

## Chapter 1 : Youth Development: Strengthening Prevention Strategies

*Social, Economic, and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality.*

Basic transmission cycle for STDs. In this model,  $R_0$ , the reproductive rate of infection, represents the average number of secondary cases of STDs that arise from a new case;  $c$  is the mean rate of sexual partner change within the population;  $\beta$  is the mean probability of transmission per exposure; and  $D$  is the mean duration of infectiousness of newly infected persons. Thus, interventions can prevent the spread of an STD within a population by reducing the rate of exposure to an STD; lowering the rate of partner change; reducing the efficiency of transmission; or shortening the duration of infectiousness for that STD. An extremely important conclusion from this model is that, for communicable diseases such as STDs, if  $R_0$  remains less than 1, the infection eventually disappears from the population. A sustained prevention program can drive the infection to extinction in the entire population, even when these interventions are provided only to individuals and social networks with the highest rates of transmission Anderson, Anderson and May have highlighted differences in the epidemiology of communicable and noncommunicable diseases that have important implications for prevention of STDs. First, rates of partner change within the population and patterns of partner mixing greatly influence the spread of STDs. In essence, individuals with the highest rates of partner change, referred to as "core" groups or transmitters, disproportionately increase the rate of spread. Furthermore, mathematical models show that patterns of sex partner mixing and the characteristics of sexual networks are important determinants of the rate of spread of STDs. For example, if individuals with many partners tend to have sex with others who have Page Share Cite Suggested Citation: *Confronting Sexually Transmitted Diseases*. The National Academies Press. Thus, interventions should have the greatest impact if they reach, and are effective among, individuals who have many partners and in "dense" networks with "assortative mixing. It is important to recognize that early detection and curative treatment of individuals with communicable diseases provide not only secondary prevention at the individual level, but also primary prevention at the population level by preventing further transmission. Reduction in the duration of infectivity, particularly among those most likely to transmit the infection to others, lowers the reproductive rate of infection  $R_0$ . Thus, public health efforts to prevent the spread of communicable diseases need to include not only immunization programs but also early detection and curative treatment of communicable diseases, especially those for which vaccines are not available. For these diseases, behavioral interventions are also important. Behavioral Versus Biomedical Approaches Historically, STD programs have been based on a biomedical model that focused on the treatment of infected individuals and the development of biological and biomechanical interventions such as drugs, diagnostic tests, and barrier methods. Services have centered on the medical screening and treatment of individuals, coupled in some cases with partner notification. The system for delivering services typically has been composed of health professionals practicing in fixed clinical settings. Traditionally, STD prevention activities have involved episodic therapy driven by symptoms of disease and have provided limited clinical counseling or education to promote behavior change. In recent years, the approach to STD prevention has begun to change as a result of critiques by both affected communities and social and behavioral scientists Fee and Krieger, Both biomedical and behavioral health disciplines have made important contributions to the knowledge base for STD prevention Sparling and Aral, Because both behavioral and biomedical approaches to STD prevention are necessary, distinguishing between them is unimportant. Federal agencies recently have recognized the need to incorporate both behavioral and biomedical approaches in a more holistic approach. Wasserheit examined six changes in patterns of STDs and described how physical and social environmental changes drive these disease patterns. She called for the development of STD prevention programs based on "an appreciation of the role of risk behaviors and macroenvironmental forces" using companion Page Share Cite Suggested Citation: In another holistic approach to prevention, Stryker and colleagues identified several fundamental precedents that need to exist before effective HIV prevention is possible. Similar conditions are

probably necessary for the prevention of other STDs. In terms of the mathematical model previously described, current technology can reduce  $\beta$ , the mean probability of transmission per exposure, and  $D$ , the mean duration of infectiousness, to zero. This means that we have the technology and resources to interrupt transmission and greatly reduce many STDs in the United States. In this chapter, the committee describes the complex behavioral problems involved in reducing and  $c$  "the effective mean rate of partner change" and in ensuring that individuals have access to, and make use of, the technologies that can reduce the efficiency of transmission and duration of infectiousness. The committee also evaluates the ability to effectively and efficiently screen for and treat STDs and describes available effective methods for preventing STDs. It should be noted that most of the behavioral interventions discussed in this chapter focus more on reducing efficiency of transmission than on reducing the rate of partner change. This is because many studies of behavioral interventions use consistent condom use as the primary behavioral outcome. In actuality, many behavioral interventions have multiple objectives that include reducing the rate of partner change. Examples of this are school-based interventions that seek to delay the onset of sexual intercourse and also promote condom use. Nevertheless, research on behavioral interventions to reduce the rate of partner change have been underemphasized. It should be noted that reducing the rate of partner change or the patterns of partner selection may affect the dynamics of how groups at differing risk for STDs subsequently interact in populations Morris, The question implicit in the subsequent sections is a perplexing and disturbing one: Why has the United States been unsuccessful in significantly reducing or eliminating a group of diseases that costs thousands of lives and billions of dollars annually in health care costs, despite the fact that effective tools are available? Figure depicts the levels of potential breakdown in steps required to prevent STDs. In regard to the third level from the top of Figure , there is currently no way to influence the development of symptoms of STDs. All the other levels, however, represent a point for preventive interventions. Individual and population-level interventions are needed to a reduce individual risk behaviors and high population prevalence of STDs, both of which increase exposure to STDs; b promote safe practices and protective methods, such as condom use, necessary to reduce acquisition of an STD by those exposed; c educate the Page Share Cite Suggested Citation: Each level, except for the third from the top, represents an important point for public health or clinical intervention. The use of an epidemiological model for estimating the effectiveness of tuberculosis control measures. Bull World Health Organ ; Use of an epidemiological model for estimating the effectiveness of tuberculosis control measures. The model was also described in "Resource allocation model for public health planning-a case study of tuberculosis control," supplement to Vol. Page Share Cite Suggested Citation: The following discussion describes interventions at each of the steps designed to reduce exposure to STDs, reduce transmission to those exposed, and reduce duration of infection. Reducing Exposure and Transmission STDs result from exposure to infectious organisms through sexual contact with an infected individual. The same behavior e. For example, individuals may engage in apparently high-risk behaviors but avoid an STD if their sex partners are not infected. An important strategy for reducing the rate of spread of STDs is to identify and treat infected individuals and their partners. However, it is necessary to supplement this approach with an understanding of how individual behaviors contribute to both exposure and transmission. This is especially important in the case of STDs for several reasons. For these diseases, initial exposure must be avoided to prevent infection. Second, reduction of STDs will be facilitated not only by secondary prevention through treatment of infected individuals but also by preventing initial infections. Therefore, prevention of most STDs requires modification of the behaviors that place individuals at risk. In this section, the committee summarizes how individual factors influence exposure to and transmission of STDs. The committee then illustrates how individual factors affect condom use and summarizes behavioral and clinical methods for preventing exposure and reducing transmission of STDs. These factors include sexual and other behaviors, perception of risk, and personal Page Share Cite Suggested Citation: There are also costs and obstacles associated with adopting behaviors that reduce individual risk of STDs. In this section, immediate factors that influence individual risk of STDs are summarized. It is important to note that these factors are influenced by the social, contextual factors described in Chapter 3 , such as poverty and substance use. Sexual and Other Behaviors Aral recently reviewed the sexual and other behaviors that place individuals

