Reducing Pregnancy and the Spread of HIV and Other STDs Among Adolescents

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The **American School Health Association** is pleased to provide this presentation guide to increase your effectiveness as an advocate for improving the health and learning potential of children and youth.

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Chapter

A Comprehensive Program to Reduce Pregnancy and the Spread of HIV and Other STDs Among Adolescents

Sexual activity, pregnancy and sexually transmitted diseases among adolescents are a cause of great concern, and a call for solutions span the political spectrum.[1] Effective solutions include providing adolescents instructional programs on reproduction and contraception, which does not increase sexual activity.[2-9] Several programs have been effective in postponing sexual involvement,[10,11] encouraging the sexually active to use contraceptives [11-15] and reducing pregnancy.[16-18] These programs often require the cooperation of students, their families, the school staff and community members.

This kit was developed by the American School Health Association to help school health professionals organize colleagues in the school and the community, along with families and students, in an initiative to reduce unintended pregnancies and the spread of HIV and other STDs among youth.

The U.S. Public Health Service has identified specific goals relating to adolescent reproductive health, including preventing HIV and other sexually transmitted diseases, postponing sexual involvement, reducing adolescent pregnancy, increasing the contraceptive use among the sexually active and improving pregnancy outcomes for mothers and infants (Appendix A, *Healthy People 2000*). These goals are in the priority areas of family planning, maternal and infant health, HIV/AIDS and other sexually transmitted diseases. The *Healthy People 2000* initiative has guided the work of the Public Health Service at the national, state and local levels for the past 15 years. The goals and objectives identified were the result of a public and private effort to reach consensus on the major health problems affecting Americans.

Particularly in the area of reproductive health, health and education professionals working with youth and their families need cooperation in interventions to reduce unwanted pregnancies and sexually transmitted diseases. Because multiple factors contribute to premature sexuality, single-focus programs that rely on access to contraception or on instruction will not be as successful as multi-component programs that use a variety of strategies and are delivered by families, communities, peers and schools.[19](Figure 1.1)

This kit will help concerned individuals organize a program of continuous improvement in reducing adolescent pregnancy and the spread of HIV and other STDs that is consistent with the needs and values of the local community. The health promotion kit includes: an outline of potential activities; an overhead transparency set to raise awareness of the problem and commitment to the solutions; ideas for personal action; sample action plans for school and community committees; examples of effective curricula; a resource list; and the book *Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations.*

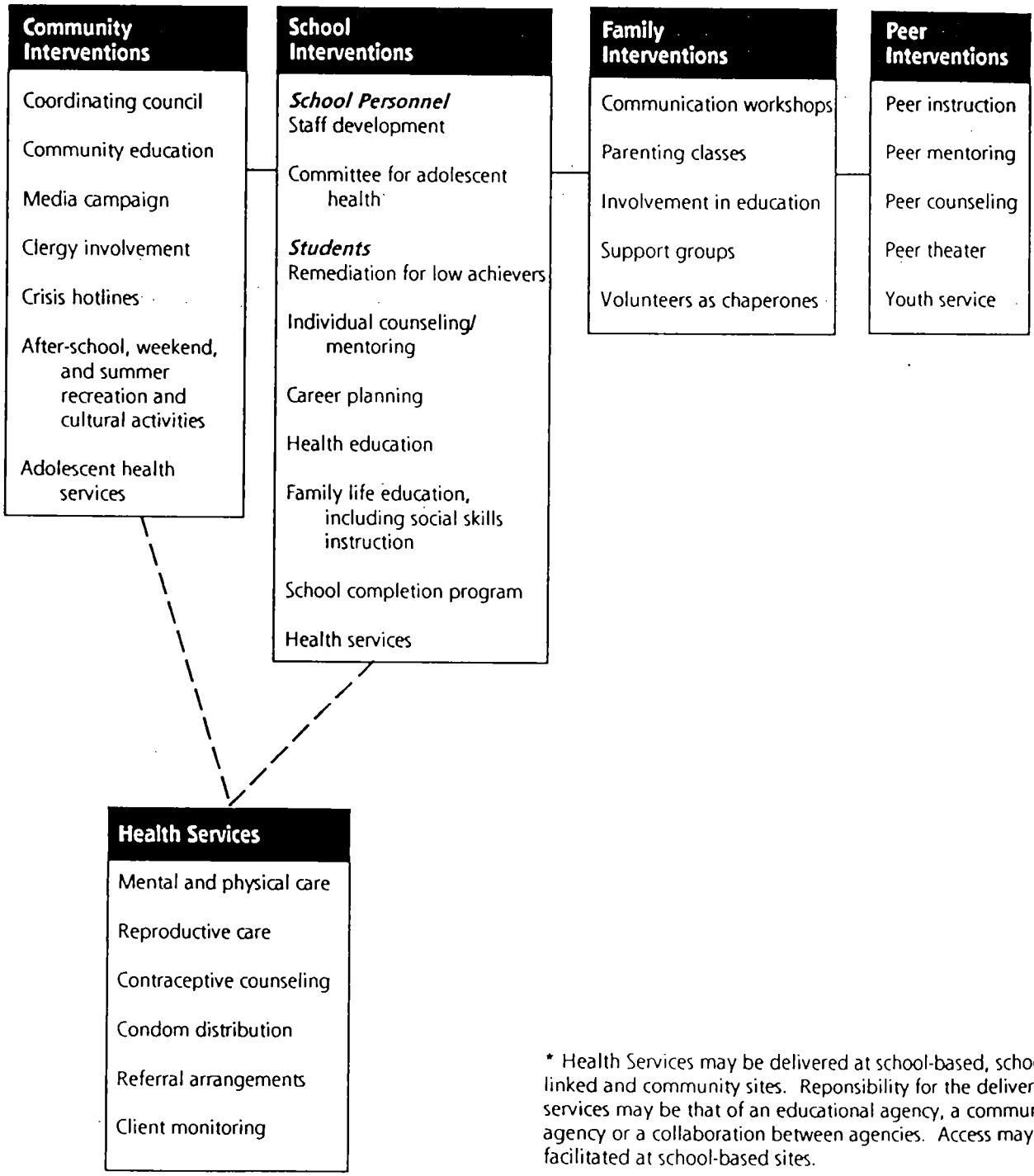
Figure 1.2 contains a brief synopsis of each component, including possible uses for the material.

Key Factors of a Successful Program

1) Early intervention (no later than middle school)
2) Access to a package of services, including capacity building, education enhancement and life options
3) Male inclusion in prevention efforts
4) Family life education that includes social skills training
5) Confidential access to contraception
6) Access to pregnancy testing and counseling
7) Parent involvement
8) Crisis intervention and referral mechanisms
9) Community organizations to deliver sexuality education, general health and mental health services and individual and group counseling, including family planning at school sites[19]

Figure 1.1

Intervention Options for the School-Community Initiative to Reduce Adolescent Pregnancy and STDs*



* Health Services may be delivered at school-based, school-linked and community sites. Reponsibility for the delivery of services may be that of an educational agency, a community agency or a collaboration between agencies. Access may be facilitated at school-based sites.

Adapted from Brindis CD. *Adolescent Pregnancy Prevention: A Guidebook for Communities.* Palo Alto, Calif: Health Promotion Resource Center; 1991.

Health Promotion Kit Components

Introduction

A brief rationale for the initiative is provided.

Overview of Potential Activities

A suggested plan for launching the initiative is provided along with the instructions for using resources in this kit and elsewhere.

Overhead Transparency Script

A scripted set of transparencies can be used to inform and motivate school staff, parents, community members or students to organize a local initiative. The script can be tailored to the audience, with local statistics and events interwoven into the script.

Examples of how the script might be tailored to various audiences:

General school faculty and community health professionals: 1-37

Community and family members: 1-22, 24-26, 32-37

Students: 1-11, 13-16, 18-19, 21, 24-28, 32-37

Ideas for Action

At the conclusion of the transparency presentation, a call to action could be issued. When speaking to community members, students or parents, the leader can use the *Ideas for Action*. Ask the audience to complete the work sheet individually. The audience could form groups of five to seven to share their ideas for action. An individual from each group might report the group's ideas as the leader writes them on a board.

Personal Action Plan

As a final activity, participants should complete a Personal Action Plan that has been copied on pressure sensitive paper. Personal Action Plan activities will emerge after viewing the presentation and completing the exercise at the end of the presentation that asks participants to match what their school can do with the activities and strategies outlined in Appendix G. After completing the form, participants should keep the colored copy and give the organizer the original. A four-week and six-month evaluation of action plan completion can provide helpful information on the extent to which the presentation mobilized activity. Further, the organizer can review the action plans to see who is interested in participating on a school or community committee addressing specific issues.

Sample Action Plans

Local communities can adapt these sample action plans to local needs, adding or deleting activities as needed. Local personnel who will complete each activity must be identified, along with a time line. Sample action plans are available for six activities:

1) Selecting/Revising Sexuality Education Curriculum
2) Infusing Sexuality Education Across the Curriculum
3) Coalition Building to Prevent the Spread of HIV and/or Adolescent Pregnancy
4) Organizing a School Team
5) Updating School Policies
6) Organizing a Youth Institute

A blank action plan is included for identifying the activities for additional proposed strategies.

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Chapter 2

Overview of Potential Activities to Reduce Pregnancy and the Spread of HIV and Other STDs Among Adolescents

This chapter contains suggestions for potential activities to start a program. For your information (*FYI*), each activity is followed by resources and instructions on how to use the resources.

Activities of a Successful Program

1) Involve others
2) Document local problems and local resources
3) Organize committees and action work groups
4) Review school policies
5) Develop programs for high-risk youth
6) Institute effective instructional programs
7) Assure access to health services
8) Institute effective community-wide programs
9) Provide opportunities for family involvement and education
10) Promote peer involvement
11) Provide staff development programs
12) Evaluate planning process annually

Involve others.

Organize school personnel, parents, community professionals and students. Goals can best be achieved by establishing working relationships among all systems to offer a wide range of services to youth.

FYI — Use the transparency set with colleagues, community members, families and students to raise awareness of the problem and a commitment to the solution. Use *Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations* to organize the major stakeholders in the community. (See worksheets 2, 5 and 6.)

Document local problems and local resources.

Assess the local problem and resources available to plan an effective comprehensive prevention program.

FYI — Complete worksheets 1, 3 and 4 in *Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations*. Contact the state department of education's HIV coordinator for a copy of the results of the Youth Risk Behavior Survey (YRBS) conducted in your state. A survey of local youth also may be instituted.

Organize committees and action work groups.

Assign committees to develop programs that promote adoption of health-enhancing behaviors among adolescents. If a coalition has been organized, appoint other committees to address the coalition's organizational needs (membership, finance, communications).

FYI — Use *Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations* for ideas on activities to be assigned to standing committees and work groups on coalition maintenance and school and community programming (pp. 13-18, 31-32). For additional programming ideas, see: Kerr D, Allensworth D, Gaylo J. *School-Based HIV Prevention: A Multidisciplinary Approach*. American School Health Association: Kent, Ohio; 1991.

Review school policies.

Review the district's policies for clear and appropriate policies that address: 1) family life instruction within a comprehensive health education curriculum; 2) intervention programming for high-risk youth; 3) admission of students with HIV; 4) confidentiality procedures; 5) primary health care access for adolescents; and 6) universal precautions.

FYI — The National School Boards Association maintains a database of model school policies. To improve local policies, contact: The National School Boards Association, 1680 Duke Street, Alexandria, VA 22314, 703/838-NSBA.

Develop programs for high-risk youth.

Providing a positive school environment that emphasizes success for all, promotes life options and has intervention programs targeting students at risk has been shown to be effective.

FYI — For a description of programming alterna-

tives, see Brindis CD. *Adolescent Pregnancy Prevention: A Guidebook for Communities*. Palo Alto, Calif: Health Promotion Resource Center; 1991, Dryfoos J. *Adolescents at Risk: Prevalence and Prevention*. New York, NY: Oxford Press; 1990.

Institute effective instructional programs.

Select curricula that use social learning theories to build social skills; reinforce individual and group norms about abstinence and protected sex; address social and media influences on sexual behaviors; focus on reducing risk-taking behaviors; and provide practice in communication, negotiation and refusal skills. A target-specific curriculum can supplement the K-12 comprehensive health education curriculum. Additionally, the program should coordinate school instruction with that of families, community youth agencies, religious groups, and peer instruction.

FYI — See *Programs That Work* fact sheets for examples of programs targeting adolescent sexual behaviors that postpone sexual involvement.

- For a listing of commercial comprehensive health education curricula, contact the American School Health Association, PO Box 708, Kent, OH 44240, 216/678-1601; 216/678-4526 (FAX).
- For a listing of content appropriate for K-12 family life education curricula, contact: Sex Education & Information Council of the United States (SEICUS), 130 West 42nd Street, New York, NY 10036, 212/819-9770.

Assure access to health services.

Primary health care services, including reproductive health care, may be provided at community, school-based or school-linked clinics. To encourage participation at community and school-linked clinics, clinic staff could routinely provide lectures on reproductive health to students. Further, the school nurse and guidance counselor can provide anticipatory guidance and counseling.

FYI — For a description of an effective school-linked program that reduced teen pregnancies, see Zabin LS, et al. Evaluation of a pregnancy prevention program for urban teenagers. *Family Planning Perspectives*. 1986;18(3):119-126. For a general description of programs that the school nurse could initiate with regard to HIV infection, see: *HIV Infection and the School Setting: A Guide for School Nursing Practice*. Kent, Ohio: American School Health Association; 1994.

Institute effective community-wide programs.

Multiple programs delivered through multiple channels (school, home, community agencies and media) and by multiple agents (teachers, families, peers and health and education professionals) work best. Supplement programming received at school by expanding community resources. Coordinate programs within youth, religious and health agencies.

FYI — For programming ideas, see *Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations* (pp. 13-17). For an example of a community-wide program for reducing pregnancy, see Vincent, M. *Reducing Unwanted Adolescent Pregnancy Through School/Community Intervention: A South Carolina Case Study*. A copy of the report may be obtained by contacting the Centers for Disease Control and Prevention, Division of Adolescent and School Health, 4770 Buford Highway, NE, Atlanta, GA 30333, 404/488-5323.

Use *Media Relations: It's Your Move - Prevent AIDS*, available free from the CDC National AIDS Clearinghouse: 1-800/458-5231. Also ask for the *Catalog of HIV and AIDS Education and Prevention Materials* which has free or low-cost posters, brochures, community action kits and videotapes.

Provide opportunities for family involvement and education.

Parental involvement in general education goals, as well as specific health behaviors such as preventing teenage pregnancy or drug abuse, increases positive outcomes for their children. Workshops for families can be instituted on discussing sexual issues with their children, parenting, becoming involved with school and promoting their child's educational achievement.

FYI — For specific ways to involve parents, contact: The National Parent Teachers Association, 330 N. Wabash, Suite 2100, Chicago, IL 60611-3690, 312/670-6782.

For a K-6 supplemental curriculum that has a student workbook, a teacher's guide and a parental newsletter, ask for: *Tell Me About AIDS*, American School Health Association, P.O. Box 708, Kent, OH 44240, 216/678-1601.

Promote peer involvement.

Establish peer instruction and cross-age mentoring programs that utilize social skills, communication and negotiation skills, media analysis skills and refusal

skills. Allow students to develop and implement programming relevant to their needs that utilizes peer instruction and youth service.

FYI — See *Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations* for resources on teen theater (pp. 14-15). Contact the American School Health Association to organize a local peer-focused *Why Do I Care?* initiative: American School Health Association, P.O. Box 708, Kent, OH 44240, 216/678-1601.

Provide staff development programs.

Institute general orientation programs for school staff that: 1) focus on promoting educational achievement for at-risk students; 2) raise awareness of their role in effective intervention programs that will postpone sexual involvement and reduce teen pregnancy; 3) examine HIV/AIDS from a school-based and personal perspective; and 4) describe universal precautions.

FYI — Consider providing school staff and other community members the CDC's slide show overview on condom efficacy. Ask for the slide set and script titled *CDC HIV/AIDS Prevention Marketing Initiative* when contacting: Centers for Disease Control and Prevention, Division of Adolescent and School Health, 4770 Buford Highway, N.E., Atlanta, GA 30333, 404/488-5323.

Evaluate planning process annually.

Effective programs use a planning process for continuous improvement: assessing needs, setting goals, implementing programs and evaluating the process as well as the outcomes. Based on the evaluation, plan for continuous improvement in your effort to reduce adolescent pregnancy and the spread of STDs.

FYI — Adapt worksheets 1,3 and 4 from *Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations* to annually assess outcomes and programmatic responses. The YRBS can be administered periodically to assess behaviors of adolescents. Each intervention implemented locally should include some type of process evaluation. Contact local professors in health education or adolescent medicine to assist the work teams in analyzing the data.

Chapter 3

Overhead Transparency Script for Reducing Pregnancy and the Spread of HIV and Other STDs Among Adolescents

The scripted set of 37 easily reproducible overhead transparencies can be used to inform and motivate different audiences. Reaching school staff, families, community members or students can best be achieved by using local statistics and events to tailor the script to each audience.

The transparency script is divided into seven sections, each leading up to the eighth section, call to action.

Transparency Script Topics

1) Understanding the problem
2) Factors contributing to the problem
3) Understanding solutions
4) Role of schools
5) Role of families
6) Role of students
7) Role of the community
8) Call to action

Understanding the Problem contains seven transparencies (1-7) introducing the problems associated with sexual activity that are faced by today's youth, particularly the spread of STDs and HIV. This section highlights statistics on high school students' emerging sexuality and sexual activity.

