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#3 AIDS PREVENTION: GENDER-SPECIFIC PROGRAMS TARGET ADOLESCENTS

A heightened awareness of the rising rate of HIV among young people has prompted several organizations to sponsor gender-specific HIV/AIDS prevention programs. A Boston-area organization has a tailored HIV prevention program -- called "Girls in Charge" -- addressing issues specific to female adolescents, especially minorities, the AP/San Jose Mercury News reported. The program targets females ages 13 to 16 through 10 sessions addressing issues of self-esteem, sexual decision-making and sex education. The program focuses on early intervention through "such activities as role-playing, question-and-answer sessions and discussions about personal experiences." Program coordinator Judah-Abijah Dorrington said, "Most of the programs out there were invented to address other populations like adult, homosexual males [and] IV drug users." Dr. Cynthia Gomez of the AIDS Prevention Center at the University of California-San Francisco agreed, saying, "(Young women) really are being viewed as the population with the largest number of new infections. They don't realize they're at risk, partly because we've so much emphasized certain groups, rather than behaviors." Girls in Charge will expand this month to include two more Boston communities. It is funded by Boston's Public Health Commission and the Boston Foundation (AP/San Jose Mercury News, 10/4).

FITTING IN: 'GO BOYZ'

A similar program in Seattle's Snohomish County -- Go Boyz - targets gay and bisexual young men and "teaches safer sexual behavior, distributes condoms and encourages people to be tested for AIDS." It also provides opportunities for young gay and bisexual men to socialize in an atmosphere that emphasizes healthy behaviors. Group treasurer Nick Tipton explained, "The mission of the Go Boyz is to create a sense of community among young gay and bisexual men (ages 21 to 31) in Snohomish County, to prevent new HIV infections among our peers, and to increase HIV-positive care services." Health district educator Michael McKee noted that the program attempts to respond to "emerging data suggest[ing] that younger gay and bisexual men were becoming infected with HIV at greater rates than their 30-something or older peers." Go Boyz coordinators found that programs sponsored by the Gay Men's Task Force failed to draw a younger crowd. The Go Boyz program specifically addresses the concerns of young gay men in an attempt to lower the rate of HIV infection. "No statistics yet prove whether that goal is being realized," said district health educator Dennis Worsham. "What we have found is that people who feel like they belong to a community are less likely to take risks with their own lives, whether that be

*Groups - Youth -
Prevention
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smoking or suicide," he said (Muhlstein, The Herald, 10/4).
[Click here for previous coverage of adolescent HIV education.](#)

*HIV-Prevention Education — Continued***TABLE 1. Percentage of states and school districts that required teaching of selected health education topics and percentage of middle/junior and senior high schools that included each topic in a required course, by topic — United States, School Health Policies and Programs Study, 1994***

Topic	States requiring topic (n=51)	School districts requiring topic		Middle/junior and senior high schools that include topic in a required course	
	%	%	(95% CI) [†]	%	(95% CI)
Alcohol- and other drug-use prevention	75.0	86.0	(±5.3%)	90.4	(±3.1%)
Conflict resolution and violence prevention	38.5	61.0	(±8.4%)	58.3	(±5.8%)
Dietary behaviors and nutrition	68.9	80.1	(±6.6%)	84.3	(±4.4%)
HIV prevention	78.7	83.0	(±5.3%)	85.6	(±4.2%)
Injury prevention and safety	62.2	74.5	(±8.0%)	66.2	(±5.6%)
Physical activity and fitness	65.2	81.9	(±5.6%)	77.6	(±5.2%)
Pregnancy prevention	43.9	72.1	(±7.1%)	69.3	(±5.5%)
Sexually transmitted disease prevention	65.1	80.9	(±6.0%)	84.1	(±4.4%)
Suicide prevention	37.8	66.7	(±8.1%)	58.1	(±5.7%)
Tobacco-use prevention	71.7	83.2	(±6.2%)	85.6	(±4.0%)

* The unweighted sample size for school districts was 398 and for middle/junior and senior high schools was 531. Data were missing for eight school districts and 76 schools.