at greater risk of exposure to STDs. Initiation of sexual intercourse at an early age. Persons who initiate intercourse at an early age may be at greater risk of STDs because of the longer time they are sexually active and the greater likelihood of risk factors for STDs such as nonvoluntary intercourse, greater number of partners, and less consistent use of condoms. In addition, adolescents are biologically more susceptible to STDs than adults. Greater number of partners. The greater the number of partners an individual has, the greater is the risk of exposure. This association may be due to the increased risk of exposure to an infected partner with increasing number of partners and the fact that having multiple partners may be associated with other risk factors such as high-risk partners and less consistent use of condoms. Having sex with a partner who is likely to have had many partners increases the risk of an STD. Increased frequency of intercourse and certain sexual practices. The greater is the frequency of intercourse with an infected partner, the greater are the chances of transmission. Risk of HIV infection, hepatitis B virus infection, and other STDs is greater with anal intercourse than with vaginal or oral intercourse. Lack of circumcision of male partner. As discussed in Chapter 3, men who are not circumcised appear to have a greater risk of acquiring and transmitting certain STDs, such as HIV infection and chancroid, compared to men who are circumcised. Women with male partners who are circumcised are at reduced risk of exposure compared to those with uncircumcised partners. Use of vaginal douching. Women who douche are at higher risk for later complications of STDs, such as pelvic inflammatory disease, as discussed in Chapter 3. Lack of barrier contraceptive use. Consistent use of condoms and barrier contraceptives reduces the risk of STDs. Mays and Cochran reported on a study of African American college students who believed that African Americans were less likely to get AIDS than European Americans, even though the reverse is true. Of the sexually active women in the sample, almost a third had taken no actions to avoid STDs. Another nationwide survey of 1, persons in found that Americans underestimated their risk of STDs and were therefore not taking appropriate protective measures EDK Associates, This survey found that 62 percent of men and 50 percent of women were at moderate to high risk for STDs see Figure for definitions of risk. Single and divorced men and women were most likely to be at high or moderate risk for STDs compared to married persons Figure Among those at high risk for STDs, 77 percent of women and 72 percent of men stated that they were not worried about getting an STD. Perceived susceptibility has played a central role in most theories of health behavior e. Such perceptions may be reinforced by periodic negative testing. With consistent reinforcement of negative results in light of high-risk behavior, beliefs congruent with "genetic immunity" or "super invulnerability" may develop, leading to reduced motivation to adopt protective behaviors. Knowledge is necessary but not sufficient to motivate action. Without knowledge, individuals may be unaware of risk or not know what actions to take to protect themselves against STDs. However, among those who do have sufficient knowledge, other factors will affect whether they take action. Thus, among populations with sufficient knowledge, knowledge itself is not related to the behavior Morrison et al. Morrison and others studied adolescents who were incarcerated in the juvenile justice system.

**Chapter 2 : Effective Sex Education**

*You can use it to inform yourself, and to be aware of risk factors, transmission methods, symptoms, and methods of prevention. You can use it to help you pick your partners sensibly, and decide what you do and don't feel comfortable doing with them.*

Context There is no information for this section. Four studies qualified for the review and reported on six interventions. Unprotected anal intercourse UAI: Summary of Economic Evidence An economic review of this intervention did not find any relevant studies. Applicability The following addresses HIV behavioral interventions at individual, group, and community levels. Results of these reviews should be applicable across a range of settings and MSM populations in the U. Important questions remain, however, about whether and how interventions can be adapted to different cultural contexts, as well as to understudied subgroups, such as MSM of color, non- gay-identified MSM, and substance-using MSM. Evidence gaps can exist whether or not a recommendation is made. In cases when the CPSTF finds insufficient evidence to determine whether an intervention strategy works, evidence gaps encourage researchers and program evaluators to conduct more effectiveness studies. When the CPSTF recommends an intervention, evidence gaps highlight missing information that would help users determine if the intervention could meet their particular needs. For example, evidence may be needed to determine where the intervention will work, with which populations, how much it will cost to implement, whether it will provide adequate return on investment, or how users should structure or deliver the intervention to ensure effectiveness. Finally, evidence may be missing for outcomes different from those on which the CPSTF recommendation is based. Identified Evidence Gaps The following outlines evidence gaps for behavioral interventions at individual, group, and community levels. Results from the Community Guide reviews of the effectiveness of individual-, group-, and community-level HIV behavioral risk-reduction interventions for adult men who have sex with men MSM indicate that a number of interventions are effective in reducing HIV risk behaviors among MSM. Yet, important research issues remain. Evidence gaps are provided for the following categories. Subgroups and Settings Although available results suggest robustness in effectiveness across populations and contexts, differences in effectiveness among subgroups of MSM have not been ruled out. Only three studies conducted in the U. None of the studies identified in this review specifically targeted non- gay-identified MSM, who may have different HIV prevention needs than gay-identified men. Several reports have linked increased recreational or "club" drug use e. For example, combination of methamphetamines with erectile dysfunction drugs has become increasingly popular, and has raised serious concerns in both the gay and public health communities. Only two studies included in this systematic review evaluated interventions targeting substance-using MSM. The findings of these two studies were inconsistent in the direction of change and not significant. Further research is needed. The interventions in this systematic review were evaluated among participants in a variety of settings, including gay bars, community-based organizations, health clinics, and research study sites. However, a new "sexual marketplace" has emerged that provides greater opportunities for MSM to acquire potential partners in settings not well represented in this body of evidence e. These high-risk settings, which facilitate access to not only homosexual men but to non- gay-identified and bisexual MSM, increase the potential for rapid spread of STDs. Future research is needed to evaluate behavioral interventions in high-risk venues. Outcome Assessment Continued improvement is also needed in the quality of behavioral assessment in HIV intervention evaluations. These Task Force recommendations are based on self-reported change in sex behavior that can be potentially biased by faulty recall and social desirability. Studies in this review used different strategies to minimize the bias of self-report, including assurances of confidentiality, the use of self-administered questionnaires, and shorter recall periods. One study used the new technology of audio computer-assisted self interviewing ACASI to enhance the quality of behavioral assessment. Because self reported behaviors are subject to potential biases, many investigators have called for the use of biological outcomes e. Few studies measure biological outcomes because of the extensive costs and large sample sizes required to assess disease acquisition over a long period of time. Like behavioral outcomes, biological

outcomes are also subject to potential biases in measurement. STD incidence may be an invalid "surrogate" for HIV incidence because STD acquisition is not only dependent on behaviors such as consistent condom use or frequency of unprotected sex, but also on correct condom use, effectiveness of condoms in preventing different types of STDs, partner selection, acceptance and adherence to STD treatment, and STD prevalence rates within a particular community.

