Safer Choices

Preventing HIV, Other STD and Pregnancy

Implementation Manual

Revised Edition

ETR

and

Center for Health Promotion Research and Development

University of Texas–Houston, Health Science Center

Advancing Science
Reducing Risk
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Acknowledgments

Individuals Involved in the Original Project

The success of *Safer Choices* reflects, in part, the talent and dedication of all the individuals involved in its development, implementation and evaluation. Numerous individuals played an instrumental role in the project.

The research team was headed by Guy Parcel and Douglas Kirby, Principal Investigators. Karen Basen-Engquist and Karin Coyle, Co-Principal Investigators, ensured that all phases of the project were developed and implemented as designed. Marsha Weil, Co-Investigator, provided expertise regarding the Councils and the school organization component, as well as the curriculum and staff development component.

Barbara Collins, Chris Markham, Jesse Nodora and Duane Wilkerson, the *Safer Choices* project liaisons, helped develop program materials, trained teachers and other school staff for program implementation, and provided continued support at the school sites to facilitate program implementation. Jacqueline Lilliard assisted with teacher training and curriculum support. Gayle Fields helped with the creation of the role model story calendar and posters.

The data collection and management were guided by Chris Harvey and Deborah Ivie. Ronald Harrist, Co-Investigator, oversaw the statistical analyses, and worked closely with Elizabeth Baumler and Scott Carvajal, who spent countless hours analyzing the complex, multilevel data set. The research team was supported by Nancy Calvin and Margo Parr, the project administrative assistants.

(continued)

Several other individuals provided support in developing and/or implementing key project activities. Joyce Fetro played an instrumental role in developing the *Safer Choices* curriculum. Parts of the curriculum were taken from *Reducing the Risk: Building Skills to Prevent Pregnancy, STD and HIV*, a curriculum developed by Richard Barth. Donnovan Somera and Cecile Cummings of the northern California Mid-Peninsula YWCA AIDS Prevention Program assisted with the Peer Resource Team training design and training.

The project was funded by the Division of Adolescent and School Health of the Centers for Disease Control and Prevention. CDC investigators included Stephen Banspach, our *Safer Choices* Project Officer, along with Janet Collins and Deborah Rugg.

The project could not have been a success without the support of the district representatives, principals, teachers and school staff who welcomed us at their schools. Of critical importance were the contributions of the school district contacts, the Site and Peer Coordinators, the members of the School Health Promotion Councils, the members of the Peer Resource Teams, the students who served as Peer Leaders for the classroom curriculum, the teachers who taught the curriculum, the HIV-positive speakers who shared their stories, and the many community organizations who shared staff and materials in support of the project. Critical to the evaluation were the thousands of students who completed the study questionnaires.

Finally, ETR's publishing division helped us transform the project materials into this set of user-friendly guidebooks.

About *Safer Choices*

Program Overview

Safer Choices was funded by the Centers for Disease Control and Prevention, Division of Adolescent and School Health, to test the effectiveness of a state-of-the-art program to prevent HIV, other sexually transmitted disease (STD) and unintended pregnancy among high school students. The *Safer Choices* program is designed to reduce the number of students engaging in unprotected sexual intercourse by reducing the number of students who begin or have sexual intercourse during their high school years, and by increasing use of condoms and other methods of protection among students who do have sex.

The program seeks to modify several factors related to sexual risk-taking behavior, including students':

- knowledge about HIV and other STD
- attitudes about sexual behavior and condom use
- perceived peer norms regarding sexual behavior and condom use
- belief in their ability (self-efficacy) to refuse sexual intercourse or unprotected sexual intercourse, use a condom, and communicate about safer sexual practices
- perceived barriers to condom use
- perceived risk of becoming infected with HIV or other STD
- communication with parents

(continued)

Students Say...

The comments listed here and throughout this manual are from real teenagers who were involved in the original **Safer Choices** study. Their names have been changed to protect their privacy.

Now I know you can't look at someone and say he/she has HIV.
—James, 14

Talking about CONDOMS isn't saying, "Have sex." It's saying, "If you have sex, protect yourself and your partner." —Leslie, 15

Safer Choices *helped me realize that I'm making the right choice not to have sex until I get married.* —Elisa, 15

The **Safer Choices** *program helped me to have a little more respect for myself. I'm more careful today than I was a few months ago.* —Ron, 15

It has taught me to have a positive attitude about turning down sexual pressures without feeling bad about myself. —Heather, 15

You hear the statistics and get to hear the testimonies of people living with HIV. It makes you realize that some people think, "It only happens to strangers, people I don't know." Well, to someone else, you are that person. I think this is a great class. You learn so much and the more you learn, the better.
—Robert, 15

I can talk to my boyfriend about having sex a lot easier now. I've decided to wait to have sex until I'm sure that is what I want and that I'm ready. —Sharnelle, 15

Program Overview

(continued)

The *Safer Choices* intervention is based on social cognitive theory (Bandura, 1986), social influence theory (Fisher, 1988; McGuire, 1972; McGuire and Papageoris, 1961), and models of school change (Marsh et al., 1988). The program consists of 5 primary components:

1. School Organization
2. Curriculum and Staff Development
3. Peer Resources and School Environment
4. Parent Education
5. School-Community Linkages

The uniqueness of the multiple component intervention is its focus on schoolwide change and the influence of the total school environment on student behavior. By involving teachers, parents, community members, and especially students, the program is designed to have a positive influence on adolescents' decisions regarding sex and help them feel supported in making the safest choices.

Key features of the program components are summarized in Figure 1. A more detailed discussion of the original program has been published by Coyle, Kirby, Parcel et al., 1996, and can be found in Appendix A.

Students Say...

First, when I started on **Safer Choices** *I'm like, "Oh, wow, another boring program trying to influence my decisions on sex." But I was wrong. This program was different. I could see the message every time. This program made me realize, sex isn't everything in a relationship.*

—Sonya, 15

Figure 1

Safer Choices Program Components

Component	Key Features
School Organization	The **School Health Promotion Council** plans and conducts program activities. It involves teachers, students, parents, administrators and community representatives. The **Site Coordinator** plays a central role in establishing the council and coordinating its efforts.
Curriculum and Staff Development	The sequential 21-session **Curriculum** is taught over 2 school years (11 lessons at level 1 and 10 lessons at level 2). **Peer Leaders** are trained to help facilitate certain classroom activities (e.g., leading small-group roleplaying). **Teacher Training** is available to assist classroom teachers in implementing the curriculum. **Staff development** activities can further support the program.
Peer Resources and School Environment	Young people on the **Peer Resource Team** meet with an adult **Peer Coordinator** to plan and host schoolwide activities designed to alter the normative culture of school.
Parent Education	**Newsletters** provide parents with information about the *Safer Choices* program; background knowledge on HIV, other STD and teen pregnancy; and tips on talking with teens about these issues. The curriculum includes **Student/Parent Homework** activities to facilitate family communication. Parents also serve on the School Health Promotion Council, and can help plan other parent-related events.
School-Community Linkages	The curriculum includes **Homework Assignments** requiring students to gather information about local community resources and services. Level 2 also includes a lesson involving **HIV-Positive Speakers**. A **Resource Guide** developed by the School Health Promotion Council lists local resources related to HIV, other STD and pregnancy prevention.

Evaluation

The initial *Safer Choices* study was implemented during the 1993–94 and 1994–95 school years. The evaluation used a randomized trial involving 20 schools—10 schools in southeast Texas and 10 in northern California. The schools ranged in size from 961 to 2,733 students, with an average of 1,767 students. Within each site, half the schools were randomly assigned to receive *Safer Choices*; the remaining half were assigned to a comparison group.

Data were collected from students over a 3-year period (approximately 7, 19 and 31 months following baseline) to assess the effectiveness of the program. The results suggest that *Safer Choices* produced numerous statistically and programmatically significant effects (Coyle et al., 2001). For example, at all 3 follow-ups the program had a positive impact on the majority of the psychosocial variables related to sexual risk-taking behaviors (e.g., HIV and other STD knowledge, self-efficacy to get and use condoms, condom use norms, parent-child communication).

Safer Choices also reduced the number of acts of unprotected intercourse among students in the cohort at the 7-month follow-up, and increased the use of effective STD and pregnancy prevention methods at last intercourse among sexually experienced students. These trends were still evident at the 31-month follow-up. In addition, among Hispanic youth, *Safer Choices* delayed the initiation of sex for 31 months (Kirby et al., 2004). The evidence suggests that theory-driven, school-based multicomponent programs can play an important role in protecting students from STD, including HIV, and unintended pregnancy.

It is important to note that these evaluation results reflect the entire program, not just the impact of the curriculum; however, the curriculum was the most intensive program component.

See Appendixes B and C for articles detailing the evaluation.

Students Say...

I didn't know the real importance of latex condoms. I learned a lot and now I don't have sex without a condom.

—Kenneth, 16

I learned that the safest way to prevent any disease is by not having sex at all.

—Jose, 15

Implementing Safer Choices

The *Safer Choices* program was designed to be implemented as an integrated program including all 5 key components. Although it is possible to implement individual components, it is important to note that the evaluation tested the program as a whole, and did not test the effectiveness of individual components.

The following sections provide overviews of each of the 5 *Safer Choices* program components. They detail key activities for each component and provide materials to help with implementation.

Selected Articles About Safer Choices

Coyle, K., D. Kirby, G. Parcel, K. Basen-Engquist, S. Banspach, D. Rugg and M. Weil. 1996. Safer Choices: A multicomponent school-based HIV/STD and pregnancy prevention program for adolescents. *Journal of School Health* 66 (3): 89-94.

Basen-Engquist, K., L. C. Masse, K. K. Coyle, D. Kirby, S. Banspach, J. Nodora and G. Parcel. 1998. Sexual risk behavior, belief, and self-efficacy scales. In *Handbook of Sexuality-Related Measures,* ed. C. M. Davis, W. L. Yarber, R. Bauserman, G. Scheer and S. L. Davis. Thousand Oaks, CA: Sage Publications.

Coyle, K., K. Basen-Engquist, D. Kirby, G. Parcel, S. Banspach, R. Harrist, E. Baumler and M. Weil. 1999. Short-term impact of Safer Choices: A multicomponent school-based HIV, other STD and pregnancy prevention program. *Journal of School Health* 69 (5): 181-188.

Markham, C., E. Baumler, R. Richesson, G. Parcel, K. Basen-Engquist, G. Kok and D. Wilkerson. 2000. Impact of HIV-positive speakers in a multicomponent, school-based HIV/STD prevention program for inner-city adolescents. *AIDS Education and Prevention* 12 (5): 442-54.

Wang, L. I., M. Davis, L. Robin, J. Collins, K. Coyle and E. Baumler. 2000. Economic evaluation of Safer Choices: A school-based human immunodeficiency virus, other sexually transmitted diseases, and pregnancy prevention program. *Archives of Pediatrics and Adolescent Medicine* 154:1017-1024.

Coyle, K., K. Basen-Engquist, D. Kirby, G. Parcel, S. Banspach, J. Collins, E. Baumler, S. Carvajal and R. Harrist. 2001. Safer Choices: Reducing teen pregnancy, HIV, and STDs. *Public Health Reports* 116 (Suppl. 1): 82-93.

Basen-Engquist, K., K. Coyle, G. Parcel, D. Kirby, S. Banspach, S. Carvajal and E. Baumler. 2001. Schoolwide effects of a multicomponent HIV, STD and pregnancy prevention program for high school students. *Health Education and Behavior* 28 (2): 166-185.

Kirby, D., E. Baumler, K. Coyle, K. Basen-Engquist, G. Parcel, R. Harrist and S. Banspach. 2004. The "Safer Choices" intervention: Its impact on the sexual behavior of different subgroups of high school students. *Journal of Adolescent Health* 35 (6): 442-452.

Markham, C., K. Basen-Engquist, K. Coyle, R. C. Addy and G. Parcel. 2004. Safer Choices, a school-based HIV, STD, and pregnancy prevention program for adolescents: Process evaluation issues related to curriculum implementation. In *Process Evaluation for Public Health Interventions and Research,* ed. A. Steckler and L. Linnan. Indianapolis, IN: Jossey-Bass.

Kirby, D., E. Baumler, K. Coyle. 2011. The impact of "Safer Choices" on condom and contraceptive use among sexually experienced students at baseline. Unpublished manuscript submitted in response to PPRER@mathematica-mpr.com "Call for studies."

Component 1

School Organization

About This Component

The school improvement approach demonstrates that meaningful educational change does not occur without change in a school's social and organizational climate. A School Health Promotion Council (SHPC) established at the school serves as the organizational mechanism to ensure the *Safer Choices* program becomes schoolwide and an inherent part of the school environment. This can be a new group, or schools can use existing council or group on campus.

The Council should include parents, teachers, administrators, other staff, students and members of local community agencies, as well as a Site Coordinator, who is a representative of the school.

During program implementation, the Council plans, conducts and monitors activities for the other 4 components: Curriculum and Staff Development; Peer Resources and School Environment; Parent Education; and School-Community Linkages (see Figure 2 on page 9).

Activities are designed to effect change at the individual student and schoolwide levels, and to enhance students' connections at home and with relevant community resources.

Component 1

School Organization

Key Activities and Materials

1. Select a Site Coordinator

- **Job Description:** Site Coordinator

2. Establish the School Health Promotion Council

- **Job Description:** School Health Promotion Council
- **Meeting Agendas:** Ad Hoc Committee
- **Council Membership List**

3. Provide Council Orientation and Planning Sessions

- **Orientation Session Outlines**
- **Sample Mission Statements**
- **Planning Retreat Session Outline**
- **Planning Process Agenda**
- **Planning Forms**

4. Conduct Regular Council Meetings

- **Council Meeting Attendance and Minutes Form**

Select a Site Coordinator

The Site Coordinator plays a central role on the School Health Promotion Council and in program coordination. This individual also serves as a liaison between the Council and other important school committees to ensure that the Council is an integral part of the existing school structure. Ideally the individual in this position should receive release time or a stipend to support coordination of Council activities.

The goal in selecting a Site Coordinator is to find a key leader within the school organization capable of fulfilling the responsibilities of the position. This individual should be an employee of the school and be highly motivated and committed to the goals of the program. The Site Coordinator should also have successful experience working with diverse staff within a school environment, and demonstrate organizational, communication and leadership skills.

The Site Coordinator will be responsible for:

- Meeting with school leaders to identify appropriate members for the School Health Promotion Council (SHPC).
- Recruiting and training members of the SHPC.

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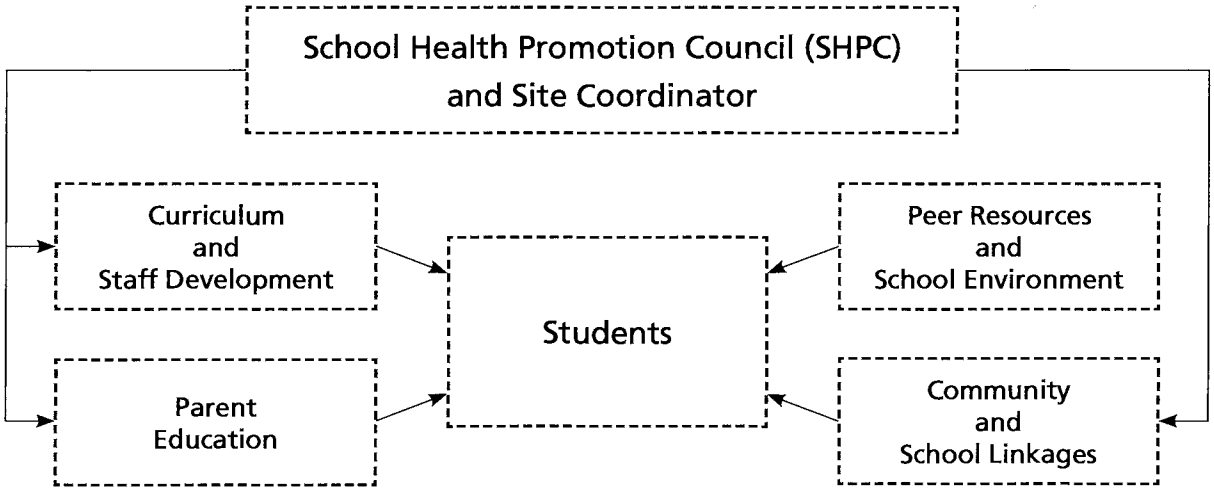
Figure 2
The Role of the Council



Select a Site Coordinator

(continued)

- Scheduling and facilitating SHPC meetings and maintaining records (e.g., agendas, minutes).
- Training, coordinating, supporting and monitoring the activities of the SHPC.
- Acting as liaison to school administration and staff in communicating the goals and activities of the program.
- Guiding the SHPC in planning for implementation of the program.

The Site Coordinator can expect to spend about 3–5 hours a week on various program activities (e.g., coordinating Council meetings and assisting with activity planning and implementation). Amount of time and intensity may vary throughout the year based on planned activities.

The Site Coordinator should be recruited and selected by school administrators using hiring procedures consistent with district and school policies. Several approaches may be applicable. For example, the position could be posted and announced at faculty meetings. Interested candidates could be asked to submit their names and a brief statement about why they are interested in the position. Interviews could then be held with candidates who meet the position qualifications.

Administrators also could identify specific individuals who meet the qualifications and talk with those individuals directly to describe the project and determine their interest in the position. A job description that can be used or modified for the hiring process is provided at the end of this section (see page 19).

Establish the School Health Promotion Council

The School Health Promotion Council works with the Site Coordinator to:

- Establish HIV, other STD and pregnancy prevention health promotion goals for the school.
- Develop, implement and monitor plans for achieving those goals.
- Review program materials.
- Assess the achievement of program goals.
- Plan for and implement activities to facilitate program continuation.

Ideally, the Council should include from 13–16 members including parents, teachers, administrators, other school staff, students and members of local community agencies. A recommended configuration is as follows:

- 1 Site Coordinator
- 4 teachers
- 1 school administrator
- 1–2 school staff (e.g., school nurse, counselor)
- 2–4 students (minimum of 2)
- 2 parents
- 1 community member (e.g., business, nonprofit agency)
- 1 local, health-related agency representative (e.g., health department, family planning clinic, teen health center)

It is important to ensure that the Council includes members from a broad array of relevant constituent groups (e.g., PTA, student organizations) and that the members have a strong interest in and commitment to the project.

Establish the School Health Promotion Council

(continued)

Establishing an Ad Hoc Recruitment Committee

The Site Coordinator, with assistance from an ad hoc Council recruitment committee, should take responsibility for identifying, selecting and recruiting Council members. Using an ad hoc committee for Council recruitment helps obtain involvement and support of the program from school and community leaders. Some ad hoc committee members may choose to join the Council themselves as ongoing members. At a minimum, the ad hoc committee will help create the Council and serve to broaden the support base for the program.

The ad hoc committee should include 6–8 people selected by the school administration in consultation with the Site Coordinator. Ad hoc committee members should represent the different constituencies within the school (e.g., teachers, students, parents, ethnic specific groups, etc.).

The ad hoc committee should meet at least twice. (Additional meetings may be necessary to repeat the recruitment steps if potential candidates choose not to accept a position on the Council.) Before the first meeting, ad hoc committee members should receive a reminder of the date, time, place and meeting agenda, as well as the School Health Promotion Council Job Description (see page 21).

Identifying Potential Council Members

The ad hoc meetings will be facilitated by the Site Coordinator. Agendas for the first 2 meetings can be found at the end of this section (see page 23).

At the first meeting, committee members and the Site Coordinator should identify relevant constituent groups to be represented on the Council (e.g., PTA, student organizations, community representatives) and a contact person from each group. The Site Coordinator then assigns an ad hoc member to contact each constituent group and solicit potential candidates who meet the qualifications outlined in the SHPC Job Description.

During the first meeting, the ad hoc committee must also consider requirements specific to their school site, such as union involvement or other administrative concerns. For example, depending on the union requirements, the SHPC position may have to be posted on campus for a specified period of time. If the Council positions must be posted, the ad hoc committee will need to clarify how to proceed if no one applies for the positions.

After the first meeting, ad hoc committee members will call their assigned group's contact person to describe the project and solicit recommendations for potential Council members.

Recruiting Council Members

Once a group of potential candidates has been identified (through referral from constituent groups and/or position announcements on campus), the ad hoc committee will meet again to select, prioritize and make assignments for final recruitment of candidates.

At this second meeting, the Site Coordinator will assign ad hoc committee members to candidates to make the initial contact. Committee members will provide each candidate with a project summary and SHPC Job Description.

If the candidate expresses interest, the Site Coordinator will arrange to meet with the candidate to review the qualifications for the position, and to welcome the candidate to the SHPC.

If a candidate decides *not* to participate, the ad hoc committee will select another potential candidate from the list, and repeat the recruitment procedures. Once the full Council has been recruited, the Site Coordinator should prepare and circulate a membership list. A sample form for the membership list is provided at the end of this section (see page 25).

Provide Council Orientation and Planning

Prior to program implementation, Council members should participate in a series of orientation activities and develop action plans for the year.

Once the full Council has been established, scheduling a series of brief orientation sessions and a longer planning retreat will enable Council members to get to know each other and begin planning activities for the year. Ideally, the orientation and planning sessions should occur in the spring of the year before the program is to be implemented. If this is not possible, they should be held in early fall. The content of the sessions can vary based on the needs and backgrounds of Council members.

Orientation Sessions

A series of 3 or 4 brief orientation sessions should be held to provide Council members with an overview of the *Safer Choices* program, enable them to get to know each other, and provide some basic information about HIV, other STD and pregnancy among adolescents. The orientation sessions should be facilitated by the Site Coordinator, although outside speakers could be used for selected presentations (e.g., update on status of HIV, other STD and pregnancy among teens). The Peer Coordinator and other Council members also may be asked to help facilitate selected activities (e.g., Peer Coordinator could be asked to provide an overview of the Peer Resource component; Council members could be asked to facilitate a warm-up activity). Content outlines and activities for 3 orientation sessions are provided at the end of this section (see page 27).

In addition to the sessions provided in this manual, other ideas could include a session hosted by a local teen clinic on issues related to adolescent sexuality (e.g., relationships, dating, pregnancy, STD); a session on team building (e.g., participating in a ropes course or similar challenge course); or a session on fostering school change.

Activity Planning Retreat

An activity or action planning retreat should be held to provide Council members with an opportunity to work as a group to think about and plan activities for the year. This session should be facilitated by the Site Coordinator with assistance from the Peer Coordinator. Ideally the retreat should be held off-site (e.g., at a District meeting room or at a local community center), and extend for 4–6 hours. Having concentrated time away from school facilitates the planning process and emphasizes the importance of the task. It also provides an additional opportunity for fostering group cohesion.

The format for the planning retreat can vary based on the needs and background of Council members. An outline with an agenda and activities for such a planning session is provided at the end of this section (see page 45).

The Council should be informed if they have a budget to support the development of selected activities. Ideally the Council will have a small budget for the year (e.g., $1,000–$2,000). Council members also can plan fund-raising activities to help support planned activities or designate selected members to assist with seeking donations from local businesses.

Implementation Tips

- If more than one school in a district is implementing *Safer Choices*, it can be beneficial to have all the Councils participate jointly at the planning retreat. The agenda should provide time for each Council to meet separately, as well as a period during which Councils share their activity ideas with each other. Councils benefit from hearing ideas and strategies planned by other schools.
- A planning retreat for the Council should be scheduled each year *Safer Choices* is implemented. After the first year, the agenda should include time for Council members to discuss their observations about what worked well, what they would change, etc. If more than one Council is meeting for the planning retreat, each Council should be asked to share their year's accomplishments and discuss changes they would make for the coming year.

Conduct Regular Council Meetings

The Council should meet regularly (e.g., monthly) to plan and coordinate activities. Council members may want to organize in subcommittees that parallel the key program components or form smaller work groups based on planned activities (e.g., conducting an inservice for faculty or planning activities for World AIDS Day).

Council meetings should be facilitated by the Site Coordinator. To ensure efficient use of time, the Site Coordinator may want to prepare an agenda for each meeting. One of the Council members should be asked to take meeting minutes (see the sample Meeting Attendance and Minutes Form on page 77). Responsibility for taking minutes can be rotated among Council members each meeting.

To the extent feasible, meetings should be structured around activity planning and problem solving to ensure successful implementation of program activities. If the Council works in smaller work groups, each group could be asked to provide a status report on their planned activities. Meetings can also serve as working sessions to complete planned projects. A few meetings should be used to celebrate the Council's accomplishments (e.g., in December and June of each year).

It's best if meetings can be held on an established day (e.g., first Wednesday of every month) and at a standard time so Council members can schedule the meetings on their calendars. If Council meeting dates or times vary to accommodate participation by parents or other members, the meetings should be scheduled for several months at a time to enable members to plan.

Implementation Tips

- The Council may find it most effective to brainstorm and plan activities for each component as a large group and then form smaller work groups to carry out the activities.
- The Site Coordinator may find it helpful to send out reminder notices a day or two before scheduled meetings, or to enlist the help of a few Council members in making reminder calls.

School Organization Materials

- ❑ **Job Description:** Site Coordinator
- ❑ **Job Description:** School Health Promotion Council
- ❑ **Meeting Agendas:** Ad Hoc Committee
- ❑ **Council Membership List**
- ❑ **Orientation Session Outlines**
- ❑ **Sample Mission Statements**
- ❑ **Planning Retreat Session Outline**
- ❑ **Planning Process Agenda**
- ❑ **Planning Forms**
- ❑ **Council Meeting Attendance and Minutes Form**

Safer Choices
Site Coordinator
Job Description

Program Description

The *Safer Choices* program involves the delivery of a comprehensive, multi-component school health program in HIV, other STD and pregnancy prevention. The program includes a school organization element, featuring a School Health Promotion Council (SHPC), which is responsible for coordinating many of the activities to be implemented at the schoolwide level.

The goal of *Safer Choices* is to reduce unprotected sex among students ages 14–18. The program has 2 primary objectives:

- To reduce the number of students who begin or have sexual intercourse during their high school years.
- To increase latex condom use among students who have sexual intercourse.

Safer Choices was originally part of a 5-year demonstration project funded by the Centers for Disease Control and Prevention (CDC).

Job Summary

The Site Coordinator assumes major responsibility for the overall coordination of project activities at the school site, including working with the School Health Promotion Council to plan and implement the project.

Responsibilities

1. Meet with school administrators and leaders to identify and recruit appropriate members for the School Health Promotion Council (SHPC).
2. Train and guide the SHPC in preparing for implementation of the program.
3. Schedule and facilitate the SHPC meetings and maintain records (e.g., agendas, minutes).
4. In collaboration with other Council members, plan, coordinate, support and monitor program activities.
5. Act as the liaison to the school administration and school staff in communicating the goals and activities of the program.

(continued)

Safer Choices
Site Coordinator
Job Description

(continued)

Qualifications

The Site Coordinator will be someone who:

1. Is an employee of the school.
2. Is an enthusiastic and strong supporter of the goals and objectives of the *Safer Choices* program.
3. Has successful experience working with diverse staff within a school environment.
4. Has the ability to successfully coordinate multiple activities and plans concurrently.
5. Demonstrates excellent communication skills.
6. Is highly regarded within the school community.
7. Can work in a flexible and fluid manner.
8. Has demonstrated leadership skill.

No candidate will be excluded for consideration based upon employment, race, gender, ethnicity, creed, sexual orientation or handicapping condition.

Time Expectations

The Site Coordinator can expect to spend about 3–5 hours a week on various program activities (e.g., coordinating Council meetings and assisting with activity planning and implementation). The amount of time and intensity may vary throughout the year based on planned activities.

Remuneration

The Site Coordinator's time may be secured through a variety of options (e.g., release time, stipend for hourly time, etc.).

Safer Choices
School Health Promotion Council
Job Description

Program Description

The *Safer Choices* program involves the delivery of a comprehensive, multi-component school health program in HIV, other STD and pregnancy prevention. The program includes a school organization element, featuring a School Health Promotion Council (SHPC), which is responsible for coordinating many of the activities to be implemented at the schoolwide level.

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- To increase latex condom use among students who have sexual intercourse.

Safer Choices was originally part of a 5-year demonstration project funded by the Centers for Disease Control and Prevention (CDC).

Job Summary

The School Health Promotion Council (SHPC) will work with the Site Coordinator to:

- Establish HIV, other STD and pregnancy prevention health promotion goals for the school.
- Develop, implement and monitor plans for achieving those goals.
- Review program materials.
- Assess the achievement of program goals.
- Plan for and implement activities to facilitate program continuation.

Configuration of Council

The SHPC will include 13 to 16 members. Representation will include:

- 1 Site Coordinator
- 4 teachers
- 1 school administrator
- 1–2 school staff (e.g., school nurse, counselor)
- 2–4 students (minimum of 2)
- 2 parents
- 1 community member (e.g., business, nonprofit agency)
- 1 local, health-related agency representative (e.g., health department, family planning clinic, teen health center)

(continued)

Safer Choices
School Health Promotion Council
Job Description

(continued)

Responsibilities

1. Attend regularly scheduled SHPC meetings and participate as an active member.
2. Commit for a minimum of 1 school year. (If a Council member must resign from the Council, she/he is expected to give the Site Coordinator a minimum of 30 days notice.)
3. Be an advocate and spokesperson, when appropriate, for the program (e.g., sharing the goals of the project with other school staff or interested community members).
4. Share and express concerns and insights regarding program activities in a collegial and positive manner.
5. Provide support for the Site Coordinator in planning and coordinating program activities.

Qualifications

A Council member will be someone who:

1. Represents one of the identified constituents (e.g., teacher, student).
2. Is an enthusiastic and strong supporter of the goals and objectives of the *Safer Choices* program.
3. Has successful experience working with a variety of different people.
4. Is willing to take an active role working on the SHPC and selected program activities.
5. Has the support of the constituency he or she is representing.
6. Can attend the SHPC meetings on a regular basis.
7. Can work cooperatively and effectively in large and small groups.

No candidate will be excluded for consideration based upon employment, race, gender, ethnicity, creed, sexual orientation or handicapping condition.

Time Expectations

Times for all meetings will be decided by the SHPC members and the Site Coordinator. Council members should expect to meet at least once a month for approximately an hour to an hour and a half, and spend an additional 1–2 hours a month helping with program activities (e.g., helping to develop materials or monitoring an activity). The amount of time and intensity of involvement is likely to vary throughout the year based on the number and type of planned activities.

Ad Hoc Committee Meeting Agendas

First Meeting

1. **Complete introductions.** Have people introduce themselves and tell what they do in relationship to the school. (Pass roster to get attendance list.)

2. **Assess information needed.** Ask what information committee members were given about the meeting, and whether they have received/read the School Health Promotion Council Job Description.

3. **Review purpose of Ad Hoc Committee** (as needed).

   - Ad hoc committee is formed to identify approximately 16 people to serve on the School Health Promotion Council. The SHPC will be involved with the Site Coordinator in planning and managing a schoolwide intervention to reduce student risk behaviors for HIV, other STD and pregnancy.
   - At this first meeting, the committee will review the *Safer Choices* project, look at Council membership considerations and begin identifying sources to find members. One or two more meetings will be needed to complete the Council recruitment.

4. **Review program.** Explain the *Safer Choices* program briefly, and answer any questions from the group.

5. **Review SHPC Job Description.** Go over roles, qualifications, and other considerations (e.g., gender mix; cultural balance to reflect student population; experience with adolescents in areas of sexuality, HIV, pregnancy, etc.; representation from unions, PTSA, School Site Council, other influential groups; appeal to different groups of students—not just "mainstream"). Ask members to suggest other considerations in composing the Council.

6. **Begin discussion of Council membership.** On chart paper or chalkboard, list Council roles, ideas for recruiting, candidates, and assignments (who will make the contacts).

Example:

Role	Potential Resource	Responsibility
Teachers (4)	1 from Social Studies 1 from Science 1 from Jr./Sr. courses 1 Union representative	Site Coordinator will ask department heads to recommend

(continued)

Ad Hoc Committee Meeting Agendas

(continued)

7. **Discuss how to introduce the program to potential candidates.** Discuss approaches to recruiting different candidates, including what to say, questions that might be asked and how to respond. Ask if everyone feels ready to begin recruitment.

8. **Set next meeting.** Agree on date, time, place and agenda.

Second Meeting

1. **Review response to recruitment.** Ask for general responses to recruitment efforts. Any problems? surprises? common or difficult questions asked? follow-up needed?

2. **Review nominees and assignments from last meeting.** Discuss status of each candidate.

3. **Determine remaining Council vacancies.** Review commitments and uncovered positions. Decide how to fill remaining spaces and assign contacts.