[†] Confidence interval.

CI=±4.2%) of all middle/junior and senior high schools (Table 1). Similar percentages of middle/junior and senior high schools included the following topics in their curricula: HIV prevention, alcohol- and other drug (AOD)-use prevention, dietary behaviors and nutrition, physical activity and fitness, sexually transmitted disease prevention, and tobacco-use prevention. Topics included in curricula less often than HIV prevention were conflict resolution and violence prevention, injury prevention and safety, pregnancy prevention, and suicide prevention.

In all states that required HIV-prevention education in schools, in-service training for teachers was provided on this subject (Table 2). Of the school districts that required HIV-prevention education, 61.0% (95% CI=±8.1%) provided in-service training. For all health education topics except AOD-use prevention, the percentages of states and school districts that provided in-service training for those topics were significantly lower than for HIV-prevention education. Approximately one third (31.0% [95% CI=±3.6]) of all teachers reported receiving in-service training on HIV prevention during the 2 years preceding the survey (Table 2). The percentage of teachers who received in-service training on HIV prevention was significantly higher than that for teachers who received training on other health education topics. Health education teachers in health education classes were significantly more likely than health education teachers in other subjects to have received training on HIV prevention during the 2 years preceding the survey (38.6% [95% CI=±5.0%] versus 24.1% [95%

*HIV-Prevention Education — Continued***TABLE 2. Percentage of states and school districts that provided training on required health education topics and percentage of teachers who received in-service training,* by topic — United States, School Health Policies and Programs Study, 1994†**

Topic	States that provided training on required topic (n=51)	School districts that provided training on required topic		Teachers who received in-service training on required topic	
	%	%	(95% CI) [§]	%	(95% CI)
Alcohol- and other drug-use prevention	100.0	51.9	(± 9.2%)	22.9	(±3.3%)
Conflict resolution and violence prevention	93.3	41.3	(±10.2%)	13.9	(±3.1%)
Dietary behaviors and nutrition	90.3	19.7	(± 8.6%)	9.7	(±2.4%)
HIV prevention	100.0	61.0	(± 8.1%)	31.0	(±3.6%)
Injury prevention and safety	42.9	10.4	(± 4.7%)	7.8	(±2.7%)
Physical activity and fitness	73.3	16.0	(± 5.8%)	8.9	(±2.1%)
Pregnancy prevention	72.2	15.2	(± 6.1%)	5.7	(±1.6%)
Sexually transmitted disease prevention	85.7	32.5	(± 8.3%)	15.6	(±2.6%)
Suicide prevention	50.9	22.2	(± 7.8%)	9.5	(±2.9%)
Tobacco-use prevention	84.8	24.9	(± 6.8%)	9.3	(±2.2%)

*During the 2 years preceding the survey.

†The unweighted sample size for school districts was 397 and for teachers was 1018. Data were missing for five school districts and 22 teachers.

§Confidence interval.

CI=±5.1%)). In addition, health education teachers in health education classes were significantly more likely than health education teachers in other subjects to have received preservice training† in health education (21.0% [95% CI=±3.8%] versus 4.5% [95% CI=±2.3%]) or health and physical education (33.9% [95% CI=±5.3%] versus 6.1% [95% CI=±2.5%]).

Of health education teachers in health education classes, at least 50% reported teaching 16 of 17 specific HIV-prevention topics (Table 3); 37.1% (95% CI=±4.7%) taught "correct use of condoms." Health education teachers in other subjects were significantly less likely than health education teachers in health education classes to teach each of the 17 topics; however, at least 54% taught "basic facts about HIV/AIDS," "how HIV is and is not transmitted," "how HIV affects the immune system," "sexual behaviors that transmit HIV," "needle-sharing behaviors that transmit HIV," and "reasons for choosing sexual abstinence."

