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Turn Down For What? The Run Down Before it Goes Down: A Comprehensive Sexual Health Education Program

Tunicia Walker

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Turn Down For What? The Run Down Before it Goes Down: A Comprehensive Sexual Health Education Program

By

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Howard University

A Capstone Submitted to the Graduate Faculty of

Georgia State University in Partial Fulfillment

of the Requirements for the Degree

MASTER OF PUBLIC HEALTH

Atlanta, Georgia 30303
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Abstract

The United States has seen an increase in incident HIV/AIDS rates in the past five years, especially amongst adolescents and young adults aged 13 to 24. Prior studies have shown that comprehensive sexual health education with an emphasis on HIV/AIDS education could be effective in reducing sexual risk behaviors that contribute to increases in HIV and Sexually Transmitted Infections (STIs) amongst adolescents, however, increased funding from congress in the past decade to promote abstinence only education has limited programs that teach this type of sexual health education, especially in states that have some of the highest rates of HIV and STIs in the United States. The purpose of this capstone project, entitled “Turn Down For What: The Run Down Before It Goes Down” is to provide a comprehensive sexual health education curriculum to schools in communities located in zip codes with high HIV rates and increasing adolescent sexually transmitted disease rates. This program will provide students with the knowledge and tools they need to negotiate safer sex, increase condom use and in turn, decrease STD incidence rates among adolescents aged 13 to 18 that reside in these zip codes. This program will serve as an update to existing programs that have already been identified as effective by including modern-day aspects such as references to social media and reality television.

Keywords: Comprehensive Sexual Health Education, sex education, abstinence education, sexual health education curriculum
I. Background

Human Immunodeficiency Virus (HIV) is a disease that is rapidly spreading throughout the United States. According to the Centers for Disease Control (CDC), approximately 50,000 people become infected with HIV each year. As of 2010, about 47,500 people were diagnosed with HIV. (CDC, 2014) The numbers of adolescents being diagnosed with the disease is staggering. Adolescents and young adults aged 13-24 are the second highest group with HIV diagnoses, with young adults aged 25-34 being the highest group. Of the 47,500 people who were diagnosed with HIV in 2010, 26 percent of them were adolescents and young adults. Two-thirds of that group did not know that they were infected. Other sexually transmitted diseases (STDs), such as syphilis, Chlamydia and gonorrhea, have seen increases in incident infections amongst adolescents age 15-19. In 2013, incident syphilis infection amongst males in this age group increased from 5.8 cases per 100,000 to 6.4 cases per 100,000. Also, young women in this age group had the second highest incident gonorrhea infection compared to other age groups in surveillance with an incident rate of 459.2 cases per 100,000. (CDC, 2014)

The economic impact of STDs, including HIV, is staggering. The CDC (2013) estimated that the lifetime medical costs of treating the most common STDs in the United States was approximately $15.6 billion for only one year of treatment. One of the most common STDs, Chlamydia, is the costliest at $742 million. Considering that Chlamydia is fairly commonplace among adolescents, it would be appropriate to implement programs
that will further reduce the rates of STD and HIV infection to help lower the economic burden on the healthcare system.

**Georgia and Atlanta**

The state of Georgia is home to the highest STD rates in the country. In 2013, Georgia was ranked 9th in Chlamydia infection rates, 8th in gonorrhea infection rates, 5th in HIV infection rates, and 1st in primary and secondary Syphilis rates. (CDC, 2012) Among adolescents, 19,978 cases of STDs were reported to the state in 2012. (Georgia Department of Public Health, 2012) The average incident infection rates of sexually transmitted diseases in Georgia are significantly higher than United States averages for each disease. Chlamydia infection rates amongst adolescents aged 15-19 in the state of Georgia in 2012 were staggering, with approximately 2,428 cases per 100,000. The national average is approximately 2002 cases per 100,000. Gonorrhea rates are much lower yet still higher than the national average with 558.5 cases per 100,000, versus the national average of 376.8. Lastly, the syphilis infection rates are 7.0 per 100,000 versus a national average of 4.1.

HIV infection rates in Georgia are one of the highest in the United States. As previously stated, Georgia is ranked 5th in the nation for the total number of adults and adolescents living with HIV infection as of 2012. When sorting data for age group, the number of adolescents and young adults living with HIV infection places Georgia as 4th in the nation, with 1,031 diagnoses being reported. (CDC, 2012) Approximately 64 percent of people in the state of Georgia living with HIV reside in the Atlanta-Sandy Springs-Marietta Metropolitan Statistical Area (MSA). (Georgia Department of Public Health, 2013) The zip codes with the highest rates of HIV overall are 30308 (an area encompassing the Peachtree
Street and Pine Street areas) with 5,527 cases per 100,000, 30312 (an area encompassing the Freedom Parkway corridor) with 3,530, 30314 (an area encompassing the Atlanta University Center) with 3,436, 30318 (an area encompassing the Vine City area) with 3,051, and 30310 (an area encompassing Martin Luther King, Jr. drive area east of Westview Cemetery) with 3,047. (Georgia Department of Public Health, 2013) Because of these statistics, adolescents have been a target for health promotion programs that address sexual risk behaviors. Most programs implemented in schools consist of abstinence-only promotion components, such as how to avoid peer pressure, healthy relationships, harmful effects of sexual activity prior to marriage, and decision-making. This is due to an addition to Title V, Section 510 of the Social Security Act in 1996 by Congress, called the Abstinence Education Grant Program. Until recently, this addition earmarked funding each year to provide abstinence education, which promotes abstinence from sexual intercourse but fails to educate about sexually transmitted diseases and contraceptive use. This addition was defined by congress as:

“A program that

(A) Has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

(B) Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

(C) Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

(D) Teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

(E) Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
(F) Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

(G) Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

(H) Teaches the importance of attaining self-sufficiency before engaging in sexual activity”. (Social Security Administration, 2010)

Research has shown that abstinence-only programs fail to work as intended. For example, in a study done by Trenholm, et. al, (2008) none of the four programs assessed in the impact study had a statistically significant impact on sexual debut or condom use. The four programs in this study include Recapturing the Vision, Teens in Control, My Choice, My Future, and Families United to Prevent Teen Pregnancy. Recapturing the Vision is an elective, classroom based program that targets high-risk females in Miami, Florida. This program consisted of material that covered abstinence, healthy relationships, and drug and alcohol prevention. Teens in Control, set in Clarksdale, Mississippi, is a program that targets single-parent, African-American households with low socio-economic status. It presents material on abstinence and how to resist peer pressure to have sex. My Choice, My Future, based in Powhatan, Virginia, focused on character development, abstinence, resisting peer pressure, and relationship skills. This program was nine weeks long. Families United to Prevent Teen Pregnancy, based in Milwaukee, Wisconsin, covered social and decision making skills, abstinence, sexually transmitted diseases and values.

In contrast, there are interventions and community-based programs that are considered comprehensive. Comprehensive sexual health education is defined as programs that teach about abstinence as the best method for avoiding STDs and unintended pregnancy. They also teach about condoms and contraception to reduce the risk of
unintended pregnancy and of infection with STDs, including HIV. It also teaches interpersonal and communication skills and helps young people explore their own values, goals, and options. (Advocates for Youth, 2001) They include education on STDs, including HIV, contraceptives and their use, pregnancy, healthy relationships, condom negotiation, drug and alcohol use. Table 1 demonstrates the differences between abstinence-only education and comprehensive sexual health education.

**Table 1. Abstinence-Only Education versus Comprehensive Sexual Health Education**

*Source: Advocates for Youth (2001)*

<table>
<thead>
<tr>
<th>Abstinence-Only Education</th>
<th>Comprehensive Sexual Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaches that sexual expression outside of marriage will have harmful social, psychological, and physical consequences</td>
<td>Teaches that sexuality is a natural, normal, healthy part of life</td>
</tr>
<tr>
<td>Teaches that abstinence from sexual intercourse before marriage is the only acceptable behavior</td>
<td>Teaches that abstinence from sexual intercourse is the most effective method of preventing unintended pregnancy and sexually transmitted diseases, including HIV</td>
</tr>
<tr>
<td>Teaches only one set of values as morally correct for all students</td>
<td>Provides values-based education and offers students the opportunity to explore and define their individual values as well as the values of their families and communities</td>
</tr>
<tr>
<td>Limits topics to abstinence-only-until-marriage and to the negative consequences of pre-marital sexual activity</td>
<td>Includes a wide variety of sexuality related topics, such as human development, relationships, interpersonal skills, sexual expression, sexual health, and society and culture</td>
</tr>
<tr>
<td>Often uses fear tactics to promote abstinence and to limit sexual expression</td>
<td>Provides positive messages about sexuality and sexual expression, including the benefits of abstinence</td>
</tr>
<tr>
<td>Discusses condoms only in terms of failure rates; often exaggerates condom failure rates</td>
<td>Teaches that proper use of latex condoms, along with water-based lubricants, can greatly reduce, but not eliminate, the risk of unintended pregnancy and of infection with sexually transmitted diseases (STDs) including HIV</td>
</tr>
<tr>
<td>Often includes inaccurate medical information and exaggerated statistics regarding STDs, including HIV; suggests that STDs are an inevitable result of premarital sexual behavior</td>
<td>Includes accurate medical information about STDs, including HIV; teaches that individuals can avoid STDs</td>
</tr>
</tbody>
</table>
Many studies have shown that comprehensive programs that aim to reduce sexual risk behaviors have a significant impact on condom use, STD and HIV knowledge, pregnancy and risky behaviors. (Coyle, 2001; Boyer, 1997; Minaya, 2008) However, many adolescents lack resources, such as transportation, money, and time, to access effective interventions such as these. The purpose of this capstone project, entitled “Turn Down For What: The Run Down Before It Goes Down” is to provide a comprehensive sexual health education curriculum to schools in communities located in zip codes with high HIV rates and increasing adolescent sexually transmitted disease rates. This program will provide students with the knowledge and tools they need to negotiate safer sex, increase condom use and in turn, decrease STD incidence rates among adolescents aged 13 to 18 that reside in these zip codes. This program will serve as an update to existing programs that have already been identified as effective by including modern-day aspects such as references to social media and reality television.