**Intervention Components** The person-to-person HIV behavioral risk reduction approach, as defined in this review, includes a broad class of interventions that work across various groups and settings. What remains to be determined is the identification of intervention components considered to be most effective, least effective, and cost effective. Most behavioral intervention research to date involved a variety of populations, outcome measures, content, duration, and sessions, making it difficult to replicate findings. Results of a recent review indicate that interventions for MSM promoting interpersonal skills training i. Among the group-level interventions in this review, effectiveness may have been enhanced by the provision of multiple sessions, the use of MSM deliverers, and the inclusion of role plays, live demonstrations, or practice of skills. Further research is necessary to determine what works best, in what context, and with whom. One way this can be accomplished is by considering and incorporating into interventions biomedical advances, technologic innovations, and social changes in HIV transmission. Advances in technology and medicine over the past decade have drastically altered the social and behavioral landscape of the MSM community. As HIV is increasingly considered to be a chronic and often manageable disease, commitment to reducing sex risk behaviors, as observed in the first decade of the epidemic, may have declined among many MSM after the introduction of HAART. A recent metaanalysis showed that MSM who believed that receiving HAART protects against transmitting HIV had reduced concerns of engaging in unsafe sex, and had engaged in higher rates of unprotected intercourse. Studies conducted in the U. Internet chat rooms provide a venue through which MSM, who may be HIV seropositive or at high risk for STDs, can seek casual sex partners while avoiding face-to-face rejection. Although the Internet increases the opportunities for MSM to meet potential sex partners, this communication web also provides expanded opportunities for the broad dissemination of risk-reduction information and the recruitment of diverse MSM subgroups into HIV prevention programs. The phenomenon of "barebacking," or intentional anal sex without a condom with someone other than a primary partner, has been recently reported in the literature. Although HIV-seropositive men typically engage in this behavior with other HIV-seropositive men, one study reported a sizeable proportion of men having partners of negative or unknown serostatus. In a survey of MSM in New York City, the barebacking phenomenon was attributed to the increased availability of willing partners identified through Internet chat rooms and websites, confidence in effective treatments for HIV, emotional fatigue regarding HIV prevention messages, and the increased popularity of "club" drugs. Sought to modify knowledge, attitudes, beliefs, self-efficacy, and emotional well-being Involved individualized risk-reduction counseling or motivational interviewing delivered by a trained counselor, educator, peer, or other professional Following are characteristics of studies included in the reviews of HIV behavioral interventions at individual, group, and community levels. Most of the included studies were conducted in the U. Of the 19 included studies, 13 were conducted before , the year highly active antiretroviral treatment HAART was introduced. Participants were recruited in a variety of settings, including clinics, community-based organizations, and gay community venues such as bars and public cruising areas.

Chapter 3 : STD's (Sexually Transmitted Diseases) - [calendrierdelascience.com](http://calendrierdelascience.com)

*chapter on community and individual behavior change interventions is one of nine. With many STDs, such as syphilis, on a downward trend, now is the time to employ new strategies and new ways of looking at STD control.*

These infections can have a devastating impact on sexual and reproductive health if they are not diagnosed and treated. Traditionally, public health efforts to prevent and control bacterial STDs have been through surveillance, clinical services, partner management, and behavioral intervention strategies. However, the persistence of disparities in STDs indicates that these strategies are not achieving sufficient impact in African American communities. It may be that factors such as limited access, acceptability, appropriateness, and affordability of services reduce the efficacy of these strategies for African American communities. In this article we describe the STD prevention strategies and highlight the challenges and implications of these strategies in addressing disparities in African American communities. Surveillance, clinical services, partner management, and behavioral interventions have been used to prevent and control bacterial sexually transmitted diseases STDs “gonorrhea, chlamydia, and syphilis” in the United States. These traditional strategies, with the exception of clinical services, are routinely funded in part by the Centers for Disease Control and Prevention CDC through a program announcement, which provides federal funding to support activities of STD prevention programs in health departments nationwide. Clinical services are an integral part of STD prevention programs. Health department programs generally support public STD clinical services through state and local funds. African Americans carry the largest disease burden for gonorrhea, chlamydia, and syphilis in the United States. These strategies as currently applied may be less successful in African American communities than other racial and ethnic communities. STD surveillance includes the monitoring of STDs or their sequelae, pathogen-specific antimicrobial resistance, sexual behaviors, screening, and healthcare quality and coverage. It is a useful strategy for understanding and addressing the burden of bacterial STDs in African American communities. The essential components of effective clinical STD prevention and control services are routine screening of asymptomatic individuals-at-risk, and prompt diagnosis and accurate treatment for individuals infected with, or exposed to, bacterial STDs. However, there are key challenges that can impact clinical service-based STD prevention and control for African Americans: Partner services typically involve interviewing and counseling STD patients to identify their sex partners and facilitate their access to care, thereby reducing the transmission of STDs and preventing adverse outcomes. There are challenges to the successful implementation of partner services as an effective public health tool; however, when offered in a culturally sensitive manner that respects community norms with the intent of providing a comprehensive approach to STD case management, this modality can be an effective tool for reducing STD rates and, perhaps, disparities. STD behavioral interventions are aimed at helping individuals reduce their behavioral risks for acquiring and transmitting STDs. The focus of behavioral interventions is generally on risk reduction e. For these interventions to reduce the disparate rates of STDs in African American communities, they must 1 be culturally competent, 2 engage the audience, and 3 address cultural and societal constraints on behavior, including the availability of partners. Although these traditional strategies are described separately, in practice they usually function in seamless cooperation with each other. Currently a number of these strategies do not seem as effective at preventing and controlling STD infections among African Americans as among other groups. Tailoring them to enhance their outcomes to better meet the needs of African Americans is clearly warranted. As an example, in a study from the National Longitudinal Study of Adolescent Health, researchers reported that the traditional strategies targeting individual risk behaviors, although suitable for whites, are not necessarily so for African Americans. Surveillance Surveillance is a core public health function and is essential for identifying and monitoring STD disparities. In addition to monitoring the incidence and prevalence of STDs or their sequelae, STD surveillance may include the monitoring of pathogen-specific antimicrobial resistance, sexual behaviors, STD screening, and quality of healthcare services. Most state and local areas focus surveillance efforts on case reporting of gonorrhea, chlamydia, and syphilis for which prevention and control programs have been established. It is only through

the use of multiple surveillance approaches, routine data analysis and interpretation, and evaluation that the burden of these complex infections may be truly understood. High-quality STD surveillance data are essential for identifying and monitoring health disparities. Knowledge of the STD surveillance methods used, the types of data collected, and the context in which the data are collected is essential for interpretation of surveillance data and provides insight into how the data contribute to our understanding of health disparities in various communities.