Factors Contributing to the Problem, made up of 10 transparencies (8-17) discusses the different factors that may promote or retard early sexual involvement. Individual factors, such as age and adolescence, risk-taking and psychoendocrinological changes, are highlighted in this section. Other risk factors discussed are those influenced by families, communities (including the media) and schools.

Understanding Solutions, containing two transparencies (18-19), introduces the upcoming roles and strategies proposed to help solve the problems.

Role of Schools, comprised of nine transparencies (20-28), combines effective instruction and curriculum, coordinated programs, multiple strategies, planning teams, systematic planning process and staff development to achieve desired goals.

Role of Families, which includes one transparency (29), and **Role of Students**, containing two transparencies (30-31), promotes both family and student involvement.

Role of the Community, referring to two transparencies (32-33), highlights promoting health and safety, preventing disease and injury and providing support and assistance to those with special needs by soliciting the help of community members.

All seven of these topics lead up to the **Call for Action**. This section, comprising four transparencies (34-37), is intended to motivate the audience by helping them to think more about the issues affecting their own community. In the Call for Action, the audience is asked to consider:

- *What should be our local focus?*
- *Who should be the target population?*

Finally, and most importantly, this section asks — *How do we proceed?* Audience members are challenged to commit to helping improve the health and well-being of adolescents by signing a contract. A sample copy of a contract is included after the script, in Figure 4.1 titled **Personal Action Plan**.

1 — Understanding the Problem

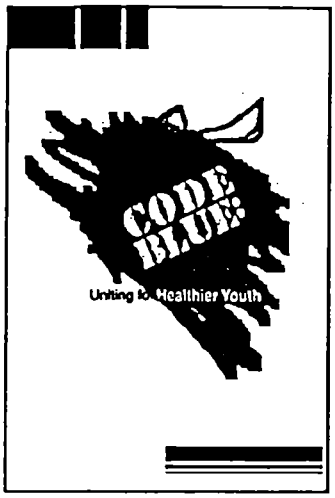
Transparencies 1 - 7

Today, students are often at a crossroads, where making the wrong choice may have life or death consequences. Most students, unlike the seminarian, will choose to become sexually active.[1] *(Refer to transparency #1)*

#1

A publication depicting the current health status of adolescents by the American Medical Association (AMA) and the National Association of State Boards of Education (NASBE) was titled *Code Blue*,[2] the universal phrase used in hospitals to signal a life-threatening emergency.
(Refer to transparency #2)

#2



With many youth, life-threatening emergencies result from unhealthy behaviors. Much of the unhealthy behavior revolves around the adolescent's emerging sexuality.

- Fifty-four percent of high school students have had sexual intercourse (57 percent of males and 51 percent of females);[3]
- Of students who have ever had sexual intercourse, 69 percent reported having had sexual intercourse during the preceding three months (currently sexually active);[3]
- Twenty-three percent of male high school students reported having had sexual intercourse with four or more partners, compared to 14 percent of female high school students;[3]
- Only 46 percent of currently sexually active high school students used a condom at last sexual intercourse;[3]
- Approximately one sexually experienced youth in four becomes infected with a sexually transmitted disease each year.[4] *(Refer to transparency #3)*

(In transparency #3, you should substitute state or local data, if available. Ask the HIV coordinator at the state department of education for results of the Youth Risk Behavior Survey).

#3

Unhealthy Lifestyles That Impede Educational Achievement

- 54% of high school students have had sexual intercourse
- 69% of sexually active students have had sexual intercourse within the last three months
- 23% of male high school students have had four or more partners compared to 14% of females
- 46% of currently sexually active high school students used a condom at last sexual intercourse
- One sexually active youth in four becomes infected with an STD each year

When we compare the sexual behavior of students 25 years ago with the behavior of students today, more students are sexually active. Further, we find students are becoming sexually active at younger and younger ages. In 1970, 4.6 percent[5] of adolescents age 15 reported having sexual intercourse. By 1991, the percentage had increased to 48 percent.[6] *(Refer to transparency #4)*

#4

Percentage of women ages 15-19 years who reported having had premarital sexual intercourse, by race and age - United States, 1970-1991

Race/age	1970+	1980+	1991*
All races			
9th grade			
Age 15	4.6	16.7	48
12th grade			
Age 18	39.4	56.2	66.7
Overall	28.6	42	54

+ Vital statistics of the National Center for Health Statistics, 1990.
* Public Health Reports, 1993.

Every time a teenage girl has intercourse, her chances of becoming pregnant range from 3 percent to 30 percent. However, over the course of a year of unprotected intercourse, her risk of pregnancy increases to 90 percent.[1] (Appendix B lists consequences of adolescent pregnancy.) *(Refer to transparency #5)*

#5

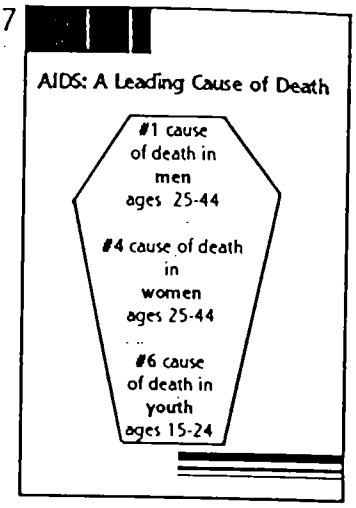
Pregnancy is not the only risky outcome. The high and rising rate of sexually transmitted diseases such as gonorrhea and syphilis among adolescents is of great concern.[7] While the exact incidence of STDs among adolescents is unknown because not all STDs are reportable,[8] the American Social Health Association estimates that every year, one in six adolescents contract an STD.[9] These STDs frequently produce no early symptoms in females and may result in more serious conditions such as pelvic inflammatory disease and, if left untreated, permanent sterility.[9]
(Refer to transparency #6)

#6

Sexually Transmitted Diseases

HIV is the most serious sexually transmitted disease risk confronting young people. This is the virus that causes the disease AIDS, for which there is no cure. Although the number of diagnosed AIDS cases for 13-19 year-olds is relatively small when compared to adults, there is cause for concern.[10] The signs and symptoms of contracting HIV may not be evident for as long as 10 years. Even so, it is the sixth leading cause of death in youth 15-24.[11] In young women, other STDs, such as gonorrhea and chlamydia, also may be initially asymptomatic. (Appendix B contains consequences of STDs.) *(Refer to transparency #7)*

#7

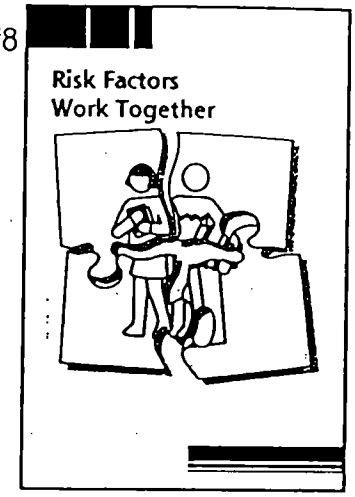


2 — Factors Contributing to the Problem

Transparencies 8 - 17

Various factors contribute to premature sexual activity.[12-14] Some factors are unique to the individual, while others are biological, social and environmental. For ease in understanding, the social and environmental factors will be discussed according to the social systems important in the adolescent's environment: family, peers, schools and communities. Within each system are factors that promote or retard early sexual involvement (Appendix C contains examples). However, often no single factor precipitates early sexual involvement, but a constellation of events. The variable most highly correlated with sexual activity is age.[1,14] *(Refer to transparency #8)*

#8

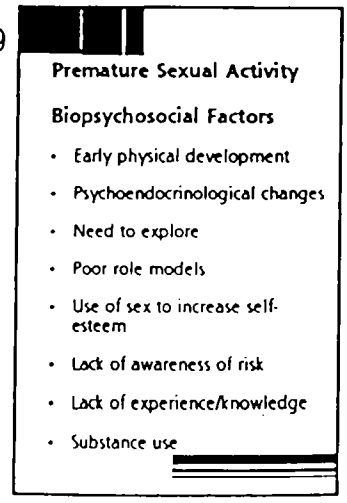


Individual Factors

Age is highly correlated with the timing of sexual initiation. Males engage in sex at an earlier age than females. Although it's a difficult phrase to pronounce, another factor leading to sexuality is "psychoendocrinological changes."[12] The rush of hormones circulating in the body of a maturing adolescent provides new motivations — it's as if the body decides to throw a party, but forgets to invite the head! The close relationship between pubertal development and pubertal hormones cannot be overlooked.[14]

Adolescence is also a period that frequently involves risk-taking, challenging authority and pushing limits. Risk-taking behaviors sharply increase with age. This may be related to a need to explore, poor role models and a lack of awareness of risk, experience or knowledge. Premature sexual activity also has been linked to early use of alcohol, tobacco, marijuana or other drugs[12-14] and delinquency.[13] *(Refer to transparency #9)*

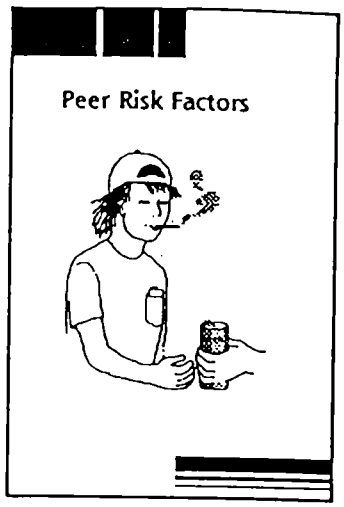
#9



Peer Risk Factors

An individual's behavior is influenced by family, friends and the community. Peer influence and modeling may supplant the family as a source of social influence.[14] Youth are likely to become involved with others who demonstrate attitudes and behavior like their own, or alter their behavior to fit into a group they deem desirable. Studies have concluded that having a same-sex best friend or close friends of both sexes who engage in premarital intercourse is one of the most powerful predictors of an individual's likelihood to have premarital sex.[14] ***(Refer to transparency #10)***

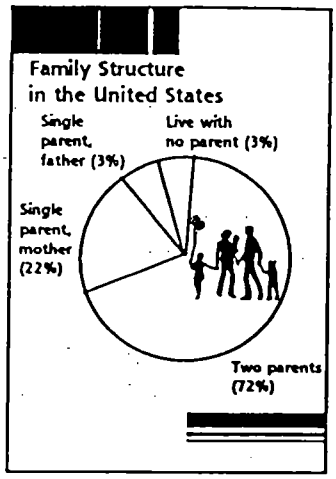
#10



Family Risk Factors

Family factors associated with premature sexual activity include family composition, income level, parental education and family bonding.[13] Families do not always comprised of provide the positive modeling and supervision they once did.[14] Further, families are not always comprised of two biological parents. A dramatic increase in out-of-wedlock births and divorce has contributed to about one in four children living in a single-parent family. It is estimated that of the children born this year, 60 percent will live in a single-parent family before they are 18 years old.[15] Those living with a single parent often reside in poverty. Regardless of one or two parents, young women from economically disadvantaged families are more likely to engage in early intercourse, more likely to conceive and more likely to become a single mom than women whose families are not impoverished.[1] ***(Refer to transparency #11)***

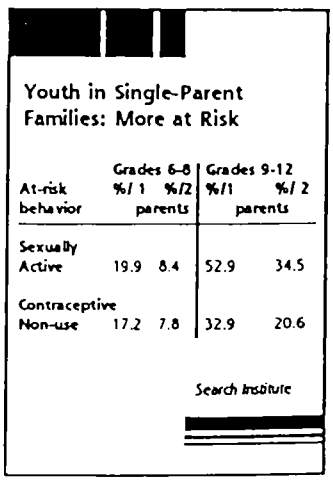
#11



Family structure does not dictate well-being, but on the average, youth in single-parent families are at greater risk. Regardless of the risk category or age group, the data[15] from a survey of 47,000 students found that the 8,266 youth living in single-parent families, on average, engaged in more risky behavior. (The risk remained even when researchers controlled for ethnicity or mothers' educational background.) For example, an adolescent from a one-parent family in grades 6-8 was more than twice as likely to be sexually active and not use contraceptives.[15]

- By *sexually active*, the researchers mean the young person has had sexual intercourse two or more times.
- The term *contraceptive non-use* refers to the student who was sexually active and the student or partner did not always use contraceptives. ***(Refer to transparency #12)***

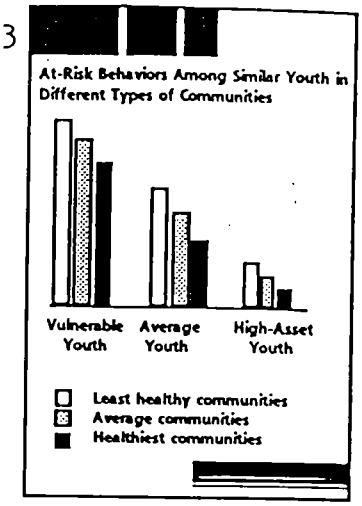
#12



Community Risk Factors

Just as family structure and income can contribute to risky behavior, so can community structure and income. Poverty, high unemployment and segregated neighborhoods are associated with early sexual activity.[13] The Search Institute looked at differences in the average number of risk behaviors of vulnerable, average and high-asset youth in communities rated from least healthy to healthiest.[16] The effect of community can be observed. While high-asset youth engage in fewer risky behaviors in each community than more vulnerable youth, the healthier the community, the fewer risky behaviors for all youth. ***(Refer to transparency #13)***

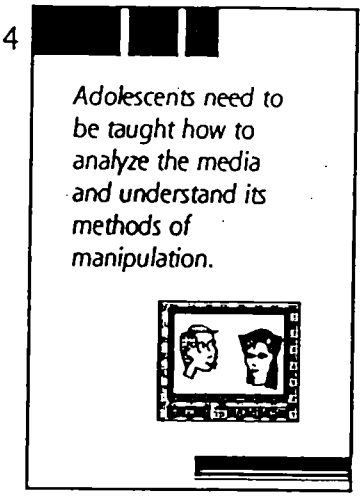
#13



Community Risk Factors: Media

The media is a powerful environmental factor. The amount of time a child spends watching television is inversely related to learning.[17] In addition, researchers have found that watching TV for more than three hours per day is related to engaging in a variety of health-debilitating behaviors.[18] Generally, the more time students spend watching TV, the less time they devote to learning.[17] As caring parents and professionals, we also should be concerned with the media content to which children are exposed. There are approximately 20,000 scenes of suggested sexual intercourse and behavior, sexual comments and sexual innuendo in a year of prime-time television. Messages of infidelity seem to overshadow those of fidelity. Television portrays six times more extra-marital sex than sex between spouses and 94 percent of sexual encounters on soap operas are between people not married to each other.[19] Given that adolescents watch approximately 24 hours of television per week,[20] they should learn to analyze the media and understand its methods of manipulation.
(Refer to transparency #14)

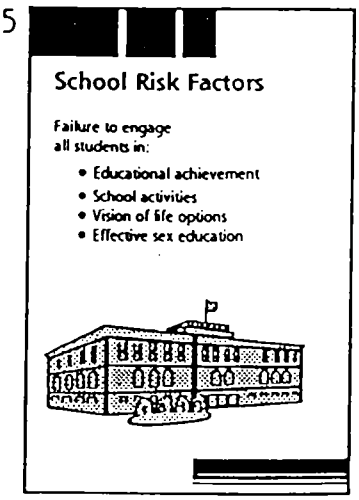
#14



School Risk Factors

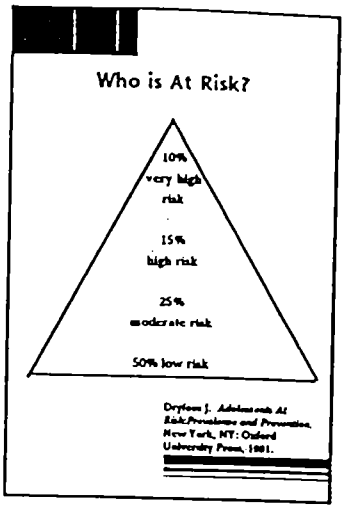
Schools also may be part of the problem. Students who have low grades, who are not engaged in school activities or who have low educational goals are more likely to engage in early sexual activity.[13,14] Ineffective sex education also has been cited as a cause of premature sexuality.[12] Certainly sufficient evidence shows an *effective* sex education program can postpone sexual involvement.[14] Zabin found that providing school-based counseling and school-linked reproductive services also delayed first sexual activity.[14,21] A caring and supportive school environment, along with motivated and committed students, improves the school climate and students' health. ***(Refer to transparency #15)***

#15



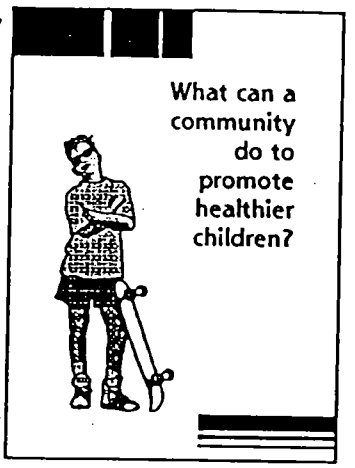
Often, there is a tendency to view adolescent behaviors in isolation. This prevents us from acknowledging that a young person involved in one health-debilitating behavior is probably involved in others, as well. Fortunately, many adolescents (50 percent) are at little or no risk.[13] Many teens do not use tobacco or other drugs or engage in intercourse. They may drink alcohol, but only occasionally. An additional 25 percent may adopt some of these behaviors experimentally, but not on a regular basis. An additional 15 percent engage in these behaviors periodically. The remaining 10 percent are considered very high risk: they do poorly in school, they abuse alcohol, engage in unprotected sexual intercourse and have multiple sexual partners.[13] *(Refer to transparency #16)*