4. **Review additional tasks.** Decide what else (if anything) needs to be done (e.g., get information to members who have already agreed to serve).

5. **Set next meeting,** if necessary. Agree on date, time, place and agenda.

Safer Choices

School Health Promotion Council Membership List

School _____

Site Coord. _____ Position* _____ Address _____ _____ Phone _____ Notes** _____ _____	Name _____ Position* _____ Address _____ _____ Phone _____ Notes** _____ _____
Name _____ Position* _____ Address _____ _____ Phone _____ Notes** _____ _____	Name _____ Position* _____ Address _____ _____ Phone _____ Notes** _____ _____
Name _____ Position* _____ Address _____ _____ Phone _____ Notes** _____ _____	Name _____ Position* _____ Address _____ _____ Phone _____ Notes** _____ _____

**Position:* teacher, student, parent, administrator, community member, local agency representative, other school staff

***Notes:* special interests, availability, etc.

Orientation Session Outlines

Session 1
Inaugural Meeting

(1.5 hours)

Objective

By the end of the meeting, participants will be able to define the goal of the *Safer Choices* program, the different components, and their role in the program and on the Council.

Agenda

1.1 **Welcome**

1.2 **Warm-Up Activity/Introductions**

1.3 **Groundrules**

1.4 **Overview of Safer Choices Program** (goals, components and Council's role)

1.5 **Review and Brainstorming for Upcoming Meetings**

Activity 1.1

(5 minutes) 

Welcome

Purpose

To welcome participants to the first *Safer Choices* School Health Promotion Council meeting.

Materials

None

Procedure

The Site Coordinator and school administrator provide brief opening remarks. Presenters should highlight why the school or district decided to implement *Safer Choices*, the importance of the program and the importance of the Council's role.

Activity 1.2

(5 minutes) 

Warm-Up Activity/Introductions

Purpose

To help participants and facilitators get to know each other.

Materials

- **Option 1:** 3" x 5" index cards, 1 per person
- **Option 2:** half-sheets of chart paper and markers, 1 per person
- **Option 3:** Scavenger Hunt worksheet and pencils, 1 per person

Procedure

Option 1—Interview a Partner

- List the following items on chart paper or the chalkboard: (1) name and role on Council (i.e., group represented, such as parent, student, teacher, etc.); (2) favorite food; (3) one dream for the program; (4) why this person wants to be part of the Council.
- Ask everyone to pair up with someone they don't know and find out the information listed on the board about that person.
- Give participants index cards to use for taking notes while they are interviewing their partners. Allow about 5 minutes for interviews.

- After 5 minutes, have participants introduce their partners to the group.
- Briefly discuss the activity (e.g., What did you learn about other members of the group?).

Option 2—Personal Posters

- Hand out a half-sheet of chart paper and a marker to each participant. Have participants write their first names in large letters down the left side of the paper.
- For each letter, have participants write a word or phrase that describes them in some way (e.g., for "S": swimmer, sure of myself, silly, spaghetti lover). Demonstrate using own name.
- Allow participants to work for 5 minutes.
- When participants finish their names, have them write an ending to each of the following sentences at the bottom of their papers:
  - I want to be a Council member because...
  - One thing I'd like to see happen this year is...
  - This program will be a success if...
- When participants finish, have them circulate with their posters and introduce themselves to 4 people they don't know and read each other's signs.
- Post the signs in the room for the rest of the day.
- Briefly discuss the activity (e.g., What did you learn about other members of the group?).

(continued)

Activity 1.2

(continued)

Option 3—Scavenger Hunt

- Tell Council members that each of them will get a worksheet with several statements on it. Show the worksheet and give an example (e.g., Find someone who likes pineapple on pizza). Explain that they will have 5 minutes to circulate and talk to others in the room, looking for people who match the statements on the worksheet. They should write each person's name next to the appropriate statement.
- Tell participants they can only use a name once, and that it's OK to use their own names once.
- Ask someone to describe what they will do once they get their worksheets. Clarify as needed.
- Pass out worksheets and pencils. Allow Council members to circulate for 5 minutes.
- Debrief by asking questions such as: Who has all the statements signed? Who met someone who likes pineapple on pizza? Whom did you meet?

Scavenger Hunt

(*Note:* Alter the statements to match the group and purpose of the training.)

Find a person who matches the description. Write his or her name on the line. Use a name only once. *It's OK to use* your *own name once.*

Find someone who:

1. Knows what STD means. _____

2. Has lived in or traveled to another country. _____

3. Has been a member of a school committee before. _____

4. Likes pineapple on pizza. _____

Activity 1.3
(5 minutes) 

Groundrules

Purpose

To establish a set of groundrules for Council meetings with which all Council members feel comfortable.

Materials

- Chart paper
- Sample groundrules from *Safer Choices* curriculum

Procedure

The Site Coordinator facilitates a discussion of groundrules that will provide a comfortable and supportive atmosphere for dialogue among Council members. (Refer to the *Safer Choices* curriculum for further details.)

Because the Council will include a combination of students and adults, the Site Coordinator also should raise and discuss how Council members would like to address each other when working as a group. Ideally, Council members should be encouraged to address each other by first names when meeting and working together. This allows all members to feel as if they are equal members of the Council. Outside Council meetings and functions, however, other standard protocols should apply (e.g., if a school requires students to address teachers and other adults by their last names then students on the Council should do so outside Council functions).

Activity 1.4

(45 minutes) 

Overview of Safer Choices Program

Purpose

To review the overall program, the individual components, and Council members' role.

Materials

- Visuals of project goals and components
- Overview of each component

Procedure

The Site Coordinator and Peer Coordinator can work together using a variety of approaches to present the information. Ideally this presentation should be participatory rather than didactic. For example, the Site Coordinator could have Council members work in small groups, giving each group a small part of the project to review (goals, overview of each component, etc.). Within the small groups Council members would discuss and summarize the information and then present it to the whole group. The Site and Peer Coordinator could then add more detail about each section, if needed.

Activity 1.5
(15 minutes)

Review and Brainstorming for Upcoming Meetings

Purpose

To review upcoming orientation sessions and get Council members' input on ideas for additional sessions.

Materials

- Chart paper and markers

Procedure

The Site Coordinator or a designated Council member should review the topics and dates for the upcoming orientation sessions. Council members should be asked to identify other topics of interest for additional sessions.

This can be done as a large group or in smaller groups. If small groups are used, each group should be given a piece of chart paper and be asked to list their ideas. At the end of the brainstorm sessions, the small groups should present their ideas to the rest of the Council.

Duplicate ideas should be crossed off the lists. All remaining ideas should be numbered consecutively. Council members should then be asked to vote for 3 ideas/topics they would like to have developed for orientation/ training sessions.

The Site Coordinator should recruit 2–3 individuals per topic to further develop and plan the session. These individuals can be asked to share preliminary ideas at the next Council orientation session.

Session 2
Information About HIV/AIDS

(1.5 to 2 hours)

Objective

By the end of the meeting, participants will know basic facts about HIV/AIDS and have an understanding of the impact of having HIV on an individual's life.

Agenda

2.1 **Welcome**

2.2 **Overview of HIV Information**

2.3 **HIV-Positive Speaker or Panel**

2.4 **Discussion and Debrief**

Note: If a speaker is not available, you can show a video instead. Be sure the video relates accurate information about HIV, including transmission, prevention, risk reduction, treatment and testing. Be prepared to answer any questions Council members may have about the video.

Activity 2.1 Welcome

(2 minutes) 

Purpose

To welcome participants.

Materials

None

Procedure

The Site Coordinator welcomes Council members to the meeting and provides any brief updates as needed.

Activity 2.2 Overview of HIV Information

(20–30 minutes) 

Purpose

To provide Council members with an update on basic information about HIV/AIDS and its impact on adolescents.

Materials

- Visuals and copies of written information
- 3" x 5" index cards *(optional)*

Procedure

A variety of procedures can be used to present basic information on HIV/AIDS:

- The community agency representative on the Council could be asked to provide this overview.
- A guest speaker from a local clinic could be invited to present the session.
- The Site Coordinator or Peer Coordinator could select one of the HIV-related lessons from the *Safer Choices* curriculum to use as a basis for discussion.

The presentation should focus on important information related to HIV and the behaviors that place individuals at risk. Keep in mind that the Council's role will be to help identify activities that can help teens prevent HIV, so they need basic information about how teens acquire the virus and what teens can do to prevent it or reduce their risk.

At the end of this activity, prepare Council members for the presentation by the HIV-positive speaker(s). Explain that the speaker(s) will present for about 30 minutes and then Council members will have time to ask questions. You can give Council members 3" x 5" index cards on which to write questions anonymously. Explain that you will collect the cards toward the end of the presentation and give them to the speaker. Remind Council members that they can ask questions directly if they are comfortable. Review groundrules if necessary.

Activity 2.3 HIV-Positive Speaker or Panel

(45–60 minutes) 

Purpose

To provide Council members with an opportunity to hear what it is like to live with HIV.

Materials

- 3" x 5" index cards

Procedure

Detailed procedures for having a guest speaker discuss his/her experience living with HIV are provided in the Level 2 *Safer Choices* curriculum.

Before the presentation, ask how the speaker would like to be introduced, and review the content and length of the presentation. Suggest that the speaker spend 20–30 minutes sharing his/her experience with HIV, and leave the remaining time for Council members' questions.

The speaker should address some or all of the following issues:

- Decisions that put him/her at risk for HIV
- The impact of HIV on daily life, personal relationships with family and friends, health status, and long-term goals

Once all questions have been answered, thank the speaker and ask a Council member to guide the speaker back to the office or parking area.

Activity 2.4

(15 minutes) 

Discussion and Debrief

Purpose

To debrief the presentation by the HIV-positive speaker.

Materials

None

Procedure

The Site Coordinator should lead a discussion to enable Council members to share their thoughts and feelings about the presentation, and to discuss how the information may be relevant to developing prevention activities (e.g., important messages, activity ideas, etc.).

Debrief questions could include:

- What feelings did you experience as you listened to the speaker?
- What did you learn from the presentation?
- How have your attitudes and/or feelings about people living with HIV changed since hearing the presentation?
- Did hearing the speaker change your thoughts about who is at risk for HIV? Why or why not?
- What questions about HIV/AIDS came up for you during or after the presentation that you would like clarified?
- How can we use the information we heard in planning HIV prevention activities for students at this school?

Note: If you showed a video instead of having a speaker, adapt the questions accordingly.

Session 3
Writing a Mission Statement

(2 hours)

Objective

By the end of the meeting, Council members will have written a health promotion mission statement in preparation for the activity planning session.

Agenda

3.1 **Welcome**

3.2 **Overview of Mission Statement**

3.3 **Writing the Mission Statement**

3.4 **Preview of Activity Planning Session**

Activity 3.1

(2 minutes) 

Welcome

Purpose

To welcome participants.

Materials

None

Procedure

The Site Coordinator welcomes Council members to the meeting and provides any brief updates as needed.

Activity 3.2

(10 minutes) 

Overview of Mission Statement

Purpose

To review the reasons for creating a mission statement and how it will be central to activity planning.

Materials

None

Procedure

The Site Coordinator should review the purpose of a mission statement and explain how it will be used as part of the activity planning retreat. The Site Coordinator may want to begin by asking Council members to describe what a mission statement is and how it can be used. It's likely that administrators and other school personnel will be more familiar with mission statements than will students, parents and community representatives.

Key discussion points regarding the mission statement include:

- The mission statement will function as a guiding principle around which the Council will develop plans for *Safer Choices* activities. It will function much like a school's mission statement that guides schoolwide planning.
- The mission statement will reflect the views of the entire Council and will have a health promotion theme consistent with the goals and objectives of *Safer Choices* (i.e., prevention of HIV, other STD and pregnancy).

- The mission statement may incorporate a larger view of health promotion than *Safer Choices*, to allow for future expansion of the Council's activities to include other important health areas.
- When planning activities, the Council will refer back to the statement to ensure each activity furthers the Council's mission.

Activity 3.3

(45 minutes) 

Writing the Mission Statement

Purpose

To develop the Council's mission statement.

Materials

- **Sample Mission Statements**
- Chart paper and markers

Procedure

The Site Coordinator reviews the guidelines for developing the mission statement and facilitates the development process using the steps outlined below. Sample Mission Statements from schools involved in the original *Safer Choices* study are included on page 43.

- Have Council members brainstorm ideas they would like to see included in some way in the mission statement. Be sure to solicit ideas from all Council members. Record ideas on chart paper.
- Once all ideas are listed, help the group begin to distill them by sorting or grouping them into similar areas of concern.
- Have Council members review the sorted list and prioritize the ideas within each group using a systematic approach. For example, give each Council member 3 colored dots to represent 3 votes and have them place the dots next to the ideas they feel are most important to include in the mission statement; or number each idea and have Council members rate each idea on a 1 to 5 scale—from least important to most important—and compute the average score for each idea.

(continued)

Activity 3.3
(continued)

- Review the votes and begin the process of trying to reach consensus on the most important ideas to reflect in the mission statement. If the initial voting reflects a rather homogeneous view, the consensus process will be relatively easy. If there are varying views, it will be necessary to tease out what aspects of each idea are most important for those supporting it, with the goal of trying to find common ground.
- Once the group has agreed on the general ideas for inclusion in the statement, the Site Coordinator should work on reaching consensus on what form and content the statement will take (e.g., how to word the mission statement; whether to include graphics, etc.).
- The final mission statement should be prepared and posted in the Council meeting space. Council members should be encouraged to think about the statement before the activity planning retreat so the group can make any last revisions at the beginning of that session.
- Once the mission statement is final, volunteer Council members may want to prepare a more polished version of the statement for use during the school year.

Activity 3.4
(5–10 minutes)

Preview of Activity Planning Session

Purpose

To review purpose and logistics of SHPC planning retreat.

Materials

None

Procedure

The Site Coordinator should review the purpose and logistics of the Council's planning retreat. If the retreat has not yet been scheduled, the Council should discuss when and where to have the retreat, and review the agenda. A sample agenda is provided on page 45.

Sample Mission Statements

School A

The SHPC will promote responsible decision making that supports a healthful way of life within the school community.

In beginning to accomplish this vision, we will focus on human sexuality through:

- Providing accurate information to promote responsible decisions, including abstinence.
- Fostering development of decision-making skills.
- Creating an environment that supports positive norms.
- Promoting open communication between parents, students, staff and community.
- Nurturing self-esteem and mutual respect.

School B

It is the mission of the School Health Promotion Council to ensure that all students receive necessary information and skills to make safer choices regarding health issues.

The Council will provide the school and community with the knowledge to reduce risk factors and promote positive peer pressure.

In addition, the Council will involve students, staff, parents and community in creating a safer environment in providing the skills necessary for good decision making, and in reducing risk factors for all students.

School C

The mission of the *Safer Choices* Committee is to enable students to make educated decisions regarding sexual and reproductive behavior. In a supportive, nonthreatening environment, students will be provided with life skills, useful information and access to resources, which will assist them in making safer choices.

School D

The School Health Promotion Council will serve to coordinate on-site activities that address the well-being of the whole student through concerted, ongoing and interactive curriculum and strategies that:

- Promote personal responsibility.
- Provide an environment that values respect for individual differences.
- Encourage honest communication between parents, students and teachers.
- Assist students in the development of decision-making skills that can be applied to a variety of situations.

Planning Retreat Session Outline

Goal for First Year

To develop a plan for introducing and implementing *Safer Choices* in the coming school year.

Goal for Subsequent Years

To celebrate and review accomplishments of the past year and develop a school plan for implementing and sustaining *Safer Choices* in the coming school year.

Agenda

1.1 Refreshments and Check-In

1.2 Welcome

1.3 Goals for the Day

1.4 Revisit Mission Statement

1.5 Miscellaneous Updates

1.6 Council Planning

1.7 Closure

Note: Lunch and breaks should be scheduled depending on the length of the meeting. Music can be used at breaks or during working sessions to help energize the group.

Activity 1.1 Refreshments and Check-In

(10–15 minutes before scheduled start time)

Purpose

To register participants and distribute materials (if applicable).

Materials

- Refreshments
- Sign-in sheet
- Materials for distribution (if applicable)

Procedure

The Site or Peer Coordinator oversees registration and greets participants as they arrive.

Activity 1.2 Welcome

(10 minutes)

Purpose

To welcome participants to the planning retreat.

Materials

- Chart paper with warm-up activity directions (see below)

Procedure

The Site and Peer Coordinators welcome Council members to the planning retreat, then lead the following warm-up activity:

- Tell the group to think about 1 thing they hope to see or hear from students and faculty/staff that will tell them that the *Safer Choices* program is having an impact. Post this instruction on chart paper so it is visible to all Council members.
- Ask participants to take 1 minute to think about the instruction. After a minute have them turn to the person next to them and share their vision with that person. Facilitators should participate along with other Council members.
- Allow a few minutes for sharing in pairs.
- After everyone has shared their vision in pairs, ask for volunteers to share what they or their partners said with the full Council.
- Let Council members know that their visions are important in thinking about what activities to plan in order to reach these goals.

Activity 1.3 Goals for the Day

(5 minutes) 

Purpose

To review the goals for the day.

Materials

- Chart paper showing goals

Procedure

Introduce the goals for the day and point them out on the chart paper. Review the agenda for reaching these goals.

Goal for first year:

- To develop a school plan for introducing and implementing *Safer Choices* in the coming school year.

Goals for subsequent years:

- To celebrate and review accomplishments of the past year.
- To develop a school plan for implementing and sustaining *Safer Choices* in the coming school year.

Activity 1.4: Revisit Mission Statement

(5–10 minutes) 

Purpose

To review the mission statement created during the Council orientation sessions and make any final adjustments.

Materials

- Chart paper showing mission statement

Procedure

Remind Council members of the mission statement that was written during the Council orientation sessions. (Refer to statement on chart paper.)

Ask Council members if they have any comments or suggested changes for the statement. Discuss suggestions and make final modifications.

Ask for volunteers to create a final version of the statement (e.g., typed or designed on a computer) that can be posted at the school and used when describing the program to others.

Activity 1.5 Miscellaneous Updates

(5–10 minutes) 

Purpose

To review miscellaneous updates and logistics for the day.

Materials

None

Procedure

Provide any updates and ask Council members to do the same.

Review logistics for the day (e.g., location of restrooms, lunch plans, etc.).

Activity 1.6 Council Planning

(2–3 hours, or longer if desired) 

Purpose

To develop a plan for implementing *Safer Choices* in the coming school year.

Materials

- **Planning Process Agenda**
- **Planning Forms**

Procedure

The Site Coordinator reviews the Planning Process Agenda (see page 51) and distributes the Planning Forms (see pages 53–75). Planning should focus on each program component, using the steps described in the Planning Process Agenda.

Emphasize that one of the goals of *Safer Choices* is to saturate the overall school environment (including faculty/staff, peers and parents) to support the new behaviors emphasized in the curriculum (i.e., choosing not to have sex, or using condoms every time if having sex).

Activity 1.7

(10 minutes) 

Closure

Purpose

To solidify next steps and thank Council members for their participation.

Materials

None

Procedure

The Site Coordinator reviews the day's accomplishments and congratulates the Council on its progress. Verify next steps, including the next scheduled planning meeting.

Encourage Council members to share how they felt about the day and how they feel about the upcoming year. For example:

- Using a single word, how would you summarize today's activities?
- How would you summarize your feelings about the coming year?

Thank the group.

Planning Process Agenda

1. **Decide on order of planning for components**—which component to discuss first, second, etc. Follow steps 2 through 7 for each component.

2. **Review the list of Important Tasks** on the Planning Form for the component.

3. **Review the list of Suggested Activities** used by schools in the original *Safer Choices* study to get a sense of possible activities. (These are located on the last page of the Planning Form for the component.)

4. **Discuss and answer the Planning Questions.**

5. **Brainstorm activity ideas and make a general schedule** of activities by semester or quarter.

6. **List next steps** for getting the first activities started.

7. **Assign tasks to Council members** for implementing the next steps.

Important Note: When planning for Peer Resource and School Environment activities, the Council should be advised that they are generating a list of ideas that the Peer Resource Team members will then discuss and consider when participating in a similar planning session of their own. It is important to emphasize that allowing the Peer Team to do the final planning for this component is an important part of fostering ownership and commitment among Peer Team members.

Planning Form

School Health Promotion Council and School Organization

Important Tasks

- ❑ Meet as a Council at least once a month to plan, report on and evaluate activities in the other 4 component areas. Keep minutes.
- ❑ Meet in small work groups at least once a month to develop and implement component activities. Keep minutes for Council reports.
- ❑ Serve as liaison between *Safer Choices* and other school organizations and groups.

Planning Questions

Council Organization and Meetings

What schedule of meetings will work for the entire group?

_____

_____

Where should the meetings be held?

_____

_____

What kind of reminder system should we use for the meetings?

_____

_____

Do we want to organize work groups by components or for specific activities as needed?

_____

_____

(continued)

School Health Promotion Council and School Organization

(continued)

Networking and Linkages

What can the Council do to make sure the entire school community is aware of the *Safer Choices* program and activities?

What organizations and informal groups can be invited to cosponsor, advise and collaborate on *Safer Choices* activities?

How can *Safer Choices* assist other groups?

Council Recruitment (for Year 2 and Beyond)

Are new/additional Council members needed to carry out the tasks for this year?

Is there some specific expertise or connection needed (e.g., who will represent the Peer Resource Team)?

Where and how will new members be recruited? By whom?

(continued)

School Health Promotion Council and School Organization *(continued)*

Schedule of Activities and Next Steps

Activity	Date	Steps	Responsibility
Council meetings			
Liaison activities			
Work group meetings			
Liaison activities			
Other			

Planning Form

Curriculum and Staff Development

Important Tasks

- ❑ Provide program updates for faculty and staff (1 per year).
- ❑ Conduct 1–2 staff development activities per year on project topics (e.g., HIV, other STD, sexuality).
- ❑ Conduct curriculum implementation support activities (e.g., assist with parent nights, consent forms, HIV-positive speakers for Level 2, training in-class Peer Leaders, etc.).

Planning Questions

Curriculum Implementation

In what subject area is the *Safer Choices* curriculum going to be taught?

_____

_____

_____

Who will provide training for teachers implementing the curriculum?

_____

_____

_____

When should the curriculum be taught (e.g., fall or spring)?

_____

_____

How can we assist teachers who will be implementing the curriculum?

_____

_____

_____

(continued)

Curriculum and Staff Development

(continued)

Staff Development

When should we introduce the program to the entire school faculty and staff?

How often should we provide program updates to faculty and staff?

What other staff development activities should we do to promote and support the program?

(continued)

Curriculum and Staff Development *(continued)*

Schedule of Activities and Next Steps

Activity	Date	Steps	Responsibility
Program updates	_____	_____	_____
Other staff development activities	_____	_____	_____
Curriculum implementation support	_____	_____	_____
Other	_____	_____	_____

(continued)

Curriculum and Staff Development

(continued)

Suggested Activities

- Hold faculty inservice sessions to increase sensitivity to importance of prevention education for teens. Include guest speakers (e.g., HIV-positive person or representative of local teen clinic), skits by Peer Team and updates from curriculum teachers.
- Make a Resource Guide or Handbook for faculty with teen statistics on HIV, STD and pregnancy, ideas for cross-curricula activities, and ideas for posters or prevention messages to post in classrooms.
- Provide program updates at faculty meetings.
- Announce when curriculum is being taught so that other teachers can include HIV, other STD or pregnancy activities in their classrooms.
- Design lesson ideas for incorporating HIV, other STD and pregnancy information in other subjects (e.g., graphing AIDS cases by year for Math, etc.).
- Have a show of appreciation for teachers implementing the *Safer Choices* curriculum at the end of the implementation period (e.g., certificates, breakfast/luncheon, letter from principal).

Planning Tip: When planning teacher inservice activities, try to include activities that enhance teachers' skills, e.g., responding to difficult questions, knowing procedures for referrals.

Planning Form

Peer Resources and School Environment

Important Tasks

- ❑ Ensure involvement and continuation of Peer Resource Team and provide training for Peer Team members.
- ❑ Assist Peer Team to complete *Safer Choices* projects, including:
  - Resource area
  - School newspaper and other media
  - Small media projects (e.g., contests, buttons, posters)
  - Public forums
  - Opinion polls
  - Discussion sessions
  - Drama productions

Planning Questions

How will we recruit new members for the Peer Team? (Discuss any differences needed by grade level.)

_____

_____

_____

Who will train Peer Team members, and when?

_____

_____

_____

How can we support the Peer Team in conducting activities?

_____

_____

_____

(continued)

Peer Resources and School Environment

(continued)

Ideas for Peer Team Activities

List activity ideas for Peer Team members to consider when they complete their own planning session. Be specific and list the names of Council members who are willing to help with the idea.

Resource Area _____

School Newspaper _____

Small Media Projects _____

Public Forums _____

Opinion Polls _____

Discussion Sessions _____

Drama Productions _____

Other _____

(continued)

Peer Resources and School Environment *(continued)*

Schedule of Activities and Next Steps

Activity	Date	Steps	Responsibility
Recruiting Peer Team members	_____	_____	_____
Training Peer Team members	_____	_____	_____
Helping Peer Team with projects	_____	_____	_____
Peer Team meetings	_____	_____	_____
Other	_____	_____	_____

(continued)

Peer Resources and School Environment

(continued)

Suggested Activities

Resource Area

- Have pamphlets, resource materials and referral information available for students on a regular basis (e.g., students staff a resource table in the cafeteria at lunch time; or obtain space on campus for a permanent resource library).

School Newspaper and Other Media

- Submit articles on HIV, other STD and teen pregnancy to school newspaper.
- Create *Safer Choices* newsletter.
- Give out regular prevention messages on school PA system.
- Use in-school TV monitors to air skits or plays by Peer Team to homerooms or at lunch.

Small Media Projects

- Make display cases.
- Change posters on a regular basis.
- Set up a graphic depiction of HIV/AIDS, other STD or pregnancy statistics (e.g., colored jelly beans, pennies in a jar). Have students guess numbers.
- Hold a writing contest or music contest. Publish winning entries in school newspaper.
- Create or redesign a *Safer Choices* T-shirt. Have Peer Team members wear it on a set day each month.
- Distribute buttons, pens or other promotional items with *Safer Choices* logo.
- Create stationery with *Safer Choices* logo.
- Create e-based projects, such as texting campaigns or a website.

(continued)

Peer Resources and School Environment

(continued)

Suggested Activities

(continued)

Public Forums

- Include guest speakers (e.g., from local clinics/organizations; HIV-positive speakers, teen parents) or host educational skits by the Peer Team.
- Hold an AIDS awareness week or pregnancy prevention week before senior prom or include prevention messages in senior prom activities.

Opinion Polls

- Conduct schoolwide survey on knowledge and attitudes about HIV/AIDS, other STD and pregnancy.
- Print results in school newspaper or post on school website for students.

Discussion Sessions

- Host small-group meetings on different topics (e.g., monthly brown-bag or lunch-time groups) led by Peer Resource Team members or guest speakers from local organizations.

Drama Productions

- Schedule a theater production about HIV/AIDS and invite actors to talk with students after the play.
- Create skits about HIV, other STD or pregnancy issues and perform them at an assembly or rally.

Planning Tip: When planning activities, try to focus on awareness and skill-building, emphasizing skill-building more each year. Small-group discussions can have a greater impact on behavior change than large-group activities.

Planning Form
Parent Education

Important Tasks

- ❑ Distribute parent newsletters to all parents (2–3 per year).
- ❑ Provide at least 1 program update per semester to be inserted into parent newsletter, presented at PTA meeting, or shared through another avenue for communicating with parents.
- ❑ Conduct parent education workshop(s).
- ❑ Invite parents to a theatrical production or schoolwide event on HIV/AIDS.
- ❑ Assist with curriculum implementation support activities (e.g., consent letters, parent curriculum review).

Planning Questions

Parent Newsletters

How many issues of the parent newsletter will we distribute each year?

_____

_____

How will the newsletters be distributed?

_____

_____

To which parents will we distribute them? How?

_____

_____

Strategies for Distributing Newsletters

- Mail the newsletter to parents along with PTA materials or report cards.
- Staple the newsletter to report cards for students to take home.
- Give out extra copies at school events that parents attend.
- Have extra copies in the principal's office.
- Include raffle tickets with the newsletters. Have parents sign and return them.
- Send newsletters as part of email communications to parents, or post on the school website.

(continued)

Parent Education

(continued)

Parent Education

How should we update parents about specific program activities?

What type and how many parent education sessions do we want to sponsor each year?

How can we enhance parent participation in the education sessions?

What other organizations or individuals (e.g., school clubs or parent organizations, local community organizations, religious groups) could we work with to increase parent education and involvement?

(continued)

Parent Education *(continued)*

Schedule of Activities and Next Steps

Activity	Date	Steps	Responsibility
Parent newsletters			
Parent education workshops			
Drama production or schoolwide event			
Other			

(continued)

Parent Education

(continued)

Suggested Activities

- Invite HIV or sexaul health educators from local community organizations to talk to parent groups on Parent Involvement Day or Teacher-Parent nights.
- Have bilingual HIV or sexaul health educators present workshops on HIV or teen pregnancy prevention.
- Hold a dinner for parents of Peer Resource Team members and Peer Leaders. Have speakers and skits by the students.
- Work with other clubs or parent organizations to have a joint event focusing on *Safer Choices*.
- Conduct workshops on "How to Talk to Your Teen About Sexuality" or "Social Media and Sexual Health."
- Have a Mother-Daughter or Father-Son Breakfast. Invite guest speakers.
- Invite parents to a *Safer Choices* Health Fair.
- Invite parents to theatrical productions about HIV or teen pregnancy prevention, or to student performances by the Peer Resource Team.
- Identify parents with skills or professional backgrounds (e.g., counselors, doctors, nurses) to serve as guest speakers at workshops. Topics could include identity development, emotional health, healthy relationships, or social media and relationships.
- Ask a local bilingual radio station to air public service announcements promoting activities or providing information.
- Make a list of videos, movies or upcoming TV shows that parents could watch with their children to start a dialogue about prevention issues.

Planning Tip: When planning Parent Education activities try to focus on awareness and skills-building, emphasizing skill-building more each year (e.g., how to talk with your child about sexuality). Plan ahead for the best dates and times to ensure parent participation.

Planning Form
School-Community Linkages

Important Tasks

- ❑ Establish link with agency for HIV-positive or sexual health speakers.
- ❑ Link with community agencies to assist with small-group discussion sessions hosted by Peer Resource Team.
- ❑ Review student referral procedures. Modify or establish procedures as needed.
- ❑ Develop or identify an existing Resource Guide for students.
- ❑ Distribute student Resource Guide to all teachers, or develop a separate guide for teachers (e.g., referral procedures, suggestions for listening/helping).

Planning Questions

Community Agencies

Which community agencies have a speakers' bureau for HIV-positive speakers or are a source for speakers on sexual health?

_____

_____

_____

_____

What community agencies might be appropriate to help cofacilitate small-group discussions with the Peer Team?

_____

_____

_____

_____

(continued)

School-Community Linkages

(continued)

Referral Procedures

What are the school's procedures for referring students who seek help for issues related to HIV, other STD or pregnancy?

How widely known are the referral procedures?

How can the referral procedures be improved and/or made more widely known?

(continued)

School-Community Linkages

(continued)

Resource Guides

Does the school or community have a resource guide of health-related services for teens? If so, when was it last updated?

If there are no existing resource guides, what health services should we include in such a guide?

How and when should we distribute the resource guide?

Do we want a separate guide or supplement for teachers, or should we provide them with the student version?

Other Ideas

What other school-community linkage activities do we want to pursue?

(continued)

School-Community Linkages *(continued)*

Schedule of Activities and Next Steps

Activity	Date	Steps	Responsibility
Link with HIV-positive or sexual health speakers			
Link with agencies to assist with discussions			
Review student referral procedures			
Develop or obtain a Resource Guide for students (Update it in subsequent years)			
Provide a separate guide or supplement for teachers (Update it in subsequent years)			
Other			

(continued)

School-Community Linkages

(continued)

Suggested Activities

- Send a survey to local organizations to have them list available services (youth services, counseling and testing, speakers, other resources).
- Develop a phone card listing local youth services (include available services, location, hours, cost) and distribute to all students.
- Add a teacher supplement to the student resource guide, or develop a separate guide for teachers that lists local youth services, and includes sections on referral procedures and answering difficult questions.
- Recruit local community organizations to help the Peer Resource Team conduct small-group discussion sessions.
- Conduct a Health Fair in cooperation with local organizations and clinics.
- Visit a local HIV/AIDS service organization. Invite students and faculty to participate.
- Arrange for volunteer service activities with local community agencies.