**Surveillance Methods** The types of surveillance data needed to monitor STD program activities include 1 data to monitor the magnitude of STDs, and their demographic and geographic distribution, and 2 data to define and monitor effective behavioral interventions and diagnostic and therapeutic procedures e. Surveillance data can be captured at the appropriate level local, state, or federal of the public health system by using one or more of the following methods: Case Reporting Case reporting is the process of reporting cases of notifiable STDs by healthcare providers or laboratories to local and state health departments. Case reporting data for the nationally notifiable STDs other than HIV infection “chancroid, chlamydia, gonorrhea, and syphilis” are voluntarily reported from states to CDC. To improve data quality, standardized surveillance case definitions specify the clinical, laboratory, and epidemiologic criteria for each nationally notifiable STD. Incidence is expressed as the absolute number of new STD cases occurring during a given period in a specified population or as a rate per population subgroup e. To improve our understanding of trends in STD incidence in population subgroups, local and state health departments often collect additional data about cases reported through routine notifiable STD surveillance e. Prevalence Monitoring Disease prevalence is the number of people that have a given condition e. In the United States, the best systems for monitoring STD prevalence have been established by the federally funded Regional Infertility Prevention Projects in family planning and other clinics. Consequently, little behavioral information is available about individuals with STDs identified through prevalence monitoring. Sentinel Surveillance The sentinel surveillance approach can also be used to monitor a variety of STDs when ongoing, detailed surveillance of the entire population is not feasible. Sentinel surveillance typically involves the collection of data from a sample “ideally representative” of the population of interest. An example of sentinel surveillance is the Gonococcal Isolate Surveillance Project that monitors trends in antimicrobial susceptibilities of strains of *Neisseria gonorrhoeae* in the United States. When resources are limited, intermittent sentinel surveillance may be useful. However, additional information about patient behaviors can also be very useful. Behavioral surveillance is the periodic collection and interpretation of behavioral risk factor information e. These data provide critical contextual information to help explain changes in STD rates over time e. Behavioral surveillance information from national and state-specific representative samples of the general population e. The National Health and Nutrition Examination Survey is the largest national survey that includes both the collection of biologic samples for STD identification and information on health care seeking and behavioral risk factors. This nationally representative probability survey of the noninstitutionalized United States population has examined the prevalence of positive test results for gonorrhea, chlamydia, syphilis, and other STDs, allowing the population burden of these infections to be estimated. However, acknowledging the disparity in STD rates by race or ethnicity can be one of the first steps in motivating public health officials and mobilizing affected communities to act. The asymptomatic nature of bacterial STDs results in substantial under detection by case reporting. People who are asymptomatic may not seek care and therefore are not likely to generate a case report. Additionally, different STDs may be distributed differently in the same racial or ethnic group. For example, in , African American men aged 20 to 24 have the highest rates of gonorrhea and African American men aged 25 to 39 have the highest rates of primary and secondary syphilis. Depending on the findings, further investigation may be needed to elucidate the reasons for the distributions of STD incidence distributions. Using mapping and spatial analyses of STD incidence, prevalence, and their correlates allows visualization and monitoring of the spatiotemporal distribution of STDs in a given community and can lead to detection of clusters of STD cases in small geographic areas and data-based redirection of case management and intervention resources. It is essential that surveillance methods beyond tracking STD case-associated demographics be used to adequately understand the dynamics of STD transmission in African American communities. In most state and local public health systems, the workforce capacity for STD prevention

programs is insufficient to support routine data analysis and use. Clinical Services Bacterial STDs can easily be diagnosed with laboratory tests and treated with antibiotics. Providing routine screening services for asymptomatic individuals-at-risk and prompt diagnosis and accurate treatment for individuals infected with, or exposed to, bacterial STDs are the essential components of effective clinical STD prevention and control. Therefore, ensuring availability of quality STD services, even for African Americans, involves expanding partnerships between public and private agencies and organizations and the community. Screening Services Screening is used to detect infection in individuals who have no symptoms and is important because most women and many men have no symptoms when infected with gonorrhea and chlamydia. For example, in a study examining the outcomes of screening for gonorrhea and chlamydia in an inner-city hospital emergency department serving a predominantly underserved African American community, the prevalence of gonorrhea and chlamydia was For example, the criteria for syphilis screening are designed primarily for pregnant women. Preventive Services Task Force recommends gonorrhea screening for all sexually active women having one or more of the following risks: Given the limited resources available to most public health departments and other healthcare agencies, more specific screening criteria could assist in the more efficient use of limited resources. The challenge then becomes how to develop more specific criteria, perhaps based on the burden of disease, and how to address the impact these criteria will have, particularly if these criteria include a race-based criterion. Adherence to Screening Criteria In addition to the need for increased screening criteria specificity, an equally important issue is adherence. A number of studies have shown that providers often fail to follow screening criteria for bacterial STDs. Diagnosis and Treatment Accurate diagnosis and appropriate treatment are key elements of STD clinical care, but they are not the only important elements of STD management. Partner services and counseling to reduce risk are critical components too and will be further discussed later in this article. Highly effective medications are also available for the treatment of bacterial STDs. For example, can those in need find STD healthcare services, get an appointment for services, take time off from work to keep the appointment, receive appropriate care, and afford the cost of care and treatment? Although the scope of the current screening recommendations may need to be better defined, it is important that healthcare providers adhere to existing screening recommendations particularly for African Americans who can and do access the healthcare system. For African Americans who have no or limited access to the healthcare system, especially African American men, interventions are needed to ensure better access to quality and acceptable care. Partner Services Partner services is the process by which individuals diagnosed with an STD, commonly known as index patients, are interviewed to identify their sex partners and help arrange for their evaluation and treatment. Partner services has two goals 1 reducing the incidence of STDs; and 2 preventing the adverse consequences of STDs, including adverse outcomes of pregnancy associated with untreated or undetected STDs. When sex partners are treated, STD patients have reduced risk for reinfection. At a population level, notifying sex partners can disrupt networks of STD transmission and reduce disease incidence. Legal authority for conducting partner notification and referral of partners for services varies from state to state. STD prevention programs have a duty to warn 49 individuals that they may have been exposed to an STD. Partner services should be offered to all patients diagnosed with STDs, whether they are diagnosed by public or private agencies. As reported case data suggest, larger numbers of individuals are being diagnosed and treated in settings other than health departments. In addition to facilitating access to care for individuals exposed to STDs, partner services should also include risk-reduction counseling and, whenever appropriate, referral services to other medical and social services such as drug treatment. In addition, the use of expedited partner therapy is an innovative approach to partner referral service. Partner Referral Methods The two most widely practiced methods of partner notification are 1 asking infected individuals to notify their partnersâ€”patient referral, and 2 assigning notification to public health professionalsâ€”provider referral. A third type of referral called contract referral refers to the practice of contracting with infected individuals to use self-referral for a period of time, after which the partners who have not been notified will be contacted by the provider. This method of referral is least used. Some local health departments have contracted with community-based organizations to provide services. This is in part because of the long period between syphilis infection and becoming infectious in comparison with the shorter

