



Y-R.I.S.E.

SERVICE-LEARNING AND HIV/AIDS PREVENTION



A White Paper

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Y-R.I.S.E.: Service-Learning and HIV/AIDS Prevention

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Y-R.I.S.E. is Youths Replicating Innovative Strategies and Excellence in HIV prevention

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Introduction to NYLC and

Y-RISE: The Service-Learning and HIV/AIDS Initiative

The National Youth Leadership Council began as a council of organizations providing leadership training for young people. In succeeding years, it pioneered the concept of service-learning, emphasizing active citizenship, curricular connections, and service to others as vehicles for young people to lead change in their own communities. In 2002, NYLC launched *Y-RISE: The Service-Learning and HIV/AIDS Initiative* (Youths Replicating Innovative Strategies and Excellence in HIV/AIDS prevention), to investigate and promote the role of service-learning in confronting the HIV/AIDS pandemic. This White Paper is part of the *Y-RISE* initiative and attempts to assemble a knowledge base of the research, best practices, and resources in service-learning and HIV/AIDS prevention. Based upon the White Paper and consultations at national conferences, the initiative will educate young people to serve as HIV/AIDS prevention peer resources; support HIV/AIDS organizations, particularly those focusing on young people of color who are interested in integrating service-learning strategies; create training tools and evidence-based curricular resources; and increase the awareness of resources and organizations working worldwide to stem the HIV/AIDS tide. Ultimately, the initiative will result in an interactive, vibrant, and inclusive HIV/AIDS prevention community anchored by research, a global peer assistance network, and a computer-based interactive HIV/AIDS prevention resource portal. For more information on *Y-RISE*, please visit www.nylc.org.

It is not the purpose of this White Paper to repeat the vast amount of writing on HIV/AIDS that is currently available through the exceptional work of countless research and policy organizations. Rather, it will attempt to present basic data on the pandemic, the theoretical groundwork for connecting prevention efforts in HIV/AIDS with service-learning, and document successful youth HIV/AIDS prevention programs in North America and around the world. Since there are a very limited number of HIV/AIDS prevention programs specifically using the term service-learning, the White Paper will review a wide range of promising practices related indirectly to service-learning for working with youths (10-24 year olds) in schools and communities throughout the world.

Y-R.I.S.E.: Service-Learning and HIV/AIDS Prevention

I. Introduction

Two program components emerged as important across all reviews: service-learning and mentoring. Service-learning was a particularly crucial program component for youths ages 15 to 18. The vast majority of the programs reviewed were school-based and included young people of all ages.

– National Research Council, *Community Programs to Promote Youth Development*, 2002

Given the hundreds of types of youth development programs throughout the United States and the world, it is a powerful statement to conclude that service-learning and its related activity, mentoring, are among the strongest interventions with youths. It is also somewhat surprising that this “technique,” which has been around in one form or another for over two decades, is seldom mentioned in broader youth development literature or, specifically, in HIV/AIDS literature. This White Paper attempts to fill that gap. It is important to state that service-learning is not a magic bullet that will solve all the ills of a society. It is equally important to state, however, that not only anecdotal evidence but also hard research has found it to be an important tool in helping young people live and work successfully in many different societies. It is also important to note that, though these service-learning methodologies are widely used in the schools and non-formal educational agencies of the United States and a few other countries such as Argentina and Singapore, they are almost unheard of in Africa, India, China, Russia, and Eastern Europe – regions facing the heaviest HIV/AIDS burdens.

II. What is Service-Learning?

Service-learning is a teaching method, a philosophy, and a community development model.

A. A Teaching Method

Service-learning is a teaching method that engages students in meaningful service to their schools and communities, thereby encouraging critical thinking and problem-solving. Through careful integration with established curricula and learning goals, lessons gained from hands-on service heighten interest and enhance academic achievement, citizenship, and character development. Service-learning is a proven key to educational reform and also makes significant contributions to community development (NYLC, 1994).

Regrettably, too many classroom techniques throughout the world are characterized by rote memorization, copying off a chalkboard, group recitation of lessons, and anything but “active learning.” Students seldom have the opportunity to confront real-life issues in their communities, and teachers fear involving their students in anything except the memorization of the national curriculum.

B. A Philosophy

As a philosophy, service-learning embraces young people as a community resource and asset with a capacity to contribute, no matter their age.

This view of young people stands in stark contrast with the majority of youth programs, which view adolescents as the cause of, rather than the solution to, societal problems. Many times, young people who are infected and affected by HIV/AIDS are referred to as “at risk,” “helpless,” or “alienated.” It is the fundamental thesis of this White Paper that until young people are seen in a positive light, the problem of HIV/AIDS in youths stands almost no chance of being solved. The following table (Lofquist, 1987) exemplifies the necessary shift for youths to take their proper leadership role in leading the fight against HIV/AIDS, which is destroying a whole generation of young Africans and millions more around the world.

A Paradigm Shift in Views of Young People

Traditional Views of Young People	A Service-Learning View of Young People
Utilize resources	Act as resources
Passive	Active
Consumer	Producer
Needs help	Offers help
Recipient	Giver
Victim	Leader

It is our contention that, without this major paradigm shift, any real “solutions” to the HIV/AIDS challenge facing our world will at best be partial victories.

C. A Community Development Model

Service-learning is also a development model that takes on real societal issues. In many communities around the world, there is no issue more “real” and pressing than HIV/AIDS. One of the purposes of this White Paper is to outline possible ways in which service-learning can help confront this issue in countries and cultures across the world.

D. Essential Components of Service-Learning

Though service-learning shares much with volunteerism, community service, and community-based learning, it is critical to understand that it emphasizes both the service *and* the learning goals, something not shared by those previously mentioned counterparts. The key elements of service-learning are student ownership, a genuine community need, reflection, clear connections to curricular learning objectives, and the project process. This White Paper will highlight programs that are characterized by student ownership and are clearly related to curricular learning objectives. That they meet a genuine community need in HIV/AIDS prevention almost goes without saying. This is not to say that the tying of service-learning to HIV/AIDS is an easy effort, given the controversies over sexuality in general, to say nothing of adolescent sexuality. It is our strong belief, however, that youths are the key to dealing with the issue, and that school- and community-based service-learning can be a powerful tool in confronting the pandemic.

There are several components crucial to successful service-learning. The following table presents ways in which these essential components of service-learning can assist the effort in addressing the current HIV/AIDS crisis.

Service-Learning and Possible Lessons for HIV/AIDS Interventions

Essential Components of Service-Learning	Possible Lessons for HIV/AIDS Interventions
Youth Voice	Too many HIV/AIDS programs are adult-designed, managed, and evaluated, with little or no youth input. Young people, not just “experts,” need to be involved in planning, implementing, and evaluating all HIV/AIDS interventions.
Genuine Community Needs	Addressing the HIV/AIDS pandemic as a genuine need in all communities around the world. By tackling this monumental issue, young people can feel like they are truly making a difference.
Partnerships	There is a plethora of organizations doing great work around HIV/AIDS. Collaboration and sharing resources, rather than repetition of services, will make the biggest impact.
Learning Objectives	Youths involved in HIV/AIDS prevention can not only improve their own communities, but also learn valuable skills themselves. Specific learning objectives should be set to ensure learning is tied to the service.
Preparation	Before young people begin taking on this issue in their communities, it is crucial they are educated, trained, and understand their roles.
Academically and Developmentally Appropriate Service	A youth’s involvement in HIV/AIDS prevention and education should be suited to their age and developmental capacity. All youths, regardless of age, can play an important role in the community, but a young child’s role will be different than an adolescent’s role.
Reflection	Participants should be engaged in a wide variety of reflection activities before, during, and after the service. This will ensure they are learning from the experience and are thoughtfully serving their community.
Youth Assessment	Young people’s assessment of HIV/AIDS interventions is crucial. If they believe the intervention has been unsuccessful with their peers, they are likely correct.
Program Evaluation	In addition to youth assessment, it is important that some type of program evaluation be conducted. Without measuring knowledge and attitudes, for example, it is impossible to know whether an intervention has had an impact on young people.
Diversity	HIV/AIDS does not discriminate. It affects every group of society in some way. It is important, therefore, that a diverse group of youths are involved in planning and implementing HIV/AIDS interventions. It is also crucial that the role of culture is carefully considered when planning such programs.

III. Programs for Youths

There is great diversity of focus and character found in community programs for youths. Community Counts (McLaughlin, 2000) examined more than 120 community organizations that differed in almost every possible way. Less than half of the programs studied utilized service-learning, yet each of them made a solid contribution to promoting positive assets in youths. In doing so, they utilized one or more of the following:

- character development and ethnical enrichment activities.
- mentoring activities, including one-to-one relationship-building and tutoring.
- community youth centers and clubs.
- non-school hours, weekend and summer programs, and camps.
- sports, recreation, and other activities promoting physical fitness and teamwork.
- services that promote healthy development and behavior on the part of youths, including risk-avoidance programs.
- academic enrichment, peer counseling and teaching, and literacy.
- camping and environmental education.
- cultural enrichment, including music, fine arts, and performing arts.
- workforce preparation, youth entrepreneurship, and technological and vocational skill-building, including computer skills.
- opportunities for community service.
- opportunities that engage youths in civic participation and as partners in decision-making.
- special interest groups or courses including video production, cooking, gardening, pet care, photography, and other youth-identified interests.
- public and private youth-led programs, including those provided by youth-serving and youth development organizations.
- developmental rites of passage, including bat and bar mitzvahs, first communion and confirmation ceremonies, and American Indian rituals.

The Committee on Community-Level Programs for Youth of the National Research Council (2002) concluded that effective youth strategies incorporate the following positive developmental features:

Physical and psychological safety includes creating not only a safe environment, but also handling conflicts among participants as they arise.

Clear and consistent structure with appropriate levels of adult supervision, including setting limits, consistent rules and expectations, and clarity about behavioral expectations.

Supportive relationships provide youths with a strong sense of warmth, closeness, caring, support, and guidance from adult leaders.

Opportunities to belong help youths develop confidence and personal identity, regardless of gender; ethnicity; sexual orientation; personality; or physical, intellectual, or social limitations.

Positive social norms require a commitment by youths to uphold rules of behavior, to be held accountable, and to live up to a set of morals and values.

Support for efficacy and mattering in which youths participate in leadership of the program, including designing, delivering, and evaluating the activities.

Opportunities for skill-building utilize community service, adventure and outdoor activities, art, drama, music, religious instruction, sports, cultural awareness, academic improvement, and career preparation. These skills might include developmental skills such as cooperation, creativity, or communication; cognitive abilities and intellectual growth; or skills such as tutoring, computer training, recreational activities, team-building programs, and youth leadership activities.

Integration of family, school, and community efforts in what Benson (1996) describes as a shared commitment to youths; daily opportunities to acknowledge, encourage and support youths; and the intentional involvement of countless community organizations to provide youths with positive experiences.

IV. Resiliency in Youths

In keeping with the emphasis on the positive roles that young people must play in dealing with the HIV/AIDS crisis, we begin our discussion with what Scales and Leffert (1999) call the “building blocks” of healthy development. Listing 40 specific external and internal assets, their research concludes that the following constructs can be consistently identified in assisting young people in their positive growth and development:

- The caring relationships and connections young people have with others.
- The development of various skills and competencies, such as planning and decision-making.
- The effective occupation of young people’s time.
- The establishment of consistent norms and expectations for behavior.
- The positive connection to social institutions, such as schools and religious congregations.
- The development of positive self-perceptions.

When the lives of young people are characterized by these factors, students are far less likely to become involved in high-risk behavior. The tables on the following pages (Search Institute, 2004) list the basic external and internal assets affecting young people.

EXTERNAL ASSETS		
Support	Family support	Family life provides high levels of love and support.
	Positive family communication	Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).
	Other adult relationships	Young person receives support from three or more non-parental adults.
	Caring neighborhood	Young person has caring neighbors.
	Caring school climate	School provides a caring, encouraging environment.
	Parent involvement in schooling	Parent(s) are actively involved in helping young person succeed in school.
Empowerment	Community values youth	Young person perceives that adults in the community value youths.
	Youths as resources	Young people are given useful roles in the community.
	Service to others	Young person serves the community one hour or more per week.
	Safety	Young person feels safe at home, at school, and in the neighborhood.
Boundaries and Expectations	Family boundaries	Family has clear rules and consequences, and monitors the young person's whereabouts.
	School boundaries	School provides clear rules and consequences.
	Neighborhood boundaries	Neighbors take responsibility for monitoring young people's behavior.
	Adult role models	Parent(s) and other adults model positive, responsible behavior.
	Positive peer influence	Young person's best friends model responsible behavior.
	High expectations	Both parent(s) and teachers encourage the young person to do well.
Constructive Use of Time	Creative activities	Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
	Youth programs	Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
	Religious community	Young person spends one hour or more per week in activities in a religious institution.
	Time at home	Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS		
Commitment to Learning	Achievement motivation	Young person is motivated to do well in school.
	School engagement	Young person is actively engaged in learning.
	Homework	Young person reports doing at least one hour of homework every school day.
	Bonding to school	Young person cares about her or his school.
	Reading for pleasure	Young person reads for pleasure three or more hours per week.
Positive Values	Caring	Young person places high value on helping other people.
	Equality and social justice	Young person places high value on promoting equality and reducing hunger and poverty.
	Integrity	Young person acts on convictions and stands up for her or his beliefs.
	Honesty	Young person tells the truth, even when it is not easy.
	Responsibility	Young person accepts and takes personal responsibility.
	Restraint	Young person believes it is important not to be sexually active or to use alcohol or other drugs.
Social Competencies	Planning and decision making	Young person knows how to plan ahead and make choices.
	Interpersonal competence	Young person has empathy, sensitivity, and friendship skills.
	Cultural competence	Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
	Resistance skills	Young person can resist negative peer pressure and dangerous situations.
	Peaceful conflict resolution	Young person seeks to resolve conflict nonviolently.
Positive Identity	Personal power	Young person feels he or she has control over "things that happen to me."
	Self-esteem	Young person reports having a high self-esteem.
	Sense of purpose	Young person reports, "my life has a purpose."
	Positive view of personal future	Young person is optimistic about her or his personal future.

The Search Institute reports a high relationship between the number of assets listed above that an adolescent possesses and what they call “thriving behavior.” While each culture might list different “thriving” indicators, these appear to be nearly universal.

The Relation of Assets to Thriving Indicators among Adolescents

Thriving Behavior	Definition	% of Adolescents With:			
		0-10 Assets	11-20 Assets	21-30 Assets	31-40 Assets
Succeeds in school	Gets mostly As on report card.	7	19	35	53
Helps others	Helps friends or neighbors one or more hours per week.	69	83	91	96
Values diversity	Places high importance on getting to know people of other racial/ethnic groups.	34	53	69	87
Exhibits leadership	Has been a leader of a group or organization in the past 12 months.	48	67	78	87
Resists danger	Avoids doing things that are dangerous.	6	15	29	43
Delays gratification	Saves money for something special rather than spending it all right away.	27	42	56	72
Overcomes adversity	Does not give up when things get difficult.	57	69	79	86

Though it is possible to conclude that young people without many external and internal assets are in greater danger of becoming involved in risky behaviors, it has been shown that a large percentage of adolescents – even those with 10 or fewer assets – help others, exhibit leadership, and overcome adversity. The findings appear to remain fairly constant for U.S. adolescents across differences of race and ethnicity, gender, age, socioeconomic background, community size, and geographical region. To our knowledge, however, the studies have not yet been replicated in developing nations, specifically in Africa, where the HIV/AIDS virus is taking such a heavy toll on the young.