#16



We know that adolescence is a bumpy, twisting road to adulthood filled with potholes big enough to swallow a Buick. What can we, as parents, teachers (students) and concerned community members do to make sure that our children (friends) are well-prepared to face this challenge? We know the nature of the problems and fortunately, we know some strategies that can make a difference. An integrated, multi-component approach that engages peers, families, schools and communities holds the most promise.
(Refer to transparency #17)

#17

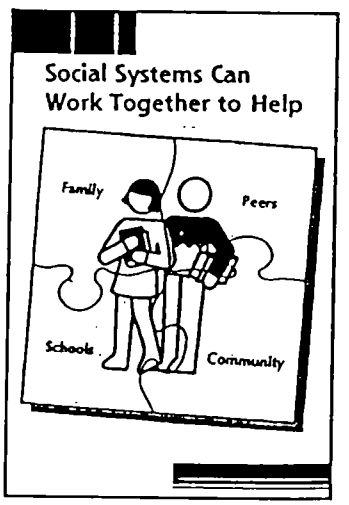


3 — Understanding Solutions

Transparencies 18 - 19

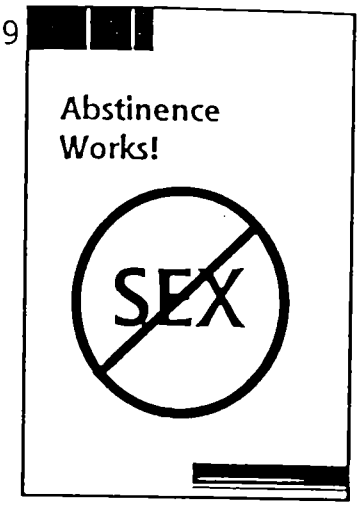
The same social systems that could be part of the problem can also be part of the solution. Social systems can work together to keep young people's lives intact. An integrated approach allows schools, families and communities to work with adolescents to postpone early sexual involvement, and other health-debilitating behaviors known to be part of a risk-filled lifestyle — alcohol, tobacco and other drugs. *(Refer to transparency #18)*

#18



Clearly, many young adolescents are not having sex or engaging in other high-risk behavior. For them, the repeated message of abstinence needs constant reinforcement. This strategy works very well with preteens and teens who value a sense of duty and accomplishment and who take behavioral cues from adult role models. For other adolescents, however, additional strategies will be necessary to protect their future. *(Refer to transparency #19)*

#19



4 — Role of Schools

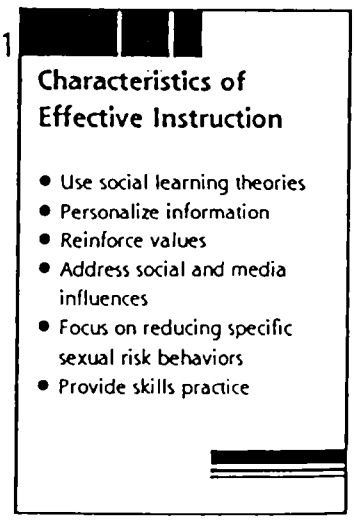
Transparencies 20 - 28

When society perceives a problem with young people, it often turns to schools to provide instruction to fix the problem. If there is anything we have learned, it is that knowledge alone will not be sufficient to prepare young people for these important choices. (Students, like the wolves viewing the succulent piglets in the picture, often choose to disregard what they know.) For example, 91 percent of young people believe sexually active teens should use condoms, and 86 percent know condoms are effective at reducing the risk of disease transmission. Yet only 46 percent of sexually active high school students actually used a condom at their last sexual intercourse.[3] In that regard, young people are much like the rest of us; we know what we should do, but often we continue to behave in health-compromising ways. *(Refer to transparency #20)*

#20

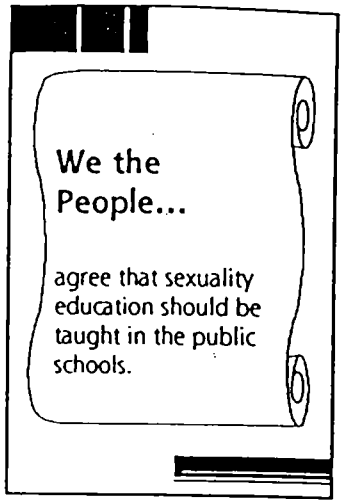
Effective Instruction — Accurate knowledge is important, to be sure, but only one of many components necessary in a successful program. School programs effective in helping teens postpone sexual activity have several common features:[22] 1) they are rooted in *social learning theories* that help students recognize social factors that influence behaviors and correctly assess group norms; 2) they provide accurate, *personalized* information using instructional methods that actively involve students; 3) they *reinforce* the message of *abstinence* and discourage unprotected sex; 4) they *analyze media* messages to distinguish truth from fiction; 5) they focus on specific *behaviors* (abstaining or using protection); and 6) they provide ample opportunities for students to *practice the skills* of positive communication, negotiation and refusal.
(Refer to transparency #21)

#21



Numerous studies have provided consistent evidence that the overwhelming majority (90 percent) of parents support the need for sexuality education in schools.[23] A comprehensive program of school health must support and sustain an effective prevention program that meets the needs of the students and families in our community. A comprehensive program unites the various systems that influence the adolescent: schools, communities, peers and families, but an effective curriculum provides a foundation to the program. *(Refer to transparency #22)*

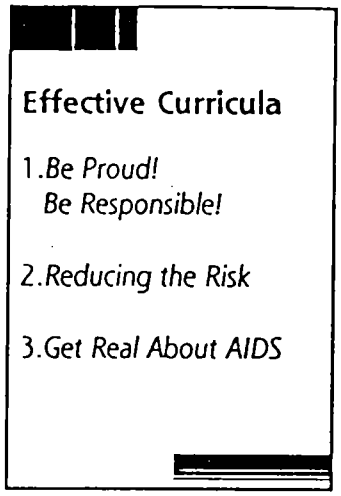
#22



Effective Curricula — Programs that provide teens with information about reproduction and contraception ***do not*** increase sexual activity.[24-31] However, they are not necessarily successful in reducing sexual activity. As of 1994, of 23 curricula evaluated by the Division of Adolescent and School Health (DASH) of the Centers for Disease Control and Prevention, only a few significantly reduced the number of sexually active teens or reduced the number of teens engaging in unprotected sex.[22] (A description of these programs is in Appendix D.)

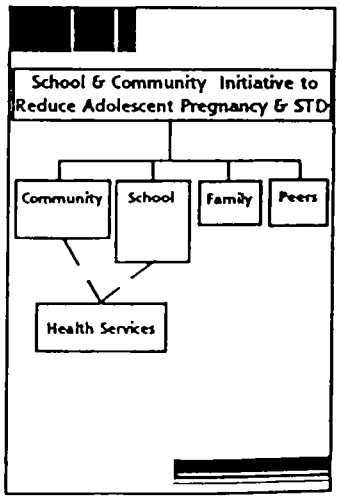
While there is evidence that these curricula are effective, classroom instruction is only one aspect of a well-crafted program.[13,19-20,23-24] *(Refer to transparency #23)*

#23



Coordinated Programs — Other critical components include access to health services that address physical and emotional needs, a counseling program for students at risk and a healthy school climate that reinforces positive habits and academic success. Further, school programs must be linked with community programs that reinforce and supplement the messages we want to communicate to our youth. The responsibility for health services can be in the hands of community agencies or the schools, or can be shared. School-based and school-linked clinics have both been shown to effectively postpone sexual activity.[32,33] Engaging families and peers also is critical. *(Refer to transparency #24)*

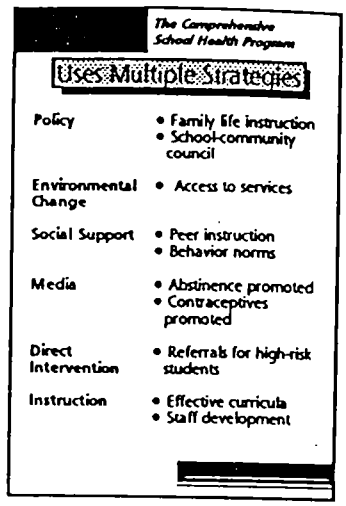
#24



Multiple Strategies — Reinforcing health-enhancing behaviors is a complex endeavor that requires using multiple strategies including school policy, environmental changes, social support, media and direct intervention, as well as instruction. These strategies can be provided at the school and community levels. (See Appendix E for additional strategies for pregnancy reduction. See pages 37-38 in *Building Coalitions to Prevent the Spread of HIV: Planning Considerations* for additional examples of STD reduction strategies.)

While instruction is critical and must begin before participation in the behavior is possible or probable, other strategies that reinforce, support and extend the curricular messages include policy mandates (i.e., admission of students with HIV, universal precautions, access to health care), environmental change (i.e., access to services), social support (i.e., peer instruction and role modeling), media (i.e., articles in student newspaper, PSAs on Channel One, posters) and direct intervention (i.e., referral of high-risk students to appropriate interventions). ***(Refer to transparency #25)***

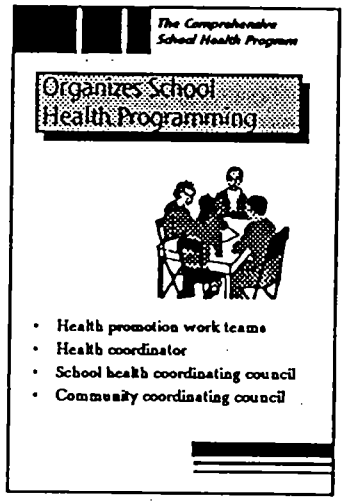
#25



Planning Teams — Individuals representing school faculty and staff must confer with parents, community representatives and students to craft an effective program. Remember the acronym TEAM: (Together Each Achieves More). A team approach can enhance program effectiveness.[34] Specific work teams (committees) that focus on a specific health promotion issue such as pregnancy prevention or STD and HIV prevention can successfully implement all-school programming targeting the specific health issue.

As schools organize work teams to address various issues within their school, they organize a school health coordinating council to coordinate activities of various work teams. Each school might have a school health council or committee that coordinates the work teams within the school. As the number of schools increases within a district, the district can convene a representative from each school's council at a community health coordinating council or coalition. ***(Refer to transparency #26)***

#26

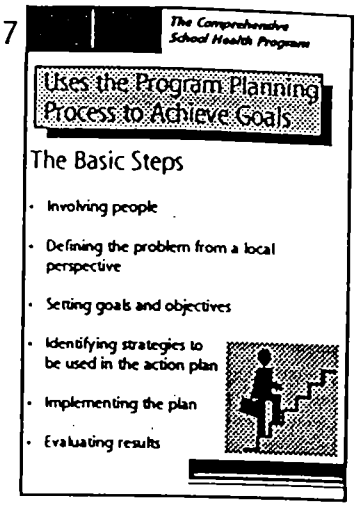


Systematic Planning Process — Program development needs to be made in an orderly, consistent manner in which goals are established, based on a variety of data. From needs assessment through evaluation, the program should be data-driven and responsive to local needs and values.

The basic steps in planning a school health improvement project include:

- involving people;
- defining the problem from a local perspective (assessment);
- setting local goals and objectives;
- identifying strategies to be used in the action plan;
- implementing the plan; and
- evaluating results.

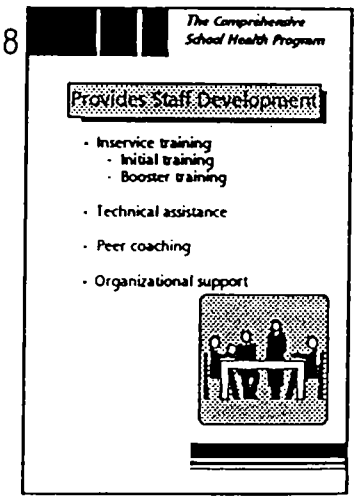
#27



The ideal school health improvement project links professionals within the school and integrates school activities with the community. School-based professionals, such as teachers, nurses, counselors, psychologists and administrators, can work with parents, community agency personnel, youth groups, the council of churches and students to devise a multi-faceted program delivered through curricular and extra-curricular efforts. Programs that provide teens with information about reproduction and contraception *do not* increase sexual activity.[24-31] *(Refer to transparency #27)*

Staff Development — Those who implement the program must feel prepared and confident so they can help their students achieve success. While many teachers, counselors and school nurses have accumulated graduate hours in addition to the minimum required to enter their professions, many individuals currently practicing within a school setting received training when little attention was directed to health, social and psychological factors that may interfere with learning. During the 1970s, health issues such as substance abuse and teenage pregnancy were identified as problems that could interfere with learning. HIV and AIDS were not addressed in the public schools until the late 1980s. All of these health issues present obstacles to learning for today's youth.[35] *(Refer to transparency #28)*

#28

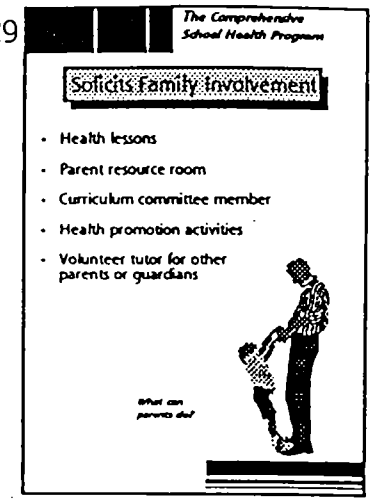


5 — Role of Families

Transparency 29

Families are the primary sexuality educators of their children. Schools can assist and support families in their efforts to nurture and prepare their children by actively involving them in the planning process. Families can make a difference in the quality of their children's general education if schools actively involve families in the education process.[36-38] Research documents the value of involving families in the school health program, regardless of whether the health behavior involves flossing,[37] preventing pregnancy,[39] refusing alcohol and other drugs[38] or choosing appropriate nutrients.[36] Thus, it is probably a fair assumption that parental involvement would also be valuable in HIV/AIDS prevention. ***(Refer to transparency #29)***

#29



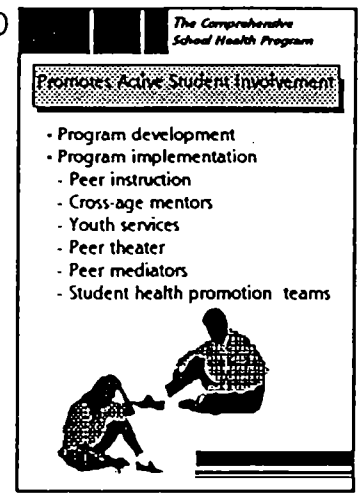
6 — Role of Students

Transparency 30

Peer instruction has proven effective in disseminating knowledge, changing attitudes and changing behavior.[22,40-43] Students are more likely to turn to peers for advice and behavior change is more likely to occur if someone similar to them recommends the change.[44] Peer instruction has been effective in improving decision-making and problem-solving skills, which may be prerequisite steps for implementing behavior change. Role modeling and peer support systems represent additional benefits of peer education programs. Peer involvement may occur in a variety of ways such as peer counseling, peer instruction, peer theater, peer mediation and cross-age mentoring.[45]

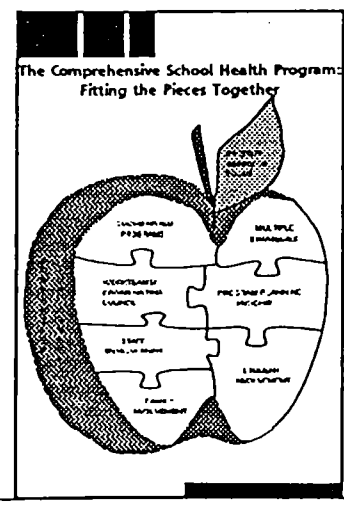
The rationale for using peer education is grounded in research from many disciplines. Peer resource programs enhance the academic and social development of youth. ***(Refer to transparency #30)***

#30



Schools can be instrumental in reducing teen pregnancy and sexually transmitted diseases by integrating the following elements: ***coordinating multiple programs*** within the school such as health instruction, health services, counseling and guidance; integrating school and community programs; using ***multiple strategies*** (policy, social support, environmental change, instruction and media — remember that knowledge alone is ineffective); using ***work teams*** and a ***program planning process*** that provides ***staff development***; and soliciting the ***active involvement of families and students.*** ***(Refer to transparency #31)***

#31

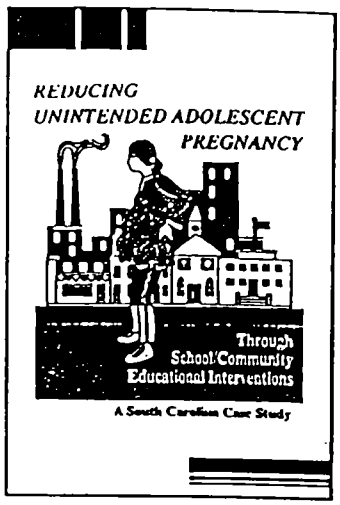


7 — Role of the Community

Transparencies 32 - 33

A South Carolina program effectively reduced pregnancy rates by using an intensive school and community-based education approach. This program involved parents, clergy and community leaders through workshops; trained students as peer counselors; provided teachers with graduate-level sexuality education programs; conducted media campaigns;[37] and used school nurses to provided contraceptive counseling, services and supplies for those who would not follow the prevailing message to delay sexual intercourse.[46] Schools working with community agencies can be effective. *(Refer to transparency #32)*

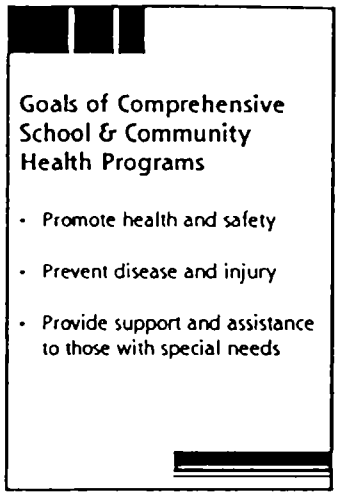
#32



Linking school and community programs is a means to improve and maintain the health and well-being of children and youth. The goals of a comprehensive school and community health program are:

- to **promote** health and safety;
- to **prevent** disease and injury (including STDs and unplanned pregnancy); and
- to **provide** support and assistance to those with special needs (including those at risk for premature sexual activity). *(Refer to transparency #33)*

#33



8 — Call to Action

Transparencies 34 - 37

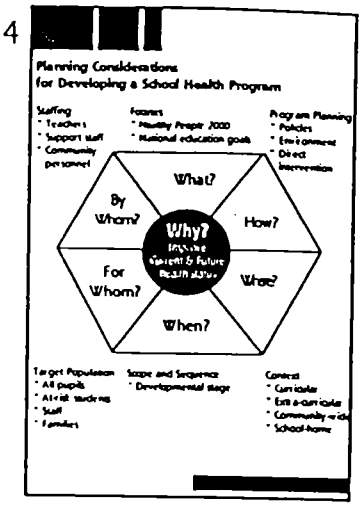
We have identified the problem, described factors contributing to the problem and provided a brief overview of the potential strategies to reduce the problem. The comprehensive school health program can serve as a process to bring everything together. Now we must decide if we are ready to act.