II. Literature Review

Sexually Transmitted Diseases and Adolescents

Adolescents and young adults are susceptible to STDs. The literature has documented multiple risk factors. Behavioral risk factors such as a lack of condom use and multiple partners place adolescents at a higher risk of contracting a STD. For example, according to the 2011 Youth Risk Behavioral Survey, 47.4 percent of high school students in grades 9 through 12 have had sexual intercourse. Of that percentage, 39.8 percent of them did not use a condom. (NCHHSTP, 2011) Literature shows that when used correctly and consistently, condoms prevent the transmission of HIV and some STIs. Many
adolescents and young adults lack the self-efficacy to use condoms. Also, adolescents and young adults perceive that they are invulnerable to acquiring a disease as serious as HIV. According to a survey done by the Kaiser Family Foundation, respondents in this age range were not concerned with contracting HIV, and do not take the precautions needed to protect themselves. (Kaiser Family Foundation, 2013) Lastly, while there are several effective HIV prevention education programs that target adolescents and young adults, many young people may not have access to effective interventions that give comprehensive information about STI and HIV transmission and prevention and the activities to decrease their risk.

Abstinence-Only Education

During the past two decades, abstinence-only education has been the preferred source of sexual health education by school systems and some community-based organizations. Abstinence education focuses on delaying intercourse until marriage and rarely speaks on how to handle adverse situations if one does have sexual intercourse. A typical abstinence-only education course in today’s classroom includes fear-based lessons about the psychological dangers of sex and the failure rate of condoms. Evidence shows that abstinence education, as a form of sexual education for adolescents, is ineffective. (The Community Guide, 2014) Despite research showing that abstinence-only education is not effective in reducing risk behaviors that lead to pregnancy and sexually transmitted diseases, many states continue to use this type of programming to educate pre-teens and adolescents about the dangers of sex.
In the state of Georgia, the law requires that all boards of education develop and implement a sex education and AIDS prevention curriculum that emphasizes abstinence from sexual activity until marriage. The curriculum is recommended to be implemented in the 6th grade. The decision of what to include in the curriculum is the decision of the local school board; however, the state also require that students be taught that abstinence is the only sure method of preventing pregnancy and sexually transmitted diseases. (Georgia Campaign For Adolescent Pregnancy Prevention, 2013) A school board in the state of Georgia may choose to adopt an “Abstinence-Plus” curriculum, which includes clinically-proven information about contraception and other ways to prevent disease, but they will not receive funding earmarked under the Title V of the Social Security Act of 1996.

Many of the studies reviewed below (Borawski et al, 2005; Denny et al, 2002; Bearman and Bruckner, 2005) concerning abstinence-only education presents either inconsistent results or results that are not statistically significant. However, there are a few studies (Jemmott et al, 2010) that produced positive results but only with students that were sexually inexperienced.

In a study done by Borawski et al, a non-randomized control trial was performed during the 2001-2002 school year using 3017 adolescents who were enrolled in 7 middle schools in the Midwest United States. These students were already participating in a state-funded pregnancy prevention program whose focus was abstinence until marriage. The researchers had several hypotheses, including the students having an increased knowledge of HIV/AIDS, stronger beliefs in abstinence, and greater intentions to abstain from sex in
the future. They also hypothesized since there was a lack of information on contraceptives, there will be no group differences in condom-use efficacy. (2005)

The curriculum, titled *For Keeps*, was a weeklong classroom based curriculum that emphasized character development and the danger of teen pregnancy or sexually transmitted disease and how it would interfere with life goals. The curriculum also emphasized that condoms do not protect adolescents from the emotional consequences of sex. At baseline, students received a 72 question paper-based assessment that assessed demographics, HIV/STD knowledge, abstinence values, self-efficacy (condom use and impulse control), behavioral intentions, and behavioral outcomes. Classrooms assigned to the intervention part of the study received the *For Keeps* curriculum during the fall semester, while the control students received the curriculum in the spring semester, following the posttest survey, which consisted of 70 questions and was given approximately 21 weeks after the completion of the curriculum. Only 2069 of the students completed the posttest survey.

At the completion of the intervention, the results exhibited that students who participated in *For Keeps* demonstrated and maintained a significant increase in HIV and STD knowledge when compared to the control group. Also, the intervention group demonstrated significant increases in their beliefs about being abstinent until they were older, especially among the female and sexually inexperienced students. There were no effects on self-efficacy. However, while there was a decrease in intention to have sex within the next three months with the intervention group, there was also a decrease in intention to use condoms if the students chose to be sexually active in the future, when compared to
the control group. This was also true with students who had already indicated at baseline that they were sexually active.

This study found that even though this particular abstinence-only curriculum had an effect on HIV and STD knowledge, intention to have sex and abstinence beliefs, it did not have an effect on the students’ confidence to avoid a risky sexual situation nor did it reduce the likelihood of sexual initiation or frequency of sexual intercourse among those students who were already sexually active. This study was limited by generalizability, a short follow-up time period and a small effect size.

Some abstinence-only programs that have a theoretical base have more favorable results than those that do not. Denny, et. al, evaluated the efficacy of the abstinence-only curriculum entitled Sex Can Wait. Sex Can Wait comprises three age-appropriate components for upper elementary age students in the 5th and 6th grade, middle school students in the 7th and 8th grade, and high school students that are based on Social Cognitive theory. It consists of 23 or 24 lessons, depending on the grade level. Main lessons address self-esteem, anatomy, values, decision skills, communication skills, goal setting and life planning. (Denny, 2002) None of these lessons included anything about contraception. The schools that were selected for the study already had a curriculum in place, which was used as a control. Sex Can Wait was taught to the intervention group. Data were collected using teacher reaction sheets, teacher checklists, and a student self-report questionnaire. The student self-report questionnaire included questions that tested knowledge items based on the intervention curriculum, an attitude scale, and a scale that tested expectations for the future. The questionnaires for high school students included additional sexual
behavior questions. At the conclusion of the study, it was found that there were significant differences between the intervention and control groups at the elementary level concerning knowledge and self-efficacy. The middle school group saw no significant differences, whereas the high school group saw significant differences concerning attitudes and desire to remain abstinent. There were no significant differences in knowledge at the middle or high-school level.

Abstinence-only programs designed not to meet federal requirements may be more efficacious than those that meet federal requirements. Jemmott, Jemmott and Fong (2010) also evaluated the efficacy of a theory-based, abstinence only intervention with 662 African-American middle school students. This particular intervention was not created to meet federal criteria for abstinence programs, and was compared to a safer-sex intervention, comprehensive intervention, and health promotion intervention. The health promotion intervention served as a control. All interventions in this study were based on social cognitive theory, theory of reasoned action and theory of planned behavior. The researchers hypothesized that when compared to the control groups, the abstinence-only intervention would have fewer participants report having sexual intercourse by the 24 month follow up. The abstinence intervention encouraged abstinence to eliminate the risk of HIV and pregnancy; the safer sex intervention encouraged condom use to reduce risk, and the comprehensive interventions, which had an 8 and 12 hour version, combined the content of the abstinence and safer sex interventions. The health promotion control intervention discussed behaviors that place one at risk for chronic diseases that are of concern in the African-American community. Follow up was conducted at 3, 6, 12, 18 and 24 months using questionnaires. Hypothesized outcomes were self-report of having sexual
intercourse by 24 month follow up, multiple partners, unprotected intercourse and consistent condom use. At 24 month follow up, it was found that the abstinence only intervention reduced sexual initiation, while the safer sex and comprehensive interventions had no effect on this measure. The abstinence only intervention and 12 hour comprehensive interventions also had a significant effect on reducing recent sexual intercourse when compared to the control group. The abstinence only intervention had no effect on reports of multiple partners, while the comprehensive intervention did. No interventions had an effect on condom use, which is similar to other studies evaluating the effects of an abstinence only intervention. This measure was limited by the small number of sexually active participants in the study.

Virginity pledges as a substitute for an abstinence only public health intervention are not effacious in reducing risky behavior. Bearman and Bruckner (2005) examined the consequences of these pledges on sexually transmitted diseases and adolescents who took these pledges. Data from the 3rd wave of National Longitudinal Study of Adolescent Health (ADD Health) Survey was analyzed and urine samples were taken to obtain the STD status of the original participants in the survey that was given in 1995. Participants were classified as inconsistent pledgers (those who specified taking a pledge at one point and then said they did not take a pledge at another time point), consistent pledgers (those who specified they took a pledge during all 3 time points) and non-pledgers (those who did not take a pledge at all). While those who took virginity pledges had fewer sexual partners than those who didn’t, they were significantly less likely to use a condom at first intercourse and were also less likely to be aware of STD status than those who did not take a pledge. The pledgers also had similar STD rates in comparison to the non-pledger group.
Comprehensive Sexual Health Education

While literature has shown that comprehensive sexual health education programs are more effective than abstinence-only programs, many policy makers stand by the belief that these comprehensive programs encourage adolescents to have sexual intercourse or encourage students who are already sexually active to increase the frequency that they have intercourse. When abstinence messages are paired with education on the use of condoms and other contraceptives, the programming delays or decreases sexual activity and increases intentions to use condoms. (Kirby, 2007) Evidence has provided support for the success of comprehensive programs, and because of this, congress replaced the abstinence-based education program that was introduced in 1996 with a new evidence-based teen pregnancy prevention program. This $114.5 million dollar program was passed in December of 2009. Also, within the 2010 health care reform, congress created the Personal Responsibility Education Program (PREP), whose purpose is to educate adolescents on both abstinence and contraception and to prepare them for adulthood. The PREP program includes material on healthy relationships, financial literacy, parent-child communication and decision-making. (Guttmacher Institute, 2010) While both abstinence-only and comprehensive programs can be effective at reducing risk behaviors that lead to HIV or other STDs, some comprehensive programs have longer lasting effects with adolescents who are already sexually active.

Kohler, Manhart and Lafferty conducted a study using data from the National Survey of Family Growth (NSFG). This study addressed the questions of whether comprehensive or abstinence-only education is more effective at reducing risk behaviors that lead to teen
pregnancy and also if educating adolescents about contraception increased their risk for sexual activity before marriage. (2008) The study sample included heterosexual teens aged 15 to 19 years who answered questions on the survey that concerned the type of sexual education they may have or may have not received. Adolescents who reported that they were sexually active before receiving any form of sex education were excluded. Of the sample, a majority of the respondents had comprehensive sexual health education, while approximately one-quarter of the sample had abstinence-only education. About 10 percent of the sample reported no sex education. The results showed that comprehensive sexual health education programs were significantly associated with a reduced risk of teen pregnancy and a marginal decrease in the chance that a teen will become sexually active. Abstinence-only education programs had no significant effect in delaying sexual intercourse or reducing risk-behaviors. Neither program had a significant reduction in STD risk when compared to no formal sexual education.