V. Youths At Risk

The underlying assumption that rational people will not engage in risky behavior if they are informed fully about the risk probably is erroneous. It has argued persuasively that risky behavior by adolescents often is explicable by an economic rational choice model. If one perceives few long-term opportunities, behavior in pursuit of immediate pleasure or gain, seen in the face of potentially deadly long-term consequences, is rational, especially if the means of minimization of risk (e.g., use of condoms) are perceived as aversive.

— Gardner and Herman, 1990

We begin with this quotation, as it serves as a warning to researchers attempting to explain human behavior. Risky behavior, particularly among adolescents in poor countries, may be inexplicable in traditional terms, but must be understood in light of their present reality and future hope. Having said that, the following models assist us in understanding why HIV/AIDS so greatly impacts the young throughout the world.

There are many groups at risk of contracting HIV/AIDS in every society, but they vary greatly between countries and regions of the world. Though the initial surge in HIV in the United States primarily affected homosexual males, the virus has recently spread more widely among intravenous drug users and their sexual partners, with growing numbers of women becoming infected. In Thailand, it has largely spread from sex workers, male and female, to their clients; this is also a growing problem on the Indian subcontinent. In Sub-Saharan African, HIV/AIDS is primarily heterosexual in nature. Many countries currently find significantly larger percentages of women than men suffering from the infection. Though all these at-risk groups are of concern, the major focus of this White Paper is that of young people, both in the United States and internationally.

Throughout history, adolescence has been the period when young people establish a sense of identity and autonomy. It is also a period of rapid growth in all dimensions, and while most young people successfully confront the challenges, far too many participate in risky behaviors – often with tragic consequences. Historically, infections accounted for much of disease and mortality among the young, but in the 20th and 21st centuries, so-called social morbidities involving social, environmental, and behavioral factors play an ever-increasing role. Normal adolescent behavior involves increasing independence and autonomy from family, placing greater importance of peers, growing sexual awareness, identity formation, and physiological and intellectual maturation.

Many behaviors place adolescents at risk in the United States and other wealthy nations. Irwin (1993) has studied many risk behaviors, finding high school students significantly more likely to participate in them than middle school students. Obviously, many if not most of these factors are highly dependent on wealth, and thus are not readily available to the poor in developing nations.

One of the largest and most influential studies of American adolescents was conducted by the Search Institute in the 1980s. Though the study focused primarily on the internal and external assets that help provide resiliency for young people, it also listed and analyzed the patterns of assets and high-risk behavior among adolescents. Not surprisingly, they found that young people with more assets participated in significantly fewer high-risk behaviors. (See chart of following page.)

Patterns of Assets and High-Risk Behavior among Adolescents

Risk Behavior Pattern	Definitions	% of Adolescents With:			
		0-10 Assets	11-20 Assets	21-30 Assets	31-40 Assets
Alcohol	Has used alcohol three or more times in the past month or gotten drunk once or more in past two weeks.	53	30	11	3
Tobacco	Smokes one or more cigarettes every day or uses chewing tobacco frequently.	45	21	6	1
Illicit drugs	Used illicit drugs three or more times in the past year.	42	19	6	1
Sexual Intercourse	Has had sexual intercourse three or more times in lifetime.	33	21	10	3
Depression/Suicide	Is frequently depressed and/or has attempted suicide.	40	25	13	4
Antisocial behavior	Has been involved in three or more incidents of shoplifting, trouble with police, or vandalism in the past year.	52	23	7	1
Violence	Has engaged in three or more acts of fighting, hitting, injuring a person, carrying or using a weapon, or threatening physical harm in the past year.	61	35	16	6
School Problems	Has skipped school two or more days in the past month and/or has below a C average.	43	19	7	2
Driving and Alcohol	Has driven after drinking or ridden with drunk driver three or more times in the past year.	42	24	10	4
Gambling	Has gambled three or more times in the past year.	34	23	13	6

Another study of both middle school and high school students in the early 1990s found rather startling percentages of young people involved in risky behavior. Though many behaviors have seen a drop in adolescent participation in the past decade, there still remain millions of American youths involved in behaviors with profound life-and-death implications.

Percentages of Middle School and High School Aged Youths Engaging in High-Risk Behaviors

Health Risk Behavior	Middle School	High School	Total
Alcohol (ever used)	71.8%	84.4%	78.4%
Alcohol (> 0 -1 /month)	13.8%	42.8%	28.7%
Marijuana (ever used)	31.9%	61.4%	47.1%
Marijuana (< 0 - /month)	9.4%	33.0%	21.6%
Sexual intercourse	21.4%	43.9%	33.3%
Casual sex	8.0%	19.7%	14.4%
Unprotected sex	11.0%	32.6%	22.8%
Take chances on bike/skateboard	68%	59.5%	63.3%
Use bike/skateboard under influence	7.7%	19.5%	14.0%
Not use seatbelt in car	56.9%	71.9%	64.0%
Drive/ride in car over speed limit	63.8%	73.4%	70.7%
Passenger in car with impaired driver	36.9%	58.3%	48.3%
Drive car/motorcycle under influence	3.9%	9.4%	6.8%

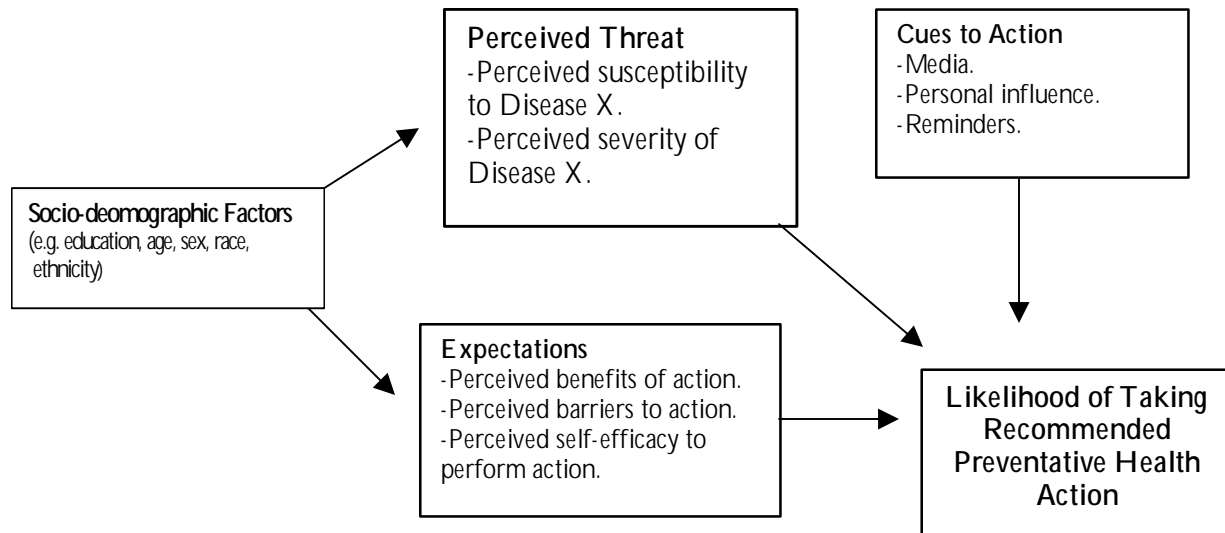
N = 640, ages 11-14, N = 68, ages 14-18
 Irwin (1993)

VI. Theories of Behavior Change and Risk-Taking Behavior Models

What has likely puzzled adults for millennia is what motivates the young to participate in high-risk behaviors. For several decades, scientists have been probing social, psychological, familial, genetic, and other factors that appear to lead to risky behaviors. We now turn our attention to some of the behavior and risk-taking models that shed light on why youths are at a particularly high risk of HIV infection, and then examine the implications each of those models has on the use of service-learning in HIV/AIDS prevention.

A. Health Belief Model

The Health Belief Model (HBM) describes and predicts health behavior in terms of an individual's beliefs and perceptions about the disease. Perceived susceptibility to and severity of the disease, along with the benefits of and barriers to preventative action, are brought together in the mind of the individual in something of a cost-benefit analysis, with the susceptibility and severity providing the energy or force to act (Rosenstock, 1994).



Possible Implications for Service-Learning and HIV/AIDS Prevention:

Through exposing young people to community resources and helping them establish ties with trusted adults, service-learning has the potential to decrease perceived barriers to adopting healthy behaviors. Serving those who are infected and affected by HIV/AIDS within their own communities will likely heighten perceived susceptibility and severity of the disease in the minds of young people. Efficacy of youths that participate in life-skills lessons will increase as each group is trained in communication and negotiation skills.

B. Cognitive Dissonance Model

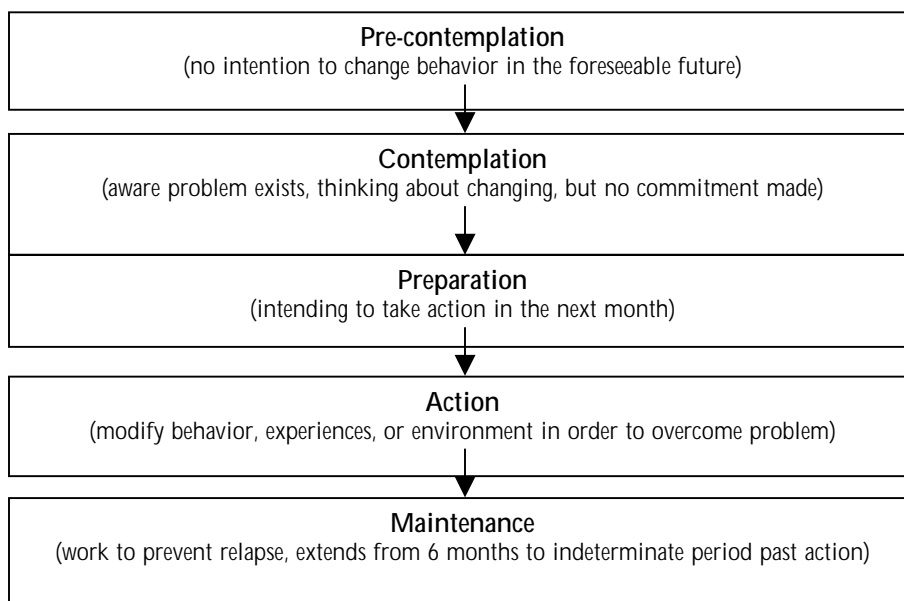
The Cognitive Dissonance Model states that knowledge may run counter to the actions a person takes, and inconsistency may exist between behavior and beliefs. Dissonance may arise from cultural mores, specific opinions, or past experience (Advocates for Youth, 2002).

Possible Implications for Service-Learning and HIV/AIDS Prevention:

Service-learning attempts to place young people in active learning settings where the values, norms, and beliefs of their particular culture and religion are compatible with their behaviors. Thus, service-learning has been shown to have effects on sexual behavior, even when the activities related to sexual knowledge and practice form only a small part of the program.

C. Stages of Change Model

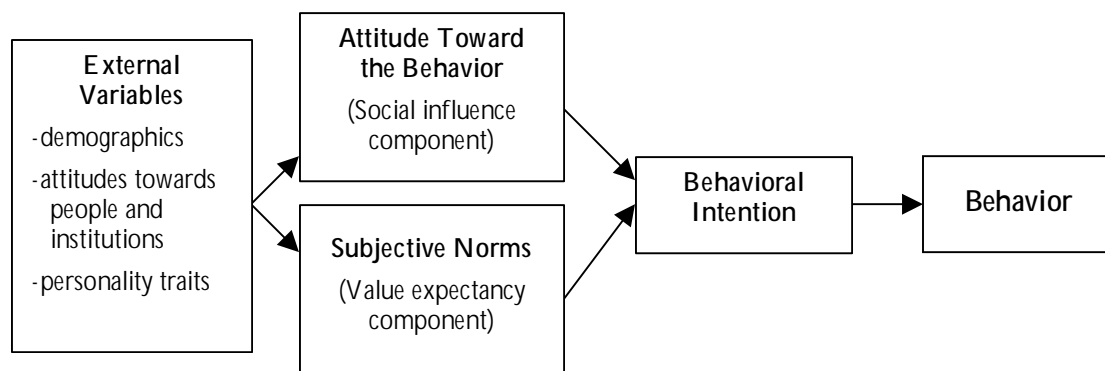
The Stages of Change Model, also known as the Transtheoretical Model, asserts that a person may go through a sequence of stages when attempting to change a behavior. At each stage of change, different intervention approaches are needed.



Possible Implications for Service-Learning and HIV/AIDS Prevention: Service-learning involves planning, implementing, evaluating, and reflecting, which can parallel the stages of change theory. It is harder, however, to connect sexual behavior directly to such stages, where many carefully planned decisions can be lost under strong peer pressure.

D. Theory of Reasoned Action Model

Another approach to human behavior is that of “reasoned action,” a general theory that deals with the relationships among beliefs, attitudes, intentions, and behavior (Fishbein, 1994). The theory has been successfully used to predict and explain why people have or have not engaged in a wide variety of behaviors, including smoking, drinking, entering a treatment program, using contraceptives, dieting, wearing seat belts or safety helmets, exercising regularly, voting, breast-feeding, donating money, and choosing a career. The theory assumes that a causal chain links beliefs to behavior. Behavior is viewed as a function of intention, and intention is seen as a joint function of one’s overall positive or negative feeling about performing the behavior and one’s overall perception of social pressure to perform or not perform it.



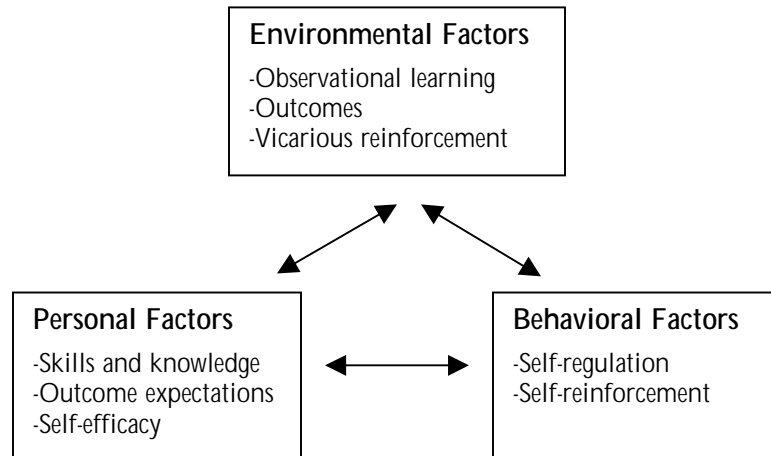
Possible Implications for Service-Learning and HIV/AIDS Prevention:

Abstinence programs are often based on personal intention and perceptions of social pressure. Positive peer action for individual and societal good through service-learning can influence personal intention regarding the choices young people make about sex. Through serving as leaders among their peers and communities, youths involved in peer education will likely develop more positive attitudes about preventive behaviors and more negative attitudes about risk behaviors. As they raise HIV/AIDS awareness and educate their peers, these young people will inspire more positive social norms in their communities about HIV/AIDS prevention.

E. Social Cognitive Theory

One of the most recognized theories on HIV-infection control comes from social psychology and the work of Albert Bandura (1994). To date, a large percentage of the programmatic effort(s) to prevent the spread of HIV has been through informing the public about the virus, how it is spread, and what precautions to take. Regrettably, there is little evidence that information alone is sufficient. Bandura makes the case that, to achieve self-directed change, people need to be given not only the reasons to alter their risky behavior, but also the behavioral means, resources, and social support to do so. There is a great difference between possessing self-regulative skills and being able to use them effectively and consistently under difficult circumstances. In the passion of the moment, millions do not use or have their partner use condoms or other protection. In the often-problematic arena of gender relations, women all too often are unable to protect themselves or their partners. Coercive threat, allurements, desire for social acceptance, social pressures, situational constraints, fear of rejection, and personal embarrassment make it almost impossible for many people, not just the young, to control their interpersonal situations.