Safer Choices

School Health Promotion Council Meeting Attendance and Minutes Form

School _____ Date _____

Type of Meeting _____

I. Record of Attendance

Name (please print)	Position

(continued)

Safer Choices

School Health Promotion Council Meeting Attendance and Minutes Form

(continued)

II. Decisions and Action Items

Decision/Action Item	Responsibility	Due Date

III. Discussion Summary

Component 2

Curriculum and Staff Development

About This Component

The *Safer Choices* curriculum consists of 2 separate units to be taught over 2 school years. The 10 lessons in Level 2 reinforce and build on the 11 lessons in Level 1. Consistent with social cognitive theory and social influence models, *Safer Choices* lessons address functional knowledge, attitudes and beliefs (including self-efficacy), social skills (particularly refusal and negotiation skills), social and media influences, peer norms and parent/child communication.

Staff development activities encourage broader support and participation in the program.

Students Say...

The roleplays we did encouraged me to never get weak, that you shouldn't care what people say.

—Vanessa, 16

I learned you have to be strong and not be afraid when someone wants to have sex with you and you don't want to. You have to give a clear statement and say "No!"

—Jessica, 15

Component 2

Curriculum and Staff Development

Key Activities and Materials

1. Identify Classes in Which Curriculum Will Be Taught

- **Level 1 and Level 2 Curriculum books** (provided separately)

2. Use In-Class Peer Leaders

- ***Peer Leader Training Guide*** (provided separately)

3. Notify Parents

4. Train Teachers

- **Sample Teacher Training Agendas**
- **Teacher Preparation Form**

5. Plan Staff Development Activities

Identify Classes in Which Curriculum Will Be Taught

Because the goal of curriculum implementation is to reach a majority of students in the targeted grade levels, the curriculum should be implemented in a required class, such as science or health education (if required of all students), rather than an elective class. Teachers selected to implement the program should have knowledge of the content areas covered in the curriculum, be comfortable discussing the material, have experience teaching a skills-based program, and be interested in and committed to the goals of the program. Ideally, all teachers implementing the program will receive training regarding the curriculum and the accompanying skill strategies.

Implementation Tips

- Teachers found it helpful to meet with each other periodically during curriculum implementation to share ideas, discuss problems and brainstorm solutions.
- Some teachers also found it helpful to watch a colleague teach selected lessons before they taught the lessons themselves.

Use In-Class Peer Leaders

To capitalize on peer modeling, the curriculum uses student Peer Leaders as facilitators for selected activities. Five to eight students from each classroom (roughly 20% of each class) are elected by their classmates to serve as Peer Leaders. These students receive approximately 3 hours of additional training, and are asked to model skills and assist with small group activities (e.g., lead brainstorming, organize small-group roleplaying).

It is important to use the Peer Leaders as part of the curriculum. Implementation plans must allow time for selection and training of Peer Leaders. Guidelines for selecting Peer Leaders are included in the curriculum. Detailed training activities for Peer Leaders are provided in the Peer Leader Training Guide.

(continued)

Students Say...

Being a peer leader in **Safer Choices** *has made my belief about not having sex stronger.*

—Andy, 14

Implementation Tip

- Many teachers found using in-class Peer Leaders was an effective way to involve students in the instruction. These teachers planned to use Peer Leaders for other classroom instruction as well.

Notify Parents

Prior to implementation of the curriculum, parents should receive written notice describing the goals of *Safer Choices* and the nature of the content to be covered, and be given an opportunity to view the curriculum and related materials if they wish.

Parents should be given the option of excluding their children from participating in the curriculum. More details regarding parent notification and a sample parent notification letter are included in the curriculum itself.

Train Teachers

ETR offers science-based training, technical assistance and consultation services to strengthen and support the implementation and sustainability of programs. ETR's Professional Learning Systems team uses cutting edge best practices, research on the effective elements of professional development, neuroscience, and adult learning theory to design and deliver trainings that lead to the implementation of new skills.

All of ETR's trainings use an innovative, science-based approach to adult learning. Research in the field of professional development shows that, in order to influence outcomes, learning needs to take place over time, rather than at a one-time event. This is why all of ETR's teacher trainings use a Distributive Learning Approach. *Distributive learning is the distribution of a learning process, over time, in a planned and pedagogically sound manner.* Training for *Safer Choices* includes pre-assessment, pre-work, a 3-day in-person training, and follow-up support for educators to ensure their learning is transferred to the classroom.

The goal of the teacher training is to prepare educators with the knowledge and skills to implement the *Safer Choices* curriculum component effectively and with a high degree of fidelity.

Key objectives of the training include assisting teachers to:

- Share accurate information related to:
  - The five components of the *Safer Choices* Program
  - Key findings from the student outcomes of the *Safer Choices* evaluation
  - Facts about STDs and HIV prevention methods
  - Pregnancy prevention methods
  - Adolescent risk behaviors for pregnancy, STDs, and HIV
- Increase student proficiency to:
  - Set and stick to personal limits
  - Respect other people's refusals
  - Assess and avoid risky situations
  - Avoid sex or say no to unprotected sex
  - Obtain and use condoms
- Effectively use teaching strategies:
  - Brainstorming
  - Roleplay
  - Small-group work
  - Large-group discussion
- Answer student questions accurately and sensitively.
- Teach *Safer Choices* lessons and activities with fidelity.
- Identify the impact of personal values on teaching.
- Determine acceptable adaptations to the curriculum component.
- Identify potential barriers and potential solutions for implementing *Safer Choices*.
- Create an action plan to implement *Safer Choices*.

(continued)

Train Teachers *(continued)*

Training for teachers who will implement the *Safer Choices* curriculum is critical for successful implementation. The Professional Learning Systems team at ETR, which provided the educator training for the schools in the original *Safer Choices* study, provides skills-based training for educators on a fee-for-service basis. Districts or schools interested in talking with ETR about training for Safer Choices can contact a training specialist at www.etr.org/ebi/training-ta.

Training Outline for Teachers

Among the most critical aspects of the training ETR provides for teachers are modeling key skill lessons and lessons that exemplify the use of key teaching strategies that are used throughout the curriculum, and providing practice sessions for teachers to implement the lessons in front of their peers. The Sample Training Agenda at the end of this section shows the content covered during the 3-day *Safer Choices* Training of Educators (see page 91). Teachers may find the Teacher Preparation Form (page 93) helpful in preparing for practice session and for actual implementation.

Booster Trainings

It is important to provide booster trainings after the first year the curriculum is taught. The overall goal of update trainings is to help teachers who have implemented the curriculum before prepare to teach the curriculum again, with improvements in the implementation and use of the skill strategies.

This type of booster training was well-received by teachers participating in the original *Safer Choices* study. ETR offers booster sessions in a variety of ways, ranging from virtual learning opportunities to full-day, in-person trainings.

Plan Staff Development Activities

In addition to teacher training, schoolwide staff development activities should be conducted to:

- Provide updates to all school personnel regarding facts about HIV, other STD and pregnancy.
- Apprise school staff and faculty of the program's activities.

Ideally, the School Health Promotion Council should plan and implement 1 or 2 schoolwide staff development activities each school year. Activities can take multiple forms and do not have to be time intensive. Examples of staff development ideas used by the schools in the original *Safer Choices* study include the following:

- Present the *Safer Choices* paradigm and provide an overview of the program and planned activities. Include ideas on how staff and faculty can get involved.
- Invite an HIV-positive speaker or a speaker on reducing sexual risk taking and promoting adolescent health to give a presentation during a faculty meeting or as part of a staff development day.
- Present an activity from the curriculum (e.g., the HIV Risk Activity in Class 5B of Level 1) to faculty and staff.
- Create a brief quiz about HIV, other STD and pregnancy, and give prizes to individuals who answer all items correctly.
- Have the Peer Leaders develop and perform a skit for faculty and staff on ways for teens to handle sexual pressures.
- Develop and present criteria on how to be an "askable" adult (e.g., listen, don't judge, give accurate information or help students find accurate information) and have Peer Leaders model strategies for handling student questions.
- Distribute copies of the Resource Guide developed by the School Health Promotion Council and Peer Resource Team to all faculty and staff.
- Invite a small panel of experts from the community (e.g., physician from a local teen clinic, HIV counselor, health educator from local HMO or community agency) to talk about teen issues and services related to HIV, other STD and pregnancy prevention.

Curriculum and Staff Development Materials

- ❑ **Sample Teacher Training Agenda**
- ❑ **Teacher Preparation Form**

Sample Training Agenda

Day 1

8:30 Welcome, Introductions and Training Overview

Safer Choices Curriculum Overview, Theory and Research

BREAK

Model Level 1: Classes 1–3

12:00 **LUNCH**

1:30 Introduction and Preparation for Practice Sessions

Model Level 1: Classes 4–6

BREAK

Level 1 Practice Session: Class 7

4:30 Closure and Process Check

Day 2

8:30 Review Day 1/Overview Day 2

Model Level 1: Classes 8–10

BREAK

Answering Sensitive Questions

11:50 **LUNCH**

1:00 Model Level 2: Classes 1–4

BREAK

Practice Session Level 2: Class 5

Values Clarification

4:30 Closure and Process Check

Day 3

8:30 Review Day 2/Overview Day 3

Peer Leaders

BREAK

Level 2 Practice Session: Class 6

BREAK

Model Level 2: Classes 7–9

12:30 **LUNCH**

1:30 Model Level 2: Class 10

Making Adaptations

Action Planning

4:00 Closure and Overall Evaluation

Teacher Preparation Form

Safer Choices

Level 1 ❑ **Level 2** ❑

Class _____

Title: _____

Directions: *Use this form to record your notes on implementing this lesson.*

Overall goal or purpose of lesson:

_____

_____

_____

_____

_____

_____

Special preparation and Peer Leader instructions:

_____

_____

_____

_____

_____

_____

Key teaching strategies used (e.g., leading large-group discussion, small-group activities, roleplays, etc.):

_____

_____

_____

_____

_____

_____

(continued)

Teacher Preparation Form

(continued)

Activity ____: _____ Page: _____ Time: _____

Notes:

_____

_____

_____

_____

Activity ____: _____ Page: _____ Time: _____

Notes:

_____

_____

_____

_____

Activity ____: _____ Page: _____ Time: _____

Notes:

_____

_____

_____

_____

Activity ____: _____ Page: _____ Time: _____

Notes:

_____

_____

_____

_____

Component 3

Peer Resources and School Environment

About This Component

Lessons and messages students receive at school outside the classroom can reinforce what they learn in the classroom. Thus, the major purpose of this component is to saturate the school environment with activities, information, events and services that reinforce the key messages of the classroom-based instruction, and to create an environment that supports HIV, other STD and pregnancy prevention.

Targeting the school environment through a peer education approach provides positive role models for students on campus, reinforces norms against unprotected sex, provides opportunities for youth to help one another, and empowers students through meaningful involvement. It also helps establish personal responsibility for HIV, other STD and pregnancy prevention.

Activities conducted as part of this component are planned and carried out by a representative group of youth who will be organized and trained as a Peer Resource Team or Club. These students should be selected from a wide range of groups in the school so that Peer Team activities will appeal to a broad range of students. Peer Team members should be encouraged to participate for at least one school year and should receive training to provide them with the knowledge and skills needed to function in their various roles.

The Peer Team should meet on an ongoing basis with an adult Peer Coordinator to plan ideas for new activities, work on implementation and assess completed activities for effectiveness.

Component 3

Peer Resources and School Environment

Key Activities and Materials

1. Recruit a Peer Coordinator

- **Job Description:** Peer Coordinator

2. Recruit Peer Resource Team Members

- **Application Form**
- **Sample Parent Consent Form**
- **Peer Team Membership List**

3. Provide Peer Team Orientation and Training

- **Peer Team Training Activities**
- **Sample Peer Team Certificate**

4. Plan Peer Team Projects

- **Project Guidelines**
- **Project Planning Sheet**

5. Work with the Peer Team

- **Peer Team Meeting Summary Form**

Recruit a Peer Coordinator

The Peer Team should be under the leadership of an adult who meets with them regularly and coordinates and supports their efforts. The Peer Coordinator should be a member of the School Health Promotion Council. This individual should relate well to students and be interested in and committed to the goals of the project. Ideally this person will receive a stipend to help support the coordination of Peer Team activities.

The Site Coordinator, with assistance from school administration and the ad hoc committee involved in recruiting Council members, should play an active role in recruiting the Peer Coordinator, using the Peer Coordinator Job Description (see page 109). Recruitment strategies include identifying specific individuals who meet the qualifications of the position and talking directly with them; posting the job description in a central location on campus (e.g., teachers' lounge, beside faculty mailboxes); and announcing the position at staff meetings.

Recruit Peer Team Members

The Peer Resource Team should include approximately 20–25 students from the school (to account for likely attrition throughout the year). The Team should be representative of students attending the school. It must include students from all grade levels (9–12) and genders and a variety of social networks on campus.

Students Say...

Not only did **Safer Choices** *affect me, it also affected many of my friends. I told my friends about everything I learned.*

—Kelly, 14

The Site Coordinator, Peer Coordinator, and selected members of the School Health Promotion Council should work as a recruitment committee to identify, recruit and select Peer Team members. The primary goal of the recruitment and selection process is to involve a diverse group of young people who can help design and conduct activities that will be meaningful for a broad range of students on campus.

Ideally, recruitment should begin in the spring of the year before *Safer Choices* is implemented widely on campus. A second recruitment should be conducted at the beginning of the school year to recruit ninth graders to participate in the program. If the recruitment cannot be done in the spring of the preceding year, then all the recruitment can be done in the fall. Recruit between 20 to 35 students to allow for drop outs in the first few months.

(continued)

Recruit Peer Team Members

(continued)

The following steps may be helpful when recruiting the Peer Team:

Identify the various student social groups on campus. Invite input from the students on the Council and talk with staff members familiar with the social networks on campus.

Consider diversity among the school's student body. Strive to include students who represent a variety of ethnicities, sexual orientations and gender identities.

Clarify the basic requirements for involvement on the Peer Resource Team. Members of the Team should be interested in helping other youth as well as committed to the issues addressed by the program. In addition, students should be

- Able to meet regularly (e.g., once a week)
- Enthusiastic towards the program
- Willing to make the time commitment (e.g., weekly meetings and helping to conduct activities at various times throughout the year)
- Willing to work as part of a team
- Able to "connect" with and motivate other students

Get recommendations of students who represent the various social networks from teachers, counselors, administrators, social workers, coaches, school club sponsors, and/or coordinators of programs for high-risk youth. Recommendations should also be obtained from the students on the School Health Promotion Council and students involved in other student organizations.

Use the following strategies for broader recruitment if you don't receive enough recommendations from staff and students:

- Conduct presentations about the program in selected classes.
- Advertise in the school newspaper.
- Develop recruitment flyers and place them around campus.
- Make announcements at school assemblies.

- Include announcements in the daily bulletin.
- Hold information meetings during lunch or after school.

Hold an orientation meeting for potential participants to describe the project and confirm their interest and commitment. This can be done on a one-on-one basis or as a group. If students are not interested, ask them to make additional recommendations.

Explain and be sure each Peer Resource Team member can meet the following time commitments:

- **Peer Team Training.** Students must be able to take part in the Peer Resource Team Training. (Length may vary by school, but it is likely to be 1 day.)
- **Peer Team Meetings.** Team members will be expected to meet regularly (e.g., once a week) for approximately 45 minutes to 1 hour with the Peer Coordinator. The Peer Coordinator and Team members will be responsible for selecting a time for these regular meetings (e.g., during lunch, before school, after school).
- **Peer Team Projects.** Students should also expect to help conduct selected projects throughout the year. The time required will vary depending on the number of students involved on the Team and the number of projects conducted.

Have each interested student complete a brief Application Form (see sample on page 111) that provides some background information. If there are more than 35 students who are interested in the project, this information can be used to help with the final selection process. Try to limit the group size to 35 or fewer students, particularly for the first year. Starting a new program with a larger group may compromise the effectiveness of the program.

Review all applications to identify students who can meet the basic requirements of the program (e.g., can meet once a week). Avoid selecting

(continued)

Recruit Peer Team Members

(continued)

too many students who are already involved in "everything" (e.g., several clubs, student government, athletics), as they may lack the time needed to be actively involved in the project.

Determine a procedure for making final selections if there are more than 35 interested students who can meet the basic time requirements. One approach is to conduct brief interviews with students. The interview team should include a student from the School Health Promotion Council, a staff member from the Council, and the Peer Coordinator. The interviewers should use a standard set of questions so that the interviews are consistent.

Decide on a procedure for notifying selected students (this can be formal or informal). If you have more than 35 applicants, the recruitment team should decide on appropriate procedures for notifying those students not selected.

Check school policy to determine parental consent requirements for participation on the Peer Team. If parent consent is required, have each member of the Peer Team get parental approval. (The Peer Coordinator should keep the consent forms on file.) A Sample Parent Consent Form is included at the end of this section (see page 113).

No student should be excluded for consideration based upon his or her race, gender, ethnicity, creed, sexual orientation or handicapping condition.

Students should be asked to commit to the program for the entire school year. Those who are interested in participating during subsequent years should be encouraged to do so.

Provide Peer Team Orientation and Training

In general, the goal of training should be to introduce Peer Team members to the *Safer Choices* project and prepare them for their role. Ideally, by the end of an initial training, Peer Team members should:

- Understand the goals of the *Safer Choices* program and the importance of the Peer Resource Team in the success of the program.
- Feel they have accurate information about preventing HIV, other STD and unintended pregnancy.
- Have an initial plan for projects they want to implement during the year (or at least the first semester).
- Feel a sense of group cohesion.
- Feel enthusiastic about the Peer Team and their role on the Team.
- Know when and where they will meet for their regular meetings.

The Site Coordinator and Peer Coordinator should cofacilitate the training. Other members of the School Health Promotion Council can assist as well. Schools might also want to seek assistance from local agencies that provide this type of training (e.g., YWCA, Planned Parenthood). If outside agencies are used, it is important to meet with them ahead of time to discuss the goals of the program and training, and to review the content they intend to cover.

If possible, hold the training off-campus at a nearby community center or district office. If the training will be held at the school, try to find a room with carpet and comfortable chairs rather than using a classroom. The room should have a table for the trainers and work tables for students.

A few weeks before the training, be sure to notify Peer Team members and Council members of the date, arrange for refreshments and audiovisual equipment (e.g., monitor for any DVDs, music for breaks), confirm any guest speakers and prepare the training materials (e.g., handouts, chart paper, markers, nametags, etc.). If possible, create special certificates for students who will complete the training (see sample on page 136). Certificate templates are often available with existing computer software or can be purchased at office supply stores.

(continued)

Provide Peer Team Orientation and Training

(continued)

Peer Team Training Outline

Ideally, the first training should last a full school day (e.g., 8:00 a.m.–3:00 p.m.). Be sure to select a date that doesn't conflict with other schoolwide events. Having students participate for a full day at the beginning of the year solidifies their involvement on the Team, provides an opportunity to get to know each other, and reinforces that their participation is special and an important part of the overall project. If the training cannot be held all day, several shorter sessions (e.g., 3 hours each) should be scheduled.

The content and format of the training can vary based on students' experience with peer programs and the extent of their background with HIV, other STD and pregnancy prevention. The agenda in Figure 3 may be helpful in planning the training. More details about these and other potential training activities are provided at the end of this section (see page 117).

Figure 3

Sample 1-Day Agenda for Peer Team Training

- Registration (provide refreshments if possible)
- Warm-up activity/introductions
- Group agreements for the day (from Level 1 curriculum)
- Overview of *Safer Choices* program and goals
- Overview of the Peer Team's role in program
- *Safer Choices* Challenge Game (from Level 2 curriculum)
- HIV-positive speaker or video
- Lunch
- Project planning for the year
- Logistics, next steps, etc.
- Closure and distribution of certificates

Ongoing Training Updates

In addition to the initial orientation and training, it can be helpful to provide periodic training updates throughout the year (e.g., once a quarter or once a semester during a regularly scheduled Team meeting or as a special session). Using mini-training activities throughout the year can energize students, provide a change of pace, or help prepare students for a specific project (e.g., a brief theatrical training if students decide to produce their own drama production about HIV or teen pregnancy).

Topics and formats for these mini-trainings are limitless and can be based on numerous criteria, such as perceived need by the Peer Coordinator or students' stated needs and interests. The collection of Training Activities at the end of this section provides several ideas for training updates. There are also numerous curricula and resource guides on planning and implementing peer helper programs that may be useful.

Implementation Tips

- Use music during the training (e.g., for breaks and during work sessions) to energize the group.
- Schedule a training update for January to help energize and refocus students for the spring semester.
- Schedule an end-of-the-year training retreat (e.g., picnic in the park) before the end of school to review accomplishments for the year, decide on changes for next year, and celebrate a year of hard work.

Plan Peer Team Projects

Members of the Peer Resource Team should help plan and complete the following 7 types of *Safer Choices* projects at their schools:

- Staff and maintain a **resource area** on campus where students and school staff can go for information and materials about HIV, other STD and pregnancy.
- Write stories for the **school newspaper** and announcements for **bulletins**.
- Use posters, buttons, contests and other **small media** to increase awareness about HIV, other STD and pregnancy prevention.
- Sponsor assemblies and other schoolwide **public forums** on HIV, other STD and pregnancy prevention issues.
- Conduct a school **opinion poll** about HIV, other STD and pregnancy prevention topics.
- Hold lunch-time or after-school **discussion sessions** on HIV, other STD and pregnancy prevention issues.
- Sponsor a **drama production** about HIV, other STD or pregnancy.

Guidelines for various types of projects are provided at the end of this section (see pages 137–154). These guidelines include a summary of the project, objectives, details regarding preparation and materials, specific instructions for developing activities where needed, and tips for evaluation.

Peer Team members should be encouraged to play an active role in shaping the actual activities planned for each type of project. This will promote program ownership and maintain students' interest in the program.

A Project Planning Sheet can help Peer Team members with planning their activities for the year (see sample on page 155).

Work with the Peer Team

One of the most important functions of the Peer Coordinator is to maintain interest and enthusiasm among the Peer Team members. The following tips can help the Coordinator establish the Peer Resource Team and maintain their involvement over time.

Space and Recognition on Campus

One important factor in establishing group cohesion and rapport is to have an identified space where the Peer Team can meet and work on materials for activities. The SHPC can help identify a space on campus for these activities.

In addition, the Peer Coordinator may want to work with the school administration to secure official "club" status for the Peer Team. As an official club, students may be able to access school resources (e.g., audiovisual equipment, the school newspaper) more easily, and may be recognized in the school yearbook for their efforts.

Regular Meetings

The initial Peer Team orientation prepares students for their roles in influencing the school environment, has them prepare activity plans, and gets them started creating messages they want to use to influence their peers. Regular meetings (e.g., weekly or every other week) should begin very soon after the initial orientation to avoid losing momentum.

Getting the Team working on their first project right away will help them feel a sense of immediate accomplishment. It may be helpful to form students into small working groups to begin planning for different activities. The Peer Coordinator's role includes helping students learn the process of setting realistic, worthwhile goals and achieving them through organized action.

(continued)

Work with the Peer Team

(continued)

Regular 1-hour meetings will go quickly. Taking time to plan agendas and time frames for the meetings will help the Peer Team feel and be more efficient and effective. Although some organizational tasks (such as selecting working groups and making decisions) and additional training will need to take place, it's best to use *most* of the meeting time to work directly on project activities (e.g., poster development, resource area updating, calls to possible outside presenters). Beware of a tendency to focus on team-building for the Peer Team members themselves at the expense of influencing others through their efforts.

It is helpful to assign a Peer Team member to take notes or minutes at each meeting to document decisions and next steps. A sample Peer Team Meeting Summary Form is provided at the end of this section (see page 157).

Students Say...

Many teenagers do things because they are tempted by their friends. **Safer Choices** *has made me say that if friends do that, then they are not your friends.*

—Jerome, 14

Linkages with Other Campus Groups

A major thrust of the Peer Resources and School Environment component of the *Safer Choices* program is the active involvement of as many students as possible in project activities. Working cooperatively with other campus groups is a valuable mechanism for attaining this end. Getting support from other student organizations (e.g., student government, athletic teams, culture-related groups, academic clubs, etc.) will expand the Peer Team's capacity to reach all members of the student body with their *Safer Choices* messages.

The skills learned through this networking process (negotiating mutually beneficial arrangements) will enhance the experience for all concerned. Encourage students to think of ways to engage other groups in their activities (e.g., ask the Spanish Club to translate poster or button messages and give their members free buttons).

Linkages with Other Safer Choices Components

It's important to make sure the Peer Resource Team is linked with the School Health Promotion Council. At least 2 of the students on the Peer

Team should also be active members of the Council. Council members should be available to assist with Peer Team activities.

The Council has responsibility for contacting health and teen-related services in the community, to link students with their services and to bring speakers and services into the school. Producing a Student Resource Guide could be a joint project between the Council and the Peer Team.

The Peer Coordinator will want to work closely with the Site Coordinator and other Council members to coordinate additional Council/Peer activities. Peer Team members may have valuable input into development of programs and written materials for parents, faculty and staff.

Maintaining Involvement and Commitment

Research on peer programs has clearly demonstrated the importance of personal investment on the part of the peers. The most crucial mechanism for ensuring such investment is **active involvement of youth in every step of the program**—the program should be perceived as one that was developed *with* and *by* youth, not simply for youth.

For example, students should participate in the decision-making processes related to the Peer Team. They will take primary responsibility for selecting, planning and implementing projects and will participate in identifying specific goals for the program each year. Each Peer Team member should be given the opportunity to take a leadership role on at least one project.

Additionally, several activities should be planned each year to help strengthen the cohesiveness and unity of the group as well as reward peers for their involvement in the program. The following are some examples:

- Have students choose their own name for the Peer Team (e.g., "*Safer Choices* Club") and design a logo. If funds are available, buttons or T-shirts displaying the logo could then be given to all Team members.
- Provide certificates or other recognition for completed projects.

(continued)

Work with the Peer Team

(continued)

- Hold a social event each semester (e.g., a pizza dinner or a trip to the movies) for members of the Peer Team and School Health Promotion Council to strengthen group identity and spirit, and enhance students' commitment to the program.
- Hold an end-of-the-year celebration for all Peer Team Members and in-class Peer Leaders. Students would be asked to suggest ideas for the celebration.
- Plan a fund raiser to raise money to send 2 Peer Leaders or Peer Team members to a national event, such as the National Peer Helpers Conference.

Peer Resources Materials

- ❑ **Job Description:** Peer Coordinator
- ❑ **Application Form**
- ❑ **Sample Parent Consent Form**
- ❑ **Peer Team Membership List**
- ❑ **Peer Team Training Activities**
- ❑ **Sample Peer Team Certificate**
- ❑ **Project Guidelines**
- ❑ **Project Planning Sheet**
- ❑ **Peer Team Meeting Summary Form**

Peer Coordinator
Job Description

Program Description

The *Safer Choices* program involves the delivery of a comprehensive, multi-component school health program in HIV, other STD and pregnancy prevention.

The program includes a peer resources and school environment component. Under the direction of the School Health Promotion Council, a group of students will be recruited and trained to serve as a Peer Resource Team. With the guidance of a Peer Coordinator, these students will plan and implement a variety of schoolwide HIV, other STD and pregnancy prevention activities.

The goal of *Safer Choices* is to reduce unprotected sex among students ages 14–18. The program has 2 primary objectives:

- To reduce the number of students who begin or have sexual intercourse during their high school years.
- To increase latex condom use among students who have sexual intercourse.

Safer Choices was originally part of a 5-year demonstration project funded by the Centers for Disease Control and Prevention (CDC).

Job Summary

The Peer Coordinator assumes responsibility for the overall coordination of the Peer Resource Team. The Team will consist of 25–30 students who will conduct special projects within the school. The Peer Coordinator will meet with the Peer Resource Team on a regular basis to plan, discuss and implement program activities.

The primary goals of the Peer Resource Team are to:

- Provide positive role models for students on campus.
- Reinforce norms against unprotected sex.
- Provide opportunities for youth to help one another.
- Empower students through meaningful involvement in the program.

The Peer Coordinator will be a member of the School Health Promotion Council and will work closely with the Site Coordinator on matters related to the Peer Resource Team. The Peer Coordinator may be a staff person at the school (e.g., teacher, counselor, nurse) or a community member with experience and knowledge of high school issues.

(continued)

Peer Coordinator

Job Description

(continued)

Responsibilities

1. Work closely with the Site Coordinator and other School Health Promotion Council members to recruit Peer Resource Team members.
2. Work with the Site Coordinator and Council to train members of the Peer Resource Team.
3. Schedule, facilitate and maintain minutes of the Peer Resource Team meetings.
4. Provide training, support and coordination for the Peer Resource Team and the activities developed and implemented by the Team.

Qualifications

The Peer Coordinator will be someone who:

1. Has a thorough understanding of and familiarity with the students in the school.
2. Relates well to students and is well liked and respected by a wide spectrum of the student body.
3. Demonstrates excellent organizational and coordination skills.
4. Possesses strong communication and group facilitation skills.
5. Can work in a flexible and fluid manner.
6. Supports the goals and objectives of the program.
7. Has knowledge of adolescent sexuality and is comfortable discussing it with students.
8. Is committed to helping students learn leadership and organizational skills.
9. Is committed to serve at least 1 school year.

No candidate will be excluded for consideration based upon employment, race, gender, ethnicity, creed, sexual orientation or handicapping condition.

Time Expectations

The Peer Coordinator can expect to spend about 2-3 hours per week on various program activities (e.g., meeting with Peer Team members, assisting students with activity planning and implementation). Amount of time and intensity will vary throughout the year based on planned activities.

Remuneration

A stipend or release time should be provided for the Peer Coordinator's participation in the project.

Peer Team Application Form

Date: _____

Your Name: _____

Address: _____

Phone: _____ Grade Level: _____ Age: _____

Gender: _____ Race/Ethnicity: _____

In what other activities are you currently involved (such as work, clubs, sports, etc.)? How much time per week do you spend doing each of these activities?

Activity	**Time Spent Each Week**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please explain briefly why you want to be part of the Peer Team.

_____

_____

_____

_____

Will you be able to attend a 1-hour Peer Team meeting each week during the school year?

❑ Yes ❑ No ❑ Not Sure

Have you ever been involved in a Peer Program before (such as peer tutoring or peer counseling)? ❑ Yes ❑ No If you have, what kind of program was it?

_____

_____

_____

_____

(continued)

Peer Team Application Form

(continued)

Please list any outside interests, hobbies, skills or knowledge that you feel may be useful for the Peer Team, such as artistic talents, creative writing, musical talents, ability to get along with others, ability to motivate others, etc.

The Peer Team will be involved in planning and conducting many different projects on campus. Which of the following projects are most interesting to you. (Check up to 3.)

- ❑ Writing articles for the school paper or website.
- ❑ Creating bulletin boards on campus.
- ❑ Designing flyers to promote activities.
- ❑ Conducting a survey of students on campus.
- ❑ Planning to have guest speakers come to campus.
- ❑ Developing posters, buttons and other materials.
- ❑ Planning contests.
- ❑ Helping with a theater production on HIV.
- ❑ Helping with small-group discussion sessions on teen issues.
- ❑ Creating a website.

❑ Other (please describe):

Sample Parent Consent Form

(Modify as necessary)

Dear Parent/Guardian:

Your teen has expressed interest in participating on a Peer Resource Team for *Safer Choices*, an HIV/AIDS, sexually transmitted disease (STD), and pregnancy prevention program being taught at your teen's school beginning **(insert date)**. Approximately **(insert number)** other students will be involved on the Peer Resource Team.

The Peer Team members will be learning information and skills about how to prevent HIV, other STD and unintended pregnancy. The students on the Team will be involved in designing educational activities about HIV, other STD and pregnancy prevention for other students at the school.

As part of the Peer Team, your teen will be asked to participate in a training session. The training will be held on **(insert date)**. Members of the Peer Team will also meet regularly with the Peer Coordinator, **(insert name)**. These meetings will occur on **(insert day)** from **(insert times)**.

If you would like further information about the project or the activities in which your teen will participate, feel free to call **(insert contact person and phone number)**.

Sincerely,

Please return this permission slip to: _____

by _____ (date).