Reported by: Div of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: Since 1988, CDC has provided fiscal and technical assistance to state and local education agencies and national health and education organizations to assist schools in implementing effective HIV-prevention education for youth. These agencies and organizations develop, implement, and evaluate HIV-prevention policies and programs and train teachers to initiate effective prevention efforts and implement curricula in classrooms. As a result of these and other efforts, school-based HIV

†An undergraduate or graduate degree, 30 graduate credits, or certification.

*HIV-Prevention Education — Continued***TABLE 3. Percentage of health education teachers in health education classes* and health education teachers in other subjects† who teach specific HIV education topics, by topic — United States, School Health Policies and Programs Study, 1994§**

Topic	Health education teachers in health education classes		Health education teachers in other subjects	
	%	(95% CI¶)	%	(95% CI)
Basic facts about HIV/AIDS	86.6	(±3.6%)	72.2	(±5.3%)
How HIV is and is not transmitted	83.8	(±4.0%)	70.0	(±5.6%)
Needle-sharing behaviors that transmit HIV	79.6	(±4.4%)	57.3	(±5.9%)
How HIV affects the immune system	78.5	(±4.6%)	61.5	(±5.9%)
Sexual behaviors that transmit HIV	77.7	(±4.6%)	58.8	(±6.0%)
Reasons for choosing sexual abstinence	77.6	(±4.1%)	54.5	(±7.4%)
Disease progression of AIDS	71.1	(±4.5%)	46.4	(±6.7%)
Influence of alcohol and other drugs on HIV risk behaviors	69.9	(±4.7%)	40.3	(±6.8%)
Societal impact of HIV/AIDS	68.5	(±4.5%)	48.6	(±7.8%)
Perceptions of risk for HIV/AIDS	64.1	(±5.4%)	44.0	(±5.8%)
Social norms toward risk behaviors related to HIV	63.6	(±5.1%)	46.1	(±6.2%)
Compassion and support for persons living with HIV/AIDS	58.7	(±5.1%)	42.3	(±6.3%)
Statistics on adolescent death and disability related to HIV/AIDS	58.4	(±4.8%)	30.9	(±5.1%)
Condom efficacy/how well condoms work	56.4	(±5.0%)	33.3	(±5.8%)
Information on HIV testing and counseling	55.9	(±5.3%)	27.7	(±5.8%)
True prevalence of risk behavior related to HIV	50.8	(±5.6%)	28.1	(±5.1%)
Correct use of condoms	37.1	(±4.7%)	15.2	(±4.4%)

* Teachers of courses that focus primarily on health education topics.

† Teachers of courses that include health education content but focus primarily on another subject.

§ The unweighted sample size for health education teachers in health education classes was 562 and for health education teachers in other subjects was 462. Data were missing for two health education teachers in health education classes and one health education teacher in other subjects.

¶ Confidence interval.

education is widely implemented in the United States. From 1987 to 1994, the number of states requiring HIV-prevention education in schools increased from 13 states (4) to 39 states plus the District of Columbia. This high level of policy support is consistent with public support; 95% of U.S. residents in a 1996 survey reported that information about AIDS should be provided in school (7).

The findings in this report indicate that, despite wide implementation of HIV-prevention education in U.S. schools, improvements in HIV-prevention programs are needed. In particular, efforts are needed to increase the percentage of teachers who teach HIV prevention in a health education setting and who receive in-service training

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on HIV prevention. A national health objective for the year 2000 is "to increase to at least 95% the proportion of schools that provide age-appropriate HIV and other sexually transmitted disease (STD) curricula for students in 4th through 12th grade, preferably as part of comprehensive school health education, based on scientific information that includes the way HIV and other STDs are prevented and transmitted" (objective 18.10/19.12) (8). Based on the findings from SHPPS, to meet this objective, an 11% increase is needed in the percentage of middle/junior and senior high schools that implement HIV- and STD-prevention education programs.

Although all states and most school districts that required HIV-prevention education also offered in-service training on this topic, only approximately one third of teachers had received this training during the 2 years preceding the survey. Current in-service training is especially important for HIV education because new methods are being identified to assist youth in developing the skills needed to prevent HIV infection.