Social cognitive theory holds that people's beliefs in their own ability to motivate themselves and regulate their behavior play a crucial role in altering dangerous health habits. Belief in one's personal power to exercise control over one's sexual behavior has emerged as the best predictor of sexual risk-taking behavior.



Possible Implications for Service-Learning and HIV/AIDS Prevention:

Self-determination or self-esteem are important goals and by-products of most service-learning programs. When young people are placed in learning environments, often in the community, and are able to take effective action, self-esteem has been shown to rise. Service-learning provides a positive peer environment. Observational learning and imitation (environmental factors) parallel the importance of mentors, teachers, and other adult role models in how youths can make good choices in their sexual lives.

F. Risk-Taking Model

The following table lays out the bio-psychological and environmental factors that appear to affect youths predisposed to risk-taking behavior. Irwin and his colleagues present the bio-psychological and environmental factors that seem to lead to increased vulnerability in risk situations, and the precipitating factors that lead some young people to take a risk.

RISK-TAKING BEHAVIOR	
Bio-psychological Factors (Endogenous)	Environmental Factors (Exogenous)
Predisposing Factors: <ul style="list-style-type: none"> • Aggressiveness • Asynchrony of biological/psychological and social development • Cognitive style • Developmental drives during adolescence • Gender • Genetics • Hormonal effects in boys • Internalization of role models • Race/ethnicity • Self-esteem 	Predisposing Factors: <ul style="list-style-type: none"> • Low parental support and controls • Maladaptive family situations • Parental denial • Parental involvement in risk behavior • Parental style • Socioeconomic status • Lack of structure • Ignorance of behavioral consequences • Peer behavior • School transitions • Societal denial and responsiveness
INCREASED VULNERABILITY AND/OR RISK SITUATION	
Precipitating Factors: <ul style="list-style-type: none"> • Lack of experience/knowledge • Lack of skills to resist peer pressure • Substance use/multiple substance use 	Precipitating Factors: <ul style="list-style-type: none"> • Peer initiation • School transitions • Social pressure • Substance use availability

Modified from Irwin and Millstein (1986) and Irwin and Ryan (1989)

Possible Implications for Service-Learning and HIV/AIDS Prevention:

Participation in service-learning can impact several of the factors that predict risk-taking behavior. In particular, through providing valuable contributions to their schools and communities in service-learning projects, young people often experience an increase in self-esteem. Service-learning also provides an opportunity for youths to encounter positive role models and internalize their behaviors.

VII. Service-Learning and Theories of Behavior Change

As indicated by the relationships of service-learning to the various theories above, there are multiple components to any successful behavioral-change program. Though disseminating information on HIV/AIDS is absolutely critical, it is almost never sufficient. Much research has been done on what young people or adults know or do not know about the virus. While school and out-of-school programs providing good information are critical to any overall strategy, cognitive factors are seldom sufficient. The motivation to maintain or change a behavior is another critical factor in any successful program, but motivation in and of itself seldom is sufficient. While information-sharing is perhaps the most widely adopted intervention, life-skills curricula are now being used throughout the world to assist young people to initiate and sustain new behaviors. Many of the programs described throughout this White Paper include a wide range of life skills to assist young people in dealing with the pressures that face them; decision-making, relationship, communication, thinking, emotional management, assertiveness, gender roles, resistance, and a host of other skills are taught in short and long courses around the world. Good service-learning programs include many of these life-skills as part of young people's preparation for work in their communities.

One of the more abstract, but critical, components in preparing young people for life in an HIV/AIDS-affected world is the concept of hope, or the belief that change is not only possible, but that one can actually make a difference for one's self, community, nation, and the world. While the word "empowerment" has been overused in recent years, it is fundamental to any successful HIV/AIDS prevention effort, and it is here that service-learning is perhaps the most powerful tool in the prevention arsenal. While students can be empowered by their culture, religion, families, and many other sources, service-learning often provides the tangible evidence and skills necessary to believe that they can make a difference both individually and as a group. In fact, it is our observation that a lack of hope on the part of so many young people in the world makes it so difficult for HIV/AIDS campaigns to succeed. It is important to state here that service-learning is not intended as a panacea or magic bullet to give young people hope. Still, there is strong evidence that it is more successful than mere information-sharing or life skills taught alone.

Community norms are difficult to change, but research indicates that societal norms on a wide range of individual behaviors can be changed. Media campaigns, such as MTV's worldwide efforts on HIV/AIDS, and work by religious organizations, businesses, and other community organizations can help change norms. In countries that recognized the nature of the HIV/AIDS epidemic early on, political, economic, and other leaders took on public roles. They brought about changes in education, politics, law, and the economy necessary to support behavioral change. Regrettably, many world leaders were slow to become involved, and many of their countries are now in a state of major crisis.

Information on HIV/AIDS has seldom been sufficient as a major behavior-change mechanism. Millions of children are given lectures, handed pamphlets, shown videos, and offered a wide range of information on causes and prevention of HIV/AIDS. If schools were successful not only in providing information, but also ensuring that students learned and acted differently, then much of the problem would be solved.

Service-learning appears to relate well to several of the prevention theories listed above. A growing body of research literature supports its efficacy as a positive resource. Just as the tool of service-learning can be integrated into theory-based programs, so can established service-learning programs take lessons from behavior-change theories, such as:

1. Service-learning is not just an individual change model, but involves groups of peers, family and community members, and supportive agencies within the community.
2. Young people are provided with outlets for leadership, helping others, creativity, caring, and other positive external and internal assets.
3. Self-determination has been shown in many studies to be enhanced through service-learning activities.
4. Positive peer-group activities are a significant part of the process; they reinforce many values necessary to resist involvement in high-risk behaviors.
5. While many orphaned children in the developing world have been deprived of parental support and even of adult relatives, service-learning can offer opportunities for other community adults to fill some of these critical roles.
6. While schools in many communities and countries may not be open to service-learning, other organizations such as religious communities, sports clubs, and NGOs can assist young people in utilizing this methodology to gain personal skills and improve their communities.

VIII. Youth Sexual Activity

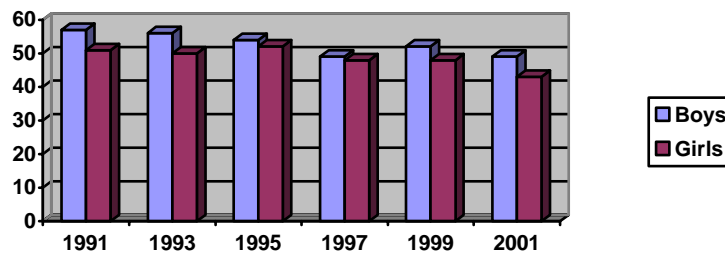
“Service-learning programs may have stronger evidence that they reduce actual teen pregnancy rates while youths are in the programs than any other type of intervention.”

– Kirby, 2003

In the quotation above, Douglas Kirby – one of the world’s leading researchers on adolescent sexual behavior – was not referring directly to HIV/AIDS prevention. However, he was speaking about sexual behavior in youths, and his conclusion provides a strong argument for this White Paper on the role that service-learning can play in reducing adolescent risk. The United States has seen an explosion of service-learning programs from primary through higher education, but it is still a somewhat unknown phenomenon in much of the world. In fact, on the continent most affected by the virus, Africa, few schools have adopted this promising methodology.

While risky sexual behavior has led to unwanted pregnancies and STIs throughout human history, it can now lead to exposure to HIV/AIDS – a death sentence for most of the poor of this world. The following table (Henry J. Kaiser Foundation, 2003) provides data on the sexual activity of American youths. It reports that fewer than half of all 9th- through 12th-graders have had sexual intercourse, with the percentages falling over the decade. Males are more likely than females to report having had sex. The median age at first intercourse is 16.5 years, with 35% of 9th-graders and 61% of 12th-graders reporting having had sexual intercourse.

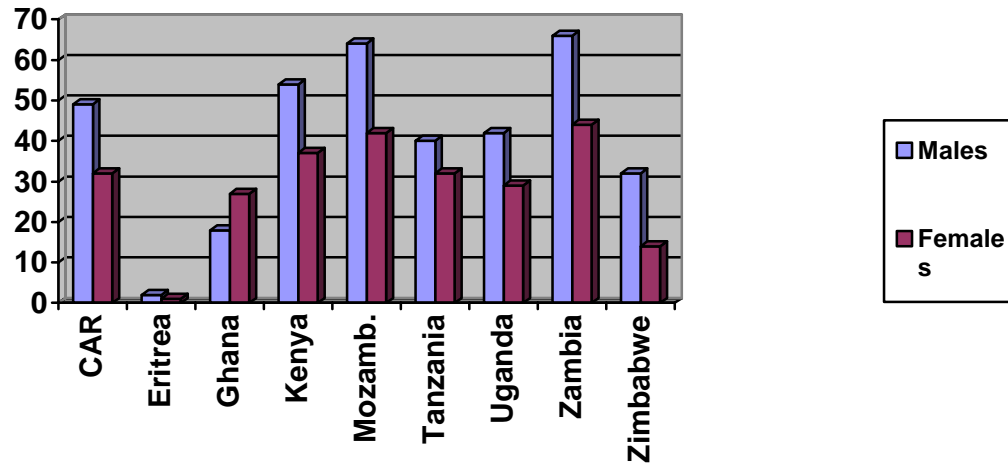
Percentage of U.S. 9-12th Graders, by Gender, Who Have Had Sexual Intercourse, 1991-2001



With the African continent suffering so greatly from the HIV/AIDS epidemic, a perception has grown that African young people have considerably higher levels of sexual intercourse. This is not borne out, however, in data on the sexual activities of 15- to 19-year-old unmarried youths.

As depicted in the following table, research throughout the continent reported by the Johns Hopkins Center Population Information Center (2003) shows tremendous variability between countries. In many countries, African youths report similar or lower sexual activity than in the U.S., despite the surveys going up to age 19 (generally one to two years beyond grade 12 in the U.S. setting).

Sexual Activity Among Unmarried Youths Ages 15-19 in Selected African Countries, Surveys 1991-1999



It should be noted that data from throughout the developing world are generally of questionable quality. With the exception of Brazil, the Dominican Republic, Jamaica, and Haiti, countries throughout Latin America, Asia and the Middle East tend to report lower percentages of youth sexual activity than either Africa or the U.S.

IX. Scope of the HIV/AIDS Epidemic

According to UNAIDS, over 20 million people have died of HIV/AIDS worldwide, and an estimated 40 million are living with the virus. While HIV can be found in every part of the world, over 96% of cases are found in developing nations. An estimated five million people were newly infected in 2001, with more than three million deaths that same year. AIDS is the number one cause of death in Africa, and the fourth leading cause of death worldwide. Though early reports of the epidemic primarily impacted men who have sex with men and intravenous drugs users, the proportion of women infected is now as high or higher than that found among males in most countries in the world (UNAIDS, 2002). The scope of this broad epidemic can be seen in the following table from the same UNAIDS report.

HIV/AIDS Prevalence and Incidence by Region

Region	Adult (ages 15-49) Prevalence Rates	Total Nr. (%) Persons Living with HIV/AIDS (end 2003)		Newly Infected (2003)
Sub-Saharan Africa	8.0%	26.6 million	(67%)	3.2 million
Caribbean	2.5%	470,000	(1%)	62,500
Eastern Europe and Central Asia	0.7%	1.5 million	(4%)	230,000
South and Southeast Asia	0.6%	6.2 million	(16%)	855,000
Latin America	0.6%	1.6 million	(4%)	150,000
North America	0.6%	995,000	(2%)	45,000
Western Europe	0.3%	600,000	(1%)	35,000
North Africa and Middle East	0.3%	600,000	(1%)	55,000
East Asia and Pacific	0.1%	1 million	(2%)	210,000
Australia and New Zealand	0.1%	15,000	(<1%)	875
Global Totals	1.1%	40 million	100%	5 million

UNAIDS, 2003

Before turning our attention to the youth focus of this White Paper, it is important to document the broad range of effects of the HIV/AIDS epidemic.

- In countries with more than a 20% prevalence rate, the epidemic can lead to reductions in the Gross Domestic Product (GDP) of as much as 2.6% annually (UNAIDS, 2002).
- Life expectancy in many of the hardest hit countries could drop below 30 years of age, from expectancies in the 60s and 70s when AIDS was not prevalent (U.S. Census Bureau, 2002).
- Schools are being hit dramatically in many countries, with thousands of teachers dying and many schools being closed (World Bank, 2002).
- Health systems in developing countries are overwhelmed by high needs and insufficient funds. Even with the cost of anti-retroviral drugs falling, few of the poor yet have access to even minimal care. Current total expenditures amount to around \$1.5 to 2.8 billion, whereas current needs are from \$7 to 10 billion, with projected needs increasing to \$20 to 25 billion annually by 2015 (UNAIDS, 2002).

X. Youths and HIV/AIDS

While the term “youths” is officially defined as individuals between the ages of 15 and 24, the HIV/AIDS crisis reaches beyond these boundaries to younger ages. There is strong evidence that 16% of all new HIV infections are found in the under-15 age group. UNAIDS and other reporting groups tend to include 10- to 24-year-olds in the category, and use the terms “young people,” “youths,” and “adolescents” interchangeably. It is recognized, however, that in many cultures, young people are considered adults long before the age of 24. With more than five million new infections each year, these statistics break down to more than 6,000 new infections every day, or one every 15 seconds (UNAIDS, 2001). The numbers of youths or adults infected is not exact, but the same U.N. report estimates the following:

**Estimated Numbers of Young People,
Ages 15 to 24, Living with HIV/AIDS (2001) (numbers rounded)**

Region	Young People	Young Women	Young Men
Sub-Saharan Africa	8,600,000	67%	33%
East Asia and Pacific	740,000	49%	51%
South Asia	1,100,000	62%	38%
Latin America and Caribbean	560,000	31%	69%
Middle East and North Africa	160,000	41%	59%
Eastern Europe and Central Asia	430,000	35%	65%
North America	150,000	32%	68%
Western Europe	89,000	38%	62%
Total	11.8 million	7.3 million	4.5 million

UNICEF, 2002

The startling figure of 58% of new HIV infections being found among under 24-year-olds forms the foundation for NYLC’s service-learning and HIV/AIDS initiative, and underscores the urgency felt by parents, educators, and health professionals to find and develop successful models for HIV prevention. An even more distressing estimate is that even if HIV risk were cut in half by 2015, in some countries 20 to 80% of today’s 15-year-old young men would still die of AIDS (Population Information Center, 2004). In most African countries, the estimates of young women infected significantly outnumber that of young men, and has now reached extremely high levels, as is evidenced by the following table:

HIV Prevalence Among Youths: Ages 15-24, (end of 1999)

Country	Young Women	Young Men
Botswana	32.6 - 36.1%	4.1 - 7.5%
Swaziland	25.9 - 31.2%	8.7 - 17.4%
Lesotho	23.9 - 28.9%	8.0 - 16.1%
South Africa	22.5 - 27.1%	7.6 - 15.1%
Zimbabwe	23.3 - 25.8%	9.8 - 12.9%

There are significant differences in the rates of infection between regions, countries within regions, and groups within countries. Sub-Saharan Africa contains 10% of the world’s youths, but accounts for three quarters of all youths currently living with the HIV/AIDS virus. Southern Africa tends to be the most highly impacted, with Eastern African countries in the middle, and comparatively low rates for West

Africa. Within Asia, Cambodia, Myanmar (Burma), and Thailand have the highest infection rates, but UNAIDS has recently been raising major concerns about both China and India, where the virus appears to be spreading rapidly. The Caribbean countries are more highly impacted than most of Latin America, although there are high numbers of infected youths in Brazil.