My teen _____

❑ May participate in the *Safer Choices* Project as a Peer Resource Team member

❑ May *not* participate in the *Safer Choices* Project as a Peer Resource Team member

Signature of parent/guardian: _____

Date: _____

Peer Team Membership List

School _____

Peer Coordinator _____ Phone _____ Mailing Address _____ _____ _____	Name _____ Grade _____ Phone _____
	Name _____ Grade _____ Phone _____
Name _____ Grade _____ Phone _____	Name _____ Grade _____ Phone _____
Name _____ Grade _____ Phone _____	Name _____ Grade _____ Phone _____
Name _____ Grade _____ Phone _____	Name _____ Grade _____ Phone _____
Name _____ Grade _____ Phone _____	Name _____ Grade _____ Phone _____
Name _____ Grade _____ Phone _____	Name _____ Grade _____ Phone _____

Peer Team Training Activities

Purpose

These activities can be used as part of the initial Peer Resource Team orientation and training, or throughout the year. Each activity includes a description of the purpose, a list of required materials, and a brief outline of the activity procedures.

Activities

1. **Warm-Up Activity/Introductions**
2. **Preparation for HIV-Positive Speaker**
3. **HIV-Positive Speaker**
4. **Project Planning for the Year**
5. **Identifying Target Audiences**
6. **Media Messages**
7. **Identifying Influences on Decisions**
8. **Helping Skills**

Activity 1

(5–15 minutes) 

Warm-Up Activity/Introductions

Purpose

To help participants and facilitators get to know each other.

Materials

- **Option 1:** 3" x 5" index cards, 1 per student
- **Option 2:** half-sheets of chart paper and markers, 1 per student
- **Option 3:** Scavenger Hunt worksheet and pencils, 1 per student

Procedure

Option 1—Interview a Partner

- List the following items on chart paper or the board: (1) name and grade, (2) favorite foods, (3) one dream for the future, (4) why this person wants to be part of the Peer Team.
- Ask everyone to pair up with someone they don't know and find out the information listed on the board about that person.
- Give students index cards to use for taking notes while they are interviewing their partners. Allow students to talk for about 5 minutes.
- After 5 minutes, have students introduce their partners to the group.
- Briefly discuss the activity (e.g., What did you learn about other members of the group?).

Option 2—Personal Posters

- Hand out a half sheet of chart paper and a marker to each student. Have students write their first names in large letters down the left side of the paper.
- For each letter, have students write a word or phrase that describes them in some way (e.g., for "S": swimmer, sure of myself, silly, spaghetti lover). Demonstrate using own name.
- Allow students to work for 5 minutes.

- When students finish their names, have them write an ending to each of the following sentences at the bottom of their papers:
  - A friend is someone who...
  - The most important thing in a love relationship is...
  - A person should wait to have sex until...
- When students finish, have them circulate with their posters, introduce themselves to 5 people they don't know and read each other's signs.
- Post the signs in the room for the rest of the day.
- Briefly discuss the activity (e.g., What did you learn about other members of the group?).

Option 3—Scavenger Hunt

- Tell students each of them will get a worksheet with several statements on it. Show the worksheet and give an example (e.g., Find someone who likes pineapple on pizza). Explain that they will have 5 minutes to circulate and talk to others in the room, looking for people who match the statements on the worksheet. They should write each person's name next to the appropriate statement.
- Tell students they can only use a name once, and that it's OK to use their own names once.
- Ask students to describe what they will do once they get their worksheets. Clarify as needed.
- Pass out worksheets and pencils. Allow students to circulate for 5 minutes.
- Debrief by asking students questions such as: Who has all the statements signed? Who met someone who likes pineapple on pizza? Whom did you meet?

Scavenger Hunt

(*Note:* Alter the statements to match the group and purpose of the training.)

Find a person who matches the description. Write his or her name on the line. Use a name only once. *It's OK to use* your *own name once.*

Find someone who:

1. Knows what STD means. _____

2. Has lived in or traveled to a different country. _____

3. Wears a size 10 shoe. _____

4. Likes pineapple on pizza. _____

Activity 2
(5–10 minutes)

Preparation for HIV-Positive Speaker

Purpose

To prepare students for a presentation by an HIV-positive speaker.

Materials

- 3" x 5" index cards, 1 per student

Procedure

Remind the group that an HIV-positive speaker will be coming to speak to them. Explain that the speaker will share his or her experience living with HIV, including life as a young person, the decisions that put him/her at risk for HIV, the internal and external pressures that affected his/her health-related decisions, and the impact of HIV on daily activities, personal relationships and long-range plans.

Address any concerns students may have about having an HIV-positive speaker visit the classroom (e.g., being in the same room with someone who has HIV, thinking about people they know who have been affected by HIV, etc.)

Tell students they will be given an opportunity to ask the speaker questions during the presentation. Explain, however, that some students may feel uncomfortable asking questions in front of the entire group. Hand out index cards and ask students to write any questions they would like the speaker to answer. Collect all the cards, whether they contain questions or not.

(*Note:* Review questions for appropriateness before giving them to the speaker.)

Note: If a speaker is not available, you can show a video instead. See Class 3 in the Level 2 *Safer Choices* curriculum for criteria for video selection.

Activity 3
(45–60 minutes)

HIV-Positive Speaker

Purpose

To enable students to hear what it is like to live with HIV.

Materials

None

Procedure

(*Note:* Prior to the presentation, talk with the speaker about the program—e.g., goals and objectives, role of the Peer Team, other components, etc. Review what you would like the speaker to discuss and how to respond to inappropriate questions. Detailed procedures for having a guest speaker discuss his/her experiences living with HIV are provided in the Level 2 *Safer Choices* curriculum.)

Introduce the speaker and allow him/her to share experience related to HIV with the group. During the question-and-answer period, be prepared to assist the speaker if inappropriate questions are asked by students (e.g., questions about personal sexual practices).

Thank the speaker and ask 2 Peer Team members to guide the speaker back to the main office.

Ask the group to share their reactions to the presentation.

Optional: Some students may want to write thank-you notes to the speaker. Let students know if this is an option. Inform them that you will review their letters and mail all appropriate letters to the speaker. Give students a date by which to write their letters.

Note: If you showed a video instead of having a speaker, adapt this activity accordingly.

Activity 4

(60–90 minutes) 

Project Planning for the Year

Purpose

To enable students to begin planning projects for the year.

Materials

- List of 7 project types: Resource Area, School Newspaper, Small Media Projects, Public Forums, Opinion Polls, Discussion Sessions, Drama Productions
- Tape, chart paper and markers
- Set of 7 color-coded index cards with 1 project type written on each card, 1 set per student
- Paper bag or box

Procedures

Tell the group it's time to start planning what they want to do this year. Explain that there are 7 types of projects that will provide a framework for the Peer Team. Show the list and review the types of projects:

- Staffing and maintaining a **resource area** on campus where students and school staff can go for information and materials about HIV, other STD and pregnancy.
- Writing stories for the **school newspaper** and announcements for **bulletins** and other media.
- Using posters, buttons, contests and other **small media** to increase awareness about HIV, other STD and pregnancy prevention.
- Sponsoring school assemblies and other **public forums** on HIV, other STD and pregnancy prevention issues.
- Conducting school **opinion polls** about HIV, other STD and pregnancy prevention topics.
- Holding lunch-time or after-school **discussion sessions** on HIV, other STD and pregnancy.
- Sponsoring **drama productions** about HIV, other STD or pregnancy.

(continued)

Activity 4

(continued)

Explain that students are going to work in small groups to brainstorm ideas for each of these 7 project areas. Randomly assign students to 7 small groups. Have each group select one of the project types. (Once a project area is picked, the other groups must select from the remaining areas.)

Have each group identify a recorder to take notes. Distribute pieces of chart paper and markers to each recorder.

Have students brainstorm 5–8 ideas for their project area. They should also suggest approximate dates or months for their activities (e.g., Valentine's Day buttons), and cover details specific to their project area.

For example: For the resource area project, they should brainstorm where the area should be located, how to find out what type of materials students will read, other types of media to include (e.g., online resources, videos), when it should be open, etc. For drama productions, they can decide what type of productions they might want to do (e.g., host an existing play, create their own production, do several smaller skits during assemblies or existing events), etc.

Allow students to work for 25–35 minutes (or longer if needed). Play music in the background while students work. Circulate to assist as needed.

Once students have finished, have each group share their ideas with the larger group. Post the lists on the wall.

Ask other students to share ideas. Add them to the lists. Congratulate students on their creative thinking.

Time permitting, tell students that they will now have a chance to prioritize what they would like to do first in each of the areas.

Give each student a set of 7 color-coded index cards, with a project area written on each one. Have students circulate and review the idea lists, writing down their favorite 2 ideas for each project area. Tell students not to put their names on their cards.

When students finish, have them fold their cards and place them in a bag or box.

Give students a break. During the break, have 4–7 volunteers help sort the cards and tally votes. Have the volunteers write the number of votes for each activity directly on the chart paper lists.

After break, review voting. Tell students that during the first Peer Team meeting the group can discuss in more detail the next steps in developing these project ideas. Thank the group for their efforts.

Activity 5

(30–40 minutes) 

Identifying Target Audiences

Purpose

To identify different social groups on campus to whom prevention messages can be targeted.

Materials

- 3" x 5" index cards, 10 per student
- Markers, 1 per student
- Tape or tacky putty

Procedures

Tell students that in order to develop messages that will actually have some influence with their fellow students, they need to assess the "target audiences" and the peer culture in the school. Then they can develop messages that have the potential to reach everyone in some way.

Ask students to think about all the groups they belong to or have contact with at the school. These can be organized groups (clubs, activity groups, student government, classes), or social, informal groups. Give each student 10 index cards and a marker and have them write down as many groups as they can think of, 1 group per card.

(*Note:* Pre-cut pieces of tape or tacky putty and have them ready for the cards to keep the activity moving.)

(continued)

Activity 5

(continued)

When nearly everyone is finished, tell students that the next step is to have everyone post some or all of their cards on the wall. Begin by designating one large area for formal groups and another for informal groups. Ask a student volunteer to read his/her cards and post them in the correct areas on the wall. Do this with a few more volunteers, eliminating duplicates. Have the rest of the group post their cards in the designated areas, eliminating duplicates as they post the cards.

When all cards are posted, comment on how many groups students have in their network of contacts. Ask if there are groups in the school, including cultural groups, academic groups, etc. that are not represented in their network. Write these on cards and place them on the wall in a separate area.

Remind students that each of their contacts is an opportunity for influence. Pick a card at random and ask which of the students on the Peer Team are part of that group. Have those students answer the following questions:

- What does this group have in common?
- If you know, or if you had to make a guess, how would you say the people in this group would complete these sentences?
  - A friend is someone who...
  - The most important thing in a love relationship is...
  - A person should wait to have sex until...

Pick a second card and repeat the process (Who belongs to this group? How would they respond to the sentence stems?). Tell students that these responses could be considered this group's social norms around friendship and love relationships.

Ask if there's a group whose responses might be very different. Are members of this group represented on the Peer Team? If not, how might they be reached with messages that are meaningful for them? (e.g., talk to a representative of that group, invite them to send someone to the Peer Team, etc.) Briefly discuss ideas and record them for later reference.

Activity 6

(50–60 minutes) 

Media Messages

Purpose

To examine the influence of media on behaviors and to develop positive media messages that might be used in schoolwide activities.

Materials

- Chart paper, 1 piece per group
- Magazine ads or posters. *Note:* Post on the wall before activity.
- Collage supplies: teen magazines, scissors, glue, tape, paper, markers

Procedure

Part 1—The Influence of the Media

Ask students to name some popular music groups. Get several suggestions. Ask what brand of jeans are best. Get several suggestions, or count who's actually wearing what styles/brands of clothing. Ask which shoes are most popular. Get several suggestions.

Ask what influences them or others to choose these items. Make a list on newsprint (e.g., advertising, television/movies/videos, what friends say or do, what role models say or do, comfort, personal taste, wanting to fit in or be "cool," fads, wanting to be different, etc.).

Tell students that all these influences are considered in developing effective advertising strategies or successful films, videos, TV shows, etc. Media producers and advertisers study the people they want to buy their products or watch/listen to their shows. They find the best methods of reaching these people by incorporating subtle or obvious images that appeal to this "target audience."

(continued)

Activity 6
(continued)

Select a magazine ad or poster from the wall and have students suggest messages stated or implied in it. *Examples:* According to the media...

- *A girl should:*
  - be soft
  - be beautiful
  - protect her reputation
- *A boy should:*
  - be in control
  - never cry
  - get as many girls as he can (double standard)
- *A relationship should:*
  - always have a sexual aspect

Ask students if they think television, movies, videos, etc., influence people's beliefs or behavior in other ways. Get suggestions (e.g., about relationships, what people do in their spare time, what success is, what "real" men or "real" women do, etc.).

Praise students for their observation skills. Ask:

- How do you feel about these messages?
- What problems might arise for teens as a result of these messages from the media? (e.g., inability to live up to the images presented; unrealistic goals are set up so individuals might start feeling bad about themselves; expectations and stereotypes may result in disappointment and blocked communication)
- What do you think is important in a relationship?

Tell students it's important to be aware of the messages we're receiving every day, and to choose the ones we respond to. For the Peer Team, it's important to know the messages fellow students are getting all the time, in order to offer new ones that can counteract the negative messages and support the positive ones.

Ask students:

- How do the media messages compare with the beliefs you wrote this morning on your Personal Posters? Refer to posted name signs and compare. (See Activity 1, Option 2.)
- What other influences are there on a person's beliefs about masculinity, femininity, relationships, sex, etc.? (e.g., peer norms, parents, experiences, etc.)
- Ask volunteers to summarize any conclusions they drew from this activity. Record these on newsprint.

Part 2—Positive Messages

Divide students into 5 small groups. Have each group select a discussion leader/reporter. (*Note:* Each time you use small groups combine students in new ways to help them get to know each other.)

Announce that each group represents a major advertising agency. Their newest account is to come up with a dynamic advertising idea for promoting *Safer Choices* about sexual behavior. They should choose a target audience, and tailor their campaign to that group. They should think about ways their message would be promoted using **visual** media (e.g., posters).

Remind groups of the campaign parameters:

- They are to promote the *positive* aspects of waiting to have sex or saying "no" or "not without protection."
- The messages should be appropriate for use on their school campus.

Tell students they will be expected to make a visual presentation of their idea using the materials provided, and then present their campaign to the rest of the group. Each group will have 30 minutes to design, and then 3 minutes to present their projects. Ask if there are any questions. Hand out collage supplies.

(*Note:* Music can be played during the activity as background for creative work if students wish.)

(continued)

Activity 6

(continued)

- When groups have finished working, have students present their ideas to the larger group. Give each group 3 minutes to present. Encourage applause.
- Have the whole group discuss briefly the similarities and differences among the ideas presented, and analyze the extent to which the ideas will appeal to a range of students on campus. Have students identify groups that might not be influenced by their ideas, and brainstorm media messages for those groups.

Possible Student Messages

The following list gives possible messages generated by students. These are not exhaustive and do not necessarily reflect what your students will generate.

- You're important, protect yourself.
- You can make smart and safe decisions about sex.
- It's not who you are, it's what you do.
- Condoms can be fun.
- HIV is invisible to the eye.
- Girls can carry condoms.
- Don't share needles.
- Teens can get HIV too.
- Just say "know."
- Cover yourself, use a condom.
- Stop the madness, learn about AIDS.
- If you decide to wait, you are not alone.
- Your sexual decisions are your own. No one can make them for you.
- In real life you have to say "No" if you have any respect for yourself.
- Every human being has a right to say "No."
- To stay in control of emotional situations, you need to know what you believe is right and wrong, and stick to it.
- When in doubt, don't.
- You are in charge of what you do with your own body.
- If you respect yourself, you also respect the other person.

Activity 7

(30–40 minutes) 

Identifying Influences on Decisions

Purpose

To identify internal and external influences on the decision of whether or not to have sex, and to examine how these influences can be used in media messages.

Materials

- Chart paper, 2 pieces per group. *Note:* Label 1 piece "YES to Sexual Intercourse" and the other "NO to Sexual Intercourse."

Procedure

Acknowledge that the desire to have sex is natural in people of all ages and can be very strong. Remind students that people also have difficulty resisting sexual intercourse for reasons other than sexual drive. To work effectively as peer educators, it is important for them to understand the variety of influences on teens around having or not having sex. It is also important for them to evaluate their own decisions and behaviors, so they can be helpful as role models for other students.

Divide students into 4 groups of 7 or 8. Have each group select a discussion leader/reporter who has not done the job yet.

Give each group 2 pieces of chart paper, one labeled "YES to Sexual Intercourse" and the other labeled "NO to Sexual Intercourse." Have them post the charts on the wall near their group. Explain that each group member will write at least one reason why teens would make the decision listed on each chart, then pass the marker to another member.

They will keep going for 5–10 minutes or until ideas run out. Remind students that reasons include internal pressures (their own feelings, sex drive, etc.) and external pressures (peer or girl/boyfriend pressure, messages from the media).

Allow 5–10 minutes for groups to work. Provide additional sheets of paper as needed.

(continued)

Activity 7
(continued)

Examples of Influences

Why Some Teens Say YES to Sexual Intercourse

- Pressure from peers
- To communicate warm, loving feelings
- To keep from being lonely
- To get affection
- To show independence and adulthood
- To hold on to a relationship
- To become a parent
- To satisfy curiosity
- Pressure from partner
- To fit in

Why Some Teens Say NO to Sexual Intercourse

- Violates religious beliefs
- Violates personal beliefs
- Not ready
- Risk of pregnancy
- Risk of HIV and other STD
- Don't want to jeopardize goals
- Relationship with parents
- Not "in love"
- Not interested at this time
- Want to build a relationship that isn't just about sex

When groups have finished, ask them to evaluate their lists. Which do they think are the strongest, most convincing reasons on the lists? Have each group agree on and mark the top 3 reasons on the YES list and the top 3 reasons on the NO list.

Have the discussion leader for each group report the top 3 reasons from each list. Ask students: How might knowing this information be important to you as Peer Team members in deciding the best ways to influence others? (e.g., knowing the reasons teens choose to have sex or not to have sex will help the Team choose effective messages). Discuss briefly and record significant items on newsprint.

Activity 8

(45 minutes) 

Helping Skills

Purpose

To practice handling other students' questions about HIV, other STD and pregnancy.

Materials

- 3" x 5" index cards, 8 per group
- 2 paper bags

Procedure

Tell students that as the Peer Resource Team becomes more well known around campus, other students may come to them for information or even for help with personal concerns. Explain that they will spend some time practicing ways to respond to different kinds of questions, and give each other feedback on their answers.

Ask students to describe people with good listening skills: What do they do or say that lets you know they are listening? List students' ideas on chart paper.

Identify and model some nonverbal listening skills (e.g., nod, lean forward, make eye contact, etc.). Then identify and model some verbal listening skills (e.g., open-ended questions, restating, encouragement).

Explain that part of being a good listener is helping people clarify their question or think through their situation. Define "helping" as supporting the other person's own decision-making process.

Review the differences between asking for *information*, asking for *attention* (what most people want from a listener) and asking for advice. Explain that *very few people really want advice.* Tell students they sometimes can tell if they're giving unwanted advice if the person responds with, "Yes, but... (I tried that; he'd never go for that; that won't work for me; etc.)." If the person doesn't ask "What would you do?" or "What should I do?" *don't give advice!* Just listen, offer sympathy, and/or ask a few questions to show you're listening.

Activity 8

(continued)

Tell students they will now have a chance to brainstorm a list of questions their peers might ask them about HIV, other STD or pregnancy, and questions they are concerned about being asked. Explain that they will work in small groups to develop the questions, and will record their questions on index cards.

Divide students into small groups of 3 or 4 and give each group 8 index cards. Allow groups to work for 10 minutes.

Collect the cards from each group. Give students a break. Review and screen the cards for appropriateness. Remove inappropriate questions. Divide the eligible questions into 2 bags. If there are duplicate questions put 1 in each bag.

Tell students they will now be trying out some listening and responding skills to give them practice answering questions they might get from their peers. Explain that students will work in groups of 10–15. (*Note:* A trainer or the Peer Coordinator should be available to lead each group.) The adult will pick a question and ask for volunteers to respond. After the volunteer responds to the question, there will be an opportunity for the group to discuss the answer and give feedback. Ask if there are any questions about the activity.

Divide students into groups of 10–15, with an adult in each group. Choose a volunteer to respond first and have the adult pick a question to which the volunteer will respond. Other group members should listen silently.

After each question and response, ask the volunteer to comment briefly on his or her answer. Then ask the other group members what they liked about the answer and what else could have been said. Be sure to keep the activity moving. Encourage all students to try answering a question, but don't make them participate if they are uncomfortable.

As a whole group, discuss:

- What were some of the most helpful ways to respond to the questions?
- What can peers do to help a person follow through with a decision (without jeopardizing confidentiality)?
- When should peers refer the person to a professional or get help with a situation? To whom can peers go when they aren't sure what to do?

Ask students what ideas they might use to be more helpful for their friends or others who need help. List their ideas on chart paper or the board.

Remind Peer Team members that they are likely to get questions as they become more known around school. Emphasize, however, that they are *not* counselors, and that they should not tell someone what to do. Rather, they should listen and give accurate information or direct the person to an accurate source of information.

Certificate of Completion

This Certificate is Awarded to

_____

for participation in the *Safer Choices* curriculum Peer Resource Team training

at _____ High School

_____

Date

_____ _____

Safer Choices Peer Coordinator Presenter

Project Guidelines
Resource Area

Summary

The health resource area provides students with an easily accessible source of information on HIV, other STD, pregnancy and related issues. The Peer Resource Team will set up and maintain the resource area on campus (e.g., in a small section of the school library or in a nurse or counselor's office). Available materials can include pamphlets, information on local health clinics and services, videos and other resources (hotline numbers, credible online resources).

Objectives

- Students and staff will be familiar with the resource area and the services it provides.
- Students and staff who use the resource area will receive the information they request.

Preparation and Materials

- Space to display and store educational materials, and approval to use the space
- Multiple copies of HIV, other STD and pregnancy prevention materials (e.g., pamphlets, resource guides, etc.)
- Promotion for resource area (when open, types of materials, etc.)
- Special equipment and supplies (shelves or tables, display rack, monitor to view DVDs, etc.)

Instructions

Develop a Plan

Creating a plan will help ensure the resource area is used by students and staff. The plan should address the following:

- Appropriate approval
- Educational materials
- Access and visibility
- Promotional materials

Each of these items is discussed in more detail below.

(continued)

Resource Area

(continued)

Secure appropriate approval. The Peer Coordinator and the Peer Resource Team should get approval for the use of a room or a designated space (e.g., in the school library). Once space is available, the Coordinator and Team members should decide when and for how long the area will be open to other students and staff.

Gather educational materials. The resource area should have the following materials:

- educational pamphlets and fact sheets
- videos
- local health resource directories
- other materials the Peer Team and School Health Promotion Council feel are appropriate

(*Note:* All materials should be reviewed and approved by the Peer Coordinator, the Site Coordinator, and other key school personnel, such as the principal, before being distributed.)

Ensure access and visibility. The resource area should be located in a space where students feel comfortable looking at the materials. Ideally the resource area will be accessible to students and staff before, during and after school.

Promote the service. The Peer Team should promote the resource area using posters, flyers, the PA system, etc.

Evaluation

- ❑ The Peer Coordinator, Peer Team members and School Health Promotion Council members should discuss general observations about the resource area and the materials being used, and make adjustments for future supplies.
- ❑ A suggestion box can be used to elicit comments and ideas from students and staff who use the resource area.

Project Guidelines

School Newspaper and Other Media

Summary

Newspaper and other school media provide an opportunity for a large number of students to see and hear about HIV, other STD and pregnancy prevention issues. School media should be used to increase knowledge, develop more positive attitudes, and promote safer choices regarding health behavior. The media messages will be designed and sponsored by the Peer Resource Team with the help of the Peer Coordinator and School Health Promotion Council members.

Objectives

- Students will be familiar with the *Safer Choices* project and the Peer Resource Team.
- Students will be able to describe important issues related to HIV, other STD and pregnancy prevention.
- Students will be able to take steps to protect themselves from HIV, other STD and pregnancy by choosing not to have sex (the SAFEST choice) or by using latex condoms and other protection every time if having sex (the SAFER choice).

Preparation and Materials

- Appropriate approval for media messages (articles, ads, video clips, etc.)
- Space in the school newspaper, school bulletin, school website or other media sources
- Deadline schedules for school paper and other media

Suggested Topics and Ideas

Articles should be designed to reach a large portion of the school population. The messages can be of any length (e.g., a brief advertisement promoting responsible behavior, or a longer article on the latest information about HIV and teens).

If there is no school paper, a brief HIV/STD/pregnancy student-focused "newsletter" could be created, or other forms of print or online media could be used (e.g., daily bulletin, flyers, blog posts, etc.).

(continued)

School Newspaper and Other Media

(continued)

The following ideas may be useful in planning messages for the school paper and other media:

- **Create a new "Ask Us" column** for the school newspaper and invite students to submit anonymous questions about HIV, other STD and pregnancy, which are then answered in the paper.
- **Interview people** who have HIV, and then write an article about the interviews, respecting their privacy in the article.
- **Develop advertisements** that provide information on how to prevent HIV, other STD and pregnancy, and where to go to get more information about these topics, including where to go to get tested.
- **Write articles** for the paper or website that include issues related to HIV (e.g., how to prevent it, discrimination, confidentiality laws, etc.), or other sexual health issues (e.g., dating violence, factors that influence decisions to have sex).
- **Sponsor a music contest** where students are asked to create a rap or other song about preventing HIV, other STD and pregnancy, and publish the winning song.

(*Note:* Be sure each message is reviewed for accuracy by the Peer Coordinator.)

Evaluation

- ❑ The Peer Coordinator should maintain copies of all stories or flyers used.
- ❑ The Peer Coordinator, Peer Team members and School Health Promotion Council members should discuss general observations about the media materials and make adjustments for future media activities.

Project Guidelines

Small Media Projects

Summary

Small media materials (e.g., T-shirts, posters, buttons, flyers, etc.) should be used throughout the year to help create a school environment that supports ongoing efforts to prevent HIV, other STD and pregnancy.

Objectives

- Through small media materials, all students, teachers and staff will learn about HIV, other STD and pregnancy, and ways to prevent them.
- The school community will learn about ongoing *Safer Choices* activities and resources.

Preparation and Materials

- Appropriate approval of materials (content, layout, etc.)
- Appropriate approval for method of displaying or using materials (putting posters in hallways, wearing red ribbons, passing out flyers, texting campaign, etc.)
- Special equipment or materials (posterboard, paper, markers, etc.)
- Promotional materials for contests, etc.

Instructions

Develop a Plan

Creating a plan for small media materials will help ensure they are successful. The plan should address the following:

- Themes and materials
- Coordination and collaboration
- Locations, times and promotion
- Appropriate approval

Each of these items is discussed in more detail below.

(continued)

Small Media Projects

(continued)

Decide on themes and materials. Each small media campaign should have a theme to educate students and staff about HIV, other STD and/or pregnancy (see page 143 for ideas). The Peer Team can use any acceptable small media (e.g., posters, flyers, buttons, T-shirts, etc.) to get the message out. To select a theme, it may be helpful to review existing *Safer Choices* materials (*Safer Choices* Curriculum, *Safer Choices Implementation Manual*). Also, each campaign should have a target audience (all students, girls only, boys only, Latino students, seniors only, etc.).

Assign coordinators and promote collaboration. Several Peer Team members should be responsible for planning and carrying out each small media campaign. The Peer Coordinator should assist the Peer Team members in getting needed approvals, preparing appropriate materials, and inviting participation from the School Health Promotion Council and other student groups on campus.

Determine locations and times and promote activities. Small media campaigns should be ongoing. If the Peer Team has a special event, the small media campaign can be part of the event. Small media campaigns also can go along with other *Safer Choices* activities, such as the Level 1 and Level 2 curriculum. The goal is to keep *Safer Choices* and the issues of HIV, other STD and pregnancy prevention visible all year long.

Whenever possible, try to post flyers, posters and other materials in a visible location where they won't get torn down easily (e.g., display cases, classrooms, cafeteria, restrooms, locker rooms, etc.).

Secure appropriate approval. Once the Peer Team has decided on a theme and the materials to be used, the Peer Coordinator and the Peer Team members working on the campaign should get approval for the campaign. Approval may be needed from the School Health Promotion Council, the principal or other key school personnel. It is important to get approval while the campaign is being planned.

Evaluation

- ❑ The Peer Coordinator may want to save the original materials for future reference or to display in the *Safer Choices* resource area.
- ❑ The Peer Coordinator, Peer Team members and School Health Promotion Council members should discuss general observations about the materials being used, and make adjustments for future materials.
- ❑ A suggestion box (physical or online) can be used to elicit comments and ideas from students and staff.

(continued)

Small Media Projects

(continued)

Possible Themes:

- Basic information about HIV or other STD (what it is, how it's passed from person to person, how to prevent it, etc.).
- Specific messages about HIV, other STD and pregnancy prevention (e.g., delay sex, use latex condoms, use most effective methods of birth control such as IUDs and implants, etc.).
- Importance of talking with your partner about preventing HIV, other STD and pregnancy.
- Information on HIV, other STD and pregnancy prevention resources (local services, information center, hotlines, referrals, etc.).

Possible Materials:

- **Posters** created by Peer Team members or obtained from existing sources such as the Red Cross, Centers for Disease Control and Prevention, etc.
- **Writing contests** open to all students to write a short essay on HIV, other STD or teen pregnancy. Winners can be displayed or featured in the school paper or website.
- **Guessing contests** where a jar is filled with jelly beans or beads to represent the number of AIDS, other STD or teen pregnancy cases in your county and students try to guess the number. Winner and correct answer are announced to the school.
- **Art contests** to create posters or other artwork using HIV, other STD and pregnancy prevention messages. Winners are displayed in the halls or featured in school paper or website.
- **Music contests** where students create raps or other songs featuring prevention messages.
- **Announcements** (e.g., daily bulletin, PA system, etc.).
- **School marquee**, trophy or display cases.
- **Buttons, T-shirts, and other materials** distributed and visible to all students.

Project Guidelines

Public Forums

Summary

Public forums provide an opportunity for a large number of students to participate in HIV, other STD and pregnancy prevention activities. The activities should be designed to increase knowledge, develop more positive attitudes, and promote safer choices regarding health behavior. The public forums will be designed and sponsored by the Peer Resource Team with the help of the Peer Coordinator and School Health Promotion Council members.

Objectives

- Public forum participants will be familiar with the *Safer Choices* project and Peer Resource Team sponsoring the event.
- Public forum participants will be able to describe important issues related to HIV, other STD, pregnancy prevention and sexual health.
- Public forum participants will be able to take steps to protect themselves from HIV, other STD and pregnancy by choosing not to have sex (the SAFEST choice) or by using latex condoms and other protection every time if having sex (the SAFER choice).

Preparation and Materials

- Appropriate approval for activity (topic, speakers and materials used)
- Space to hold activity
- Confirmation from any guest speakers or visitors
- Promotional materials
- Special equipment or materials (microphone, DVD player, prizes, etc.)

Suggested Topics and Ideas

The following ideas may be useful in planning the public forum activities:

- **Invite speakers** who are involved with preventing HIV and other STD or pregnancy (e.g., representatives from local community agencies devoted to these issues) to talk during lunch.

(continued)

Public Forums

(continued)

- **Invite speakers** on topics more broadly related to adolescent sexual health, such as dating violence, electronic dating aggression or healthy relationships, to talk during lunch.
- **Sponsor a rap music contest** where students develop rap songs about HIV/AIDS and then have the top entries perform the songs during lunch, a rally or a dance. If a dance is held, proceeds could be donated to an AIDS foundation.
- **Make a Safer Choices presentation** at a school-sponsored event, such as a rally or half-time at a sporting event.
- **Sponsor an event** where students provide support for persons infected with HIV (e.g., a food drive, a letter-writing campaign, volunteer assistance for people with HIV). This event could be initiated following a presentation by a person who has HIV.
- **Hold a "Teen Speak-Out"** where students can discuss why they feel it is important for teens to think about HIV, other STD and unplanned pregnancy, and to avoid risk behaviors.
- **Host a talk show** where students and teachers appear as "guests" and can discuss controversial issues related to HIV, other STD and pregnancy prevention.

Evaluation

- ❑ The Peer Coordinator and Peer Team members involved keep a file with copies of any materials used for each event (e.g., promotional flyers). The Peer Coordinator also can keep records on the number of students reached.
- ❑ The Peer Coordinator, Peer Team members and School Health Promotion Council members should discuss general observations about the event and make adjustments for future events.
- ❑ A suggestion box can be used to elicit comments and ideas from students and staff.

