sisters saving sisters

GRANTEE GUIDE

Loretta Sweet Jemmott, Ph.D., R.N., F.A.A.N.
John B. Jemmott III, Ph.D.

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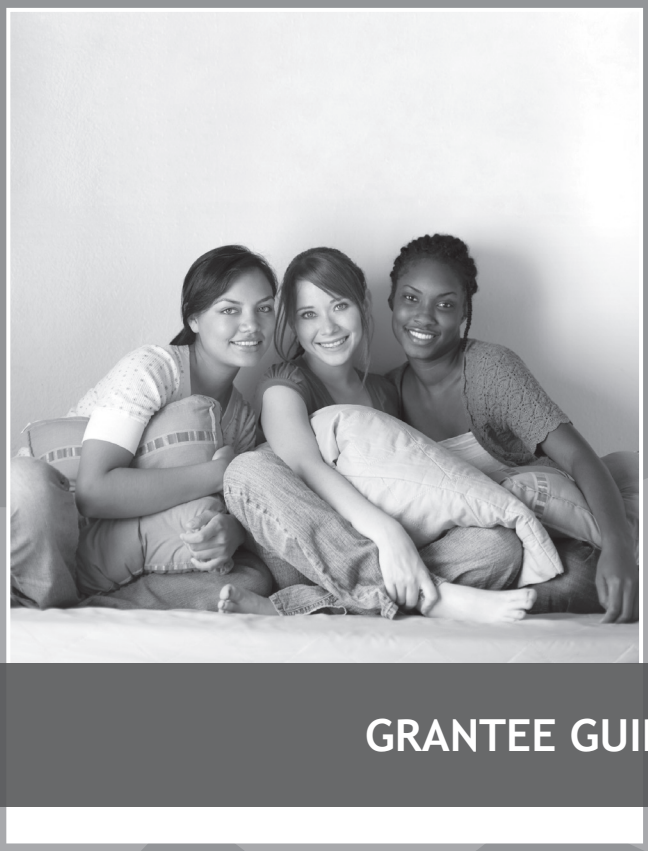

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This curriculum was selected by the Office of Adolescent Health as an "Eligible" Evidence-Based Teen Pregnancy, HIV & STD intervention.

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GRANTEE GUIDE

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MODULE-BY-MODULE OUTLINE

MODULE 1: INTRODUCTION AND OVERVIEW	TIME (MIN)
Activity A: Introduction and Overview	1
Activity B: Group Introductions	4
Activity C: Creating Group Rules	5
Activity D: DVD: *The Subject Is: HIV*	25
Activity E: Myths and Facts About HIV/AIDS	10
Activity F: High, Low, No Risk (Red Light/Green Light/Yellow Light)	15
MODULE 2: UNDERSTANDING PERSONAL VULNERABILITY	**TIME (MIN)**
Activity A: Why Should I Worry About HIV/AIDS?	15
Activity B: DVD: *The Subject Is: STDs*	25
Activity C: The Transmission Game	20
MODULE 3: DEVELOPING CONDOM USE SKILLS	**TIME (MIN)**
Activity A: Barrieres to Condom Use	5
Activity B: DVD: *Nicole's Choice*	25
Activity C: Condom Use Skills	10
Activity D: Mini-Lecture: Basics of Sexual Response	5
Activity E: Making Condoms More Fun and Pleasureable	5
Activity F: Condom Card Activity With a Twist	10
MODULE 4: IMPROVING SEXUAL CHOICES & NEGOTIATION	**TIME (MIN)**
Activity A: DVD: *Wrap It Up*	10
Activity B: Teaching Safer-Sex Negotiation Skills	15
Activity C: Introduction To Role-Playing	5
Activity D: Team Role-Plays	30
MODULE 5: ROLE-PLAYS, AIDS BASKETBALL, AND REVIEW	**TIME (MIN)**
Activity A: Dyad Role-Plays	25
Activity B: DVD: *The Hard Way* and Discussion	25
Activity C: AIDS Basketball Review and Closing Game	10

MODULE GOALS AND OBJECTIVES

MODULE 1

GOALS

The goals of this module are to:

- Provide participants with an overview of the program.
- Increase participants' personal investment and comfort in participating in the program.
- Increase participants' confidence about protecting themselves and their community from HIV/AIDS, STDs and unplanned pregnancy.
- Increase participants' knowledge about HIV/AIDS and HIV riskassociated behaviors.
- Help participants identify behaviors that place people at risk for pregnancy and for contracting sexually transmitted diseases, including HIV infection.

OBJECTIVES

After completing this module, participants will be able to:

- Identify several rules for group participation that will facilitate discussion and learning.
- Identify the basic facts about HIV and AIDS.
- Distinguish myths from facts about HIV and AIDS.
- Identify a person's risk of HIV infection as a result of engaging in various sexual and nonsexual behaviors.
- Identify which behaviors are high risk, low risk, and no risk for contracting HIV infection.
- Identify how HIV transmission can be prevented.

MODULE 2

GOALS

The goals of this module are to:

- Increase participants' perceived vulnerability to the consequences of engaging in risky sexual behavior and to provide information to reduce those risks.
- Confront stereotypes about who can become infected with HIV and learn more about how people can and cannot become infected.
- Weaken negative beliefs and attitudes that foster risky sexual behavior.

OBJECTIVES

After completing this module, participants will be able to:

- Identify their feelings of perceived personal vulnerability to HIV and STDs.
- Identify their attitudes toward risky sexual behavior.
- Recall correct information about HIV/AIDS.

MODULE 3

GOALS

The goals of this module are to:

- Increase participants' knowledge of how using latex or polyurethane condoms can reduce their risk for HIV/STDs and pregnancy.
- Increase participants' understanding of barriers to condom use and increase their strategies for reducing those barriers, including how to make condom use fun and pleasurable.
- Increase participants' confidence in using condoms.
- Increase participants' skills in using condoms correctly.

OBJECTIVES

After completing this module, participants will be able to:

- Identify how latex or polyurethane condoms can prevent STDs, including HIV, and pregnancy.
- Identify the barriers to condom use and strategies for overcoming those barriers.
- Demonstrate the ability to respond to excuses a partner may give with statements in support of condom use.
- List the correct steps to using condoms.
- Demonstrate the correct steps for using a condom on an anatomically correct penis model.
- Describe ways to make condoms a more pleasurable part of the sexual experience.

MODULE 4

GOALS

The goals of this module are to:

- Improve participants' communication and negotiation skills so that they can negotiate condom use with a sexual partner.
- Enhance participants' ability to resist situations that place them at risk for HIV/STD infection and pregnancy.
- Increase participants' refusal skills regarding condom use.

OBJECTIVES

After completing this module, participants will be able to:

- Identify strategies for negotiating condom use with their partners.
- Demonstrate negotiation, communication and refusal skills when talking to their partner about condom use and unprotected sex in a role-play situation.
- Demonstrate confidence in their ability to negotiate condom use with their sexual partner in a role-play situation.

MODULE 5

GOALS

The goals of this module are to:

- Enhance participants' communication, negotiation, and refusal skills regarding condom use.
- Enhance participants' ability to resist situations that increase their risk for STDs, HIV and pregnancy.
- Review participants' knowledge about HIV/AIDS, STDs and pregnancy and prevention strategies.
- Enhance participants' confidence and skills in being safe sexually; respecting themselves and protecting themselves because they are worth it.

OBJECTIVES

After completing this module, participants will be able to:

- Identify strategies for negotiating condom use with a sexual partner.
- Demonstrate body language and strategies for effectively saying "No" to unprotected sex.
- Demonstrate the ability to negotiate condom use with a partner.
- Recall correct information about HV/AIDS, STDs, and pregnancy and prevention strategies.
- Express pride about sticking to their decision to being safe sexually, respecting themselves and protecting themselves because they are worth it.

CORE ELEMENTS, KEY CHARACTERISTICS AND LOGIC MODEL

CORE ELEMENTS:

Core Elements are components of a curriculum that must be maintained without alteration in order to ensure the program's effectiveness. They are required elements that represent the theory and internal logic of the program and most likely produce the program's main effects. Core Elements must be maintained with fidelity – and without alteration to ensure the effectiveness of the program. Fidelity is conducting a program by following the Core Elements, protocols, procedures, and content set by the research study that determined its effectiveness.

The developers reasoned that when teaching adolescents strategies to practice abstinence as a strategy to reduce their risk for HIV, STDs and pregnancy, it is necessary to give them correct information, build their perception of vulnerability, bolster positive attitudes and outcome expectancies, and build self-efficacy and skill to negotiate and practice abstinence. Therefore, the core elements have been organized in two sections: Content Core Elements and Implementation Core Elements. Content core elements are the essential elements of WHAT is being taught in the intervention that is believed to change risk behaviors. Implementation Core Elements are the essential characteristics of HOW the intervention can be implemented with fidelity that would that result in a positive learning experience with good outcomes. A comprehensive list of these elements follows:

CONTENT CORE ELEMENTS

Content Core Element 1: Teach correct information about HIV, STDs and Pregnancy and prevention strategies.

- Content on HIV, etiology, transmission and prevention,
- Content on STDs, etiology, types, transmission and prevention,
- Content on pregnancy and prevention.
- Content on prevention strategies (negotiation, condom use, problem solving)
- Content focusing on gender specific safer sex issues for female adolescents.

Content Core Element 2: Bolster four types of behavioral attitudes/outcome expectancies emphasized in Sisters Saving Sisters!

- Prevention Belief (the belief that condom use can eliminate the risk of HIV, STDs and pregnancy).
- Partner Reaction Belief (the belief that one's partner would not approve of using condoms and react negatively to it; i.e. hit them, leave them, find another girlfriend).
- Hedonistic Belief (the belief that condoms interfere with sexual pleasure, not natural, ruins the mood, don't fit etc.)
- Personal Vulnerability to HIV/STD and Pregnancy Belief (the personal belief that HIV. STD and pregnancy could happen to them if they have unprotected sex).

Content Core Element 3: Teach negotiation skills and problem solving skills.

- Teach negotiation, refusal and reframing skills using the 4-step STOP Negotiation Strategy to respond to partner's negative reaction towards abstinence or condom use.
- Use role-plays activities to practice negotiation, refusal, and reframing skills.

Content Core Element 4: Teach Condom use skills (2-step procedure)

- The facilitator teaches condom use skills by demonstrating how to use a condom on an anatomically correct penis model.
- The participant demonstrates and practices the skill on the same model.
- The facilitator and the participant discuss strategies on how to make condoms more fun and pleasurable

Content Core Element 5: Build self-efficacy and confidence in negotiating condom use and condom use skills.

- Incorporate the theme "Sisters Saving Sisters: Respect Yourself! Protect Yourself! Because You Are Worth It" throughout the intervention.
- Build participant's confidence in their skills by incorporating positive reinforcement, support and constructive feedback in all intervention activities, especially in the role-plays and in demonstrating condom use skills.

IMPLEMENTATION CORE ELEMENTS

Implementation Core Elements are integral to the intervention. They describe the ***HOW*** the intervention should be implemented.

Implementation Core Element 1: Demonstrate a caring and supportive attitude.

- The facilitator must create a supportive and caring environment.
- For example, the facilitator should demonstrate a feeling throughout the intervention of, "I truly care about you and your success, I believe in you and you can do this," using engaging strategies, including active listening, eye contact, supportive feedback, be non-judgmental, etc.).

Implementation Core Element 2: Integrate and use the core intervention materials only.

- The Intervention Curriculum Manual, posters and activity materials
- The DVDs specifically selected for the intervention.

Implementation Core Element 3: Type of Facilitator

- Implemented by specially trained female facilitator (who has attended a Jemmott Certified Training). You cannot change the gender of the facilitator.
- Facilitator must facilitate this curriculum using highly participatory and interactive skills.
- Facilitator must be able to work with youth and relate to them and their life circumstances. They must believe in the teens and believe in their resilience.

Implementation Core Element 4: Gender composition of the group

- In the original study the groups were all adolescent females. You should not change the gender composition of the group

Implementation Core Element 5: Implementation Delivery Style

- Delivery of intervention must be engaging, highly participatory, and very interactive facilitation
- Facilitator cannot add any other educational materials, social gathering, community events, etc to this program during the span of the evaluation.

KEY CHARACTERISTICS

Key Characteristics: Key Characteristics are activities and delivery methods for conducting a program that, while considered of great value and assistance, can be altered without changing the effectiveness of the program. These activities and delivery methods can be modified for different agencies and populations. Changes to the Key Characteristics allow your agency to make accommodations to meet the needs of your participants. Adaptations to this program should only occur when steps can be taken to enhance the delivery of the program to the participants. There are 7 Key Characteristics of the Sisters Saving Sisters Program.

There are 7 key characteristics of the "Sisters Saving Sisters!" Intervention.

1. **Type of facilitator/educator:** In the original study the facilitators were all female. They were nurses, health educators, counselors and teachers, who had experience working with adolescent girls. You can vary your facilitator type to include others women as long as they have experience working with the female adolescents and are knowledgeable about the population.
2. **Setting:** In the study the original study the intervention was implemented in an adolescent medicine clinic that provided reproductive services to teens. You may vary the setting to include other sites, such as community based organization, or schools during the regular school day or after school programming, etc. However the activities must remain interactive and all of the girls must have a chance to participate and practice new skills. If you are integrating this curriculum into the school class period for girls only, you must remember that class periods are less than an hour (for which the curriculum is designed). You need to contact the Jemmotts and their training team to determine who to spread the curriculum over more than four sessions to cover all of the material with fidelity.
3. **Number of days to deliver of modules:** In the original study the intervention was implemented on one Saturday, consisting of the 5 modules. You can vary the delivery of the modules in different ways. All 5 modules must be implemented in order. However, you should try to complete this intervention in a 2-week period.
4. **Race of facilitator:** In the study the facilitators were African American and Latino women. You can use facilitators from different ethnic backgrounds as long as they are female and demonstrate they have the skills and characteristics of a good facilitator, including good listening skills, caring attitude, non-judgmental, etc.

5. **Race of the participants:** In the original study the participants were African American and Latina female adolescents. You can vary this and use this curriculum with teens from different races. You might want to change the names of the teens in the role-plays and the settings of the situations to reflect the participants in your program.
6. **Age of the participants:** The students in the study were age sexually active adolescent girls ages 12-19. The mean age was 15.5 years. We did not mix younger teens with older teens. Therefore you can implement this intervention with different groups of adolescent girls; with all female adolescents ages 12-19, with younger adolescent girls only, or with older teens only. If you have girls ages 12-19 then you should divide the groups into groups of teens with similar age range.
7. **Group size:** In the original study the group size was 6-8 girls in a group. If you want to enlarge your group size and implement this curriculum with fidelity you need to contact the Jemmotts and be trained by the Jemmott training team. The activities must remain interactive and the girls must be able to participate and practice new skills, therefore the developer needs to because it reflects the need to additional facilitators and some adaptation of the activities.

IMPLEMENTATION FIDELITY CONCERNS:

Below are things that would make your implementation of "Sisters Saving Sisters" difficult to do with fidelity:

1. **Peer-facilitation:** Two peers should not implement this intervention. The best way to use peers is to have a peer co-facilitate with an adult facilitator. If you really want to use 2 peers as co-facilitators, they need to go through an extensive certified training by the Jemmott training team and have extensive Technical Assistance.
2. **Integration into a normal classroom setting:** Normal classroom settings time frame is about 45 minutes. Our intervention modules are 55 minutes. Therefore you cannot integrate this curriculum with fidelity into a normal classroom setting. If you want strategies on how to do this, with fidelity, you need to contact the researchers so that we prepare a different version of the curriculum for you that would be worked into your budget prior to your grant submission, and your staff would be trained by the Jemmott training team.

3. **Implementing this curriculum with large groups of more than 15 students:** This intervention was evaluated with adolescent females in small groups of about 6-8 in a group. If you are implementing this intervention in a larger group setting, you are not implementing it with fidelity. If you want to use large group settings you need to be trained by the Jemmott training team to assist you in this process.

Implementation Fidelity Concerns:

If you still have concerns about implementing with fidelity for this grant, you may contact the developer. If you need to discuss your application in detail, however, you can schedule a TA call with Dr. Loretta Jemmott by contacting Select Media at 800-707-6334.