XI. Special Vulnerability of Youths

The demographic reality of most developing nations, and particularly those in Sub-Saharan Africa where the majority of the population is under age 18, makes prevention efforts crucial. According to a Population Information Center report released in 2004, the physical, psychological, and social attributes of adolescence make young people particularly vulnerable to HIV and other sexually transmitted infections (STIs). Adolescents are often unable to fully comprehend the extent of their exposure to risk. Societies often compound young people's risks by making it difficult for them to learn about HIV/AIDS and reproductive health. Moreover, many youths are socially inexperienced and dependent on others. Peer pressures easily influence them, often in ways that increase their risk.

HIV/AIDS experts point out a number of factors that make children and adolescents particularly vulnerable to HIV infection:

- While educational campaigns are underway throughout the world, a large percentage of young people (as high as 90% in some countries) are still unaware of how to protect themselves or have misconceptions about the disease (Population Reference Bureau, 2000).
- Information and education have proven insufficient. Risk avoidance skills, delay of sexual initiation, negotiation with sex partners, and early education before children become sexually active are needed.
- Many young people living with HIV/AIDS do not know they are infected; many sexually active young people, regardless of country, do not perceive themselves as being at risk (UNAIDS, 2001).
- Youths tend not to have a strong political voice and are thus not given a high priority for funding or action.
- HIV/AIDS tends to infect the most vulnerable children and youths: those living in the poorest countries and regions of the world, and those who suffer from a lack of education, economic opportunity, and health services commonly found in wealthier nations (Henry J. Kaiser Foundation Fact Sheet, May 2002).
- Condoms are not readily accessible or available to youths.
- Young people, particularly young women (for physiological reasons), are at greater risk for STIs and HIV infection than are adults.
- Few services are currently "youth friendly," offering sufficient counseling, health care, and referrals.
- Many cultural norms and practices place young people, particularly females, at greater risk.
- Too few programs involve youths in the planning and running of prevention activities; more effective means are needed to reach parents, teachers, and other adults who can interact with and influence youths (Population Information Program, 2004).

The comparatively low numbers of youths currently living with HIV/AIDS in the United States, 31,293 (CDC, 2002), mask some very important national and international data. The CDC estimates that a high percentage of adults now living with HIV/AIDS contracted the virus while in their teens and 20s, and at least half of all new HIV infections are among people under the age of 25. The virus is not an equal

opportunity infector, with 49% of all current AIDS cases in the United States among men who have sex with men (MSM), 10% among injection-drug users (IDUs), and 9% among young men infected heterosexually. Among young women, 45% of all AIDS cases reported were acquired heterosexually, and 11% were acquired through injection-drug use.

A. Youths of Color in the United States

The AIDS epidemic disproportionately impacts African Americans and other ethnic minority populations in the United States. Based on CDC data, the Henry J. Kaiser Family Foundation reports the following (Kaiser, 2003): African Americans account for 38% of AIDS cases since the beginning of the epidemic, and about half (49%) of new cases reported in 2001. HIV was the leading cause of death for African-Americans ages 25 to 44 in 2000, compared to the fifth leading cause for whites and fourth for Latinos in that age group. In 2001, the AIDS case rate among African-Americans was almost 10 times higher than among whites (76.3 per 100,000 compared to 7.9). Although African-American teenagers (ages 13-19) represent only 15% of U.S. teenagers, they accounted for almost two-thirds (61%) of new HIV/AIDS cases reported among teens in 2001.

The statistics among Latinos are not as devastating: Whereas they represent 14% of the population; they account for 18% of the overall AIDS cases and 19% of new cases. Latino teenagers, however, contract AIDS at a rate three times higher than whites, 28.0 per 100,000 compared to 7.9. Though AIDS cases have declined among all groups in the United States between 1993 and 2001, the decline among whites is 73%, as compared to 56% among Latinos and 45% among African Americans.

Components of successful HIV/AIDS prevention programs for youths of color appear to be similar to those recommended for young people throughout society. The following table provides important points to be considered in working with young people of color on HIV/AIDS prevention issues.

Culturally Competent Programs

1. To address one's internal biases, it is critical to assess one's own values, attitudes, and beliefs.
2. While recognizing that youths are individuals, not representatives of a particular ethnic or racial group, it is critical to build on cultural beliefs, practices, and behaviors. It is also important to recognize that many youths see themselves as bicultural or multicultural. Youths need to be asked how they identify themselves.
3. Incorporate traditional elements of the culture of the youths being served: gender roles, assertive vs. passive styles, etc.
4. Acknowledge young people's religious beliefs, particularly as they relate to sexual and reproductive health.
5. A zero-tolerance policy must be instituted regarding discriminatory words and behaviors as they relate to sexual orientation, gender identity, and racial/ethnic or cultural identity.
6. Families are critical components of any program, and must be looked to for support and participation.
7. Collaborative communities are key to assessing needs and forming partnerships. Community organizations can be invaluable in providing services to youths.
8. A diverse staff that is reflective of the youths being served is critical, as are leaders, speakers, and volunteers from similar backgrounds.
9. Bilingual, bicultural staff members are critical in settings where language and cultural differences exist.
10. Diverse materials, including brochures, videos, and other media that reflect the cultural reality of the group being served are critical.

Adapted from Augustine, 2004

XII. HIV/AIDS Prevention

The effects of HIV/AIDS can now be felt in all nations; while prevention dominates discussions in low-impact nations, in highly impacted nations the priority is curtailing the spread of the disease and coping with morbidity, mortality, and lost productivity (Gibney, 1999). Despite recent progress in providing cost-effective anti-retroviral therapies for many of those living with HIV, biomedical and behavioral interventions remain the only hope for reducing the trauma associated with the HIV infection.

A. Biomedical Approaches

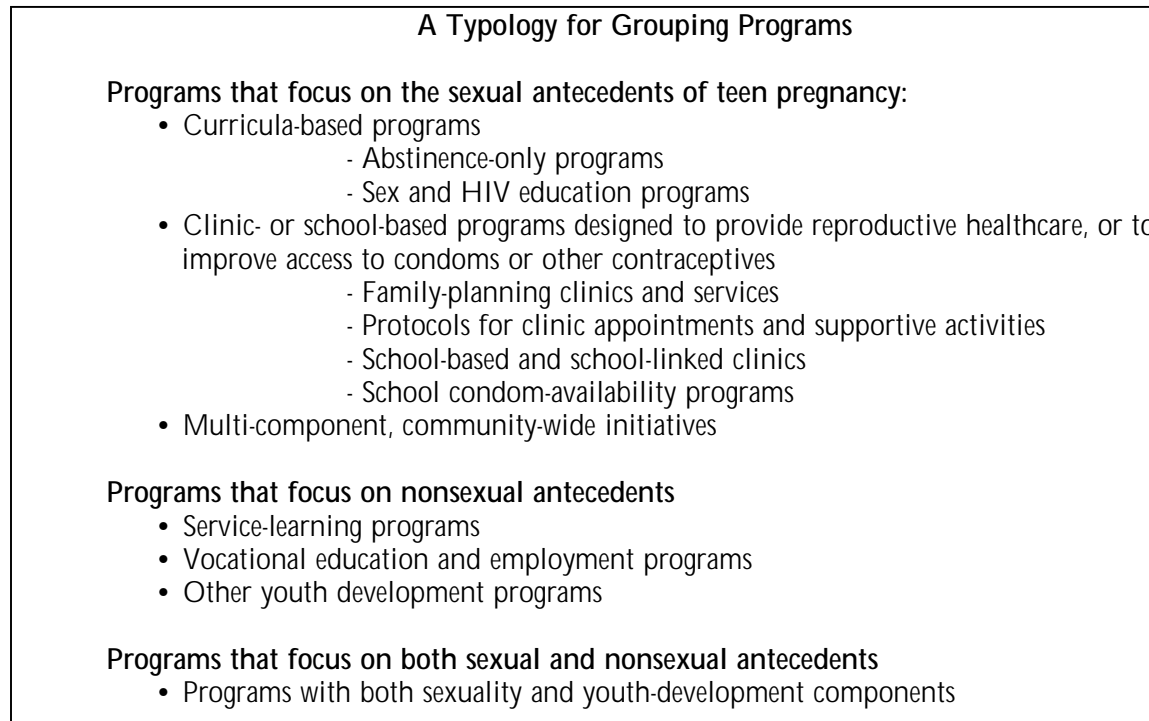
Biomedical approaches are a major line of defense against HIV/AIDS. The following is a list of major biomedical approaches currently in use, as well as major research priorities:

- Condoms (male and female)
- Microbiocides
- Physical barriers
- Research on vaccines to prevent acquisition
- Preventing perinatal transmission
- Preventive treatment therapies
- HIV testing interventions to prevent infection of the blood supply or to influence risk behaviors

While some of these biomedical approaches to HIV/AIDS have implications for youths, their families, and communities, they are not directly related to the major focus of this White Paper, and we will not go into more depth about them.

XIII. Interventions for Adolescents

Kirby (2003) presents a typology for grouping programs that deal with teen pregnancy. While the typology does not deal with HIV/AIDS prevention specifically, there are areas of considerable overlap between the two topics.



Kirby 2003

Kirby describes programs that focus on the sexual antecedents of teen pregnancy as those educational programs that focus on knowledge, beliefs, values, attitudes, and skills regarding sexual activity and use of contraception; those that focus on access to contraception; and a few multi-component initiatives that concentrate on both. Since our focus is not on sexual antecedent programs, we will only briefly mention Kirby's major conclusions, based on a review of several research studies:

- a. Abstinence-only, sexual education, and HIV education programs do not divide neatly into groups, but exist along a continuum.
- b. Very little rigorous evaluation has been conducted on abstinence-only programs, and one should be cautious about drawing any conclusions about the impact of abstinence-only programs in general.
- c. Both sex- and HIV-education programs generally emphasize abstinence as the safest method, and condoms as providing protection from STIs and pregnancy.
- d. There is strong support for the conclusion that sexuality and HIV curricula do not increase sexual intercourse, its onset, frequency, or the number of partners, and that they may delay or reduce sexual activity.
- e. The data suggest that sex- and HIV-education programs may be more effective with higher-risk youths.

(Kirby, 2003)

Kirby then refers to a study by Dusenbury and Falco (1995) that lists the curricular criteria for effectively dealing with at-risk behavior. While service-learning is not mentioned directly, several of the criteria are employed in good service-learning programs. (Letters e-j in the following table have profound implications for service-learning and HIV/AIDS prevention.)

Criteria for Curricula to Effectively Prevent At-Risk Behavior	
a.	Focused on reducing one or more sexual behaviors that lead to unintended pregnancies or HIV/STIs.
b.	Were based on theoretical approaches demonstrated to be effective in influencing other health-related risk-taking behavior.
c.	Sent a clear message about sexual activity and condom or contraceptive use, and continually reinforced that message.
d.	Provided basic, accurate information about the risks of teen sexual activity, methods of avoiding intercourse, or using protection against pregnancy and STIs.
e.	Included activities addressing social pressures that influence sexual behavior.
f.	Provided modeling and practice of communication, negotiation, and refusal skills.
g.	Employed a variety of teaching methods designed to involve the participants and personalize the information.
h.	Incorporated behavioral goals, teaching methods, and materials that were appropriate to the age, sexual experience, and culture of the students.
i.	Lasted a sufficient length of time to complete important activities adequately.
j.	Selected teachers or peers who believed in the program they were implementing and provided them with training.

Kirby, 2003

Service-learning can help counteract negative peer social pressures. It provides modeling; includes skill-building for negotiating personal and social relationships; uses a wide variety of teaching methods; incorporates behavior goals, methods, and materials that are age appropriate; generally lasts for a full semester or a year; and incorporates carefully selected and trained teachers and peers to lead the experience.

Programs that focus on nonsexual antecedents are the ones most relevant to this White Paper. These programs focus on the reasons why teens get pregnant or contract STIs, including HIV/AIDS. It is here that Kirby (2003) makes the following statement: "Service-learning programs may have stronger evidence that they reduce actual teen pregnancy rates while youths are in the programs than any other type of intervention."

One of the leading figures in the area of youth risk and protective factors for HIV is Dr. Robert Blum of the University of Minnesota. Blum analyzed over 11,000 articles (published after 1990) dealing with young people, ages 10-24, in both developed and developing countries, and noted a wide range of factors that interact with political realities, economic issues, and historical events.

Blum breaks these factors down to various levels, as demonstrated in the following chart:

Level	Risk Factors	Protective Factors
Community Level	Single-parent households	Rural residence
	Child-headed households	Receive family planning information from health care provider
	Percent unemployed	
Family Level	Mother opposed to contraception	Living with parents
	Non-nuclear family structure	Interest of the mother in schooling
	Frequent conflict between parents	Education of the mother
	Low education of father or mother	Higher income
	The death of the mother	Mother or mother-in-law discussing family planning
	Not living with parents	Husband approving of contraception Parents exerting behavioral control
Peers and Partners	Multiple sex partners	Engaged to be married
	Sex with prostitutes	Having a boyfriend who approves of contraception
	Greater number of lifetime partners	Perceiving that peers use contraceptives
	Friends using drugs or alcohol	
School Environment	School failure	Family life education programs
	Attention deficit hyperactivity disorder	Higher educational aspirations
	Risk of women being sexually exploited by male teachers (Africa)	Completing secondary school or higher
		Attending school regularly
		School connectedness
Individual Level	Low education	Consistent condom use
	Unemployment	Older age at first sex
	Anal intercourse	Circumcision
	History of STIs	Abstinence
	Being older	High self-esteem
	Early age at first sex	Sound knowledge of family planning
	Inconsistent condom use	
	Unprotected intercourse	
	Physical or sexual abuse	
	Early puberty	
	Early marriage	
	Drug, alcohol, tobacco use	

Blum, 2003

As indicated earlier, an important figure in the HIV/AIDS research world is Douglas Kirby, who began his presentation at a recent international conference with this statement: “We should be dedicated to the lives of young people, not our own ideologies.” The following table from Kirby (2003) provides important insights into critical issues. The chart refers to Kirby’s study of teen pregnancy prevention programs that had been evaluated through rigorous criteria.

The Number of Programs with Different Effects on Sexual and Contraceptive Behaviors

	Sex and HIV Education Programs in the United States	Sex and HIV Education Programs in Developing World
Initiation of Sex		
Delayed initiation	9	2
Had no significant impact	18	7
Hastened initiation	1	0
Total	28	9
Frequency of Sex		
Decreased frequency	5	1
Had no significant impact	13	0
Increased frequency	1	0
Total	19	1
Number of Sexual Partners		
Decreased number	3	2
Had no significant impact	7	3
Increased number	0	0
Total	10	5
Use of Condoms		
Increased use	10	2
Had no significant impact	8	3
Decreased use	0	0
Total	18	5
Use of Contraception		
Increased use	4	1
Had no significant impact	7	2
Decreased use	0	0
Total	11	3

Kirby, 2003

Kirby concludes that programs promoting abstinence (A) and condoms (C) have contributed to a steady decrease in pregnancy and STI rates among 15- to 19-year-olds in the United States, and that there should be a greater emphasis on being faithful (B). Policies in both the United States and developing countries need to encourage A, B, *and* C, not just one or two of the approaches.