Project Guidelines

Opinion Polls

Summary

A school opinion poll provides an opportunity for students and/or teachers to share views about issues related to HIV, other STD and pregnancy prevention. The primary goal of the opinion poll is to reinforce norms for choosing not to have sex or for using latex condoms and other methods of protection every time if having sex.

The poll will give students information on attitudes and perceptions regarding HIV, other STD and pregnancy prevention issues. The opinion poll will be designed and conducted by the Peer Resource Team with the help of the Peer Coordinator and School Health Promotion Council members.

The Peer Team may want to involve students from other clubs on campus to help with the opinion poll. For example, members of the Math or Computer club could help summarize and display the results.

Objectives

- Students will be able to describe their peers' attitudes and perceptions regarding issues related to prevention of HIV, other STD and pregnancy.
- Students will have accurate and positive information regarding ways to prevent HIV, other STD and pregnancy.

Preparation and Materials

- Appropriate approval for the poll (questions, procedures, when, where, etc.)
- Sufficient copies of the poll or a link to an online poll
- Access to a computer for entering and analyzing the results

Instructions

There are several steps to follow when planning your opinion poll:

- **Decide** if the poll will be a written survey or if Peer Team members will interview students.
- **Keep the poll short**—for example, 8 to 10 questions for written or online surveys and 3 to 5 questions for interviews.

(continued)

Opinion Polls

(continued)

- **Include questions** about students' attitudes and beliefs, not their sexual behaviors. (For example, ask "Do you think students your age should be having sex?" instead of "Are you having sex?")
- **Phrase** some of the questions so that students are very likely to express norms against unprotected sex (e.g., "Do you think people who have sex should use condoms to prevent HIV, other STD and pregnancy?"). Remember, the goal is to show support for preventing HIV, other STD and pregnancy.
- **Do not ask** participants to put their names on the survey or to give their names to the interviewers.
- **Include a range of students** at the school, not just one group.
- **Follow school guidelines** about parental consent.
- **Summarize and publish** the results for all students and staff at the school.

Suggested Topics and Ideas

The following ideas may be useful in planning the opinion poll:

- Include a copy of the survey in the school newspaper and have students complete it and return it to a designated location (such as a box in the Peer Coordinator's room or office).
- Have students complete the survey during homeroom.
- Conduct the survey by interviewing students during lunch.
- Publish the survey results in the school paper and/or post the results on a bulletin board at the school.

Evaluation

- ❑ The Peer Coordinator should maintain a copy of the survey used and a copy of the results.
- ❑ The Peer Coordinator, Peer Team members and School Health Promotion Council members should discuss general observations about the poll and polling process and make adjustments for future polls.

Project Guidelines

Discussion Sessions

Summary

Small-group discussion sessions give interested students the chance to discuss important issues about sexuality in a small-group setting (e.g., 12–14 students). These sessions can include prearranged topics or can be held as an open forum, where participants decide upon the discussion topics. The sessions will be organized and carried out by the Peer Resource Team with the help of the Peer Coordinator and School Health Promotion Council members.

Objectives

- Group discussion participants will be familiar with available *Safer Choices* resources.
- Group discussion participants will have their questions about HIV, other STD, pregnancy prevention and related topics answered.

Preparation and Materials

- Appropriate approval for session (topic, speakers, and materials used)
- Space to hold session
- Confirmation from any guest speakers or visitors
- Promotional materials
- Special equipment or materials (videos, equipment to project slide presentations or show DVDs, etc.)

Instructions

Develop a Plan

Creating a plan will help ensure the discussion session is successful. The plan should include the following:

- Topic (prearranged or open forum)
- Coordination and collaboration
- Location and time
- Appropriate approval
- Promotional materials
- Agenda

Each of these items is discussed in more detail below.

(continued)

Discussion Sessions

(continued)

Decide on a topic. The session can have a prearranged topic or can be an open forum. The Peer Team can choose a specific topic based on the interests of students or Peer Team members. Examples include relationships, talking with a partner, HIV and other STD testing, pregnancy, sex and the media, methods of protection, and how to make HIV/STD and pregnancy prevention more inclusive for all youth, including lesbian, gay, bisexual, transgender and questioning youth.

In an open forum discussion, participants can ask any questions or raise any concerns they have. The Session Coordinator, guest speaker and/or Peer Team members respond to questions and participate in the discussion. It may be best if the open forum sessions follow a schoolwide *Safer Choices* activity (auditorium activity, specific lesson in curriculum, etc.).

Assign coordinators and promote collaboration. The sessions can be lead by a guest speaker, a teacher or counselor, or the Peer Coordinator along with Peer Team members.

Several Peer Team members should be assigned as Discussion Coordinators. These students will be responsible for planning each discussion session. The Peer Coordinator should assist the Discussion Coordinators to prepare the appropriate materials, find speakers (if necessary), and invite participation from the School Health Promotion Council.

Determine locations and times. Discussion sessions should be held in a quiet, comfortable environment. If possible, use the Peer Team Resource area. Choose a time that will maximize student attendance (e.g., lunch periods, after school).

Secure appropriate approval. Once the Peer Team has decided on a topic, and where and when the session will be held, the Peer Coordinator and Discussion Coordinators should get approval for the session. Approval may be needed from the School Health Promotion Council, the principal or other key school personnel. It is important to get approval while the session is being planned.

Promote the session. Peer Team members can assist in developing flyers, posters, announcements or other appropriate promotional materials for each discussion session. The promotional materials should contain the topic, location, time and contact person. Remember to get appropriate approval for advertisements before they are posted.

Set agenda. The session agenda determines how the session will be conducted. It is helpful for the Peer Team to agree on a standard process. For example:

1. Discussion Coordinator welcomes everyone and gives a brief summary of the session topic. (If there is no set topic, let the participants know it is an open discussion and they can ask questions on any relevant subject.)
2. Discussion Coordinator goes over group agreements. (Modify existing group agreements from the *Safer Choices* curriculum.)

(continued)

Discussion Sessions

(continued)

3. Begin process for topic or open discussion. This will differ based on the topic. For example, for the topic of "Love, Relationship and Sex," the following process could be used:
   - Small groups decide on definitions for each term.
   - Discuss definitions as a whole group.
   - Play a game that shows how love, relationships and sex can differ from couple to couple (e.g., many couples express respect and love without having sex, or love means using protection all the time, etc.).
4. Discussion Coordinator or other Peer Team member briefly describes available *Safer Choices* resources.
5. During the last few minutes of the discussion, ask participants for feedback on what they thought about the topic, the format (process), and if they have any suggestions for future sessions.

The main goal is to create a process that is fun and provides a learning opportunity for the participants.

Evaluation

❑ The Discussion Coordinators should record the following information on the back of the agenda:

- topic
- number of participants
- participant feedback (on the session process)
- suggestions for future discussion group topics
- any other general observations

It may be helpful to keep all agendas and related materials for each session in a binder for future reference.

❑ The Peer Coordinator, Peer Team members and School Health Promotion Council members should discuss general observations about the sessions and make adjustments for future sessions.

❑ A suggestion box can be used to elicit comments and ideas from students and staff.

Project Guidelines

Drama Productions

Summary

Drama productions provide an opportunity for a large number of students to receive information about HIV, other STD and/or pregnancy prevention. Ideally the play(s) should increase students' awareness regarding these issues and encourage positive health choices. The play should be followed by a discussion session during which students are invited to ask questions about these issues.

Some communities have drama groups that perform these types of plays (e.g., in some regions, Kaiser Permanente offers a play on HIV/AIDS entitled SECRETS). If local drama groups do not offer such plays, schools can create and host their own plays or skits.

Objectives

- Participants attending the play will be familiar with the *Safer Choices* Project and the Peer Resource Team sponsoring the event.
- Participants attending the play will be able to describe important issues related to HIV, other STD and pregnancy prevention.
- Participants attending the play will be able to take steps to protect themselves from HIV, other STD and pregnancy by choosing not to have sex (the SAFEST choice) or by using latex condoms and other protection every time if having sex (the SAFER choice).

Preparation and Materials

- Script and production guidelines
- Appropriate approval for play
- Space to hold activity
- Confirmation from any guest speakers or visitors
- Promotional materials
- Special equipment or materials (microphone, materials for set, etc.)

(continued)

Drama Productions

(continued)

Suggested Topics and Ideas

The following activities may be used to supplement the play(s):

- **Invite** a person with HIV or a local health education specialist from a community-based agency to participate in a question-and-answer session after the play.
- **Host a question-and-answer session** with members of the Peer Team after the play.
- **Set up a table** at lunch on the day of or the day after the play where members of the Peer Team answer questions and give out more information about preventing HIV, other STD and pregnancy.
- **Provide teachers with suggestions** for in-class follow-up activities or discussions related to HIV, other STD and pregnancy.

Evaluation

- ❑ The Peer Coordinator and Peer Team members involved should keep a file with copies of any materials used for the play (e.g., copy of script, name of production group, promotional flyers). The Peer Coordinator also can keep records on the number of students reached.
- ❑ The Peer Coordinator, Peer Team members and School Health Promotion Council members should discuss general observations about the play and make adjustments for future events.
- ❑ A suggestion box can be used to elicit comments and ideas from students and staff.

Project Planning Sheet

Name of Project or Activity: _____

Goal of the Project or Activity: _____

_____

Describe the Project or Activity: _____

_____

_____

_____

_____

Main messages(s) you want to give: _____

_____

_____

_____

_____

What students will learn (if applicable): _____

Number of students you will reach: _____

Date: _____

Place: _____

This project will be approved by: _____

(continued)

Project Planning Sheet

(continued)

Tasks to Be Completed	By whom	By when

Materials Needed: _____

_____

_____

_____

Estimated Budget: _____

_____

_____

_____

Peer Team Meeting Summary Form

School: _____ Meeting Date: _____

I. Record of Attendance

Members Present	Others Present

(continued)

Peer Team Meeting Summary Form

(continued)

II. Decisions and Action Items

Decision/Action Item	Responsibility	Due Date

III. Discussion Summary

Component 4

Parent Education

About This Component

Parents, guardians, and other family members play a key role in influencing students' behavior. The Parent Education* component of *Safer Choices* is designed to help parents or guardians provide accurate information to their children, increase parent-child communication about sex and relationships, and reinforce the norm that adolescents should avoid unprotected intercourse.

The primary activities include parent involvement on the School Health Promotion Council, parent newsletters, student/parent homework activities, and Council-sponsored activities for parents and guardians.

**Note:* In this section, the term "parent" is used to refer to parents, guardians or other significant caregivers in students' lives.

Students Say...

I can use the knowledge I've learned and pass it on to my little sister or talk to my mom.

—Alex, 16

Now I feel more comfortable talking to my mother about sex.

—Carmen, 15

Component 4

Parent Education

Key Activities and Materials

1. Recruit Parents for the School Health Promotion Council

2. Develop Parent Newsletters

- Sample Parent Newsletters

3. Encourage Completion of Family Homework

4. Plan Activities for Parents

Recruit Parents for the School Health Promotion Council

The Council should include parent representatives. The procedures for recruiting parent members for the Council are discussed in the section for Component 1. When thinking about recruiting parents, it can be helpful to identify all the different parent groups on campus (e.g., PTA, Latino Parents' Association, etc.). Representatives from these groups may be interested and available to participate. If they cannot participate themselves, they may know of other parents to contact. Schools may want to list the position in the parent newsletter and/or post it at the school.

Implementation Tip: Some schools in the original *Safer Choices* study had difficulty recruiting parents because of the timing of Council meetings. To address this challenge, consider varying meeting times to accommodate parents' schedules, or have several parents share the position to minimize the number of meetings each parent needs to attend.

Develop Parent Newsletters

Newsletters for parents sent 3 times each year are an excellent way to foster parent education and involvement. The focus of the newsletters can vary each time. Some ideas for newsletter topics and features include:

- Background information on the *Safer Choices* program, particularly in the introductory newsletter
- Information on HIV, other STD and teen pregnancy
- Quizzes for parents to test what they know about these issues
- Tips for parents on talking with teens about healthy relationships, sexuality and protection
- Quotes and suggestions from parents involved in the *Safer Choices* program

Sample newsletters and quizzes using material from the original *Safer Choices* study are provided following this section (see pages 167–182).

(continued)

Develop Parent Newsletters *(continued)*

At a minimum, parents of students receiving the *Safer Choices* curriculum should receive copies of the newsletters. Ideally parents of all students in the school will have access to the newsletters. Potential strategies for distributing newsletters include:

- Mailing newsletters to parents along with other PTA materials or sending through online communication channels.
- Enclosing the newsletters with school report cards.
- Giving newsletters to students to take home to parents.
- Giving out copies at school events that parents attend (e.g., PTA meetings, teacher-parent nights, athletic events).

Implementation Tip: To encourage parent involvement in reading the newsletters, try these strategies:

- Offer extra credit to students for delivering the newsletter to their parents and discussing it with them. Provide a sign-off sheet for students to turn in with their parents' signatures.
- Include raffle tickets with the newsletters, and have parents sign and return them to the teacher.

Encourage Completion of Family Homework

Each level of the curriculum includes 2 student/parent homework activities designed to facilitate communication regarding HIV, other STD and pregnancy. For example, in one activity, teens and their parents (or another adult) list and discuss reasons it can be difficult to talk about sensitive issues such as relationships and sexuality, then identify ways to make these discussions easier.

The curriculum provides details on when and how to use the homework activities. To help encourage participation, many teachers find it helpful to provide students with extra credit points for completing the assignments.

Plan Activities for Parents

The School Health Promotion Council can sponsor additional activities to assist parents in communicating with their children about sexuality. Examples of Council-sponsored parent activities include the following:

- Hold back-to-school night activities introducing parents to the *Safer Choices* program (e.g., show the materials, distribute parent newsletters, teach a specific lesson from the curriculum to parents).
- Invite health educators from local community organizations to talk to parent groups on Parent Involvement Day or teacher-parent nights.
- Have bilingual HIV educators present workshops on HIV/AIDS.
- Hold a dinner for parents of Peer Resource Team members and Peer Leaders. Invite speakers and feature skits by the students.
- Work with other clubs or parent organizations at the school to have a joint event focusing on *Safer Choices*.
- Conduct workshops on "How to talk to your teenager about sexuality."
- Have a Mother-Daughter or Father-Son Breakfast. Invite guest speakers.
- Invite parents to a *Safer Choices* Health Fair.
- Invite parents to theatrical productions about HIV/AIDS or to student performances by the Peer Resource Team.
- Identify parents with skills or professional backgrounds (e.g., doctors, nurses, counselors) to serve as guest speakers at workshops.
- Ask a local bilingual radio station to air public service announcements promoting activities or providing information.
- Make a list of videos, movies or upcoming TV shows that parents could watch with their children to start a dialogue about prevention issues.
- Include *Safer Choices* program updates in the school newsletter.
- Present information about the program at PTA meetings.

Parent Education Materials

❑ **Sample Parent Newsletters**

Safer Choices News

A Newsletter for Parents **Fall**

Welcome to Safer Choices!

◆ What Is Safer Choices?

Safer Choices is a health education program at your child's school. Its goal is to help teens protect themselves from HIV, other sexually transmitted disease (STD), and unintended pregnancy.

Safer Choices has 2 important messages:

- NOT having sex is the SAFEST choice for preventing HIV, other STD and pregnancy.
- People who do have sex should protect themselves by using latex condoms EVERY TIME they have sex.

◆ How Does Safer Choices Teach These Messages?

The *Safer Choices* program includes many different activities for students, teachers and parents.

- Students will take part in lessons about HIV, other STD and pregnancy prevention.
- Other activities—poster contests, discussion groups, school newspaper articles or a play—are sponsored by students, teachers and parents at your child's school.
- Parents will receive 2 more issues of this *Safer Choices* newsletter.

◆ Why Teach Safer Choices?

Teens are at risk for STD and pregnancy. Here are some facts:

- More than 6 out of 10 high school students in the U.S. will have sexual intercourse before they finish high school.[1]
- Young people ages 15 to 24 get half of all new STD infections.[2]
- About 1 in 4 of all new HIV infections in the United States occur among people ages 13 to 24.[3]

◆ Who's Involved?

Safer Choices events are planned by a group of students, parents, teachers, administrators and community members at your child's school called the *School Health Promotion Council.*

◆ How Can I Get Involved with the Safer Choices Program?

Call the Principal's office and ask for the name of the Site Coordinator for the *Safer Choices* program at your child's school. The Site Coordinator will be able to tell you more about the program and what you can do to help.

[1] Kann, L., Kinchen, S., Shanklin, S. et. al. Youth Risk Behavior Surveillance—United States, 2013. *Morbidity and Mortality Weekly Report* 63 (SS-4): 1–168.

[2] Centers for Disease Control and Prevention. 2014. *Sexually Transmitted Disease Surveillance 2013.* Atlanta, GA: U. S. Department of Health and Human Services.

[3] Centers for Disease Control and Prevention. 2015.HIV Among Youth. www.cdc.gov/hiv/library/reports/surveillance.

Parents' Corner

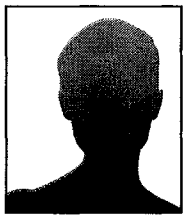
Here's what some parents who are already involved in Safer Choices *said about what parents can do to help their children deal with HIV, other STD and pregnancy issues.*

Q: Do you think STD and pregnancy are problems for teens?

Jan: "I would like to think that my children wouldn't be affected by these problems. You know, famous last words, 'Not **my** kids!' However, it doesn't always happen to someone else's family."

Fernando: "As a parent, you think back to when you were a teenager. Your attitude was, 'Nothing can happen to me!' The generations are the same. HIV and other sexually transmitted diseases are a real problem, and it's important to talk with teens about the problem."

Q: How do you think Safer Choices will help the students at your child's school?



Jess: "*Safer Choices* encourages dialogue between teachers, students, parents and the community. Through *Safer Choices*, perhaps students can find the support network they need to make healthful decisions in their lives."

Beth: "*Safer Choices* can benefit students in many different ways, more than just education. It can give kids a sense of self-worth and a sense of value just by participating, being a group leader or being on the School Health Promotion Council."

Q: How can parents help their children avoid HIV, other STD and pregnancy?

Sandy: "Parents need to talk to their kids, and also go beyond talk into demonstrations, 'what if' or 'how to handle it' situations, or just 'choices and consequences,' so that their kids really get a clear picture."

Jan: "Parents can help by being supportive and willing to listen to teens; by not being judgmental; by being aware of facts around HIV, other STD and pregnancy; and by expressing their beliefs and hopes. Teens want to know that a parent or guardian will be there no matter what, and that their parents have confidence that once the teen has all the information, he or she will try to make safe choices."

Q: How can Safer Choices help parents help their children?

Fernando: "We have to get the message into the home in as many different ways as possible. Not just with a flyer or a poster, but through the church, the media, and a newsletter from the school. I would like to get more parents involved in the Council...then we could really get the activities going."

These parents are already involved with Safer Choices. *You can get involved too. Know the facts. Talk to your child. Ask your child about the* Safer Choices *program and get involved in activities at your school.*

Information & Resources

- CDC-INFO
  1-800-232-4636
  www.cdc.gov
- **National Campaign to Prevent Teen and Unplanned Pregnancy**
  www.thenationalcampaign.org

Questions & Answers About HIV and AIDS

Do you know the facts about HIV and AIDS? Test yourself and find out.

1. HIV/AIDS is a curable disease.

❑ True ❑ False

2. The 3 main ways that someone can get HIV are

_____

_____

_____

3. Only certain kinds of people get HIV.

❑ True ❑ False

4. You can get HIV from the following:

Mosquito bites

❑ True ❑ False

Saliva

❑ True ❑ False

Toilet seats

❑ True ❑ False

Sharing utensils with someone who has HIV

❑ True ❑ False

5. If someone at your child's school has HIV, your child could get HIV from that person through regular classroom contact.

❑ True ❑ False

6. Teenagers and young adults are not at risk for HIV.

❑ True ❑ False

7. People who receive blood, for example during surgery, are at great risk for HIV.

❑ True ❑ False

8. Three ways people can protect themselves from getting HIV are

_____

_____

_____

(answers on back)

Questions & Answers About HIV and AIDS

Quiz Answers

1. **False:** At this time, there are no vaccines or cures for HIV or AIDS. HIV is a virus that damages the immune system.

2. The 3 main ways that someone can get HIV:
   - By having sexual intercourse (vaginal, anal or, rarely, oral) without using a latex condom.
   - By sharing needles for drug or steroid injection, piercing or tattooing.
   - Babies may get HIV from their mothers during pregnancy or birth, and on occasion through breastfeeding.

3. **False: Anyone** can get HIV, regardless of age, gender, race, sexual orientation or ethnicity, if he or she participates in risky behavior such as sexual intercourse without a latex condom or sharing needles with someone who has HIV.

4. All are **False:** There are many myths about HIV. There are no reported cases of a person getting HIV through mosquito bites, toilet seats, saliva, or sharing utensils with someone who has HIV.

5. **False:** Studies are very clear that the virus is not passed through casual contact, such as sitting near someone who has HIV, sneezing, shaking hands, coughing, etc.

6. **False:** Estimates from the Centers for Disease Control and Prevention indicate that approximately 1 out of 4 people diagnosed with HIV is under age 25.*

7. **False:** Before 1985, people did get HIV from receiving blood. Since 1985, a very accurate blood test has made this method of transmission very rare. No one has ever gotten HIV from donating (giving) blood.

8. Three ways people can protect themselves from getting HIV:
   - Not having sexual intercourse.
   - Using a latex condom every time if having sex.
   - Not sharing needles for any reason.

How Did You Do?

Give Yourself:

1 point for each correct response (Question 4 is worth 4 points!)

Total Possible Score: 15 points

Your Score:

13–15: Great job! Have you told your teen what you know about HIV and AIDS?

10–12: You know a lot about HIV and AIDS. Do you think your teenager would miss the same questions you did?

9 or Under: If you would like more information about HIV and AIDS, call CDC-INFO: 1-800-232-4636 or visit www.cdc.gov/hiv.

* Centers for Disease Control and Prevention. 2015. HIV Among Youth. www.cdc.gov/hiv/risk/age/youth/index.html.

Safer Choices News

A Newsletter for Parents **Winter**

Talking to Your Teen About Sexuality

◆ Helping Your Teen

If you are like most parents, you probably do many things to help your teen toward a happy and healthy future. But you may not have spent much time talking about sex with your teen. This is often because:

- Parents don't think they know enough.
- Parents may be uncomfortable or not know how to begin.
- Parents don't believe their teen could be having sexual intercourse.
- Parents may not be sure what values they want to communicate.

Many teens say they would like to talk to their parents about sexuality and relationships. Talking with your teen about sex isn't easy, but it is very important.

◆ Why Talk?

- **To be sure your teen knows the facts.** If you don't talk, your teen is likely to learn somewhere else—from friends, the media or online. The information your teen gets from these sources may not be correct. And it may not match your values. Parents who talk openly about relationships and sexual behavior can have a positive influence on their teens.
- **Because teens are at risk.** The rates for sexually transmitted disease (STD) and unplanned pregnancies among teens in the U.S. are very high:
  - — Young people ages 15 to 24 account for nearly half of the 20 million new cases of STDs each year.[1]
  - — In 2013, there were over 273,000 births to girls ages 15 to 19.[2]

◆ Before You Begin

Think about what values are important to you. If you want, talk with your partner or other parents about what they would say. Ask yourself:

- What important values do I want my teen to know about relationships?
- What important values do I want my teen to know about sexual behavior?
- How do I want to communicate these values to my teen?

◆ How to Begin

Sometimes the hardest part of talking with your teen about sexuality is knowing how to begin. Here are some ways to start:

- Ask your teen what he or she is learning in the *Safer Choices* program at school.
- Start a conversation based on a TV episode or an article in a newspaper or magazine.
- Talk about it if your hear that someone at your child's school is pregnant, or if someone in the media has HIV or AIDS.

Information & Resources

- CDC-INFO
  1-800-232-4636 • www.cdc.gov
- **National Campaign to Prevent Teen and Unplanned Pregnancy**
  www.thenationalcampaign.org

[1] Centers for Disease Control and Prevention. 2014. *Reported STDs in the United States.* www.cdc.gov/nchhstp/newsroom/docs/STD-Trends-508.pdf.

[2] Hamilton, B. E., J. A. Martin, M. J. K. Osterman, and S. C. Curtin. 2015. Births: Final Data for 2013. Hyattsville, MD: National Center for Health Statistics.

Parents' Corner

We talked with parents who have already spoken with their children about HIV, other STD and pregnancy, and asked them what advice they would give to other parents.

Q: What values about relationships/sexual behavior do you want your child to know?

Marian: "I wanted to let them know that sex wasn't anything bad, that it wasn't something to hide, but that it should be shared between husband and wife."

Debbie: "I want my teen to know sex is something you have when you already have a meaningful relationship with someone in other ways."

Q: How did you prepare to talk with your child?

Alex: "The hardest thing is realizing that you need to talk about it, not necessarily that you want to talk about it, but that you need to talk about it. The information I received from *Safer Choices* made me realize that my children needed to be aware of these problems."

Louise: "If you have teens and have never talked about this, sit them down and say, 'Look, I know we've never talked about this before but we have to talk now, because I love you and care about you.'"

Q: How did you first bring up the topic?

Louise: "I have books in my house and you see stuff in magazines. One magazine had an article about herpes, so we talked about the article together."

Debbie: "When my daughter started to date, about 9th grade, she had health class, and they were talking about HIV and STD, so we talked about stuff then."

Samuel: "We were watching a movie the other night. Two people in the movie ended up in bed on their first date. I asked the kids if they thought the scene was realistic. We had a good conversation."

Alex: "Having my daughter in the *Safer Choices* class gave us the opportunity."

These parents are already involved with Safer Choices. *You can get involved too. Know the facts. Talk to your child. Ask your child about the* Safer Choices *program and get involved in activities at the school.*

Communication Tips

- **Be real, be yourself.** If you feel embarrassed or uncomfortable, say so. (For example, say, "This isn't easy for me but...")
- **Practice** talking about sexual issues with your partner, a friend or another adult first.
- **Listen as much as you speak.** This lets your teen know you value his or her opinion. Don't interrupt or criticize.
- **Avoid** asking your teen direct questions about specific sexual behavior or experience. (For example, *don't* ask, "Are you having sex?" or "Have you ever had sex?") Your teen may feel threatened or interrogated, and it could stop the talk. Instead ask what your teen and/or his or her friends think about these issues in general.
- **Show appreciation** when your teen is honest with you, even if you aren't always happy with what was shared. (For example, say, "I'm glad we talked about this.")
- **Be open** about what you don't know. Let your teen know you may not have all the answers, but you are willing to help find out. It's OK to say, "I don't know," or "I don't know, let's find out."
- **Talk more than once.** Keep the lines of communication open.

Questions & Answers About Teen Pregnancy

How much do you know about teen pregnancy? Test yourself and find out.

1. True or False. Teens can't get pregnant the first time they have sex.

❑ True ❑ False

2. True or False. The only method of birth control that is 100% effective is choosing *not* to have sexual intercourse.

❑ True ❑ False

3. True or False. An IUD is a safe method of birth control for teenage girls.

❑ True ❑ False

4. True or False. Douching (washing sperm out of the vagina) immediately after sexual intercourse protects against pregnancy.

❑ True ❑ False

5. True or False. Condoms are the only birth control method that can prevent sexually transmitted disease as well as pregnancy.

❑ True ❑ False

(answers on back)

Questions & Answers About Teen Pregnancy

Quiz Answers

1. **False.** Pregnancy can happen any time a couple has intercourse, if an egg has been released.

2. **True.** Choosing *not* to have sexual intercourse is the only 100% effective way of preventing pregnancy *and* infection from sexually transmitted disease, including HIV!

3. **True.** The IUD is a safe form of birth control for most teenage girls. It is an extremely effective and long-acting means of birth control that does not require remembering to take a pill, change a patch or get a shot on a regular schedule. However, the IUD does *NOT protect against HIV or STD.*

4. **False.** Douching offers no protection at all from pregnancy.

5. **True.** Latex condoms are the *only* form of birth control that can prevent pregnancy *and* sexually transmitted disease, including HIV. However, they must be used correctly and consistently every time a person has sexual intercourse.

How Did You Do?

Give Yourself:

1 point for each correct response.

Total Possible Score: 5 points

Your Score:

5: Great job! Have you told your teen what you know about teen pregnancy?

3–4: You know a lot about teen pregnancy. Do you think your teenager would miss the same questions you did?

1–2: If you would like more information about teen pregnancy, contact the *Safer Choices* Site Coordinator at your child's school for information about local resources on teen pregnancy.

Safer Choices News

A Newsletter for Parents **Spring**

Helping Teens Protect Themselves

◆ The Safer Choices Approach

The *Safer Choices* program at your child's school uses 2 approaches to help teens reduce their risk of HIV, other sexually transmitted disease (STD) and unintended pregnancy:

1. *Safer Choices* encourages teens to delay sex as part of their relationships until they are older.
2. *Safer Choices* encourages teens who are having sex to protect themselves by using latex condoms correctly every time they have sexual intercourse.

Safer Choices teaches teens the skills they need to make these choices—communication skills to say no to sex or to unprotected sex, decision-making skills, and skills in using condoms and other protection if they are having sex.

◆ Will talking about sex encourage teens to have sex?

No. When teens are given clear information on the reasons to delay sexual intercourse, ways to say no, information on protection, and clear values on postponing sexual involvement until they are older, they do not rush out and have sex!

◆ Isn't talking about both abstinence and protection sending a double message?

Not if we give teens a clear message. It is 1 message—PROTECT YOURSELF—with 2 ways to say it. It is much like the message "Don't drink, but if you do—don't drive!" This message doesn't encourage drinking. But it lets teens know that if they don't follow the first piece of advice they should pay attention to the second. This type of message has been effective with teens.

◆ Why discuss sexual behavior and protection now?

There are good reasons to discuss sexual behavior and proper methods of protection with your teen as early as possible.

Teens who receive this information *before they begin having sexual intercourse* respond more positively. They are more likely to wait until they are older to have sex. They also are more likely to protect themselves when they do begin having sexual intercourse.

◆ What are the options?

- *Safer Choices* reminds students that the SAFEST way to protect themselves is to choose not to have sex. As a parent, you may want to repeat this message to your teen. The choice of not having sex is always available, even for those teens who have had sex before.
- Latex condoms protect against HIV, other STD *and* pregnancy. Other forms of birth control (like the pill or contraceptive foam) do not protect against HIV and other STD. They only protect against pregnancy.
- If latex condoms are used along with other contraceptives, they provide greater protection against HIV, other STD and pregnancy than other contraceptives alone.

Helping Teens Protect Themselves

◆ How can parents help?

There are several ways parents can help to ensure their teens protect themselves from HIV, other STD and pregnancy:

- Be open and willing to discuss these important issues with your teen in a nonjudgmental manner. When you talk, don't pry into your teen's present sexual behavior.
- Encourage your teen to learn how to use latex condoms before he or she needs them. Practicing this skill without pressure to have sex is the best way to be prepared.
- Share your values about relationships and responsibility. (For example, emphasize the importance of choosing not to have sex, or of protecting oneself and others from HIV, other STD and unintended pregnancy.)

Talking with your teen can help your teen make better choices.

Information & Resources

- CDC-INFO
  1-800-232-4636
  www.cdc.gov
- **National Campaign to Prevent Teen and Unplanned Pregnancy**
  www.thenationalcampaign.org

◆ Information About Condoms

Not having sex is the best way to prevent pregnancy, HIV and other STD. For people who have sex, using a latex condom during vaginal, anal or oral sex can greatly reduce the risk of infection or pregnancy.

Here are some facts about condoms: [1]

- **Condoms work!** Research shows that condoms are effective in preventing pregnancy and the spread of HIV and other STD. But they must be used correctly and consistently. When used correctly (called perfect use), latex condoms prevent pregnancy 98% of the time. Typical use prevents pregnancy 82% of the time.
- **Latex condoms block HIV.** Latex condoms form a barrier that can't be penetrated by microorganisms, including HIV. Natural membrane (e.g., lambskin) condoms do not block HIV.
- **Condoms must be used correctly to work.** Most condom failure is due to user error or inexperience.

  For example, condoms may break if they are pulled on instead of unrolled. They also break if they are used with an oil-based lubricant (e.g., Vaseline™) instead of a water-based one (e.g., Astroglide™, K-Y Jelly™). They can also be torn with teeth or fingernails.
- **Condoms should be stored in a cool, dry place.** They can be damaged when exposed to heat or sunlight.
- **Never use a condom after the expiration date** on the package.