SISTERS SAVING SISTERS LOGIC MODEL

Issue/Problem

Having unprotected sex due to:

- Limited information
- Negative attitudes and beliefs regarding condom use
- Minimal negotiation and condom use skills
- Low self-efficacy to negotiate condom use or lack of confidence
- Minimal problem-solving skills

Inputs:

- Sisters Saving Sisters curriculum and materials
- Facilitator training and materials
- Participant recruitment
- Agency space

Activities:

- Conduct risk assessment
- Provide activities that will increase knowledge about HIV/STD transmission and pregnancy prevention strategies
- View DVDs
- Provide opportunity for negotiation and condom-use skill-building activities
- Facilitate activities that build confidence and self-efficacy to negotiate condoms
- Facilitate activities that build skills in problem solving and how to get out of risky situations
- Provide gender-specific activities to build a sense of self-worth and self-respect
- In a group environment, create an atmosphere of care and trust.
- Facilitate referrals

Outputs:

- Sisters Saving Sisters curriculum implemented with fidelity
- DVDs viewed
- Condom use and negotiation discussed
- Negotiation skills practiced, using role-plays
- Referrals made
- Immediate Outcomes
- Increase knowledge about HIV/STD infection, transmission, unplanned pregnancy and condom use
- Increase perception of risk for HIV, STD and unplanned pregnancy
- Bolster positive attitudes and beliefs regarding condom use and condom negotiation
- Increase intentions to use condoms, consistently and correctly

Intermediate Outcomes:

- Improve negotiation skills
- Reduce the incidence of unprotected sex
- Increase consistent and correct condom use
- Increase confidence to use condoms

Long Term Outcomes:

- Consistent condom use
- Reduction in risky behaviors
- Reduction of unprotected sex

Impact:

- Reduction in HIV among young women
- Reduction of STDs incidence young women
- Reduction of unplanned pregnancy

ASSUMPTIONS

Young women may not use condoms because:

- They don't perceive themselves to be at-risk
- They don't have knowledge about HIV/STD transmission, unplanned pregnancy, risk behaviors and condom use
- They have negative attitudes towards using condoms
- They fear their partner's reaction to condom use
- They don't know how to make condoms fun and pleasurable
- They don't have the skills to negotiate condoms use
- They don't have the confidence or power to introduce condoms into the relationship
- Don't feel valued

Young women will change their behavior if:

- Program and messages targeted for them are gender specific
- Program is implemented in a caring and supportive manner
- They can learn the skills needed, i.e., condom use and negotiation skills
- They have positive attitudes and beliefs towards condoms use, i.e., condoms can be fun and pleasurable
- They feel that their partner will react positive to condom use
- They feel that condom use will prevent HIV/STD transmission and unplanned pregnancy
- They feel validated and believe in the themselves and their skills
- They have opportunity to practice these skills with supportive feedback

SAMPLE OF PROGRAM MONITORING AND EVALUATION WITH SMART OBJECTIVES

Monitoring and evaluation often begins with the identification of program objectives. It is a good idea to write SMART process and outcome objectives for your evaluation program. To be SMART, these objectives must be Specific, Measurable, Appropriate, Realistic, and Time-Based.

Specific: Identifies concrete events or actions that will take place; answers the question, "Does the objective clearly specify what will be accomplished?"

Measurable: Quantifies resources, activities, or changes; answers the question, "Does the objective state how much is to be delivered or how much change is expected?"

Appropriate: Logically relates the overall problem statement and desired effects of the program; answers the question, "Does the objective make sense in terms of what the program is attempting to accomplish?"

Realistic: Provides an attainable action that can be achieved with available resources and plans for implementation; answers the question, "Is the objective achievable given available resources and experience?"

Time-Based: Specifies the time within which the objective will be achieved; answers the question, "Does the objective specify when desired results will be achieved?"

You can refer to the following table to develop SMART objectives for your fundamental questions.

SMART PROCESS OBJECTIVES:

These objectives address what processes or activities need to take place before HIV prevention outcome objectives can be met. The activities identified in the logic model in the previous section can be used to identify variables for SMART process objectives. SMART process objectives identify specific activities to be completed by specific dates, such as the number of teens to recruit with the characteristics of the adolescents in the target population or the use of skilled facilitators to implement group sessions.

Question	Monitoring and evaluation activity	Sources of information about the question	How answers can be used to improve the program
Recruitment			
How many participants did we plan to recruit?[1]	n/a	Pre-Implementation planning data SMART Objectives Recruitment plan Number of participants recruited documented by session sign-in sheets Comparison between planned and actual numbers of recruits	Data can be used to strengthen recruitment efforts and inform more accurate planning.
How many participants did we actually recruit?[2]	Process monitoring		
Was there a difference?	Process evaluation		
Target Population			
What are the characteristics of our target population (e.g., race, ethnicity, age, behaviors, and risk factors)?	n/a	Pre-Implementation planning data Logic model's problem statement Participants' demographics and risk factors collected with a youth intake form Comparison between the characteristics of participants you planned to recruit and the characteristics of the actual participants.	Data can be used to target recruitment activities and provide evidence of prevention needs for additional at-risk populations.
What were the characteristics of the participants?	Process monitoring		
Was there a difference?	Process evaluation		

Question	Monitoring and evaluation activity	Sources of information about the question	How answers can be used to improve the program
Participant Retention			
How many participants did we think would complete all sessions?	n/a	Pre-Implementation planning data SMART objectives Sign-in sheets from each session Comparison between planned and actual participation	Data can be used to strengthen recruitment efforts, inform agency policies on use of incentives, and foster discussion of strategies for teen engagement.
What actually happened?	Process monitoring		
Was there a difference?	Process evaluation		
Fidelity of Implementation			
Was the program carried out in accordance with the Implementation Manual and with fidelity to core elements?	Process monitoring and process evaluation (also referred to as quality assurance)	Fidelity checklists on required activities and core elements Quality assurance plan Notes from facilitators Notes from persons who observed the program	Completed fidelity checklists and other sources of information can indicate whether the evidence-based program was implemented properly and can be used to understand subsequent outcome monitoring data.

Question	Monitoring and evaluation activity	Sources of information about the question	How answers can be used to improve the program
Outcomes			
What outcomes did we expect participants to achieve?	n/a	Pre-Implementation planning data Logic model's outcomes in terms of mediating variables and behavior change variables Monitoring and evaluation plan SMART objectives Data that measure mediating variables and variables for behavior change collected with a pre- and post-test instrument Comparison between planned outcomes and actual outcomes measured with outcome monitoring instruments/tools	Positive outcomes can be used to show intervention success Post-test data that reveal unwanted outcomes can indicate that changes are needed in either program design or delivery or both.
What outcomes did participants actually experience?	Outcome monitoring		
Was there a difference?	Assessment of pre- and post-test data		

HIV/STD Risk Reduction Interventions for African American and Latino Adolescent Girls at an Adolescent Medicine Clinic

A Randomized Controlled Trial

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Background: Adolescent girls in the United States and around the world are at a heightened risk for sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV).

Objective: To determine the efficacy of a skill-based HIV/STD risk-reduction intervention in reducing self-reported unprotected sexual intercourse among African American and Latino adolescent girls.

Design: Randomized controlled trial with 3-, 6-, and 12-month follow-ups.

Setting and Participants: Sexually experienced African American and Latino adolescent girls recruited from the adolescent medicine clinic of a children's hospital serving a low-income inner-city community (N=682, mean age, 15.5 years); 88.6% were retained at the 12-month follow-up.

Interventions: Three 250-minute interventions based on cognitive-behavioral theories and elicitation research: an information-based HIV/STD intervention provided information necessary to practice safer sex; a skill-based HIV/STD intervention provided information and taught skills necessary to practice safer sex; or a health-promotion control intervention concerned with health issues unrelated to sexual behavior.

Main Outcome Measures: Primary outcome measure was self-reported frequency of unprotected sexual intercourse; secondary outcomes included the frequency of sexual intercourse while intoxicated, the number of sexual partners, biologically confirmed STDs, and theoretical mediator variables, including the intention to use condoms, beliefs about using condoms, and condom-use knowledge.

Results: No differences between the information intervention and the health control intervention were statistically significant. Skills-intervention participants (mean [SE], 2.27 [0.81]) reported less unprotected sexual intercourse at the 12-month follow-up than did information-intervention participants (mean [SE], 4.04 [0.80]; $P=.03$), or health control–intervention participants (mean [SE], 5.05 [0.81]; $P=.002$). At the 12-month follow-up, skills-intervention participants (mean [SE], 0.91 [0.05]) reported fewer sexual partners ($P=.04$) compared with health control–intervention participants (mean [SE], 1.04 [0.05]) and were less likely to test positive for STD (mean [SE], 10.5% [2.9%]) than were health control–intervention participants (mean [SE], 18.2% [2.8%]; $P=.05$). No differences in the frequency of unprotected sexual intercourse, the number of partners, or the rate of STD were observed at the 3- or 6-month follow-up between skill-intervention participants and information-intervention or health control–intervention participants.

Conclusion: Skill-based HIV/STD interventions can reduce sexual risk behaviors and STD rate among African American and Latino adolescent girls in clinic settings.

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One quarter of the 15 million cases of sexually transmitted diseases (STDs) in the United States occur among adolescents, and sexually active adolescents have the highest rate of STDs of any age group.[1,2] The chances of a sexually active 15-year-old girl having pelvic inflammatory disease is 1:8 compared with 1:80 for a 24-year-old woman.[3] Moreover, the number of cases of sexually transmitted human immunodeficiency virus (HIV) infection among adolescent girls continues to increase,[4] especially among African Americans and Latinos.[4] The high rate of STDs in adolescent girls is due to several biologic and psychosocial factors.[5-7] If adolescents choose not to be abstinent, the prevention of STDs, including HIV, requires correct and consistent use of condoms. Yet only half of sexually active adolescent girls report having used condoms the last time they had sexual intercourse.[5] The high rate

of STDs even in adolescent medicine clinics where condoms are provided[8] suggests that simply providing access to condoms is insufficient to prompt their correct and consistent use. There is a need for programs that are designed to eliminate the unsafe sexual practices that persist among adolescents who have access to condoms.

To be sure, randomized controlled trials have demonstrated that HIV/STD prevention interventions for adolescents are effective in reducing sexual risk behavior.[9,10] However, few such trials have been conducted in adolescent medicine clinic settings,[11] and fewer still have considered the relative efficacy of different intervention strategies. For instance, interventions can simply provide information about how to reduce risk or interventions can provide skills training to empower adolescents to protect themselves. Furthermore, although HIV/STD risk-reduction interventions have been successful in reducing self-reported sexual risk behavior, less well documented is whether such interventions also reduce the rate of STDs among adolescents.[12,13]

The present study tested the effects of HIV/STD risk-reduction interventions on unprotected sexual intercourse and the rate of STDs among African American and Latino female patients in a low-income, inner-city adolescent medicine clinic that provided confidential and free family planning services. We randomly assigned the participants to 1 of 3 interventions based on cognitive behavioral theories and formative research. An information-based HIV/STD intervention provided information needed to reduce sexual risk, but it provided no practice or direct experience with condoms or role-playing. A skill-based HIV/STD intervention provided information and taught skills necessary to practice and negotiate condom use. A health-promotion control intervention concerned health issues unrelated to sexual behavior.

We hypothesized that (1) the skill-based intervention would reduce unprotected sexual intercourse and STD rate compared with the health-promotion control intervention, (2) the information-based intervention would reduce unprotected sexual intercourse and STD rate compared with the health-promotion control intervention, and (3) the skill-based intervention would reduce unprotected sexual intercourse and STD rate compared with the information-based intervention.

METHODS

PARTICIPANTS

The participants were 682 sexually experienced African American (n=463) and Latino (n=219) adolescent girls, 12 to 19 years of age (mean age, 15.5 years) who were family planning patients at the adolescent medicine clinic in a children's hospital serving a low-income, inner-city community in Philadelphia, Pa. Of the Latinos, 92.7% were Puerto Rican. The participants had volunteered for the "Women's Health Project" designed to reduce the chances that African American and Latino adolescent girls would develop devastating health problems, including cardiovascular diseases, cancer, and AIDS. They were reimbursed up to $120 for participating: $40 for completing the intervention and the preintervention and postintervention questionnaires, $25 for the 3-month follow-up, $25 for the 6-month follow-up, and $30 for the 12-month follow-up.

PROCEDURES

The institutional review boards of Princeton University, Princeton, NJ, and the University of Pennsylvania, St Christopher's Hospital for Children, and the Family Planning Council, Philadelphia, approved the study. African American and Latino adolescent girls were eligible to participate if they (1) were patients at the adolescent medicine clinic, (2) were sexually experienced, (3) were not pregnant, (4) were 12 to 19 years of age, (5) could read and speak English, and (6) did not plan to move from the area of the clinic. During the adolescents' biannual STD screening visit, clinicians referred eligible adolescents to the site coordinator who informed them about the study and scheduled interested adolescents to participate.

RANDOMIZATION TO INTERVENTIONS

The study was a randomized controlled trial conducted at the hospital where the adolescents were recruited. Participants were stratified by age, and based on computer-generated random number sequences, they were assigned to 1 of the following 3 interventions: skill-based HIV/STD intervention, information-based intervention, or health-promotion control intervention. One researcher conducted the computer-generated random assignments; others executed the assignments. One week later, mothers of participants who consented to having their mother invited to participate were randomized to 1 of 3 interventions—skill-based HIV/STD intervention, information-based intervention, or health-promotion control intervention—to help them communicate with their daughter about health issues. The mothers' randomization was independent of the daughters' randomization. Findings from that aspect of the trial will be the subject of a separate article.

FORMATIVE RESEARCH

Before conducting this trial, we conducted focus groups and elicitation surveys, and we pilot tested both the questionnaire and the interventions with African American and Latino adolescent girls from the study population. The results suggested that it was feasible to develop, and acceptable to use, interventions that would be implemented with both Latino and African American participants.

INTERVENTION METHODS

The interventions were based on cognitive behavioral theories[14-18] and the formative research we conducted with adolescents from the study population. Designed to be culturally and developmentally appropriate for inner-city African American and Latino adolescent girls, each intervention involved 250 minutes of group discussions, videotapes, games, and experiential exercises implemented in a single session with 2 to 10 participants (mean, 5.3 participants). Many of the activities have been used successfully in previous studies with inner-city African American adolescents.[19-23]

INFORMATION-BASED HIV/STD RISK-REDUCTION INTERVENTION

The information-based HIV/STD risk-reduction intervention addressed the elevated risk of HIV and STD among inner-city African American and Latino young women, personal vulnerability to HIV and STD, HIV transmission, the diverse messages about sex to which adolescents are exposed, responsibility for sexual risk reduction in romantic relationships, and the importance of using condoms. It also addressed the belief that con-

doms interfere with sexual enjoyment. Human immunodeficiency virus educational videotapes illustrated correct condom use with a demonstration model and depicted effective negotiation of condom use. However, participants were not given the opportunity to practice skills relevant to negotiating condom use or using condoms correctly.

SKILL-BASED HIV/STD RISK-REDUCTION INTERVENTION

The skill-based HIV/STD risk-reduction intervention addressed beliefs relevant to HIV/STD risk reduction, illustrated correct condom use, and depicted effective condom-use negotiation. It differed from the information intervention in that participants practiced the skills needed to use condoms. It addressed the elevated HIV and STD risk among inner-city African American and Latino young women and personal vulnerability to HIV. It addressed barriers to condom use, including alcohol and drug use and the belief that condoms interfere with enjoyment, and ways to surmount such barriers. Most important, participants handled condoms, practiced correct use of condoms with anatomical models, and engaged in role-playing to increase skill in negotiating the use of condoms.

HEALTH-PROMOTION CONTROL INTERVENTION

To control for Hawthorne effects to reduce the likelihood that effects of the HIV/STD interventions could be attributed to nonspecific features,[24] including group interaction and special attention, some participants received a health-promotion control intervention designed to be as valuable and enjoyable as the HIV interventions. It covered beliefs and skills relevant to behaviors associated with the risk of heart disease, cancer, and stroke. Specifically, it concerned food selection and preparation, physical activity, breast self-examination, cigarette smoking, and alcohol use.

FACILITATORS AND FACILITATOR TRAINING

The facilitators were 14 African American women (mean age, 38.2 years) who had at least a baccalaureate degree and experience working with inner-city adolescents. Implementation fidelity was emphasized during the 8-hour facilitator training and before each intervention session when the facilitators met with the project coordinator.