The SHPPS data used in this analysis are subject to at least two limitations. First, the study was not designed to explore the link between school health programs and students' health-related knowledge, beliefs, and behaviors. Second, although the state and district levels of SHPPS measured policies and programs in grades K-12, the school and classroom levels of SHPPS focused only on middle/junior and senior high schools.

CDC's *Guidelines for Effective School Health Education to Prevent the Spread of AIDS* recommends that qualified health education teachers provide education about AIDS (9). The findings from SHPPS indicate that health education teachers in health education classes are more likely than health education teachers in other subjects to have appropriate preservice and in-service training. Furthermore, HIV-prevention education is more comprehensive when taught within the context of health education than when taught within other subjects. However, teaching HIV prevention in other subjects may be an important adjunct to a planned course of study in health education classes.

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Physical Violence and Injuries in Intimate Relationships — New York, Behavioral Risk Factor Surveillance System, 1994

Women are more likely than men to sustain injuries and to require medical attention as a result of physical violence in an intimate relationship (1). To determine the prevalence of physically violent acts by intimate partners, injuries, and the use of medical services for injuries sustained from intimate partner physical violence, the New York State Department of Health (NYSDH) analyzed data from the 1994 Behavioral Risk Factor Surveillance System (BRFSS). This report summarizes the analysis of these findings, which indicate that women are more likely to be injured than men and that their injuries are underreported.

The BRFSS is a population-based, random-digit-dialed telephone survey of the noninstitutionalized U.S. population aged ≥ 18 years. In 1994, seven additional questions about intimate-partner violence (i.e., spouse, partner, or ex-partner) were added to New York's BRFSS survey. Data were weighted to reflect the 1994 New York population, and 95% confidence intervals (CIs) were calculated using SUDAAN.

Overall, 692 women and 546 men aged 18–44 years were interviewed. Among women, 43 (5.6% [95% CI=3.8%–7.4%]) reported being the victim of a physically violent act by an intimate partner during the preceding year. Of women reporting such violence, 26 (57.7% [95% CI=41.0%–74.4%]) reported being shoved, grabbed, or slapped; 17 (42.3% [95% CI=25.6%–59.0%]) reported being kicked, bitten, punched, or beaten or threatened/assaulted with a knife, gun, or other object. In comparison, 29 (6.9% [95% CI=4.0%–9.8%]) men reported physical violence by an intimate partner, of whom 13 (47.7% [95% CI=25.8%–69.6%]) reported more severe forms of violence.

Injuries as a result of the most recent violent act by an intimate partner were more prevalent among women than men. Among women reporting physical violence by an intimate partner, 23 (53.6% [95% CI=36.9%–70.3%]) reported injuries to their head or face or injuries causing pain on other parts of the body lasting longer than 1 hour; four (12.4% [95% CI=0–26.0%]) men who experienced physical violence reported being injured. During the 12 months preceding the survey, medical attention to treat injuries sustained from such violence was sought by seven (19.6% [95% CI=5.4%–33.8%]) women and two (7.6% [95% CI=0–19.1%]) men. Among women reporting less severe violent acts by an intimate partner, two (8.9% [95% CI=0–21.9%]) reported seeking medical care for violence-related injuries; among women reporting more severe violence, five (34.1% [95% CI=7.8%–60.4%]) reported seeking medical attention for injuries.

Among both sexes, the prevalence of reported physical violence was higher among younger persons. Among women aged 18–30 years, 6.7% (95% CI=3.7%–9.7%) reported being victims of physical violence by an intimate partner, compared with 4.6% (95% CI=2.4%–6.8%) of women aged 31–44 years. Among men aged 18–30 years, 10.2% (95% CI=5.0%–15.4%) reported physical violence by an intimate partner compared with 3.5% (95% CI=1.4%–5.6%) of men aged 31–44 years.

AIDS Education Sessions Successful

In Inner-City Study, Small-Group Counseling Reduced Unsafe Sex

By SUSAN OKIE
Washington Post Staff Writer

A large, multi-city study of urban blacks and Hispanics at high risk of contracting the AIDS virus has found that those who attended small-group educational and counseling sessions used condoms more often and had unprotected sex less frequently. The results suggest that implementing similar prevention efforts more widely could help to slow the AIDS epidemic.