Will you join with me to improve the current and future health of our students? We must decide:[27]

- What should be our local focus?
  - HIV prevention?
  - other STD prevention?
  - pregnancy prevention?
  - pregnancy management?
- Who should staff our program?
  - teachers?
  - support staff?
  - community agency personnel?
  - parents?
  - students?
  - all (or a combination) of the above groups?
- Who should be the target population?
  - all pupils?
  - at-risk students?
  - staff?
  - parents?
  - all of the above
- Where and when should we deliver programs?
  - within the curriculum?
  - extracurricular events?
  - community-wide events?
  - homework assignments?
  - or a combination of the above?
- How do we proceed?
  - policy mandate (sexuality education, admission of HIV-positive students, universal precautions)?
  - environmental change (school-based or school-linked primary health care, coalition addressing reproductive health)?
  - direct intervention (for students engaging in high-risk behaviors, recommending confidential testing sites)?
  - role modeling and social support (peer instruction programs, support groups for students engaging in high-risk behaviors)?
  - media (public service announcements, distribution of literature at schools, churches, youth agencies)?
  - instruction (comprehensive health education, infused instruction across curriculum, peer instruction)?
  - or a combination of strategies?

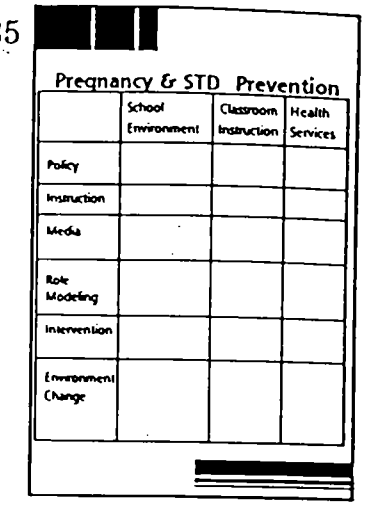
(Refer to transparency #34)

#34



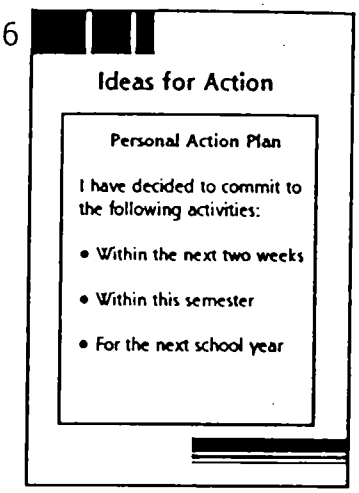
Will you work with me to organize a school/community response to HIV prevention and pregnancy prevention? Look at Appendix E, *A Multidisciplinary Approach to Pregnancy and STD Prevention*. Find the column that most closely approximates your role and read the suggested activities. Underline interventions that our school and community have already initiated and put an "X" by those that should be continued. Circle those that should be initiated. Talk to your neighbor and compare notes. What strategies need to be initiated in our community? Can we identify three to five specific initiatives that need to be implemented? ***(Refer to transparency #35)***

#35



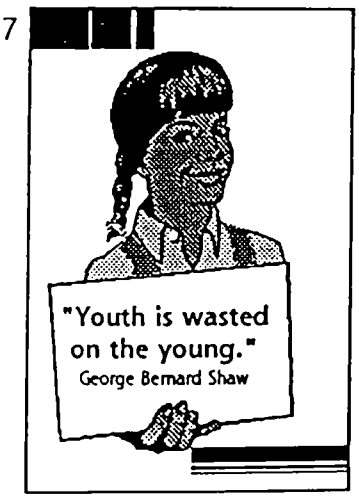
Will you sign a contract to improve the health and well-being of adolescents? A number of activities and ideas for action are listed on the second handout (*Ideas for Action*). Will you pledge to work individually or collectively to improve the health, well-being and educational achievement of the youth in our community? Please complete the personal action plan and return the top sheet. ***(Refer to transparency #36)***

#36



"George Bernard Shaw said that youth is wasted on the young, but unless we stop the spread of AIDS, too many of our young will never experience the peculiar delight of such a squander." — Deborah Prothrow-Stith, a physician at Harvard University.[47] ***(Refer to transparency #37)***

#37



Ideas for Action

This section should be used at the conclusion of the transparency presentation. The group leader can use these ideas for action when speaking to community members, students or families.

Areas for Involvement

1) Advocacy

2) Instruction

3) Counseling

4) Community integration

5) Family focus

6) Personal growth

7) Student focus

Advocacy

- Talk with principal, superintendent, or school board about the need to initiate or expand an existing adolescent pregnancy and STD prevention program that coordinates the activities of school nurse, health educator, guidance counselor and others.
- Talk with faculty as a group or individually about the need to initiate or expand an existing prevention program.
- Conduct a workshop for faculty, parents, students or community members on some aspect of a comprehensive approach to pregnancy and STD prevention.
- Organize an interdisciplinary task force to develop prevention programming.
- Organize a school-community coalition.
- Volunteer to speak at a PTA meeting on the role of parents, students, schools and communities in preventing teen pregnancy and STDs.
- Lobby for a sensitive and appropriate school policy on pregnancy and STD prevention.

Instruction

- Promote use of effective curriculum.
- Incorporate techniques that promote behavior change, decision-making, skill building and social action.
- Celebrate AIDS Awareness Week and Family Life Sexuality Month, encouraging parent-child dialogue.
- Conduct staff development programs on adolescent development and sexuality issues.
- Conduct parent training workshops on communicating with adolescents about sexuality issues.

Counseling

- Become a tutor or mentor for a student needing to enhance academic achievement.
- Organize a support group for students who are HIV-positive or living with AIDS, parenting teens or students at risk.
- When students enter the office for routine matters, initiate a dialogue about STDs and pregnancy prevention.
- Work one-on-one with a student in need.
- Link career planning, dropout prevention and job training programs with pregnancy prevention and family life education.

Community Integration

- Organize a coalition to improve adolescent reproductive health.
- Assess resources to determine gaps in services, accessibility and quality of existing services.
- Talk with community agency personnel about collaborating on prevention programs.
- Volunteer to assist with prevention programming.
- Market reproductive health services for adolescents.
- Expand recreational and cultural opportunities for youth.

Family Focus

- Initiate a conversation with your family members about reducing premature sexual activity,

adolescent pregnancy and STDs, including HIV.

- Attend a workshop on enhancing parent-child communication or adolescent development and sexuality.

Personal Growth

- Read one piece of literature on human sexuality, HIV prevention and growth and development needs of adolescents.
- Volunteer to help persons living with AIDS in the community.
- Write your elected officials when important bills are pending promoting reproductive health for adolescents.
- Challenge jokes and comments that inappropriately blame gay and bisexual men, blacks, Hispanics or IV drug-users for the transmission of HIV/AIDS.

Student Focus

- Organize a peer instruction group to promote reproductive health issues at school and community youth groups.
- Organize a theater group to perform street theater presentations on HIV, other STDs and pregnancy prevention.
- Raise funds to support community AIDS services and education.

Figure 4.1 — Personal Action Plan Worksheet

Personal Action Plan

"Small service is true service...the daisy, by the shadow that it casts, protects the lingering dewdrop from the sun."
— William Wordsworth

Having reviewed material documenting the components of a comprehensive school health education program, and having assessed the contribution of a comprehensive HIV education program in preventing the spread of HIV, I have decided to commit to the following activities.

Within the next two weeks:

_____

_____

_____

Within this semester:

_____

_____

_____

For the next school year:

_____

_____

_____

Signed:_____ **Date:** _____

Witness:_____

Home Address:_____ **Phone Number:** _____

_____

Figure 4.2

Sample Action Plans

This figure contains a variety of sample action plans to be used by community members, students or families. Sample action plans are available for six activities:

- Selecting Sexuality Education Curriculum;
- Infusing Sexuality Education Across the Curriculum;
- Coalition Building;
- Updating School Policies;
- HIV Prevention TEAM Management; and
- Dealing with Opposition.

Local communities can adapt these action plans to local needs, adding or deleting activities as needed. Local personnel who will complete each activity must be identified, along with a time line.

A master action plan is included at the end of this section for use in identifying the activities for additional proposed strategies as needed for a local initiative.

Figure 4.2 — Selecting Sexuality Education Curriculum

Name of school _____ Project leader_____

Choose goals for local initiative based on Appendix A (*Healthy People 2000* Objectives) or local needs.

Strategies	Activities	Personnel	Time Frame
Implement HIV prevention curricula within a comprehensive school health curriculum	1. Identify team members to review/select curriculum: health education specialist, curriculum specialist, teacher, school/district administrator, school counselor, principal, parents, school nurse, student, representative from a community health agency, such as the local health department; and representative from a local voluntary health agency. 2. Develop realistic, attainable goals for the curriculum. 3. Determine how the curriculum will fit into the overall comprehensive health program. 4. Provide committee members with analyses of expert testimony on sexuality education curricula.* 5. Carefully review the criteria for new curriculum. 6. Find out what curricula are being used by other districts, identifying and resolving potential problems and creating an idea network. 7. Secure copies of the curriculum that will be developed.		

* Examples:
- National Guidelines Task Force. *Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade*. New York, NY: Sex Information and Education Council of the United States, 1991.
- Kirby D, et al. School-based programs to reduce sexual risk behaviors: A review of effectiveness. *Public Health Reports*. 1994;109(3):339-360.
- Klein NA, et al. Evaluations of sex education curricula: Measuring up to the SIECUS guidelines. *Journal of School Health*. 1994;64(8):328-333.

Name of school _____ Project leader _____

Strategies	Activities	Personnel	Time Frame
Implement HIV prevention curricula within a comprehensive school health curriculum	8. Each team member should rate each curriculum independently for: • goals & objectives clarity; • content comprehensiveness and attainability; • teaching strategies; • learning activities; • materials required; • time required; • cultural equity; • sex equity; • evaluation ease; and • other. 9. Tally the scores for each curriculum based on the criterion for analysis. 10. The committee resolves any significant individual discrepancies, coming to a consensus about any necessary revisions. (Do not use the numerical score alone to make the final determination.) 11. Present the recommendations to staff, PTA, community, asking for comments. 12. Make final recommendations to administration.		

Infusing Sexuality Education Across the Curriculum *

Name of school _____ Project leader _____

Choose goals for local initiative based on Appendix A (*Healthy People 2000* Objectives) or local needs.

Strategies	Activities	Personnel	Time Frame
Infuse lessons on HIV prevention throughout the curriculum	1. Organize interdisciplinary team to write infused curriculum or to review and adapt commercial materials. 2. Set criteria for use of material. 3. Develop new lessons or adapt commercially prepared materials. 4. Photocopy lessons from curriculum for grades __, __, __, __, for distribution. 5. Notify faculty of curriculum infusion project at faculty meeting. 6. Provide staff development as needed. 7. Prepare note asking staff to use lessons during • Family Health Month (Oct.) • World AIDS Day (Dec.) 8. Distribute lessons explaining the need for their participation. 9. Conduct follow-up evaluation to ascertain use and acceptability.		
Infuse lessons on alcohol and other drugs throughout the curriculum	1. Photocopy lessons from curriculum, grade(s) __, __, __, __ for distribution. 2. Notify faculty of ESR curriculum at faculty meeting. 3. Prepare note asking staff to use lessons during • Red Ribbon Week (Oct.) • Drugged and Drunk Driving Month (Nov.) • Inhalant Awareness Week (March 20-26) • Alcohol Awareness Month (April) 4. Distribute lessons to colleagues in Language Arts, Science, Mathematics, Home Economics, Health and Art. 5. Conduct follow-up evaluation to ascertain use and acceptability.		

* One example of an inexpensive infused curriculum is ***Education for Self-Responsibility*** prepared by the Texas Education Agency. Infused lessons are available for HIV prevention; alcohol, tobacco and other drug prevention; and nutrition. Lessons are available for four levels: K-3, 4-6, 7-9, and 10-12. Each level for each topic costs $5.00. Contact: Texas Education Agency, 1701 North Congress Ave., Austin, TX 78701-1494.

Name of school _____ Project leader _____

Choose goals for local initiative based on Appendix A (*Healthy People 2000* Objectives) or local needs.

Strategies	Activities	Personnel	Time Frame
Coordinate school's HIV prevention programming with community coalition's HIV prevention programming.	**Organizing a Community Coalition** A. Document need 1. Identify epidemiological and social indicator data justifying need 2. Identify students' knowledge, attitudes and behaviors regarding prevention of HIV. 3. Identify community resources for HIV prevention and management. 4. Identify needs of parents and professionals with regard to preventing spread of HIV. B. Identify members 5. Identify individuals currently promoting health of children and youth. 6. Conduct interviews with potential coalition members. C. Organize members 7. Identify potential steering committee members. 8. Convene steering committee to identify common purpose and potential coalition members. 9. Invite potential coalition members to an organizational meeting. 10. Schedule organizational facilities, equipment, refreshments. D. Define governance 11. Develop mission statement. 12. Identify structure of coalition. 13. Establish governance procedures. 14. Develop a strategic plan.		

Name of school _____ Project leader _____

Strategies	Activities	Personnel	Time Frame
	Organizing a Community Coalition (continued) E. Initiate Projects 15. Organize committees/action work groups. 16. Develop programming to disseminate information. 17. Develop programming that promotes adoption of health enhancing behaviors. 18. Develop programming that coordinates community services. 19. Develop programming for advocacy efforts (media utilization/proclamations/positions/lobbying). 20. Secure funds to support coalition. F. Maintain Momentum 21. Build linkages 22. Develop programming to blunt criticism of controversial strategies. 23. Keep membership involved. 24. Address potential problems.		
Coordinate school's HIV prevention programming with community coalition's HIV prevention programming.	**Participation in Ongoing Coalition** 1. Identify schools' representative to community coalition. 2. Contact community coalition's CEO to set a date to discuss mutual programming. Include school representative in meeting. 3. Secure a listing of coalition meeting dates. 4. Inform the school's representative that payment for attending is contingent upon developing minutes of meeting that can be distributed to school. 5. Secure from the coalition representative minutes of every meeting. 6. Inform school staff of coalition's activities and seek their involvement as needed. 7. Conduct evaluation of process and outcomes of coalition activities. 8. Submit evaluation to district office.		

Name of school _____ Project leader _____

Choose goals for local initiative based on Appendix A (*Healthy People 2000* Objectives) or local needs.

Strategies	Activities	Personnel	Time Frame
Enhance "working policies that support prevention of HIV and other STDs.	1. Review policy to assure the existence of: • admission of staff/students with HIV/AIDS; • confidentiality procedure for both students and staff; • identification and referral procedures for high-risk students; • promotion of reproductive health care via school-based clinic; • reproductive health care in school-linked facility; • staff development to promote HIV prevention programs; • implementation of universal precautions • instruction on HIV prevention; • condom availability from school-based or school-linked clinic. 2. Collaborate with health department and community professionals to develop/review policies. 3. Pass resolutions detailing school policy on HIV prevention, if not currently available. 4. Explain school policies to students, family members and community. 5. Develop school and community displays to promote policies and programs to students and their families. 6. Collaborate with community coalitions to enforce policies, screening and treatment and educational programs. 7. Conduct staff development programs to acquaint staff with policies and programs.		

Healthy People 2000 Objectives

This section gives goals for reproductive health and the prevention of HIV and other STDs. Under the topic of reproductive health, objectives are highlighted for both family planning and maternal and infant health.

Consequences of Early Sexual Involvement

This table contains the consequences associated with certain behaviors. It highlights both short- and long-term consequences that adolescents face when they engage in sexual intercourse or become pregnant at young age.

Factors Associated with Premature Sexuality and Childbearing

This table uses demographics, personal traits, peers, family, school and community to define youth more highly at risk for early sexual intercourse, nonuse of contraception and early childbearing.

Examples of Effective Curricula

The Centers for Disease Control and Prevention (CDC) has identified four curricula that are effective in reducing behaviors leading to STDs and pregnancy. Further, the CDC has published a monograph on a community-wide program in South Carolina that significantly reduced teenage pregnancy.

A Multidisciplinary Approach to Pregnancy and STD Prevention

At the conclusion of the transparency presentation to school staff and community professionals, the call to action should be guided by reviewing appropriate strategies for 1) various disciplines, 2) community agency personnel and 3) family members. *A Multidisciplinary Approach to Pregnancy and STD Prevention* (Appendix E) provides an overview of potential roles and responsibilities for school staff, community members, families and students. Instructions on using the grid are provided on page 23.