DATA COLLECTION AND MEASURES

The adolescents completed confidential self-administered questionnaires preintervention, immediately after the intervention, and at the 3-, 6-, and 12-month follow-ups. Preintervention and follow-up questionnaires assessed sexual behavior, demographic variables, and conceptual mediator variables. The postintervention questionnaire included conceptual mediator variables and evaluations of the interventions. Biological specimens for STD testing were collected at baseline and at the 6- and 12-month follow-ups.

We attempted to increase the validity of self-reported sexual behavior. To reduce potential memory problems, we asked adolescents to report their behaviors over a brief period (ie, 3 months), wrote the dates comprising the period on a chalkboard, and distributed calendars clearly highlighting the period. To reduce the likelihood of demand from giving their responses to the intervention facilitators, proctors blind to the participants' intervention assignment collected the questionnaire data. The proctors emphasized to participants the importance of responding honestly and assured them that their responses were confidential. Participants signed an agreement pledging to answer the questions honestly, a procedure that has been shown to yield more valid self-reports on sensitive issues.[25]

Primary Outcome Measure

The primary outcome measure was the number of days on which the adolescent reported having unprotected sexual intercourse in the previous 3 months.

Secondary Outcome Measures

The secondary outcome measures included other sexual risk behaviors in the previous 3 months, STD rate, and conceptual mediator variables. Participants reported the number of sexual partners, the number of days on which they had sexual intercourse while high on drugs or alcohol, and the number of days on which they had unprotected sexual intercourse while high on drugs or alcohol in the previous 3 months.

The routine screening procedures in the adolescent medicine clinic included screening all sexually experienced adolescents, including asymptomatic patients, for *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, and *Trichomonas vaginalis* every 6 months by performing a pelvic examination. As patients in the clinic, all the participants would have undergone biannual STD screening by clinicians who were blind to their intervention assignment. Sexually transmitted disease data were obtained by clinical medical record review, and any participants who did not return for their routine biannual STD screen were followed up to arrange for an expedited clinic appointment. The presence of *N gonorrhoeae*, *C trachomatis*, or *T vaginalis* infection was used as the measure of STD presence. Participants who tested positive for STDs were notified and treated according to Centers for Disease Control and Prevention guidelines. Details about STD testing methods are available from us.

Several variables from the theory of reasoned action,[16,17] the theory of planned behavior,[18] and social cognitive theory[14,15] that might mediate the efficacy of our interventions were measured with 5-point Likert scales. These theoretical mediator variables were targeted by the HIV/STD interventions. Three items measured the intention to use condoms ($\alpha = .86$). Condom use hedonistic beliefs were measured with 7 items concerning the belief that condoms do not interfere with sexual enjoyment ($\alpha = .84$). One item measured normative beliefs regarding sexual partner's approval of using condoms. Three items measured condom use technical skills beliefs (participants' confidence they could use condoms skillfully; $\alpha = .65$). Two items measured condom use impulse control beliefs (participants' confidence they could control themselves enough to use condoms; $\alpha = .61$). Three items measured condom use negotiation beliefs ($\alpha = .82$). In addition, HIV/STD risk-reduction knowledge was the number correct on 48 true-false items regarding the transmission and consequences of AIDS and STDs, and knowledge specific to condom use was the number correct on 6 true-false items.

Participants also evaluated the interventions. A 5-item scale measured how much participants liked their intervention ($\alpha = .87$). A 3-item scale measured how much they thought they learned ($\alpha = .83$). One item measured the extent to which they would recommend it to others.

SOCIAL DESIRABILITY RESPONSE MEASURE

The Marlowe-Crowne Social Desirability Scale[26] assessed the tendency of participants to describe themselves in favorable, socially desirable terms. The scale has been used extensively in studies of adolescents, including inner-city adolescents.

SAMPLE SIZE AND STATISTICAL ANALYSES

With $\alpha = .05$, 2-tailed, a total sample size of 506 participants completing the trial was projected to provide a power of 80% to detect a 0.25-SD difference in self-reported frequency of unprotected sexual intercourse between each of the 2 HIV/STD risk-reduction interventions and the health-promotion control intervention.

χ^2 Tests, analyses of variance, and Poisson regression analyses were performed to identify significant differences among conditions on preintervention measures. The χ^2 and t tests were performed to analyze attrition. Hypotheses regarding primary and secondary outcomes were tested in analyses that used planned contrasts[27] of prespecified hypotheses, controlling for preintervention scores on the criterion, ethnicity (Latino vs black), and a 4-category variable on which 3 categories represented the 3 aforementioned mothers' conditions (ie, health promotion, information, and skill) and the fourth category represented mothers who did not participate. The first planned contrast compared the information-based intervention with the health-promotion control intervention. The second contrast compared the skill-based intervention with the health-promotion control intervention. The third compared the skill-based intervention and the information-based intervention. The standardized effect size estimate (d) is presented for each significant contrast. Analyses on counts of sexual behaviors were performed using Poisson regression. Analyses on conceptual mediator variables used analyses of covariance. Hypotheses regarding STDs and sexual behaviors measured with dichotomous variables were tested in logistic regression analyses. Interactions were tested hierarchically, that is, by controlling for the main effects of all variables involved in the interactions.

RESULTS

PARTICIPANTS

As shown in the **Figure**, 59.3% of the eligible adolescents (ie, 682 of 1150) participated. Those enrolled were younger than were the eligible nonparticipants (mean age, 15.5 vs 16.1 years, $P<.001$). A greater percentage of the eligible African Americans compared with Latinas enrolled in the study (68.7% vs 46.0%, $P<.001$). Participants and eligible nonparticipants did not differ in STD prevalence at baseline ($P=.42$).

At baseline, 87.1% of the respondents reported having sexual intercourse in the previous 3 months. About 52.0% of the respondents had unprotected sexual intercourse in the previous 3 months, 15.8% had sexual intercourse with multiple partners in the previous 3 months, 9.5% had a least 1 child, and 21.6% tested positive for *N gonorrhoeae*, *C trachomatis*, or *T vaginalis*. Few respondents (0.4%) reported having same-gender sexual relationships or using injection drugs (0.6%).

PREINTERVENTION COMPARABILITY OF INTERVENTION CONDITIONS

Table 1 gives the descriptive statistics for preintervention reports of demographic characteristics, sexual behavior, conceptual mediator variables, and STD test results by intervention assignment. Analyses revealed no statistically significant differences among the conditions.

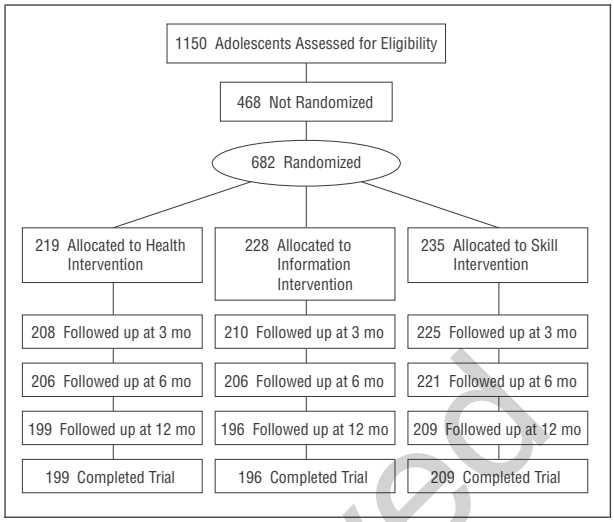

Figure. Progress of participants through the trial. Those not randomized failed to appear for unknown reasons.

ATTRITION

As shown in the Figure, there was little attrition. About 97.6% of the adolescents attended at least 1 follow-up: 94.3% attended the 3-month follow-up, 92.8% attended the 6-month, and 88.6% attended the 12-month follow-ups. The intervention conditions did not differ significantly in the percentage of adolescent participants who attended at least 1 follow-up, 2 follow-ups, or all 3 follow-ups.

Considering preintervention STD prevalence, sexual behavior, conceptual variables, evaluations of the interventions, and demographic variables, there were only 4 significant differences between returnees (ie, adolescents who attended a follow-up) and nonreturnees (ie, adolescents who failed to attend a follow-up). Nonreturnees reported more frequent intercourse while intoxicated (mean, 3.44 vs 0.40, $P<.001$) and more unprotected sexual intercourse while intoxicated than did returnees (mean, 0.94 vs 0.24, $P<.001$). Latinos compared with African Americans were less likely to return (95.9% vs 98.5%, $P=.04$). Adolescents who did not live with their mother were less likely to return than were those who lived with their mother (93.9% vs 98.7%, $P=.001$).

About 87.8% returned for the 6-month STD examination and 82.3% returned for the 12-month STD examination. The interventions did not differ significantly in the percentage of adolescents who returned for STD examinations.

UNPROTECTED SEXUAL INTERCOURSE

As given in **Table 2**, although the interventions did not differ significantly at the 3- or 6-month follow-up, the participants who received the skill-based intervention reported less frequent unprotected sexual intercourse at the 12-month follow-up than did those who received the health-promotion control intervention ($d=0.28$; $P=.002$) or the information-based intervention ($d=0.19$; $P=.033$).

Table 1. Demographic Characteristics, STD Test Results, Self-reported Sexual Behavior, and Theoretical Mediator Variables at Baseline by Intervention Condition*

Variable	Intervention Condition			*P* Value
	Health-Promotion Control (n = 219)	Information (n = 228)	Skills (n = 235)	
Age, y†	15.52 (0.10)	15.49 (0.10)	15.53 (0.10)	.97
African American, No.‡	67.6	68.0	68.1	.99
Live with mother, No.‡	80.4	75.0	79.6	.32
No. of children§	0.10 (0.03)	0.10 (0.03)	0.14 (0.03)	.53
STD positive‡	16.9	26.0	22.8	.07
Sexually active in the past 3 mo‡	89.8	85.8	85.6	.34
No. of days unprotected sex in the past 3 mo§	3.02 (0.50)	3.22 (0.45)	2.52 (0.50)	.57
No. of sexual partners in the past 3 mo§	1.11 (0.04)	1.14 (0.05)	1.04 (0.05)	.32
Multiple partners in the past 3 mo‡	16.4	18.9	12.3	.15
No. of days had sex while high in the past 3 mo§	0.61 (0.20)	0.55 (0.21)	0.26 (0.10)	.30
No. of days unprotected sex while high on drug or alcohol in the past 3 mo§	0.38 (0.15)	0.22 (0.05)	0.20 (0.13)	.55
HIV/STD knowledge†	34.64 (0.28)	34.53 (0.27)	33.88 (0.27)	.10
Condom use knowledge†	4.29 (0.08)	4.18 (0.08)	4.15 (0.08)	.41
Condom use intention†	4.20 (0.06)	4.17 (0.06)	4.25 (0.06)	.61
Hedonistic beliefs†	3.47 (0.06)	3.57 (0.06)	3.53 (0.06)	.49
Sexual partner normative belief†	4.03 (0.08)	3.89 (0.07)	3.85 (0.07)	.22
Technical skill beliefs†	3.96 (0.06)	4.02 (0.06)	3.92 (0.06)	.48
Impulse control beliefs†	3.85 (0.06)	3.89 (0.06)	3.87 (0.05)	.90
Negotiation beliefs†	4.33 (0.05)	4.40 (0.05)	4.33 (0.05)	.49

Abbreviations: HIV, human immunodeficiency virus; STD, sexually transmitted disease.

*Data are given as the mean (SE) percentage unless otherwise indicated. The percentage of STD is the percentage that tested positive for gonorrhea, chlamydia, or trichomonas. Multiple partners is 2 or more sexual partners in the past 3 months.

†Using analysis of variance.

‡χ^2 Test.

§Using Poisson regression analysis.

OTHER SEXUAL RISK BEHAVIORS

The skill-based intervention also had significant effects on other sexual risk behaviors. At the 12-month follow-up, the adolescents who received the skill-based intervention reported fewer sexual partners than did the adolescents who received the health-promotion control intervention (d=0.17; P=.04). Those who received the skill-based intervention were also less likely to report having multiple partners than were their counterparts who received the health-promotion control intervention (d=0.25; P=.002). No differences in the reported number of sexual partners were observed at the 3- or 6-month follow-up. The skills-based intervention caused a significantly lower self-reported frequency of sexual intercourse while intoxicated compared with the health-promotion control (d=0.18; P=.03) and information-based (d=0.18; P=.03) interventions at the 3-month follow-up and compared with the health-promotion control intervention (d=0.23; P=.005) at the 6-month follow-up. No differences were observed at the 12-month follow-up. In addition, although no difference was observed at the 3- or 6-month follow-up, the skill-based intervention caused less frequent reports of unprotected sexual intercourse while intoxicated at the 12-month follow-up than did the health-promotion control intervention (d=0.20; P=.02).

STD RATE

The skills intervention did not reduce the STD rate at the 6-month follow-up. However, at the 12-month follow-up, adolescents who received the skill-based intervention were significantly (d=0.18; P=.05) less likely to have an STD (10.5%) than were those in the health-promotion control intervention (18.2%). There were no significant differences between the information-based intervention and the other 2 interventions at either of the follow-ups where STD data were collected.

CONCEPTUAL MEDIATOR VARIABLES

The HIV/STD risk-reduction interventions also had significant effects on the conceptual mediator variables. As given in **Table 3**, adolescents who received the skill-based intervention scored higher in postintervention HIV/STD knowledge (d=0.62; P<.001), condom use knowledge (d=0.59; P<.001), intentions (d=0.21; P=.008), hedonistic beliefs (d=0.28; P<.001), sexual partner approval (d=0.20; P=.009), technical skills beliefs (d=0.20; P=.01), and impulse control beliefs (d=0.19; P=.02) than did those who received the health-promotion control intervention. In addition, the skill-based intervention caused significantly greater increases in condom use knowledge than did the information-based intervention (d=0.30; P<.001). No other differences on conceptual mediator variables between the skill- and information-based interventions were statistically significant.

Information-based intervention participants scored higher in HIV/STD knowledge (d=0.72; P<.001), condom use knowledge (d=0.30; P<.001), intentions (d=0.29; P<.001), hedonistic beliefs (d=0.31; P<.001), technical skills beliefs (d=0.15; P=.049), and impulse con-

Table 2. Self-reported Sexual Behavior in the Previous 3 Months and Clinically Documented STD Rate by Intervention Condition and at Baseline* and Follow-up Data-Collection Periods