XIV. International Programs

The 2003 World Bank publication “Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs” provides an excellent description of the most successful interventions on the African continent. We have excerpted the following list of characteristics of effective programs, after reviewing hundreds of international programs:

- Community-based
- Developed by the people they serve
- Whole community involvement
- Parental involvement
- Deal with the broader context of sexual behavior
- Education and prevention over several years
- Teacher-led involvement in the school health programs
- Youth-friendly
- Gender-sensitive
- Peer education (age-graded)
- Research and monitoring
- Use of local languages
- Involvement of faith-based organizations (FBOs)
- Involvement of non-governmental organizations (NGOs)
- Cost-effective
- Confront stigmas

Among the most widely used interventions found in many of the programs throughout Africa are:

- Peer education
- Drama, song, and dance
- Participatory techniques and activities
- Youth-friendly clinical and counseling services
- Media campaigns including T.V., radio, and print advertising
- Youth centers
- Condom use
- Curricular integration
- Life skills approaches
- Sensitization workshops
- Anti-AIDS clubs
- Communication initiatives and skills
- Decision-making skills
- Income-generating activities to promote self-sufficiency

UNAIDS (2000) produced an important book titled “Innovative Approaches to HIV Prevention.” The international organization presents criteria for evaluating the program examples it presents, and suggests that successful national programs include the following activities:

- General awareness activities
- Persuasive action
- Multi-sectoral action
- Community involvement
- Integration between prevention and care
- Action to build social resistance

The report lists the following approaches as particularly important for young people. (Please note the many parallel traits of successful HIV/AIDS prevention programs to service-learning programs.)

- Take into account the diversity of young people and their needs.
- Encourage youth participation in project design and implementation.
- Create a climate of openness that recognizes and respects the realities that young people face.
- Focus on young men’s sexual health, as well as sexual health issues relating to young women.
- Examine the positive aspects of sexual health.
- Promote greater awareness of the sexual and reproductive health of young people, including their need for improved rights and protection.
- Improve access to basic education and timely sex- and HIV-related education.
- Provide access to voluntary counseling, testing services, and appropriate referrals.
- Increase access to youth-friendly health services.

Though this list may appear obvious to those who regularly work with youths, especially those in the service-learning movement, many of these approaches have too often been ignored in HIV/AIDS interventions targeted at youths. In evaluating HIV/AIDS prevention programs, UNAIDS (2000) suggests the following criteria, all of which apply to youth programs:

1. Relevance: perceived as relevant by target groups, including relevant culture and context.
2. Efficiency: well-coordinated planning, implementation, and reach.
3. Impact: on reported rates of STI and HIV; on HIV and AIDS-related knowledge, beliefs, and attitudes; and on safer sex practices and safer forms of drug use.
4. Sustainability: cost-effectiveness and applicability to other contexts.
5. Ethical soundness.

Given the rapid growth of the pandemic and the desire just “to do something,” far too many programs violate one or more of these basic criteria.

UNICEF has developed a comprehensive list of lessons learned in life-skills education to prevent the spread of HIV among young people (2000, 2002). The following list is based on their recommendations:

1. **Focus on the learners/participants**
 - a. Respect youths' abilities, feelings, and beliefs.
 - b. Focus on risks that youths actually confront, and respect youths' feelings and beliefs regarding risks.
 - c. Ensure that the program's objectives, teaching methods, and materials are appropriate to the age, gender, sexual experience, and culture of the young people and the communities in which they live.
 - d. Encourage participants to learn from each other, as well as from educators, family, and community.
2. **Focus on content**
 - a. Emphasize information, attitudes, and skills based on their ability to promote healthy behaviors and prevent risky behaviors.
 - b. Ensure that youths understand sexual and reproductive health, the behaviors that place individuals at risk, and their social contexts.
3. **Focus on processes**
 - a. Use advocacy to influence leaders, mobilize communities, and secure commitments from policy-makers.
 - b. Coordinate education programs with other effective components, such as positive public health policies, youth-friendly health services, social marketing, condom and contraceptive availability, community development, and media campaigns.
 - c. Involve students, parents, out-of-school youths, and community members in all stages of a program's design, development, implementation, and operation.
 - d. Ensure that programs continue in an orderly sequence and progress over time, building on earlier efforts.
4. **Focus on the environment**
 - a. Provide a safe and supportive environment for all youths, particularly teenage parents, and children and youths living with or affected by HIV/AIDS.
 - b. Work to meet the special needs of children and youths in unstable and crisis situations.
5. **Focus on outcomes**
 - a. Consider the full range of available strategies that may contribute to the main goal. Conduct research and choose the most effective, relevant strategies.
 - b. Evaluate program objectives, processes, and outcomes.
 - c. Focus on the main goals: promoting sexual health by increasing youths' ability to avoid and/or reduce risk behaviors; increasing self-esteem; promoting a more positive and hopeful view of the future; increasing youths' ability to resist pressure; encouraging sexually inexperienced youths to delay the onset of sexual activity; and encouraging youths to decrease the incidence of unprotected sexual intercourse and reduce the number of sexual partners.

adapted from UNICEF, 2000 and 2002

Creating culturally competent programs is critical in working with young people in a multicultural society. Culturally derived health beliefs and practices demand attention from all individuals working with young people.

The benchmarks written to evaluate exemplary UNAIDS programs throughout the world appear to have been written by service-learning advocates, as so many of their criteria parallel those found in service-learning programs: respect for youths and their leadership, age-appropriateness, skill-building, development of relationships with peers and adults, community involvement, and school curricular ties, to mention a few.

UNAIDS Benchmarks for Excellence in HIV/AIDS Programming

- Recognizes the child/youth as a learner who already knows, feels, and can do much in relation to healthy development and HIV/AIDS-related prevention.
- Focuses on the risks most common to the learning group; responses are appropriate and targeted to the age group.
- Includes not only the knowledge, but also the attitudes and skills needed for prevention.
- Understands the impact of relationships on behavioral change and reinforces positive social values.
- Is based on analysis of learners' needs and broader situational assessment.
- Offers training and continuous support of teachers and other service providers.
- Uses multiple participatory learning activities and strategies.
- Involves the wider community.
- Ensures sequence, progression, and continuity of messages.
- Is placed in an appropriate context in the school curriculum.
- Lasts a sufficient time to meet program goals and objectives.
- Is coordinated with a wider school health-promotion program.
- Contains factually correct and consistent messages.
- Has established political support through intense advocacy to overcome barriers and go to scale.
- Portrays human sexuality as a healthy and normal part of life, and is not derogatory toward gender, race, ethnicity, or sexual orientation.
- Includes monitoring and evaluation.

World Bank, 2003

XV. Conclusion

Though service-learning does not yet appear to have entered the vocabulary of most HIV/AIDS prevention programs either in the United States, Africa, or other continents, it is encouraging to see its compatibility with almost all guidelines, benchmarks, and listings of programmatic excellence. Not only is service-learning compatible, but there is now solid research evidence for its inclusion as a powerful strategy as a youth behavior change mechanism, and as a component of school reform.

XVI. Resources

A. Programs with Strong Components of Service-Learning



Young People We Care!

A Book of Ideas to help Young People Supporting each other in their Communities

ZIMBABWE

<http://www.jsiuk.com/wecare.htm>

This publication, published in September 2003 by Judith Sherman, working with John Snow International out of the U.K. and Zimbabwe, is an excellent initial resource for those wishing to make use of community service in HIV/AIDS prevention and care. While it is not technically a service-learning “program,” it was designed to encourage and help groups of young people support either younger children or their peers living in communities and households affected by AIDS. It provides facts about HIV and AIDS, peer education, life skills, and community outreach. It includes a training guide for a facilitator with a good knowledge of HIV and AIDS. The “Community Activities” section is written for young people, and suggests ways to help support other young people and children in the community.

While the ideas in the book are primarily of the “community involvement” type, rather than being tied to the curricular components of the school, it is one of the few guides available in the African context for actively involving young people and their communities in HIV/AIDS work. The training guide offers many of the same life and facilitation skills found in programs throughout the world, including references to the “Peace Corps Life Manual.” The Community Activities section has a wide range of suggested ways young people can be involved. (We include them in some detail, as it is the best and most complete list of what children and young people can and have been doing throughout Africa to confront the pandemic.)

School and Community-Based Activities for Young People

- Conduct a survey** in your community or school and present the results as part of a debate, report, or role-play. Make posters with the facts about HIV and AIDS, and hang them at school and in public places.
- Get training as caregivers:** Be a good role model. Be a supportive and good listener. Be generous with your time, energy, and skills. Be able to judge what is needed and know when to ask for help.
- Find out what home-based care organizations** are working in the area that could provide or receive support. Talk to the young person or child and the person who is sick about asking home-based care workers to visit.
- Share correct information** about HIV and AIDS throughout the community.
- Treat people living with HIV and AIDS with respect;** play with affected and infected children.
- Share information** at schools or local youth clubs.
- Encourage respected people in the community,** those with or without HIV/AIDS, to talk positively about their status and the importance of role models.
- Things to do with a person who is sick:** Spend time with them. Ask them about their lives. Make “memory boxes.” Remind them to take their medicines. Help them take a walk outside. Talk or read to them. Encourage them to help themselves. Put them in touch with those who can attend to their needs. Pray with them if they would like you to.

If the father or mother needs to go to the hospital: Find out if there is an adult who can stay with the children, or a neighbor who can check on them every day. Go with the children to the hospital to visit their parents, as this can be very frightening for them.

Things to do around the home: Clean. Make the surroundings as bright and cheerful as possible. Make the bed. Wash the clothes. Chop firewood. Fetch water. Sweep the floors. Help with gardens or fields. Do errands. Cook and prepare food. Bring food. Play with the children while the adults in the household rest or do chores.

Be a good friend by being there for them; playing sports together; helping with homework; telling stories; helping them make up their own stories or poems; making drawings; walking them to school; talking with them about their feelings; and playing games with them.

Making “Memory Boxes”: Help a young person make a memory box, including a family history from parents and grandparents about graduations, births, weddings, and special events. Ask questions about what life was like when they were young. Develop a list of relatives and where they live. Ask about their favorite animal, color, food, or holiday. Ask them about what they know of your life: birth, first words, first steps, first day at school, things that made you laugh, and any special stories about you. You can also add copies of special passages from the Bible, clippings from the newspaper of special events, letters and photographs, drawings, and other meaningful things.

On the death of a parent: Ask the care-worker or counselor to talk with the children about their feelings. Show your sympathy and encourage them to talk about their feelings. Assure them that they are not to blame for their parent’s death. Bring food to the funeral. Visit the home. Help identify a close relative, teacher, counselor, pastor, priest, or social worker. Visit the grave with the children. Look at the memory box together, and add new things to it.

Foster community awareness through plays, puppet shows, songs and dances, essays, poems and stories, outreach talks by nurses or counselors, community workshops, legal rights for widows and children, and youth representation on AIDS action committees.

School-based activities: Talk to the teacher or head of school about a family’s situation. Find out how children who don’t have school fees can still go to school. Have a school meeting to discuss how to provide school uniforms. Start a school garden to produce food for children with no lunch.

This is perhaps the most complete listing of actions young people can take in their own schools and communities. As stated earlier, each of these activities could be tied to the ongoing curriculum of the school, along with a strong reflective component, and thus become service-learning.



(GEEP) The Group for the Study and Teaching of Population Issues: An Experiment to Prevent the Spread of HIV/AIDS Among School Children

SENEGAL

<http://www.refer.sn/geep> (in French)

contact geepop@syfed.refer.sn

The GEEP program concentrates on two main areas: population education and family life education (FLE) clubs. These FLE clubs are designed to deal with population issues, including the sexual and reproductive health of adolescents, the prevention of STIs, and an understanding of HIV/AIDS. As with all good service-learning programs, the lessons are situated within the socio-educational and extracurricular activities of the classroom and school. The program targets students between the ages of 12 and 19, and aims to promote responsible sexual behavior.

Students are targeted through the FLE clubs at not only secondary schools but also at the universities in Senegal. In addition to students, “patron supervisors” are trained in leadership, another critical component of service-learning. The program utilizes a wide array of approaches to reach young people, including conferences, debates, talks, sketches and role-plays, sponsored sports events, leisure activities, theatrical events, documentaries, radio programs, excursions, poetry and song competitions, lessons in class, awareness marches, open days, blood donations, and counseling by patron supervisors (mentors).

As with good service-learning around the world, population education is implemented in the schools through both a cross-curricular model and as a specific curriculum for young people, with the goal of permeating all aspects of the educational system. The program reaches into the community through communal activities, bringing together large numbers of students and community members from around the region or country. Unique components are a “community podium event,” where students target the broader community using films, plays, talent shows, and musical entertainment. A “reproductive health competition” is regularly held with students competing with each other using their knowledge relating to HIV/AIDS. Teams from each school compete on a regional and national level. Clubs meet each other for an exchange of activities and experiences, and a three-day FLE Festival brings four peer educators and one patron supervisor to Dakar every three years for a wide range of sessions and activities under the auspices of the president of the country.

A unique holiday camp is held for seven days during school holidays, in which peer educators from rural and urban areas can learn about each other’s lives, share experiences, and creatively confront the issue of HIV/AIDS in their lives, schools, and communities. With the collaboration of the Ministry of Education, GEEP conducts an annual essay competition, dealing not only with HIV/AIDS, but also environmental issues. A national awards ceremony is held each year on World Population Day, with prizes from the Ministries of Education, Finance, and Economy.



Teen Outreach Program (TOP)

UNITED STATES

<http://www.cornerstone.to/top/top.html>

Further details can be found in National Research Council (2002), *Community Programs to Promote Youth Development*. Washington DC: National Academy Press

Target Population: 9th-12th graders

Evaluation: Experimental Design with random assignment of 695 studies

Cost: \$500-\$700/student/academic year for class of 18-25 students. Under \$100 per pupil, with in-kind contribution from the school and community service organization.

The Teen Outreach Program promotes decision-making and communication skills to help young people build relationships, resist peer pressure, and clarify roles. It also includes a community service element to advance young people's sense of self-worth. In addition to community service, it is one of the few programs that also has a strong school-based service-learning program, which is carefully tied to the ongoing curriculum, and involves regular discussion and reflection. With its "hands-on" learning and interactive, age-appropriate approach to dealing with sexual topics, it is considered one of the outstanding models in the United States today.

In a 12-year evaluation of its effectiveness, research found that TOP participants had an 11% lower rate of course failure, a 14% lower rate of school suspension, a 33% lower rate of pregnancy, and a 60% lower rate of school dropouts than the control group. While HIV/AIDS rates were not one of the variables, this provides solid evidence of the value of a comprehensive life-skills approach utilizing service-learning. The National Research Council has declared the Teen Outreach Program as one of three model programs, and since it includes a strong dimension of service-learning, we provide more detail on this exceptional program.

TOP involves a school-based discussion curriculum focused on life skills, parent-adolescent communication, and life planning, along with intensive volunteer experience. While the evaluation focused on teenage pregnancy, school suspension, and school failure, the program itself focused very little attention directly on sexual behavior and reproduction. The program is an almost complete model of what service-learning should look like, with supervised community service (service-learning), classroom-based discussions of the service experience (reflection), and activities related to the social and developmental stages of adolescence (life skills). Each adolescent participates in an intensive volunteer activity, chosen from a wide array of opportunities, and works with trained staff from the cooperating volunteer organization.

Similar to programs throughout the service-learning world, TOP participants worked as aides in nursing homes and hospitals, participated in "walkathons," and served as peer tutors, among other experiences. Unlike many volunteer programs, however, TOP participants were involved at least once a week in classroom discussion of the service-learning placement, with reflection occurring under the leadership of trained teachers or guidance personnel. The Teen Outreach curriculum offered a wide range of activities, including structured discussions, role-plays, guest speakers, and informational presentations. These activities and discussions help the participants to gain self-confidence; clarify values; manage family relationships; handle close relationships; and develop social skills, assertiveness, and self-discipline – all characteristics which have been shown to be closely connected to sexual behavior in adolescence.

The study participants included 695 high school students in 25 schools nationwide, each randomly assigned either to the intervention or control group. Baseline data were collected at the start of the program; post-test data were gathered nine months later at the end of the program. After controlling for

initial experimental and control-group non-equivalence on the outcome measures, fewer youths in the intervention group were suspended, failed a course, or became pregnant than students in the control groups. Great care was taken to assess dosage (amount of time spent in classroom sessions and volunteer service). No significant dosage effects were found for either the amount of classroom sessions or volunteer time as a predictor of pregnancy or academic suspension, although those who performed more volunteer service were at lower risk for course failure during the program. The fact that 25 different sites were used gives confidence that the program has a high degree of generalizability. Researchers suggest the program could benefit from a more elaborate theory of change, something this White Paper is attempting to do. Follow-up studies are also critical to assess the sustainability of the program effects. The program appears particularly effective with at-risk youths.