[1] Hatcher, R. A., et al. 2011. *Contraceptive technology.* 20th rev. ed. New York: Ardent Media.

Parents' Corner

We talked to parents who are involved in Safer Choices *and asked them what other parents can do to help their children deal with HIV, other STD and pregnancy.*

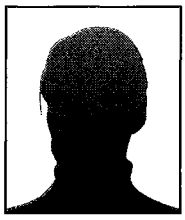
Q: What made you realize that your teen could be at risk for HIV, other STD and pregnancy?

Luisa: "When my daughter came back from camp and wanted to get an HIV test. That's when she broke down and said she'd had her first sexual encounter. I told her I'd take her to get tested and that I'd pay for it, but just that once. After she got tested, we talked about the importance of protection."

Alex: "From talking with other parents, I found out that many kids are sexually active. Once you know this, you realize they are at risk."

Terry: "My daughter had the idea that sex was part of the regular girl-boy relationship, even early in a relationship. I don't know where she got that from, maybe the TV. So we've had talks about that."

Q: Have you talked to your child about HIV, other STD and pregnancy?



Mary Ann: "Yes, I felt my three teenagers needed to be aware of these issues as soon as possible. Although my husband gets nervous about talking to the kids about sex, I don't. I started when they were in fifth grade. Health education is important; if they are informed, they can make informed decisions."

Ava: "When my daughter was 13, we sat down and talked about protection from pregnancy and STD. I said to her, 'I hope you will wait until after high school before you choose to have sex. But whenever you do, I want you to know how to protect yourself from getting pregnant, or an STD.'"

Alex: "Through *Safer Choices*, I learned that adolescents have a very high risk of being infected with an STD; this prompted me to have a discussion with my kids. I had another opportunity to talk with my daughter when she participated in the *Safer Choices* curriculum."

Q: What was difficult about discussing these issues with your child?

Mary Ann: "The hardest thing is that I want my children to wait until they get married, but I had to take the emotion out of it and talk to them about sex. I couldn't just ignore that sex is out there. If they choose to be sexually active, we will all have to deal with the consequences."

Jan: "The easiest way to bring it up was to talk about pregnancy. Last year, one of our cheerleaders got pregnant. There was obviously no protection there, so I used that as an opening."

Questions & Answers About Sexually Transmitted Disease (STD)

Do you know the facts about sexually transmitted disease? Test yourself and find out.

1. True or False. Sexually transmitted diseases (STDs) are not a problem for teenagers in the U.S.

❑ True ❑ False

2. True or False. STD can lead to serious health problems, especially if left untreated.

❑ True ❑ False

3. What are 3 of the most common STDs among teenagers?

_____

_____

_____

4. True or False. Teens can tell if they have an STD because the symptoms are easy to notice.

❑ True ❑ False

5. What is the best way for teens to protect themselves against STD?

_____

_____

_____

6. What should teens do if they think they may have an STD?

_____

_____

_____

(answers on back)

Questions & Answers About Sexually Transmitted Disease (STD)

Quiz Answers

1. **False.** STDs are a serious health problem for teenagers in the U.S. Young people ages 15 to 24 account for nearly half of the 20 million new cases of STD each year.*

2. **True.** Many STDs, if left untreated, can cause serious reproductive health problems for males and females. Some STDs can cause permanent sterility. Some, such as syphilis, can cause death if untreated.

3. 3 of the most common STDs among teenagers:
   - chlamydia
   - genital herpes
   - HPV (genital warts)

4. **False.** While many STDs have some common symptoms (e.g., sores or blisters around the genital area, a burning sensation while urinating, an unusual discharge from the penis or vagina), some STDs show no symptoms at all (chlamydia), and others may show no symptoms for years (HIV).

5. For teens, the best protection against STD is to choose not to have sex at this time in their lives. For teens who do have sex, the next best choice is using latex condoms *correctly every time* they have sex.

6. Teens who think they have an STD should go to a clinic or see a doctor. Many STDs (e.g., chlamydia, syphilis and gonorrhea) can be cured with no permanent damage, if they are treated quickly and properly. Many local clinics offer free or low-cost STD testing for teens.

How Did You Do?

Give Yourself:

1 point for each correct response (Question 3 is worth 3 points!)

Total Possible Score: 8 points

Your score:

7–8: Great job! Have you told your teenager what you know about preventing STD?

4–6: You know a lot about STD. Do you think your teenager would miss the same questions you did?

3 or Under: If you would like more information about STD, including HIV, call CDC-INFO: 1-800-232-4636 or visit www.cdc.gov/std.

* Centers for Disease Control and Prevention. 2014. *Reported STDs in the United States.* www.cdc.gov/nchhstp/newsroom/docs/STD-Trends-508.pdf.

Component 5

School-Community Linkages

About This Component

The School-Community Linkages component is designed to extend school-based activities and provide students with access to support and services outside of school. This reinforcement can further enhance students' ability to prevent HIV, other STD and pregnancy.

The primary activities include involvement of community representatives on the School Health Promotion Council, resource guides for students and staff, homework activities in which students gather information about local resources, and presentations by HIV-positive speakers.

Component 5

School-Community Linkages

Key Activities and Materials

1. **Recruit Community Representatives for the School Health Promotion Council**

2. **Develop Resource Guide**

3. **Encourage Completion of Homework Activities**

4. **Arrange for Presentations by HIV-Positive Speakers**

5. **Plan Other Community Activities**

Recruit Community Representatives for the School Health Promotion Council

The Council should include community representatives (e.g., health educator from local HMO or community-based organization, physician from local clinic). The procedures for recruiting community members for the Council are discussed in the section for Component 1.

When thinking about which community agencies to contact, it may be helpful to first identify any past or existing links your school has with community agencies that address teen and health issues. Staff at these agencies may be interested and available to participate. If they cannot participate themselves, they may know of other agencies to contact.

It is also helpful to think about the type of background, expertise and resources an agency can offer. Many community agencies are interested in working with schools, but have not had the opportunity or are not sure how to get involved. This project provides a unique opportunity for schools and local community representatives to work together on an important health issue for teens.

Develop or Use Existing Resource Guide

A Resource Guide that lists local resources related to HIV, other STD and pregnancy is an important feature of the *Safer Choices* program. The School Health Promotion Council will be responsible for developing or securing this guide. The format can vary, from a booklet to a wallet card.

It's important to tailor the guide to the local community and to include a range of resources, from information only (e.g., hotlines) to service-oriented resources (e.g., counseling and testing). The council may wish to send a survey to local organizations to have them list available services. It's recommended that the guide provide the following information in an easy-to-read format for each listing.

- Name and general description of services
- Address and phone number of agency
- Days and hours agency is open or providing a particular service
- Directions to agency on public transportation
- Eligibility criteria (e.g., age, insurance, gender)
- Cost
- Whether services are confidential or anonymous (e.g., HIV testing)

(continued)

Develop or Use Existing Resource Guide

(continued)

Many of the schools in the original *Safer Choices* study expanded the guide to include a range of health issues important for teens, such as abuse, alcohol, crisis counseling, eating disorders, education and work programs, rape and date rape, and suicide. Some schools also included a page that listed resources for parents, such as stress hotlines and poison control.

Sample listings for HIV, other STD and pregnancy resources from Resource Guides developed by schools in the original *Safer Choices* study are provided in Figure 4.

Figure 4

Sample Resource Guide Listings

HIV/AIDS and Other STD

Mayfield Community Clinic

HIV, other STD and pregnancy services

Address _____

Phone _____

Hours _____

CDC-INFO

1-800-232-4636

www.cdc.gov

Family Planning and Pregnancy

Heritage House

Pro-life home for pregnant girls. Religious school available for duration of pregnancy. Birthing classes, tutoring.

Address _____

Phone _____

Hours _____

Planned Parenthood

Pro-choice. Testing, counseling, birth control.

Address _____

Phone _____

Hours _____

National Campaign to Prevent Teen and Unplanned Pregnancy

www.thenationalcampaign.org

Ideally, Resource Guides should be distributed to each student at the school through the *Safer Choices* classes, a health class or science class. If wide distribution is not feasible, guides can be made available in a central location (e.g., nurse's office, *Safer Choices* Resource Area). Guides also should be distributed to all teachers (e.g., placed in their mailboxes or given out during a staff meeting) to inform them of local resources appropriate for teens.

Encourage Completion of Homework Activities

Each level of the *Safer Choices* curriculum includes homework activities regarding community resources. These activities are designed to help familiarize students with available resources related to HIV, other STD and pregnancy. For example, in one activity, students call or visit local health clinics to gather information regarding available services.

The curriculum provides details on when and how to use the homework activities. To help encourage participation, many teachers find it helpful to provide students with extra credit points for completing the assignment.

Arrange for Presentations by HIV-Positive Speakers

Lesson 3 of the Level 2 curriculum includes a presentation by an individual who has HIV. Speakers are drawn from local speakers' bureaus. The curriculum provides details about making arrangements for the presentation. Speakers also can be used in classes outside the *Safer Choices* curriculum, (e.g., during special assemblies, or as part of HIV-related staff development activities).

Although speakers are generally trained by their respective speakers' bureaus, it is important to meet with them ahead of time to review the program goals. This allows the speakers to reinforce key program messages during their presentations. This meeting also provides an opportunity for school personnel to review school policy regarding what can and cannot be discussed during the presentations. If there are no HIV speakers' bureaus in your area, teachers can use a video featuring HIV-positive individuals.

Plan Other Community Activities

The Council should be encouraged to plan and implement additional activities that focus on establishing linkages between the school and local community resources. Examples of Council-sponsored community linkage activities include:

- Develop a resource guide specifically for teachers, including advice on referral procedures and answering difficult questions.
- Recruit a local community organization to help the Peer Resource Team conduct small-group discussions.
- Conduct a Health Fair in cooperation with local organizations and clinics.
- Set up an information booth at community-sponsored Health Fairs.
- Arrange for Peer Team presentations at youth events sponsored by local organizations.
- Sponsor a food drive or walkathon for local HIV service agencies.
- Arrange for service activities with local service organizations.

Students Say...

A lady came to speak to us. She told us that she had AIDS. When she talked to us, she was so straight up with us and I really liked that. So I decided to wait a little longer before I become sexually active because I would hate to come up with HIV or an STD, or I would hate to get pregnant. I have a life ahead of me and I have goals. I plan on fulfilling all my goals and I'm not going to let anything or anyone stop me.

—Tracey, 14

Appendix A

Safer Choices: A Multicomponent School-Based HIV/STD and Pregnancy Prevention Program for Adolescents

Karin Coyle, Douglas Kirby, Guy Parcel, Karen Basen-Engquist, Stephen Banspach, Deborah Rugg, Marsha Weil

Abstract: *Given the serious consequences of HIV infection, other STD and pregnancy among teens, professionals must develop and evaluate new approaches to reduce risks associated with adolescent sexual behavior. The Safer Choices intervention is a comprehensive, theoretically based program designed to reduce risk behaviors and increase protective behaviors to prevent HIV, other STD, and pregnancy among high school adolescents. The program includes 5 components: a School Health Promotion Council involving administrators, school staff, students, parents, and community members; curriculum and staff development activities; school environment activities designed and implemented by a team of peer educators; parent education activities; and school-community linkage activities. The School Health Promotion Council is responsible for planning and overseeing program implementation. This article describes the theoretical framework, process for intervention development, and key intervention strategies used in Safer Choices.*

The human immunodeficiency virus (HIV) which causes AIDS has led to an epidemic unparalleled in recent history.[1] In the United States, an estimated 630,000 to 900,000 people currently are infected with HIV. As of October 31, 1995, 501,310 cases of AIDS had been reported to the Centers for Disease Control and Prevention (CDC).[2] Other sexually transmitted diseases (STDs) also present an increasing health threat. Some STDs such as chlamydia produce few symptoms yet lead to serious consequences such as infertility. Other STDs increase a person's risk of contracting HIV.[3]

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In the battle against the spread of HIV and other STD, youth represent an important target group. Although relatively few reported AIDS cases have occurred among adolescents, approximately 20% of cases exist among individuals in their twenties, many of whom probably were infected as adolescents.[4] Furthermore, approximately 3 million teens acquire an STD each year, a rate equivalent to roughly 1 in 8 youth ages 13-19 or 1 in 4 teens who have had sexual intercourse.[5] Likewise, unintended teen pregnancy represents yet another consequence of unprotected sexual intercourse. In 1990, there were approximately 835,000 pregnancies among teenagers, ages 15-19.[6] Most of the pregnancies produce a negative impact on the mothers' subsequent education and employment.[7]

Not all teens engage in risk behaviors, but a significant proportion practice behaviors that place them at risk for HIV infection, other STD and pregnancy. Approximately 56% of females and 73% of males have had intercourse before their 18th birthday.[8] Also, 37.6% of high school youth reported having sexual intercourse in the past 3 months.[9] Of these, only 52.8% reported using a condom the last time they had sexual intercourse.[9]

Evidence suggests school-based prevention programs can reduce unprotected sexual intercourse among teens.[10,11] Effective school-based prevention programs have been documented in other health areas as well.[12,13] Despite these successes, effect sizes for reducing risk-taking behavior are relatively small, and some evaluations had methodological limitations. Given the consequences of HIV

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infection, other STD, and unintended pregnancy, the field must build on what has been learned thus far, and test new programs using rigorous evaluations.

This paper describes the theoretical framework and key intervention components of *Safer Choices*, an innovative multicomponent program being tested in 20 schools in Texas and California. It also describes a systematic process for intervention development, which can enable practitioners to apply theory more effectively.

Overview of Safer Choices

The *Safer Choices* project seeks to develop and evaluate the effectiveness of a school-based intervention to reduce risk behaviors or increase protective behaviors to prevent HIV infection, other STD and pregnancy in students ages 14-18. *Safer Choices* includes 5 primary components: school organization, curriculum and staff development, peer resources and school environment, parent education, and school-community linkages.

The primary purpose of *Safer Choices* is to reduce the number of students engaging in unprotected sexual intercourse by reducing the number of students who begin or have sexual intercourse during their high school years, and by increasing condom use among those students who have sex. Secondary purposes include reducing the number of students who have multiple sexual partners or who use drugs, particularly injectable drugs, and increasing the number of students who seek HIV/STD counseling, testing, and consultation, of those students whose past or current behavior place them at risk for HIV/STD infection.

The Intervention Framework

Theoretical and Conceptual Foundations

Safer Choices uses a multicomponent approach that addresses change at the student, school, and community levels.[14] To increase the likelihood of producing behavioral changes, the program was designed to shape both individual and environmental influences. This approach has been applied successfully to other school-based health promotion programs.[13,15-18] The primary conceptual bases for the program include social cognitive theory,[19] social influence theories,[20-22] and school/change improvement models.[23-26]

Social cognitive theory holds that behavior is determined by interaction of personal, environmental, and behavioral influences. Personal factors include characteristics and cognitions that increase or decrease the likelihood of engaging in a particular behavior, such as level of knowledge, personal values, attitudes and beliefs, and perceived self-efficacy. Environmental factors include any aspect of the environment (social or physical) that supports or discourages a particular behavior, such as influential role models, social or normative support, and availability of facilities/resources. Finally, behavioral influences affect behavior directly and include factors such as current behavioral patterns and behavioral capabilities. Because these 3 influences constantly interact, *Safer Choices* addresses all 3 factors.

For example, given the goal of reducing unprotected sexual intercourse, personal factors of interest include functional knowledge (an understanding of what must be done to delay sex or to use protection), motivation (beliefs about the anticipated benefit of delaying sex or using protection), outcome expectancy (the belief that particular skills or methods of protection will be effective), and self-efficacy (the belief that one can use these skills or methods of protection effectively). Environmental factors include peer and parental norms regarding sex and use of protection, media influences, and access to appropriate health services. Behavioral influences include current behavioral patterns and behavioral skills to resist pressure to engage in unprotected sex.

Social cognitive theory also addresses the acquisition of new behaviors, acknowledging that people can learn these behaviors from a variety of experiences, including directly through education and experience and indirectly through observation of others' behavior and consequences of their behavior. As a result, the intervention includes cognitive and behavioral skills training as well as modeling.

Social influence processes address how people influence each other, directly and indirectly. Mechanisms of social influence include social norms, network membership, conformity pressures, media influences, social comparison and modeling.[20,21,27,28] Although differing in specifics, social influence approaches emphasize behavioral expectations and standards (social norms) present in the environment and prepare the learner to resist pressure to engage in risk-taking behavior.

One unique aspect of *Safer Choices* involves its focus on change within the school and the influence of the school environment on student behavior. Evidence for the potential of this approach can be found in studies of effective schools, in which a cluster of similar factors accounted for much of the variance in student outcomes.[23-26] While some factors related to curriculum and instruction, most pertained to school climate and educational culture such as high expectations for all students and the opportunity for meaningful student involvement.

Changes in school organization also offer a means to modify the school environment and culture to better support program goals. Research on effective schools identifies organizational factors such as policy and practices, organizational mission, and new structures and roles as important levers of institutional change.[25,26]

Due to the importance of school climate and organization, many of these elements were included in *Safer Choices*. For example, a School Health Promotion Council was formed at each intervention school. Each Council was responsible for formulating clear health promotion missions to guide their prevention efforts.

Program components also were designed to provide extensive opportunities for meaningful student involvement both inside and outside the classroom.

From Theory to Practice

To ensure theories were applied appropriately in the intervention, an intervention matrix was constructed to guide the development work (Figure 1). The first step in developing the matrix involved identifying determinants of behavior to be targeted, which included social norms, attitudes, functional knowledge, self-efficacy, and behavioral capability. These variables were selected based on existing evidence regarding their link to health behavior and the potential for changing them by using school-based intervention strategies.

The second step involved identifying specific aspects of each determinant on which to focus, based on theory and empirical literature. For example, with self-efficacy, the program focused on self-efficacy related to condom use and communication about not having sex or using condoms. These aspects of self-efficacy relate to individuals' intentions and actual behavior regarding decisions to have sexual intercourse and use condoms.[29,30]

The next step involved reviewing the theory to identify methods to change each determinant. For example, Bandura[19] posits that self-efficacy is influenced in 4 ways: mastery experiences (successful completion of a task), modeling (observing others similar to oneself perform a task successfully), social persuasion (information from others that one can perform the task successfully), and physiological arousal states (information from one's physiological state such as anxiety). Three of the 4 approaches were included: mastery experiences, modeling, and social persuasion. The fourth approach—feedback of physiological arousal states—is more appropriate for a clinical setting, and thus was deemed inappropriate for this intervention.

Finally, specific intervention strategies were developed. For example, to apply the concept of mastery experiences, a classroom curriculum was designed to include roleplay exercises in which students practice and receive feedback on refusal skills and condom use negotiation skills. The process of intervention development helped ensure that each program component was theoretically based, and enhanced the likelihood that program elements will produce the desired outcome.

Specific Intervention Components

School Organization. Drawing from the school improvement approach, which demonstrates that meaningful educational change does not occur without change in a school's social and organizational climate, a School Health Promotion Council was established at each program school. The Council serves as the organizational mechanism ensuring the intervention becomes schoolwide, and is an inherent part of the school environment and structure. Each Council includes parents, teachers, administrators, other staff, students, and members of local community agencies.

Each Council has a Site Coordinator, who is a representative of the school. This individual receives release time or a stipend to support coordination of Council activities. The Site Coordinator also serves as the liaison between the Council and other important school committees to ensure that the Council is an integral part of the existing school structure.

During program implementation, the Council works with *Safer Choices* Project staff to plan, conduct, and/or monitor activities for the 4 components: curriculum and staff development, peer resources and school environment, parent education, and community-school linkages (Figure 2). The activities are designed to effect change at the student and school levels, and to enhance students' connections at home and with relevant community resources.

Prior to program implementation, Council members participated in training activities and developed action plans for each component. To ensure program consistency across schools, intervention protocols were developed stipulating the type and quantity of program activities required for each component. For some components, schools were expected to tailor the content and format to meet the needs of their students. During the school year, Councils meet monthly to plan and coordinate project activities. Council members also meet in small work groups as needed to follow through with planned activities. Specific examples of Council-sponsored activities from the first year of the project are described below for each of the components.

Curriculum and Staff Development. The curriculum consists of separate 10-lesson series for ninth and tenth grade students. The tenth grade series reinforces and builds on the ninth grade lessons. The curriculum is based on *Reducing the Risk: Building Skills to Prevent Pregnancy, STD and HIV* (RTR), which was effective in reducing unprotected intercourse among youth who had not yet initiated intercourse.[31] Consistent with social cognitive theory and social influence models, the lessons address attitudes and beliefs (including self-efficacy), social skills (particularly refusal and negotiation skills), functional knowledge, social and media influences, peer norms, and parent-child communication.

The lessons clearly and consistently highlight that it is not healthful to engage in unprotected intercourse. The norm against unprotected sex is reinforced throughout the curricula using the *Safer Choices* paradigm. The paradigm emphasizes that, in most cases, young people have choices about sex. Some choices, such as having sex without using latex condoms and other methods of protection, having sex before a person is ready, or having sex when a person does not want to, are unsafe choices. Young people who choose to have sex should use protection for HIV infection, other STD and pregnancy correctly, every time. The safest choice is to not have sex, even if a person has had sex before.

One important curriculum feature involves use of a systematic approach for skill development, based on social cognitive theory methods. The approach includes clear explanations of skills to be learned, ample opportunity for skill practice, and positive as well as corrective feedback. For example, one refusal skill involves use of clear "no" statements. First, students learn and discuss characteristics of clear "no" statements and the context in which the skill can be used. Students see the skill modeled, then practice the skill in large and small groups. Finally, students receive feedback on their performance and discuss ways to strengthen use of the skill. Practice situations are structured to increase in difficulty during the curriculum to enhance students' sense of self-efficacy about performing the skill.

The curriculum is implemented by classroom teachers trained by project staff; teachers also receive on-site technical assistance and coaching.

To capitalize on peer modeling, the curriculum uses students as facilitators for selected activities. Five to 8 students from each classroom (roughly 20% of each class) are elected by their classmates as peer leaders. These students receive approximately 3 hours of additional training, and are asked to model skills and assist with small-group activities such as leading small-group brainstorming and organizing small-group roleplaying. This approach has been used successfully in other programs.[12,32,33]

Although the curriculum is taught by classroom teachers, the *Safer Choices* Councils supported the curriculum implementation in important ways. For example, Council members coordinated tasks such as preparing parent consent letters, holding parent information meetings, handling parent calls regarding the curriculum, and assisting with training for in-class peer leaders. Councils also conducted faculty inservice activities on HIV/AIDS and the project as a whole.

Peer Resources and School Environment. Lessons and messages students learn outside the classroom can be as powerful as messages learned in the classroom.[34] Thus, the major purpose of this component is to saturate the school environment with activities, information, events, and services to reinforce key messages of the classroom-based instruction, and to create an environment that supports HIV, other STD and pregnancy prevention. Targeting the school environment through peer education also provides positive role models for students on campus; reinforces norms against unprotected sex; provides youth with opportunities to help one another; and empowers youth through meaningful involvement and establishment of personal responsibility for HIV, other STD and pregnancy prevention.

A representative group of students were trained as peer facilitators at each intervention school. These students, who function separately from the curriculum-based peer leaders, are organized and recognized as *Safer Choices* Peer Teams. Members meet regularly with an adult Peer Coordinator to plan and host 6 types of activities aimed at altering the normative culture of the school: use of the school newspaper or other schoolwide media; school opinion polls; public forums such as public speakers and special assemblies; small media such as posters, buttons, audio tapes, T-shirts, and rap music contests; small-group discussion sessions; and drama productions. The Peer Teams also run a resource area on campus for students and staff.

Safer Choices staff developed protocols for the Peer Teams to guide development of these schoolwide activities. Protocols specify the minimum number and type of activities conducted each year, and outline important steps for a positive experience. Students design and tailor each activity to meet the needs of their school's population. This flexibility is imperative in promoting program ownership and maintaining students' interest in the program.

To augment the peer-developed activities, *Safer Choices* staff developed role model stories as another intervention strategy aimed to model positive behaviors. As part of this strategy, teenagers were recruited to tell their personal experiences in practicing healthful behaviors, such as choosing not to have sex, avoiding unprotected sex, and getting and using condoms. The stories were anonymous and were presented in a small, colorful, monthly calendar. This role model story approach has been used successfully in cancer prevention programs for adults[35,36] and is being applied in HIV prevention for adults and adolescents.

Parent Education. Parents, guardians and other family members play a key role in influencing youths' behavior.[37] The parent education component is designed to help parents provide accurate information to their children, and to reinforce the norm that youth should avoid unprotected intercourse.

Parents receive project newsletters 3 times each year. The focus of the newsletter varies each issue. The introductory newsletter includes background information on the project. The second and third newsletters provide information regarding HIV and AIDS, other STD and pregnancy; they also include tips on talking with teens about these issues, and quotes from parents who have discussed these issues with their children to serve as role models for other parents.

The curriculum also includes 2 student/parent homework activities at each grade level. These activities facilitate adult/teen communication regarding HIV, other STD and pregnancy. For example, in one activity, teens and their parents (or another adult) list and discuss reasons why it is difficult to talk about sensitive issues such as relationships and sexuality; they then identify ways to make these discussions easier.

Finally, the Councils include parent representatives, and are encouraged to offer additional activities that focus on assisting parents in communicating with their children about sexuality. Examples of Council-sponsored parent activities include back-

to-school night activities to introduce parents to the project, a multicultural/multilingual event during which physicians from a local clinic provided information and answered questions about HIV infection and other STD, and a parent night that featured students' skits about AIDS.

School-Community Linkages. This component extends the school-based activities and provides students with access to support and services outside of school. This reinforcement can further enhance students' behavioral capability in preventing HIV infection, other STD and pregnancy. One important aspect of this component is the involvement of community representatives on each School Health Promotion Council. A second aspect is classroom homework, which requires students to gather information about local resources. For example, students call or visit local health clinics to gather information regarding available services.

Another emphasis of this component involves working with schools to assess and strengthen school-community linkages. Each School Health Promotion Council is charged with developing a resource guide of youth service agencies. The Council distributes the guide to students, and provides training for school personnel regarding the services and the school's referral procedures.

Conclusion

Rates of STD and pregnancies among teens are sufficiently alarming to call for more innovative and effective prevention programs. As HIV continues to spread in the adolescent population, it becomes even more imperative to develop and evaluate new approaches to reduce risks associated with adolescent sexual behavior. School-based programs to prevent and reduce sexual risk-taking behavior are attractive because of the potential for reaching large numbers of adolescents and influencing the norms for sexual behavior. These advantages, however, are tempered by the reality that many approaches used in school programs have not been effective in reducing the risk for HIV infection, other STD or pregnancy.

The *Safer Choices* program represents a comprehensive approach that uses multiple components. Additionally, the program uses theory-based intervention strategies to influence determinants of protective behavior. The design of the *Safer Choices* program followed a systematic process for intervention development. This process consists of (1) building on the empirical findings from prior evaluation studies of school health promotion programs, (2) using theoretical and empirical support for identifying the determinants of the behavior, (3) selecting intervention methods known to be effective in changing the determinants, (4) translating methods into practical strategies compatible with existing teaching and program practices, and (5) preparing program implementors to conduct the program. Given the limits of past research, it is important to demonstrate that school-based interventions can have sufficient power to yield meaningful effects. The multicomponent *Safer Choices* program provides a basis to test the effectiveness of a comprehensive school-based intervention.

Safer Choices currently is being evaluated using a randomized trial involving 20 schools—10 schools in southeast Texas and 10 schools in northern California. Within each site, the schools were randomly assigned to the multicomponent intervention (*Safer Choices*) or the comparison condition (a standard knowledge-based curriculum). Both process and outcome data are being collected to assess the extent of implementation, the overall effectiveness of the intervention, and the relationship between implementation and student outcomes.

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Figure 1
Intervention Matrix

Determinants	Theoretical Methods	Intervention Strategies (Examples)
Self-Efficacy		
Communicating about choosing not to have sex and using condoms if having sex Condom use (getting and using) Refusing to use alcohol/other drugs	Modeling: Observing others similar to the learner perform the task successfully	Modeling: Teacher and peer leader demonstrations of targeted skills via roleplays; teacher demonstration of condom use; use of role model stories (personal stories by individuals who are similar to members of target audience); drama productions
	Mastery experiences: Successful completion of a task	Mastery experiences: Roleplays requiring use of targeted skills; guided practice using condoms; practice reading condom packaging
	Social persuasion; Information from others that the learner can perform the task successfully	Social persuasion: Peer leaders in the classroom; parent/child homework activities
Norms		
Delaying sex Condom use Changing behavior Avoiding alcohol/drug use, particularly in high-risk situations	Create a secondary reference group that is supportive of preventive behavior	Form groups of peer facilitators who plan and implement schoolwide activities such as assemblies, contests, small media materials, and small-group discussions
	Provide information about peers' attitudes and behavior	Conduct student opinion polls; data on rates of sexual behavior among similar age groups
	Elicit feelings of group cohesion and social responsibility in groups affected by HIV/AIDS	Drama production about HIV/AIDS; presentations by HIV-positive speakers
	Use opinion leaders to influence norms	Recruit students who are leaders of various formal and informal groups to be peer facilitators
Attitudes		
Delaying sex Condom use Changing behavior Avoiding alcohol/drug use, particularly in high-risk sexual situations	Source: Should be credible with expertise and trustworthiness (familiar with topic, similar to target, attractive, moderately discrepant position on issues, no vested interest, liked by target, higher social position)	Use well-liked peers to assist in classroom curriculum, plan and implement schoolwide activities, etc; develop parent-child homework activities and small media materials for parents

(continued)

Figure 1 (continued)
Intervention Matrix

Determinants	Theoretical Methods	Intervention Strategies (Examples)
Attitudes *(continued)*	Message: Message involving a moderate amount of fear arousal will lead to longer retention and more consistent behavioral compliance; two-sided messages will be effective if target is somewhat knowledgeable, but initially opposed; meld new concepts with existing knowledge	Some messages (messages from an HIV-positive speaker or video featuring HIV-positive individuals) may arouse fear in some students as they clarify perceptions of their own risk; however, most of the messages will be positive, such as presenting advantages of choosing not to have sex or using condoms. When advantages of choosing not to have sex and condoms are presented, disadvantages and how to overcome them also will be discussed. Sequencing of messages ensures new concepts meld with existing knowledge
	Receiver: Should be involved actively in developing arguments, presenting messages, etc.; making commitment to change will result in more retention of attitude change	Use roleplays and other activities in which students advocate preventive behavior; use parent interview; use commitment activity
	Channel: Should attract the attention of target audience	Use a variety of channels attractive to students, such as posters, small media materials, drama productions, etc.
	To increase consistency between attitudes and behavior, provide cues in environment to make attitude accessible	Messages infused into all intervention components
Skills	Observation/modeling	Observation of roleplays and skill demonstrations showing use of targeted skills
Refusal/negotiation Condom use Decision making/setting limits	Breakdown of skill into simpler tasks Guided practice with feedback	Identify and teach steps of each targeted skill Large-group and small-group practice of skills such as using roleplays or pair practice; feedback by teachers; having students give each other feedback in small-group roleplaying
	Contracting/self-monitoring	Commitment activity

Appendix B

Safer Choices: Reducing Teen Pregnancy, HIV, and STDs

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Objectives: *This study evaluated the long-term effectiveness of Safer Choices, a theory-based, multi-component educational program designed to reduce sexual risk behaviors and increase protective behaviors in preventing HIV, other STDs, and pregnancy among high school students.*

Methods: *The study used a randomized controlled trial involving 20 high schools in California and Texas. A cohort of 3869 ninth-grade students was tracked for 31 months from fall semester 1993 (baseline) to spring semester 1996 (31-month follow-up). Data were collected using self-report surveys administered by trained data collectors. Response rate at 31-month follow-up was 79%.*

Results: *Safer Choices had its greatest effect on measures involving condom use. The program reduced the frequency of intercourse without a condom during the three months prior to the survey, reduced the number of sexual partners with whom students had intercourse without a condom, and increased use of condoms and other protection against pregnancy at last intercourse. Safer Choices also improved 7 of 13 psychosocial variables, many related to condom use, but did not have a significant effect upon rates of sexual initiation.*

Conclusions: *The Safer Choices program was effective in reducing important risk behaviors for HIV, other STDs, and pregnancy and in enhancing most psychosocial determinants of such behavior.*

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School-aged adolescents are an important target population for health promotion programs, particularly programs addressing sexual behaviors. The number of AIDS cases among adolescents and young adults ages 13 to 24 remains relatively small (26,518 reported cases through June, 2000);[1] however, it has been estimated that approximately one-half of all new HIV infections occur among young people between the ages of 13 and 24.[2] In addition, roughly one in four adolescents ages 13-19 who have had sexual intercourse acquire an STD each year.[3] Finally, approximately 10% of 15- to 19-year-old females become pregnant each year;[4] an estimated 85% of these pregnancies are unintended.[5]

Numerous HIV, other STD, and pregnancy prevention programs have been implemented in secondary schools across the nation, but relatively few have had a significant effect on sexual risk behaviors,[6] or the effects have been modest or short term.[7-10] Given the significant consequences of unprotected sexual intercourse for adolescents and the limited results of past HIV, other STD, and pregnancy prevention studies, we developed *Safer Choices,* an innovative multi-component program.