Data-Collection Period	Unadjusted Mean (SE)			Adjusted Mean (SE)			*P* Value for Contrasts†		
	Health-Promotion Control Intervention	Information-Based Intervention	Skills-Based Intervention	Health-Promotion Control Intervention	Information-Based Intervention	Skills-Based Intervention	Information-Based vs Health-Promotion Control Intervention	Skills-Based vs Health-Promotion Control Intervention	Skills-Based vs Information-Based Intervention
No. of Days of Sex Without Condom Use in the Past 3 mo									
Baseline	2.71 (0.43)	3.06 (0.47)	2.58 (0.54)	NA	NA	NA	NA	NA	NA
3 mo	3.52 (0.60)	3.83 (0.79)	3.66 (0.76)	3.46 (0.78)	3.56 (0.75)	3.71 (0.75)	.89	.95	.83
Baseline	2.69 (0.42)	3.32 (0.50)	2.13 (0.38)	NA	NA	NA	NA	NA	NA
6 mo	3.47 (0.71)	3.17 (0.66)	2.99 (0.63)	3.26 (0.70)	2.60 (0.68)	2.98 (0.69)	.43	.66	.74
Baseline	2.82 (0.44)	3.45 (0.55)	2.23 (0.40)	NA	NA	NA	NA	NA	NA
12 mo	5.73 (0.99)	5.04 (0.81)	2.80 (0.44)	5.05 (0.81)	4.04 (0.80)	2.27 (0.81)	.32	.002	.03
No. of Partners in the Past 3 mo									
Baseline	1.10 (0.05)	1.11 (0.06)	1.06 (0.05)	NA	NA	NA	NA	NA	NA
3 mo	1.10 (0.07)	1.06 (0.07)	0.98 (0.06)	1.07 (0.07)	1.04 (0.06)	0.97 (0.06)	.490	.13	.41
Baseline	1.11 (0.05)	1.09 (0.06)	1.02 (0.05)	NA	NA	NA	NA	NA	NA
6 mo	1.04 (0.06)	1.01 (0.07)	0.93 (0.04)	1.00 (0.06)	0.98 (0.06)	0.92 (0.06)	.56	.22	.53
Baseline	1.10 (0.05)	1.06 (0.05)	1.04 (0.05)	NA	NA	NA	NA	NA	NA
12 mo	1.06 (0.06)	1.02 (0.05)	0.93 (0.04)	1.04 (0.05)	1.00 (0.05)	0.91 (0.05)	.51	.04	.17
Percentage Reporting Multiple Partners‡ in the Past 3 mo									
Baseline	15.4 (2.6)	17.2 (2.7)	12.6 (2.3)	NA	NA	NA	NA	NA	NA
3 mo	14.9 (2.6)	15.8 (2.6)	10.7 (2.1)	14.2 (2.5)	15.1 (2.4)	10.9 (2.4)	.76	.29	.17
Baseline	16.6 (2.6)	16.8 (2.7)	11.9 (2.2)	NA	NA	NA	NA	NA	NA
6 mo	15.1 (2.5)	13.2 (2.4)	9.5 (2.0)	14.3 (2.4)	12.5 (2.5)	9.7 (2.5)	.54	.12	.36
Baseline	15.3 (2.6)	15.1 (2.6)	12.4 (2.3)	NA	NA	NA	NA	NA	NA
12 mo	17.5 (2.8)	11.4 (2.3)	7.4 (1.8)	16.6 (2.5)	10.7 (2.5)	6.9 (2.5)	.09	.002	.20
No. of Days of Sex While High on Drugs or Alcohol in the Past 3 mo									
Baseline	0.36 (0.12)	0.48 (0.22)	0.24 (0.10)	NA	NA	NA	NA	NA	NA
3 mo	0.29 (0.09)	0.35 (0.13)	0.11 (0.05)	0.26 (0.09)	0.29 (0.09)	0.10 (0.09)	.98	.03	.03
Baseline	0.48 (0.15)	0.49 (0.23)	0.20 (0.10)	NA	NA	NA	NA	NA	NA
6 mo	0.36 (0.16)	0.20 (0.05)	0.10 (0.03)	0.31 (0.10)	0.15 (0.10)	0.07 (0.10)	.10	.005	.26
Baseline	0.49 (0.15)	0.55 (0.24)	0.21 (0.11)	NA	NA	NA	NA	NA	NA
12 mo	0.65 (0.30)	0.55 (0.26)	0.32 (0.14)	0.66 (0.25)	0.53 (0.25)	0.42 (0.25)	.65	.37	.65
No. of Days of Having Unprotected Sex While High on Drugs or Alcohol in the Past 3 mo									
Baseline	0.23 (0.11)	0.15 (0.04)	0.22 (0.14)	NA	NA	NA	NA	NA	NA
3 mo	0.22 (0.08)	0.10 (0.03)	0.33 (0.28)	0.30 (0.20)	0.15 (0.19)	0.44 (0.19)	.31	.44	.07
Baseline	0.39 (0.16)	0.14 (0.04)	0.18 (0.15)	NA	NA	NA	NA	NA	NA
6 mo	0.28 (0.09)	0.13 (0.04)	0.26 (0.14)	0.20 (0.11)	0.06 (0.11)	0.18 (0.11)	.21	.80	.31
Baseline	0.35 (0.15)	0.15 (0.04)	0.21 (0.15)	NA	NA	NA	NA	NA	NA
12 mo	0.50 (0.24)	0.19 (0.08)	0.10 (0.03)	0.46 (0.15)	0.22 (0.15)	0.10 (0.15)	.27	.02	.28
Percentage Testing Positive for an STD§									
Baseline	17.5 (2.9)	27.2 (3.4)	21.3 (3.1)	NA	NA	NA	NA	NA	NA
6 mo	14.6 (2.7)	16.0 (2.8)	15.5 (2.8)	14.8 (2.8)	15.5 (2.8)	15.8 (2.7)	.89	.80	.91
Baseline	14.3 (2.8)	24.7 (3.5)	23.6 (3.5)	NA	NA	NA	NA	NA	NA
12 mo	17.4 (3.0)	16.0 (3.0)	10.8 (2.6)	18.2 (2.8)	15.4 (2.9)	10.5 (2.9)	.44	.05	.23

Abbreviations: HIV, human immunodeficiency virus; NA, not applicable; STD, sexually transmitted disease.

*Baseline statistics are based on the respondents who participated in the particular follow-up. Sexual behavior counts were analyzed using log link by specifying Poisson distribution in the generalized linear model. Multiple partners and STD rate were analyzed using logit link by specifying binomial distribution in the generalized linear model. The basic model for intervention effects at each follow-up includes baseline corresponding variables, intervention condition, ethnicity (African American vs Latina), and a 4-category variable representing the 3 mothers' intervention conditions and mothers who did not participate.

†*P* values are from Wald χ^2 tests.

‡Reporting 2 or more sexual partners in the past 3 months.

§Having any of the positive test results for gonorrhea, chlamydia, or trichomonas.

trol (d=0.19; P=.02) than did health-promotion control intervention participants.

EVALUATIONS OF THE INTERVENTIONS

Participants gave high ratings of how much they liked their intervention, how much they learned, and the extent to which they would recommend it to others (means for all 3 intervention groups were >4.5 on 5-point scales). Information-based intervention participants (mean [SE], 4.67 [0.04]) gave higher liking ratings than did the health-promotion control intervention participants (mean [SE], 4.46 [0.04]; P<.001) or the skill-based intervention participants (mean [SE], 4.55 [0.04];

Table 3. Adjusted* Postintervention Means (SEs) on Conceptual Variables by Intervention Condition

Conceptual Variable	Unadjusted Mean (SE)			Adjusted Mean (SE)			*P* Values for Contrasts†		
	Health-Promotion Control Intervention (n = 219)	Information-Based Intervention (n = 228)	Skills-Based Intervention (n = 235)	Health-Promotion Control Intervention (n = 219)	Information-Based Intervention (n = 228)	Skills-Based Intervention (n = 235)	Information vs Health-Promotion Control Intervention	Skills-Based vs Health-Promotion Control Intervention	Skills-Based vs Information-Based Intervention
HIV/STD risk-reduction knowledge									
Baseline	34.64 (0.24)	34.53 (0.28)	33.88 (0.29)	NA	NA	NA	NA	NA	NA
Postintervention	35.00 (0.27)	37.79 (0.25)	37.00 (0.28)	34.89 (0.25)	37.76 (0.24)	37.36 (0.25)	<.001	<.001	.19
Condom-use knowledge									
Baseline	4.29 (0.08)	4.18 (0.08)	4.15 (0.07)	NA	NA	NA	NA	NA	NA
Postintervention	4.25 (0.08)	4.52 (0.07)	4.81 (0.06)	4.20 (0.07)	4.52 (0.07)	4.83 (0.07)	<.001	<.001	<.001
Condom use intention									
Baseline	4.20 (0.06)	4.17 (0.06)	4.25 (0.05)	NA	NA	NA	NA	NA	NA
Postintervention	4.14 (0.06)	4.32 (0.05)	4.31 (0.05)	4.14 (0.04)	4.33 (0.04)	4.27 (0.04)	<.001	.008	.24
Condom hedonistic beliefs									
Baseline	3.47 (0.06)	3.57 (0.06)	3.53 (0.05)	NA	NA	NA	NA	NA	NA
Postintervention	3.48 (0.06)	3.76 (0.05)	3.71 (0.06)	3.51 (0.04)	3.72 (0.04)	3.70 (0.04)	<.001	<.001	.67
Sexual partner approval									
Baseline	4.03 (0.07)	3.89 (0.08)	3.85 (0.07)	NA	NA	NA	NA	NA	NA
Postintervention	3.93 (0.07)	3.98 (0.07)	4.01 (0.06)	3.83 (0.05)	3.95 (0.05)	4.00 (0.05)	.06	.009	.47
Technical skill beliefs									
Baseline	3.96 (0.06)	4.02 (0.06)	3.92 (0.06)	NA	NA	NA	NA	NA	NA
Postintervention	4.00 (0.05)	4.15 (0.05)	4.12 (0.05)	4.04 (0.04)	4.15 (0.04)	4.19 (0.04)	.049	.01	.54
Impulse control beliefs									
Baseline	3.85 (0.06)	3.89 (0.06)	3.87 (0.05)	NA	NA	NA	NA	NA	NA
Postintervention	3.85 (0.06)	4.01 (0.05)	3.99 (0.05)	3.86 (0.05)	4.01 (0.05)	4.00 (0.05)	.01	.02	.94
Negotiation skill beliefs									
Baseline	4.33 (0.05)	4.40 (0.05)	4.33 (0.05)	NA	NA	NA	NA	NA	NA
Postintervention	4.26 (0.04)	4.36 (0.05)	4.25 (0.04)	4.27 (0.04)	4.33 (0.04)	4.26 (0.04)	.25	.88	.19

Abbreviations: HIV, human immunodeficiency virus; NA, not applicable; STD, sexually transmitted disease.

*For each variable, the preintervention measure, ethnicity (African American vs Latina), and a 4-category variable representing the 3 mothers' intervention conditions and mothers who did not participate are partialled out of the postintervention measure.

†*P* values are from F tests. Human immunodeficiency virus risk-reduction knowledge could range from 0 to 42. Condom use knowledge could range from 0 to 6. All other conceptual variables are measured on 5-point scales, with higher score indicating more of the construct.

P=.01). Information-based intervention participants (mean [SE], 4.75 [0.04]) also gave higher learning ratings than did the health-promotion control intervention participants (mean [SE], 4.61 [0.04]; *P*=.008). No other differences were significant.

DIFFERENTIAL EFFICACY AMONG AFRICAN AMERICANS AND LATINOS?

Analyses testing whether the efficacy of the interventions was different with African Americans and Latinos revealed no significant differences on the STD rates, sexual risk behavior, or evaluations of the interventions. However, the skill-based intervention was significantly more effective with Latinos than with African Americans in increasing condom negotiation beliefs (*P*=.02) and technical skill beliefs (*P*=.02) compared with the health-promotion control intervention, and with condom negotiation beliefs (*P*=.05) compared with the information-based intervention. In addition, the information-based intervention was more effective with Latinos than with African Americans in increasing hedonistic beliefs (*P*=.007) compared with the health-promotion control intervention, and in increasing HIV/STD knowledge (*P*=.02) compared with the skill-based intervention.

SOCIAL DESIRABILITY RESPONSE BIAS

Hierarchical multiple regression analyses revealed that social desirability scores did not interact with intervention condition to influence sexual behavior at any of the follow-ups. Analyses on the subsample of adolescents in the 2 HIV/STD interventions also revealed that social desirability scores were unrelated to self-reported sexual behavior at the follow-ups.

COMMENT

The results of this study suggest that behavioral interventions, particularly those that focus on skills training, may be helpful in reducing unprotected intercourse and STD rate among adolescent girls. This is particularly important for African American and Latino adolescents, whose rate of STDs is considerably higher than the rate among other adolescents. The skills intervention also reduced self-reports of multiple of sexual partners at the 12-month follow-up compared with the health-promotion control intervention. Both unprotected intercourse and multiple sexual partners are important risk factors for STD.

Several randomized controlled trials have demonstrated that behavioral interventions can reduce adolescents' sexual risk behavior.[28-30] However, an important feature of the present trial was the use of biologically confirmed measures of STD rate. Although other trials have shown that interventions can reduce the STD rate among adults,[31,32] this is one of the first randomized controlled trials of an intervention for adolescents to report reductions in biologically confirmed STD rates. Thus, this study shows that HIV/STD interventions for adolescents can, indeed, influence a health outcome, not only self-reported behavior.

Many writers have raised concern about the potentially adverse influence of alcohol and drug use in increasing sexual risk behavior.[33,34] This concern is not allayed by data from the 6 Centers for Disease Control and Prevention's Youth Risk Behavior surveys during 1991-2001 documenting increases over time in adolescents' reports of alcohol and drug use in conjunction with sexual intercourse.[35] Despite the concern, no previous trials have demonstrated intervention-induced reductions in alcohol and drug use during sex. In the present study, the skill-based intervention, compared with the health-promotion control intervention, significantly reduced the reported use of alcohol and drugs during sexual activity. This raises the hope that skill-based interventions can influence sexual behavior under high-risk circumstances characterized by cues that prompt failure to use condoms.

Although other sexual risk reduction studies[36,37] have contrasted skills interventions with information interventions, this study differs from many of those in an important respect. Both the skill-based intervention and the information-based intervention covered not just facts about HIV but also attitudes and beliefs regarding using condoms. The critical between-intervention difference was that the skill-based intervention focused on skills, whereas the information-based intervention did not. Thus, the present study provides some of the strongest evidence that enhancing skills should be a critical goal for interventions designed to reduce risk sexual behavior. The present results may mean that although it is necessary for interventions to cover factual information and relevant beliefs and attitudes, such a limited focus is insufficient. Interventions must also develop skills. Methods for enhancing condom use skills include handling condoms, practicing putting condoms on anatomical models, and role-playing realistic situations that involve pressure to have unprotected intercourse. The implementation of such activities with adolescents may be controversial in certain settings, yet, the present results suggest that they hold the promise of reductions in sexual risk behavior.

In the present study, the effects of the intervention were significant primarily at 12-month follow-up, not at the shorter-term follow-ups. Such a delayed effect has been observed in other prevention trials.[38,39] One possible explanation for why the magnitude of intervention effects might increase at later follow-ups is that people have difficulty introducing safer-sex practices into existing relationships.[40-42] As they become involved with new partners over time, they are able to implement those practices; hence, intervention effects on behavior are larger at longer-term follow-up.

An important issue for HIV/STD prevention research is the extent to which the same intervention can be effective with people who differ in key characteristics, including ethnicity. We know that interventions are apt to be more effective if they are tailored to the population. The trouble is sometimes it is impossible to separate people by ethnicity and provide them tailored interventions. Under such circumstances, can an intervention be effective? The present findings suggest that, at least with regard to inner-city African Americans and Latino (ie, Puerto Rican) adolescent girls, the answer may be yes. Despite the fact that some of the intervention activities had been originally designed for African Americans and African American facilitators implemented the activities, the interventions were not less effective in reducing sexual risk behavior or STD rates with Latinos than with African Americans, and Latinos and African Americans gave equally positive evaluations of the interventions. Accordingly, it cannot be assumed that an intervention developed for one ethnic group will be ineffective with another group.

The limitations of the present study should be considered. The self-report measures are a limitation. The participants were African American and Latino, chiefly Puerto Rican, adolescent girls; hence, we do not know whether similar findings would be obtained with adolescent boys or with adolescents from other Latino backgrounds. It is possible that the participants in the HIV/STD interventions, compared with the controls, were less likely to return for STD testing because they felt more ashamed for having unprotected intercourse despite receiving an intervention. However, we believe this is an unlikely explanation for our STD findings. The participants were patients attending family planning services in an adolescent medicine clinic that was their primary family-planning provider. The clinic offered a 24-hour on-call system with confidential and free services. The clinicians who performed the STD examinations were blind to the participants' intervention. Moreover, the return rates for STD testing were high and did not vary by intervention assignment.

The present study also includes particular strengths. It was a randomized controlled trial. It used a single-session intervention, which ensured that all participants attended the entire intervention. Attrition was low, and it did not differ by condition. Both self-report and biologically confirmed outcomes were collected. The significant effects of the interventions cannot be explained as a simple result of special attention the participants in the HIV/STD interventions received because the HIV/STD and control interventions were matched in length and involved similar kinds of activities. Moreover, participants' evaluations of their experiences were similar across the interventions.

CONCLUSIONS

The findings from this study are consistent with a growing body of evidence that interventions that are based on a solid theoretical framework and formative research

with members of the study population and that provide practice in risk-reduction skills are effective in reducing HIV/STD risk behavior and STD rates. A notable feature of the present results was that they were produced by a single-session intervention of only 250 minutes. This suggests that it is possible to effect significant long-term changes in sexual behavior among adolescent girls—over 12 months in the present study—without great expenditure of time and effort. Future research must explore the generalizability of the present results. Methodologically rigorous studies[20] hold considerable promise in the development of effective, evidence-based strategies for reducing sexual risk behavior—and the adverse consequences of such behavior.

Since this article has been accepted for publication, we have become aware of another randomized controlled trial of an HIV prevention intervention for adolescent girls.[43] The results of both trials support the view that theory-based interventions can reduce self-reported sexual risk behavior, theoretical mediators of such behavior, and biologically confirmed STDs. Unlike the present trial, which focused on both African American and Latino adolescent girls, the other trial focused exclusively on African American adolescent girls.