Straight Talk Foundation

UGANDA

www.straight-talk.or.ug

A program evaluation of Straight Talk can be found under

- World Bank (2003) *Education and HIV/AIDS: Sourcebook of HIV/AIDS Prevention Programmes*, chapter Uganda 2, <http://www.schoolsandhealth.org/Sourcebook/sourcebook%20intro.htm>

Straight Talk began as a newsletter in 1993, targeted at youths between ages 10 and 24, but staff soon realized that they couldn't reach such a wide range of youths with one publication. "Young Talk," which is focused on adolescents between 15 and 19, was begun in 1998, with another publication developed for primary school children between 10 and 14 years of age. While such a media-based program is not strictly a "service-learning" program, the fact the young people are involved in its wide range of peer education programs qualifies it as an exemplary international program.

Its publications, radio and television shows, and other activities provide accurate information on sexuality and growing up in Ugandan society. It builds children's and adolescents' life skills and promotes their rights. The organization receives hundreds of letters from youths, and answers them in a straight-forward, accurate, and youth-friendly manner.

Straight Talk believes that:

- Every person has dignity and self-worth.
- Young people explore their sexuality as a natural part of growing up.
- Adolescent sexual activity brings great risks.
- For all adolescents, abstaining from sexual intercourse is the most effective method of preventing pregnancy and HIV/AIDS infection.
- Adolescents have the right to information about sexual and reproductive health and safer sex options, including condom use.
- Sexual and reproductive health information does not cause adolescents to be more sexually active.

While the information in the various newspapers sent to schools across Uganda is a critical component to the program's success, the peer-to-peer Straight Talk Clubs are an example of service-learning at its best. Elected youth leaders work as a team and lead the club, often with a committed teacher or other adult offering guidance.

Straight Talk Clubs involve, among other things:

- Debates and discussions, often about the latest newsletters and radio shows.
- Skits about issues on HIV/AIDS facing adolescents.
- Discussions led by invited health workers.
- Inter-club activities with games, songs, drama, and talent shows.
- Sports and games between clubs.
- Volunteer work such as painting the school, tree planting, and community clean-ups.
- Visits to primary schools to assist children in reading and understanding "Young Talk."

Straight Talk involves many components of good service-learning, including youth leadership, peer and cross-age tutoring and programming, school and community volunteer programs, and sensitization workshops. In addition to working with schools throughout Uganda, Straight Talk also works with prevention training centers, community-based organization, churches, non-governmental organizations, and health facilities.



Bridges to Healthy Communities

UNITED STATES

<http://www.stlcc.edu/aidsf/bridges.htm>

Bridges to Healthy Communities is a community college program in the U.S. that offers education, information, and services leading to HIV prevention and prevention of other serious health problems. It is one of the few HIV prevention programs in the United States that emphasize service-learning as both a community-building and an intervention strategy. As part of the prevention effort for these college-age young adults, the program provides data collection, dissemination, a clearinghouse, advisory groups, and mentor teams.

This model mobilizes policy- and decision-makers to support institution-wide health promotion programs, including the inclusion of HIV prevention and related issues into the curriculum. The service-learning component connects the campus to the community, involving not just individuals, but their families, the schools, and the rest of the community. Service-learning is used to stimulate community-building activities that will move beyond individual behavior change into “caring accountability, and active commitment to community health.”

St. Louis Community College is one of ten community colleges across the nation to receive an implementation grant, each of which covers:

- Training student leaders to promote the prevention of HIV and other serious health problems among students.
- Service-learning program expansion in collaboration with community organizations.
- Curriculum infusion, including production of a video to be used in communications and other classes.
- Wellness program expansion, including an annual wellness awards ceremony on each campus.
- Social Norms Marketing Program.

The Bridges program is perhaps the only one of its kind that targets HIV prevention through a college/community service-learning program. It is also unique in its attempts to infuse HIV education across the curriculum, not just in health or science courses. It recognizes the importance of emphasizing wellness, not just prevention. Finally, while many nations, particularly in Africa, have developed social marketing programs, it is one of the first to do so within a college context.



Teens for AIDS Prevention (TAP)

UNITED STATES

<http://www.advocatesforyouth.org/publications/tap.htm>

While the materials from Advocates for Youth's TAP program do not speak directly to issues of service-learning and HIV/AIDS, we have chosen to include them due to TAP's strength in peer education. Peer and cross-age programs are perhaps the largest group of service-learning programs, whether in schools, churches, or community-based agencies.

TAP is founded on the premise that young people tend to receive much of their information about sexual expression from other youths. TAP believes that peer-based interventions can enhance HIV education and reduce risk behaviors, because values and behaviors are influenced by peer groups. Research on the role of peer counselors has found them to be more effective than adult counselors, and other research found teen peer counseling to result in higher contraceptive use. TAP is based on the social learning theory, which states that similarities in age and interests between those giving and receiving messages will increase the persuasiveness of those messages.

The overall goal of TAP is to "promote positive changes in youths' norms related to sexual expression in order to prevent infection with HIV and other sexually transmitted infections" (Advocates for Youth, 2002). The program has three important goals:

1. Encourage teens to make safe and responsible decisions about when to have sex.
2. Encourage sexually active teens to adopt safer sex behaviors, including consistent and correct condom use.
3. Encourage sexually active teens to limit their number of sexual partners.

Research for the design of the TAP program has shown that young people are generally well informed about the transmission of the HIV virus, but generally do not feel as if they themselves are at serious risk or should change their behaviors. Some at-risk youths, however, see infection as almost inevitable, and thus also see little reason to change their behavior. While youths generally know how to protect themselves, they often object to using prevention methods consistently, and many reject abstinence. Finally, the use of condoms is problematic, as some perceive their use as indicative of infection, while others fear loss of enjoyment, condom failure, or the embarrassment of purchasing condoms.

Building support for the TAP programs is based on the principles of:

- Knowing the community – pre-existing prevention education and community perceptions.
- Involving youths from the beginning – only youths can give voice, vision, and form to a program that is meant for them.
- Knowing the informal and formal approval process for programs within a chosen setting.
- Informing the affected staff – working with teachers, principals, agency staff, and others.

The "Guide for Implementing TAP," which can be downloaded online, is filled with detailed information about the process of developing the peer education program (including arguments for and against), planning the program, finding funding, selecting and training staff, and recruiting youths to become peer educators. One of the strongest sections of the TAP training guide involves cultural competence, because each culture has its own understanding of health, including sexual health. Both staff and peer counselors need cultural competence in the beliefs, attitudes, knowledge, and skills of the diverse young people they work with.

Youth leadership is one of the major areas that this peer education training program shares with service-learning. If youths are to be empowered and feel comfortable working as peer educators, they need a high level of training and extensive involvement in each and every part of the organization. Youths must be full partners with adults in solving community problems. This is more easily said than done, as many schools and communities must undergo significant change for youths to be treated as full partners.

The training objectives of TAP members include:

- Increasing knowledge and eliminating misinformation about HIV/AIDS and sexually transmitted infections.
- Identifying ways to prevent transmission of the HIV virus.
- Developing compassion for people living with HIV/AIDS.
- Increasing skills in communication and resistance to peer pressure.
- Developing skills in decision-making.
- Developing leadership skills, such as planning and leading programs, public speaking, and facilitating group discussions.
- Identifying resources for additional information about HIV/AIDS and sexually transmitted infections.

The TAP Guide contains literally dozens of excellent activities, games, role-playing scenarios, and tests that have been proven valuable in peer training programs dealing with HIV/AIDS.



Reach for Health: Community Youth Service Program: New York City
UNITED STATES

(for program evaluation, see O'Donnell, 1999)

This is one of the few carefully evaluated programs involving economically disadvantaged minority youths in service-learning. The program sought to reduce high-risk sexual behaviors among African American and Hispanic urban adolescents. Two large public schools served as the intervention and control sites in this program, and involved 68 seventh and eighth grade classes, including bilingual and special education students. The participants were self-identified as 15.9% Hispanic, 79.2% non-Hispanic black, and 4.9% "other." Whole classrooms were assigned to one of three groups: one received the core "Reach for Health" curriculum, one a combined health curriculum along with community youth service (CYS), and one acted as the control group. Students in the CYS classrooms spent approximately three hours per week in community placements such as nursing homes, health clinics, day care centers, and senior citizen centers.

The formal "Reach for Health" curriculum concentrated on three primary health risks: drug and alcohol use; violence; and sexual behaviors that can lead to HIV, STIs, or unintended pregnancy. The results of the study found the greatest effects of CYS on the use of condoms and birth control.

Rates of "recent sex" without a condom in the CYS group decreased by 30.8% and "recent sex" without birth control decreased by 27%, compared to decreases of only 5.6% and 9.5% in the curriculum-only group, and increases of 5.7% and 11.9% in the control group. Lower rates of ever having intercourse, "recent sex," and no experience of intercourse at baseline were all in favor of those with community experience, although the differences were not as significant. Finally, the study found that the curriculum-only option was especially effective with special education students.

B. Additional Programmatic Examples of Service-Learning and HIV/AIDS Prevention

Since most U.S.-based programs offer a standard array of partnership-building examples, reflection, curriculum development, assessment, and improvement tools, these will not be provided. Only those components specific to HIV/AIDS programs will be described.



Key Factors in Life Skills Approaches to Improving Youth's Sexual and Reproductive Health UNITED STATES

www.advocatesforyouth.org/publications/iag/lifeskills.htm

Life skills are the behaviors that enable individuals to adapt to and deal effectively with the demands and challenges of life. Life-skills education is an interactive, educational methodology that transmits knowledge and aims at shaping attitudes and developing interpersonal skills. Participants are taught to take responsibility for healthier choices, resist negative pressure, and avoid risk behaviors. The methods are youth-centered, gender-sensitive, interactive, and participatory. Among the many approaches used in life-skills programs are working in groups, role-playing, story-telling, debating, and brainstorming.

The core skills emphasized in the programs are:

- Making decisions, solving problems, and thinking critically and creatively
- Clarifying and analyzing values
- Communicating, listening, building empathy, being assertive, and negotiating
- Coping with emotions and stress
- Feeling empathy towards others and being self-aware

Service-learning shares many, if not all, of these life-skills approaches to learning, but also adds the components of working in the community, tying active learning to the curriculum, and other characteristics outlined earlier.



Better Life Options

INDIA

www.cedpa.org

"Better Life Options," a program in India run by the Centre for Development and Population Activities (CEDPA), concentrates on empowering young women through referring them to age-appropriate reproductive health services; building individual skills through education; offering vocational training and recreation; and mobilizing individuals, families, and communities in seeking solutions.



UNAIDS Best Practices in School AIDS Education: the Zimbabwe Case Study

ZIMBABWE

www.unicef.org/lifeskills/zimbabwe.pdf

The AIDS Action Programme for School in Zimbabwe is a partnership between UNICEF and the Ministry of Education, focusing on behavioral change through the provision of information on sexually transmitted infections, including HIV/AIDS. The fact that it is offered both as a separate subject and integrated into the ongoing curriculum is a characteristic it shares with successful service-learning programs. The New Generation newspaper for young people is an educational media approach used in many successful projects throughout Africa, as is their school drama approach.



Community-Campus Partnerships for Health, University of Washington, School of Public Health

UNITED STATES

<http://depts.washington.edu/ccph/index.html>

The Community Campus Partnerships for Health (CCPH) is a nonprofit organization that fosters partnerships between communities and higher educational institutions. The program provides students at cooperating institutions the opportunity to focus on an HIV/AIDS organization for their health-oriented, community-based service-learning experience. The organizations can include hospitals/health systems, social service agencies, community clinics, community centers, schools, homeless shelters, and others. A comparatively detailed evaluation of the program is included, in addition to focus groups, community partners, and student outcomes. Student outcomes are evaluated on satisfaction, attitudes, clinical experiences, learning and performance, career decisions, and relevance of training to actual practice. Institutions involved in the Health Professions Schools in Service to the Nation Program (HPSISN) through the Pew Charitable Trusts, Corporation for National and Community Service, and the National Fund for Medical Education are:

Georgetown Univ.

George Washington Univ.

Northeastern Univ.

Ohio Univ.

Regis Univ.

San Francisco State Univ.

Univ. of Connecticut

Univ. of Florida

Univ. of Illinois-Chicago

Univ. of Kentucky

Univ. of North Carolina

Univ. of Pittsburgh

Univ. of Scranton

Univ. of S. California

Univ. of Utah

Virginia Commonwealth

WV Wesleyan College

While not all the effects on students and faculty of the service-learning programs were directly related to HIV/AIDS programs, the findings included: transformational learning experiences; greater awareness of determinants of health; sensitivity to diversity; knowledge of health policy issues; leadership development; linkage of personal and professional lives; understanding of community issues; economic and social benefits; joint planning; partner involvement; sense of reciprocity; long-term community relationships; service-learning as a powerful pedagogy; and community as an effective educator.



University of Arizona with AAC and the University's Program in Health and Higher Education

UNITED STATES

<http://www.diversityweb.org/Digest/W99/fostering.html>

In this program, the development of HIV/AIDS education provides an opportunity for interdisciplinary collaboration, as students pursue their own values and ideas about responsible human behavior. The program challenges stereotyping of ethnic minority and gay communities, and equips students with the skills to question the politics of national priorities in scientific research and health care funding. A new course, "Sex, Health and AIDS," was created with content from a range of disciplines. The course syllabus connects HIV/AIDS to students' knowledge, attitudes, and behaviors, along with global and domestic perspectives on the epidemic. Students were involved in designing community AIDS prevention and treatment programs for inner city neighborhoods in the U.S. and NGOs in Thailand.



Community Health and Public Service, Stanford University, School of Medicine

UNITED STATES

<http://med.stanford.edu/chps/>

As societies become increasingly interdependent and diverse, rife with gender and other inequalities based on social, political, environmental, economic, and other factors, medical education is faced with new challenges. One particular challenge is the question of how to address health issues through public service, including substantive, reflective service-learning and rigorous, community-responsive scholarly and civic engagement.

The Scholarly Concentration in Community Health and Public Service, a cooperation of centers at Stanford, offers medical students the opportunity to gain the knowledge and skills necessary for addressing the health challenges of diverse and often underserved communities domestically and overseas. A goal of this program is to graduate an increased number of physicians with the commitment and capacity to become effective, life-long leaders in community health, and community-focused domestic and international health policy.

While each of the centers involved in the program has some relationship to HIV/AIDS and service-learning for youths, those most closely connected are the John W. Gardner Center for Youth and Their Families and the Public Service Medical Scholars under the directorship of Timothy K. Stanton, a long-time service-learning advocate.



Peace Corps, World Wise Schools, Service-Learning Module
UNITED STATES/GLOBAL

<http://www.peacecorps.gov/wws/service/projideas/menu.html>

The Peace Corps has produced an excellent Life Skills Manual, now in use throughout the world. Though topics of HIV/AIDS are often difficult to confront head-on in traditional cultures, the Peace Corps has found real success when approaching them as part of an overall life-skills program. The program is geared at comprehensive behavior change, including the development of skills in communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, and relationships.