Some comprehensive programs may be effective for one gender, but not the other. Coyle and associates introduced the *Draw the Line/ Respect the Line* intervention to middle school adolescents in California. The aim of this program was to reduce the number of students who initiate sexual intercourse and to increase condom use among those who choose to have sexual intercourse. *Draw the Line* used social cognitive theory to guide the intervention. The effectiveness of the intervention was evaluated using self-report surveys given at baseline and each follow-up that measured knowledge, attitudes, normative beliefs, self-efficacy and decision-making. At the completion of the intervention, it was found that more boys than girls reported ever having sex when compared to control schools. With boys during the 2nd year follow up, there was a significant decrease in the
number of times they had sexual intercourse and the number of sexual partners. There was no significant effect on condom use. The reasoning for no effects on female participants may be due to the material not being supportive enough for the situations females may find themselves in, such as coercion, especially from an older partner.

Taking into consideration that some interventions may be tailored more for one gender than the other, Morrison-Beedy and associates (2005) created an intervention specifically for sexually active adolescent females that was guided by the information-motivation-behavioral skills (IMB) model. Using strategies proven successful in other interventions, the program included negotiation skills, communication skills building, and the promotion of the use of condoms. Participants were adolescent females aged 15-19 who were receiving clinical and educational services at a Planned Parenthood Clinic. Self-administered questionnaires were assessed at baseline and after 3-month follow-up that measured eight sexual risk behaviors and other behavior antecedents. Participants were randomized into either the HIV risk reduction intervention or a health promotion control group that targeted nutrition and anger management. Results of the intervention showed that participants in the HIV intervention group had a significant increase in knowledge and saw fewer cons of condom use than the control group. Also, the HIV intervention group demonstrated that they engaged in five of the eight risk behaviors less often than the control group.

When developing comprehensive programs, they should be culturally congruent. Cultural congruence, also known as cultural competence, is defined as having the capacity to function effectively as an individual and an organization within the context of the
cultural beliefs, behaviors and needs presented by consumers and their communities. (U.S. Department of Health and Human Services, 2015) A program that includes these definitions shows the community you are targeting that you are respectful and responsive to the beliefs and needs of the target population. Kinsler and colleagues (2004) introduced an intervention called Project Light to schools located in Belize City, Belize. Prior to this intervention, schools in this area did not have a formal sexual education program, and some schools would not implement the intervention due to it conflicting with the beliefs of the Catholic Church. If a school did teach sex education, it was only taught to students enrolled in science or engineering classes, whose students were mostly male. Project Light was evaluated by community stakeholders for appropriateness for the Belizean culture prior to implementation. The intervention was guided by the Social Cognitive Theory and the Theory of Reasoned Action. Lead by peer educators aged 14 to 19, Project Light consisted of 7 two-hour sessions that aimed to increase HIV and AIDS related knowledge, attitudes and intention to use condoms, communication skills, and negotiation skills in regards to resisting peer pressure. These particular items were measured at baseline and follow-up, which was a month after the intervention was completed. Students in the Project Light intervention had significant increases in HIV knowledge, reported higher levels of condom use and intention to use condoms at next intercourse. They also had more positive attitudes toward the use of condoms. (Kinsler, 2004) However, there was no significant impact on peer norms toward condoms and self-efficacy, which could be due to cultural influence. This study was not culturally congruent enough in the consideration of social, cultural and political influences that impose on the student outside of the intervention.
When looking at the literature, it shows us that a need for culturally congruent, evidence-based programs that address the needs of adolescents who have not initiated sexual intercourse and those who have. Successful programs included those that used theoretical constructs to guide their programs to help increase self-efficacy, decision making, attitudes about condom use, attitudes about abstinence, and knowledge of HIV and other STDs. The components from these successful programs will be used in the creation of the curriculum for *Turn Down For What: The Run Down Before It Goes Down*.

**III. Program Description**

"Turn Down for What: The Run Down Before It Goes Down" is a community-based, culturally-congruent, comprehensive sexual health education program designed to target both female and male adolescents between the ages of 13 to 18. Also, this program is to target adolescents residing in zip codes 30308, 30312, 30314, 30310 and 30318, as these zip codes have some of the largest HIV infection rates in the state of Georgia. Core elements of the “Turn Down for What: The Run Down Before It Goes Down” will consist of skills and knowledge-building activities, role-play and self-efficacy building sessions to help reduce risk-behaviors that adolescents of this age exhibit that place them at heightened risk for Sexually Transmitted Diseases, particularly HIV. Using the guidelines set by the Sexuality Information and Education Council of the United States (SIECUS), the curriculum will include components that fall under the six key concepts of comprehensive sexual health education (SIECUS, 2004):

1) Human Development
2) Relationships
3) Personal Skills
4) Sexual Behavior
5) Sexual Health
6) Society and Culture

The participants in the program will learn about Sexually Transmitted Diseases, condom use, other contraception options, sexual decision-making, self-love, and healthy relationships over the course of 6 90-minute after school sessions. The goal of this program is in line with Healthy People 2020 objectives. With this reduction, this will hopefully reduce the incident rates of STDs, especially HIV, among adolescents.

Theoretical Framework

*Turn Down For What: The Run Down Before It Goes Down* was developed using several theories that are well known for their use in behavior change interventions and programs. This program will be based on social cognitive theory, theory of reasoned action, and the health belief model. These theories, in addition to others, are most commonly used when developing a health education program. Social Cognitive Theory, developed by Bandura in 1986, is one of the most valued theories when needed to evaluate health behaviors. The Theory of Reasoned Action states that the beliefs of health behaviors and social influences share equal weight in shaping behavioral intentions. Lastly, the Health Belief Model attempts to predict health behaviors by looking at the attitudes and beliefs of an individual about a specific health behavior. Table 2 includes some of the theoretical constructs from the program curriculum and the activities that address them.
Table 2. Theories and Their Respective Constructs in the Program Activities

<table>
<thead>
<tr>
<th>Social Cognitive Theory</th>
<th>Theory of Reasoned Action</th>
<th>Health Belief Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Rock the Value Vote”: Observational Learning</td>
<td>“Countdown”: Subjective Norms</td>
<td>“What is Love, What is Violence?”: Perceived Severity</td>
</tr>
<tr>
<td>“Condom Cards”: Self-Efficacy</td>
<td>“Act Like a Woman, Think Like a Man”: Subjective Norms</td>
<td>“Is it Risky, or Nah?”: Perceived Severity</td>
</tr>
<tr>
<td>“It Takes Two”: Decision-making</td>
<td>“It Takes Two”: Behavioral Beliefs</td>
<td>“Abstinence: A Healthy Decision”: Perceived Benefits</td>
</tr>
<tr>
<td>“What is Love, What is Violence”: Outcome expectations</td>
<td>“Cultural Collage”: Normative Beliefs</td>
<td>“Abstinence: A Healthy Decision”: Perceived Barriers</td>
</tr>
</tbody>
</table>

**Rationale**

Adolescents aged 13 to 18 are becoming increasingly susceptible to sexually transmitted diseases, especially HIV. As previously stated, adolescents only make up 27 percent of sexually active people in the United States, but they account for nearly half of all new incident infections each year (CDC, 2014) Also, many adolescents know what HIV is and the effects of it, but very few have knowledge of the other most common sexually transmitted diseases: Chlamydia, gonorrhea, herpes and human papillomavirus (HPV). In a study done by Clark, et. al, a majority of adolescents surveyed correctly identified HIV as a major STD, but only 2 percent of the group could identify all eight major STDs presented to them in the study. (2002)

According to the 2013 Youth Risk Behavior Survey, the percentage of students receiving comprehensive sexual health education that teaches them about sexually transmitted diseases other than HIV or AIDS has decreased over 10 percent since 1997. (CDC, 2014) As previously
stated, until recently, Title V of the Social Security Act, better known as the Abstinence Education Grant Program, provided funds to states that implemented curricula that use definitions outlined by congress. In those definitions, proper contraceptive use and negotiation are not mentioned, nor are any other components that would be covered under the six standards mentioned in the description of this program. The state of Georgia has school systems that are recipients of these funds; however, the state government gives discretion to local school systems on how they will present the guidelines, provided they follow the basic national guidelines. Since Turn Down For What will not be sponsored by a school system; it does not have to abide by these guidelines.

Program Implementation

Turn Down For What: The Run Down Before It Goes Down was presented and proposed to several key stakeholders in our target zip codes of interest in Atlanta, Georgia. These stakeholders consisted of community leaders from the Neighborhood Planning Units (NPUs) in each of the target zip codes, educators, community organization leaders, and parents. The proposal presented is in Appendix A. A logic model was created for the program and this was also used in the presentation to the stakeholders. This logic model is included in Appendix B. The curriculum for the program is included in Appendix C.

The logic model for Turn Down For What was created to illustrate the various working parts and considerations for implementing and conducting the program. According to McKenzie, a logic model is a systematic and visual way to present and share understanding of relationships among resources available to operate the program, the activities planned, and the changes that are anticipated to happen. (2013) It includes
inputs, which are the resources needed to plan, implement, finance and run a program; outputs, which are the actual activities that will take place in the program, and outcomes, which are the results that one intends to see and are broken down into three phases: immediate, short term, and long term. In the instance of this program, the logic model was based off of my prior experience with working with the Adolescent Females Learning about Sexual Health (AFLASH) program that I observed during my practicum at Aniz, Incorporated. The logic model allowed the stakeholders to have a visualization of how the implementation of the program will proceed and the outcomes that will favor their communities.

When meeting with the community stakeholders, many expressed the need for age-appropriate comprehensive sexual education. Shacole Pearman, a Program Coordinator with the City of Atlanta Department of Parks and Recreation, leads a program called GIRL$ that targets adolescents aged 8 through 14. She described the influences children interact with daily, such as social media and televised media. She expressed that adolescents would benefit from a structured program that emphasizes learning about healthy relationships. Hillery Kelly, a soon to be mom, expressed that abstinence-only lessons are not enough to reduce the risk. She suggests that any program include lessons about how to say no for males and females, and also lessons about other forms of contraception. Hillery felt that the onus is placed on females entirely too often to be the one to say no. April, a Special Education Teacher Assistant at Scott Elementary School (located in the 30318 zip code) feels as though most programs that already exist are great, but the effects are not long lasting. She feels like any program should be tailored in such a fashion that the effects are longer-lasting. When presented with the stakeholder proposal, many
were pleased that the proposed curriculum for *Turn Down For What* included many of the concerns they already had.

**Program Objectives**

The program has two objectives, which are:

- To help participants decrease risky behaviors that lead to sexually transmitted diseases by 10 percent within 5 years.
- To increase knowledge of the 5 major sexually transmitted diseases by 25 percent within 2 years.

These objectives were based off of the Healthy People 2020 objectives for this specific population.