General Resources

Other resources from the American School Health Association are provided, along with references found in most libraries.

Overhead Transparency Masters

The overhead transparency masters are provided to be used with the overhead transparency script.

Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations

This manual provides a step-by-step outline for organizing a community coalition. While the document focuses on HIV prevention, it also can be used to organize the community to address reducing teen pregnancy. The local planner may follow the guide and organize a coalition or use the worksheets from the manual 1) to assist a community group that already has been organized; or 2) to organize an ad hoc task force to launch this initiative. It is strongly recommended that families, students, community members and school staff be included in the initiative.

Appendix A

Healthy People 2000 Objectives: Reproductive Health

Family Planning

5.1 Reduce pregnancies among girls ages 17 and younger to no more than 50 per 1,000 adolescents. (Baseline: 71.1 pregnancies per 1,000 girls ages 15 through 17 in 1985.)

5.2 Reduce to no more than 30% the proportion of all pregnancies that are unintended. (Baseline: 56% of pregnancies in the previous five years were unintended, either unwanted or earlier than desired, in 1988.)

5.4 Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15% by age 15 and no more than 40% by age 17. (Baseline: 27% of girls and 33% of boys by age 15; 50% of girls and 66% of boys by age 17; reported in 1988.)

5.5 Increase to at least 40% the proportion of ever sexually active adolescents ages 17 and younger who have abstained from sexual activity for the previous three months. (Baseline: 24% of sexually active girls ages 15 through 17 in 1988.)

5.6 Increase to at least 90% the proportion of sexually active, unmarried people ages 19 and younger who use contraception, especially combined method contraception that effectively prevents pregnancy and provides barrier protection against disease. (Baseline: 78% at most recent intercourse and 63% at first intercourse; 2% used oral contraceptives and the condom at the most recent intercourse; among young women ages 15 through 19 reporting in 1988.)

5.8 Increase to at least 85% the proportion of people ages 10 through 18 who have discussed human sexuality, including values surrounding sexuality, with their parents and/or have received information through another parentally-endorsed source, such as youth, school, or religious programs. (Baseline: 66% of people ages 13 through 18 have discussed sexuality with their parents; reported in 1986.)

5.10 Increase to at least 60% the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline: data available in 1992.)

Maternal and Infant Health

14.4 Reduce the incidence of fetal alcohol syndrome to no more than 0.12 per 1,000 live births. (Baseline: .22 per 1,000 live births in 1987.)

14.5 Reduce low birth weight to an incidence of no more than 5% of live births and very low birth weight to no more than 1% of live births. (Baseline: 6.9% and 1.2%, respectively, in 1987.)

14.10 Increase abstinence from tobacco use by pregnant women to at least 90% and increase abstinence from alcohol, cocaine, and marijuana by pregnant women by at least 20%. (Baseline: 75% of pregnant women abstained from tobacco use in 1985.)

Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington, DC: US Dept of Health and Human Services publication (PHS) 91-50212; 1991.

Healthy People 2000 Objectives: Prevention of HIV and Other Sexually Transmitted Diseases

HIV/AIDS

18.1 Confine annual incidence of diagnosed AIDS cases to no more than 98,000 cases. (Baseline: An estimated 44,000 to 50,000 diagnosed cases in 1989.)

18.2 Confine the prevalence of HIV infection to no more than 800 per 100,000 people. (Baseline: An estimated 400 per 100,000 in 1989.)

18.10 Increase to at least 95% the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education. (Baseline: 66% of school districts required HIV education but only 5% required HIV education in each year for 7th through 12th grade in 1989.)

Other Sexually Transmitted Diseases

19.1 Reduce gonorrhea among adolescents ages 15-19 to an incidence of no more than 750 cases per 100,000 people. (Baseline: 1,123 per 100,000 in 1989.)

19.2 Reduce Chlamydia trachomatis infections, as measured by a decrease in the incidence of non-gonococcal urethritis, to no more than 170 cases per 100,000 people. (Baseline: 215 per 100,000 in 1988.)

19.3 Reduce primary and secondary syphilis to an incidence of no more than 10 cases per 100,000 people. (Baseline: 18.1 per 100,000 in 1989.)

19.5 Reduce genital herpes and genital warts, as measured by a reduction to 142,000 and 385,000 respectively, in the annual number of first-time consultations with a physician for the conditions. (Baseline: 167,000 and 451,000 in 1988.)

19.6 Reduce hospitalizations for pelvic inflammatory disease to no more than 250 per 100,000 women ages 15 through 44. (Baseline: 311 per 100,000 in 1988.)

19.7 Reduce sexually transmitted hepatitis B infection to no more than 30,500 new cases. (Baseline: 58,300 cases in 1988.)

19.10 Increase to at least 50% the proportion of sexually active, unmarried people who used a condom at last sexual intercourse. (Baseline: 19% of sexually active, unmarried women ages 15 through 44 reported that their partners used a condom at last sexual intercourse in 1988.)

19.12 Include instruction in sexually transmitted disease prevention in the curricula of all middle and secondary schools, preferably as part of quality school health education. (Baseline: 95 % of schools reported offering at least one class on sexually transmitted diseases as part of their standard curricula in 1988.)

Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington, DC: US Dept of Health and Human Services publication (PHS) 91-50212; 1991.

Appendix B

Consequences of Early Sexual Intercourse and Early Pregnancy

Behavior	Consequences	
	Short-Term	*Long-Term*
Early Sexual Intercourse		
Frequent sex with multiple partners	Sexually transmitted diseases (STDs) Pelvic inflammatory disease (PID)	Infertility Ectopic pregnancies Cervical cancer Infections in newborn
With use of intravenous drugs, or partner using drugs, or bisexual	HIV positive	AIDS Mortality
Contraceptive problems • Failure of method • IUD side effects • Pill side effects	Unintended pregnancy PID Inconsequential, if under medical supervision	Possible long-term health effects (conflicting evidence)
Unprotected intercourse	Pregnancy: usually unintended	(See *Early Pregnancy*)
Early Pregnancy		
	Early childbearing *Mother:* complications, toxemia, anemia, prolonged labor If <15, higher risk of mortality	*Mother:* reduced educational attainment, more subsequent births closer together and unintended, marital instability, lower status jobs, poverty, welfare
	Baby: prematurity, low birth weight	*Child:* lower achievement, more emotional problems, high risk of becoming a teen parent, life in poverty
	Abortion	Possible future spontaneous abortions
	Adoption	Effects unknown

Dryfoos J. *Adolescents at Risk: Prevalence and Prevention*. New York, NY: Oxford University Press; 1990.

Appendix C

Factors Associated with Premature Sexuality and Childbearing

Antecedent	Early Sexual Intercourse	Nonuse of Contraception	Early Childbearing
Demographic			
Age		** Early sex	** Early sex
Pubertal development	* Males		
Sex	** Males		
Race/ethnicity	** Blacks	* Hispanics	** Blacks
Personal			
Conformity-rebelliousness	* Nonconformity		
Beliefs about risk		* Unconcerned	
Involvement in other high-risk behaviors	* Early delinquency * Substance use		
Psychological factors		* Impulsive	
Self-esteem		* Lack locus of control	
Conduct, general behavior	** Truancy		** Delinquency
Religiosity	** Low attendance		** Low Attendance
Peers			
Peer influence	** Heavy influence		* Peer attitudes
Peer use		* Emulate peers	
Relationship to partner		** Uncommitted	
Family			
Household composition	* Single-headed		** Single-headed
Income, poverty status	** Low income		** Low income
Parental education	** Low level	** Low level	** Low level
Parental role, bonding	** Lack of support and communication	** No communication	** Lack of support and monitoring
Parental practice of high-risk behaviors	* Permissive parents		** Mother was teen mom
Culture in home			* Lack resources
Siblings	* Large family		** Unmarried sisters are teen moms
Schools			
Expectations for education	** Low	** Low	** Low
Perception of life options	* Poor prospects	* Poor prospects	* Poor prospects
School grades	** Low	** Low	** Low
Community			
Neighborhood quality	* Poverty area		** Poverty area
Segregation	** Blacks in segregated schools		** Blacks in segregated schools
Employment situation	* High unemployment		** High unemployment

* = Several sources agree that factor is a major predictor
** = Most sources agree that factor is a major predictor

Dryfoos J. *Adolescents At Risk: Prevalence and Prevention*, New York, NY: Oxford University Press; 1990.

Appendix D

Research to Classroom

Dissemination Project of the Division of Adolescent and School Health (DASH), National Center for Chronic Disease Prevention & Health Promotion and Centers for Disease Control and Prevention (CDC)

Consistent with CDC's practice of applying research findings to prevent disease and injuries, the Division of Adolescent and School Health (DASH) has initiated a project to identify and disseminate curricula that have credible evidence of effectiveness in reducing health risk behaviors among youth. Although the CDC can identify curricula that meet predetermined criteria, it does not endorse curricula. Schools should decide what curricula best meet their students' needs.

DASH's dissemination project is on-going, adding new curricula annually. The project involves five stages that begin with (1) selecting curricula. A set of evaluation experts and another set of program experts identify curricula that meet predetermined criteria (see "Criteria for Selection of HIV-Prevention Curricula"). Then DASH works with developers and national organizations to (2) update and revise materials for use by classroom teachers nationally.

(3) DASH introduces selected curricula to its state and local education agency (SEAs/LEAs) grantees and to members of an already established network of state-level teacher training centers. Those agencies introduce the newly selected curricula to school districts for their consideration. (4) Schools select curricula that meet the needs of their students. Meanwhile CDC, national organizations and developers arrange for (5) training of master trainers and technical assistance to SEAs/LEAs. SEAs provide training for teachers from interested LEAs.

In 1992-1993, DASH carried out the first cycle of the project with a curriculum for grades 9 and 10, *Reducing the Risk*. In order to complete the first cycle, DASH worked collaboratively with two national organizations — Education Development Corporation, Inc. (EDC) and ETR Associates. Each year the number of curricula selected will depend on how many meet the criteria, the degree of local interest and available funding.

Currently the curricula selected must show evidence of influencing sexual risk behaviors for infection with HIV, other STDs and unintended pregnancies. As funding becomes available, DASH intends to expand the project to include curricula that reduce other risk behaviors among youth. Although these curricula address categorical areas, CDC encourages schools to incorporate such curricula into planned, sequential comprehensive school health education that is a component of a broader comprehensive school health program.

Curriculum Facts

Target Audience

Grades 9 and 10.
The curriculum also has been successfully implemented in both middle and high schools

Objectives

At the completion of the program, students will be able to:

- evaluate the risks and lasting consequences of becoming an adolescent parent;
- recognize that abstaining from sexual activity or using protection consistently are the only ways to avoid pregnancy or HIV and other STDs;
- conclude that factual information about conception and protection is essential for avoiding teenage pregnancy or HIV and other STDs; and
- demonstrate effective communication skills for remaining abstinent and for avoiding unprotected sexual intercourse.

Topics

- Vulnerability to pregnancy and HIV
- Advantages of abstinence
- Refusal skills and delay tactics, and how they can be effectively used to avoid unprotected sex
- Recognizing and avoiding high-risk situations
- Getting and using protection to avoid unwanted pregnancy, and STDs including HIV, through having students:
  - -learn about contraceptive products;
  - -research prices and descriptions of non-prescription products;
  - -locate and/or contact clinics to obtain information about services; and
  - -apply knowledge about protection to decide which method(s) might be best for them.
- Information about transmission and prevention of five STDs
- Behaviors that place individuals at greatest risk for exposure to HIV
- Developing plans for protection, including talking to a partner, getting protection and using protection
- Maintaining plans to avoid sex or unprotected sex

Evaluation Facts

Intervention

During fall 1988 or spring 1989, 13 high schools in 10 California school districts implemented the curriculum during 15 consecutive class periods. Four hundred twenty-nine 9th and 10th grade students received the curriculum; 329 students served as a comparison group and received the standard sexuality education class taught at each school. The curriculum was implemented as part of a more comprehensive, required health education class.

Behavioral Findings

After 18 months, students who had not had sexual intercourse before the intervention reported significantly less initiation of intercourse than students in the comparison group. Those who were sexually active 18 months later reported using contraception more often than those in the comparison group.

Other Significant Findings

Intervention group students had a greater increase in knowledge about risk of pregnancy and STDs, proper use of condoms and other forms of contraception than did students in the comparison group. The program also significantly affected students' perception of the proportion of their peers who had ever had sexual intercourse.

Observers who assessed implementation found 95 percent of teachers using RTR followed the lesson plan, completed the activities and gave accurate answers to students' questions. More than 85 percent were comfortable teaching the curriculum and were adequately prepared.

Research Design

In the quasi-experimental design, 23 health education classes received intervention and another 23 classes received standard health classes. Following implementation, students, teachers and parents assessed the curriculum. Students were surveyed through confidential questionnaires before (baseline), immediately after and six and 18 months after intervention. In addition, observers visited participating classes at least once to assess the fidelity of implementation as well as teachers' levels of comfort and preparation with teaching the curriculum.

Be Proud! Be Responsible!
Strategies to Empower Youth to Reduce their Risk for AIDS

Curriculum Facts

Target Audience
African-American, Hispanic and white youth, ages 13-18, who attend inner-city schools and community-based programs

Objectives
At the completion of this program, students will:
- increase their knowledge about HIV, AIDS, and other STDs;
- believe in the value of safer sex, including abstinence;
- have confidence in their ability to negotiate safer sex and to use condoms correctly;
- be able to use condoms and negotiate sexual situations;
- intend to practice safer sex;
- reduce sexual risk behaviors; and
- take pride in and responsibility for choosing responsible sexual behaviors.

Topics
- Knowledge about the etiology, transmission and prevention of HIV, AIDS and other STDs
- Beliefs about a) personal risk of HIV infection, b) abstinence and use of condoms and spermicide as means to reduce the risk of HIV infection, c) a partner's willingness to accept safer sex practices and d) condoms as a means for enhancing sexual enjoyment
- Skills to reduce risky behaviors-negotiation, refusal and condom use
- Self-efficacy and confidence in using the skills taught

Length
Five hours. Can be implemented in five to six sessions of 45-60 minutes, in two, two and one-half hour sessions or in one, five-hour session.

Activities
A series of fun and very interactive learning experiences designed to increase participation and enhance learning. Activities include educational videos, trigger films, role plays, condom demonstrations and other exercises. Most are brief, lasting no more than 20 minutes.

Evaluation Facts

Intervention
In the research study, the five-hour curriculum was implemented in the single-day format on a Saturday at a local school.

Behavioral Findings
Three months following the study, the intervention students reported less risky sexual behavior than did students in the control condition. Students in the AIDS risk-reduction condition reported having sexual intercourse on fewer occasions and with fewer women. Those who had sexual intercourse used condoms more consistently and a smaller percentage of them reported engaging in anal intercourse.

Other Significant Findings
Students who participated in the AIDS risk reduction curriculum scored higher on a test of AIDS and STD knowledge, expressed less favorable attitudes toward risky sexual behavior and reported weaker intentions to engage in risky sexual behavior than students who had participated in the control condition.

Research Design
Participants were 157 inner-city African-American male adolescents. Their ages ranged from 12-19, with a mean of 14.6 years. Students were assigned randomly within age to the AIDS risk-reduction intervention or a control condition which received instruction on career opportunities. Students received the curriculum in groups of 6-8 by a trained adult facilitator. Because students were stratified by age, each group had a mix of ages, the average age being about the same. One-half of the groups were led by a male facilitator and one-half were led by a female facilitator.

Participants completed questionnaires before, immediately after and three months after intervention. Of the original 157 students, 150 or 96 percent returned to complete the three-month follow-up questionnaire. The measures included HIV risk-associated sexual behavior, intentions to engage in risky sexual behaviors, attitudes toward risky sexual behaviors and AIDS and STD knowledge.

Get Real About AIDS

Curriculum Facts

Target Audience
Grades 9-12

Objectives
At the completion of the program, students will:
- reduce their risk of becoming infected with HIV;
- delay sexual activity;
- increase their use of condoms, if they are sexually active; and
- decrease the number of their sexual partners, if they are sexually active.

Topics
- Perception of vulnerability to HIV
- Functional knowledge about HIV, including its transmission, its nontransmission, its effects and the following:
  - -myths and facts about HIV
  - -testing for the presence of antibodies to HIV
  - -the use of condoms
  - -sexually transmitted diseases other than AIDS
- Skills to avoid risky situations
- Norms related to sex and AIDS

Length
13 classes

Activities
Entertaining activities easy to teach and fun to learn, including discussions, role plays, simulations and videos

Components
- A Teacher's Guide, including 13 lessons, fact sheets, teacher sheets, work sheets, an overview section which includes a scope and sequence, student learning objectives and a chart of materials used in the unit.
- Kit materials needed to teach the lessons.
- Parent newsletter, including the Surgeon General's *Report to the American Public on HIV Infection and AIDS.*
- A container holding the Teacher's Guide and all the materials needed to teach the lessons.
- A variety of training options, including training of trainers.

Evaluation Facts

Intervention
Six Colorado school districts delivered the intervention during fall 1991. More than 2,800 grade 9-12 students received the skills-based curriculum for 15 consecutive school days. Many intervention schools also implemented activities that reinforced lesson themes, such as displaying HIV posters and distributing wallet-sized HIV information cards. In comparison schools, teachers continued to offer their usual HIV programs.

Behavioral Findings
Intervention students were more likely to report purchasing a condom than students in the control condition. Sexually active students reported having fewer sexual partners within the past two months and using a condom more often during sexual intercourse. The intervention did not significantly postpone the onset of sexual intercourse.