It is filled with interactive approaches, role-playing, theater, games, puzzles, group discussions, and a variety of other innovative teaching techniques. The materials have been successfully used in anti-AIDS clubs, girls' clubs, boys' clubs, women's groups, NGOs, health centers, and secondary schools. Though the program does not specifically call itself a "service-learning" program, it is filled with related activities, and could be characterized as a predominantly peer education program. A listing of its major components includes:

- Active, hands-on learning in communication skills.
- Interacting with a person living with AIDS.
- Peer and cross-age tutoring in school and non-formal educational settings.
- Peer communication and teaching skills.
- Peer support mechanisms, assertiveness training, and strategies to avert peer pressure.
- Working with groups.
- Holistic treatment plans involving spiritual, general, psychological, social and physical well-being, and involvement with community organizations that facilitate each of these.
- Dramatization of HIV/AIDS information.
- Strong emphasis on gender roles, including refusal skills.
- Human rights standards and the nature of state obligations.
- Family exercises on dealing with HIV/AIDS.
- Values and character development.
- Self-esteem.
- Risk behavior.
- Decision-making skills.
- Thinking skills.
- Relationship skills.
- Culture and the "Game of Life."
- Theater to be presented in school, in public, or in the community.



Milwaukee Community Service Corps (MCSC)

UNITED STATES

For more information, contact mcsc@execpc.com

This life-skills class works with AmeriCorps members in community service and vocational education. About 100 youths per year ranging in age from 18 to 23 participate in the program. Eighty percent have not completed high school, three-quarters are male, and 60% are ex-offenders. A key component is community service, in which members renovate vacant homes, plant community gardens, landscape vacant lots, remove graffiti, intern in youth service agencies, distribute food for food pantries, engage in recycling projects, and construct new playgrounds.

Revenue from these fee-for-services accounts for 50 to 60% of the organization's funding, while students gain new skills, serve their communities, and earn a high-school-equivalency diploma. All corps members participate in HIV/AIDS, pregnancy prevention, and other reproductive-health issues training. No specific results on prevention are mentioned in the report.



Baltimore Youth Opportunity Grant (YO!) System

UNITED STATES

For more information, contact jcooper@oedworks.com

YO! Baltimore provides services in tutoring, short- and long-term occupation skills training, job placement, and mentoring to 1,400 youths. Most participants are out of school youths from four "at-risk" high schools. Fifty-seven percent of the participants are female, and while few of YO!'s members become pregnant post enrollment, more than 40% are already parents. The program is affiliated with a range of agencies, including the Baltimore city health department, Planned Parenthood, and other youth-serving agencies. Training is provided in primary health, reproductive, and vision/dental health care. HIV/AIDS prevention workshops are offered at all YO! Centers through the local Black Educational AIDS Project (BEAP), a non-profit organization that educates the community on the reduction of risk behaviors and HIV prevention.

Grants were provided to 36 youths to link them to local school systems and other Workforce Investment Act (WIA) programs. These 14- to 21-year-olds gain access to employment, skills training, and educational and support services. The five-year initiative is intended to place youths in long-term, private-sector jobs, help them earn their high school credentials, keep them in school, and provide community-service work experience.



Caring for carers: Managing stress in those who care for people with HIV and AIDS
UNAIDS Case study, May 2000

GLOBAL

www.unaids.org

One of the greatest needs in the world today is for people willing to care for those with HIV/AIDS. UNAIDS has written an exceptional document on the challenges, stresses and needs of those who currently provide care for millions of those suffering. These are predominantly women and girls, although countless examples of children as young as six as caregivers for their whole families have been documented. The stress for unprepared and overworked caregivers is almost unprecedented in human history, and for this reason, we include UNAIDS' work in our discussion of "service-learning" programs and opportunities.

The stresses on the caregivers are overwhelming. They include financial hardship; oppressive workloads; secrecy and fear of disclosure; personal identification of those suffering from AIDS; the unmet needs of countless children; lack of an effective voice in decisions that affect their work; inadequate support, supervision, and recognition of their work; lack of medication and health care materials; isolation, insecurity, and fear of the future; and the effects on family dynamics, to name just a few. In the wealthy nations of the world, there is a wide range of mechanisms to provide at least some relief from these pressures. Among the poor of the world, however, there is little that most governments, agencies, or others can do. This is why thousands of volunteers, mostly from religious communities, become exemplary of one form of "service-learning."

Throughout much of Africa, volunteers are the backbone of community care programs for people with HIV and AIDS. Some are friends and neighbors, many are members of a church, while others are fellow sufferers who reach out to those in similar need to keep active, be useful, and find purpose in life.

Volunteers in many parts of the continent are receiving training in:

- counseling clients and their families;
- advancing listening skills;
- exploring options for those with various problems;
- working closely with health services;
- linking people from their homes to services;
- collecting drugs for bedridden patients; and
- encouraging nurses or doctors to make home visits.

These and countless other service-learning types of activities could be carried out not only by neighbors, friends, fellow church members, and adult community members, but also by trained young people, if schools were to design programs with service-learning.



Home Care Programme

CAMBODIA

For program evaluation, see:

<http://www.aidsmap.com/web/pb4/eng/0FD1033B-87FF-11D5-8D06-00508B9ACEB1.htm>

While this home-care program in Phnom Penh would appear to have little connection to service-learning, there are some interesting parallels. The numbers of HIV positive people in Cambodia was listed as 170,000 adults and 4,600 children in 1999. Tuberculosis, prostitution, and other related factors have led to its rise in recent years. In 1998, NGOs created a network of Home Care Teams, employing a mix of government and NGO workers, including those from the Indra Devi Association, WOMEN, Hope Cambodia, CUHCA, Khemara, World Vision, and Maryknoll. This widely representative set of NGOs provided much of the effort's strength. Strong links were made between the Home Care Teams and community resources such as local community leaders, traditional healers, and the members of the Buddhist temples.

The service component of the project is evident in its volunteers, who were given 60 hours of training, and in many cases went on to paid staff positions. Training included counseling, prescribing practices, physiotherapy for pain relief, and peer education. Home visits are made by teams of volunteers, who provide emotional support and encourage good hygiene and nutrition, refer patients to hospitals, and encourage voluntary counseling and testing. More formal educational sessions are held during local special events and with local religious leaders.



Centre for Socio-Medical Assistance (CASM)

COTE D'IVOIRE

Program description in: UNAIDS (2001). *Reaching Out, Scaling Up*. Geneva: UNAIDS.

The Centre for Socio-Medical Assistance in Abidjan is an outpatient clinic for persons living with HIV/AIDS in Cote d'Ivoire (Ivory Coast). The country is currently the one hardest hit by the AIDS epidemic in West Africa, with a predicted 1.3 million people living with HIV/AIDS in 2005.

The project was initiated in 1991 by HOPE worldwide, with motivation coming from volunteers (mainly from the Church of Christ). The basic goals of the program are to promote decentralized care for people living with HIV/AIDS; to provide accessible, affordable and compassionate care; to support and encourage patients to live positively with HIV; to develop a comprehensive continuum of care for people living with HIV/AIDS through referrals and 'care linking' with other services or institutions; to integrate people living with HIV/AIDS into care and prevention programs; and to mobilize community resources to develop and promote sustainable local action.

The service-learning connection of this exceptional program is not only through the professional counseling, testing, and home-based support of some 20 community agents, but also through the Club des Amis (Friends' Club), whose 300 members share common experiences, hopes, and fears; together, they attempt to rebuild dignity, a sense of self-worth, hope, and friendships. The club also promotes responsible sexual behavior among its members. Club members serve as counselors, peer educators, and members of a theatre group; they also provide nutritional, material, and financial assistance. Income-generation comes through small businesses (card-making) and donations, and small cash incentives are given to viable projects. In addition, the club supports a number of orphaned children, providing them with basic support and provisions. In recent years, the group has targeted those at high risk of infection – women, young people, prisoners, and the underserved.



Kariobangi Community-based Home Care and Home-based AIDS Care Programme

KENYA

Program description in: UNAIDS (2001). *Reaching Out, Scaling Up*. Geneva: UNAIDS.

The Kariobangi program involves community health worker training and the creation of a backup team of medical and social services professionals. It seeks its community health workers from the small Christian communities in the neighborhood of this town east of Nairobi. Volunteer health workers provide medical care and support for hundreds of neighbors suffering from HIV/AIDS. Since they are neighbors, they are viewed positively, and with their training, professionals regard them with respect. Some volunteers have worked for more than 12 years with no remuneration, most out of religious devotion to others. Each volunteer is responsible for one small area of their "slum" and visits those who have been identified as ill. Crisis care is provided for the very ill, as is medical care to children living with HIV. Kariobangi also includes a Child Crisis Centre, where children can stay temporarily when a mother is too sick to cope or when a mother dies suddenly. It also provides a safe haven, with moral and emotional support. Finally, child-headed households are increasingly common, and the Centre provides special assistance and training for children who are or soon will be orphaned on how to bring up younger brothers and sisters, and helps them form support groups.



**The Bambisanani Project, Eastern Cape,
SOUTH AFRICA**

<http://www.equityproject.co.za/MobilizingTextOnly.htm>

For more information, contact: rsmart@netactive.co.za

This Eastern Cape province is one of the regions hardest hit by AIDS in South Africa. While home-based care has been identified in South Africa and elsewhere as a high priority, the common experience is that “home care” too often means home neglect. A group came together to form Bambisanani (in partnership to help each other), an innovative project that now serves as a nationwide community mobilization project, responding to the urgent need for home-based AIDS care. While most of its programs are quite traditional in nature, the following table outlines the expected outcomes by target groups, many of which have strong service-learning implications:

Target Group	Expected outcomes adopted as indicators of program success/failure
Patients/Clients	Reduced suffering and improved quality of life. Appropriate treatment, care, and support. Enhanced end-of-life care.
Families	Improved capacity to cope and to care. Practical support. Bereavement support.
Care-givers	The capacity, resources, and support to deliver quality care. Access to colleagues and community. Networks of support.
Communities	Improved capacity to cope. Enhanced environment for care. Reduced stigma. Skills-development and job creation.
Children	Early identification of children in distress. Access to holistic care and support.
Persons living with HIV/AIDS	Skills-development. Access to networks of support.
Health Services	Reduced pressure on services. Effective referrals among service providers. Cost-savings.
Welfare services	Improved utilization of social services. Better access to grants.
South Africa as a whole	Lessons learning. Replicable models.



The Mildmay Centre

UGANDA

<http://www.mildmay.org.uk/UgandaCentre.html>

For more information, contact: Mildint2@infocom.co.ug

The Mildmay Centre’s objective is to provide palliative care and rehabilitation for persons living with AIDS in the local community. The center, located near Kampala, uses multidisciplinary therapies involving a team of doctors, nurses, nursing assistants, counselors, physiotherapists, occupational therapists, aromatherapists, nutritional advisers, pastoral care workers, laboratory personnel, pharmacy staff, and a volunteer workforce to accompany patients around the country. Seldom in Africa is such a complex multidisciplinary team found in an HIV/AIDS setting. While volunteers are involved in the process, the opportunities for mentoring and service-learning in a complete setting are the reasons for its inclusion in this White Paper. In fact, many volunteers begin their training for a career while serving at the Mildmay Centre.



Kafue Adolescent Reproductive Health Project (KARHP)

ZAMBIA

For more information, contact: flmz@zamnet.zm

For program information, see: http://www.fieldvisits.org/organization_30.html

The Kafue Adolescent Reproductive Health Project works with adolescents in Zambia on reproductive health issues including: training of peer counselors; sensitizing teachers on the sexual and reproductive health needs of young people; and a parent/elder strategy aimed at obtaining community support for the provision of reproductive health information and services to youths. The project works on three fronts: school, community, and clinic approaches. It is funded by Sida of Sweden, and works in collaboration with the Planned Parenthood Association of Zambia (PPAZ), the Family Life Movement of Zambia (FLMZ), and the Swedish Association for Sexual Education (RFSU).

While the approaches to HIV/AIDS in this program are not unique, the roles that each of the three major components plays is outlined in the following table:

Clinic Approaches	School Approaches	Community Approaches
<ul style="list-style-type: none"> - SRH service access - SRH information access - Moral behavior - Respecting individual rights - Sexuality/HIV/AIDS/STDs 	<ul style="list-style-type: none"> - Behavioral change and life skills - Peer education - Respecting individual rights - SRH information access - Building self-determination and self-esteem - Sexuality/HIV/AIDS/STDs 	<ul style="list-style-type: none"> - Promotion of parent/child dialogue - Moral behavior and respecting individual rights - Communication skills - SRH information access - Building self-determination and self-esteem



Mema Kwa Vijana Program

TANZANIA

For more information, contact: gavyolea@amrefmza.org, maendem@amrefmza.org

Mema Kwa Vijana (Good Things for Young People) operates in primary schools and health facilities in the Mwanza region of Tanzania. The program involves peer educators who use informal and participatory techniques to teach young people about reproductive health. It also has an important component on training health workers to be more youth-friendly. While not a formal service-learning program, it does mobilize communities once a year to participate in Youth Health Weeks. The program utilizes a life-skills approach, including many of the activities listed earlier.

The program is a collaboration of the African Medical and Research Foundation (AMREF) with the London School of Hygiene and Tropical Medicine (LSHTM), and the Tanzanian National Institute for Medical Research (NIMR).



Student Partnership Worldwide (SPW): School Health Education Program (SHEP)

TANZANIA, (INDIA, NEPAL, SOUTH AFRICA AND UGANDA)

www.spw.org

SPW trains and deploys 18-25 year old Tanzanians and Europeans as peer educators in its campaign against HIV/AIDS in seven districts in the Iringa region of Tanzania. As with most HIV/AIDS programs, it uses a wide range of participatory activities in both the classroom and as extracurricular activities. Students are exposed to the School Health Education Program, then become peer educators in their schools and for adults in the communities. Tanzania, like many former colonies, has an educational structure in which non-exam-based subjects receive little emphasis in the curriculum. With this in mind, it was decided to make it a non-academic, non-formal, skills-based, student-centered and participatory program



GOAL: The Baaba Project

UGANDA

www.goal.ie

One of the major at-risk groups throughout the world, but particularly in Africa, is that of street children and youths, many of whom are orphaned or deeply affected by HIV/AIDS. GOAL, an Irish humanitarian organization, partners with six Ugandan NGOs to increase awareness and knowledge of HIV/AIDS and other sexual reproductive health issues among street children and youths. NGO staff who work closely with young people empower street children and youths with the skills, motivation and support necessary to sustain existing safe sexual behavior and change unsafe behavior, and reduce the sexual and physical risks of life on the street. The programs are based on self-determination; a participatory approach; one-on-one counseling; peer education; a rights-based approach; and partnering with NGOs for food, education and shelter. Children learn trade skills to be able to support themselves in less risky manners.

**Africare: Adolescent Reproductive Health Project: AIDS Action Clubs in Schools****ZIMBABWE**For more information, contact: africare@mweb.co.zw

While many components of this program can be found in HIV/AIDS clubs and curricula throughout Africa, Africare contains a strong element of income-generating projects. There are 21 income-generating projects in schools and eight projects for out-of-school youths. Membership is open to youths ages 10 to 24. The in-school youths work with patrons and matrons (often teachers) on their income generating activities, while the out-of-school youths work with traditional leaders. Activities currently involve carpentry, shoemaking and shoe repair, dressmaking, entertainment, poultry rearing, and oil pressing. Profits are reinvested; they contribute to school fees, uniforms and food, and some money is given to out-of-school youths as an allowance.

**Midland AIDS Service Organization (MASO): Youth Alive Initiatives Project****ZIMBABWE**For more information, contact: maso@adtech.co.zw

This program also contains a wide range of approaches to youth HIV/AIDS programming similar to others throughout the continent: information, behavior change, promotion of healthy sexual behavior, abstinence, life skills development, peer education, peer counseling, moral behavior, and social values. In addition to the use of condom distribution, discussions, lectures, print materials, films, drama, songs, and games, it has added a component of community outreach, including visits to give support to sick people on home-based care.