**Program Curriculum**

As previously stated, *Turn Down For What* will consist of six 90-minute sessions that will be held after school in a group setting. It is suggested that participants for the program be recruited from schools in the target areas and organizations they may frequent, such as the Boys and Girls Club. Consent will be needed due to the age of the target participants. Because the majority of the residents residing in these zip codes are African-American, the program is tailored to be culturally congruent to that particular population. The program will meet once a week for 6 weeks during the Atlanta Public Schools calendar year. Each session will be led by a trained adult facilitator, and the human development, sexuality and contraception sessions will be led by a trained facilitator based on gender (female facilitator with girls, male facilitator with boys), using a manual
designed specifically for this program, which is included in Appendix C. The number of facilitators will be established based on the number of participants in the program. Using activities from other successfully implemented programs as observed from literature, participants will partake in several different activities. During the first week, classroom rules will be established to ensure respect for the facilitator and for the students themselves. The students will also participate in icebreakers so that they can get to know each other and the facilitator that will be with them for the subsequent six months. After the icebreakers, the students will participate in a discussion and group activity about values and what values are important to them. This satisfies the key concept of personal skills. During the second week, the students will participate in activities that satisfy the key concept of society and culture. For example, the students will use magazines to create a collage that illustrates how they feel society views them. The students will be allowed time to go around the classroom to express why they feel the collage is a representation of them. Also in week two, students will be assigned several different images and they will have to categorize them into either a positive category or negative category. These activities will teach the students that people may view things differently from person to person. For the third week, we will discuss the key concept of relationships. One activity during this time will involve the students having a group discussion about how they define healthy and unhealthy love. They will also view a video that will challenge their views about appropriate relationships. The students will discuss their opinions about the video and the facilitator will help guide their answers. During the fourth week, we will discuss human development. Students will receive handouts that reflect the male and female reproductive systems with boxes for them to identify each part of the system. The students will discuss
how each part works in reference to sexuality. Another activity will be “Human Jeopardy” where the students will answer questions about the reproductive system and will have the opportunity to win a small prize for that day. The prize will hopefully keep the students motivated to keep coming to the classes. The fifth week will consist of modules discussing sexual health. There will be activities and discussions on HIV, STDs and how they are transmitted. During the last week of the program, we will wrap up by discussing sexuality and its impact on everyday life. Students will observe and then demonstrate how to use both a male and female condom. Students will also participate in a group activity that will involve them demonstrating the proper steps to apply a male condom without using an actual condom. We will also discuss the importance of sexual abstinence. Students who attend 5 of the 6 sessions will be able to “graduate” from the program and will receive a certificate and a small award.

**Evaluation Plan**

Part of the curriculum for *Turn Down For What* includes an evaluation plan for program implementers and that includes several components. A process evaluation description can be used to make sure that all parts of the program are working as intended. An outcome evaluation can be used to ensure that the program worked as intended. As part of the process evaluation plan, the following questions can be answered:

- Is this program reaching its intended population?
- Are the facilitators accurately disseminating all program material in a clear and consistent manner?
- Did the students’ knowledge of key concepts increase?
- Did the students enjoy the curriculum and activities?
As part of the outcome evaluation plan, the following questions can be answered:

- Did the program decrease risky behaviors that lead to sexually transmitted disease by 10 percent in the specified time period?
- Did the program increase knowledge about the 5 major sexually transmitted diseases by 25 percent in the specified time period?

It is recommended to use data triangulation to enhance evaluation where 3 types of qualitative and quantitative data can be used to answer questions for the evaluation portion of the curriculum. A Student Pretest/Posttest, student satisfaction survey, and a facilitator observation checklist are included.

**Data Collection Instruments**

At the beginning of the program, students will take a STD/HIV knowledge test (Appendix D) that will assess demographic characteristics, sexual risk behavior and knowledge about sexually transmitted diseases, including HIV. The demographic characteristics and sexual risk behavior questions are based on questions from the Youth Risk Behavior Survey (CDC, 2015). This same test should be administered at the completion of the program. The results should be analyzed using SPSS Version 21 software, if available.

The second data source included in the evaluation is to measure the completion and quality of the program activities via a student satisfaction survey (Appendix E). This survey collects basic demographic data (such as age, gender, and race/ethnicity), without disclosing identification information. This survey will indicate if the students enjoyed the program material and activities.
To conclude the data collection process for the evaluation of the curriculum, a checklist used during the observation process of the facilitators (Appendix F) will be used to answer the evaluation question concerning the accurate dissemination of program material.

**IV: Conclusion and Discussion**

Comprehensive sexual health education has been shown to be beneficial for young adults in reducing the risk for STDs, especially HIV and can be used as a gateway to introduce healthier behaviors to adolescents. There is little evidence in the literature to suggest that comprehensive sexual health education programs, which include information on condom use and other forms of contraception, increase the likelihood of adolescents having sexual intercourse. Adolescents who participated in abstinence-only interventions are more likely to delay the initiation of first intercourse, but less likely to use condoms. Adolescents who participate in comprehensive sexual health education programs are also more likely to use condoms upon the initiation of intercourse, and participate in less risky behavior than those who did not receive comprehensive programming. The literature has also revealed that comprehensive programming is more successful with adolescents who are already sexually active versus those who have not engaged in sexual activity.

It is evident that there is a need for comprehensive sexual health education that is culturally congruent, theory based and inclusive of adolescents who are sexually active and those who are not. Although programs should still stress abstinence, they should also
encompass aspects of relationships, values, dating violence, and decision-making. The curriculum of *Turn Down For What* includes all of these aspects.

There are some limitations that could limit the success of *Turn Down For What*. First, this program may not be compatible to other African-American adolescents who reside in areas outside of those that are in our target zip codes. Also, the curriculum may not have an impact on adolescents who identify as lesbian or gay. For example, it may be difficult to stress abstinence until marriage to an adolescent who identifies with a group that cannot marry legally in the state that they reside in. Also, as previously stated, the curriculum may not have a great impact with adolescents who have yet to have sexual intercourse.

Despite these limitations, *Turn Down For What* can be a successful program. Findings from this project can serve to inform practitioners and policy makers of the need for consistent, effective comprehensive programming to reduce the risky behaviors that lead to STI and HIV infection in adolescents. *Turn Down For What* will also contribute to the growing database of interventions in use and will hopefully increase knowledge of which types of HIV and safer sex education are more effective. As the years pass and more effective interventions are implemented, our hope is to see a decrease in HIV incidence in adolescents and an increase in their concern about their health.
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teen sexual activity, risk of pregnancy, and risk of sexually transmitted diseases. *Journal of Policy Analysis and

Appendix A-Stakeholder Proposal

“Turn Down For What: The Run Down Before It Goes Down” Comprehensive Health Education Program

Proposal

Purpose: To provide a comprehensive sexual health education curriculum to community-based organizations in communities located in zip codes with high HIV rates and increasing adolescent sexually transmitted disease rates.

Objectives: To help reduce the percentage of sexually transmitted diseases in adolescents in the city of Atlanta in communities that already demonstrate high rates of persons living infected with Human Immunodeficiency Virus (HIV). The program will also aim to reduce risky behaviors in adolescents that place them at risk for these diseases by 10 percent.

Rationale: Adolescents aged 13 to 18 are becoming increasingly susceptible to sexually transmitted diseases, especially HIV. As previously stated, adolescents only make up 27 percent of sexually active people in the United States, but they account for nearly half of all new incident infections each year (CDC, 2014) Also, many adolescents know what HIV is and the effects of it, but very few have knowledge of the other most common sexually transmitted diseases: chlamydia, gonorrhea, herpes and human papillomavirus (HPV). The state of Georgia ranks in the top 10 when it comes to STDs (Chlamydia, Gonorrhea, Syphilis, Herpes and HIV). Many zip codes in the metropolitan Atlanta area with the highest rates of HIV in the state.

Projected time frame: 6 months, during the calendar school year (September-February)

Location: City of Atlanta Centers of HOPE in each affected zip code

Short-term impact: Students will understand the importance of making better decisions. They will also gain an increased knowledge about sexually transmitted diseases, including HIV/AIDS, condom use and other contraception options, how the reproductive system works, and healthy relationships. They will also gain confidence in negotiation skills when it comes to risky situations.

Long-term impact: There will be a reduced risk of sexually transmitted diseases in adolescents in the Atlanta area in the impacted communities. Also, among students in the program that are not sexually active, there will be a 10 percent decrease in any intention to have sex in their immediate future. Among students in the program that are already sexually active, there will be a 5 percent reduction in the amount of sexual partners that student will have. Also among that same population, there will be a 10 percent increase in condom use. Over time, we will hopefully see an overall decrease of 10 percent in adolescents in the Atlanta metropolitan area that have sexually transmitted diseases.
Appendix B- Logic Model

Program: “Turn Down For What: The Run Down Before It Goes Down” Logic Model

Situation:
“Turn Down For What: The Run Down Before It Goes Down” is a culturally congruent comprehensive sexual health education program for adolescents aged 13-18 that are students enrolled in schools in the Atlanta Public Schools system. The program will be held at community centers that are located in zip codes with high HIV infection rates. The purpose of “Turn Down For What” is to provide a comprehensive sexual health education curriculum to schools in communities located in zip codes with high HIV rates and increasing adolescent sexually transmitted disease rates. The objectives of the program are to help reduce risky behaviors that lead to STD infection, increase knowledge about STDs, contraceptives and abstinence, and to build skills and self-confidence when it comes to negotiating safer behaviors with their peers.

Inputs
- Financial Resources
- Students
- Community Stakeholders
- Trained Facilitators
- Community Centers
- Time
- Facilitation Manuals

Activities
- Introduce program to stakeholders to get community feedback
- Train Facilitators on how to properly facilitate program
- Educate students about values and decision making
- Educate students about healthy relationships
- Educate students about STDs/HIV, contraceptive use

Outputs
- Participation
- Facilitators, Stakeholders, Students
- Adolescents will have increased understanding of importance of good decisions
- Adolescents will have increased knowledge of HIV, Chlamydia, Gonorrhea, Syphilis, Herpes and HPV
- Adolescents will have increased knowledge about sex and sexuality
- Adolescents will have increased knowledge about contraception and abstinence from sex
- Adolescents will have increased self-efficacy to protect oneself in risky situations and awareness of healthy relationships

Outcomes
Immediate
- Adolescents will have increased understanding of importance of good decisions
- Adolescents will have increased knowledge of HIV, Chlamydia, Gonorrhea, Syphilis, Herpes and HPV
- Adolescents will have increased knowledge about sex and sexuality
- Adolescents will have increased knowledge about contraception and abstinence from sex
- Adolescents will have increased self-efficacy to protect oneself in risky situations and awareness of healthy relationships

Outcomes Short
- There will be a reduced risk of sexually transmitted diseases in adolescents
- Condom use will increase 10 percent among students in program that are already sexually active
- A 5% reduction of sexual partners among students already active; 10% decrease in intention to have sex in those that are not

Outcomes Long
- There will be a 10 percent decrease in adolescents that have a STD in the City of Atlanta.