Other Significant Findings
Intervention students scored significantly higher on an HIV knowledge test than comparison students. Intervention students expressed greater intention to engage in safer sexual practices and they were more likely to believe someone their age who engaged in risky behaviors could become infected with HIV.

Classroom observations indicated teachers included 75 percent of lesson components and taught those components with 89 percent fidelity (i.e. taught as written). Most teachers rated all lessons as more effective than their usual lessons and reported student reactions as extremely positive.

Research Design
In the quasi-experimental design, 17 schools were assigned to intervention (n = 10) or comparison (n = 7) groups. Within each district, comparison and intervention schools were matched on grade, gender and racial/ethnic distribution. Students completed a self-report questionnaire at baseline, at the end of the first semester and at the end of the school year (i.e., six months after the intervention). Trained observers also collected program implementation data to determine the extent that students received the entire curriculum (completeness) and the extent that teachers adhered to specific activities within each lesson (fidelity).

Where to Obtain Materials and Training

Contact the following organizations to order materials or to arrange for training from the curriculum developers. They are the best source of information about prices, which often vary depending on your needs. In addition to the developers, many state education agencies and the two organizations that collaborate with CDC on this project have the capacity to train on one or more of the curricula. For information about other training options, contact the HIV coordinator in your state education agency, Phyllis Scattergood at EDC, 617 / 969-7100, or Julie Taylor at ETR Associates, 408 / 438-4060. For information about the identification of a curriculum as a Program that Works, contact CDC at 404 / 488-5356.

Be Proud! Be Responsible! Strategies to Empower Youth to Reduce Their Risk for AIDS

By Loretta Sweet Jemmott, John Jemmott and Konstance McAffree

Materials available from:
Select Media, 212 / 431-8923

Components include:
- a teacher's guide;
- kit materials needed to teach the lessons; and
- video clips.

Training available through:
Rocky Mountain Center for Health Promotion and Education Staff Development Office, 303 / 239-6494.

Get Real About AIDS

2nd Edition, High School Level

By Comprehensive Health Education Foundation (CHEF)

Materials available from:
CHEF Customer Service Department, 800 / 323-2433.

Components include:
- a teacher's guide;
- kit materials needed to teach the lessons;
- parent newsletters;
- video clips; and
- a container for the components.

Training available through:
CHEF's Training Coordinator, 800 / 323-2433

Reducing the Risk

2nd Edition

By Richard Barth

Materials available from:
ETR Associates, 800 / 321-4407

Components include:
- a teacher's manual and
- optional student workbook.

Available in the fall of 1995:
- Revised manual
- Optional kit
- Optional student workbooks in English and Spanish versions.

Training available through:
ETR Associates Training Department, 800 / 321-4407

Appendix E

A Multidisciplinary Approach to Pregnancy and STD Prevention

	Total School Environment *Superintendents, Principals, School Boards*	Classroom Instruction *Elementary and Secondary Teachers*	Physical Education *Content Specialists, Coaches, Trainers*	Health Services *Nurses, Nurse Practitioners, School Physicians*
Policy	**Develop** policies on: family life education within K-12 health curriculum, elective junior high secondary classes, primary health care in school-based and school-linked clinics, admission of staff and students with HIV/AIDS, confidentiality procedures, universal precautions.	**Assist** in the development of pregnancy prevention and management policies when requested. **Comply** with AIDS/HIV policies.	**Comply** with policies.	If school has no primary health clinic, **promote** policy to have school clinic staffed several times a week from 2:30 to 5 PM for individual and group counseling on reproductive health. **Implement** universal precautions policy.
Environmental Change	**Establish** a school-based clinic or open school clinic once a week for reproductive health instruction and services. **Implement** day care for teen mothers, tutoring, and remedial programs. **Organize** a Teen Pregnancy/STD Prevention Coalition.	**Use** teachable moments to reinforce pregnancy prevention and universal precautions messages. **Offer** elective classes on family life education. **Implement** a lending video and print library for parents focusing on reproductive health and communication on sexual issues with children.	**Use** teachable moments to raise HIV/AIDS awareness and the value of postponing sexual involvement.	**Prominently** display in clinic pamphlets on puberty, talking to parents about sex, etc. **Implement** school-based/school-linked primary care which includes reproductive services. **Promote** universal precautions. **Participate** in Pregnancy/STD Prevention Coalition.
Media Utilization	**Promote** use of school media to increase awareness of the consequences of unprotected sexual activity, early pregnancy, STDs/HIV. **Identify** in student handbook directory and local agencies providing reproductive health services.	**Use** a variety of classes, movies, pamphlets, and fact sheets to address prevention, management, and consequences of premature sexuality. **Promote** student theater and music programs which promote pregnancy prevention and postponing sexual activity. **Use** student newspaper and PA system for messages.	**Use** gymnasium and locker room bulletin boards to provide information on consequences of premature sexuality, adolescent parenthood, and sexually transmitted diseases.	**Distribute** announcements advertising teen health clinics. **Write** an "Ask a Nurse" column in the school newspaper which focuses on sexual and other teen issues. **Distribute** list of agencies providing reproductive and parenting services. **Distribute** fact sheets on HIV and other STDs to students and staff.
Direct Intervention	**Provide** programming to pregnant students that encourages their completion of school. **Link** pregnancy prevention with education remediation, dropout prevention, and employment training programs. **Identify** local STD clinics and anonymous testing sites in student handbook.	**Identify** and refer high-risk students for intervention programming. **Develop** in conjunction with the counselor programs targeting specific high-risk populations. **Facilitate** self-referral of students for STD/HIV testing.	**Initiate** dialogue with students on reproductive health issues as appropriate. **Facilitate** self-referral of high-risk students for intervention program. **Adopt** physical activity program for pregnant students or those with HIV.	**Initiate** questions about reproductive health when students come to clinic for routine care. **Facilitate** self-referral of students to screening and intervention programming. **Ensure** all pregnant students receive early prenatal care and information on the effects of alcohol and drugs on developing fetus.
Role Modeling/ Social Support	**Institute** special programs to help pregnant girls and teen mothers complete school (tutors, infant day care, vocational training). **Model** support for individuals with HIV/AIDS.	**Develop** instructional sequences for parental involvement with health lessons. **Promote** peer intervention programs. **Model** support for individuals with AIDS/HIV infection.	**Provide** nonjudgmental referral for those seeking pregnancy prevention or management information. **Model** first aid and universal infection control precautions for bleeding.	**Promote** peer programming for high-risk individuals. **Provide** confidential, nonjudgmental referral for those seeking pregnancy or STD prevention and management information. **Model** universal precautions for infection control.
Instruction	**Celebrate** Family Health Month and Family Sexuality Education Month by encouraging all content areas to focus instruction on the topic. **Institute** an AIDS/HIV Awareness Week. **Promote** inservice programs for faculty and staff on adolescent development and sexuality.	**Implement** family life education within K-12 health education. **Use** strategies which promote decision making, behavioral change, skill building, and social action. **Coordinate** extracurricular instruction on pregnancy and STD prevention. **Create** independent learning centers which focus on postponing sexual involvement, STDs, and pregnancy prevention.	**Provide** adapted physical education classes for pregnant students and students with HIV. **Instruct** about universal precautions.	**Distribute** a listing of community agencies providing reproductive and parenting services. **Provide** supplemental family life instruction to students and parents. **Facilitate** the development of integrated services network between school and community.

A Multidisciplinary Approach to Pregnancy and STD Prevention

	Counseling and Guidance *Counselors, Psychologists, Social Workers*	Integrated School and Community Programs		
		Students	*Parents*	*Community Members Health Practitioners*
Policy	**Comply** with policies and assist in their development as requested.	**Advocate** just, reasonable, and relevant policies in regard to providing instruction, counseling, and health services to promote reproductive health. **Advocate** reproductive health services in school clinic.	**Advocate** the implementation of after-school and summer school life option programs, such as Teen Outreach, Fifth Ward Enrichment Program, and Summer Training and Education Program.	**Initiate** a Teen Pregnancy Prevention Coalition. **Encourage** county and private industry to give special attention to teenage parents in job training and employment placement services.
Environmental Change	**Integrate** counseling role into primary care clinic. **Provide** courses for students at risk, linking career planning, dropout prevention, employment training programs with pregnancy prevention, family life education, and HIV and other STD prevention.	**Participate** in a Teen Prevention Pregnancy Coalition. **Initiate** teenage reproductive health conferences. **Staff** reproductive health hotlines.	**Encourage** children to ask questions. **Participate** in a Teen Pregnancy Prevention Coalition.	**Participate** in a Teen Pregnancy Prevention Coalition. **Conduct** programs at teen centers. **Assure** community has easily accessed teen clinic(s); employment training, life options programs. **Use** community agencies to raise awareness of STDs/HIV, the value of postponing sexual involvement, and condom use for the sexually active.
Media Utilization	**Use** counseling facilities to raise awareness of reproductive health issues, STD clinics, and anonymous testing sites. **Provide** easily accessed pamphlets on pregnancy prevention, consequences, testing, management, parenting, and HIV and other STDs.	**Design** messages for school newspaper, bulletin boards, display cases, table tents in cafeteria, shirts, buttons, homeroom, classrooms, etc., on pregnancy and STD prevention. **Distribute** messages at hairdressers and barber shops, laundromats, supermarkets, malls and other places teens meet.	**Provide** children with books and pamphlets on reproductive health. **Organize** a parental task force to advocate the depiction of responsible sexual activity in the media.	**Encourage** community agencies to organize reproductive health hotlines. **Use** positive male and female role models to provide media messages and PSAs. **Advertise** reproductive health services within the community.
Direct Intervention	**Develop** specific intervention programs for individuals engaging in high-risk behaviors. **Provide** individual and/or group counseling on HIV/AIDS issues and family planning issues. **Initiate** education remediation programs for students who are failing.	**Organize** peer tutoring for pregnancy and STD prevention. **Conduct** community surveys to assess ease by which adolescents can purchase condoms and over-the-counter contraception.	**Initiate** discussions about reproductive health with your child.	**Coordinate** and improve reproductive services in the community to facilitate positive outcomes for pregnancy, STDs, and teenage parents. **Provide** counseling (group, individual, family, marriage) for pregnant teens, teen parents, and their families. **Develop** programs for drop-out populations.
Role Modeling/ Social Support	**Develop** peer instruction programs targeting all subpopulations within schools. **Implement** support groups for high-risk students, pregnant teen parents, and those who are HIV- positive.	**Model** behaviors promoting reproductive health. **Encourage** self-referrals of students to appropriate services. **Use** behavioral contracts to encourage health-enhancing reproductive health behavior. **Promote** programming for in-school and drop-out populations.	**Become** sexuality educators of children via PTA and community agency classes on parenting, communicating sexual issues, etc.	**Develop** peer instruction programs at community youth organizations, religious, health, and social service agencies. **Coordinate** support networks for students and families with HIV/AIDS.
Instruction	**Implement** inservice programs on reproductive health and pregnancy prevention. **Implement** programs to assist parents to become the primary sexuality educator of their children. Provide confidential counseling regarding psychosocial and psychosexual needs of students.	**Participate** in instruction and counseling program on reproductive health using materials such as The Grady Teen Services Program, "Postponing Sexual Involvement," and the play "Making Responsible Decisions." **Organize** teen theater productions which focus on sex education. **Target** males for programs.	**Provide** parenting classes for parents and pregnant teens. **Send** parents a list of community resources on parenting, pregnancy management, and adolescent reproductive health. **Involve** parents in instructional sequences on sex education.	**Update** materials in the school and community library related to STDs, teenage sexuality and parenthood. **Implement** programs to build self-esteem in "Choices/Challenges," "Changing Directions," and "Youth Leadership." **Target** males for programs. **Coordinate** instructional programs with religious and youth-serving organizations.

General Resources

American School Health Association

• Kerr D, Allensworth D, Gayle J. *School Based HIV Prevention: A Multidisciplinary Approach*. Kent, Ohio: American School Health Association; 1991.

This practical manual outlines the "how to" of initiating school health efforts to prevent the spread of HIV. More than 50 prevention strategies for schools and communities are described in this multidisciplinary manual.

• Bradley BJ. *HIV Infection in the School Setting: A Guide for School Nursing Practice*. Kent, Ohio: American School Health Association; 1991.

This text uses the standards of school nursing practice to demonstrate effective techniques for applying clinical knowledge, program management, the nursing process and interdisciplinary collaboration to address the needs of those students with HIV infection in the school setting.

• *How Physicians Work and How to Work With Physicians: A Guide for Educators to Enhance HIV Education Initiatives*. Kent, Ohio: American School Health Association; 1995.

Educators and physicians share tradition of working together to support health promotion for adolescents. Physicians can be valuable community resources for schools seeking to provide effective HIV education programs for student. This document explains how to locate physicians who can meet your needs for HIV prevention programming. Teachers may pass up opportunities to teach about certain topics because of community reactions. This handbook provides guidelines to anticipate and manage controversy.

• *Tell Me About AIDS*. Kent, Ohio: American School Health Association; 1992.

An elementary AIDS supplemental curriculum is available for different grade levels, K-1, 2-3, 4-5 and 6. Materials for each grade level include student workbooks, parent guides and teacher guides.

• Newman M, Farrell KA. *Thinking Ahead: Preparing for Controversy*. Kent, Ohio: American School Health Association; 1991.

School personnel may pass up the opportunity to teach about certain topics or use particular teaching strategies because of fear of community reactions. This handbook provides guidelines to anticipate and manage such controversy.

Comprehensive School Health Education

• Combined Health Information Data Base
• Centers for Disease Control and Prevention
• Center for Health Promotion and Education
• Division of Health Education
Attn: School Health Education Subfile
Atlanta, GA 30333
404/329-3492

To locate nationally validated curriculum projects, access computerized bibliographic data base of health information and health education/health promotion resources as well as programs, curricula guidelines, policies, regulation and materials.

To search CHID to locate information, request a password form BRS Information Technologies (telephone 800/345-4277), or write BRS, 1200 Route 7, Latham, NY 12110. The password fee is $75.

Hotline Opportunities

• Classroom Calls: CDC National AIDS Hotline, 800/342-AIDS

The classroom calls provide an opportunity for students to ask tough questions about serious issues in a relaxed environment. They will learn that the CDC National AIDS Hotline is always available as a resource for learning about HIV and AIDS.

• From One Teen to Another, 800/440-TEEN.

A national HIV teen hotline that is sponsored by the Orange County Chapter of the American Red Cross in Carboro, NC. Open Friday and Saturday evenings from 6:00 p.m. until 12:00 midnight Eastern Standard Time.

Clearinghouse

• CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003, 800/458-5231, FAX 301/251-5343

The clearinghouse contains a data base with biblio-

graphic descriptions and abstracts of more than 10,000 materials in a variety of formats including brochures, posters, video tapes, reports, manuals, training guides and monographs. Selected publications include fact sheets about condoms and their use in preventing HIV and other STDs.

America Responds to AIDS Community Kit: It's Your Move to Prevent AIDS

America Responds to AIDS PSA video tapes: It's Your Move to Prevent AIDS

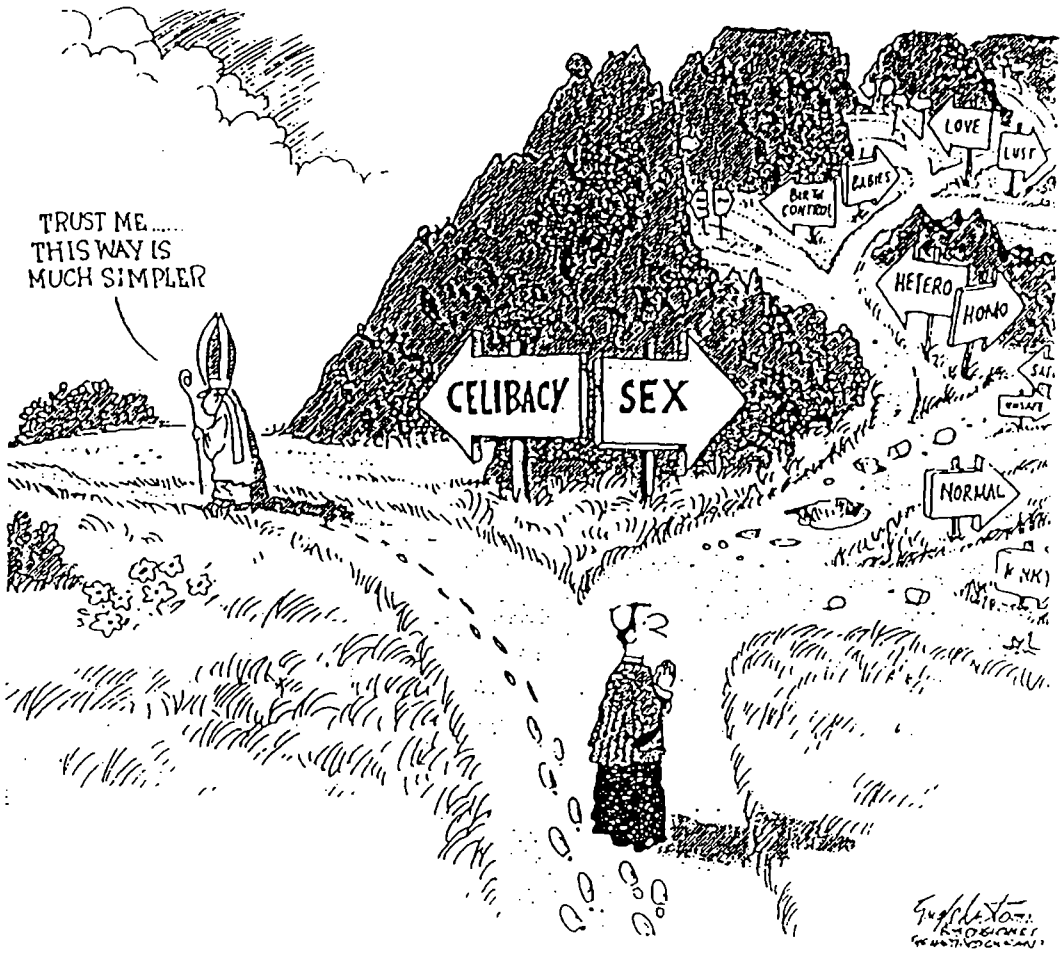
Call for a catalog describing kits, displays, brochures and posters, all available in English and other languages.