incubation periods of gonococcal and chlamydial infections. Preventing further transmission of an STD by promptly identifying, notifying, examining, and treating sex partners is the primary goal of the patient interview. Client-centered counseling on risk reduction and making referrals to other medical and social services are also important goals of the patient interview. One of the main objectives of the interview is partner elicitation. The success of the interview is dependent on motivating patients to voluntarily divulge very sensitive and personal information about their sexual practices. It involves the clinical practice of treating the sex partners of patients with a diagnosis of chlamydia or gonorrhea by providing prescriptions or medications to the patient, who in turn takes them to the partner without a requirement that the healthcare provider first examines the partner. For patients diagnosed with gonorrhea and chlamydia, EPT can be used to treat partners when other strategies are impractical or unsuccessful. Symptomatic male partners and all female partners should be encouraged to seek medical attention, in addition to accepting EPT. For MSM, EPT should not be considered a routine partner management strategy, because data are lacking on its efficacy in this population and because of a high risk for comorbidity, especially undiagnosed HIV infection, in partners.

### Chapter 4 : Prevention - STD Information from CDC

*Objectives By the end of the session participants will be able to: Explain 3 theories of behavior change used in STD prevention and education.*

There are treatments available for all STDs; however, there is no cure for genital herpes or genital warts. If left untreated, STDs may cause sterility or cancer. Sometimes a person can have an STD and not know it because there are no obvious symptoms. All sexually involved people need to remember this fact when making sexual decisions. Fast Facts Of the 12 million new STD infections in the United States each year, two-thirds 8 million occur in people under 25, and one-fourth 3 million are teenagers. About one in four sexually experienced teens acquires an STD annually. Young people have immature immune systems that are less able to fight off infection. Young women have cervical tissue that is different from that of older women, and it is more vulnerable to infection. But men can and do become infected with STDs. What can the media do to better inform the public about STDs? Bacterial STDs - including chlamydia , gonorrhea , and syphilis - usually can be cured by antibiotics but continue to spread at epidemic rates. Because chlamydia and gonorrhea often have no symptoms, many cases are undetected and untreated. Because, I mean, your mortality is flushed right in your face. While discussing safer sex is often difficult, practicing it may be even more difficult. For example, a person may find it uncomfortable and strange to use condoms in a situation that was previously pleasurable without them. Young people who have grown up during the age of AIDS often feel cheated. As they are beginning to understand and explore their sexuality, they must also become proficient in understanding the risks of sexual involvement; utilizing the methods of protection; and negotiating protection - or abstinence - with a partner. The issue of behavioral change is complicated. It involves many forces including motivation, self-image, and family support. Information alone can not eliminate the social and psychological pressures that often lead to risky behavior. Yet, having access to life-saving information is an important prerequisite to healthy behavioral change. In addition, all people must feel that their lives are valued so that they are motivated to remain safe. Fast Facts It is estimated that half of all HIV infections have occurred in 15 to 24 year olds since the beginning of the epidemic. Was there a time in your life when you had to change your behavior in order to stay healthy or become healthier? What was most challenging about attempting or making that change? How can you support them and others at risk for HIV infection?

**Chapter 5 : STDs (Sexually Transmitted Diseases)**

*To prevent getting a sexually transmitted disease, or STD, it was once thought that using condoms with nonoxynol-9 helped to prevent STDs by killing the organisms that can cause disease.*

Also available in [ PDF ] format. The study concluded that 88 percent of pledge-takers initiated sex prior to marriage even though some delayed sex for a while. Rates of STIs among pledge-takers and non-pledgers were similar, even though pledge-takers initiated sex later. Pledge-takers were less likely to seek STI testing and less likely to use contraception when they did have sex. In fact, of six evaluations that assessed short-term changes in behavior, three found no changes, two found increased sexual activity from pre- to post-test, and one showed mixed results. False information about the effectiveness of contraceptives; False information about the risks of abortion; Religious beliefs as scientific fact; Stereotypes about boys and girls as scientific fact; and Medical and scientific errors of fact. In fact, 89 percent believed that it is important for young people to have information about contraception and prevention of STIs and that sex education should focus on how to avoid unintended pregnancy and STIs, including HIV. Only 15 percent of Americans wanted abstinence-only education taught in the classroom. Pediatrics ; 1: Weinstock H et al. Sexually transmitted diseases among American youth: Mosher WD et al. Sexual behavior and selected health measures: Advance Data ; National Campaign to Prevent Teen Pregnancy, Kirby D et al. Family Health International, Advocates for Youth, Science and Success, Second Edition: Santelli J et al. Abstinence and abstinence-only education: Journal of Adolescent Health ; 38 1: No Time to Lose: National Academy Press, Society for Adolescent Medicine. Abstinence-only education policies and programs: Baldo M et al. World Health Organization, Martin JA et al. National Vital Statistics Reports ; 54 2: Hamilton BE et al. National Vital Statistics Reports ; 54 8: Darroch JE, Singh S. Why Is Teenage Pregnancy Declining? Alan Guttmacher Institute, National Campaign to Prevent Teen Pregnancy. Journal of Adolescent Health ; American Journal of Sociology ; 4: Feijoo AN, Grayton C. Special Investigations Division, U. American Medical Association, Legislators craft alternative vision of sex education to counter abstinence-only drive. The Guttmacher Report on Public Policy ; 2: Hickman-Brown Public Opinion Research. National Public Radio et al. Sex Education in America: Written by Brigid McKeon.