Assumptions
- Students will be available for every session
- All facilities are available for each session
- The community will accept the program

External Factors

Rev. 7/09
Appendix C- Program Curriculum

Turn Down For What? The Run Down Before It Goes Down

Facilitator Manual

And

Program Curriculum
What is “Turn Down For What?”

“Turn Down for What: The Run Down Before It Goes Down” is a community-based, culturally-congruent, comprehensive sexual health education program designed to target both female and male adolescents between the ages of 13 to 18. Core elements of the “Turn Down for What: The Run Down Before It Goes Down” will consist of skills and knowledge-building activities, role-play and self-efficacy building sessions to help reduce risk-behaviors that adolescents of this age exhibit that place them at heightened risk for Sexually Transmitted Diseases, particularly HIV.

The American South is witnessing a dramatic exponential increase in the number of children who are at risk of HIV infection or who have AIDS. Adolescents only make up 27 percent of sexually active people in the United States, but they account for nearly half of all new incident infections each year (CDC, 2014) Also, many adolescents know what HIV is and the effects of it, but very few have knowledge of the other most common sexually transmitted diseases: chlamydia, gonorrhea, herpes and human papillomavirus (HPV).

The participants in the program will learn about Sexually Transmitted Diseases, condom use, other contraception options, sexual decision-making, self-love, and healthy relationships over the course of 6 90-minute after school sessions. The goal of this program is to reduce risk behaviors among adolescents in the metro Atlanta area and to reduce the number of adolescents infected with sexually transmitted disease.
Session 1 Overview

Session 1

Introductions/Icebreaker

-Upon the start of the program, the facilitator will introduce himself/herself and set classroom rules and expectations about respect, personal space and privacy.

-After the facilitator discusses the classroom rules, the facilitator and the students will participate in an icebreaker called “Two truths and a lie”

Values Lesson

-After the icebreaker, students will participate in a group activity that demonstrates values and how different people view values with their lives.

-After this lesson is complete, the students will receive worksheets with different sets of values on them. This exercise will challenge some of their values exposed in the initial values lesson.
Session One

Getting to know you: Two truths and a Lie

Objective: The purpose of this activity is for students to get to know each other by letting the students guess which statement is true about the presenting student.

Materials: n/a

Time: 15 minutes

Procedure:

1) Instruct the students to think about 3 statements that they would want to share with the class. Two of the statements are to be true statements; one of the statements is to be false.

2) Starting with yourself, share your 3 statements. After sharing your 3 statements, ask the students to raise their hand if they think that they know what the lie is. The student that guesses the correct answer starts the activity with the students.

3) Have students go around the room and share their three statements. For the students to give their answer, they must raise their hand.

Discussion points: n/a
Session One

“Countdown”: Values Activity

Objective: Students will identify and rank a list of values in order from least important to most important.

Time: 25 minutes

Materials: “Countdown” worksheet, 1 for each group member, scissors, clear tape, pieces of colored 8-1/2" x 11" paper, 1 piece for each group member

Procedure:

1. Distribute the “Countdown” worksheet and a piece of colored paper to each student. Have them cut the words out on the worksheet into ten strips. Inform the students that one way to find out what their values are is to rank them – selecting the one that is the least important and placing it on top, followed by the one that is second-least important, and so on. The most important value should be at the bottom of the sheet.

2. Tell the students to look over the value statements to carefully and to move them around until they have a list with their most important value at the top and their least important value at the bottom.

Make the students aware that they should work slowly and think carefully about each statement. They may change the order of the statements if they change their minds—the ranking should show how they really feel about the statements, and no one else. They should tape the statements in their final order to the piece of colored paper. Allow 5 minutes for them to work.
3. Remind the students of the classroom rules. Then, go around the room and have each student share her or his “Countdown” list. The facilitators should also share.

4. After everyone has had an opportunity to share, lead a discussion using the following questions:
   - What might be the reason for the different values in the group? (Different families, religions, gender, ages, socioeconomic, cultures, etc.)
   - How do you think your family would rank the items?
   - Can you think of any important values that aren’t listed here?
   - How would making choices that keep you from getting HIV or another STD support your top two values?
   - How would getting HIV or another STD affect your top two values?

**Discussion Points**

Summarize by stating that people need to think about their values and what is most important to them when they make decisions and decide how they will behave, especially in relationships. The next activity will demonstrate how people can have different relationship values.

*(Let students take a break after this activity)*
Session One

“Rock the Value Vote” Activity

Objective: To help students observe personal values about family, relationships and sexuality and to lead a discussion amongst the class about how values differ from person to person.

Time: 40 minutes

Materials: “Agree” and “Disagree” signs, “Rock the Value Vote” worksheets, tape.

Procedure

1. Remind the group of the classroom rules established in Session 1.
2. Put the Agree and Disagree signs at opposite ends of the room.
3. Distribute the Rock the Value Vote worksheet. Explain that everyone is about to do an activity that will challenge some of their values. Let the students know that this exercise is done anonymously, and that they are NOT to write their names anywhere on the worksheet. Ask them to read each statement to themselves and then mark the appropriate box indicating whether they “Agree” or “Disagree.” There no middle ground – they must choose the side that comes closest to representing their values. Allow 2-3 minutes for group members to select their answers. Remind them not to put their names on the sheet.
4. When students have finished, collect and shuffle all of the worksheets. Once they are well shuffled, redistribute the sheets. Explain to the students that if they think they received their own worksheet back, they should just hold on to it because no one will know whose answers they have.
5. Have all of the students stand in the middle of the room. Explain that you are going to read the statements from the worksheet one at a time. Each time they should move to the Agree or Disagree side of the room based on the answer on the worksheet in their hand—even if the opinion on the worksheet they have is the opposite of what they themselves think. Explain that for this activity, they are going to represent and argue for the position on the worksheet they are holding, which may not match their own. Check to make sure everyone understands the exercise.

6. Begin the activity by reading a statement from the worksheet. Encourage students to move quickly to the Agree or Disagree side of the room, based on the opinion on the worksheet in their hand.

7. Ask one or two students from each side to offer suggestions as to why someone would agree or disagree with the statements.

8. Once the argument has been made for both sides, read another statement from the worksheet and repeat the process for about 15 minutes.

9. When all of the statements have been read, have the students return to their seats. Lead a discussion using the following questions:
   - When you were filling out the worksheet, what it hard to pick a side? What made it easy?
   - Did you find yourself wanting to stand in the middle? What influenced you to choose the side you eventually chose?
   - Did this activity make you think about things you usually take for granted?
   - Did anyone change his or her mind after hearing a good argument for the opposing view?
   - How would your parents have chosen? Share one area where you and your parents might have different feelings.
   - Were there any items you think that young men and women would have different opinions about? Which ones?

10. Summarize by asking what they learned about their values from this activity.

**Discussion Points**
Discuss how understanding their values might help them make decisions to prevent getting infected with HIV or another STD. For example, it is easier to carry out a decision supported by your values.
Session 2 Overview

Session 2

“Pretty Hurts” Self-Esteem/Perception Activity

-The students will view several different media images to decide what a positive image and what a negative image might be.

-At the conclusion of this lesson, students will discuss the importance of viewing oneself in a positive light.

Cultural Collage Activity

-This activity will allow students to create a pictorial depiction of themselves. This will show the students in the class that even though they think they may be all the same, they are also a little different.

“Act Like a Woman, Think Like a Man” Gender Roles Activity

-This activity will allow students to demonstrate the mannerisms they perceive of the opposite sex. They will then discuss why they have these perceptions and how stereotypes can be limiting in life.
Session Two

“Pretty Hurts” Self-Esteem/Perception Activity

Objective: The purpose of this activity is to allow students to distinguish between positive and negative media images.

Materials: 10 images from magazines

Time: 15-20 minutes

Procedure:

1. Explain that there are various images of females portrayed in the media. Some images maybe positive, while others maybe negative.
2. Give each student an image.
3. Explain that they should place the images in either a positive or negative category.
4. Allow youth 2-3 minutes to view their image and note whether it is positive or negative.
5. After each youth has had a moment to decide, go around the room and let each student share their picture and state their choice (positive or negative) and why they decided as such.

Discussion points:

Indicate that at times people have different views about what is positive and negative.

Share the importance of viewing oneself in a positive manner.
Session Two

Culture Collage Activity

Objective: The purpose of this activity is to allow students to use different images and drawings to create a collage that represents them (culture, religion, family). This will allow students to learn how to critically examine the world around them for biases based on gender, sexual orientation, culture, ethnicity, and race.

Materials: Magazines, markers, colored paper, safety scissors, glue sticks

Time: 25 minutes

Procedure:

1. Explain that the world we live in is made of persons from different races, cultures, religions and places.
2. Explain to the students that they will be creating a collage that represents them as a person. Stress that they are to cover all aspects of their life that they are comfortable with sharing.
3. Distribute materials to each student for their personal use. Allow youth about 15 minutes to complete their collage.
4. After each student has had time to complete their collage, have each student share their collage and what each item on the collage stands for.

Discussion points:

Reiterate that even though we may all come from the same communities, we may not share the same things in life. Society works in our best interest when different people respect other people’s views.

(Allow students to take a break here)
Session Two

“Act Like A Woman, Think Like A Man”

Gender Roles Activity

Objective: The purpose of this activity is to allow students to demonstrate what they perceive what a man is like/what a woman is like. During this exercise students will see what the perceptions are and then will discuss why they hold these perceptions.

Materials: None

Time: 35 minutes

Procedure:

1. Pair students off and explain to them that they are to create a skit that demonstrates everyday behavior of women and men in society today. Remind the students that it is to be appropriate for class.
2. Allow the students 15 minutes to come up with their skits. Afterwards, let the students share their skits and the reasoning behind their skits.
3. Based off of the students' skits, explain to the students that gender role stereotypes can be limiting in everyday life. Stereotypes lead to assumptions that may lead to negative outcomes. Also stress that the way a person expresses their gender (male or female) has nothing to do with their sexual preference (heterosexual, homosexual, etc). Express that men and women should always be given equal opportunity, especially when it comes to making decisions for oneself.

Discussion points: None
Session 3 Overview

Session 3

“Healthy Love” Activity

-This activity will allow students to discuss healthy relationship behaviors versus unhealthy behaviors. They will also discuss how to handle unhealthy behaviors if they observe them.

