention. Outreach intervention is the visitation of educators to the community by going door to door or talking to individuals that is on the street corner. Outreach programs focus on meeting the community in their neighborhoods by going into the community and giving out education information on the prevention of HIV/AIDS. Outreach intervention has a theoretically sound program structure, it is accessible and available to at risk population and the staff is well trained. It is an education prevention program that is done in a place that is comfortable for the individual which usually means they are more willing to listen and try to make changes in their lives. The structure of this program makes it easy to get the education message out. Being very accessible and available to the community has an impact on the success of the program. The staff of outreach intervention program are individuals from the community in which they are educating about HIV/AIDS prevention.

Some benefits to the public from this program recommendation is less new cases of HIV/AIDS by African Americans, the death rates for AIDS will decrease and more awareness in the communities about how individuals can protect themselves from contracting the HIV virus.