Safer Choices is a 2-year, school-based HIV, other STD, and pregnancy prevention program for high school students. It has recently been identified as a "program that works" by the Centers for Disease Control and Prevention (CDC). The primary aim of *Safer Choices* is to reduce the number of students engag-

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ing in unprotected sexual intercourse by reducing the number of students who begin or have sexual intercourse during their high school years and by increasing condom use among those students who have sex. In addition, the program seeks to modify several factors related to sexual risk-taking behavior: knowledge about HIV and other STDs; attitudes about sexual behavior and condom use; normative beliefs regarding sexual intercourse and condom use; students' beliefs in their ability (self-efficacy) to refuse sexual intercourse or unprotected sexual intercourse, use a condom, and communicate about safer sexual practices; perceived barriers to condom use; perceived risk of becoming infected with HIV or other STDs; and communication with parents.

This randomized controlled trial tested the effects of *Safer Choices.* We hypothesized that adolescents who received *Safer Choices* would initiate sexual intercourse at a slower rate than adolescents in the comparison group. We also hypothesized that adolescents in the intervention group who had ever had sexual intercourse would have unprotected intercourse fewer times and with fewer partners in a 3-month period than would adolescents in the comparison group, after adjustment for individual-level baseline values. Further, we hypothesized that students in the intervention group who reported sexual intercourse would report fewer sexual partners, greater condom use at first intercourse (among those who initiated intercourse during the study), greater contraceptive use at last intercourse, less alcohol and drug use prior to sexual intercourse, and more frequent testing for HIV and other STDs. Finally, we hypothesized that intervention students would score more favorably on the psychosocial scales than would comparison students.

The evaluation results after the first year of program implementation showed a positive effect on condom use and most psychosocial mediating variables among students in the cohort.[11] In this paper, we discuss the 31-month follow-up results, conducted approximately one year following the intervention.

Methods

Procedures and assignment. The *Safer Choices* intervention was implemented during the 1993-1994 and 1994-1995 school years. The evaluation used a randomized controlled trial involving 10 public schools in an urban area in northern California and 10 public schools in an urban area in southeast Texas. The schools ranged in size from 961 to 2733 students (mean = 1767). Five schools in each state were randomly assigned to the *Safer Choices* program; the remaining schools were assigned to a comparison program (a standard, knowledge-based HIV prevention curriculum). We used a restricted randomization process in which schools were ranked based on an index score of possible confounding variables (such as percent college bound and number of students in school); adjacent schools in the ranking were then paired and randomly assigned to either the intervention or control condition.[12] The school districts were chosen because they served diverse populations in terms of ethnicity and socioeconomic status, were in areas of the country with high HIV prevalence rates, and were in close proximity to the investigative team. We chose districts in two different areas of the country to improve the generalizability of study results.

We collected self-report data from a cohort of ninth-grade students at all 20 schools using trained data collectors. The baseline data were collected in fall 1993, immediately before the intervention. Follow-up data were collected in spring 1994 (7 months after baseline and immediately following the first year of the intervention), spring 1995 (19 months after baseline and immediately following the second year of the intervention), and spring 1996 (31 months after baseline and 12 months following the second year of the intervention).

Active parental consent was required for survey participation; 80% of students returned parental consent forms (5184 of 6488); a total of 4733 students had consent to take the survey. Baseline surveys were completed by 91% of these students. Because schools were the unit of randomization, we used multi-level statistical analyses to account for the clustering of students within schools. A detailed discussion of the evaluation methods is published elsewhere.[12] We also collected cross-sectional data at three time points to assess the school-wide effects of the intervention. The cross-sectional results are presented in a separate paper.[13]

Participants. The cohort consisted of 3869 ninth-grade students who completed the baseline survey in the fall of 1993 and who were officially enrolled in the second year of the intervention (fall 1994). We excluded students (at both intervention and comparison schools) who were in 11th or 12th grade; we also excluded students who left school during the 1993-1994 school year and did not reenroll in the fall for the 1994-1995 school year. These criteria were adopted because the intervention program was multi-year. Baseline demographic characteristics for the cohort are summarized in Table 1.

A total of 3058 (79%) of the 3869 students in our final cohort were surveyed at the 31-month follow-up. Response rates for the 7-month and 19-month follow-ups were 95% and 83%, respectively.

Intervention. The *Safer Choices* intervention is based on social cognitive theory,[14] social influence theory,[15-17] and models of school change.[18] The program consists of five primary components: school organization (a School Health Promotion Council involving teachers, students, parents, administrators, and community representatives); curriculum and staff development (a sequential 20-session classroom curriculum for 9th- and 10th-grade students that includes 10 sessions at each grade level taught by trained teachers); peer resources and school environment (a *Safer Choices* peer team or club that hosts school-wide activities); parent education (activities for parents including parent newsletters, student-parent homework activities, and other parent events); and school-community linkages (activities to enhance students' familiarity with the access to support services

outside school, such as homework to gather information about local services, resource guides, presentations by speakers who are HIV-positive). The Figure includes a brief overview of each component. A more detailed description of the intervention is provided elsewhere.[19]

During each year of the program, intervention schools implemented activities across all five components. Students received their most intensive exposure to the program from the 20-lesson curriculum and school-wide, peer-sponsored events.

Measures. The survey consisted of items assessing demographic characteristics, sexuality-related psychosocial factors, sexual behaviors, and program exposure. The psychosocial scales were: HIV knowledge; other STD knowledge; attitudes about sexual intercourse; attitudes about condoms; normative beliefs about sexual intercourse; normative beliefs about condoms; self-efficacy in refusing sex; self-efficacy in using condoms; self-efficacy in communicating with partners; barriers to condom use; HIV risk perceptions; other STD risk perceptions; and communication

Table 1

Baseline demographic characteristics of the Safer Choices student cohort sample (*N* = 3869)

		Baseline survey data intervention group (n = 1983)		*Baseline survey data comparison group (n = 1886)*	
Characteristic	***Category***	Number	Percent	Number	Percent
Race/ethnicity	African American	384	19.6	270	14.5
	Asian	267	13.7	418	22.4
	Hispanic	562	28.7	491	26.3
	White	591	28.7	576	30.9
	Other	151	7.7	111	5.9
Gender	Male	981	49.7	874	46.4
	Female	994	50.3	1008	53.6
GPA	Mostly A's and B's	936	48.1	958	51.6
	Mostly B's and C's	789	40.5	694	37.4
	Mostly C's and D's	196	10.1	188	10.1
	Mostly D's and F's	25	1.3	18	1.0
Parent student lives with most of time	Both parents	1224	62.2	1278	68.3
	One parent	519	26.4	395	21.1
	Neither parent	225	11.4	197	10.5
Mother's education	<High school	266	13.5	261	13.9
	High school graduate	426	21.6	369	19.7
	Some college	396	20.1	324	17.3
	College graduate	546	27.7	658	35.1
	Not sure	339	17.2	265	14.1
Father's education	<High school	215	10.9	222	11.8
	High school graduate	350	17.7	255	13.6
	Some college	268	13.6	236	12.6
	College graduate	697	35.3	827	44.1
	Not sure	442	22.4	336	17.9
Ever had sex	Yes	609	31.1	474	25.5
	No	1348	68.9	1388	74.5
Had sex in the last 3 months	Yes	367	18.9	287	15.5
	No	1574	81.1	1561	84.5
Used a condom at last intercourse (among students who have had sex)	Yes	351	60.5	254	56.3
	No	229	39.5	197	43.7

with parents. The scales and their psychometric properties are discussed in more detail elsewhere.[11,12,20]

Primary outcomes. The survey measured three primary behavioral outcomes: (a) whether students delayed initiation of sexual intercourse; (b) the number of times students had intercourse without a condom in the last three months (among those reporting intercourse); and (c) the number of sexual partners with whom students had intercourse without a condom in the last three months (among those reporting intercourse).

Secondary outcomes. The survey also assessed numerous secondary behavioral outcomes: use of a condom at first intercourse among students who initiated sexual intercourse following baseline; use of protection at last intercourse; number of times had sexual intercourse in the last three months; number of sexual partners in the last three months; use of alcohol or drugs before sexual intercourse in the last three months; and being tested for HIV and for other STDs. The survey item assessing use of protection at last intercourse was analyzed as two dichotomous variables: use of a method that effectively protects against HIV and other STDs (condom) and use of a method that effectively protects against pregnancy (condom alone, condom and birth control pills, birth controls pills alone).

Statistical analysis. Multilevel models were used to adjust for the correlation between students within schools, and correlation within students because of repeated measurements over time. The three-level models included survey measurement occasion as level 1, students as level 2, and school as level 3. We used linear and logistic multilevel models to analyze continuous and dichotomous data, respectively, and Poisson or negative binomial multilevel models to analyze count data. The negative binomial regression model is a generalization of the Poisson regression model and is often used for modeling over-dispersed count data in which the variable of interest is the number of occurrences during a given time period. We carried out computations for the multilevel models using MLn Software for Multilevel Analysis, Version 1.0a.[21]

Figure

Features of the Safer Choices program

Program component	*Features*
School organization	*A School Health Promotion Council involving teachers, students, parents, administrators, and community representatives.* The Council plans and conducts program activities.
Curriculum and staff development	*A sequential, 20-session classroom curriculum for ninth- and tenth-grade students (10 lessons at each grade level).* The curriculum includes in-class peer leaders to facilitate selected activities (e.g., leading small-group role playing) and is implemented by classroom teachers trained by project staff.
Peer resources and school environment	*A* Safer Choices *peer team or club at every school.* The club members meet with an adult peer coordinator to plan and host six types of school-wide activities designed to alter the normative culture of school. Peer teams also run a resource area on campus. Additionally, project staff developed role model stories in which teens tell their personal stories modeling positive behaviors; the stories are presented in a poster format (and were presented in a monthly calendar during the study).
Parent education	*Activities for parents.* Parents receive three project newsletters a year that provide information about the program; functional information regarding HIV/AIDS, other STDs, and pregnancy; and tips on talking with teenagers about these issues. The curriculum includes student-parent homework activities to facilitate communication regarding HIV, other STDs and pregnancy. Parents also serve on the health promotion councils and help plan other parent-related events.
School-community linkages	*Activities designed to enhance students' familiarity with and access to support services outside school.* The curriculum includes homework assignments requiring students to gather information about local resources and services. It also includes a lesson in the 10th grade involving HIV-positive speakers. Students and teachers receive resource guides that provided a list of HIV, other STDs, and pregnancy-related services for adolescents.

NOTE: The published program materials are available for purchase through ETR Associates 1-800-321-4407 (customer service).

We examined the effect of the intervention from baseline to the final follow-up measurement, a period of approximately 31 months. The analyses included the baseline and three follow-up measures of each outcome to provide a test of the overall intervention effects. The follow-up measures were modeled as dependent variables in random effects models. We modeled the following variables as predictors for each outcome: participants' baseline responses on the outcome; intervention group; geographic location (Texas or California); an intervention group-by-geographic location interaction term; measurement occasion; intervention group-by-measurement occasion interaction terms; and a set of outcome specific covariates. We also created a variable representing the number of weeks between baseline and follow-up, and a variable denoting whether the survey data were collected via mail or in school. Variables were included as covariates for a particular outcome if they were significantly related to the outcome and intervention condition, and remained significant in the final state of multilevel modeling. The multilevel models provided a flexible framework for handing missing data. Students with incomplete data (missing one time point, for example) were included in the analysis and contributed to the estimation of the overall intervention effects across time. Students with missing data on the covariates were excluded from the analyses.

We used two-tailed tests and made no adjustments for multiple tests of significance. Our primary and secondary hypotheses were stated a priori and were limited in number. All other analyses beyond those for the primary and secondary hypotheses were considered exploratory. Statistical significance was set at $P \leq 0.05$.

Estimates of the magnitude of effects were calculated for all outcomes. We used odds ratios to estimate overall effects for dichotomous behavioral variables. The effects for the Poisson or negative binomial models represent the ratio of the adjusted mean for the intervention group to the adjusted mean for the comparison group. Thus, an effect size of 1.00 indicates no difference, <1.00 indicates a lesser mean for the intervention group relative to the comparison group, and >1.00 indicates a greater mean for the intervention group relative to the comparison group. For the psychosocial variables, we used group coefficients from the multilevel models as an expression of effect size. This approach to estimating the magnitude of program effects was used because further computations of effect size (for example, conversion to Cohen's d or r family effect sizes) would not fully use all the elements of the multilevel analytic model. These group coefficients represent the difference between the two adjusted means (intervention vs. comparison group) on the scale of the outcome variable being measured (such as HIV knowledge or self-efficacy for refusing sex). Because the coefficients are unstandardized, only those that are measured on the same scale can be compared.

Results

Estimates of the average overall effects of the intervention are presented for the behavioral and psychosocial measures over the 31-month follow-up period. We also discuss trends over the three follow-up assessments.

Behavioral factors. Among the primary outcomes, all three were in the desired direction and two were statistically significant (Table 2). Sexually experienced students in the intervention schools reported having intercourse without a condom fewer times during the three months preceding the follow-up survey than did sexually experienced students in the comparison schools ($P = 0.05$) by a ratio of 0.63. The group-by-location interaction was significant for this variable ($P = 0.05$); it indicated the effects were greater in Texas than in California. Similarly, *Safer Choices* students reported having fewer partners with whom they had sexual intercourse without a condom during the previous three months than did sexually experienced students in the comparison schools ($P = 0.02$); the ratio of the adjusted means was 0.73. We found no statistically significant difference in the incidence of sexual initiation between students in the *Safer Choices* and comparison schools at the final follow-up; the effect was in the desired direction (odds ratio = 0.83), but not close to significant ($P = 0.39$).

Among the secondary outcomes, students who reported having sexual intercourse during the three months prior to the survey in the intervention schools were 1.68 times more likely to have used condoms ($P = 0.04$), and 1.76 times more likely to use an effective pregnancy prevention method (birth control pills, birth control pills plus condoms, or condoms alone) ($P = 0.05$) at last intercourse than were students in the comparison schools.

We found no significant differences at final follow-up between intervention conditions on any other secondary behavioral outcomes after we adjusted for baseline values ($P = 0.16$ to 0.51), although the mean differences between the two groups are in the desired direction for five of the six remaining outcomes.

Psychosocial factors. Table 3 shows the results of the multi-level analyses for the 13 psychosocial scales. Significant differences—all favoring the intervention schools—were found for 7 of the 13 psychosocial scales. Intervention students scored significantly higher than comparison students on the HIV and other STD knowledge scales (by an adjusted mean difference of 11 and 9 percentage points); expressed significantly more positive attitudes about condoms ($P = 0.01$); and reported greater condom-use self-efficacy ($P = 0.00$), fewer barriers to condom use ($P = 0.01$), and higher levels of perceived risk for HIV ($P = 0.02$) and other STDs ($P = 0.04$). Intervention students also reported greater normative beliefs about condom use and more communication with parents than did comparison students; these differences neared significance ($P = 0.06$ for each variable).

There were no significant differences between students in the two program groups in their attitudes regarding sexual intercourse ($P = 0.95$), normative beliefs regarding sexual intercourse ($P = 0.79$), self-efficacy to refuse sex ($P = 0.10$), or self-efficacy to communicate with a partner about sexual limits ($P = 0.60$).

There were two significant group-by-location interactions—knowledge about other STDs and condom use self-efficacy. The data suggest the effects on other STD knowledge were greater in Texas than in California, and the effects on condom-use self-efficacy were greater in California than in Texas.

Table 2

Parameter estimates for multilevel models of behavioral variables: cohort sample, 31-month follow-up

Behavior variable	*n*[a]	*Estimated effect size*[b]	*Standard error*	*Ratio of group estimate to group standard error*	*95% CI*	*P*
Primary outcomes						
Sexual initiation	2029	0.83	0.22		0.54, 1.27	0.39
Frequency of intercourse without a condom in last 3 months	1371	0.63	0.23	-1.97[c]		0.05
Number of sexual partners without a condom in last 3 months	1371	0.73	0.14	-2.37		0.02
Secondary outcomes						
Use of condoms at first intercourse (among initiators only)	733	1.44	0.27		0.85, 2.44	0.17
Use of condoms at last intercourse	549	1.68	0.25		1.02, 2.76	0.04
Use of protection against pregnancy at last intercourse	549	1.76	0.29		1.01, 3.07	0.05
Number of times had sexual intercourse in last 3 months	1371	0.81	0.13	-1.61		0.12
Number of sex partners in last 3 months	1371	1.02	0.13	0.13		0.89
Use of alcohol and other drugs before sex in last 3 months	1371	0.04	0.04	0.97		0.33
Tested for HIV	3616	1.20	0.24		0.75, 1.92	0.45
Tested for other STDs	3627	1.52	0.30		0.85, 1.13	0.16

n[a] represents the number of individuals included in the analyses. The tests of significance are based on the number of observations rather than the number of individuals. Each individual had from two to four observations.

[b] Odds ratios were used to estimate overall intervention effects for dichotomous outcomes; ratio of adjusted means was used to estimate over-all effects for Poisson or negative binomial models.

[c] Group-by-location interaction was significant at $P = 0.05$; ratio of interaction estimate to interaction standard error = 2.57.

CI = confidence intervals

Trends over time. As discussed in the analysis section, we included group-by-time interaction terms in the multilevel models to examine changes in the magnitude of effects over time. These interaction terms demonstrate that both the behavioral and psychosocial effects endured over the 31-month follow-up period. Only one of the interaction terms (number of partners unprotected) was statistically significant ($P = 0.04$); it indicated that the intervention had a smaller effect at the final follow-up relative to the first follow-up. The other group-by-time interaction terms also indicated that the intervention effects diminished somewhat over time [data not shown], although not to a significant degree.

We also analyzed the data following each time period to examine the average effects up to a given time point. (For example, at the 19-month follow-up the effects represent the average of the 7-month and 19-month results.) The majority of the findings were relatively consistent over time. Among the behavioral factors (Table 4), four were consistently significant at one of the three follow-up assessments: frequency of intercourse without a condom in the previous three months; number of partners with whom students had sex without a condom; use of a condom at last intercourse; and use of protection against pregnancy at last intercourse. Three of these four outcomes were statistically significant and favored the intervention at the 7-month follow-up; one of the four was statistically significant at the 19-month follow-up; and all four were statistically significant by the final follow-up.

Among the 13 psychosocial variables (Table 5), 9 were significant and favored the intervention condition among cohort students at the 7-month and 19-month follow-ups. They were HIV knowledge, other STD knowledge, attitudes about condoms, normative beliefs about condoms, self-efficacy in using condoms, barriers to condom use, HIV risk perceptions, other STD risk perceptions, and communication with parents. Seven of these variables remained significant at the 31-month follow-up (all but normative beliefs about condoms and parent communication, which were both significant at ($P = 0.06$).

Discussion

Our findings suggest that the *Safer Choices* program produced numerous positive and programmatically important effects among cohort students. In general, *Safer Choices* had a consistent effect on condom use and use of other protective methods. It also had a positive effect on most of the psychosocial variables, particularly HIV and other STD knowledge and variables related to condom use.

Among students who reported having sexual intercourse, the *Safer Choices* students had decreased intercourse without a condom by slightly more than one-third. Although multi-level analyses do not enable direct calculation of the adjusted means, we can extrapolate from the raw means. Over the study period, students in the comparison group reported having intercourse without a condom an average of 3.82 times during the previous three months. An effect size of 0.63 indicates that, after proper adjustments, students in the intervention group had intercourse without a condom an average of 2.40 times. The results also suggest that *Safer Choices* students reduced the number of sexual partners with whom they had intercourse without a condom by nearly one-quarter: comparison students reported having unprotected sex with an average of .69 partners during the three months prior to the follow-up survey, and *Safer Choices* students reported .50 partners. The *Safer Choices* students also significantly increased the use of condoms and pregnancy prevention methods (condoms, birth control pills, condom plus birth control pills) at last intercourse.

Counter to our expectations, the intervention did not significantly delay the onset of sexual intercourse, although the effect was in the desired direction for this variable. Notably, the intervention clearly did not hasten the onset of intercourse. The program emphasized choosing not to have sex as the safest choice for preventing HIV, other STD, and unplanned pregnancy; nearly all lessons in the curriculum reinforced this message. Many of the school-wide activities also emphasized the importance and value of choosing not to have sex. It is possible that the social norms supporting sexual activity were too strong for such an intervention to reverse. Indeed, from one-fourth to one-third of the students in the study had reported having sex at baseline, and many others were probably considering it before the intervention began. Given the potential influence of such norms, it is possible that high school is too late to have a substantial effect on the initiation of sexual intercourse, and that condom use behavior may be more salient for this population. Several studies of HIV prevention programs have found that programs are often more effective at changing condom use than at changing the incidence of sexual intercourse.[8,9,22] Finally, it is also possible that the lack of a significant effect on delaying sexual initiation was statistical in nature. Because a limited number of students initiated sex between baseline and the 31-month follow-up (14%), we may have lacked statistical power to detect the differential rate of initiation between the two groups.

The intervention produced its most pronounced effects on HIV knowledge. The program also had a positive effect on other STD knowledge and most other psychosocial variables, particularly those related to condom use.

The program did not significantly affect students' perceived ability to refuse intercourse or unprotected intercourse or their perceived ability to communicate with a partner about not having sex or using protection, despite the fact that these skills were among the core skills addressed in the curriculum. However, students' baseline scores on both the refusal self-efficacy and communication self-efficacy scales were high initially (2.4 and 2.7 out of 3.0), thereby limiting room for positive change for these variables.

We noted statistically significant group-by-location interactions for two of the psychosocial effects in the cohort sample: other

STD knowledge and *condom use self-efficacy.* Students in both states demonstrated significant gains on both scales. The gains in other STD knowledge were stronger in Texas, whereas the gains in condom use self-efficacy were stronger in California. Students in the California schools had higher baseline scores on other STD knowledge than did students in Texas, which may have restricted potential gains for California students. Similarly, Texas students had higher baseline condom use self-efficacy scores. By the final follow-up, the mean values for these variables were similar in both states, suggesting the intervention was equally effective in both sites, and that there may be a ceiling effect for these measures.

The results are strengthened by their relative consistency over time. The majority of effects remained significant over time, although the magnitude of many of the effects dissipated somewhat. This pattern is typical of other health promotion intervention tri-

Table 3

Parameter estimates for multilevel models of psychosocial variables: cohort sample, 31-month follow-up

Variable	*Scale range*[a]	*n*[b]	*Estimated effect size*[c]	*Standard error*	*Ratio of group estimate to group standard error*	*P*
Knowledge						
HIV	0-1	3601	0.11	0.02	5.58	0.00
Other STDs	0-1	3552	0.09	0.02	5.06[d]	0.00
Attitudes						
Sexual intercourse	1-4	3771	0.00	0.04	0.06	0.95
Condoms	1-4	3751	0.07	0.02	2.79	0.01
Normative beliefs						
Sexual intercourse	1-4	3736	0.01	0.05	0.26	0.79
Condoms	1-4	3584	0.06	0.03	1.88	0.06
Self-efficacy						
Refusing sex	1-3	3633	0.04	0.02	1.65	0.10
Condom use	1-3	3592	0.11	0.03	4.15[e]	0.00
Communication	1-3	3576	0.01	0.02	0.53	0.60
Barriers to condom use	1-4	3682	-0.11	0.04	-2.51	0.01
Risk perceptions						
HIV	1-5	3584	0.11	0.05	2.27	0.02
Other STDs	1-5	3685	0.09	0.04	2.05	0.04
Communication with parents	1-3	3632	0.05	0.03	1.89	0.06

NOTES: All models were adjusted for baseline values and other relevant covariates (such as gender, parents' education, number of parents or guardians in household, grade point average, and ethnicity). All models also included independent variables: group (intervention = 1, control = 0); location (California = 1, Texas = 0), and group-by-location interaction terms (California intervention = 1, remaining = 0).

[a] Higher values (3-5, depending on the scale) reflect more of the desired attribute, except for variables *barriers* to condom use and *risk perceptions,* for which higher scores reflect greater barriers and risk perceptions.

n[b] represents the number of individuals included in the analyses. The tests of significance are based on the number of observations rather than the number of individuals. Each individual had from two to four observations.

[c] Estimate of magnitude of effects representing the difference between the two adjusted means (intervention vs. control) on the scale of the outcome variable being measured (such as *HIV knowledge* or *self-efficacy for refusing sex*). Because the coefficients are unstandardized, only those that are measured on the same scale can be compared.

[d] Group-by-location interaction significant at $P < 0.05$; ratio of interaction estimate to interaction standard error = -2.18.

[e] Group-by-location interaction significant at $P < 0.05$; ratio of interaction estimate to interaction standard error = 2.97.

als.[23,24] Despite the general consistency of effects over time, there were fewer significant behavioral effects at the 19-month follow-up than there were at the 7-month and 31-month follow-ups. This may be due to the difficulty we experienced in tracking the cohort in the Texas schools at the 19-month follow-up, resulting in lower statistical power at that time point. This hypothesis is supported by the fact that the trends for the behavioral variables are in the desired direction at the 19-month assessment, and the magnitude of the effects are fairly sizeable. The presence of significant effects at both the 7-month and 31-month assessments lend further support to this hypothesis.

Study limitations. The results of this study are encouraging; however, several methodological limitations should be noted. The outcome data were collected by using self-report questionnaires and there are few, if any, acceptable approaches for examining the criterion validity of students' responses. However, it is reasonable to assume that privacy and confidentiality affect the veracity of self-report.[25,26] Thus, several approaches were used to create a safe and comfortable environment for completing the questionnaire. These included using trained data collectors, providing students with paper to cover their answers, and providing a formal assurance of confidentiality. Although it is impossible to rule out potential biases due to self-report, some evidence supports the general reliability and validity of adolescents' reports of sexual and contraceptive behaviors.[25,27]

Student dropped from the cohort or lost to follow-up differed from students retained in the cohort. Dropped or lost students were older, less likely to live with both parents, more likely to be

Table 4

Summary of effects at each follow-up: behavioral outcomes

	7-month follow-up		*19-month follow-up*		*31-month follow-up*	
Variable	Effect size[a]	*P*	Effect size[a]	*P*	Effect size[a]	*P*
Primary outcomes						
Sexual initiation	1.13	0.60	0.83	0.44	0.83	0.39
Frequency of intercourse without a condom in last 3 months	0.50	0.03	0.69	0.14	0.63	0.05
Number of sexual partners without a condom in last 3 months	0.68	0.07	0.66	0.04	0.73	0.02
Secondary outcomes						
Use of condoms at first intercourse (among initiators only)	0.68	0.42	1.23	0.52	1.44	0.17
Use of condoms at last intercourse	1.91	0.02	1.51	0.26	1.68	0.04
Use of protection against pregnancy at last intercourse	1.62	0.03	1.40	0.38	1.76	0.05
Number of times had sexual intercourse in last 3 months	1.16	0.35	0.96	0.76	0.81	0.12
Number of sex partners in last 3 months	0.91	0.57	0.93	0.61	1.02	0.89
Use of alcohol and other drugs before sex in last 3 months	0.06	0.39	0.00	0.13	0.04	0.33
Tested for HIV	0.78	0.49	1.36	0.19	1.20	0.45
Tested for other STDs	1.05	0.88	1.39	0.19	1.52	0.16

NOTE: Effects at each time point represent the average effects to the measurement period.

[a] Odds ratios used to estimate overall effects for dichotomous outcomes; ratio of adjusted means used to estimate overall effects for Poisson or negative binomial models.

males, reported more risk behavior at baseline, and had less favorable scores on many of the psychosocial scales. In light of these differences, our study results may not generalize to all adolescents who are absent frequently from school or who have left school. Yet, the students in our study represent an important heterogeneous population of young people.

Finally, we did not correct the statistical procedures to adjust for multiple tests of significance. However, we did limit our analyses to a small number of primary and secondary hypotheses, and further testing was regarded as exploratory. We also considered the overall pattern of the results: if selected results had occurred by chance, one might expect results in both the positive and negative direction. The significant results of this study all were consistent with the program's theoretical foundation and consistent over time, suggesting that the observed results are not attributable to chance.

Conclusion

Safer Choices was successful in changing four of five outcomes addressing condom use and other protective behaviors. The program also enhanced numerous behavioral determinants, particularly those related to condom use. These positive effects lasted over a 31-month period. *Safer Choices* did not significantly delay the onset of sexual intercourse, decrease the frequency of intercourse, or reduce the number of sexual partners; however, it did not increase these behaviors, either.

When the results of this cohort study are combined with the results of the cross-sectional study that examined school-wide effects of *Safer Choices*,[13] the data support the value of a comprehensive, multi-component intervention that includes an intensive 20-lesson sequential curriculum for 9th- and 10th-grade students supported by broad-reaching, school-wide activities. The intensive component provides an opportunity for individual skill practice and mastery that is not easily gained through school-wide activities. The school-wide activities, on the other hand, reinforce the classroom component by serving as environmental cues; they also contribute to a more supportive environment for practicing healthful behaviors.

These results represent stronger and more consistent behavioral findings than reported in other randomized school-based evaluations of HIV, other STD, and pregnancy prevention programs.[28-30] Several randomized studies conducted in community settings have also found behavioral changes, but they were conducted with adolescents who volunteered to participate in the project.[8,10] Such participants are likely to be more motivated and interested in making behavioral changes than were the participants in our study. The population-based approach we used is a more conservative test of the intervention effects.

A high level of rigor was employed in evaluating the program. The study included random assignment of 20 schools, a large cohort sample, long-term follow-up assessments, assessment of multiple sexual and contraceptive behaviors, and the use of multilevel analyses to adjust for the clustering of students within schools. Confidence in these results is also strengthened by the consistency of results across time and across multiple measures involving condom use.

This study indicates that theory-driven, school-based, multicomponent programs with a clear message can enhance psychosocial variables and reduce sexual risk behaviors related to HIV, other STDs, and pregnancy prevention among high school students. It also suggests that additional research is needed to identify successful approaches to delaying sexual initiation and enhancing potentially important determinants (such as self-efficacy to refuse intercourse and communication with partners about sexual limits), and that even larger samples may be needed to measure the effect on sexual initiation.

Safer Choices has some of the strongest data supporting its effectiveness in reducing important sexual risk-taking behaviors. Several other programs also have been shown to be effective.[6] To the extent feasible, school districts interested in addressing these issues should adopt programs that have been shown to be effective through research and implement them with fidelity. Our interviews with school personnel involved in the program suggested that *Safer Choices* is well received by students and staff and can be implemented with appropriate planning. Indeed, the year following the study, most schools in the study continued offering parts of the program, although we do not have extensive data regarding the extent of implementation. For school districts interested in *Safer Choices*, the published program materials include detailed implementation manuals and other materials that provide extensive guidelines regarding how to implement each program component.[31]

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Appendix C

The *Safer Choices* Intervention: Its Impact on the Sexual Behaviors of Different Subgroups of High School Students

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Purpose: *To measure the relative impact of a school-based human immunodeficiency virus (HIV), sexually transmitted disease (STD), and pregnancy-prevention intervention on sexual risk-taking behaviors of different subgroups of students.*

Methods: *Twenty schools were randomly assigned to receive Safer Choices or a standard knowledge-based HIV-education program. Safer Choices was designed to reduce unprotected sex by delaying initiation of sex, reducing its frequency, or increasing condom use. Its five components included: school organization, an intensive curriculum with staff development, peer resources and school environment, parent education, and school-community linkages. A total of 3869 9th-grade students were tracked for 31 months. Results are presented for initiation of sex, frequency of unprotected sex, number of unprotected sexual partners, condom use, and contraceptive use. These results are presented separately by gender, race/ethnicity, prior sexual experience, and prior sexual risk taking. Statistical analyses included multilevel, repeated measures logistic and Poisson regression models.*

Results: *Safer Choices had one or more positive behavioral effects on all subgroups. On four outcomes that could be affected by condom use, it had a greater impact on males than on females. It had greater effects on Hispanics, including a delay in sexual activity, than on other racial/ethnic groups. Its greatest overall effect was an increase in condom use among students who had engaged in unprotected sex before the intervention.*

Conclusions: *Safer Choices reduced one or more measures of sexual risk taking over 31 months among all groups of youth, and was especially effective with males, Hispanics, and youth who engaged in unprotected sex and thus were at higher risk for HIV, other STD infections and pregnancy.*

KEY WORDS:

Sex and HIV education, Teen HIV/STD and pregnancy prevention, Sexual behavior, Gender differences, Racial/ethnic differences

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Both randomized trials and meta-analyses have demonstrated that some sex- and HIV-education programs can either delay initiation of sex, reduce the frequency of sex, reduce the number of sexual partners, increase condom use, or increase contraceptive use among young people. These effects have been demonstrated in different settings for as long as 1 year[1–5] and even for 31 months[6]. Furthermore, researchers have identified the common characteristics of these effective programs that may contribute to their success[7,8].