“What is Love? What is Violence?” Teen Domestic Violence PSA

-During this activity, students will view a Public Service Announcement on Teen Domestic Violence. They will discuss which actions in the video demonstrate domestic violence amongst their peers and how to handle the situations if they find themselves or a friend in that situation.

“It Takes Two” Decision Making/Communication Activity

-Students will read a vignette about two adolescents that find themselves in a compromising position and will discuss what decisions the teens might make and how they relate to values, relationships, family and their health. They will also discuss why open communication is important when making decisions.
Session Three

Healthy Love

Objective: The purpose of this activity is to allow students to distinguish between what is a healthy behavior in a relationship versus an unhealthy behavior.

Materials: None

Time: 30 minutes

Procedure:

1. Read each statement to the students (on next page) and have them discuss whether or not it is a healthy or unhealthy relationship behavior. If there are conflicting views, remind the students of the classroom rules and let them debate their differences respectfully.

Discussion points: Share the importance of being able to identify unhealthy behaviors in relationships and how important it is to remove oneself from those situations if they manifest.

<table>
<thead>
<tr>
<th>Signs of UNHEALTHY boundaries...</th>
<th>Signs of HEALTHY boundaries...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trusting no one - trusting anyone - black and white thinking - tendency towards racism</td>
<td>Appropriate trust - accepting people regardless of caste or color</td>
</tr>
<tr>
<td>Tell all</td>
<td>Revealing a little of yourself at a time, then checking to see how the other person responds to your sharing</td>
</tr>
<tr>
<td>Talking at intimate level on first meeting</td>
<td>Moving step by step into intimacy</td>
</tr>
<tr>
<td>Falling rapidly in love with new acquaintance</td>
<td>Putting a new acquaintanceship on hold until you check for compatibility</td>
</tr>
<tr>
<td>Falling in love with anyone who reaches out</td>
<td>Deciding whether a potential relationship will be good for you</td>
</tr>
<tr>
<td>Being overwhelmed by a person - preoccupied - 'snowed under'</td>
<td>Staying focused on your own growth and recovery</td>
</tr>
<tr>
<td>Acting on first sexual impulse</td>
<td>Weighing the consequence before acting on sexual impulse</td>
</tr>
<tr>
<td>Being sexual for partner, not self</td>
<td>Being sexual when you want to be sexual - concentrating largely on your need for pleasure rather than monitoring reactions of partner</td>
</tr>
<tr>
<td>Going against personal values or rights to please others</td>
<td>Maintaining personal values despite what others want</td>
</tr>
<tr>
<td>Not noticing when someone invades your boundaries</td>
<td>Noticing when someone else displays inappropriate boundaries</td>
</tr>
<tr>
<td>Not noticing when someone invades your own boundaries</td>
<td>Noticing, and acting upon this fact, when someone invades your boundaries</td>
</tr>
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<td>Accepting food, gifts, touch, sex, advice that you don't want</td>
<td>Saying 'No' to food, gifts, touch, sex, advice you don't want</td>
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<tr>
<td>Touching a person without asking</td>
<td>Asking a person before touching them</td>
</tr>
<tr>
<td>Taking as much as you can get for the sake of getting</td>
<td>Respect for others - not taking advantage of someone's generosity</td>
</tr>
<tr>
<td>Giving as much as you can give for the sake of giving</td>
<td>Self respect - not giving too much in the hope that someone will like you</td>
</tr>
</tbody>
</table>
Session Three

Teen Domestic Violence PSA: What is Love? What is Violence?

Objective: Students will view a public service announcement that allows them to view examples of dating violence among their peers.

Materials: Youtube video

Time: Approximately 30 minutes

Procedure:

1. Lead a discussion by first asking students what they think the signs of domestic violence among their peers are. Explain that any form of violence is wrong and not acceptable.
2. Allow students to view video. Discuss what was seen in the video.

Discussion Points: Domestic violence at any age is wrong. If one has a friend that may be experiencing domestic violence, approach them cautiously about getting help. If you notice your partner exhibiting signs of violent or inappropriate behavior, there are several resources available. (Give students list of resources if they request it)

(Let students break after this activity)
Session Three
It Takes Two: Decision Making/Communication Skills
Activity
(Source: ReCAPP website)

Objective: The purpose of this activity is to help students identify and understand how poor communication can lead to compromising situations and how to identify ways to avoid them. Students will also discuss reasons why you may postpone sexual activity.

Materials: The Jamal and Jasmine story

Time: 25 minutes

Procedure:

1. Initiate the discussion by:
   a. Reading the Jamal and Jasmine story.
   b. Asking youth to take a few minutes to write down two or three reasons why Jamal and Jasmine should decide to wait for sex.
   c. Ask the students to share some of their reasons. Record their answers on the board as they state them. Encourage students to include reasons that relate to family, religious beliefs, health and relationships.

2. Continue the discussion by asking students the following questions:
   1. Ask youth to look at the reasons listed and discuss how Jamal’s reasons might be different from Jasmine’s.
   2. What might be the advantage of waiting to have sex for Jasmine? For Jamal? What might be the disadvantages?
   3. What do you think Jasmine and Jamal will do?
4. How might Jamal and Jasmine talk to each other about their decision?

5. What might get in the way of their talking with each other?

6. How might Jamal and Jasmine express affection to each other without having sex?

3. Conclude the discussion by using the following questions to help youth generalize and personalize what they've learned.
   
   a. How is Jamal and Jasmine’s story like real life?
   
   b. What “reasons to wait” might have the most impact on your friends and peers?
   
   c. Looking at the list of reasons we have developed, what are the strongest reasons for you to wait to have sex when you are in a relationship?

Discussion Points: Communication is key in any relationship is key. It is important to voice concerns no matter what the situation is. One should not feel pressured into doing something they do not want to do because of a lack of communication or decision-making.

The Jamal and Jasmine Story

Jamal and Jasmine have been seeing each other for seven months. Jasmine is a ninth grader, and Jamal is in tenth grade. Last Saturday night after a movie, things went pretty far. Jasmine got scared and told Jamal to stop. Jamal said he loved Jasmine a lot and wanted to go all the way with her. Jasmine said she wanted to think about things first and asked that they talk about whether or not to have sex later. What should Jamal and Jasmine do?
Session 4 Overview

Session 4

Reproductive Health

-The students will identify parts of the reproductive system in both men and women. They will then discuss what each part is responsible for and how they can be affected by sexually transmitted diseases.

Human Jeopardy

-This activity will allow students to practice what they know about the male and female reproductive systems. They will mimic the game show “Jeopardy” and will win prizes.
Session Four

My Body: Reproductive Health

Objective: To discuss the male and female reproductive system, what each part is responsible for and how they play a part in pregnancy and sexually transmitted diseases.

Materials: Male and Female reproductive system handouts

Time: 40 minutes

Procedure:

1. Pass out the handouts to each student. Allow them about 15 minutes to try to complete the sheets independently.

2. Review the answers with the students. As you review each part, explain to them the function of the particular part of the organ (i.e. ovaries produce eggs that are released once a month during a woman’s menstrual cycle)

3. Discuss how a woman’s body is prepared for pregnancy.

4. Discuss how the reproductive system is impacted by sexually transmitted diseases.
FEMALE REPRODUCTIVE ANATOMY
(INTERNAL FRONT VIEW)
Male Reproductive System

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10. 
11. 
12. 

Uncircumsized Penis
Session Four

Human Jeopardy

Objective: To help students review the reproductive system in a game-show format. At the end of the game, students should have a better working knowledge of the male and female reproductive systems.

Materials: Digital PowerPoint graphic with categories and dollar amounts, projector, list of questions/answers (for facilitator)

Time: 45 minutes

Procedure:

1. Have students break up into 3 groups. Students will be allowed to collaborate on answers as they are asked questions and must provide the answers, following the same format as the Jeopardy! game show.
2. The team with the greatest amount of points at the end of the game will win a prize for that day.

Discussion Points: none
Session 5 Overview

Session 5

“G CASH” Learning about Sexually Transmitted Diseases

-The students will learn about the most common sexually transmitted diseases that affect adolescents and young adults.

-After the review, students will create their own media campaign using the acronym G CASH (Gonorrhea, Chlamydia, AIDS, Syphilis and Herpes) and will present it to the class.

“Is it Risky, or Nah?” Risk Behavior Identification Activity

-Students will identify behaviors that are classified as risky or not risky. Risky behaviors place one at risk for STDs, especially HIV.
Session Five

*G CASH: Learning about Sexually Transmitted Diseases*

**Objective:** To review common sexually transmitted diseases that has a high prevalence among adolescents and young adults. Students will learn the acronym G.C.A.S.H to help them memorize the diseases. Following the review, students will create a media campaign (brochure, poster, skit) to help market G.C.A.S.H.

**Materials:** Cardstock paper, poster boards, markers, glue sticks, magazines, STD fact sheets

**Time:** 50 minutes

**Procedure:**

1. Pass out the fact sheet handouts to the students. Review each disease and how it impacts the reproductive system of each gender. G=Gonorrhea; C=Chlamydia; A=AIDS; S=Syphilis; H=Herpes
2. After the review, allow students to break up into groups of 4. Explain to them that they are to come up with a form of a marketing campaign that will appeal to their generation. The students can come up with any kind of marketing campaign but it must include GCASH. Give them 25 minutes to complete this activity.
3. Allow each group to present their marketing campaign.

**Discussion Points:** none

(Let students break after this activity)
Session Five

“Is it Risky, Or Nah?”

Risk-Behavior Identification Activity

Objective: Group members will identify a variety of behaviors that do and do not put young people at risk for HIV infection.

Materials: Signs with the headings Stop!-Risky!, Use Caution and Safe-Go Ahead placed at different places around the room; STD fact sheets; Safer Sex Guidelines For Me worksheet

Time: 35 minutes

Procedure:

1. Hand out the STD fact sheets and have students read it aloud, taking turns. Try to ensure that all students are given an opportunity to read.

2. Ask the students the following questions

   - What do the terms HIV and AIDS mean?
   - What is the difference between HIV and AIDS?
   - How is HIV transmitted from one person to another?
   - How do we know that casual contact (hugging, holding hands, kissing) does not spread HIV?
   - If you risk is uncertain, how can a person decide about a behavior?
- How can you prevent HIV transmission?

3. Post each of the 3 signs- **Stop!- Risky! Use Caution and Safe- Go Ahead**- at a different place in the room. Explain what each sign means as you post it:

- **Stop!- Risky!** These behaviors directly lead to possible HIV exposure.