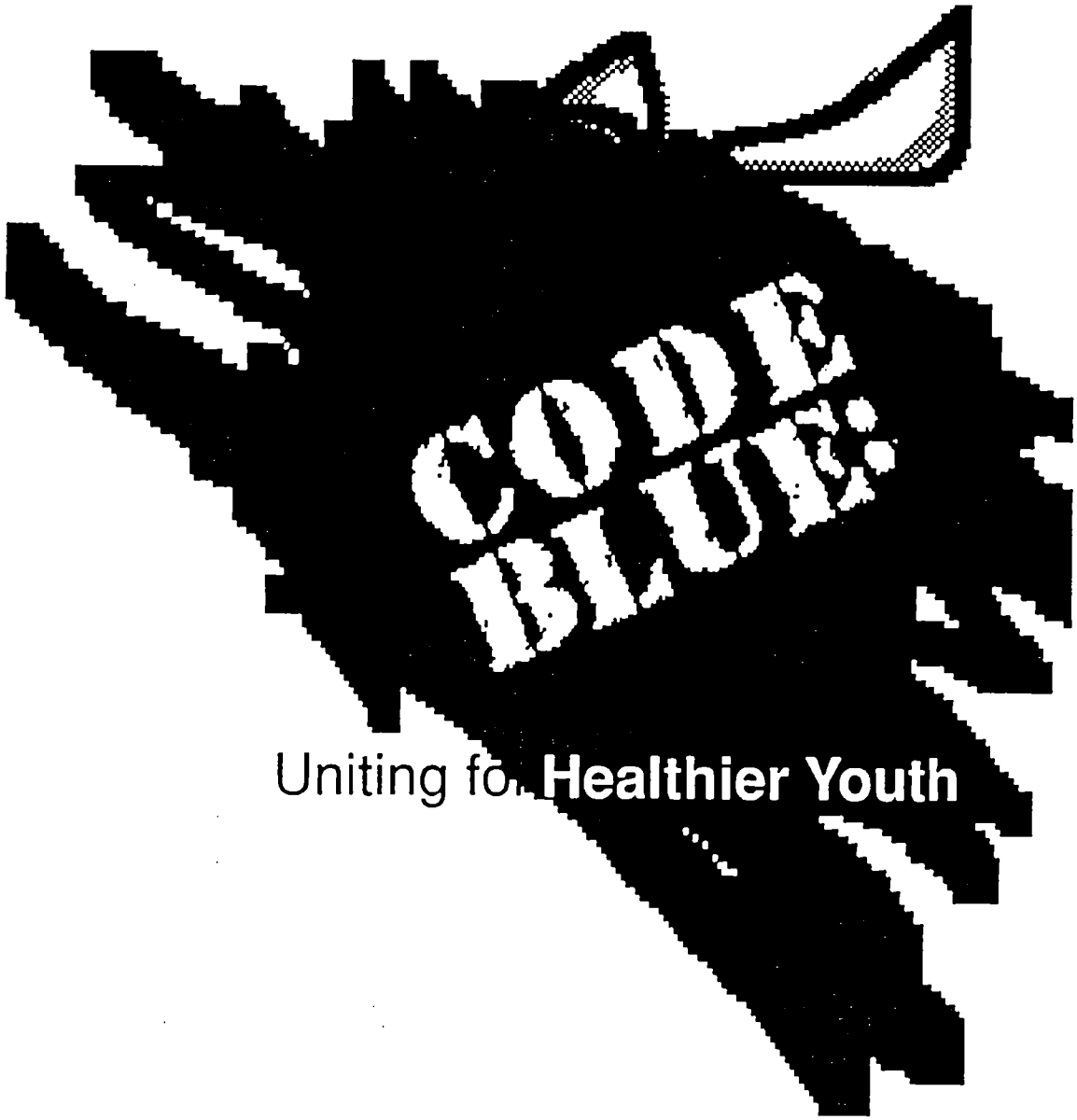
- CDC/NAC ON LINE — CDC National AIDS Clearinghouse, P.O. Box 6003 Rockville, MD 20849-6003, FAX 301/738-6616.

CDC/NAC ON LINE is a computerized information network of the CDC National AIDS Clearinghouse. The network is one way of gaining direct computerized access to the clearinghouse and its information and bulletin board services. To access, ask the CDC/NAC Clearinghouse for a registration form.

Appendix G

Overhead Transparency Masters


TRUST ME.....
THIS WAY IS
MUCH SIMPLER
CELIBACY
SEX
LOVE
LUST
BIRTH CONTROL
HETERO
HOMO
NORMAL


CODE BLUE:
Uniting for Healthier Youth

Unhealthy Lifestyles That Impede Educational Achievement

- 54 percent of high school students have had sexual intercourse (57percent males, 51percent females)[3]
- 69 percent of sexually active students have had sexual intercourse within the last three months[3]
- 23 percent of male high school students have had four or more partners compared to 14 percent of females[3]
- 46 percent of currently sexually active high school students used a condom at last sexual intercourse[3]
- One sexually active youth in four becomes infected with an STD each year

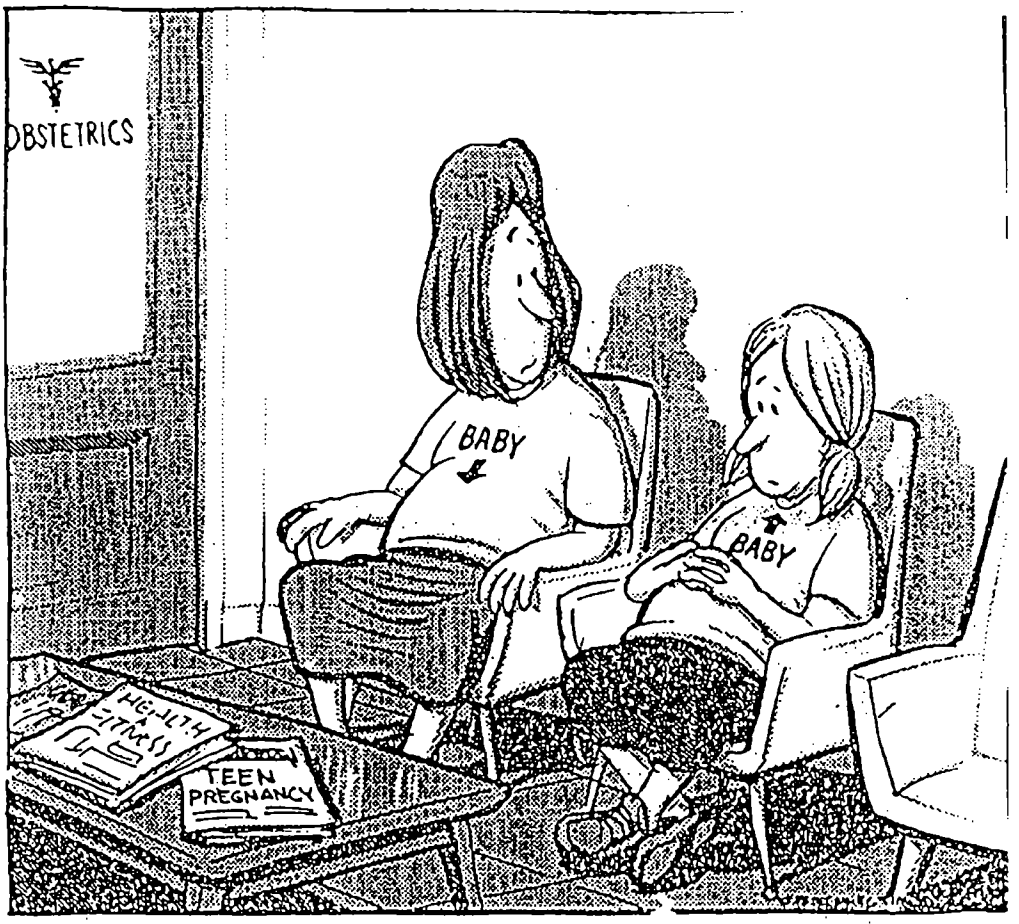
3. *Youth Risk Behavior Surveillance Survey*. Atlanta, Ga: Centers For Disease Control and Prevention 1991.
4. *Sex and America's Teenagers*. New York, NY: The Alan Guttmacher Institute; 1994.

Percentage of women ages 15-19 years who reported having had premarital sexual intercourse, by race and age - United States, 1970-1991

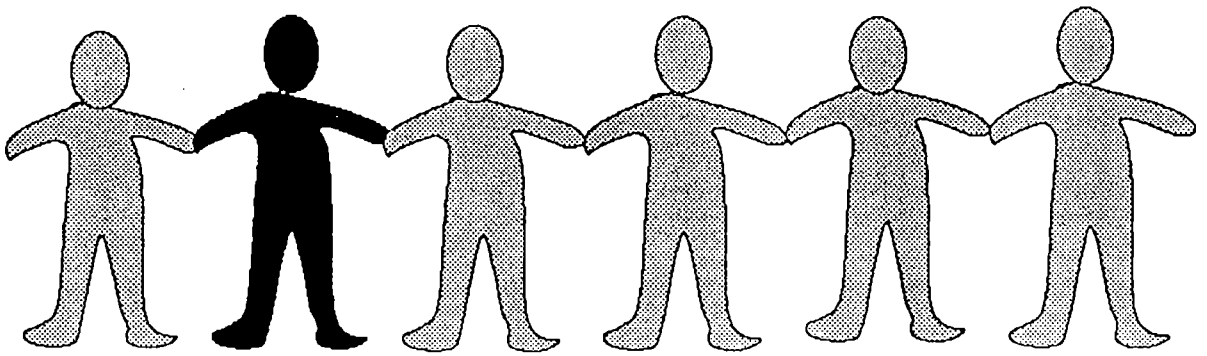
Race/Age	1970+	1980+	1991*
All races			
9th grade Age 15	4.6	16.7	48
12th grade Age 16	39.4	56.2	66.7
Overall	28.6	42	54

+ Vital statistics of the National Center for Health Statistics, 1990.

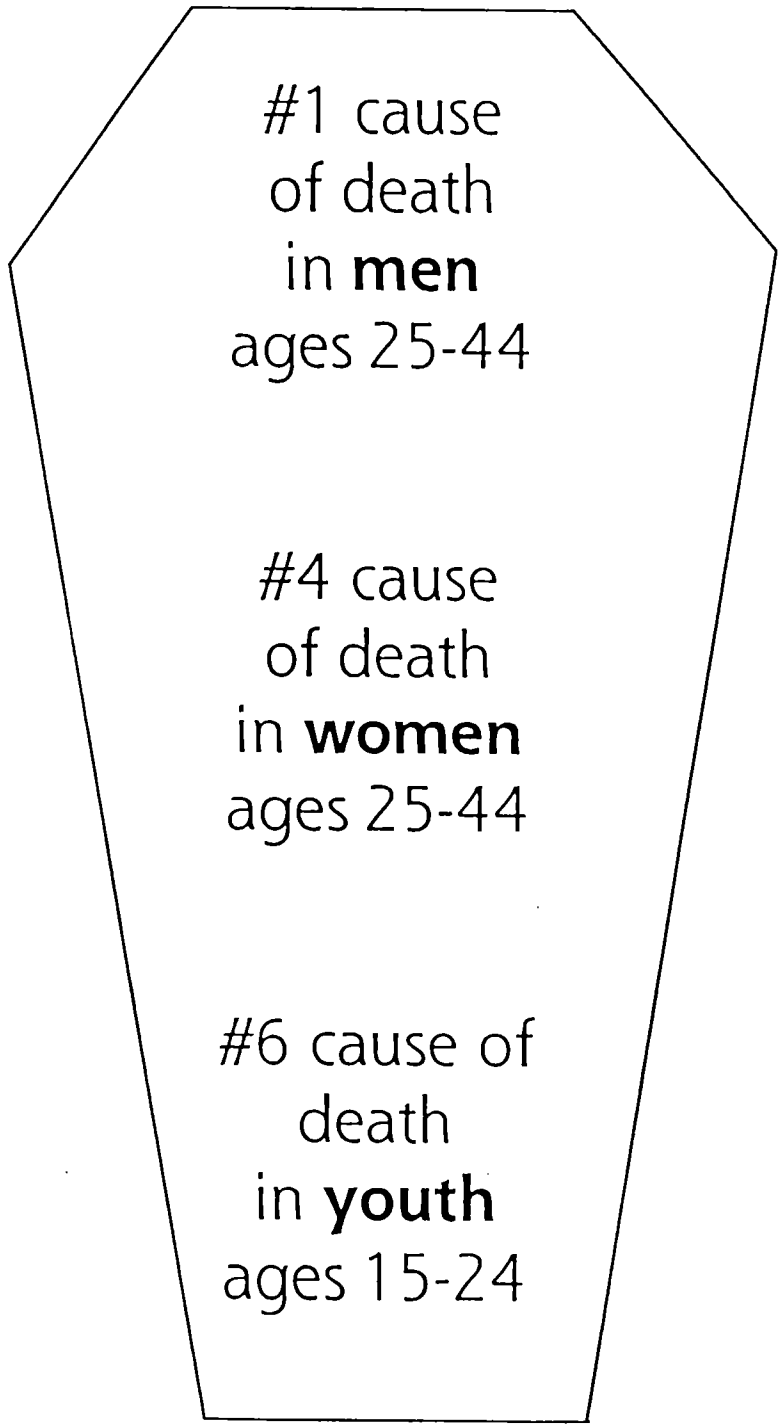
* Public Health Reports, 1993.