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IN OTHER AMA JOURNALS

ARCHIVES OF OPHTHALMOLOGY

Randomized Trial of Treatment of Amblyopia in Children Aged 7 to 17 Years

Pediatric Eye Disease Investigator Group

Objective: To evaluate the effectiveness of treatment of amblyopia in children aged 7 to 17 years.
Methods: At 49 clinical sites, 507 patients with amblyopic eye visual acuity ranging from 20/40 to 20/400 were provided with optimal optical correction and then randomized to a treatment group (2-6 hours per day of prescribed patching combined with near visual activities for all patients plus atropine sulfate for children aged 7 to 12 years) or an optical correction group (optical correction alone). Patients whose amblyopic eye acuity improved 10 or more letters (≥2 lines) by 24 weeks were considered responders.
Results: In the 7- to 12-year-olds (n=404), 53% of the treatment group were responders compared with 25% of the optical correction group ($P<.001$). In the 13- to 17-year-olds (n=103), the responder rates were 25% and 23%, respectively, overall (adjusted $P=.22$) but 47% and 20%, respectively, among patients not previously treated with patching and/or atropine for amblyopia (adjusted $P=.03$). Most patients, including responders, were left with a residual visual acuity deficit.
Conclusions: Amblyopia improves with optical correction alone in about one fourth of patients aged 7 to 17 years, although most patients who are initially treated with optical correction alone will require additional treatment for amblyopia. For patients aged 7 to 12 years, prescribing 2 to 6 hours per day of patching with near visual activities and atropine can improve visual acuity even if the amblyopia has been previously treated. For patients 13 to 17 years, prescribing patching 2 to 6 hours per day with near visual activities may improve visual acuity when amblyopia has not been previously treated but appears to be of little benefit if amblyopia was previously treated with patching. We do not yet know whether visual acuity improvement will be sustained once treatment is discontinued; therefore, conclusions regarding the long-term benefit of treatment and the development of treatment recommendations for amblyopia in children 7 years and older await the results of a follow-up study we are conducting on the patients who responded to treatment. *(2005;123:1-11)*

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PRE-QUESTIONNAIRE

Date: _____ (7-14)

The questions in this booklet ask about your attitudes, beliefs, feelings, knowledge and experiences about yourself. Some of the questions are very personal and ask about different sexual activities that some people do. These particular questions are very, very blunt and to the point, questions you probably have never seen on a questionnaire before. Most of the questions are not like this, however. If the questions bother you so much that you do not want to answer them, you can stop filling out the questionnaire. We warn you about the questions that are personal and blunt so that you will not be surprised when you see them. Please answer all of the questions honestly. Your answers will be kept private and strictly confidential. If you wish to comment on any questions or explain your answers, please feel free to write in the space in the margins. Your comments will be read and taken into account. Do not write your name on this questionnaire.

IMPORTANT! WRITE YOUR CODE NUMBER HERE: _____

Time Started: _____.

Time Finished: _____.

Asst. Reqd.? ☐ none ☐ low ☐ high

PLEASE PRINT THE FOLLOWING SENTENCE ON THE LINE BELOW:

"The quick brown fox jumps over the lazy dog."

_____

A. BACKGROUND INFORMATION

Please provide the following background information about yourself for statistical purposes:

1. How old are you? _____ years

2. What is your sex? ☐ Male ☐ Female

3. Are you now in school? ☐ No ☐ Yes

   If NO, what was the last grade you completed ? _____
   If YES, what grade are you in now ? _____

4. What is the highest level of education you would like to complete?

   ___ 1. Finish 1st, 2nd, 3rd, 4th, or 5th grade
   ___ 2. Finish 6th grade
   ___ 3. Finish 8th grade
   ___ 4. Some High School
   ___ 5. Graduate from High School (receive High School Diploma or get my GED)
   ___ 6. Some trade school
   ___ 7. Finish trade school
   ___ 8. Some College
   ___ 9. Receive Associates Degree
   ___ 10. Receive Bachelors Degree
   ___ 11. Some Graduate School
   ___ 12. Receive Masters Degree
   ___ 13. Receive Doctorate-Level Degree (JD, Ph.D., MD, Ed.D., etc.)

5. What is the highest level of education you think you will actually complete?

   ___ 1. Finish 1st, 2nd, 3rd, 4th, or 5th grade
   ___ 2. Finish 6th grade
   ___ 3. Finish 8th grade
   ___ 4. Some High School
   ___ 5. Graduate from High School (receive High School Diploma or get my GED)
   ___ 6. Some trade school
   ___ 7. Finish trade school
   ___ 8. Some College
   ___ 9. Receive Associates Degree

___ 10. Receive Bachelors Degree
___ 11. Some Graduate School
___ 12. Receive Masters Degree
___ 13. Receive Doctorate-Level Degree (JD, Ph.D., MD, Ed.D., etc.)

6. Are you Hispanic/Latino?

☐ No ☐ Yes

If Yes- Are you Puerto Rican?

☐ No ☐ Yes

Are you Dominican?

☐ No ☐ Yes

Other (Specify): _____

7. What is your race?

☐ Black ☐ Asian
☐ White ☐ American Indian
☐ Other (specify): _____

8. Are you Caribbean/West Indian?

☐ No ☐ Yes

9. What is your parent's marital status?

☐ Never married to each other ☐ Separated
☐ Married to each other ☐ Divorced
☐ Widowed

If your parents are widowed/separated or divorced, how old were you when this happened?_____

10. What kind of job does your mother have? _____

11. What kind of job does your father have? _____

12. Place a check mark next to the highest grade your mother has completed in school:

___ 1. Finished 1st, 2nd, 3rd, 4th, or 5th grade
___ 2. Finished 6th grade
___ 3. Finished 8th grade
___ 4. Some High School
___ 5. Graduated from High School (received High School Diploma or GED)
___ 6. Some trade school
___ 7. Finished trade school
___ 8. Some College
___ 9. Received Associates Degree
___ 10. Received Bachelors Degree
___ 11. Some Graduate School
___ 12. Received Masters Degree
___ 13. Received Doctorate-Level Degree (JD, Ph.D., MD, Ed.D., etc.)

13. Place a check mark next to the highest grade your father has completed in school:

___ 1. Finished 1st, 2nd, 3rd, 4th, or 5th grade
___ 2. Finished 6th grade
___ 3. Finished 8th grade
___ 4. Some High School
___ 5. Graduated from High School (received High School Diploma or GED)
___ 6. Some trade school
___ 7. Finished trade school
___ 8. Some College
___ 9. Received Associates Degree
___ 10. Received Bachelors Degree
___ 11. Some Graduate School
___ 12. Received Masters Degree
___ 13. Received Doctorate-Level Degree (JD, Ph.D., MD, Ed.D., etc.)

14. Who lives with you?

Check Yes if the person lives with you now;
check No if the person does not live with you.

Does your mother live with you?	☐ No	☐ Yes
Does your father live with you?	☐ No	☐ Yes

Does a friend of your mother's live with you? ☐ No ☐ Yes

Does a friend of your father's live with you? ☐ No ☐ Yes

Do you have any sisters living with you? ☐ No ☐ Yes

How many of your sisters live with you?_____

Do you have any brothers living with you? ☐ No ☐ Yes

How many of your brothers live with you?____

Does your grandmother live with you? ☐ No ☐ Yes

Does your grandfather live with you? ☐ No ☐ Yes

Do you have a stepmother living with you? ☐ No ☐ Yes

Do you have a stepfather living with you? ☐ No ☐ Yes

15. In the past 3 months, have you had a class on AIDS?

☐ No ☐ Yes

16. In the past 3 months, have you had a class on birth control, sex, or STDs?

☐ No ☐ Yes

17. Do you have a steady partner?

☐ No ☐ Yes

If NO, do not answer questions 2 and 3; go to the next section.

If YES, how long have you been together? _____ years.

If less than one year, how many months? _____ months.

18. Have you had sex with your steady partner in the past 3 months?

☐ No ☐ Yes

If YES, how often was a condom used?

1	2	3	4	5
Never	Sometimes	Often	Usually	Always

19. Have you have sex with someone other than your steady partner in the past 3 months?

☐ No ☐ Yes

If YES, how often was a condom used?

1	2	3	4	5
Never	Sometimes	Often	Usually	Always

B. AIDS/STD TRUE-FALSE ITEMS

TRUE or FALSE. Some of the statements below are true; some are false. Please check T for each statement that you think is TRUE; check F for each one you think is FALSE; and check "?" if you DO NOT KNOW whether the statement is true or false. The term STD means Sexually Transmitted Disease.

1. A common symptom of STDs in a man is discharge (drip) from his penis.

   ☐ T ☐ F ☐ ?

2. A common symptom of STDs is burning with urination (peeing).

   ☐ T ☐ F ☐ ?

3. A common symptom of STDs is a sore on the penis or vagina.

   ☐ T ☐ F ☐ ?

4. A common symptom of STDs in a woman is discharge from her vagina that causes itching or burning.

   ☐ T ☐ F ☐ ?

5. If you feel healthy you don't have an STD.

   ☐ T ☐ F ☐ ?

6. A woman who has an STD can get an infection in her uterus and tubes.

☐ T ☐ F ☐ ?

7. A pregnant woman who has an STD can give it to her baby.

☐ T ☐ F ☐ ?

8. There are medicines to cure all types of STDs.

☐ T ☐ F ☐ ?

9. Using a condom when you have sex will help protect you against STDs.

☐ T ☐ F ☐ ?

10. Contact with a dirty toilet seat is a common cause of STDs.

☐ T ☐ F ☐ ?

11. If you have a STD your sexual partner probably has it too.

☐ T ☐ F ☐ ?

12. AIDS is a medical condition in which your body cannot fight off diseases.

☐ T ☐ F ☐ ?

13. Stress causes AIDS.

☐ T ☐ F ☐ ?

14. If you kiss someone with AIDS you will get the disease.

☐ T ☐ F ☐ ?

15. All gay men have AIDS.

☐ T ☐ F ☐ ?

16. Anyone can get AIDS.

☐ T ☐ F ☐ ?

17. AIDS is not at all serious, it is like having a cold.

☐ T ☐ F ☐ ?

18. The cause of AIDS is unknown.

☐ T ☐ F ☐ ?

19. Just being around someone with AIDS can give you the disease.

☐ T ☐ F ☐ ?

20. Using a condom during sex can lower the risk of getting AIDS.

☐ T ☐ F ☐ ?

21. Receiving a blood transfusion with infected blood can give a person AIDS.

☐ T ☐ F ☐ ?

22. Having AIDS makes you more likely to get other diseases.

☐ T ☐ F ☐ ?

23. All gay women have AIDS.

☐ T ☐ F ☐ ?

24. I can avoid getting AIDS by exercising regularly.

☐ T ☐ F ☐ ?

25. AIDS can be cured if treated early.

☐ T ☐ F ☐ ?

26. A person can have the AIDS virus and give it to other people even if he does not look sick.

☐ T ☐ F ☐ ?

27. Only gay men and people who shoot up drugs get AIDS.

☐ T ☐ F ☐ ?

28. AIDS is not a problem among Blacks and Hispanics.

☐ T ☐ F ☐ ?

29. Condoms are 100% effective against AIDS.

☐ T ☐ F ☐ ?

30. Having sex with a man who shoots drugs is a way many women get AIDS.

☐ T ☐ F ☐ ?

31. There is a bigger chance of getting AIDS if you have sex with many people.

☐ T ☐ F ☐ ?

32. There is a bigger chance that a woman will get AIDS if she has sex with a guy who has sex with many other women.

☐ T ☐ F ☐ ?

33. Having anal sex with a guy (i.e., his penis in your anus/behind) increases your chance of getting AIDS.

☐ T ☐ F ☐ ?

34. Using Vaseline as a lubricant when you have sex lowers the chance of getting AIDS.

☐ T ☐ F ☐ ?

35. Using a spermicide (birth control foam or jelly containing Nonoxynol-9) when you have sex lowers the chance of getting AIDS.

☐ T ☐ F ☐ ?

36. Doing oral sex on a guy (your mouth on his penis) increases your chance of getting AIDS.

☐ T ☐ F ☐ ?

37. You can catch AIDS like you catch a cold because the AIDS virus can be carried in the air.

☐ T ☐ F ☐ ?

38. You can not get AIDS from sex if you have sex with only one person during your whole life.

☐ T ☐ F ☐ ?

39. There is a good chance you will get AIDS if you share a sink, shower, or toilet seat with someone who has AIDS.

☐ T ☐ F ☐ ?

40. There is a good chance you will get AIDS if you drink from the same glass or eat from the same plate as someone who has AIDS.

☐ T ☐ F ☐ ?

41 The AIDS virus is present in certain body fluids, mainly semen and blood.

☐ T ☐ F ☐ ?

42. Persons infected with the AIDS virus by shooting drugs are not likely to pass the virus to sex partners unless the partners also shoot drugs.

☐ T ☐ F ☐ ?

43. The penis should be erect when the condom is put on it.

☐ T ☐ F ☐ ?

44. When a condom is placed on the penis, space should be left at the tip of the condom.

☐ T ☐ F ☐ ?

45. The condom should be completely unrolled before it is placed on the penis.

☐ T ☐ F ☐ ?

46. Condoms can be reused.

☐ T ☐ F ☐ ?

47. To remove a condom after sex, grasp the tip and remove it gently but swiftly.

☐ T ☐ F ☐ ?

48. Storing or carrying condoms in a hot or warm place can destroy their effectiveness.

☐ T ☐ F ☐ ?

C. SEXUAL ATTITUDES

The following questions ask how you feel about different behaviors. Please indicate how good or bad an idea it is to do the following, whether others would approve or disapprove of the behavior, and whether you plan to do these behaviors in the next 3 months (90 days). Circle the NUMBER that best describes your feelings. Sexual intercourse refers to a male putting his penis in a female's vagina. (Try to answer the questions even if you have not had sexual intercourse or have never used condoms.)

How would the following people feel about you having sex in the next 3 months? (Circle one)

	1	**2**	**3**	**4**	**5**
	Strongly Disapprove	**Disapprove**	**In the Middle**	**Approve**	**Strongly Approve**
1. Yourself	1	2	3	4	5
2. Most people who are important to you	1	2	3	4	5
3. Your sexual partner	1	2	3	4	5
4. Your mother	1	2	3	4	5
5. Your father	1	2	3	4	5
6. Your friends	1	2	3	4	5

7. How likely is it that you will decide to have sexual intercourse in the next 3 months? (45)

1	2	3	4	5
Very Unlikely	Unlikely	In the Middle	Likely	Very Likely

Try to answer the following questions even if you have not had sex or have never used condoms. How would the following people feel about you using a condom if you have sex in the next 3 months? (Circle one)

1	2	3	4	5
Strongly Disapprove	**Disapprove**	**In the Middle**	**Approve**	**Strongly Approve**

8. Yourself	1	2	3	4	5
9. Most people who are important to you	1	2	3	4	5
10. Your sexual partner	1	2	3	4	5
11. Your mother	1	2	3	4	5
12. Your father	1	2	3	4	5
13. Your friends	1	2	3	4	5

14. How likely is it that you will decide to use a condom if you have sex in the next 3 months?

1	2	3	4	5
Very Unlikely	Unlikely	In the Middle	Likely	Very Likely

Try to answer the following questions even if you have not had sex or have never used condoms. How would the following people feel about you using birth control pills if you have sex in the next 3 months? (Circle one)

1	2	3	4	5
Strongly Disapprove	**Disapprove**	**In the Middle**	**Approve**	**Strongly Approve**

15. Yourself	1	2	3	4	5
16. Most people who are important to you	1	2	3	4	5
17. Your sexual partner	1	2	3	4	5
18. Your mother	1	2	3	4	5
19. Your father	1	2	3	4	5

20. Your friends 1 2 3 4 5

21. How likely is it that you will decide to use birth control pills if you have sex in the next 3 months?

1	2	3	4	5
Very Unlikely	Unlikely	In the Middle	Likely	Very Likely

In general, how important are the following people's opinons to you? (Circle One)

1	**2**	**3**	**4**	**5**
Very Unimportant	**Unimportant**	**In the Middle**	**Important**	**Very Important**

22. Your sexual partner 1 2 3 4 5
23. Your mother 1 2 3 4 5
24. Your father 1 2 3 4 5
25. Your friends 1 2 3 4 5

Now, we would like to ask you some questions about you using condoms. How much do you agree or disagree with each of the following statements about condoms? Try to answer the questions even if you have not had sex or have never used condoms. (Circle One)

1	**2**	**3**	**4**	**5**
Strongly Agree	**Agree**	**In The Middle**	**Disagree**	**Strongly Disagree**