The study of more than 3,700 inner-city clinic patients, published today in the journal *Science*, also found that participants reported fewer symptoms of sexually transmitted diseases (STDs), and fewer cases of gonorrhea among men, than a comparison group in the year following the program. Such diseases have been shown to boost a person's chances of transmitting and contracting the human immunodeficiency virus (HIV), which causes AIDS.

The findings, together with those of another recent study of STD clinic patients, offer hope that prevention programs can slow the march of AIDS, even among hard-to-reach groups in the inner cities, where the virus is spreading fastest. Although new treatments have reduced AIDS deaths in the United States in recent years, HIV continues to spread, especially among young people, women, blacks and Hispanics.

The study adds to a growing body of evidence supporting the effectiveness of various prevention strategies—including needle exchange programs for drug addicts and sex education programs for adolescents. AIDS experts and activists called on policymakers to put such strategies into greater practice.

"It did take a while to get the science into place. Now ... it's there," said Karen Hein, an AIDS specialist and the executive officer at the Institute of Medicine who wrote a commentary accompanying the study. "Now, perhaps the focus ought to be on policy and politics."

"Prevention has not been a priority for the nation," said Daniel C. Zingale, executive director of AIDS Action, a network of more than 2,400 AIDS service organizations. "If there were a medical vaccine, just imagine the forces that would be deployed. Now we have prevention as a virtual vaccine, and it's stagnant."

The new study, funded by the National Institute of Mental Health

(NIMH), recruited participants from 37 clinics in several urban areas: New York City and northern New Jersey, Baltimore, Atlanta, Milwaukee, Los Angeles and California's Orange and San Bernardino counties. All were at least 18 years old, had recently engaged in unprotected sex and were at high risk for HIV infection because they had a new sexual partner, multiple partners or a partner who had HIV or was a drug addict.

Sixty-eight percent of the 3,706 participants identified themselves as African American, 20 percent as Hispanic and 12 percent as belonging to other racial or ethnic groups. Only about 30 percent were employed. Almost half reported that they had not used condoms in the preceding three months. More than 80 percent said they had previously been tested for HIV infection.

Half of the participants were randomly assigned to attend a prevention program composed of seven small-group sessions, each lasting 1½ to 2 hours, on how to change risky sexual behaviors and reduce their chances of becoming infected. The other half were assigned to a control group whose members attended a one-hour AIDS education session. Participants were paid about \$15 to attend each session. Both groups were then questioned about sexual practices and STDs every three months for a year.

At each assessment, both groups reported more frequent condom use and fewer episodes of unprotected sex than they had at the beginning of the program. But those who participated in the small-group sessions reported greater changes in behavior. For instance, condom use among the control group increased from 21 percent at the start of the program to 48 percent a year later. In the small-group participants, it increased from 23 percent to 60 percent. Both groups reported that they maintained their changes in behavior during the year following the program.

When questioned about STDs, significantly fewer small-group session participants reported symptoms of such infections than did control group members (27.9 percent vs. 34.6 percent). That difference wasn't reflected in the overall frequency of STD infections diagnosed at clinics, which was the same in both groups. But men who attended the small-group sessions had fewer cases of gonorrhea (3.6 percent of partici-

pants) than men in the control group (6.4 percent).

Similarly encouraging results were obtained in a soon-to-be-published study by the Centers for Disease Control and Prevention on the effectiveness of individual AIDS-prevention counseling in STD clinic patients being tested for HIV. The study recruited 5,800 patients in five cities and compared the effectiveness of two 20-minute counseling sessions with more extensive counseling. A control group received two five-minute visits with a clinic doctor.

Both groups receiving the counseling reduced their overall frequency of STDs by about 30 percent, said Martin Fishbein of the University of Pennsylvania, an adviser on the project. Too few cases of HIV infection occurred during the one-year study to determine whether counseling reduced the frequency of new infections.