C. Examples of Strong HIV/AIDS Prevention Programs

The following have been chosen by UNAIDS as exemplary HIV/AIDS prevention programs, but since most lack a direct or indirect service-learning component, we will not discuss them in any detail. While some target young people, most cover all age groups. Most of the programs also include many of the following components: education, clinics, family planning, community-based components, skill-building, decision-making, audiovisual materials, counseling, dance, condom usage, media campaigns, drama and song activities, advocacy, care, games, role plays, building self-esteem, taking responsibility, rights, stigma, and many other components discussed earlier. Most, however, do not have any explicit service-learning program directly connected to school-based or out-of-school youths. Further information may be found on individual websites provided, or the World Bank website.

Action Aid Mozambique	www.actionaid.org
UNFPA and Pathfinder International: Geracao, Biz Youth-Friendly Health Clinics: Mozambique	Odete@unfpa.ueem.mz Rbadiani@pathfind.org
LoveLife: Promoting Sexual Health and Healthy Lifestyles for Young People in South Africa	www.lovelife.org.za
Soul Buddyz: A Multimedia Edutainment Project for Children in South Africa	www.soulcity.org.za
Copperbelt Health Education Project (CHEP): The In-School Program	www.chep.org.zm

D. Key Websites in Service-Learning, Sexual Education, Adolescent Development, and HIV/AIDS

(Note: Most of those listed after individual programs not listed here)

<u>Related United Nations Sites</u>	
UNAIDS, the joint United Nations Program on HIV/AIDS	www.unaids.org
UNICEF, the United Nations Children's Fund	www.unicef.org
UNICEF, HIV/AIDS	www.unicef.org/aids
United Nations, Department of Economic and Social Affairs, Committee on NGO's	www.un.org/esa/coordination/ngo
United Nations, Department of Economic and Social Affairs, Division for the Advancement of Women	www.un.org/womenwatch/daw
Office of the United Nations High Commissioner for Human Rights	www.ohchr.org
United Nations Development Programme, HIV/AIDS	www.undp.org/hiv/
United Nations Office on Drugs and Crime, The Global Youth Network	www.unodc.org/youthnet/
United Nations Educational, Scientific, and Cultural Organization (UNESCO), Action Against HIV/AIDS	www.unesco.org/hiv/human_rights
WHO, World Health Organization	www.who.int

<u>NGO Legal and Human Rights Sites</u>	
Amnesty International	www.amnesty.org
Amnesty International Health Professional Network	web.amnesty.org/rmp/hponline.nsf
Canadian HIV/AIDS Legal Network	www.aidslaw.ca
HRI - Human Rights Internet	www.hri.ca
Human Rights First	www.humanrightsfirst.org
ICASO, International Council of AIDS Service Organizations	www.icaso.org
LAWASIA, The Law Association for Asia and the Pacific	www.lawasia.asn.au

<u>HIV/AIDS Sites</u>	
International Labour Organization, Programme on HIV/AIDS	www.ilo.org/public/english/protection/trav/aids
Centers for Disease Control and Prevention	www.cdc.gov
World Bank HIV/AIDS	www1.worldbank.org/hiv_aids/
Harvard AIDS Institute	www.hsph.harvard.edu/hai/
Kaiser Family Foundation	www.kff.org
Information and Knowledge for Optimal Health (INFO) Project	www.infoforhealth.org
WFP, United Nations World Food Programme	www.wfp.org
Population Action International	www.populationaction.org
SIECUS, Sexuality Information and Education Council of the United States	www.siecus.org
Asian Harm Reduction Network	www.ahrn.net
APCASO, Asia Pacific Council of AIDS Service Organizations	www.apcaso.org
AFRICASO, African Council of AIDS Service Organizations	www.africaso.net
LACCASO, Latin American and Caribbean Council of AIDS Serving Organizations	www.laccaso.org

<u>Youth HIV/AIDS Sites</u>	
Advocates for Youth	www.advocatesforyouth.org
National Youth Leadership Council	www.nylc.org
National Youth Development Information Center	www.nydic.org
Pathfinder International, Focus on Young Adults	www.pathfind.org/focus.html
The National Campaign to Prevent Teen Pregnancy	www.teenpregnancy.org
Youth Development Strategies, Inc.	www.ydsi.org
University of California, San Francisco, Center for HIV Information	hivinsite.ucsf.edu
Center for Community-Based Health Strategies	www.healthstrategies.org
CDC National Prevention Information Network	www.cdcnpin.org
YouthHIV, for poz youth and peer educators	www.youthhiv.org
World Vision International	www.wvi.org
Family Health International, YouthNet	www.fhi.org/youthnet
Care Resource, Youth Net	www.careresource.org/youth.html
Search Institute	www.search-institute.org

<u>Resources for Youths of Color</u>	
Ambiente Joven	www.ambientejoven.org
Asian and Pacific Islander American Health Forum	www.apiahf.org
My Sistahs	www.mysistahs.org
National Council of La Raza	www.nclr.org
National Latina Health Network	www.nlhn.net
National Minority AIDS Council	www.nmac.org
National Native American AIDS Prevention Center	www.nnaapc.org
National Organization of Concerned Black Men, Inc	www.cbmnational.org
National Youth Advocacy Coalition	www.nyacyouth.org
Department of Health and Human Services, Office of Minority Health	www.omhrc.gov
Youth HIV	www.youthHIV.org
Youth Resource	www.youthresource.com

<u>Faith-Based Responses to HIV/AIDS</u>	
World Vision International	www.wvi.org
Family Health International	www.fhi.org
Policy Project	www.policyproject.com
MAP International	www.map.org
Teaching-aids At Low Cost	www.talcuk.org
Strategies for Hope	www.stratshope.org
Africa Online, Kenya	www.africaonline.co.ke
Interconnect	www.iconnect.co.ke
Social & Scientific Systems	www.tvtassociates.com
Catholic Charities USA	www.catholiccharitiesusa.org
Ecumenical Advocacy Alliance	www.e-alliance.ch

Bibliography

- Advocates for Youth (2002). *Guide to Implementing TAP: A Peer Education Program to Prevent HIV and STI*. Washington, DC: Advocates for Youth.
- Ajzen and Fishbein (1980). As quoted Fishbein, M. et.al. "Using Information to Change Sexually Transmitted Disease-Related Behaviors: An Analysis Based on the Theory of Reasoned Action." In DiClemente, R. and Peterson, J. (1994). *Preventing AIDS: Theories and Behavioral Interventions*. New York: Plenum Press.
- Augustine, J. (2004). "Creating Culturally Competent Programs" *Transitions*. Washington, DC: Advocates for Youth. Volume 15. No. 3.
- Augustine, J. (2004). "Youth of Color: At Disproportionate Risk of Negative Sexual Health Outcomes." *Transitions*. Washington, DC: Advocates for Youth. Volume 15. No. 3.
- Benson, P. (1996). "Beyond the "Village" Rhetoric." *Assets*. 1 (1):3-4
- Blum, R. (2003). "Adolescent Development and Risk and Protective Factors for HIV," in *HIV Prevention for Young People in Developing Countries: Report of a Technical Meeting*. Washington, DC: USAID Office of HIV/AIDS, the Institute for Youth Development, and YouthNet/Family Health International.
- Centers for Disease Control and Prevention (CDC), (2002). *A Glance at the HIV Epidemic*. Washington, DC. CDC (1991-2001). *Youth Behavior Surveys*.
- Centre for Development and Population Activities (CEDPA), (2001). *Adolescent Girls in India Choose a Better Future: An Impact Analysis*. Washington, DC: CEDPA.
- Des Jarlais, D. C. and Frieman, S.R. (1988). "The Psychology of Preventing AIDS Among Intravenous Drug Users: A Social Learning Conceptualization." *American Psychologist*, 43, 865-870.
- DiClemente, R. and Peterson, J. (1994). *Preventing AIDS: Theories and Methods of Behavioral Interventions*. New York: Plenum Press.
- Dusenbury, L. and Falco, M. (1995). "Eleven Components of Effective Drug Abuse Prevention Curricula." *Journal of School Health*, 65(10), 420-425.
- Fishbein, M., et. Al. (1994). "Using Information to Change Sexually Transmitted Disease-Related Behaviors: An Analysis Based on the Theory of Reasoned Action." In DiClemente, R. and Peterson, J. *Preventing AIDS: Theories and Methods of Behavior Interventions*. New York: Plenum Press.
- Gardner, W. and Herman, J. (1990). "Adolescents and AIDS Risk Taking: A Rational Choice Perspective." In W. Gardner, S.G. Millstein, and B.L. Wilcox (Eds.) *Adolescents in the AIDS Epidemic* (pp. 17-34). San Francisco: Jossey-Bass.
- Gibney, L. (1999). "HIV Prevention in Developing Countries." In Gibney, L., DiClemente, R. and Vermund, S. New York: Kluwer Academic.
- Henggeler, S. Melton, G. Rodrigue, J. (1992). *Pediatric and Adolescent AIDS: Research findings from the social sciences*. Newbury Park: Sage.
- Henry J. Kaiser Family Foundation (2002, May). *HIV/AIDS Policy Fact Sheet: The Global Impact of HIV/AIDS on Youth*.
- Henry J.Kaiser Family Foundation (2003, January). *Teen Sexual Activity*.
- Irwin and Millstein (1986) as quoted in Irwin, C. (1993). "Adolescence and Risk-Taking: How are they related." In Bell, N. and Bell, R. *Adolescent Risk Taking*. Newbury Park: Sage Publications.
- Irwin and Ryan, (1989) as quoted in Irwin, C. (1993). Adolescence and Risk-Taking: How are the related. In Bell, N. and Bell, R. *Adolescent Risk Taking*. Newbury Park: Sage Publications.
- Irwin, C. (1993). Adolescence and Risk Taking: How are they related. In Bell, N. and Bell, R. *Adolescent Risk-Taking*. Newbury Park: Sage Publications.
- Joint United Nations Programme on HIV/AIDS (UNAIDS), (2002, June). *Report on the HIV/AIDS Epidemic*. Geneva. UNAIDS.
- Kirby, D. (2003). "Risk and Protective Factors Affecting Teen Pregnancy and the Effectiveness of Programs Designed to Address Them." In Romer, D. (2003). *Reducing Adolescent Risk: Toward an Integrated Approach*. Thousand Oaks: Sage.
- Kirby, D. (2003). "What we know about Preventing Risk-Taking among Youth." In *HIV Prevention for Young People in Developing Countries: Report of a Technical Meeting*. Washington, DC: USAID Office of HIV/AIDS, the Institute for Youth.
- Lofquist, W. (1987) "Service-Learning Paradigm Shift." In *Participant Manual: NYLC Training*. St. Paul, MN: NYLC.
- McLaughlin, M. (2000). *Community Counts: How Youth Organizations Matter for Youth Development*. Washington DC: Public Education Network.

- National Research Council (2002). *Community Programs to Promote Youth Development*. Washington DC: National Academy Press.
- National Youth Leadership Council (1994). *Definition of Service-Learning*. St. Paul, MN: NYLC.
- National Youth Leadership Council. (2004). *Participant Manual: NYLC Training*. St. Paul, MN: NYLC.
- O'Donnell, L. (1999). "The Effectiveness of the Reach for Health Community Youth Service Learning Program in Reducing Early and Unprotected Sex Among Urban Middle School Students." *American Journal of Public Health*. 89(2). Pp. 176-81
- Osgood, D.W. and Wilson, J.K. (1989). *Covariation among health-compromising behaviors in adolescence*. Report to the U.S. Congress, Office of Technology Assessment, Washington, DC. (NTIS No. PB 91-154 377/AS)
- Philliber Research Associates (1997). *Preventing Teen Pregnancy and Academic Failure: Experimental Evaluation of Developmentally-Based Approach*. Accord, NY: The Associates.
- Population Information Center (2004). Center for Communication Programs, Johns Hopkins University.
- Population Reference Bureau (2000, April). *Youth in Sub-Saharan Africa: A Chartbook on Sexual Experience and Reproductive Health*.
- Romer, D. (2003). *Reducing Adolescent Risk: Toward an Integrated Approach*. Thousand Oaks: Sage.
- Rosenstock, I. Strecher, V. and Becker, M. (1994). "The Health Belief Model and HIV Risk Behavior Change" in DiClemente, R. Peterson, J. *Preventing AIDS: Theories and Methods of Behavioral Interventions*. New York: Plenum Press.
- Scales, P. and Leffert, N. (1999). *Developmental Assets: A Synthesis of the Scientific Research on Adolescent Development*. Minneapolis, MN: The Search Institute.
- Search Institute (2004). *The Framework of 40 Developmental Assets, with Definitions*. Minneapolis: The Search Institute.
- Sherman, J. (2003). *Young People We Care: A Book of Ideas to help Young People Supporting each other in their Communities*. London: JSI UK.
- Tonks, D. (1996). *Teaching AIDS*. New York: Routledge.
- U.S. Census Bureau (2002), *Unpublished Paper*.
- UNAIDS (2000). "Innovative Approaches to HIV Prevention: Selected Case Studies." Geneva: UNAIDS.
- UNAIDS (2001). *Reaching Out, Scaling Up*. Geneva: UNAIDS.
- UNAIDS (2001). *AIDS Epidemic Update*.
- UNAIDS (2003, December). *AIDS Epidemic Update*.
- UNAIDS (2002, July). *Global Estimates of HIV/AIDS Epidemic as of End 2001*.
- UNICEF (2000). *Progress of Nations*.
- UNICEF (2000). *Skills-Based Health Education to Prevent HIV/AIDS*. New York: UNICEF.
- UNICEF (2002, May). *Lessons Learned about life skills-based education for preventing HIV/AIDS related risk and related discrimination*. New York: UNICEF.
- UNICEF (2002). *Young People and HIV/AIDS: Opportunity in Crisis*. New York: UNICEF, UNAIDS, WHO.
- UNAIDS (2000). *UNAIDS Best Practices in School AIDS Education: the Zimbabwe Case Study*. New York: UNAIDS.
- World Bank (2003). *Sourcebook: HIV/AIDS Programs*. Washington DC: The World Bank.
- World Bank (2002). *Education and HIV/AIDS: A Window of Hope*. Washington DC: The World Bank.

A Personal End Note to the White Paper

In 1998, my wife and I served as volunteers for the Evangelical Lutheran Church of Tanzania, teaching at a university, and in our spare time, assisting at several children's centers, many of whose residents had been orphaned by HIV/AIDS. During that time we were privileged to get to know Wisdom (not her real name), who was a leader among the children in the center, along with leading the children's choir in a local congregation. She had incredible leadership skills, a beautiful voice, high intelligence, and what appeared to be a great future for one who had been abandoned so early in life. At the age of 14, we saw her going on to the university and making a real contribution to her society. We looked forward to seeing her again when we returned to the center in 2000, only to be told that she had run off with her boyfriend, was likely working as a prostitute on the streets of Dar es Salaam, and more than likely was now infected with HIV, if not full-blown AIDS.

Our maid shared with us the shocking nature of medical care in her community with the following story. A young friend had gone to the local hospital to give birth to her first child, but on arrival was told she had to pay several thousand shillings to be admitted and receive medical attention. She scraped together enough funds to be able to be admitted, but the baby died in childbirth, possibly due to HIV/AIDS complications. The local hospital refused to let her leave to bury the baby without first paying for an expensive ambulance to take the now deceased infant home. Having no more funds, the mother snuck out of the hospital, and hired a taxi to drive her home with her dead baby in her arms, just hours after giving birth.

Anyone who has lived among the poor of Africa can relate a thousand similar stories, each more tragic than the next. What we in the wealthy nations of the world do about this unfolding holocaust, however, is perhaps the greatest moral question facing us today. We cannot escape it. Each of us is diminished by the death of each one of these precious human beings, regardless of how they became infected by the HIV/AIDS virus.

Richard J. Kraft, March 2004