1. Sex wouldn't feel as good if my partner and I used a condom. 1 2 3 4 5
2. Condoms are embarrassing to use. 1 2 3 4 5
3. Condoms help prevent STDs. 1 2 3 4 5
4. Condoms help prevent pregnancy. 1 2 3 4 5
5. Sex feels unnatural when a condom is used. 1 2 3 4 5
6. Condoms help prevent HIV. 1 2 3 4 5

7. Condoms ruin the mood because you have to stop to put one on.	1	2	3	4	5
8. Sex still feels good when a condom is used.	1	2	3	4	5
9. Having sex is more fun when a condom is used.	1	2	3	4	5
10. Using a condom breaks up the rhythm and timing of sex.	1	2	3	4	5
11. Saying we have to use a condom would make my sexual partner think I am having sex with other people.	1	2	3	4	5
12. Saying we have to use a condom is like saying to my partner, "I don't trust you."	1	2	3	4	5
13. My sexual partner would break up with me if I said we had to use a condom.	1	2	3	4	5
14. My sexual partner would be happier if we used a condom.	1	2	3	4	5
15. If I had a condom with me, my partner would not like it.	1	2	3	4	5
16. All in all, it's a good idea to use condoms.					
17. Condoms cost too much.	1	2	3	4	5
18. It is easy for me to have a condom with me all of the time.	1	2	3	4	5
19. It is hard for me to get condoms.	1	2	3	4	5
20. It is too much trouble to carry around condoms.	1	2	3	4	5
21. I can get condoms.	1	2	3	4	5
22. I can't talk to my partner about using condoms.	1	2	3	4	5
23. I can get my partner to use a condom, even if he doesn't want to.	1	2	3	4	5

24. I can say to my partner that we should use a condom.	1	2	3	4	5
25. Before we are ready to have sex, I can talk to my partner about using a condom.	1	2	3	4	5
26. I can put a condom on my partner without ruining the mood.	1	2	3	4	5
27. If I am sexually aroused I can stop before sex to use a condom.	1	2	3	4	5
28. I can say no to sex if my partner and I don't have a condom.	1	2	3	4	5
29. I can stop sex to get a condom, if I don't have one.	1	2	3	4	5
30. I can use a condom, even if the room is dark.	1	2	3	4	5
31. I can get my partner to use a condom without ruining the mood.	1	2	3	4	5
32. I am sure that I can use a condom if I have sex.	1	2	3	4	5
33. I will try to get my sexual partner to use condoms if we have sex in the next 3 months.	1	2	3	4	5
34. I want to use condoms if I have sex in the next 3 months.	1	2	3	4	5
35. I plan to use condoms if I have sex in the next 3 months.	1	2	3	4	5

D. SEXUAL BEHAVIOR

The following questions ask you about different sexual behaviors you may or may not ever have done. There is always an answer that lets you tell us when you have not done things, as well as when you have done them. Sexual intercourse refers to a male putting his penis in a female's vagina. Please be honest.

1. Have you ever had sexual intercourse (a boy's penis in a girl's vagina)? (9)

☐ No ☐ Yes

If NO, do not answer questions 2 - 23; skip to question 24.

2. Have you ever had sex while you were high on alcohol or another drug?

☐ No ☐ Yes

3. Have you ever had sex with someone who had shot up drugs?

1	2	3	4
Definitely No	Probably No	Probably Yes	Definitely Yes

The following questions are about the first time you had sex.

4. How old were you when you first had sex? _____ years old.

5. How old was your partner when you first had sex? _____ years old.

6. The first time you had sex, were you forced to have sex?

☐ No ☐ Yes

7. The first time you had sex were birth control pills used?

☐ No ☐ Yes

8. The first time you had sex were condoms used?

☐ No ☐ Yes

The next set of questions ask about the last time you had sex.

9. The last time you had sex did you use birth control pills?

☐ No ☐ Yes

10. The last time you had sex did your partner use a condom?

☐ No ☐ Yes

11. The last time you had sex , were you high on alcohol or another drug?

☐ No ☐ Yes

12. The last time you had sex, did you have a couple of drinks and/or any drugs before having sex?

☐ No ☐ Yes

The next set of questions are about your activities in the past 3 months (90 days).

13. Have you had sexual intercourse in the last 3 months?

☐ No ☐ Yes

If NO, do not answer questions 14 - 24; skip to question 24.
If YES, how often was each of the following used?

Birth control pills:

1	2	3	4	5
Never	Sometimes	Often	Usually	Always

Condom:

1	2	3	4	5
Never	Sometimes	Often	Usually	Always

14. In the past 3 months, were you forced to have sex against your will?

☐ No ☐ Yes

15. In the past 3 months, how many times have you had sex? _____ times

16. In the past 3 months, how many partners have you had sex with? _____

17. In the past 3 months, on how many days did you have sex? _____days

On how many of those days did you have sex without using a condom? _____days

For each of the questions below, if your answer is "ZERO," write "0."

18. In the past 3 months, on how many days did you have sex with a partner who was having sex with someone else? _____ days

19. In the past 3 months, on how many days did you get high on alcohol or another drug and then had sex? _____ days

20. On how many of those days when you got high on an alcoholic drink or another drug and then had sex did you have sex without using a condom? _____ days

21. In the past 3 months, on how many days did you have sex with someone who had shot up drugs? _____ days

22. On how many of those days when you had sex with someone who had shot up drugs did you have sex without using a condom? _____ days

23. In how many of the past 12 weeks did you have sex with more than one partner in the same week?

0 1 2 3 4 5 6 7 8 9 10 11 12

24. Have you ever had anal sex with a guy (his penis in your anus/behind)?

☐ No ☐ Yes

If NO, do not answer questions 25 - 34; skip to question 35.
The following questions are about the first time you had anal sex.

25. How old were you when you first had anal sex? _____ years

26. How old was your partner when you first had anal sex? _____ years

27. The first time you had anal sex, were you forced?

☐ No ☐ Yes

28. The first time you had anal sex, did you use a condom?

☐ No ☐ Yes

The next set of questions are about your activities in the past 3 months (90 days).

29. In the past 3 months, did you have anal sex? 1. No or 2. Yes

If NO, do not answer questions 30 - 34; skip to question 35
If YES, how often was a condom used?

1	2	3	4	5
Never	Sometimes	Often	Usually	Always

30. In the past 3 months, how many times did you have anal sex? _____ times

31. In the past 3 months, how many partners have you had anal sex with? _____partners

32. In the past 3 months, on how many days did you have anal sex? _____ days

33. In the past 3 months, were you forced to have anal sex against your will?

☐ No ☐ Yes

The following question is about the last time you had anal sex.

34. The last time you had anal sex, did the you use a condom?

☐ No ☐ Yes

35. Have you ever done oral sex (your mouth on a penis or vagina)?

☐ No ☐ Yes

If NO, do not answer questions 36 - 43; skip to question 44

The following questions are about the first time you performed oral sex.

36. How old were you the first time you did oral sex? _____ years

37. How old was your partner? _____ years

38. Were you forced you to do it?

☐ No ☐ Yes

The next set of questions are about your activities in the past 3 months (90 days).

39. In the past 3 months, have you done oral sex?

☐ No ☐ Yes

If NO, do not answer questions 40 - 43; skip to question 44
If YES, how often was a condom used?

1	2	3	4	5
Never	Sometimes	Often	Usually	Always

40. In the past 3 months, how many times did you do oral sex? _____ times

41. In the past 3 months, with how many partners did you do oral sex? _____partners

42. In the past 3 months, on how many days did you do oral sex? _____ days

43. In the past 3 months, were you forced to do oral sex against your will?

☐ No ☐ Yes

44. Has anyone ever done oral sex to you?

☐ No ☐ Yes

If NO, do not answer questions 45 - 52; skip to question 53
The following questions are about the first time someone did oral sex to you.

45. How old were you when someone first did this to you? _____ years

46. How old was your partner? _____ years

47. Were you forced into it?

☐ No ☐ Yes

The next set of questions are about your activities in the past 3 months (90 days).

48. In the past 3 months, has someone done oral sex to you?

☐ No ☐ Yes

If NO, do not answer # 49 to 52; go to question # 53

49. In the past 3 months, how many times did someone do oral sex to you? _____

50. In the past 3 months, how many people did oral sex to you? _____ people

51. In the past 3 months, on how many days did someone do oral sex to you? _____

52. In the past 3 months, did anyone force you to let them do oral sex to you?

☐ No ☐ Yes

53. Have you ever exchanged sex for money?

☐ No ☐ Yes

54. In the past 3 months did you exchange sex for money?

☐ No ☐ Yes

55. Have you ever exchanged sex for drugs?

☐ No ☐ Yes

56. In the past 3 months did you exchange sex for drugs?

☐ No ☐ Yes

57. With whom do you have sex (anal, oral, or vaginal) (circle one):

1. Guys only
2. Girls only
3. Both guys and girls
4. I have never had sex

58. Have you ever had a Sexually Transmitted Disease (STD)?

☐ No ☐ Yes

If YES, what did you have?

59. In the past three months, have you had any of the following diseases?

Chlamydia	☐ No	☐ Yes
Gonorrhea (clap)	☐ No	☐ Yes
HPV (Genital warts)	☐ No	☐ Yes
Syphilis (bad blood)	☐ No	☐ Yes
HIV/AIDS	☐ No	☐ Yes
Trichomonas (Trich)	☐ No	☐ Yes
Herpes	☐ No	☐ Yes
Yeast Infection	☐ No	☐ Yes

Please answer the following questions concerning pregnancy:

1. How many times have you been pregnant? _____ times

2. How many living children do you have? _____ children

3. Were you trying to become pregnant in the past 3 months?

☐ No ☐ Yes

4. Do you plan to become pregnant in the next 3 months?

☐ No ☐ Yes

E. HARD OR EASY?

Sometimes we want to do something, but it's hard to do it. For the statements below, circle the number that best expresses how easy or hard it would be for you to do each of the things listed. Use any number from 1 to 5. The higher the number, the easier you think it is to do the behavior. The lower the number, the harder you think it is to do the behavior. (Circle One)

1	2	3	4	5
Very Hard	**Hard**	**In the Middle**	**Easy**	**Very Easy**

1.	How easy or hard would it be for you to get your partner to use condoms during sex, even if he didn't want to?	1	2	3	4	5
2.	How easy or hard would it be for you to get your partner to not have sex with you, even if he wanted to?	1	2	3	4	5
3.	How easy or hard would it be for you to get your partner to talk to you about preventing STDs, even if he didn't want to?	1	2	3	4	5
4.	How easy or hard would it be for you to get your partner to talk to you about ways you could prevent AIDS, even if he didn't want to?	1	2	3	4	5
5.	How easy or hard would it be for you to get your partner to let you use contraceptive foam or jelly when you have sex, even if he didn't want to?	1	2	3	4	5
6.	How easy or hard would it be to use condoms when you have sex?	1	2	3	4	5
7.	How easy or hard would it be to use contraceptive foam or jelly when you have sex?	1	2	3	4	5

F. HEALTH KNOWLEDGE

TRUE or FALSE. Some of the statements below are true; some are false. Please circle T for each statement that you think is TRUE; circle F for each one you think is FALSE; and circle "?" if you DO NOT KNOW whether the statement is true or false.

1. Smoking cigarettes does not affect your blood pressure.

   ☐ True ☐ False ☐ ?

2. A pregnant woman can smoke because it doesn't hurt her baby.

   ☐ True ☐ False ☐ ?

3. Being around someone who smokes cigarettes is not very dangerous to one's health.

   ☐ True ☐ False ☐ ?

4. Smoking doesn't hurt the heart very much.

   ☐ True ☐ False ☐ ?

5. Carbon monoxide in cigarette smoke takes the place of oxygen in the blood.

   ☐ True ☐ False ☐ ?

6. Low-tar and low-nicotine cigarettes are very safe to smoke.

   ☐ True ☐ False ☐ ?

7. Cigarette smoking makes the heart beat slower.

   ☐ True ☐ False ☐ ?

8. Smoking is not addictive.

   ☐ True ☐ False ☐ ?

9. High blood pressure can be caused by drinking too much water.

   ☐ True ☐ False ☐ ?

10. You can have high blood pressure and not know it.

    ☐ True ☐ False ☐ ?

11. When you have hypertension, that means you are too tense.

☐ True ☐ False ☐ ?

12. When breast cancer is diagnosed early, the rate of cure can be as high as 85%.

☐ True ☐ False ☐ ?

13. 1 in 9 women will get breast cancer.

☐ True ☐ False ☐ ?

14. 4 out of 5 women who get breast cancer have no family history of it.

☐ True ☐ False ☐ ?

15. A mammogram is an x-ray of your breast.

☐ True ☐ False ☐ ?

16. To have a healthy body, a person should exercise at least 20-30 minutes 3 to 4 times a week.

☐ True ☐ False ☐ ?

17. Aerobic exercises are the best exercises to strengthen your heart.

☐ True ☐ False ☐ ?

18. Weight lifting is a good way to strengthen your heart.

☐ True ☐ False ☐ ?

19. Exercise affects how much fat you have in your body.

☐ True ☐ False ☐ ?

20. Being overweight increases the risk of diabetes.

☐ True ☐ False ☐ ?

21. People who are overweight are less likely to get gall bladder disease.

☐ True ☐ False ☐ ?

22. Drinking plenty of water helps maintain body temperature.

☐ True ☐ False ☐ ?

23. Most teenagers eat too much salt and sugar.

☐ True ☐ False ☐ ?

24. A well balanced diet includes protein, vitamins, minerals, fat, carbohydrates, and water.

☐ True ☐ False ☐ ?

25. You can have breast cancer and not know it.

☐ True ☐ False ☐ ?

26. Meat is a good source of carbohydrates.

☐ True ☐ False ☐ ?

27. Fish is a good source of protein.

☐ True ☐ False ☐ ?

28. Fruits are a good source of fiber.

☐ True ☐ False ☐ ?

29. Eating fiber is a good way of preventing colon cancer.

☐ True ☐ False ☐ ?

30. Protein helps build cells, strengthens your body to fight against infection, and helps give you healthy hair.

☐ True ☐ False ☐ ?

31. Fluoride in drinking water is good for preventing tooth decay.

☐ True ☐ False ☐ ?

G. HEALTH ATTITUDES

How do you feel about the following actions?

1	2	3	4	5
Very Bad Idea	**Bad Idea**	**In The Middle**	**Good Idea**	**Very Good Idea**

1. How do you feel about smoking cigarettes?	1	2	3	4	5
2. How do you feel about exercising 3 to 4 times a week for at least 20 minutes?	1	2	3	4	5
3. How do you feel about having a balanced diet every day?	1	2	3	4	5
4. How do you feel about doing monthly breast self-examinations (BSE)?	1	2	3	4	5
5. How do you feel about decreasing the amount of salt in your diet?	1	2	3	4	5
6. How do you feel about decreasing the amount of fat in your diet?	1	2	3	4	5
7. How do you feel about increasing the amount of dietary fiber in your diet?	1	2	3	4	5

The following questions ask about how likely it is that you will do certain things.

1	2	3	4	5
Very Unlikely	**Unlikely**	**In The Middle**	**Likely**	**Very Likely**

8. How likely is it that you will smoke cigarettes?	1	2	3	4	5
9. How likely is it that you will exercise 3 to 4 times a week for at least 20 minutes?	1	2	3	4	5
10. How likely is it that you will have a balanced diet every day?	1	2	3	4	5
11. How likely is it that you will do a breast					

self-examination (BSE) in the next 1 month?	1	2	3	4	5
12. How likely is it that you will decrease the amount of salt in your diet?	1	2	3	4	5
13. How likely is it that you will decrease the amount of fat in your diet ?	1	2	3	4	5
14. How likely is it that you will increase the amount of dietary fiber in your diet ?	1	2	3	4	5

H. ALCOHOL AND DRUG USE

1. Have you ever drunk any of the following alcoholic beverages?

Beer ☐ No ☐ Yes

Wine/Wine Coolers ☐ No ☐ Yes

Hard Liquor ☐ No ☐ Yes

2. How many drinks of the following do you have per week?

_____ 12 oz servings of beer (a bottle or can) per week

_____ 4 oz servings of wine or a 12 oz wine cooler per week (one wine glass or a wine cooler bottle)

_____ 1 1/2 oz serving of liquor (a shot- average size used in a mixed drink) per week

3. Have you ever used Marijuana, Cocaine, Crack, PCP, Valium, Xanex, Heroin, Uppers or Downers?

☐ No, I have never used any of these drugs.