**Chapter 6 : Sexually Transmitted Diseases - Camellia Net Digital Catalog - OverDrive**

*Can Changes in Behavior Prevent STDs? Can Science Eliminate STDs? Health & Fitness Young Adult Nonfiction. Details. Publisher: ReferencePoint Press.*

Grady First published online: July 31, DOI: Black men were significantly less likely than whites to have had sex while infected. Blacks, married men and men who were affiliated with a religious group were less likely than whites, single men and those with no religious affiliation to maintain the same behavior subsequent to the diagnosis of an STD infection as before. Black men were more likely than whites to start using condoms; blacks, religious men, less-educated men and those who were older when they had their first sexual experience were the most likely to stop having sex with casual partners once they learned that they were infected with an STD. Family Planning Perspectives, Nearly 12 million Americans are infected with an STD annually; approximately 43 million have viral STDs, which cannot be cured and thus infect the individual for life. For example, even though penicillin has been an important and effective part of the public health campaign against syphilis and gonorrhea for more than 40 years, these STDs continue to be significant health problems. In fact, in some subgroups of the population, the incidence rates of these infections have risen dramatically. The control and prevention of STDs thus calls for more than technological improvements or medical innovations: It requires an understanding of the social and behavioral linkages involved in the acquisition and transmission of infection. Some studies have explored the social, demographic and behavioral characteristics associated with the acquisition of STDs. In this article, we use a population-based data set to examine the effects of individual characteristics on the likelihood that an adult male will engage in a particular type of behavior and, secondly, that he will modify his risk-related behavior once he has learned that he has an STD. Conceptual Framework We assume that individual characteristics that affect sexual and health care behavior in general—age, race or ethnicity, marital status, affiliation with an organized religion, socioeconomic status, and age and contraceptive use at first intercourse—also affect behavior subsequent to an STD infection. Younger people engage in riskier sexual behavior than do those who are older; they accumulate partners more rapidly, and they tend to choose riskier partners. We expect that infected young men are more likely than their older counterparts to continue to engage in behavior that exposes their partners and themselves to infection. In addition, since young men are less inclined than older men to seek health care services in general, we expect that when differential infection rates are accounted for, those who are younger when they become infected are also probably less likely to use STD-related medical services. Race and ethnicity are also related to sexual and health care behavior. The disproportionate representation of STDs among certain racial and ethnic groups may be due to a high likelihood of risky behavior among these groups, a biological predisposition to infection upon exposure, or differential access to and use of health care services. For example, blacks initiate sexual activity at an earlier age and have a greater number of sex partners than those of other races. However, minority populations are characterized by poor health education, poor health care-seeking behavior, and poor access to diagnostic and therapeutic health services; for example, the use of organized medical and STD clinic services is lower among blacks and Hispanics than among whites. Marital status is a reliable predictor of both sexual and health care behavior. Single people engage in riskier sexual behavior than those who are married, perhaps because norms regarding sexual exclusivity are stronger for marriage than for other types of relationships. We expect this relationship to hold also after diagnosis of an STD. On the other hand, because perceived risk is generally lower in monogamous relationships, married people are less likely than their single counterparts to use condoms. Married people are also more likely to seek medical care than unmarried people; therefore, we expect them to have better health care practices following an STD infection, as well. Men who are affiliated with an organized religion generally have a more conservative sexual ideology than those with no religious affiliation. On the other hand, a more conservative sexual ideology might stigmatize STDs and consequently suppress both the use of condoms and the use of STD-related clinical services following infection. However, among those who do seek treatment, we might expect religious affiliation to lead to better compliance with medical advice and to increased preventive behavior; such an influence may mitigate the

overall effect of religious behavior on preventive behavior. In general, as socioeconomic status increases, so does the likelihood of having multiple partners and engaging in a variety of sexual behavior with those partners. Higher socioeconomic status is generally associated with a greater sense of self-efficacy, and an STD infection may help an individual to realize the costs and consequences of risky sexual practices, resulting in greater behavior modification. In addition, higher socioeconomic status, insofar as it is marked by higher income and an increased likelihood of having health care insurance coverage, facilitates access to health care services. We hypothesize that these factors will promote the use both of condoms and of STD-related medical services after an infection. Two additional variables are included in our analysis, as indicators of a propensity for risk-taking: Similarly, we expect that those who used a birth control method at first vaginal intercourse will engage in more responsible behavior following an STD diagnosis.

**Data and Methods**  
**Study Population and Sample**  
The data used in this study were collected in from a nationally representative household sample of men aged 18-59. The National Survey of Men was based on a stratified, clustered, area probability sample design. Blacks were oversampled to allow sufficient representation in the database. Other populations known to have an elevated risk of contracting an STD were not oversampled, but are represented at a rate proportionate to their size in the population. The weighted sample accounts for the effects of stratification, clustering, the oversampling of black men and differential nonresponse. The results presented here are based on weighted data and permit generalizations to the U.S. In cases of multiple infections, the questions were repeated for each disease; to minimize potential recall problems, only data regarding the most recent infection were used. In a general population sample, the incidence and prevalence of STDs are usually so low that it is difficult to conduct separate analyses by disease. Thus, we initially lumped all STDs together. Subsequently, in an effort to account for differences among the reported STDs in infectivity rates, symptoms, treatments and the likelihood of cure, we conducted a separate analysis focusing on the men who had had gonorrhea—the most commonly reported STD in the United States. We examined 10 outcomes that capture behavior and behavior change following the diagnosis of an STD. Since the number of respondents who reported having had sex while infected was small, we were not able to assess the second outcome among the subsample of men who had had gonorrhea. The third outcome relates to whether the men returned to their doctor or clinic to be retested after treatment had been completed. The next six outcomes were derived from a multicategory question using a card listing various behavior changes that one might adopt following an STD diagnosis: Thus, if a respondent replied that he had not changed a risky behavior after becoming infected, it could mean either that he continued to engage in that behavior or that he had never engaged in it. Despite this ambiguity, the analysis of this set of questions remains useful for making policy recommendations. Importantly, the outcome "no behavioral change" is much less ambiguous, because the men in this sample are likely to have engaged in some type of risky behavior before they were infected. Since all of these variables are dichotomous, the analyses were conducted using logistic regression techniques. Table 1 lists the predictor and control variables used in the analyses, along with their percentage distributions or means and standard deviations. Five social and demographic variables were included: Age at first intercourse and contraceptive use at first intercourse were included as measures of previous risk-taking behavior. The former is a discrete variable obtained from data on date of birth and date of first intercourse; the latter is a dichotomous measure. Two control variables were included. The first is the number of months between diagnosis of the disease and the interview. This is the period during which the respondent would potentially have modified his behavior. If this period was short, there may not have been an opportunity to modify a specific type of behavior. In addition, for the first three outcomes investigated, this variable serves as a control for any changes in public health policy or recommendations regarding behavior while infected. For example, prior to about 1990, retesting following treatment was required for chlamydia and gonorrhea infections; thus, we would expect the number of months between infection and interview to have a positive relationship with retesting. Second, in the analyses of men who had had any STD, we included a control variable to indicate whether the disease was a bacterial or a viral infection. This is important because viral infections require permanent changes in behavior, whereas bacterial infections, which can be treated in a relatively short period of time, require only temporary behavior change to avoid spreading the disease. Of course, regardless of the type of infection, long-lasting