HIV prevention programs like those in the studies should be expanded, but research should continue to make sure that they actually slow the rate of new HIV infections, said Thomas J. Coates of the University of California at San Francisco.

Some AIDS experts said that because the program tested in the NIMH study involved group sessions, it might be cheaper and more practical than individual counseling. Cost has been an obstacle to implementing such programs in many states, especially in financially strapped health departments.

The cost of the seven-session program—\$278 per participant—is about the same as the cost of one week of treatment for an HIV-infected person with protease inhibitors, the newest and most effective AIDS drugs, said Steven E. Hyman, director of the National Institute of Mental Health. While funding for AIDS research and treatment programs has increased in recent years, federal funding for prevention has remained relatively flat. The CDC spends about \$600 million a year on HIV prevention efforts.

"When it comes to prevention, the watchword is, give as little as possible and expect a lot," Coates said. "That's a misguided way to look at prevention. ... We know a vaccine is a long way off. We know the treatments are imperfect and are going to be harder and harder to deliver. Prevention is still where it's at."



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Abstinence and Safer Sex HIV Risk-Reduction Interventions for African American Adolescents

A Randomized Controlled Trial

John B. Jemmott III, PhD; Loretta Sweet Jemmott, PhD, RN, FAAN; Geoffrey T. Fong, PhD

Context.— African American adolescents are at high risk of contracting sexually transmitted infection with human immunodeficiency virus (HIV), but which behavioral interventions to reduce risk are most effective and who should conduct them is not known.

Objective.— To evaluate the effects of abstinence and safer-sex HIV risk-reduction interventions on young inner-city African American adolescents' HIV sexual risk behaviors when implemented by adult facilitators as compared with peer cofacilitators.

Design.— Randomized controlled trial with 3-, 6-, and 12-month follow-up.

Setting.— Three middle schools serving low-income African American communities in Philadelphia, Pa.

Participants.— A total of 659 African American adolescents recruited for a Saturday program.

Interventions.— Based on cognitive-behavioral theories and elicitation research, interventions involved 8 1-hour modules implemented by adult facilitators or peer cofacilitators. Abstinence intervention stressed delaying sexual intercourse or reducing its frequency; safer-sex intervention stressed condom use; control intervention concerned health issues unrelated to sexual behavior.

Main Outcome Measures.— Self-reported sexual intercourse, condom use, and unprotected sexual intercourse.

Results.— Mean age of the enrollees was 11.8 years; 53% were female and 92.6% were still enrolled at 12 months. Abstinence intervention participants were less likely to report having sexual intercourse in the 3 months after intervention than were control group participants (12.5% vs 21.5%, $P=.02$), but not at 6- or 12-month follow-up (17.2% vs 22.7%, $P=.14$; 20.0% vs 23.1%, $P=.42$, respectively). Safer-sex intervention participants reported significantly more consistent condom

use than did control group participants at 3 months (odds ratio [OR] =3.38; 95% confidence interval [CI], 1.25-9.16) and higher frequency of condom use at all follow-ups. Among adolescents who reported sexual experience at baseline, the safer-sex intervention group reported less sexual intercourse in the previous 3 months at 6- and 12-month follow-up than did control and abstinence intervention (adjusted mean days over prior 3 months, 1.34 vs 3.77 and 3.03, respectively; $P \leq .01$ at 12-month follow-up) and less unprotected intercourse at all follow-ups than did control group (adjusted mean days, 0.04 vs 1.85, respectively, $P < .001$, at 12-month follow-up). There were no differences in intervention effects with adult facilitators as compared with peer cofacilitators.

Conclusion.— Both abstinence and safer-sex interventions can reduce HIV sexual risk behaviors, but safer-sex interventions may be especially effective with sexually experienced adolescents and may have longer-lasting effects.