☐ Yes, I have used at least one of these drugs at least once.

4. Have you ever used an IV or hypodermic needle to shoot up drugs?

☐ No ☐ Yes

If NO, do not answer questions 5 and 6, skip to question 7.

5. Have you ever shared hypodermic needles (works) with another person?

☐ No ☐ Yes

If NO, do not answer question 6, go to question 7.

The following questions ask about your activites in the past month (30 days).

6. In the past month, on how many days did you share hypodermic needles (works) with another person?_____

7. Have you ever smoked cigarettes?

☐ No, I have never smoked

☐ Yes, I smoke now.

☐ Yes, but I quit smoking.

8. In the past month, about how many cigarettes did you smoke?

☐ I did not smoke at all.

☐ I smoked a few cigarettes a month.

☐ I smoked a few cigarettes a week.

☐ I smoked about a half a pack of cigarettes (10) a day.

☐ I smoked about 1 pack of cigarettes (20) a day.

☐ I smoked about 1 1/2 packs of cigarettes a day.

☐ I smoked about 2 packs of cigarettes a day.

☐ I smoked more than 2 packs of cigarettes a day.

9. In the past month, how often did you drink any kind of alcoholic beverage?

- ☐ Never
- ☐ Only 1 time
- ☐ 2 or 3 times
- ☐ 1 time a week
- ☐ 2 times a week
- ☐ 3 or 4 times a week
- ☐ Almost every day
- ☐ Every day

10. In the past month, how often did you smoke marijuana? (circle one)

- ☐ I did not smoke marijuana at all
- ☐ Only 1 time
- ☐ 2 or 3 times
- ☐ 1 time a week
- ☐ 2 times a week
- ☐ 3 or 4 times a week
- ☐ Almost every day
- ☐ Every day

11. In the past month, how often did you use cocaine? (circle one)

- ☐ I did not use cocaine at all
- ☐ Only 1 time
- ☐ 2 or 3 times
- ☐ 1 time a week
- ☐ 2 times a week
- ☐ 3 or 4 times a week
- ☐ Almost every day
- ☐ Every day

12. In the past month, how often did you use crack? (circle one)

- ☐ I did not use crack at all
- ☐ Only 1 time
- ☐ 2 or 3 times
- ☐ 1 time a week
- ☐ 2 times a week
- ☐ 3 or 4 times a week
- ☐ Almost every day
- ☐ Every day

13. In the past month, how often did you use PCP? (circle one)

- ☐ I did not use PCP at all
- ☐ Only 1 time
- ☐ 2 or 3 times
- ☐ 1 time a week
- ☐ 2 times a week
- ☐ 3 or 4 times a week
- ☐ Almost every day
- ☐ Every day

14. In the past month, how often did you use valium? (circle one)

- ☐ I did not use valium at all
- ☐ Only 1 time
- ☐ 2 or 3 times
- ☐ 1 time a week
- ☐ 2 times a week
- ☐ 3 or 4 times a week
- ☐ Almost every day
- ☐ Every day

15. In the past month, how often did you use Xanex? (circle one)

- ☐ I did not use Xanex at all
- ☐ Only 1 time
- ☐ 2 or 3 times
- ☐ 1 time a week
- ☐ 2 times a week
- ☐ 3 or 4 times a week
- ☐ Almost every day
- ☐ Every day

16. In the past month, how often did you use heroin? (circle one)

- ☐ I did not use heroin at all
- ☐ Only 1 time
- ☐ 2 or 3 times
- ☐ 1 time a week
- ☐ 2 times a week
- ☐ 3 or 4 times a week
- ☐ Almost every day
- ☐ Every day

17. In the past month, how often did you use uppers/downers? (circle one)

- ☐ I did not use uppers/downers at all
- ☐ Only 1 time
- ☐ 2 or 3 times
- ☐ 1 time a week
- ☐ 2 times a week
- ☐ 3 or 4 times a week
- ☐ Almost every day
- ☐ Every day

I. MOTHER-DAUGHTER COMMUNICATION

The following questions are about you and your mom (or the person you consider to be your female guardian.) Please circle Yes if you discussed the topic with your mother. Circle No if you did not discuss the topic with her. Circle "?" if you do not know whether you discussed it with her.

1. Have you and your mother ever talked about menstruation?	☐ No	☐ Yes
2. Have you and your mother ever talked about pregnancy?	☐ No	☐ Yes
3. Have you and your mother ever talked about the father's part in conception?	☐ No	☐ Yes
4. Have you and your mother ever talked about sexual intercourse?	☐ No	☐ Yes
5. Have you and your mother ever talked about masturbation?	☐ No	☐ Yes
6. Have you and your mother ever talked about birth control?	☐ No	☐ Yes
7. Have you and your mother ever talked about AIDS?	☐ No	☐ Yes
8. Have you and your mother ever talked about condoms?	☐ No	☐ Yes
9. Have you and your mother ever discussed whether she should know if you are using birth control?	☐ No	☐ Yes
10. Have you and your mother ever discussed your dating relationships?	☐ No	☐ Yes
11. Have you and your mother ever discussed teen pregnancy?	☐ No	☐ Yes

12. Have you and your mother ever discussed abortion? ☐ No ☐ Yes

13. Have you and your mother ever discussed sexually transmitted diseases? ☐ No ☐ Yes

14. Have you and your mother ever discussed male-female psychological differences? ☐ No ☐ Yes

15. Have you and your mother ever discussed love and/or marriage? ☐ No ☐ Yes

16. Have you and your mother ever discussed sexual morality- for example, whether sex before marriage is right or wrong? ☐ No ☐ Yes

17. Have you and your mother ever discussed her sexual values?

☐ No ☐ Yes, think so ☐ Indirectly ☐ Don't Know

18. Thinking back and thinking about right now, how easy is it to talk to your mother about sex?

1	2	3	4	5
Very Hard	Hard	In The Middle	Easy	Very Easy

J. CBQ

The statements below are about you and your mother (or the person you consider to be your female guardian). Read the statement and then decide if you believe the statement is true or false. Please circle TRUE for each statement that you think is true; circle FALSE for each one you think is false. Please answer all items. Your answers will not be shown to your mother (or female guardian).

1. My mom doesn't understand me.	☐ No	☐ Yes
2. My mom and I sometimes end our arguments calmly.	☐ No	☐ Yes
3. My mom understands me.	☐ No	☐ Yes
4. We almost never seem to agree.	☐ No	☐ Yes
5. I enjoy the talks we have.	☐ No	☐ Yes
6. When I state my own opinion, she gets upset.	☐ No	☐ Yes
7. At least three times a week we get angry at each other.	☐ No	☐ Yes
8. My mother listens when I need someone to talk to.	☐ No	☐ Yes
9. My mom is a good friend to me.	☐ No	☐ Yes
10. She says I have no consideration for her.	☐ No	☐ Yes
11. At least once a day we get angry at each other.	☐ No	☐ Yes
12. My mother is bossy when we talk.	☐ No	☐ Yes
13. The talks we have are frustrating.	☐ No	☐ Yes
14. My mom understands my point of view, even when she doesn't agree with me.	☐ No	☐ Yes
15. My mom seems to be always complaining about me.	☐ No	☐ Yes
16. In general, I don't think we get along very well.	☐ No	☐ Yes
17. My mom screams a lot.	☐ No	☐ Yes

18. My mom puts me down. ☐ No ☐ Yes

19. If I run into problems, my mom helps me out. ☐ No ☐ Yes

20. I enjoy spending time with my mother. ☐ No ☐ Yes

K. RELIGION

1. What is your religion?

☐ Baptist ☐ Seventh Day Adventist

☐ Protestant ☐ Muslim

☐ Catholic ☐ Five Percenter (5%er)

☐ Jehovah's Witness ☐ None

☐ Jewish 10. ☐ Other (specify) _____

2. How religious are you?

1	2	3	4	5
Not Religious at All				Very Religious

3. How often do you attend church?

1	2	3	4	5
Not at All				Very Often

4. How active in the church are you?

1	2	3	4	5
Not Active at All				Very Active

5. How often do you read the Bible?

1	2	3	4	5
Never	Sometimes	Often	Every Week	Almost Every Day

6. How often do you say grace before you eat?

1	2	3	4	5
Never	Sometimes	Often	Regularly	Always

7. How often do you pray before going to bed?

1	2	3	4	5
Never	Sometimes	Often	Regularly	Always

L. ASSERTIVENESS SCHEDULE

Directions: Circle the number that best describes how accurately the following statements describe you.

1 Not at All Like Me	**2 Not Much Like Me**	**3 In the Middle**	**4 Somewhat Like Me**	**5 Very Much Like Me**

1. I have stopped myself from making or accepting dates because of “shyness”.	1	2	3	4	5
2. When the food at restaurants is not done the way I want, I complain to the waiter or waitress.	1	2	3	4	5
3. I try not to hurt other people’s feelings, even when I think that I have been hurt.	1	2	3	4	5
4. When someone asks me to do something, I always want to know why.	1	2	3	4	5
5. People try to use me a lot.	1	2	3	4	5
6. I usually don’t know what to say to a good-looking guy.	1	2	3	4	5

7. I feel uncomfortable making phone calls to stores and businesses.	1	2	3	4	5
8. I would rather apply for a job or admission to college by writing letters than by going to a personal interview.	1	2	3	4	5
9. I think it is embarrassing to return things I have bought at stores.	1	2	3	4	5
10. I have stopped myself from asking questions because I was scared of sounding stupid.	1	2	3	4	5
11. When I have an argument with someone, sometimes I am afraid that I will get so upset that I will	1	2	3	4	5
12. I try not to argue with salespeople about prices.	1	2	3	4	5
13. If someone has been spreading false and bad rumors about me, I "have a talk" with them about it.	1	2	3	4	5
14. I usually have a hard time saying "No".	1	2	3	4	5
15. I usually keep my feelings inside instead of making a scene.	1	2	3	4	5
16. I complain about bad service in a restaurant and other places.	1	2	3	4	5
17. Anyone who tries to push ahead of me in line (cut in line) is in for a good fight.	1	2	3	4	5
18. I express my opinions a lot.	1	2	3	4	5
19. There are times when I just can't say anything.	1	2	3	4	5

M. OPINIONS ABOUT SEX

Please respond to each item as honestly as you can. There are no right or wrong answers. Circle the number that best describes how much you agree or disagree with each statement.

	1 Disagree Strongly	2 Disagree	3 In the Middle	4 Agree	5 Agree Strongly
1. I would enjoy looking at hard-core pornography ("porno").	1	2	3	4	5
2. Pornography is obviously filthy and people should not try to describe it as anything else.	1	2	3	4	5
3. Swimming in the nude with a member of the other sex would be an enjoyable experience.	1	2	3	4	5
4. Masturbation (playing with yourself) can be an enjoyable experience.	1	2	3	4	5
5. If I found out that a close friend of mine was gay (homosexual) it would upset me.	1	2	3	4	5
6. If people thought I was interested in oral sex, I would be embarrassed.	1	2	3	4	5
7. Having group sex (a group of people having sex with each other at the same time) is an entertaining idea.	1	2	3	4	5
8. Thinking about having sex is exciting.	1	2	3	4	5
9. Seeing a pornographic movie would be sexually exciting.	1	2	3	4	5
10. I am not worried about being homosexual (gay).	1	2	3	4	5

11. The idea of my being physically attracted to members of the same sex is not depressing.	1	2	3	4	5
12. Almost all pornographic material makes me feel unconfortable.	1	2	3	4	5
13. It would be emotionally upsetting to me to see someone exposing themselves in public.	1	2	3	4	5
14. Watching a stripper of the other sex would not be very sexually exciting.	1	2	3	4	5
15. I would not enjoy seeing a pornographic ("porno") movie.	1	2	3	4	5
16. When I think about seeing pictures showing someone of the same sex as myself masturbating (playing with himself or herself) it makes me feel uncomfortable.	1	2	3	4	5
17. The thought of engaging in unusual sexual behaviors is highly exciting.	1	2	3	4	5
18. Playing with myself would probably be an exciting experience.	1	2	3	4	5
19. I do not enjoy daydreaming about sex.	1	2	3	4	5
20. I am not curious about pornography.	1	2	3	4	5
21. The thought of having long-term sexual relations with more than one sex partner is not disgusting to me.	1	2	3	4	5

N. PERCEIVED RISK

What are the chances of the following?

	1 Disagree Strongly	2 Disagree	3 In the Middle	4 Agree	5 Agree Strongly
1. How likely is it that you will get HIV?	1	2	3	4	5
2. How likely is it that any of your friends will get HIV?	1	2	3	4	5

How much do you agree or disagree with the following statements?

	1 Disagree Strongly	2 Disagree	3 In the Middle	4 Agree	5 Agree Strongly
3. I am not the kind of person who can get AIDS.	1	2	3	4	5
4. There is a good chance that some of my friends will eventually get AIDS.	1	2	3	4	5
5. There is a good chance that I will eventually get AIDS.	1	2	3	4	5
6. I am worried that I could get AIDS.	1	2	3	4	5

Any comments you wish to make about the questions are welcome:

If you are finished, check over the booklet

for any questions you forgot to answer.

Then sit quietly and do not disturb the others.

THANK YOU!

POST-QUESTIONNAIRE

Date: _____

The questions in this booklet ask about your attitudes, beliefs, feelings, knowledge and experiences about yourself. Some of the questions are very personal and ask about different sexual activities that some people do. These particular questions are very blunt and to the point, questions you probably have never seen on a questionnaire before. Most of the questions are not like this, however. If the questions bother you so much that you do not want to answer them, you can stop filling out the questionnaires. We warn you about the questions that are personal and blunt so that you will not be surprised when you see them. Please answer all of the questions honestly. Your answers will be kept private and strictly confidential. If you wish to comment on any questions or explain your answers, please feel free to write in the space in the margins. Your comments will be read and taken into account. Do not write your name on this questionnaire.

IMPORTANT!

WRITE YOUR CODE NUMBER HERE: _____

A. AIDS/STD TRUE-FALSE ITEMS

TRUE or FALSE. Some of the statements below are true; some are false. Please check T for each statement that you think is TRUE; check F for each one you think is FALSE; and check "?" if you DO NOT KNOW whether the statement is true or false. The term STD means Sexually Transmitted Disease.

1. A common symptom of STDs in a man is discharge (drip) from his penis.

   ☐ T ☐ F ☐ ?

2. A common symptom of STDs is burning with urination (peeing).

   ☐ T ☐ F ☐ ?

3. A common symptom of STDs is a sore on the penis or vagina.

   ☐ T ☐ F ☐ ?

4. A common symptom of STDs in a woman is discharge from her vagina that causes itching or burning.

   ☐ T ☐ F ☐ ?

5. If you feel healthy you don't have an STD.

   ☐ T ☐ F ☐ ?

6. A woman who has an STD can get an infection in her uterus and tubes.

   ☐ T ☐ F ☐ ?

7. A pregnant woman who has an STD can give it to her baby.

   ☐ T ☐ F ☐ ?

8. There are medicines to cure all types of STDs.

   ☐ T ☐ F ☐ ?

9. Using a condom when you have sex will help protect you against STDs.

   ☐ T ☐ F ☐ ?

10. Contact with a dirty toilet seat is a common cause of STDs.

    ☐ T ☐ F ☐ ?

11. If you have a STD your sexual partner probably has it too.

☐ T ☐ F ☐ ?

12. AIDS is a medical condition in which your body cannot fight off diseases.

☐ T ☐ F ☐ ?

13. Stress causes AIDS.

☐ T ☐ F ☐ ?

14. If you kiss someone with AIDS you will get the disease.

☐ T ☐ F ☐ ?

15. All gay men have AIDS.

☐ T ☐ F ☐ ?

16. Anyone can get AIDS.

☐ T ☐ F ☐ ?

17. AIDS is not at all serious, it is like having a cold.

☐ T ☐ F ☐ ?

18. The cause of AIDS is unknown.

☐ T ☐ F ☐ ?

19. Just being around someone with AIDS can give you the disease.

☐ T ☐ F ☐ ?

20. Using a condom during sex can lower the risk of getting AIDS.

☐ T ☐ F ☐ ?

21. Receiving a blood transfusion with infected blood can give a person AIDS.

☐ T ☐ F ☐ ?

22. Having AIDS makes you more likely to get other diseases.

☐ T ☐ F ☐ ?

23. All gay women have AIDS.

☐ T ☐ F ☐ ?

24. I can avoid getting AIDS by exercising regularly.

☐ T ☐ F ☐ ?