changes in sexual behavior are necessary to avoid repeat infections. This difference is largely because the "any STD" measure includes men who had a viral infection. Overall, there is a positive relationship between age and having sex while infected, but this relationship is not significant among men who reported only a gonorrhea infection. Younger respondents infected with gonorrhea were more likely than those who had been older at diagnosis to return to their doctor or clinic for rescreening. Race is also related to behavior after an STD diagnosis. Black men were less likely than whites to have had intercourse while infected with any STD or with gonorrhea. However, black men who had had sex while infected were significantly less likely than white men to have informed their partners that they had an STD. Single men who had had any STD were less likely than their married counterparts to have told their partners about their infection. Other results by marital status also suggest that married men may engage in better health care practices than unmarried men. The likelihood that men infected with any STD had had intercourse varied significantly according to whether or not they reported a religious affiliation. Furthermore, those with a religious affiliation were more likely to have informed their sexual partners about their infection and to have returned for the recommended follow-up. In both samples, the regression coefficients suggest that men with more than a high school education were less likely than those with a lower level of education to have had sex while infected, but the result for the overall sample is only marginally significant. However, among men who had had any STD, the better-educated were significantly more likely than those with less schooling to have told their partners that they were infected. Interestingly, respondents who had more than a high school education were less likely to have returned for a follow-up screening than were those with less education. This surprising result may reflect that individuals of relatively high socioeconomic status are likely to go to private physicians, who may not require a follow-up visit after STD treatment, whereas those of lower socioeconomic status probably seek treatment from public health facilities, which commonly require such visits. Previous risk-taking behavior had no significant effect on sexual behavior while infected among men who had had any STD. Surprisingly, among men who had had a gonorrheal infection, those who had used a contraceptive method at first sex were significantly less likely than those who had not to have obtained a follow-up screening. This might in part be a result of the change in rescreening requirements for gonorrhea and chlamydia after The type of disease i. However, the kinds of behavior changes men made in response to an STD varied with the type of infection. Men with a viral infection were less likely than those with a bacterial infection to have reduced the frequency with which they had sex and to have avoided sex with partners whom they did not know well. However, those with a viral STD were more likely to have begun using condoms. The variable reflecting the time elapsed between the STD diagnosis and the interview captures some of the period effects. For both the overall sample and those who had had gonorrhea, the longer ago the diagnosis, the more likely it was that men would report having made no behavior change. This finding may reflect the widespread public health efforts in recent years to curb the spread of HIV infection. As for the specific changes made in sexual behavior following an infection, those who had had an STD diagnosed more recently were more likely than those whose disease had been identified longer ago to have stopped engaging in sex with multiple partners and to have increased their condom use. They were, however, less likely to have refrained from having sex altogether. The relationship between length of time since diagnosis and increased condom use remained significant among men who had had gonorrhea. Individual characteristics had a strong influence on whether or not infected individuals changed their sexual behavior, but not always in the expected direction. The older the men had been at diagnosis, the more likely they were not to have changed their behavior. This somewhat counterintuitive and unexpected result could indicate that older men are less worried about future infections because they have better access to health care and are less embarrassed about obtaining services. Another possible explanation is that older men are less likely to have engaged in risky practices before becoming infected, so have less room for behavior changes. In both groups, black men were significantly less likely than white men to have maintained the same behavior after learning that they had an STD. While black men were less likely than whites to have avoided any type of sexual contact while infected, they were more likely than whites to have stopped having sex with partners they did not know well and to have begun using condoms.

### Chapter 7 : Can Facebook Help Prevent STDs?

*Surveillance, clinical services, partner management, and behavioral interventions have been used to prevent and control bacterial sexually transmitted diseases (STDs)â€”gonorrhea, chlamydia, and syphilisâ€”in the United States.*

Abstinence is not having sex. A person who decides to practice abstinence has decided not to have sex or any type of intimate sexual contact. **How Does It Work?** Some forms of birth control depend on barriers that prevent the sperm from reaching the egg such as condoms or diaphragms. Others interfere with the menstrual cycle as birth control pills do. With abstinence, no barriers or pills are necessary because the person is not being sexually intimate with others. Sometimes people who have been having sex decide not to continue having sex. Even someone who has been having sex can still choose abstinence to prevent pregnancy and sexually transmitted diseases STDs in the future. **How Well Does It Work?** Although many birth control methods can have high rates of success if used properly, they can fail occasionally. Some STDs spread through oralâ€”genital sex, anal sex, or even intimate skin-to-skin contact without actual penetration genital warts and herpes can be spread this way. Having sex even once means that the person risks getting an infection. Only complete and consistent abstinence can totally prevent pregnancy and protect against STDs. Because a person does not have any type of intimate sexual contact when he or she practices complete and consistent abstinence, there is no risk of passing on a sexually transmitted infection. Abstinence does not prevent AIDS , hepatitis B , and hepatitis C infections that come from nonsexual activities, like using contaminated needles for doing drugs, tattooing , or injecting steroids. **How Do You Do It?** But peer pressure and things you see on TV and in the movies can make the decision to practice abstinence more difficult. If it seems like everybody else is having sex, some people may feel they have to do it, too, just to be accepted. The truth is that most teens are not having sex. A couple can still have a relationship without having sex. You may have questions about making this choice or about other methods of birth control. Your doctor or nurse â€” or an adult you trust, such as a parent, teacher, or counselor â€” can help provide some answers.

**Chapter 8 : Prevention Tips |**

*Americans seriously underestimate their risk for STDs; 77 percent of women and 72 percent of men at high risk for STDs surveyed were not concerned about acquiring an STD. There are many individual- and community-based interventions and tools that are effective and can be used immediately to prevent.*

