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Preliminary Findings on a Brief Friendship-Based HIV/STI Intervention for Urban African American Youth: Project ÒRÉ

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Abstract This study presents preliminary findings of a brief friendship-based HIV/STI prevention intervention for urban African American youth. Using a no-control design, we found that the program is feasible, acceptable, and demonstrates promise with regard to changes in HIV/STI-related knowledge, beliefs, social norms, and behavior. © 2008 Society for Adolescent Medicine. All rights reserved.

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Continued innovation in prevention approaches is needed to stem the rising tide of human immunodeficiency virus (HIV) infection [1] and the ongoing sexually transmitted infections (STI) epidemic [2] in African American adolescents. Such efforts should include a focus on youth living in communities with high STI rates. This study presents initial findings on a brief friendship-based HIV/STI prevention intervention developed for urban African American youth living in a community with a high prevalence of STIs.

Social norms and network interventions

Perceived social norms and connectedness to the individuals expressing those norms have been identified as key factors in successful interventions, suggesting the need for a greater focus on these issues in basic behavioral research and program development [3]. Norms may include social or behavioral rules that proscribe or prescribe behavior; norms have a greater impact when an adolescent is closely connected to the person or group expressing those norms. Peers are highly influential at this developmental stage [4], and close friends may be particularly central for urban youth [5]. Our ongoing work with urban African American friendship groups demonstrated similarity in norms regarding sex and drug use, and in behavior [6]. Further, we found a pattern of sharing experiences and confidences around personal issues, including romance and sex [7]. Drawing on these findings, we developed a brief friendship-based HIV/STI prevention intervention designed to influence social norms and behavior related to HIV/STIs. Our approach differs from prior social network-based studies, which were multisession programs involving younger adolescent peer groups [8]. We recruited small groups of close friends for a single session program to avoid problems of irregular attendance, which may weaken program messages. Under these conditions, the intervention built on connections that underlie friendships [7], thereby providing opportunities to address the influence of social norms. The intervention also was designed to be developmentally and culturally appropriate for the participants.

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Methods

Study sample and procedures

Participants were 78 youth (48.7% female), aged 14 to 23 years (mean =16.9), representing 20 friendship groups (n = 20 network seeds, n = 58 friends). Most youth were African American (n = 70; 89.7%), with many fewer Latino/as (n = 2; 2.6%), Asian/Pacific Islanders (n = 3; 3.8%), Native Americans (n = 1; 1.3%), and other racial/ethnic groups (n = 2; 2.6%).

With approval from our institutional review board, we recruited sexually experienced African American youth between 14 and 18 years of age through outreach in a low-income urban neighborhood on the West Coast. These individuals (network seeds), in turn, recruited between two and seven close friends. Recruitment was kept as simple as possible to simulate more closely the type of recruitment that might take place at a community-based organization delivering such a program. Written, informed parental consent and youth assent were obtained for youth under age 18; respondents 18 and older provided written, informed consent. Consenting individuals participated in a single-session, 5-hour HIV/STI prevention intervention program with their friendship group of three to eight individuals at a dedicated community-based location. All participants completed pre- and immediate postintervention self-administered paper-and-pencil questionnaires that focused on HIV/STI-related knowledge, beliefs, norms, sexual behavior, and STI testing (Table 1). Process evaluation focus groups were also conducted immediately postintervention. Each youth received $40 cash and a movie ticket; food was provided during a break in the workshop. Three-month follow-up questionnaires were administered to participants ($25 remuneration).

Intervention content and format

The intervention (Figure 1), based on existing literature plus our prior qualitative and quantitative research in the study community along with input from community youth,

Table 1
HIV/STI knowledge, beliefs, social norms, and behavioral characteristics of sample at pre-, postintervention, and follow-up

Variable	Pre	Immediate post	3-Month follow-up
HIV/STI-related knowledge, beliefs and norms	N (%) [Mean]		
Knowledge	78 [11.4]	76 [11.9]*	69 [12.4]***
Perceived risk HIV (% worried)	76 (50.0)	72 (63.9)**	69 (60.9)†
Perceived risk STIs (% worried)	75 (53.3)	73 (64.4)*	68 (58.8)
Condom attitudes	78 [20.4]	76 [20.6]	69 [20.6]
Intentions to use condoms	78 (71.8)	72 (79.2)†	—
Social norms (% agree)			
Most close friends think . . .			
You should use condoms with new partner	77 (90.9)	74 (97.3)†	69 (95.7)
You should use condoms whenever have sex even with main partner	74 (78.4)	74 (90.5)*	68 (88.2)†
Not OK to have sex with others when have main partner	75 (52.0)	73 (69.9)**	68 (63.2)†
Behavior (past 3 months)	N (%) [Mean]		
Vaginal sex[b] (% yes)	76 (67.1)		66 (60.6)
Oral sex (% yes)	76 (31.6)		66 (28.8)
Anal sex[c] (% yes)	75 (2.7)		66 (7.6)†
Multiple partners (% 2+ partners)	73 (43.8)		63 (27.0)*
Number of partners	73 [2.78]		63 [1.68]
Condom use[d] (% always)	51 (70.6)		40 (52.5)
Tested for STIs (% yes)	—		68 (38.2)

STIs = sexually transmitted infections.

†≤.1, *≤.05, **≤.01, ***≤.001 (for post vs. pre or follow-up vs. pre comparisons).

[a] Ns reflect the denominator on which figures are based. HIV/STI-related knowledge, beliefs and norms: high values reflect positive direction. *Knowledge* (14 items; total score is sum of correct items; range 9–14; items include: AIDS can be cured; using condoms reduces the chance of getting AIDS; a person can always tell if he/she has an STD). *Condom attitudes* (4-point scale ranging from strongly agree to strongly disagree) (six items; range 11–24; items include: sex does not feel as good when you use a condom; it is hard to put a condom on). *Intentions to use condoms* (5-point scale ranging from never to always) (one item; dichotomized; if you have vaginal sex in the next 3 months, how often do you think that you or your partner will use a condom?) Not assessed at follow-up. *Perceived risk* (4-point scale ranging from very worried to not at all worried) (one item each STI, HIV; dichotomized; how worried or concerned are you that you will get . . . from having sex?). *Social norms* (4-point scale ranging from strongly agree to strongly disagree) (three items; dichotomized; items include: most of your close friends think . . . that people should always use a condom when having sex with a new person). Behavior Variables: history of sex assessed with one item each for *vaginal*, *anal*, and *oral* sex (in the past 3 months, did you have . . . sex?). *Number of partners* (one item: how many different people did you have sex with in the past 3 months?). *Multiple partners* was derived from previous item. *Condom use* (5-point scale ranging from never to always) (one item; dichotomized [always vs. not]; in the past 3 months how often did you or your partner use a condom when you had vaginal sex?).

[b] At preintervention, three respondents who did not have vaginal sex reported anal or oral sex. At follow-up, two respondents who did not have vaginal sex had anal or oral sex.

[c] The number of respondents engaging in anal sex was small: n = 2 at preintervention, n = 5 at postintervention.

[d] Restricted to sexually active participants (only 34 cases reported vaginal sex both preintervention and at follow-up).