- **Use Caution:** These behaviors on their own do not put one at risk for HIV, but they can lead to other behaviors that do.

- **Safe- Go Ahead:** These behaviors are considered safe and do not put you at risk for HIV.

   Explain to the students that this next activity will help them understand which behaviors place them at risk for HIV infection and which behaviors do not. Explain that some of the behaviors are common for people their age, and some might be more common for people a little older than them.

   Explain that you will read a behavior from a list and they go stand by the sign that reflects the level of risk for HIV infection they believe that behavior represents. Demonstrate by reading one risk behavior and standing under one of the signs.

4. Read the following list of behaviors one at a time. Have students move to stand by appropriate signs. After each behavior is decided upon, ask why the behavior is risky or safe. Give the students the correct answer and make sure they have the correct information before moving to the next behavior.

**Behaviors**

- Not having sex (abstinence) (**Safe**)
- Using a public toilet (**Safe**)
- Sharing needed to inject drugs or steroids (**Stop**)
- French kissing or tongue kissing (Note: Kissing can lead to sex) (**Caution**)
- Shaking hands with a person who has HIV (**Safe**)
- Unprotected sex (**Stop**)
- Avoiding getting tested for HIV (**Caution**)


- Drinking alcohol (Note: Alcohol can lead to sex) (Caution)
- Sharing needles for ear or body piercing (Stop)
- Sex with a condom (Safe OR Caution)
- Getting a blood transfusion (Safe)
- Donating blood (Safe)
- Sex using only birth control pills as a contraceptive (Stop)
- Unprotected oral sex without a condom or a dental dam (Note: Explain that semen, pre-cum and vaginal fluids can be exchanged during unprotected oral sex (Stop)
- Tattooing (Caution)
- Smoking a joint before having sex (Caution)
- Using an oil-based lubricant with a condom (Note: Oil based lubricants can cause condoms to break) (Stop)
- Foreplay (Caution)
- Masturbation (Safe)
- Cleaning an injection drug needle with water and then using it (Stop)
- Massage on the neck, back or shoulders (Safe)
- Having sex with multiple partners (Stop)
- Having sex because your friends are having sex (Stop)

5. After you’ve read all of the behaviors, have the students brainstorm a list of safe and safer sex guidelines for young people. Remember to emphasize the broad nature of sexuality and caring about another person. Examples of safe activities include talking, holding hands, and dancing. Lower risk activities include French kissing, and vaginal sex with a latex condom.

6. After the brainstorm, explain that it is very beneficial to make a list such as this for yourself. Safe sex behaviors are personal and now group members will have a chance to create some personal, realistic safer sex guidelines for themselves. Distribute the Safer Sex Guidelines For Me
worksheet and have students take 3 minutes to create their own personal guideline. Explain that it would be great for them to share their guidelines with each other and those they go out with.

7. Talk about the importance of taking steps to prevent other kinds of STD as well. Explain that other STDs can also have serious consequences, especially if a person isn’t diagnosed and treated. These include:

- Uncomfortable symptoms (burning, itching, painful urination)
- Unpleasant appearance (warts, sores, drips)
- Problems with fertility (If an STD is not treated it can cause scarring that may make it difficult or impossible to get pregnant)
- Damage to other parts of the body (untreated hepatitis B can cause permanent liver damage; untreated gonorrhea can cause heart trouble)
- Greater risk for HIV (sores or lesions make it easier for HIV to enter the body)
- Risks to others (untreated STD can be passed to sexual partners; some STDs can pass from a mother to her baby in the uterus during birth)

8. Review these highlights with the students:

- If you’ve has unprotected sex, you should get tested. Sometimes people are afraid to know, and they try to ignore the possibility. If they do have HIV or another STD and don’t find out, the disease can get worse or mess up their ability to have children later, and they can continue to spread HIV or the STD to other people.
- There is no one test for every STD. Different STDs require different tests. If you ask to be tested for STD, clinics routinely test for chlamydia, syphilis and gonorrhea. If you want to be tested for other STDs such as herpes, genital warts, HIV and others, you will have to request to be tested for those specific STDs.
- It takes up to 3 months after a person is infected with HIV for HIV antibodies to show up in the body. In rare cases it can take up to 6 months. This 3 to 6 month
period is called the window period. Sexually active people need to get tested 3 to 6 months after each time they have unprotected sex to make sure the test is accurate.

- Each HIV and STD test only determines whether you have HIV or an STD at that time, and the results are only good until you or your partner has unprotected sex. If that happens, you and your partner will need to be tested again to get a current test result.

- You can get tested at many places, including clinics, doctors’ offices or health departments.

9. Answer any question the group may have. Mention that they can get more information about HIV and STD testing by calling the CDC Info hotline, or by submitting anonymous question to the Question Box.
Session 6 Overview

Session 6

Condom Card Activity

-The students will practice the appropriate mechanics of putting on a condom prior to sexual intercourse, without a model. Students must arrange the cards given to them to demonstrate the correct order of putting on a condom.

Condom Demonstration Activity

-During this activity, students will actually practice, using a model, how to put on a condom. This will reinforce the previous activity.

“Keep Calm and Protect Yourself” Other contraception options Activity

-This lesson will teach the students about other forms of contraception. This will be an in depth discussion explaining which methods are available and the purpose they serve. It will be reiterated that abstinence is always the best option.

“Abstinence: A Healthy Decision” Activity
-Students will discuss the pros of being abstinent when it comes to their personal values and health considerations. They will also discuss why teens have sexual intercourse and why more should choose abstinence.
Session Six

Condom Card Activity

**Objective:** Students will learn accurate information about the mechanics of condom use.

**Materials:** Condom Cards

**Time:** 15 minutes

**Procedure:**

1. Emphasize that not all young people are having sex, and affirm the choice to be abstinent. Tell students that if and when they decide to be sexually active, it will be important for them to protect themselves from HIV/STD and unplanned pregnancy. Condoms are not 100% effective, but they significantly lower the risk for HIV/STD and pregnancy. Explain that there are 2 important skills for people to learn concerning condom use:
   - How to use a condom – how to put it on and discard it afterwards
   - How to bring it up the topic with a partner. Remind the group that using a condom shows that you truly care for yourself and the other person because you want to stay safe.

   Tell them that they’ll be learning about the first step- the mechanics of condom use. They’re going to start by finding out how much they already know about condoms.

2. Explain that you will be handling out cards that describe the steps to proper condom use. The students’ task will be to arrange themselves so that their cards show these steps in the correct order. Emphasize that when condoms are used properly, they rarely break or fall off. Condoms can help prevent HIV, other STDs and unwanted pregnancy, although abstinence the safest choice.

3. Hand out the Condom Cards. Be sure the cards are shuffled before handing them out. There are 13 cards. If you have more than 13 students, ask those who don’t receive cards to help you check the class’ work after they have arranged themselves in order. If you have fewer than 13 students, give 1 card to each, and help them out as they arrange themselves.
4. Provide important additional information.

- Use latex condoms. These can be found in drug stores, many grocery and convenience stores, and are often free at health clinics. Don’t use lambskin condoms, because they don’t protect against HIV.
  Polyurethane condoms, sometimes called “plastic” condoms, are often a good choice for people who are allergic to latex.
- Use only water-based lubricants, such as KY jelly, with latex condoms. Oil-based lubricants, such as petroleum jelly, massage oils or lotions will cause the condom to break.

Discussion Points:

- Know how to use condoms. Use latex condoms.
- Condoms, when properly used, are very effective in preventing pregnancy and HIV. However, abstinence is always the safest choice.
- Never use oil-based lubricants with a latex condom.
Session Six

Condom Demonstration Activity

Objective: Students will learn how to properly put on a male condom using a penile model and condom.

Materials: Penile models (if no model is available, use a banana or cucumber), male latex condoms, lubricant

Time: 15 minutes

Procedure:

1. Using what they just learned from the condom card activity let the students talk you through properly applying a condom to the model. After they complete the walk-through, speak on any points they have missed or should be discussed.
2. After you complete the walk-through, let the class pair off and practice applying the condom on the model for about 10 minutes.

Discussion Points: Ask students these questions:

- Why should people use condoms?
- Was the demonstration easy/difficult to do?
- What was the trickiest part?
- What advice would you give someone who is going to use a condom for the first time?
- Do you know where to get condoms?
- How can we make condoms more acceptable?
- How can we turn a negative view of condoms into a positive view of condoms?
Session Six
“Keep Calm and Protect Yourself”
Other Forms of Contraception Lesson

Objective: Students will explore other contraceptive methods during an in-depth discussion.

Materials: Contraceptive methods handout

Time: 30 minutes

Procedure:

1. Reiterate the classroom rules set at the beginning of the course.
2. Begin a discussion with students about contraception by asking questions:
   a. What is contraception?
   b. Why is it important to learn about contraception?
      i. Provide rationale for teaching birth control/contraception - stress that there is not an assumption that students are sexually active.
      ii. Stress that factual information is critical to make healthy decisions now and in the future.
   c. What are some different methods of contraception? Please have students list all the methods you have heard of, even if you don’t think they are reliable.
3. List the methods identified by students on the board under the heading “Methods of Contraception”. You may choose to group these into the following columns: hormonal, barrier, spermicidal, natural, myth and other. Ensure abstinence is included on this list.
4. If students do not bring it up on their own, use questions to prompt them such as, “What is the only 100% effective method of contraception?”
5. Ask students to identify which methods are unreliable on the list.
6. Of the methods, which are hormonal methods?
   a. Place the heading “Hormonal” above the column of methods identified as being hormonal. Common hormonal methods include:
-Birth Control Pill: this method contains hormones similar to the natural hormones in a woman’s body. The hormones in the pill stop the release of an egg from the ovaries. No egg = no pregnancy. The Pill is taken at the same time everyday for 21 days, at this point there is either a 7 day break from the pill or the 7 sugar pills (containing no hormones) are taken. During this time a female will get her period.

-Vaginal Ring (Nuvaring®): The Nuvaring® is a soft, flexible plastic ring that is inserted into the vagina. Hormones are slowly released and then absorbed through the walls of the vagina, into the bloodstream. The hormones stop the release of an egg. No egg = no pregnancy. Once the ring is inserted it is left in place for 21 days, at which point it is removed and left out for 7 days. During this time a female would get her period.

-Birth Control Injection (Depo Provera®): is a hormone (progestin) that is injected into a female’s arm or buttock every 12 weeks. The hormone stops the release of an egg and makes the cervical mucus thicker so that sperm cannot enter the uterus.

7. Of the methods, which are barrier methods?

Place the heading “Barrier” above the column of methods identified as being barriers to contraception.