However, it is also important to know the relative impact of effective programs on different groups of youth. For example, practitioners need to know whether an intervention that is effective with one population of youth also will be effective with youth in their own communities.

Plausible rationales have been suggested for contradictory hypotheses about the relative impact of programs on different groups of youth. For example, because some programs teach refusal skills, and because females more commonly must refuse

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male sexual advances than vice versa, it is plausible that effective programs will have a greater impact on females. In addition, programs that emphasize the consequences of pregnancy might have a greater impact on female sexual and contraceptive behavior. Alternatively, programs, especially HIV- and other STD-prevention programs that emphasize condom use, especially male condom use, may have a greater impact on males. Similarly, plausible rival explanations have been proffered for why programs may be more effective for minority or nonminority youth, lower risk or higher risk youth, and sexually experienced or sexually inexperienced youth.

Some evidence for the relative impact of effective programs has been published. Measuring and especially demonstrating differential behavioral effects of interventions on different groups of youth, however, is more challenging than measuring behavioral effects on all participants. Demonstrating differential impact may require especially strong evaluation designs (e.g., those with random assignment), large sample sizes, and behavioral impact among at least some groups of youth.

Only four studies have included a randomized experimental design, had a sample size of at least 200, measured impact on behavior, found a behavioral impact for at least 12 months, and examined relative effects among some subgroups. One program, *Becoming a Responsible Teen,* had several positive behavioral effects on all youth, but was more effective at reducing the frequency of unprotected vaginal sex among males than among females [3]. This gender effect may have been caused in part by much higher rates of unprotected sex at baseline among males than among females, thereby creating greater potential for reduction.

Two programs, *Making a Difference* and *Making Proud Choices,* were evaluated in a single study[1]. According to the study, *Making a Difference* delayed the initiation of sex for 3 months, whereas *Making Proud Choices* reduced the frequency of sex, increased condom use, and reduced the frequency of unprotected sex for 6 to 12 months, depending on the outcome. Analyses revealed that *Making a Difference* did not have a differential effect on subsequent abstinence among those who had or had not engaged in sex before the intervention. In contrast, *Making Proud Choices* did have a differential effect on frequency of sex and frequency of unprotected sex in these two subgroups. It did not significantly reduce the frequency of sex or unprotected sex among those who were sexually inexperienced at baseline, but it did significantly reduce sex and unprotected sex among those who were sexually experienced at baseline. This may reflect the fact that relatively few sexually inexperienced youth initiated sex and thus a ceiling effect may have occurred.

Finally, the last program, *Draw the Line/Respect the Line,* delayed the initiation of sex and reduced the proportion of youth that had sex during the previous year, but only among males and not among females[9].

In sum, these four studies suggest that programs might be more effective for males than for females, and one of the studies suggests that some programs may be more effective for youth who have already had sex than for those who have not yet initiated sex. However, these results are far from definitive.

The purpose of this article is to examine more thoroughly the differential impact of *Safer Choices* on several subgroups of youth. *Safer Choices* increased condom use and reduced unprotected sex among youth during a 31-month period[6]. Its effects on different subgroups, however, have not been reported.

These study results have the potential to shed light on the relative impact of that intervention on subgroups of youth for several reasons: the *Safer Choices* study was a randomized trial, and treatment and control groups were matched on characteristics such as gender, ethnicity, and poverty; the sample size was large and included substantial numbers of youth in various subgroups; the study measured impact on behavior for 31 months; and *Safer Choices* had significant positive behavior effects that could potentially vary by subgroup.

Overview of Safer Choices

Safer Choices is a 2-year, school-based HIV/STD- and pregnancy-prevention program for high school youth. Its primary aim is to reduce the number of students engaging in unprotected sex by reducing the number who begin or have sex during their high school years, and by increasing condom use among students who have sex. To achieve these behavioral results, the program seeks to modify several factors related to sexual risk-taking behavior: knowledge about HIV and other STDs; students' self-efficacy to refuse sex or unprotected sex, use condoms, and communicate about safer sexual practices; attitudes about sexual behavior and condom use; perceived barriers to condom use; perceived peer norms regarding sexual behavior and condom use; perceived risk of becoming infected with HIV or other STDs; and communication with parents and partners about abstinence and methods of protection against STDs, HIV, and pregnancy.

The *Safer Choices* intervention was based on social cognitive theory[10], social influence theory[11–13], and models of school change[14]. An unusual quality of this multiple-component intervention was its focus on school-wide change and the influence of the total school environment on student behavior.

The program included five primary components:

1) School Organization: To support and coordinate project activities, schools formed a School Health Promotion Council (SHPC). It included teachers, students, parents, administrators, and community members.

2) Curriculum and Staff Development: The curriculum included 10 lessons in the 9th grade and 10 lessons in the 10th grade. Using many interactive activities, the curriculum provided functional knowledge related to HIV, STDs, and pregnancy; taught skills about refusing sex and communicating about and using condoms and other contraception; and reinforced social norms

supportive of responsible behavior. In-class peer leaders facilitated selected curriculum activities. To teach the curriculum, teachers received initial training and ongoing technical support.

3) Peer Resources and School Environment: The major purpose of this component was to saturate the school environment with activities, information, events, and services to reinforce key messages of the classroom-based instruction and create an environment supportive of HIV/STD prevention. To do this, a student peer resource team at each school implemented activities such as publishing articles in the school newspaper, conducting school opinion polls, organizing public speakers and special assemblies, distributing small media materials (e.g., posters, buttons, and t-shirts), conducting small-group discussion sessions, and organizing dramatic productions.

4) Parent Education: To increase parent-child communication about sexuality, HIV, and other STDs, schools sent newsletters to parents three times each year; the 9th and 10th grade classes asked students to discuss sexuality topics with their parents twice each year as part of homework assignments; and schools conducted additional parent education activities.

5) School-Community Linkages: To enhance student familiarity with community HIV, STD, and pregnancy prevention resources and support, homework assignments required students to gather information about local resources, schools distributed a resource guide that listed these services for youth, and HIV-positive speakers from the community gave presentations in schools.

A more detailed discussion of the program has been published elsewhere[15].

Methods

Overview

The *Safer Choices* intervention was implemented during the 1993–94 and 1994–95 school years. The evaluation used a randomized trial involving 20 schools, 10 in southeast Texas and 10 in northern California. Within each site, 10 schools were randomly assigned to the *Safer Choices* condition or to the comparison condition. The schools in the comparison group implemented a standard 5-session knowledge-based curriculum plus a small number of other school activities that varied from school to school.

To assess *Safer Choices'* effectiveness, cohort data were collected at all 20 schools by trained data collectors using student self-report surveys. The baseline survey was administered in the fall and winter of 1993/94, and follow-up surveys in the spring of 1995, 1996, and 1997, an average of 7, 19, and 31 months after the baseline survey. These procedures were approved by the University of Texas Committee on Human Subjects.

Study Schools and Student Cohort

Study schools. The schools ranged in size from 961 to 2733 students (mean = 1767). After randomization, several school-level indicators (e.g., dropout rate, ethnicity, test scores) were used to compare the intervention and comparison schools. No significant differences (as measured by Student's t-tests) were detected between intervention and comparison schools among any variables used in randomization.

Student cohort. The cohort included all ninth grade students who completed the baseline survey in Fall 1993 and who were officially enrolled at first follow-up (Spring 1994). Students who left school during the 1993–94 school year were excluded from the cohort (at both intervention and control schools), unless they returned during the following year, in which case they were included. These criteria were adopted because of the multiyear school-wide nature of the intervention.

Active parental consent was required for study participation. Eighty percent of students (5184 of 6488) returned parental consent forms; of these students, 4733 (91%) received permission to complete the questionnaire. Completed questionnaires were collected from 4310 of these students, yielding a 91% response rate. A total of 441 students were dropped from the cohort based on cohort eligibility criteria (346 because they officially left school during the first year and 95 because they were in 11th or 12th grade), yielding a final cohort sample of 3869 students. Of these, 95% completed the 7-month survey, 83% completed the 19-month survey, and 79% completed the 31-month survey. Analyses of attrition revealed that there were demographic characteristics and psychosocial differences between eligible cohort students who completed the follow-up surveys and those who did not, but there were no significant differences between these two groups in any sexual behaviors reported.

Measures

The evaluation questionnaire included items that assessed program exposure, demographic characteristics, sexuality-related psychosocial factors, and sexual behaviors. This article reports on five important sexual behaviors: initiation of sex, the number of times sexually experienced students had sex without a condom (hereafter referred to as "unprotected sex"), the number of partners with whom sexually experienced students had unprotected sex, condom use during the last act of intercourse, and use of effective contraception during the last act of intercourse (i.e., used a condom or birth control pills or both).

We considered many student characteristics for creating student subgroups and used the following criteria: they would be conceptually meaningful; a theoretical potential would exist for *Safer Choices* to have a differential impact on the groups; they would include a small number of groups, each with a sufficiently large sample size; and they would be based on student characteristics with relatively few missing survey data.

These criteria produced four characteristics measured at baseline that formed the basis for subgroups: demographic characteristics including gender and ethnicity (Whites, Blacks, Hispanics, and Asians), behavioral characteristics including timing of initiation of sex (before versus after baseline data collection) and behavioral risk (had engaged versus had not engaged in unprotected sex during the 3 months before baseline).

The two behavioral characteristics were not conceptually and statistically independent, i.e., all students who had sex without condoms in the last 3 months had also, by definition, ever had sex. Despite this interdependence, both measures were used because youth who had engaged in unprotected sex during the last 3 months were a higher-risk group than those who had ever had sex, for two reasons. They had engaged in unprotected sex versus simply having had sex, and they had engaged in unprotected sex during a relatively short time period (the 3 months before the questionnaire) versus "ever."

Data Analysis

The analysis was designed to measure the relative impact of the intervention on subsequent behavior among different subgroups. Because schools were the unit of randomization while data were collected from individual students, multilevel statistical analyses were used to account for the intra-class correlation that resulted from the clustering of students within schools. In addition, because data were collected at four points in time (T1-T4), the data provided repeated measures of the same behaviors. Repeated measures were treated as an additional level in the multilevel analysis. This has at least two important implications for the analysis. First, student data could be included in the analyses even when data were not available for all four time-points. Second, whereas sample sizes reported in Table 1 represent the number of students in each analysis, in Table 2–5 sample sizes represent the number of student observations. Thus, students that provided data for all four points in time each contributed four observations to the sample size count.

Poisson multilevel regression models were used to analyze count data (the number of partners with whom sexually experienced students had unprotected intercourse). Owing to a problem with overdispersion, the number of times sexually experienced students had unprotected intercourse was analyzed using a negative binomial regression model. This model is a generalization of the Poisson regression model commonly used to model overdispersed count data. Logistic regression models were used to analyze dichotomous data (initiation of sex, condom use during last act of intercourse, or contraceptive use during last act of intercourse). Computations for the multilevel models were carried out using MlN Software for Multilevel Analysis, Version 1.0a[16].

To statistically control for differences between the intervention and comparison groups at baseline, each analytic model included the baseline measurement of the outcome variable and a set of outcome-specific covariates (e.g., gender, parents' education, ethnicity). The outcome-specific covariates were included if they were significantly related to intervention condition and remained significant in the final stage of multilevel modeling. This covariate screening was conducted in both the overall model and each subgroup. In addition, because the intervention was conducted in

Table 1

Sample Characteristics at Baseline (*N* = 3869)

	Percent of All Youth	
Characteristic	Intervention	Control
Gender		
Male	49.8	46.4
Female	50.2	53.6
Ethnicity		
Asian	13.5	22.2
Black	19.6	14.3
Hispanic	28.4	26.4
White	30.2	30.7
Other	8.0	6.4
Age (years)		
13	4.4	4.6
14	57.2	57.4
15	28.1	27.7
16	8.6	7.9
≥17	1.7	2.4
Sexually experienced (at baseline)		
Yes	31.2	25.5
No	68.8	74.5
	Percent of Sexually Experienced Youth	
	Intervention	Control
Had sex without a condom (last 3 months)		
Yes	26.8	31.4
No	73.2	68.6
Condom use (last time)		
Yes	60.5	56.3
No	39.5	43.7
Contraceptive use (last time)		
Yes	64.5	59.0
No	35.5	41.0

two locations (Texas and California), all analyses also included a group-by-location interaction term to test for differential intervention effects by location.

Two types of significance tests are provided in the results: tests indicating whether the impact of *Safer Choices* on each outcome variable was statistically significant for the overall sample and for each subgroup, and tests indicating whether the differential impact of *Safer Choices* on each outcome variable for each subgroup was statistically significant, i.e., did a significant interaction effect exist between the measure of effect and subgroup? In all analyses, two-tailed tests were used and no adjustments were made for multiple tests of significance.

Results

Sample Characteristics

At baseline, the sample contained a few more females (52%) than males, included a diversity of ethnic groups ranging from 30% White to 18% Asian, and was mostly aged 14 (57%) and 15 (28%) years (Table 1). Twenty-eight percent had initiated sex.

Overall Effects of Safer Choices

Overall, *Safer Choices* did not significantly delay the onset of sexual intercourse ($p = .99$), but it did appear to improve condom use. In particular, it reduced the frequency of sex without a condom ($p = .02$), reduced the number of sexual partners in the last 3 months with whom a condom was not used ($p = .04$), increased condom use during last sex among those who had sex in the last 3 months ($p = .02$), and marginally increased contraceptive use (including condoms and pills) among those who had sex in the last 3 months ($p = .07$), (Table 2). These positive results warrant an examination of effects for various subgroups.

Interaction Effects with Gender

No significant gender interaction effect on the initiation of sex was detected (Table 2). That is, the odds ratio measuring the impact of *Safer Choices* on initiation of sex for males did not significantly differ from that for females ($p = .70$).

In contrast, on all four measures involving condom use (number of times of unprotected sex, number of partners unprotected, condom use at last sex, and contraceptive use at last sex), interaction effects were detected, suggesting that *Safer Choices* had a greater impact on males than on females. The absolute value of group estimates was always larger for males than for females, and p values for tests of subgroup differences in group estimates were either significant or close to significant ($p = .05, .08, .03$, and $.10$, respectively).

This does not mean *Safer Choices* did not have an impact on females; group estimates for all four outcome variables for females were in the desired direction, and one was significant (number of times of unprotected sex, $p = .04$). Nevertheless, *Safer Choices* appeared to have a larger impact on males.

Interaction Effects with Race/Ethnicity

Safer Choices had a significant interaction effect involving impact on initiation of sex and race/ethnicity ($p = .05$) (Table 3). *Safer Choices* did not delay the initiation of sex among Blacks, Asians, or Whites, but did significantly delay the initiation of sex among Hispanic students (OR = 0.57, $p = .02$).

Safer Choices also had a significant interaction effect on one of four condom-related measures and race/ethnicity ($p = .04$). Whereas odds ratios were in the desired direction for all subgroups, *Safer Choices* increased condom use at last sex more among Hispanics and Whites than among Blacks (OR = 1.65 and 1.57 vs. 1.07, respectively).

Other outcome measures involving condoms suggest that *Safer Choices* had positive effects for each major racial/ethnic group. First, for three of four condom-related measures (number of times of unprotected sex, number of partners unprotected, and use of contraception), no significant or near-significant subgroup differences (no interaction effects) were detected. Furthermore, among Blacks, Hispanics, and Whites, one or more condom-related measures were significant or close to significance, and always in the desired direction. More specifically, among Blacks, effects were close to significance for number of partners unprotected ($p = .07$); among Hispanics effects were significant or close to significance for number of times of unprotected sex ($p = .03$), condom use at last sex ($p = .04$), and use of contraception ($p = .06$); and among Whites effects were significant for number of times of unprotected sex ($p = .04$) and condom use at last sex ($p = .04$).

In combination, these results suggest that Blacks decreased risk by reducing the number of unprotected partners; Hispanics reduced risk by delaying sex, increasing condom use, increasing contraceptive use, and thereby decreasing frequency of unprotected sex; and Whites decreased risk by increasing condom use and thereby decreasing frequency of unprotected sex.

Interaction Effects with Subgroups Based on Timing of Initiation of Sex

When observing differential effects of *Safer Choices* on those who had and had not initiated sex at baseline, the differential effects can only be examined for the remaining four outcomes and the analyses are restricted to youth who had ever had sex at follow-up (and for outcomes measuring condom and contraceptive use at last sex, the analyses were restricted to those who had sex during the 3 months before the survey).

Two interaction effects were examined that involved subgroups based on timing of initiation of sex. First, in terms of frequency of unprotected sex, *Safer Choices* had a significantly greater impact on youth who initiated sex after baseline than on youth who

Table 2
Gender Subgroup: 31-Month Follow-Up[a]

Variable	Number of Follow-Up Observations	Group Estimate (Std. Error) Estimate	*p* value	Ratio Est./SE or 95% C. I.	Tests For Subgroup Differences Contrast	*p* value
Initiation of sex						
Overall	2029	OR = 1.00	.99	(0.78, 1.29)	x^2 (2 df) = 0.72	.70
Male	809	OR = 1.08	.63	(0.80, 1.46)		
Female	1220	OR = 0.88	.54	(0.59, 1.31)		
Frequency of unprotected sex						
Overall	3103	–0.41 (0.17)	.02	–2.41	x^2 (2 df) = 6.16	.05
Male	1498	–0.44 (0.20)	.03	–2.15		
Female	1605	–0.39 (0.19)	.04	–2.09		
Number of partners unprotected						
Overall	3231	–0.26 (0.13)	.04	–2.01	x^2 (2 df) = 5.12	.08
Male	1552	–0.34 (0.15)	.02	–2.27		
Female	1679	–0.18 (0.15)	.25	–1.16		
Condom use at last sex						
Overall	2145	OR = 1.38	.02	(1.06, 1.79)	x^2 (2 df) = 7.22	.03
Male	956	OR = 1.66	.01	(1.12, 2.47)		
Female	1189	OR = 1.20	.31	(0.84, 1.70)		
Contraceptive use at last sex						
Overall	2145	OR = 1.34	.07	(0.98, 1.84)	x^2 (2 df) = 4.67	.10
Male	956	OR = 1.64	.04	(1.03, 2.59)		
Female	1189	OR = 1.15	.50	(0.77, 1.73)		

[a] Results for condom or contraceptive use at last sex were restricted to youth who had engaged in sex during the 3 months prior to each survey. Sample size for initiation of sex reflects number of students not number of observations.

were sexually experienced at baseline (p = .02). Second, in terms of condom use at last sex, *Safer Choices* had a greater impact on youth who were sexually experienced at baseline than on youth who initiated sex afterward.

However, this does not mean that *Safer Choices* had a behavioral impact on only one or the other of these two groups; it had significant positive effects on students regardless of whether they had initiated sex before program participation. This is true in three respects. First, all group estimates are in the positive direction. Second, where significant subgroup differences exist, they favor the sexually inexperienced at baseline on one measure and the sexually experienced at baseline on the other. Third, no significant subgroup differences were detected on the other two outcome measures.

In combination, these results suggest that *Safer Choices* had positive effects on youth regardless of their sexual experience at baseline. It had a greater impact on frequency of unprotected sex among those who initiated sex during or after participating in *Safer Choices*, but it had a greater impact on condom use among those who initiated sex before participating in *Safer Choices*.

Interaction Effects with Subgroups Based on Unprotected Sex in the Previous Three Months at Baseline

As above, these analyses were restricted to students who had ever had sex, and the analyses involving condom and contraceptive use were restricted to students who engaged in sex during the 3 months before each questionnaire.

Significant (or close to significant) interaction effects were detected with three of the four outcomes (i.e., frequency of unprotected sex, condom use at last sex, and contraceptive use at last sex). For all three outcomes, *Safer Choices* had a greater impact on youth who had engaged in unprotected sex before baseline than on youth who had not done so (p = .07, .01, and .02, respectively).

Once again, *Safer Choices* had a positive effect on both groups; it simply had a greater effect on higher-risk youth who had unprotected sex before their baseline survey. All subgroup coefficients were in the positive direction across both groups and across all four outcome measures. Moreover, each group of students had one or more results that were significant or close to significant.

Discussion

These results support four primary conclusions. First, *Safer Choices* had positive impacts across a variety of groups, regardless of their gender, ethnicity, or sexual experience before taking *Safer Choices*. Most regression coefficients were in the desired direction across groups, and every group had at least one positive result that was significant or close to significant. Second, regarding all four outcome measures affected by condom use, *Safer Choices* appeared to have a greater impact among males than females. This is consistent with the fact that males typically have more direct control over condom use than do females. Third, *Safer Choices* appeared to have a greater number of positive behavioral effects on Hispanics than on any other ethnic group. Fourth, *Safer Choices* appeared to have a greater impact on condom-related measures among higher-risk youth who engaged in unprotected sex before the intervention than among youth who initiated sex after the intervention.

In terms of reducing frequency of unprotected sex, *Safer Choices* apparently had its greatest impact on students who initiated sex after baseline and on students who initiated sex before baseline

Table 3
Ethnic Subgroup: 31-Month Follow-Up[a]

Variable	Number of Follow-Up Observations	Group Estimate (Std. Error) Estimate	p value	Ratio Est./SE or 95% C. I.	Tests For Subgroup Differences Contrast	p value
Initiation of sex						
Overall	2015	OR = 1.03	.83	(0.81, 1.29)	x^2 (4 df) = 9.63	.05
Black	185	OR = 1.38	.32	(0.73, 2.59)		
California Asian[b]	468	OR = 0.96	.90	(0.53, 1.74)		
Hispanic	448	OR = 0.57	.02	(0.36, 0.90)		
White	914	OR = 1.32	.10	(0.95, 1.84)		
Frequency of unprotected sex						
Overall	2887	–0.39 (0.17)	.02	–2.29	x^2 (4 df) = 6.35	.17
Black	837	–0.19 (0.27)	.47	–0.72		
California Asian[b]	274	–0.38 (0.39)	.32	–0.99		
Hispanic	911	–0.46 (0.21)	.03	–2.16		
White	865	–0.54 (0.26)	.04	–2.08		
Number of partners unprotected						
Overall	3003	–0.24 (0.13)	.06	–1.85	x^2 (4 df) = 3.83	.43
Black	847	–0.32 (0.17)	.07	–1.81		
California Asian[b]	288	–0.08 (0.32)	.79	–0.26		
Hispanic	967	–0.18 (0.18)	.33	–0.97		
White	901	–0.18 (0.21)	.40	–0.85		
Condom use at last sex						
Overall[c]	2111	OR = 1.41	.01	(1.08, 1.84)	x^2 (3 df) = 8.36	.04
Black	548	OR = 1.07	.86	(0.62, 1.87)		
Hispanic	619	OR = 1.65	.04	(1.02, 2.68)		
White	605	OR = 1.57	.04	(1.02, 2.42)		
Contraceptive use at last sex						
Overall[c]	2111	OR = 1.36	.06	(0.99, 1.86)	x^2 (3 df) = 4.35	.23
Black	548	OR = 1.16	.32	(0.61, 2.23)		
Hispanic	619	OR = 1.69	.06	(0.97, 2.93)		
White	605	OR = 1.28	.34	(0.77, 2.14)		

[a] Results for condom or contraceptive use at last sex were restricted to youth who had engaged in sex during the 3 months prior to each survey. Sample size for initiation of sex reflects number of students not number of observations.

[b] In the Texas sample, there were too few Asian students to include as a separate category.

[c] Too few Asians had engaged in sex in the last 3 months to provide separate analyses for them.

Table 4
Timing of Initiation of Sexual Intercourse Subgroup: 31-Month Follow-Up[a]

Variable	Number of Follow-Up Observations	Group Estimate (Std. Error)		Ratio Est./SE or 95% C. I.	Tests For Subgroup Differences	
		Estimate	*p* value		Contrast	*p* value
Frequency of unprotected sex						
Overall	3018	–0.40 (0.16)	.01	–2.47	x^2 (2 df) = 7.82	.02
Before Baseline	1584	–0.33 (0.18)	.06	–1.84		
After Baseline	1434	–0.57 (0.21)	.007	–2.71		
Number of partners unprotected						
Overall	3150	–0.22 (0.13)	.09	–1.66	x^2 (2 df) = 3.24	.20
Before Baseline	1677	–0.15 (0.14)	.29	–1.07		
After Baseline	1473	–0.30 (0.17)	.07	–1.79		
Condom use at last sex						
Overall	2134	OR = 1.41	.02	(1.06, 1.89)	x^2 (2 df) = 5.85	.05
Before Baseline	1129	OR = 1.59	.03	(1.05, 2.41)		
After Baseline	1005	OR = 1.23	.30	(0.82, 1.86)		
Contraceptive use at last sex						
Overall	2134	OR = 1.38	.06	(0.99, 1.93)	x^2 (2 df) = 3.53	.17
Before Baseline	1129	OR = 1.50	.10	(0.92, 2.43)		
After Baseline	1005	OR = 1.25	.36	(0.77, 2.02)		

[a] This sample was restricted to youth who had ever engaged in sexual intercourse. Results for condom or contraceptive use at last sex were restricted to youth who had engaged in sex during the 3 months prior to each survey.

and engaged in unprotected sex during the previous 3 months, and it had less impact on students who engaged in sex before baseline but did not engage in unprotected sex during the previous 3 months. Thus, when this last group is part of the "initiated sex before baseline" group as reflected in Table 4, *Safer Choices* had less of an impact on that entire group. And when this last group of students became part of the "no unprotected sex before baseline" group as reflected in Table 5, *Safer Choices* had less of an impact on that entire group. It makes intuitive sense that *Safer Choices* would have a smaller impact on students who had initiated sex before baseline but either never had sex during the previous 3 months or always used condoms than on students who later initiated sex for the first time or who had sex without condoms.

The overall patterns of results are encouraging and important for several reasons. First, they demonstrate that the impact of *Safer Choices* is not limited to any single group defined by any of the student characteristics examined. Second, few studies currently exist that demonstrate positive effects of programs on Hispanic youth[17]. Thus, multiple positive effects (including apparent delay in the initiation of sex) are particularly important for this group. Third, the results demonstrate that programs can be effective with youth both before and after they have initiated sex. This conclusion differs from the belief held by many that sex and HIV education programs are most effective when taught before youth initiate sex[18]. In addition, if higher-risk youth are defined as those who engage in unprotected sex (versus not engaging in sex or always using condoms), then these results suggest that *Safer Choices* was most effective with higher-risk youth. This is particularly encouraging because higher-risk youth are most likely to spread or contract STDs and to get pregnant (or get someone pregnant) and thus they are most in need of prevention programs.

These results also are consistent with results from previous studies noted above. For example, both *Becoming a Responsible Teen* and *Draw the Line/Respect the Line* were more effective with males than females, and *Making Proud Choices* was more effective with higher-risk youth who initiated sex before baseline[1,4].

When only a small percentage of youths has sex without condoms, it is still possible to achieve a large proportional (as opposed to an absolute) reduction, but when percentages for comparison groups are small, these proportional reductions are very difficult to measure statistically. For example, it is much easier to measure the impact of a program that reduces the percentage of youth who initiate sex from 30% to 20% (a 33% proportional reduction) than it is to measure the impact of a program that reduces initiation of sex from 10% to 5% (a 50% reduction). Thus, without further research

Table 5

Behavioral Risk Subgroup: 31-Month Follow-Up[a]

Variable	Number of Follow-Up Observations	Group Estimate (Std. Error) Estimate	p value	Ratio Est./SE or 95% C. I.	Tests For Subgroup Differences Contrast	p value
Frequency of unprotected sex						
Overall	3103	–0.41 (0.17)	.02	–2.41	x^2 (2 df) = 5.33	.07
Had unprotected sex before baseline	488	–0.48 (0.25)	.05	–1.94		
No unprotected sex before baseline	2615	–0.34 (0.18)	.06	–1.85		
Number of partners unprotected						
Overall	3167	–0.23 (0.14)	.10	–1.64	x^2 (2 df) = 2.94	.23
Had unprotected sex before baseline	493	–0.29 (0.19)	.13	–1.51		
No unprotected sex before baseline	2674	–0.11 (0.10)	.27	–1.10		
Condom use at last sex						
Overall	2093	OR = 1.42	.009	(1.09, 1.85)	x^2 (2 df) = 9.28	.01
Had unprotected sex before baseline	393	OR = 2.38	.009	(1.24, 4.55)		
No unprotected sex before baseline	1700	OR = 1.26	.12	(0.94, 1.69)		
Contraceptive use at last sex						
Overall	2101	OR = 1.36	.03	(1.17, 1.80)	x^2 (2 df) = 8.04	.02
Had unprotected sex before baseline	393	OR = 2.04	.006	(1.23, 3.40)		
No unprotected sex before baseline	1708	OR = 1.20	.24	(0.88, 1.63)		

[a] This sample was restricted to youth who had ever engaged in sexual intercourse. Results for condom or contraceptive use at last sex were restricted to youth who had engaged in sex during the 3 months prior to each survey.

designed to measure very small absolute changes in behavior, it is difficult to know whether *Safer Choices* and other effective programs have similar proportional effects on lower-risk youth.

The fact that *Safer Choices* and possibly other curricula may have a larger absolute impact on higher-risk youth has at least two important implications. The first is methodological, i.e., some programs that are actually effective with higher-risk youth may be found to be ineffective because they were implemented and evaluated with lower-risk youth, whereas programs that are actually less effective in general may be found to be effective because they were implemented and evaluated with higher-risk youth. Thus, in the future, researchers who review the effectiveness of programs should take sample characteristics into consideration.

The second implication is programmatic, i.e., given that higher-risk youth are disproportionately likely to contract an STD, including HIV, or to become pregnant, if *Safer Choices* (and possibly other programs) are more effective with higher-risk youth, then schools and communities should target higher-risk youth with these programs.

Limitations

Even though this study had a very rigorous evaluation design and analytic procedures, it nevertheless had several limitations. First, the study randomly assigned entire schools, not individual youth. Randomly assigning individual youth may have divided the subgroups more evenly and made the statistical analyses more powerful. However, as described above, to correct for the assignment of entire schools, multilevel statistical models were used that control for clustering in schools. Second, attrition, caused both by lack of parental consent and by loss to follow up, slightly

reduced the generalizability of these findings. Third, like most studies of sex- and HIV-education programs, this study relied on self-reports of behavior. To increase the validity of self-reported data, numerous procedures were implemented to assure confidentiality and make the students feel comfortable answering honestly. Fourth, the analyses were exploratory and not confirmatory. That is, because hypotheses did not specify the direction of findings before the analyses were conducted, these results need to be confirmed by other studies. Fifth, because tests of significance were not corrected for multiple testing, one or more statistically significant findings reported could have been caused by chance. To reduce the chance of Type I errors, these analyses were limited to five outcome variables and four subgroup analyses. And finally, this study measured the impact of *Safer Choices* on in-school youth, not on out-of-school youth. Although many young people, including young people who engage in sexual risk-taking behavior, remain in school through the 10th grade, youth who drop out of school typically engage in even greater sexual risk behavior.

Conclusions

These results have demonstrated that *Safer Choices*, a theory-driven multicomponent, curriculum-based intervention can have a long-term impact up to 31 months; can have positive effects on males and females, all major ethnic groups, sexually inexperienced and experienced youth, and lower-risk and higher-risk youth; and may be especially effective with Hispanic and higher-risk youth. Given that *Safer Choices* was effective with multiple groups, it can be used effectively in a wide variety of schools and communities. Because *Safer Choices* was especially effective with higher-risk youth who had already engaged in unprotected sex at relatively early ages (ninth grade), it also should be implemented in schools and communities with youth at higher risk of unintended pregnancy, HIV, and other STDs.

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