Also available in [ PDF ] format. By contrast, many youth development programs provide young people with the motivation to achieve a healthy adulthood but do not provide young people with the sexual health knowledge, skills, and services they need to avoid unintended pregnancy or infection with HIV and other STDs. Youth development programs are comprehensive and multifaceted, building on the assets and strengths of young people and assisting them to define goals, complete school, and plan their futures. Youth development seldom tackles isolated problems—such as sexual risk behaviors—but focuses instead on providing holistic support and opportunities for young people. Youth development is a strategy that attempts to meet the needs young people themselves identify—to have life skills, to be cared for and safe, to be valued and useful, and to be spiritually grounded—by building on their capabilities, assisting them to cultivate their own talents and to increase their feelings of self-worth, and easing their transition to adulthood. Youth development is especially important for young people who have little or no support from their families, schools, and communities. These hard to reach and under served youth, who frequently report high risk behavior and often lack access to health services, include: Youth development focuses on assets and strengths, not problems. Youth development—also known as life options—programs must be flexible to be able to meet the individual needs and build on the individual assets and strengths of each young participant. Programs may provide such services as tutoring, mentoring, recreational opportunities, job training, social skills, and community service. By tailoring services to meet the needs and build on the assets of the individual, these programs motivate young people to work toward achieving successful futures. Effective programs targeting hard to reach and under served teens are multifaceted, long-term, monitored, and evaluated. Planners of effective youth development programs establish areas of competence and specific outcome measures of achievement which might including: Academic competence, measured by grades or standardized test scores Social or interpersonal competence, measured by communication skills or by participation in age-appropriate school, work, recreational, and social activities Creativity, measured by artistic efforts, such as performances, canvases, or manuscripts Vocational competence, measured by job skills or employment outcomes Healthy diet and exercise, measured by nutritional journals or exercise tests Service to others, measured by hours of community service or participation in community activities. For example, a program might foster the creativity of young participants by asking them to design a social marketing campaign to promote HIV antibody testing. Or a program might assist young participants to build their social skills so they can recognize and incorporate healthy elements—such as mutual respect between partners—into their romantic relationships. Prevention planners will also need to educate their funding sources by explaining the links between youth development and effective prevention programming. Youth development programs address the real or human needs of young people. Too often, traditional public health interventions focus on issues that adult service providers perceive young people to need. These interventions are usually supported by categorical funding streams and typically ask youth to adopt new behaviors which they do not really want to adopt. But, in paying little attention to the real issues that the target population confronts—such as neighborhood violence which threatens youth with early death—the program may also fail to achieve desired changes in behaviors. Youth who think they will be dead within two or three years are not likely to worry about a disease that could kill them in 10 to 12 years. For example, young men who have sex with men YMSM most often identify two basic needs—societal acceptance and intimacy in a relationship. They need a reason to use one. Workshops might assist YMSM to acquire dating skills, determine what they really want in a partner, and teach them skills to sustain relationships. In another example, young women of color most often identify a need for intimacy as being connected to their sexual risk behaviors. Then, increasing their interpersonal, communication, and assertiveness skills would assist them to create the healthy, intimate

relationships they want. Such an approach—linking prevention and development strategies—could assist young women of color to achieve safely the intimacy they need. However, adult service providers will need to "connect the dots" between these strategies for their funding sources. Young people should participate in designing the program and in its activities. Participants will determine whether programs are appropriate and relevant for them, and they vote by leaving or staying. Youth can and should be among the leaders in programs, even when that means special training for them. Finally, programs should involve youth as educators of other youth. Programs that fully engage young people have an excellent chance of keeping youth participating because "ownership" of the program shifts to the young people themselves. Effective programs also actively engage participants in individualized activities. These educational techniques also foster maturity and a sense of empowerment. Other important skills—such as the ability to sustain a healthy relationship, the ability to make and hold friendships, and the ability to find and hold a job—may increase the motivation of young people to avoid sexual risk behaviors. Programs should involve committed and knowledgeable adults. Programs should foster trust between adults and youth. In addition to education and professional expertise, staff needs a positive, nonjudgmental attitude toward and respect for young people. Staff should also possess qualities such as willingness to work in collaboration with others, flexibility, commitment, experience working with young people, interest in youth, and the willingness to be a role model. Youth develop within, and are profoundly influenced by, their environment. Research shows that behavior change results from the interaction of individuals and their environment. Finally, planners must consider the characteristics of the community as a whole when designing programs. Successful youth development requires community partnerships. Youth develop within the contexts of family, school, peers, and community. Planners must actively involve representatives of all these groups in planning, designing, implementing, and evaluating program activities. Programs must tap the resources of community members, including parents and families, religious and business leaders, local policy makers, educators, youth-serving professionals, and health care providers. In addition, programs need to ensure access to mental health counseling for teens who face issues—such as depression, substance abuse, and family or relationship problems—which may affect their ability to thrive in a youth development program. Usually, to offer an array of services, youth development programs make collaborative arrangements with other community agencies. Many effective programs have a strong commitment to youth and to preventing risk behaviors among youth, including sexual risk-taking, dropping out of school, and using substances. Programs may monitor their own activities and may have been evaluated. Further, such links offer monetary savings and may help stretch scarce prevention funds. Linking programs requires careful planning and the commitment of all the agencies and institutions to work together to strengthen services for teens. Youth-serving professionals who hope to design effective programs which truly value young people, know that they must supply youth with far-reaching developmental support, activities, and tools to successfully complete the journey to adulthood. Youth development is a good prevention strategy. Few youth development programs have been evaluated. Communities should work together to meet the needs that young people themselves identify. They should focus on the strengths and assets of young people rather than the "problem" behaviors they may demonstrate. References National Clearinghouse on Families and Youth. Reconnecting Youth and Community: A Youth Development Approach. Youth Development and Resiliency Research: Making Connections to Substance Abuse Prevention. Pittman KJ, Zeldin S. Premises, Principles and Practices: Lesbian, Gay, and Bisexual Youth. Designing an AIDS risk reduction program for gay teenagers: Gipson LM, Frasier A. Advocates for Youth, Addressing Adolescent sexual behavior and childbearing:

*Vaccines are safe, effective, and recommended ways to prevent hepatitis B and HPV. HPV vaccines for males and females can protect against some of the most common types of HPV. It is best to get all three doses (shots) before becoming sexually active.*

Researchers say social media may provide a viable alternative to promote safe sex using online networks of friends. Researchers initially recruited study participants in community settings and through postings on popular blogs and websites, as well as advertisements in college and local papers in U. Investigators focused their recruitment efforts on African-American and Latino youth given the disparity of infections between these groups and other young adults. Each recruit was given an incentive to recruit three friends to participate, and each new recruit was also incentivized to recruit three friends, for five recruitment waves. Participants and those they recruited were randomly assigned as a network to either an intervention group or a control group. Each week a new topic such as communicating about sexual history, skills building for condom negotiation and use, and how to access STI testing was discussed on the site, with updates each day from youth facilitators in the form of video links, quizzes, blogs, and threaded discussions. Investigators collected demographic information and baseline information on condom use at last sexual encounter and the proportion of sex acts protected by condom use in the last 60 days at the beginning of the study. The effects decreased over time and a survey six months after the intervention found no difference between the two groups. There was no evidence that any demographic characteristics influenced response to the intervention. There is little evidence that youth actively seek out and engage with organizations on Facebook. Bull said that the study relied on self-reporting, and condom use may have been over-reported. Another concern is that the number of active participants declined over time, as did the treatment effect. In a commentary accompanying the article, Nathan K. Building such teams will undoubtedly require changes to traditional funding and development models, but the potential is too large to be ignored or minimized. Rick Nauert has over 25 years experience in clinical, administrative and academic healthcare. He is currently an associate professor for Rocky Mountain University of Health Professionals doctoral program in health promotion and wellness. Nauert began his career as a clinical physical therapist and served as a regional manager for a publicly traded multidisciplinary rehabilitation agency for 12 years. He has masters degrees in health-fitness management and healthcare administration and a doctoral degree from The University of Texas at Austin focused on health care informatics, health administration, health education and health policy. His research efforts included the area of telehealth with a specialty in disease management. Retrieved on November 10, , from <https://>