All barrier methods prevent sperm from entering the vagina and/or the cervix.

-Common barrier methods include:

- Condom (male): A protective covering made of latex, polyurethane or animal membrane that fits over the erect penis.

- Condom (female/internal): A loose-fitting plastic/polyurethane pouch that lines the vagina. It has soft rings at each end.

- Diaphragm: A flexible latex or polyurethane shaped product that covers the cervix.

7. Of the methods, which are spermicidal methods?

Place the heading “Spermicidal” above the column of methods identified as being spermicidal.

Explain that spermicidal methods prevent pregnancy by using chemicals to kill sperm on contact.

Note: Spermicidal products containing Nonoxynol-9® may cause skin/mucosal irritation/itchiness. This irritation may increase the risk for STI and HIV.

-Common spermicidal methods include:

- Contraceptive Foam: A product that comes in a can and has an applicator to put the foam into the vagina.

- Contraceptive Jelly: A product that comes in a tube and is usually used with a diaphragm.

- Vaginal Contraceptive Film: A very thin transparent square of film that dissolves quickly and releases nonoxynol-9®.

- Sponge (Protectaid®): A piece of soft foam that covers the cervix filled with three kinds of spermicides.

- Condom lubricated with spermicide.
Discussion Points: Abstinence is the only 100% effective way to avoid HIV/STDs or pregnancy. However, whenever you decide to become sexually active, there are many options available.

Session Six

Abstinence: A Healthy Decision
Objective: Students will be able to describe how choosing to abstain from sexual intercourse reflects both personal values and health considerations. Students will also identify reasons teens have sexual intercourse.

Materials: None

Time: 30 minutes

Procedure:

1. Ask, “Why do young people have sexual intercourse?” Have students brainstorm answers.
2. On the board, write “Personal/Ethical Values” and “Health Reasons.”
3. Ask, “Why do many teens choose abstinence?” Have students list reasons that have to do with personal/ethical values and reasons that have to do with health.
4. Ask, “What are the sources of people’s personal values?”
5. Ask, “How can people make a plan to support a decision they have made?” As an example, ask the class to draw up a step-by-step plan on how a student might improve his or her physical appearance.
6. Explain to students that they are going to create a plan to help adolescents resist sexual pressures by creating assertiveness statements that help them say no. Let the students pair off for this activity.
7. Have students role-play situations where they will have to use the statements they created.

Discussion Points: Emphasize that abstaining from sexual intercourse is not only the safest decision physically, but abstinence also helps safeguard the emotional well-being of a young person who is experiencing emotional conflict and concerns about relationships and sexual involvement.
Conclusion

At the end of the course, please allow students to take the evaluation survey and the knowledge posttest.

Present students with “graduation” certificates and tokens of appreciation.

Appendix D- Knowledge Test

Sources: Centers For Disease Control. (2015) National Youth Risk Behavior Survey

the brief HIV knowledge questionnaire (HIV-KQ-18). *AIDS Education and Prevention*, 14, 174-184

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do. The questions that ask about your background will be used only to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported.

Make sure to read every question. When you are finished, follow the instructions of the facilitator.

1. How old are you?
   A. 12 years old or younger  
   B. 13 years old  
   C. 14 years old  
   D. 15 years old  
   E. 16 years old  
   F. 17 years old  
   G. 18 years old or older

2. What is your sex?
   A. Female  
   B. Male

3. In what grade are you?
   A. 9th grade  
   B. 10th grade  
   C. 11th grade  
   D. 12th grade  
   E. Ungraded or other grade

4. Are you Hispanic or Latino?
   A. Yes  
   B. No

5. What is your race? *(Select one or more responses.)*
   A. American Indian or Alaska Native  
   B. Asian  
   C. Black or African American  
   D. Native Hawaiian or Other Pacific Islander  
   E. White
6. Have you ever had sexual intercourse?
   A. Yes
   B. No

7. How old were you when you had sexual intercourse for the first time?
   A. I have never had sexual intercourse
   B. 11 years old or younger
   C. 12 years old
   D. 13 years old
   E. 14 years old
   F. 15 years old
   G. 16 years old
   H. 17 years old or older

8. During your life, with how many people have you had sexual intercourse?
   A. I have never had sexual intercourse
   B. 1 person
   C. 2 people
   D. 3 people
   E. 4 people
   F. 5 people
   G. 6 or more people

9. During the past 3 months, with how many people did you have sexual intercourse?
   A. I have never had sexual intercourse
   B. I have had sexual intercourse, but not during the past 3 months
   C. 1 person
   D. 2 people
   E. 3 people
   F. 4 people
   G. 5 people
   H. 6 or more people

10. Did you drink alcohol or use drugs before you had sexual intercourse the last time?
    A. I have never had sexual intercourse
    B. Yes
    C. No

11. The last time you had sexual intercourse, did you or your partner use a condom?
    A. I have never had sexual intercourse
    B. Yes
    C. No

12. The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy? (Select only one response.)
A. I have never had sexual intercourse
B. No method was used to prevent pregnancy
C. Birth control pills
D. Condoms
E. An IUD (such as Mirena or ParaGard) or implant (such as Implanon or Nexplanon)
F. A shot (such as Depo-Provera), patch (such as Ortho Evra), or birth control ring (such as Nuvaring)
G. Withdrawal or some other method
H. Not sure

13. During your life, with whom have you had sexual contact?
   A. I have never had sexual contact
   B. Females
   C. Males
   D. Females and males

14. Which of the following best describes you?
   A. Heterosexual (straight)
   B. Gay or lesbian
   C. Bisexual
   D. Not sure

15. Have you ever been tested for HIV, the virus that causes AIDS? (Do not count tests done if you donated blood.)
   A. Yes
   B. No
   C. Not sure

16. Have you ever been physically forced to have sexual intercourse when you did not want to?
   A. Yes
   B. No

17. During the past 12 months, how many times did someone you were dating or going out with physically hurt you on purpose? (Count such things as being hit, slammed into something, or injured with an object or weapon.)
   A. I did not date or go out with anyone during the past 12 months
   B. 0 times
   C. 1 time
18. During the past 12 months, how many times did someone you were dating or going out with force you to do sexual things that you did not want to do? (Count such things as kissing, touching, or being physically forced to have sexual intercourse.)

A. I did not date or go out with anyone during the past 12 months
B. 0 times
C. 1 time
D. 2 or 3 times
E. 4 or 5 times
F. 6 or more times

The next set of questions is true/false questions. Please circle True (T), False (F), or Don’t Know (DK).

1. Coughing and sneezing DO NOT spread HIV.
   T   F   DK

2. A person can get HIV by sharing a glass of water with someone who has HIV.
   T   F   DK

3. Pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex.
   T   F   DK

4. A woman can get HIV if she has anal sex with a man.
   T   F   DK

5. Showering, or washing one’s genitals/private parts, after sex keeps a person from getting HIV.
   T   F   DK
6. All pregnant women infected with HIV will have babies born with AIDS.

T   F   DK

7. People who have been infected with HIV quickly show serious signs of being infected.

T   F   DK

8. There is a vaccine that can stop adults from getting HIV.

T   F   DK

9. People are likely to get HIV by deep kissing, putting their tongue in their partner’s mouth, if their partner has HIV.

T   F   DK

10. A woman cannot get HIV if she has sex during her period.

T   F   DK

11. There is a female condom that can help decrease a woman’s chance of getting HIV.

T   F   DK

12. A natural skin condom works better against HIV than does a latex condom.

T   F   DK

13. A person will NOT get HIV if she or he is taking antibiotics.

T   F   DK

14. Having sex with more than one partner can increase a person’s chance of being infected with HIV.

T   F   DK

15. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.

T   F   DK
16. A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.

T  F  DK

17. A person can get HIV from oral sex.

T  F  DK

18. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.

T  F  DK
# Student Evaluation Survey

**Turn Down For What: The Run Down Before It Goes Down**

<table>
<thead>
<tr>
<th>MALE</th>
<th>FEMALE</th>
<th>Age</th>
<th>Grade Level</th>
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**PLEASE CHECK ONE RESPONSE FOR EACH ITEM BELOW:**

<table>
<thead>
<tr>
<th></th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>UNSURE or N/A</th>
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<tbody>
<tr>
<td>1. This class has helped me to better understand how to prevent the spread of STDs.</td>
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<td>2. These classes have made me understand how important it is to abstain from sex or practice safer sex.</td>
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<td>3. I now intend to use condoms every time that I have sex.</td>
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<tr>
<td>4. The facilitator was enthusiastic about teaching this class.</td>
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<td>5. This class taught me how to have a healthy relationship.</td>
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<tr>
<td>6. I feel this class <strong>will</strong> help me to protect myself from getting OR transmitting HIV/AIDS.</td>
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<td>7. The information was presented clearly and I could easily understand it.</td>
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<tr>
<td>8. The facilitator(s) answered my questions about HIV/AIDS and STIs.</td>
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<tr>
<td>9. The facilitator answered my questions about safer sex and barrier methods like condoms.</td>
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<tr>
<td>10. I <strong>would</strong> recommend this workshop to my friends.</td>
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<tr>
<td>11. I feel more comfortable sharing what I learned in this workshop with my friends or family members.</td>
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Appendix F- Facilitator Evaluation Checklist

Classroom Observation Checklist

Facilitator:

Observer:

Date:

Respond to each statement using the following scale:

1=Not observed        2=More emphasis recommended        3=Accomplished very well

Organization

Presented overview of lesson.  
Paced lesson appropriately.  
Presented topics in assigned sequence.  
Related today’s lesson to previous/future lessons.  
Summarized major points of the lesson.

Presentation

Explained major/minor points with clarity.  
Defined unfamiliar terms, concepts, and principles.  
Used good examples to clarify points.
Varied explanations for complex or difficult material. 1 2 3
Emphasized important points. 1 2 3
Writes key terms on blackboard or overhead screen. 1 2 3

**Interaction**

Actively encouraged student questions. 1 2 3
Asked questions to monitor student understanding. 1 2 3
Waited sufficient time for students to answer questions. 1 2 3
Listened carefully to student questions. 1 2 3
Responded appropriately to student questions. 1 2 3
Restated questions and answers when necessary. 1 2 3
Demonstrates respect for diversity and requires similar respect in classroom. 1 2 3

**Content Knowledge and Relevance**

Presented material at an appropriate level for students. 1 2 3
Presented material appropriate to the purpose of the course. 1 2 3
Demonstrated command of the subject matter. 1 2 3

**Summary Comments**

21. What were the instructor’s major strengths as demonstrated in the observation?

22. What suggestions do you have for improving the instructor’s skills?