25. AIDS can be cured if treated early.

☐ T ☐ F ☐ ?

26. A person can have the AIDS virus and give it to other people even if he does not look sick.

☐ T ☐ F ☐ ?

27. Only gay men and people who shoot up drugs get AIDS.

☐ T ☐ F ☐ ?

28. AIDS is not a problem among Blacks and Hispanics.

☐ T ☐ F ☐ ?

29. Condoms are 100% effective against AIDS.

☐ T ☐ F ☐ ?

30. Having sex with a man who shoots drugs is a way many women get AIDS.

☐ T ☐ F ☐ ?

31. There is a bigger chance of getting AIDS if you have sex with many people.

☐ T ☐ F ☐ ?

32. There is a bigger chance that a woman will get AIDS if she has sex with a guy who has sex with many other women.

☐ T ☐ F ☐ ?

33. Having anal sex with a guy (i.e., his penis in your anus/behind) increases your chance of getting AIDS.

☐ T ☐ F ☐ ?

34. Using Vaseline as a lubricant when you have sex lowers the chance of getting AIDS.

☐ T ☐ F ☐ ?

35. Using a spermicide (birth control foam or jelly containing Nonoxynol-9) when you have sex lowers the chance of getting AIDS.

☐ T ☐ F ☐ ?

36. Doing oral sex on a guy (your mouth on his penis) increases your chance of getting AIDS.

☐ T ☐ F ☐ ?

37. You can catch AIDS like you catch a cold because the AIDS virus can be carried in the air.

☐ T ☐ F ☐ ?

38. You can not get AIDS from sex if you have sex with only one person during your whole life.

☐ T ☐ F ☐ ?

39. There is a good chance you will get AIDS if you share a sink, shower, or toilet seat with someone who has AIDS.

☐ T ☐ F ☐ ?

40. There is a good chance you will get AIDS if you drink from the same glass or eat from the same plate as someone who has AIDS.

☐ T ☐ F ☐ ?

41 The AIDS virus is present in certain body fluids, mainly semen and blood.

☐ T ☐ F ☐ ?

42. Persons infected with the AIDS virus by shooting drugs are not likely to pass the virus to sex partners unless the partners also shoot drugs.

☐ T ☐ F ☐ ?

43. The penis should be erect when the condom is put on it.

☐ T ☐ F ☐ ?

44. When a condom is placed on the penis, space should be left at the tip of the condom.

☐ T ☐ F ☐ ?

45. The condom should be completely unrolled before it is placed on the penis.

☐ T ☐ F ☐ ?

46. Condoms can be reused.

☐ T ☐ F ☐ ?

47. To remove a condom after sex, grasp the tip and remove it gently but swiftly.

☐ T ☐ F ☐ ?

48. Storing or carrying condoms in a hot or warm place can destroy their effectiveness.

☐ T ☐ F ☐ ?

B. SEXUAL ATTITUDES

The following questions ask how you feel about different behaviors. Please indicate how good or bad an idea it is to do the following, whether others would approve or disapprove of the behavior, and whether you plan to do these behaviors in the next 3 months (90 days). Circle the NUMBER that best describes your feelings. Sexual intercourse refers to a male putting his penis in a female's vagina. (Try to answer the questions even if you have not had sexual intercourse or have never used condoms.)

How would the following people feel about you having sex in the next 3 months? (Circle one)

	1 Disapprove Strongly	**2 Disapprove**	**3 In the Middle**	**4 Approve**	**5 Approve Strongly**
1. Yourself	1	2	3	4	5
2. Most people who are important to you	1	2	3	4	5
3. Your sexual partner	1	2	3	4	5
4. Your mother	1	2	3	4	5
5. Your father	1	2	3	4	5
6. Your friends	1	2	3	4	5

7. How likely is it that you will decide to have sexual intercourse in the next 3 months? (45)

1	2	3	4	5
Very Unlikely	Unlikely	In the Middle	Likely	Very Likely

Try to answer the following questions even if you have not had sex or have never used condoms. How would the following people feel about you using a condom if you have sex in the next 3 months? (Circle one)

	1 Disapprove Strongly	**2 Disapprove**	**3 In the Middle**	**4 Approve**	**5 Approve Strongly**
8. Yourself	1	2	3	4	5
9. Most people who are important to you	1	2	3	4	5
10. Your sexual partner	1	2	3	4	5
11. Your mother	1	2	3	4	5
12. Your father	1	2	3	4	5
13. Your friends	1	2	3	4	5

14. How likely is it that you will decide to use a condom if you have sex in the next 3 months?

1	2	3	4	5
Very Unlikely	Unlikely	In the Middle	Likely	Very Likely

Try to answer the following questions even if you have not had sex or have never used condoms. How would the following people feel about you using birth control pills if you have sex in the next 3 months? (Circle one)

	1 Disapprove Strongly	**2 Disapprove**	**3 In the Middle**	**4 Approve**	**5 Approve Strongly**
15. Yourself	1	2	3	4	5
16. Most people who are important to you	1	2	3	4	5
17. Your sexual partner	1	2	3	4	5

18. Your mother	1	2	3	4	5
19. Your father	1	2	3	4	5
20. Your friends	1	2	3	4	5

21. How likely is it that you will decide to use birth control pills if you have sex in the next 3 months?

1	2	3	4	5
Very Unlikely	Unlikely	In the Middle	Likely	Very Likely

In general, how important are the following people's opinons to you? (Circle One)

1 Completely Unimportant	**2 Unimportant**	**3 Neutral**	**4 Important**	**5 Very Important**
22. Your sexual partner	1	2	3	4	5
23. Your mother	1	2	3	4	5
24. Your father	1	2	3	4	5
25. Your friends	1	2	3	4	5

Now, we would like to ask you some questions about you using condoms. How much do you agree or disagree with each of the following statements about condoms? Try to answer the questions even if you have not had sex or have never used condoms. (Circle One)

1 Disagree Strongly	**2 Disagree**	**3 In the Middle**	**4 Agree**	**5 Agree Strongly**
1. Sex wouldn't feel as good if my partner and I used a condom.	1	2	3	4	5
2. Condoms are embarrassing to use.	1	2	3	4	5
3. Condoms help prevent STDs.	1	2	3	4	5
4. Condoms help prevent pregnancy.	1	2	3	4	5

5. Sex feels unnatural when a condom is used.	1	2	3	4	5
6. Condoms help prevent HIV.	1	2	3	4	5
7. Condoms ruin the mood because you have to stop to put one on.	1	2	3	4	5
8. Sex still feels good when a condom is used.	1	2	3	4	5
9. Having sex is more fun when a condom is used.	1	2	3	4	5
10. Using a condom breaks up the rhythm and timing of sex.	1	2	3	4	5
11. Saying we have to use a condom would make my sexual partner think I am having sex with other people.	1	2	3	4	5
12. Saying we have to use a condom is like saying to my partner, "I don't trust you."	1	2	3	4	5
13. My sexual partner would break up with me if I said we had to use a condom.	1	2	3	4	5
14. My sexual partner would be happier if we used a condom.	1	2	3	4	5
15. If I had a condom with me, my partner would not like it.	1	2	3	4	5
16. All in all, it's a good idea to use condoms.					
17. Condoms cost too much.	1	2	3	4	5
18. It is easy for me to have a condom with me all of the time.	1	2	3	4	5
19. It is hard for me to get condoms.	1	2	3	4	5
20. It is too much trouble to carry around condoms.	1	2	3	4	5
21. I can get condoms.	1	2	3	4	5
22. I can't talk to my partner about using condoms.	1	2	3	4	5

23. I can get my partner to use a condom, even if he doesn't want to.	1	2	3	4	5
24. I can say to my partner that we should use a condom.	1	2	3	4	5
25. Before we are ready to have sex, I can talk to my partner about using a condom.	1	2	3	4	5
26. I can put a condom on my partner without ruining the mood.	1	2	3	4	5
27. If I am sexually aroused I can stop before sex to use a condom.	1	2	3	4	5
28. I can say no to sex if my partner and I don't have a condom.	1	2	3	4	5
29. I can stop sex to get a condom, if I don't have one.	1	2	3	4	5
30. I can use a condom, even if the room is dark.	1	2	3	4	5
31. I can get my partner to use a condom without ruining the mood.	1	2	3	4	5
32. I am sure that I can use a condom if I have sex.	1	2	3	4	5
33. I will try to get my sexual partner to use condoms if we have sex in the next 3 months.	1	2	3	4	5
34. I want to use condoms if I have sex in the next 3 months.	1	2	3	4	5
35. I plan to use condoms if I have sex in the next 3 months.	1	2	3	4	5

C. HARD OR EASY?

Sometimes we want to do something, but it's hard to do it. For the statements below, circle the number that best expresses how easy or hard it would be for you to do each of the things listed. Use any number from 1 to 5. The higher the number, the easier you think it is to do the behavior. The lower the number, the harder you think it is to do the behavior. (Circle One)

1	2	3	4	5
Very Hard	**Hard**	**In the Middle**	**Easy**	**Very Easy**

1.	How easy or hard would it be for you to get your partner to use condoms during sex, even if he didn't want to?	1	2	3	4	5
2.	How easy or hard would it be for you to get your partner to not have sex with you, even if he wanted to?	1	2	3	4	5
3.	How easy or hard would it be for you to get your partner to talk to you about preventing STDs, even if he didn't want to?	1	2	3	4	5
4.	How easy or hard would it be for you to get your partner to talk to you about ways you could prevent AIDS, even if he didn't want to?	1	2	3	4	5
5.	How easy or hard would it be for you to get your partner to let you use contraceptive foam or jelly when you have sex, even if he didn't want to?	1	2	3	4	5
6.	How easy or hard would it be to use condoms when you have sex?	1	2	3	4	5
7.	How easy or hard would it be to use contraceptive foam or jelly when you have sex?	1	2	3	4	5

D. HEALTH KNOWLEDGE

TRUE or FALSE. Some of the statements below are true; some are false. Please circle T for each statement that you think is TRUE; circle F for each one you think is FALSE; and circle "?" if you DO NOT KNOW whether the statement is true or false.

1. Smoking cigarettes does not affect your blood pressure.

   ☐ True ☐ False ☐ ?

2. A pregnant woman can smoke because it doesn't hurt her baby.

   ☐ True ☐ False ☐ ?

3. Being around someone who smokes cigarettes is not very dangerous to one's health.

   ☐ True ☐ False ☐ ?

4. Smoking doesn't hurt the heart very much.

   ☐ True ☐ False ☐ ?

5. Carbon monoxide in cigarette smoke takes the place of oxygen in the blood.

   ☐ True ☐ False ☐ ?

6. Low-tar and low-nicotine cigarettes are very safe to smoke.

   ☐ True ☐ False ☐ ?

7. Cigarette smoking makes the heart beat slower.

   ☐ True ☐ False ☐ ?

8. Smoking is not addictive.

   ☐ True ☐ False ☐ ?

9. High blood pressure can be caused by drinking too much water.

   ☐ True ☐ False ☐ ?

10. You can have high blood pressure and not know it.

☐ True ☐ False ☐ ?

11. When you have hypertension, that means you are too tense.

☐ True ☐ False ☐ ?

12. When breast cancer is diagnosed early, the rate of cure can be as high as 85%.

☐ True ☐ False ☐ ?

13. 1 in 9 women will get breast cancer.

☐ True ☐ False ☐ ?

14. 4 out of 5 women who get breast cancer have no family history of it.

☐ True ☐ False ☐ ?

15. A mammogram is an x-ray of your breast.

☐ True ☐ False ☐ ?

16. To have a healthy body, a person should exercise at least 20-30 minutes 3 to 4 times a week.

☐ True ☐ False ☐ ?

17. Aerobic exercises are the best exercises to strengthen your heart.

☐ True ☐ False ☐ ?

18. Weight lifting is a good way to strengthen your heart.

☐ True ☐ False ☐ ?

19. Exercise affects how much fat you have in your body.

☐ True ☐ False ☐ ?

20. Being overweight increases the risk of diabetes.

☐ True ☐ False ☐ ?

21. People who are overweight are less likely to get gall bladder disease.

☐ True ☐ False ☐ ?

22. Drinking plenty of water helps maintain body temperature.

☐ True ☐ False ☐ ?

23. Most teenagers eat too much salt and sugar.

☐ True ☐ False ☐ ?

24. A well balanced diet includes protein, vitamins, minerals, fat, carbohydrates, and water.

☐ True ☐ False ☐ ?

25. You can have breast cancer and not know it.

☐ True ☐ False ☐ ?

26. Meat is a good source of carbohydrates.

☐ True ☐ False ☐ ?

27. Fish is a good source of protein.

☐ True ☐ False ☐ ?

28. Fruits are a good source of fiber.

☐ True ☐ False ☐ ?

29. Eating fiber is a good way of preventing colon cancer.

☐ True ☐ False ☐ ?

30. Protein helps build cells, strengthens your body to fight against infection, and helps give you healthy hair.

☐ True ☐ False ☐ ?

31. Fluoride in drinking water is good for preventing tooth decay.

☐ True ☐ False ☐ ?

E. HEALTH ATTITUDES

How do you feel about the following actions?

	1 Very Bad Idea	2 Bad Idea	3 In the Middle	4 Good Idea	5 Very Good Idea
1. How do you feel about smoking cigarettes?	1	2	3	4	5
2. How do you feel about exercising 3 to 4 times a week for at least 20 minutes?	1	2	3	4	5
3. How do you feel about having a balanced diet every day?	1	2	3	4	5
4. How do you feel about doing monthly breast self-examinations (BSE)?	1	2	3	4	5
5. How do you feel about decreasing the amount of salt in your diet?	1	2	3	4	5
6. How do you feel about decreasing the amount of fat in your diet?	1	2	3	4	5
7. How do you feel about increasing the amount of dietary fiber in your diet?	1	2	3	4	5

The following questions ask about how likely it is that you will do certain things.

	1 Very Unlikely	2 Unlikely	3 In the Middle	4 Likely	5 Very Likely
8. How likely is it that you will smoke cigarettes?	1	2	3	4	5
9. How likely is it that you will exercise 3 to 4 times a week for at least 20 minutes?	1	2	3	4	5
10. How likely is it that you will have a balanced diet every day?	1	2	3	4	5
11. How likely is it that you will do a breast self-examination (BSE) in the next 1 month?	1	2	3	4	5

12. How likely is it that you will decrease the amount of salt in your diet?	1	2	3	4	5
13. How likely is it that you will decrease the amount of fat in your diet ?	1	2	3	4	5
14. How likely is it that you will increase the amount of dietary fiber in your diet ?	1	2	3	4	5

F. PERCEIVED RISK

What are the chances of the following?

	1 Disagree Strongly	**2 Disagree**	**3 In the Middle**	**4 Agree**	**5 Agree Strongly**
1. How likely is it that you will get HIV?	1	2	3	4	5
2. How likely is it that any of your friends will get HIV?	1	2	3	4	5

How much do you agree or disagree with the following statements?

	1 Disagree Strongly	**2 Disagree**	**3 In the Middle**	**4 Agree**	**5 Agree Strongly**
3. I am not the kind of person who can get AIDS.	1	2	3	4	5
4. There is a good chance that some of my friends will eventually get AIDS.	1	2	3	4	5
5. There is a good chance that I will eventually get AIDS.	1	2	3	4	5
6. I am worried that I could get AIDS.	1	2	3	4	5

G. DEBRIEFING QUESTIONNAIRE

How much did you like or dislike the following?

1 Disliked Very Much	2 Disliked	3 In The Middle	4 Liked	5 Liked Very Much

1.	How much did you like today's activities?	1	2	3	4	5
2.	How much did you like the film part of today's activities?	1	2	3	4	5
3.	How much did you like the small group that you were in?	1	2	3	4	5
4.	How much did you like your group facilitator?	1	2	3	4	5
5.	How much did you like the activities you did in your group?	1	2	3	4	5

How much did you learn from the following?

1 Learned Very Little	2 Learned a Little	3 In The Middle	4 Learned a Lot	5 Learned Very Much

6. In general, how much did you learn from today's activities?
7. How much did you learn from the films you saw?
8. How much did you learn from the small group activities?
9. Would you recommend this project to other teenagers?

1 Would Not Recommend	2 Might Not Recommend	3 Might Recommend	4 Would Recommend	5 Would Strongly Recommend

Any comments you wish to make about the questions are welcome:

If you are finished, check over the booklet

for any questions you forgot to answer.

Then sit quietly and do not disturb the others.

THANK YOU!


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