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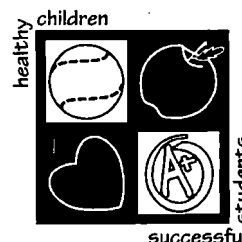
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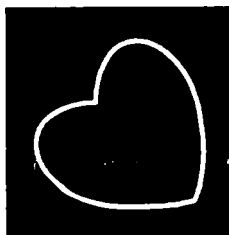
Addressing HIV prevention and comprehensive school health issues for children



What's New at the PTA

Customer Service

Callers will soon hear the voice of a customer service representative every time they phone the National PTA. Customer service representatives currently answer e-mail inquiries and calls directed to them from the National PTA's toll-free phone number. However, by the end of summer, all calls to the National PTA headquarters, including to its local number, (312) 670-6782, will be answered by the newly formed customer service department, fulfilling yet another component in the plan to better assist PTA members and the public.



Within their first six months, customer service representatives answered thousands of questions, providing convenient "one-stop information" for all callers, but especially those with questions on more than one topic. It is hard to imagine being without this department's valuable service, but until the beginning of 1998, all questions were handled by staff members, because a formal customer service department did not exist.

Previously one front-desk receptionist handled all incoming phone calls to the National PTA's Chicago office and a number of staff handled responses to e-mail queries. With the volume and variety, it was not always an easy task, and not necessarily the most efficient way to handle calls from the field requesting general information about PTA. Therefore, with the desire to provide all callers to the National PTA with the most efficient service, the customer service department was proposed and approved in June 1997. The new department's purpose is to provide information efficiently and consistently with a personal touch.

The new department began to take shape in the fall of 1997, when Claudia Soldano became the National PTA's first customer service director, followed shortly with three service representatives—Bernadette French, Phyllis Barnwell, and Cynthia Beach-Jones. The customer service department was fortunate to have been able to recruit Claudia, Bernadette, and Phyllis to these new positions as the three of them had been with the National PTA for a number of years and brought with them a knowledge base of the organization.

According to Soldano, "We're not like some businesses that put a two-minute time limit on customer service calls. Part of our philosophy is to answer all questions as completely and thoroughly as possible."

The customer service department answers a variety of questions. The most common of these, however, are requests for materials, as well as information on the national convention, the PTA's position on issues, and programs.

National PTA is excited about this new department and the ability to more quickly and efficiently handle calls and requests coming from the field. The customer service team will also be responsible for tracking the most frequently asked questions, type of information being requested, and the greatest concerns of those who are contacting us, so the organization can look at ways of providing some of this information to all of our members more proactively. ■

National PTA's customer service representatives can be reached at info@pta.org or by calling (800) 307-4PTA (4782). By the end of summer, customer service representatives can also be reached through the National PTA headquarters local phone number: (312) 670-6PTA (6782).

Building a Healthy Child

Lately we have all been faced with extremely difficult stories of violence involving children. The shootings in Jonesboro, then Springfield; the 15-year-old dying from gun shot wounds on the doorstep of a Chicago emergency room—the list goes on. These tragic situations are consuming the thoughts of everyone, not just parents, but also education, medical, and criminal justice experts across the country. Unfortunately, they also consume the thoughts of children, who hear the same stories, see the same pictures, but don't have the same capacity to integrate the information and put it into any kind of perspective (it's hard enough for adults!). A national poll conducted by Children Now and the Kaiser Foundation found that "63 percent of 7-10-year-olds and 42 percent of 11-17-year-olds worry they may die young; 80 percent of children ages 10-12 wish to know more about how to be safe from violence. Fully 64 percent of 7-10 year olds wish for more information and someone with whom to talk." Children have fears for their own safety, but don't know how to ask the questions. Often, parents may be unsure of how to respond to fears, or how to broach the topics.

Here is a sample of tips from Children Now's *Talking to Kids About Tough Issues* booklet (available for free; see "Resources" section) that may be helpful:

1. "Acknowledge their fears and reassure them of their safety." Don't brush off children's concerns casually or tell them they are being silly. Acknowledge the fear, but also assure them that you, as well as grown-ups such as school personnel and the police, are there to protect them, and that you will give them information to help them stay safe.

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