OBSTETRICS
BABY
BABY
TEEN PREGNANCY
Clay Bennet

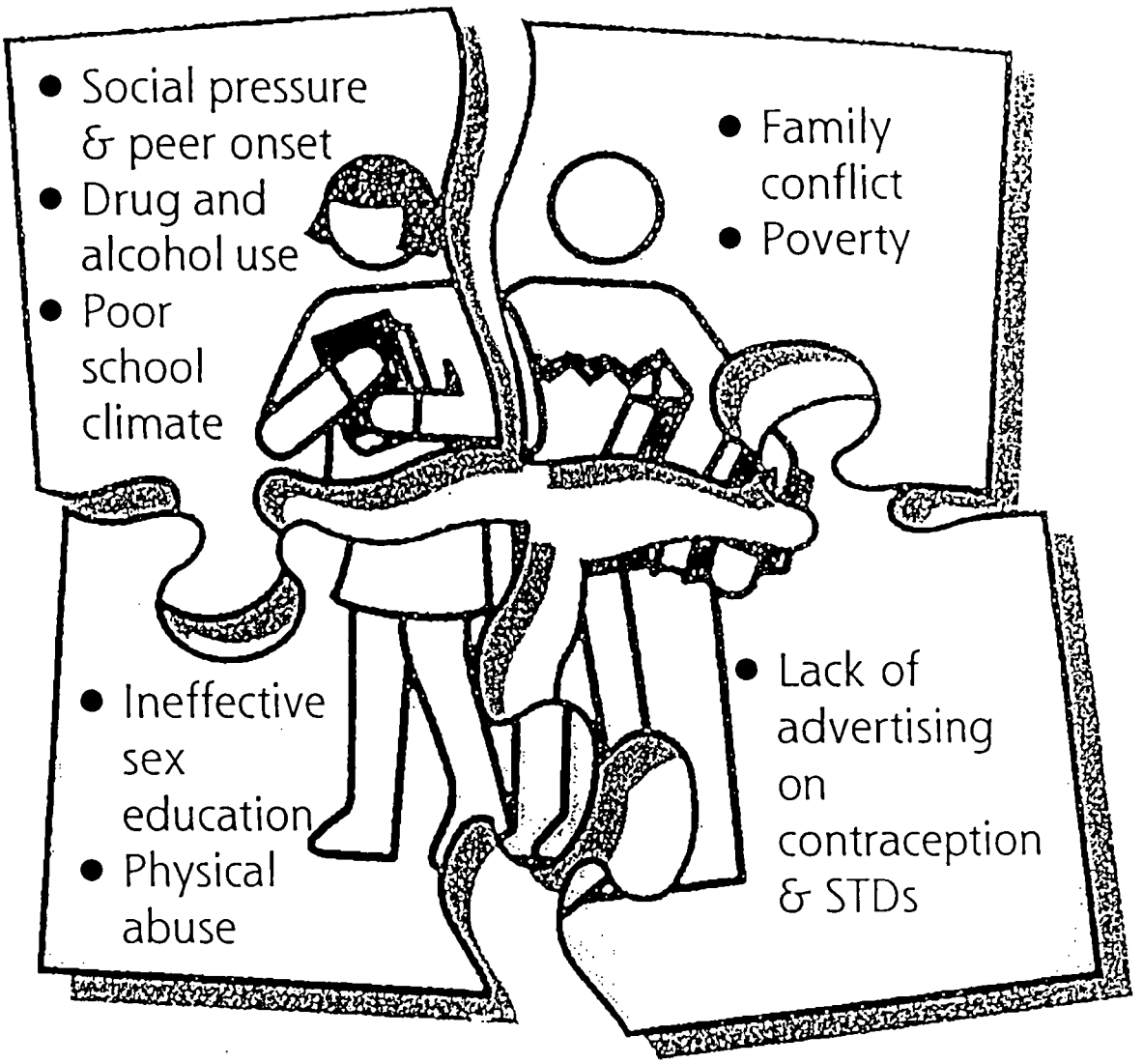
Sexually
Transmitted
Diseases



AIDS: A Leading Cause of Death



Risk Factors Work Together to Disrupt Young People's Lives



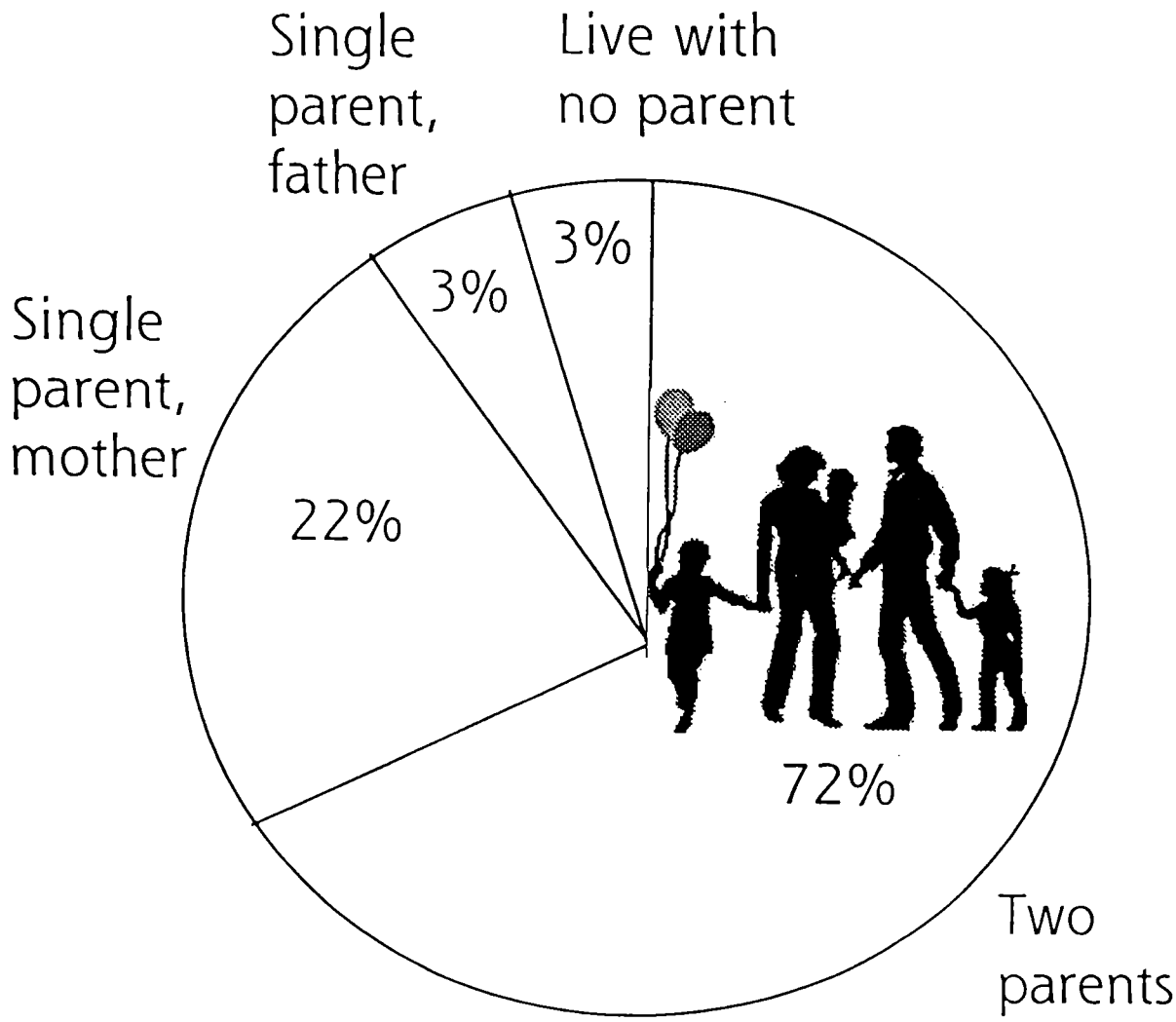
Premature Sexual Activity

Biopsychosocial Factors

- Early physical development
- Psychoendocrinological changes
- Need to explore
- Poor role models
- Use of sex to increase self-esteem
- Lack of awareness of risk
- Lack of experience/knowledge
- Substance use

Peer Risk Factors

Family Structure in the United States

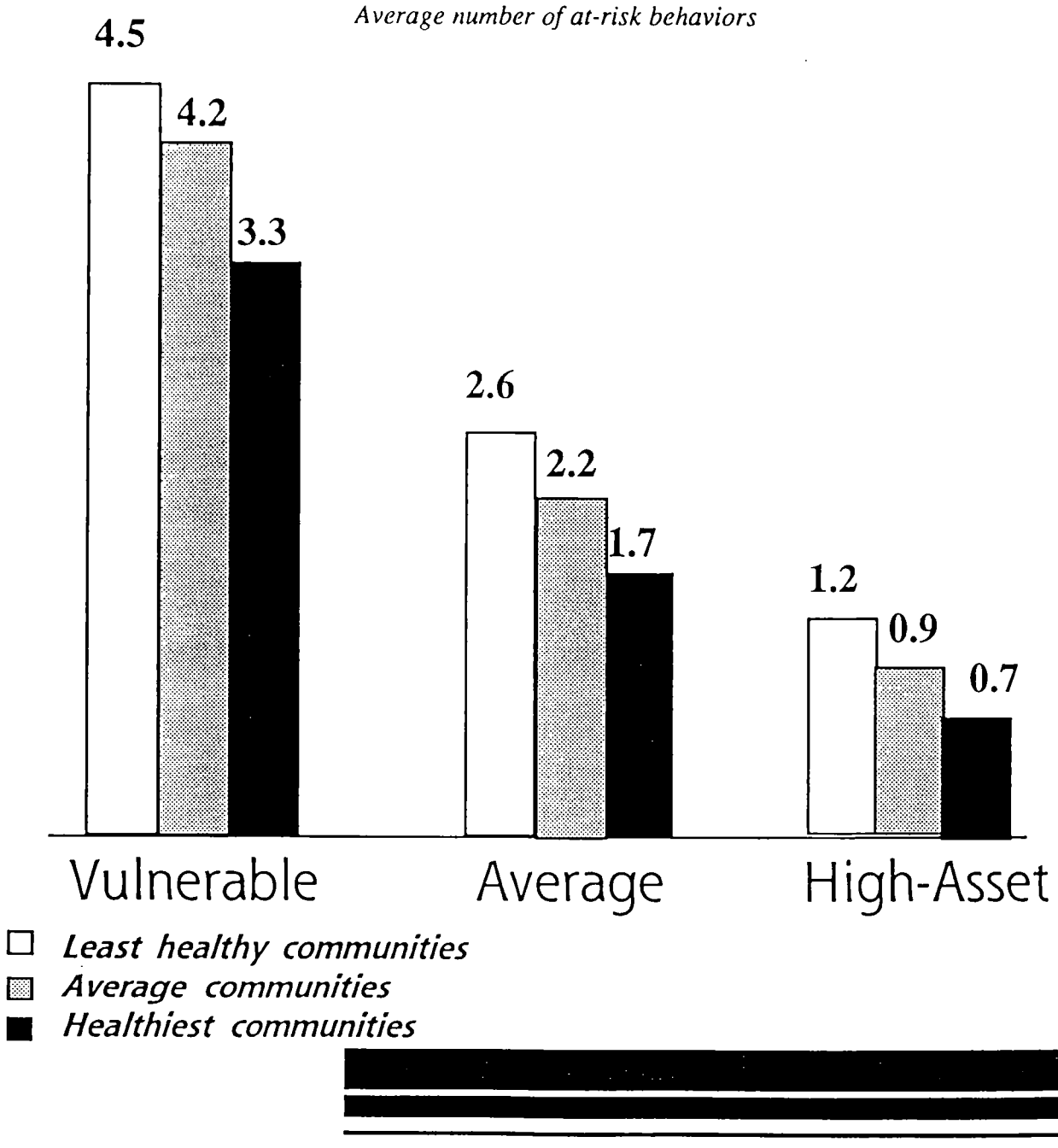


Youth in Single-Parent Families: More at Risk

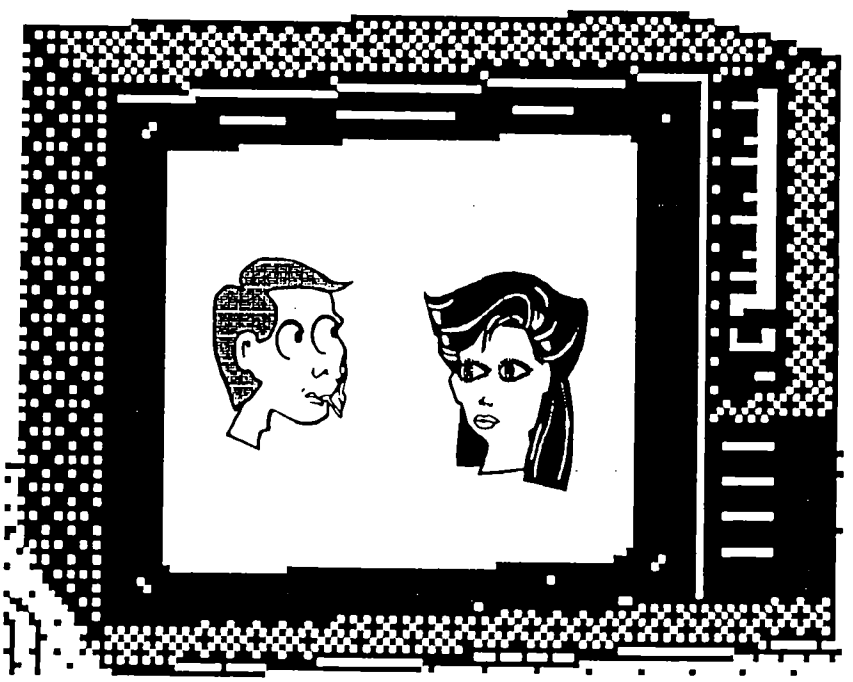
At-risk behaviors	Grades 6-8		Grades 9-12	
	%/1 parents	%/2 parents	%/1 parents	%/2 parents
Sexually Active	19.9	8.4	52.9	34.5
Contraceptive Non-use	17.2	7.8	32.9	20.6

Search Institute

At-Risk Behaviors Among Similar Youth in Different Types of Communities



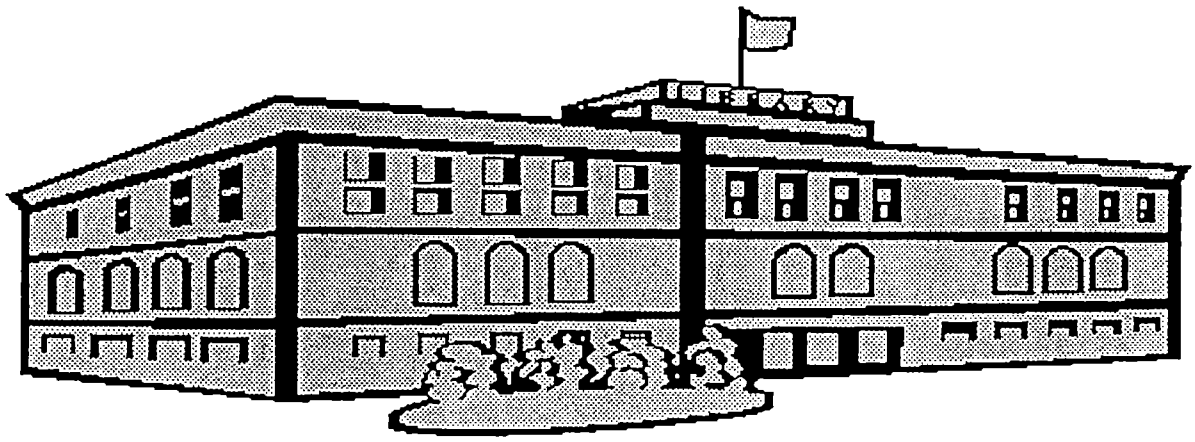
Adolescents need to be taught how to analyze the media and understand its methods of manipulation.



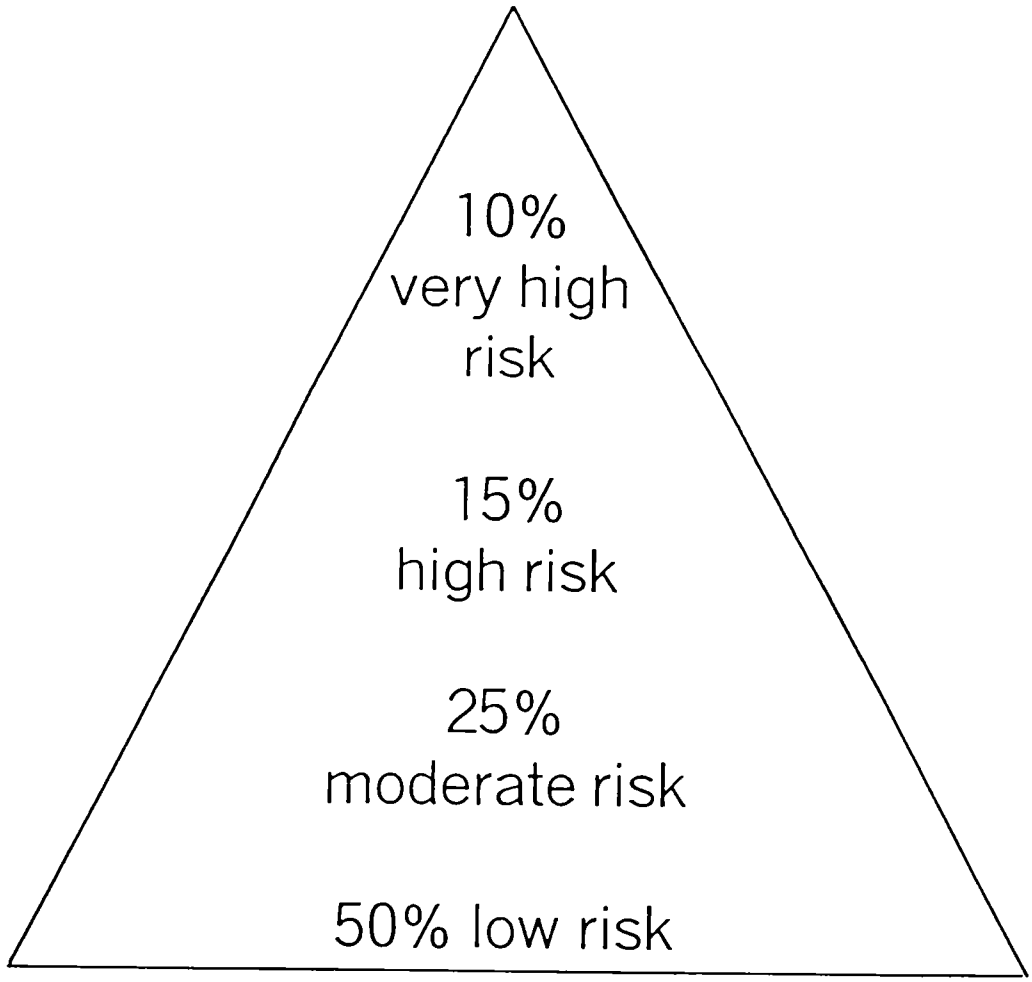
School Risk Factors

Failure to engage
all students in:

- Educational achievement
- School activities
- Vision of life options
- Effective sex education

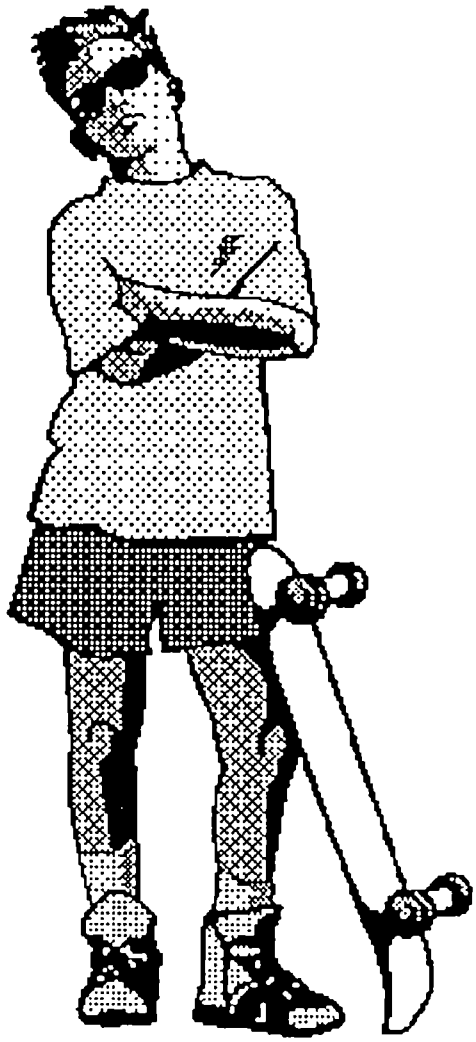


Who is At Risk?



Dryfoos J. *Adolescents At Risk: Prevalence and Prevention*. New York, NY: Oxford University Press; 1991.

What can a community do to promote healthier children?



Social Systems Can Work Together to Help